



HIV WIDOWS OF ANANTHAPURAMU A SOCIO-MEDICAL STUDY

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Abstract

Women have greater susceptibility than men to HIV infection due to social, cultural and psychological reasons, and are now being infected at a higher rate. Though the HIV epidemic initially affected mostly men, today substantial number of people living with HIV is women. Feminization of HIV/AIDS is noticed across the Globe.

Approximately 17.8 million women living with HIV. Since the start of the global HIV epidemic, in many regions, women have remained at a much higher risk of HIV infection than men. Women account for more than half the total number of people living with HIV, all adults living with HIV were accessing treatment [UNAIDS, 2016]. Majority of the women were infected through their single sexual partners especially in their marital life. Women usually have a faith that they will not get infection since they have sex with their single sexual partner/husband. Therefore, majority of the women will not be aware of their infection till their pregnancy or the death of her faithful partner [UNAIDS, 2004].

The Present Study: The Study is based on a sample of 300 HIV Widows in Ananthapuramu district of Andhra Pradesh. The primary data was collected from the respondents by use of Standardized Schedule. The socio economic and medical conditions data pertaining to the respondents' reveal that majority of respondents are in the age group, socially backward, illiterate and from rural areas.

Conclusion: The study concludes that the life of HIV infected Widows is a struggle for them. Mostly widowed at a young age, they are left to fend their children with declining health and finance. They hope to face the life with the help of different CBOs, GOs and NGOs that is grossly inadequate.

Introduction

An overview of the global scenario is essential to understand the geographical spread of the epidemic. According to the World Health Organization (WHO), there were approximately 36.7 million People Living with HIV/AIDS (PLHIV) worldwide, including 17.8 million women, New HIV infections among adults have slowed in recent years, with the estimated annual number of new infections among adults remaining nearly static about 1.7 million in 2016. The number of people who are newly infected with HIV is continuing to decline in most parts of the globe. There are 1.8 million new HIV infected; including 160 000 children became newly infected with HIV in 2016, down from 290 000 in 2010. AIDS related deaths have come down to 1.0 millions compared to 1.5 millions in 2010¹.

India has the Third Largest HIV Epidemic in the Global. The total number of people living with HIV (PLHIV) in India is estimated at 21 lakhs in 2016¹. Children (<15 years) account for 6.54%, while 40.5% of total HIV infections are among women. India is estimated to have around 86 thousand new HIV infections in 2016. Children (<15 years) accounted for 12% (10.4 thousand) of total new infections while the remaining (75.9 thousand) new infections were among adults (15+years). In 2016 an estimated 67.6 thousand people died of AIDS-related causes nationally. **Andhra Pradesh has the highest number of HIV infected persons in India.** The HIV epidemic remains a major public health challenge in Andhra Pradesh, with an estimated 3 lakhs people living with HIV/AIDS. With highest burden of PLHIV, Andhra Pradesh account for 14% of all HIV infections in India².

Women and HIV/AIDS

Women are biologically more vulnerable to HIV infection than men. The major factors responsible for differential transmissions are the larger mucosal surface areas exposed to virus in women and the semen having high concentration of virus compared with vaginal secretions. Young girls are particularly vulnerable. Their immature cervix and relatively low vaginal mucus production presents less of barrier to HIV, making them biologically more vulnerable to infection than older pre-menopausal women³.

Majority of the Indian women were HIV infected through their single sexual partners in their marital life, as reported by Sujatha Rao, the former Director General of NACO. Women usually have a faith that they will not get infection since they have sex with their single sexual partner/husband. Therefore, majority of the women come to know of their HIV infection until their pregnancy or death of her partner⁴.

Socio-Economic Status (SES) is often measured as a combination of education, income and occupation. It is commonly conceptualized as the social standing or class of an individual or group. When viewed through a social class lens, privilege, power and control are emphasized. Furthermore, an examination of socio-economic status as a gradient or continuous



variable reveals inequities in access to and distribution of resources. Socio-Economic status is relevant to all realms of behavioural and social science.

HIV is a disease that is embedded in social and economic inequity, as it affects those of lower socioeconomic status at a disproportionately high rate⁵. Socio-Economic status often determines access to HIV treatment. Individuals of low socio-economic status have delayed treatment initiation relative to more affluent people, reducing their chances of survival⁶.

The Socio-Economic status of HIV Widows in Ananthapuramu

Ananthapuramu district was purposively selected for conduct of the present study. Locating Widows living with HIV/AIDS is a difficult task. Fearing stigma and discrimination the PLHIV and HIV Widows seldom share details with others. The Network, NGOs and CBOs the support the PLHIV and HIV Widows in the district reveal no information on the identity of the PLHIV/HIV Widows they work with and the data on them is confidential. The Ananta Network of 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 almost confidentiality of the HIV Widows, the researcher could gain access of HIV Widows across Ananthapuramu district and they constituted the universe for the study. Each one of these HIV Widows registered with Ananta Network of Positives (ANP+) was approached for collection of data collection. Hence the study is a sample study of **HIV WIDOWS** registered with Ananta Network of Positives (ANP+) who live across the district. The data was mostly collected by administering a standardized Schedule prepared for the purpose and from interacting with the other 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 and cross tables. The data pertain to respondents' socio-economic information that includes respondent's age, religion, caste, residential area, medical information, type of family and educational information.

Findings and Discussion

The profile of the respondents (Table 1) reveal that all the 300 HIV widows in the study were infected through their husbands and were through sexual transmission. Majority of the HIV widows that is over 41.3% belong to one particular age group of 36-45. More than 39.3% of the respondents are young widows, and were between the ages of 18-35, and HIV infections have devastated their lives. Majority of the respondents 81.3% are Hindus. It was found in the study that majority of the Christian respondents are Scheduled Castes on records but claim the benefits of meant for the Scheduled Castes. The HIV infection does not show any religious bias as the proportion of the respondents are more less or equal to proportion of Muslim and Christians percentage of population in the district. The respondents belong to Schedule caste is found to be 23.3% and only 17% of the respondents belong to forward caste. More than 55.3% of the respondents were from Backward Castes while 23.3% respondents were from Scheduled Castes, only 17% of the respondents belong to forward castes. Majority of the respondents 64.7% are illiterate and the remaining 35.3% are literate. 42.4% respondents have completed primary education, 12.2% respondents have studied up to high school, only 2.8% has obtained graduates and 4.7% was intermediated. Majority (58%) of the respondents is involved in manual work and is spread as agriculture labour, daily wage earners and domestic servant. A large majority of the respondents (53.8%) have a monthly income between Rs. 3000-6000, while a miniscule number of the respondents (24.4%) have an income less than Rs. 3000 a month, which is quite a meager amount in managing a household for people living with HIV/AIDS. More than 154 (51.3%) respondents are living in rural areas, 86 (28.6%) in urban areas and 60 (20%) in semi urban areas. 75% of the respondents are nuclear families and 25% of them lived in Joint families in general prior they being PLHIV.

The respondents were asked whether their HIV status was known to others and the data is presented in Table 2. As predictable, all the respondents (100%) said that all their family members knew about the HIV status of them. Friends, neighbours, relatives and community in that order know less about the HIV status of the respondents, it is also significant to know from the table that the majority of the respondents did not reveal about their HIV status to their relatives (41.6%) for they fear stigma and discrimination from their relatives. Around 69.3% of the respondents were advised by Ananta Network of Positives to go for HIV tests. As said earlier in case 66 respondents the doctors have advised the respondents to take HIV test after they suspected HIV in the widows. In about 87% of respondents the ANP+ through their staff initiated HIV test in the government ICTC/FIICTC facilities located across the district of Ananthapuramu. Around 73.7% of the respondents CD4 count is in between 200-500 and their health condition was said to be risky with opportunistic infections. Opportunistic Infections and management of ART are the main medical conditions related problems (Table 2) of the HIV widows in the study. 77.3% respondents said that they suffered from some or other Opportunistic Infections related to HIV and have to visit the doctor for treatment. The common opportunistic infections that the respondent reported include bacterial infections (17.3%), Candidacies (11.7%), Chronic Diarrhea (8.3%), Tuberculosis (7%), CMC retinitis (5%) and others 17%. The ART



services are available both in ART centres and Link ART centres and they provide ART treatment and also of pre ART services such as CD4 counts and the like. 63.3% of those on ART used ART centre facility. Whereas, 36.7% of them availed Link ART centre services. More than 57.4% of those on ART use ART centre in the Government General Hospital located in district headquarters and also the medical college. ANP+ that is located in the same premises offers other support services to the locals. 32% of those who are on ART are using Bathalapalle, RDT. As more than 43% of the have used support through CCC ART treatment, they have also used the other services offered by the same institution, and 29% of those on ART have used management of side effects service.

Conclusion

The HIV infected widows in the study were infected through their husbands and the HIV infection of the respondents was through sexual transmission. Poverty, socio economic backwardness, lack of health awareness migration and limited access of health care are the major factors which is the cause for more prevalence of HIV among people of rural areas. These limited resources would limit their choice for treatment and also for nutrition food which is must of PLHIV. Socio-Economic and Opportunistic Infections and management of ART are the main medical conditions related problems of the HIV widows in the study. The HIV widows are suffering from Opportunistic Infections related to HIV and have to visit the doctor for treatment.

Table 1: Socio-Economic Profile of the Respondents N=300

Variable	Particulars	Number	Percentage
Age	18-25	19	6.3
	26-35	99	33.0
	36-45	124	41.3
	46-55	58	19.3
Religion	Hindu	244	81.3
	Muslim	11	3.7
	Christian	45	15.0
Caste	Forward Caste	50	16.7
	Backward Caste	166	55.3
	Scheduled Caste	70	23.3
	Schedule Tribes	14	4.7
Education	Illiterate	194	64.7
	Literates	106	35.3
Level of Education (N= 106)	Primary education	45	42.4
	Upper education	40	37.7
	High school	13	12.2
	Intermediate	5	4.7
	Graduates	3	2.8
Occupation	Workers	262	87.3
	Non workers	38	12.7
Type of workers (N= 262)	Agricultural labour	34	11.3
	Daily wages	122	40.6
	Tailoring	31	10.3
	Petty business	44	14.7
	Domestic servant	18	6.0
	Salaried employment	21	7.0
	Unable to work due to poor health	38	12.7
Income	Less than 3000	64	24.4
	3000-6000	141	53.8
	6000-9000	44	16.7
	9000-12000	13	4.9
Residence	Rural	154	51.3
	Urban	86	28.6
	Semi-Urban	60	20.0
Type of Family	Joint	75	25.0
	Nuclear	225	75.0



Table 2: Medical conditions of the Respondents N=300

Variables	Particulars	Number	Percentage
Know about their HIV sero-status	Family members	300	100.0
	Friends	162	54.0
	Neighbours	157	52.3
	Relatives	125	41.6
	Community at large	96	32.0
HIV Test	Ananta Network of Positives	207	69.3
	Govt. Doctor	66	21.7
	NGOs	18	8.0
	Others	9	3.7
HIV Test Centre they visited	Govt. Test facility	261	87.0
	NGOs Test facility	36	12.0
	Private Test facility	3	1.0
CD4 Count	Less than 200	45	19.3
	200-500	171	73.7
	500-1000	63	27.1
	1000-1500	21	9.0
Suffered Opportunistic Infection (OI)	Suffered OI	232	77.3
	Did not suffer OI	68	22.7
Medical Complaint	Bacterial infection	52	17.3
	Candidacies	35	11.7
	Chronic Diarrhea	25	8.3
	Tuberculosis	21	7.0
	CMC Retinitis	15	5.0
	MAC	12	4.0
	Herpes zoster	10	3.3
	PCP	7	2.3
	Meningitis	4	1.3
	Others	51	17.0
On ART	Yes	207	69.0
	No	93	31.0
ART status (N= 207)	Pre ART	79	38.1
	On ART	128	61.9
Type of Centre (N= 207)	ART centre	131	63.3
	Link ART centre	76	36.7
Use of ART Centre (N= 207)	Ananthapuramu (NACO)	119	57.4
	Kadiri (NACO)	22	10.6
	Bathalapalle, RDT	66	32.0
Facilities you have used (N= 207)	Referral to CD4 Count	89	43.0
	Management of side effects	60	29.0
	Support through CCC	58	28.0

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