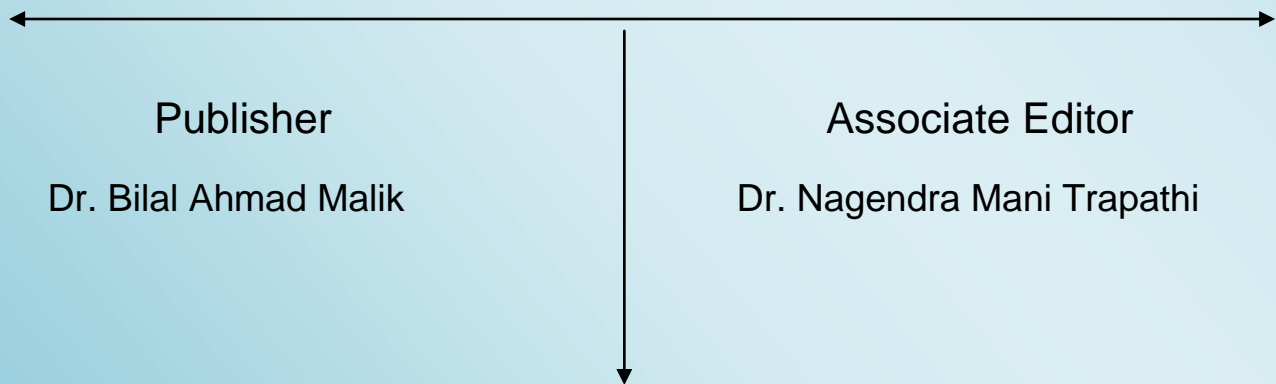


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THE SITUATIONAL ANALYSIS OF WOMEN LIVING WITH HIV/AIDS IN CHITTOOR DISTRICT OF ANDHRA PRADESH

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ABSTRACT

Chittoor is the largest district with 66 mandals and a long border with other districts and States, it also accounted for the highest number of the HIV positive cases. The reason for the increased presence of the HIV positive cases in the district was the huge influx of pilgrims into Tirupati located in the district, from different parts of the country. The district has a high epidemic potential with Moderate current transmission among HRG and GP with a large body of HRG to fuel and sustain further spread, given the large network of clients of female sex workers, as well as the female sex workers and men who have sex with men and transgender mapped in the urban areas. There is an urgent need to map the high-risk groups in the rural areas too, especially since 79% of the total district population is rural. The district has an estimated 7.5 FSWs and 3.7 MSM-T per thousand adult population.

Keywords: Women, Situational, Hiv, Aids, Chittoor, A.P

INTRODUCTION

There are certain groups, which are vulnerable to HIV/AIDS. Women are one such group. AIDS was first detected in the USA, in 1981 among male homosexuals. Initially there were more men being infected with AIDS virus than women, in the ratio of 10:1, but now the number of women infected with HIV is increasing. In 2003, 50% of all HIV infection were among women. By and large, HIV disease among women in the developing world has been acquired heterosexually (i.e. from man to woman). This is due to the following facts:

- ❖ HIV infection is transmitted more effectively during sexual contact from men to women;
- ❖ Lack of education and illiteracy among women;
- ❖ Cultural beliefs regarding the role of women in the family and society; and

❖ Lack of economic power among women.

All the above factors influence the relative vulnerability of women and their access to means of prevention and support in the face of AIDS.

Women who are infected with HIV infection can also transmit the HIV infection to others. For health care workers dealing with HIV positive women, it is important to understand the psycho-social and cultural issues as they have important implications for women and related issues such as child-bearing and breast-feeding.

Women are at risk of acquiring sexually transmitted infections and HIV infection because their reproductive organs are structured in such a way. Also almost 60 per cent of all sexually transmitted infections have no symptoms. Therefore even if a woman has one, she would not know it.

Women at the time of child birth may have several problems such as prolonged labour, caesarian section or forceps delivery. As a result of these procedures, injury to the genital tract, blood loss, risk of infection is common. Therefore it is important for women to take care of their reproductive health and have regular medical checks ups whether they have symptoms or not.

Women and young girls also suffer from biological vulnerability. Research shows that the risk of becoming infected with HIV during unprotected vaginal intercourse is as much as 2–4 times higher for women than men. Male-to-female transmission during vaginal intercourse is more efficient as women have a larger mucosal surface area exposed to their partner's semen, which has a higher concentration of HIV than a woman's vaginal secretions. In addition, women are also more vulnerable to other sexually transmitted infections (STIs) that multiply the risk of contracting HIV tenfold. Younger women are even more at risk as their immature cervix and scant vaginal secretions make them prone to vaginal mucosal lacerations. There is also evidence that women become more vulnerable to HIV infection again after the menopause. In addition, tearing and bleeding during intercourse, whether from rough sex, rape, or prior genital mutilation increase the risk of HIV infection, as does anal intercourse.

REVIEW OF LITERATURE

Nita Mawar et.al. (2005) in their study opines that AIDS related stigma poses a problem for all in the society thereby, imposing severe hardships on the people who are its targets and it ultimately interferes with treatment and prevention of HIV infection. Emphasis on the eradication of AIDS related stigma would enable in creating a social climate conducive to a rational, effective and compassionate response to this epidemic. The authors stated that the public health managers and the government need to address the following types of AIDS stigmatization: (i) Theologically/morally based blame on those who are infected, (ii) The concern for the health of

those not afflicted by disease, (iii) Eliminating risk group categories as it gives false security to its marginalized group, and (iv) The civil rights problems, human rights centered approaches are enforced.

William L. Holzemer et.al. (2009) in their article documented the levels of HIV stigma reported by persons living with HIV infections and nurses in Lesotho, Malawi, South Africa, Swaziland and Tanzania over a one-year period. HIV stigma has been shown to affect negatively the quality of life for people living with HIV infection, their adherence to medication, and their access to care. The authors used standardized scales to measure the level of HIV stigma over time. A repeated measures cohort design was used to follow persons living with HIV infection and nurses involved in their care from five countries over a one-year period in a three-wave longitudinal design. The average age of PLHAs (n = 948) was 36.15 years (SD= 8.69), and 67.1% (n= 617) were female. The average age of nurses (n = 887) was 38.44 years (SD=9.63), and 88.6% (n=784) were females. Eighty-four percent of all PLHAs reported one or more HIV stigma event at baseline. This declined, but was still significant one year later when 64.9% reported experiencing at least one HIV stigma event. At baseline, 80.3% of the nurses reported experiencing one or more HIV stigma events and this increased to 83.7% one year later. The study documented high levels of HIV stigma as reported by both PLHAs and nurses in all five of these African countries. These results have implications for stigma reduction interventions, particularly focused at health care providers who experience HIV stigma by association.

Adeline M. Nyamathi et.al. (2010) conducted a community-based participatory research study by using focus groups with 39 women living with AIDS (WLA) in the rural setting of Andhra Pradesh, India. In addition, three nurses, two physicians, and five reproductive health accredited social health activists (ASHAs) took part in focus groups. The study offered insight into the benefits of HIV-trained ASHAs including emotional support, assistance with travel to health care providers and antiretroviral therapy medication adherence. Health care providers also identified benefits of using HIV-trained ASHAs and suggested modalities for how to train these individuals. These findings will contribute to the design of a future programme of care involving HIV-trained ASHAs.

Ganesh Shanmugasundaram Anusuya et.al. (2013) made an attempt to assess the Quality of Life (QOL) and to identify the factors that influences QOL in People Living with HIV/AIDS (PLHA). A Cross sectional study of 30 adult PLHA attending the outpatient department of a community care centre in Chennai was included in the study. QOL was evaluated using WHOQOL-HIV BREF. The study has identified the worst affected domain

was social relationships domain. The study also identified gender, marital status, place of living, and CD4 counts as factors influencing the QOL of PLHA. It is recommended that the health care personnel should assess the QOL of PLHA using WHOQOL-HIV BREF questionnaire. The worst affected domain can be identified and appropriate interventions can be planned accordingly. Health education and proper counselling of the PLHA about CD4 counts, and its relation with opportunistic infections can motivate the PLHA to get initiated on ART when they become eligible for it.

Lusti-Narasimhan et.al. (2014) considers the relevance of gender norms in developing guidelines for microbicide or PrEP services. The proactive consideration of the influence of gender norms in the use of ARV-based technologies can help policymakers and programme managers facilitate women's full access to their use by considering issues such as protection of privacy and confidentiality in service delivery and reducing barriers such as parental consent that may keep adolescents at risk from using them.

Preeti Rai and Babu L Verma (2015) conducted interviews with 104 patients of HIV/AIDS at the Anti-Retroviral Therapy (ART) Clinic of a teaching hospital in Uttar Pradesh (India) to study depression and examine its prevalence and association, if any, with some socio-demographic and clinical variables. The tools used to assess anxiety and depression and their severities were General Health Questionnaire (GHQ) 28 and Montgomery-Asberg Depression Rating Scale (MADRS). As per the findings of the study majority of patients were of age 35 years and above (62%), males (67%), married (85%), Hindus (88%), literate (73.1%), unemployed (35%) and of upper-lower socio-economic status (52%). Significant association of depression was found with religion, occupation and socio-economic status. Depression and anxiety were also found to be significantly associated with each other. There was, however, no association of depression with respondents' age, gender, marital status, education, habitat, income, duration of illness from HIV/AIDS and the CD4 count. The high prevalence rate (67.3%) of depression amongst HIV patients in this study may be taken as marker to alert Counsellors of country's ART Clinics for possible risk of depression in HIV patients.

Rajeev K. H., et.al. (2016) conducted a study to assess the Quality of life of PLHA in relation to various socio-demographic and clinical correlates. The study was conducted at a community care center in Chitradurga district and it is a Cross sectional study. About 395 PLHAs registered in the centre constituted the sample. WHOQOL – 120 instrument was used for assessing quality of life. The socio demographic factors were also obtained in pre designed proforma. The study found that the Quality of Life (QOL) scores for all domains were intermediate for the PLHAs between (10 – 14). The mean scores were highest for psychological domain. There was a significant difference in QOL of PLHA who were on ART and Not on ART in some domains. PLHAs who

were literates, married, Single, employed, income more than 1500 not on ART, CD4 count more than 200, earlier stages of HIV, living with spouse and students had high mean scores. Mean difference of QOL scores with duration of ART intake were statistically significant in psychological and Spirituality domains. QOL was found to be determined by education, income, occupation, ART status, duration of taking ART and clinical categories of the disease.

PREVALENCE OF AIDS IN CHITTOOR DISTRICT

In Chittoor district AIDS is prevalent since late 1980s. But there is no accurate information when the first case was registered in the district. Recently there are instances like a woman was stoned to death because her neighbors thought they would get AIDS from her! Though we have heard of such cases before, we never thought it would happen so near. But that is the first reaction to any enormity. According to press reports a widow whose husband had died of AIDS was stoned to death after a series of incidents involving her and her neighbors. It was happened in B.C. colony of Kuppam town. The tables 1 to 3 throws light on the spread of disease from 2002 to 2008 in Chittoor district.

Table-1

Non ANC clients tested & found positive from April 2002 to March 2011 in Chittoor District

Sl. No	Years	Tested	Positive	% of Positivity
1	2002-03	3691	690	18.69
2	2003-04	9245	1466	15.86
3	2004-05	11192	1783	15.93
4	2005-06	12714	2329	18.32
5	2006-07	27093	3071	11.34
6	2007-08	28746	2958	10.29
7	2008-09	32797	3219	9.8
8	2009-10	48676	3178	6.53
9	2010-11	53083	194	0.4

Source: Annual Reports of Andhra Pradesh State AIDS Control Society-2002-03 to 2010-2011.

The table 1 reveals that in case of Chittoor district also the number of people referred for HIV test is gradually increasing as in the case of state. But the total number of people identifies with HIV positive rating is not evenly distributed. The total number of positive people gradually increased up to 2006-07. But after 2007-08 it is not evenly distributed. The percentage of positive cases is gradually decreasing and reached the lowest point of 0.4 per cent.

Table-2
Year Wise Gender wise Non ANC clients tested & found positive from April 2002 to March 2011 in Chittoor District

Sl no	Years	Tested			Positive			% of Positivity		
		Male	Female	Total	Male	Female	Total	Male	Female	Total
1	2002-03	1535	2156	3691	439	251	690	28.6	11.64	18.69
2	2003-04	3320	5925	9245	854	612	1466	25.72	10.33	15.9
3	2004-05	4733	6459	11192	1057	726	1783	22.33	11.24	15.93
4	2005-06	6290	6424	12714	1293	1036	2329	20.56	16.13	18.32
5	2006-07	12741	14352	27093	1683	1388	3071	13.21	9.67	11.34
6	2007-08	16157	12589	28746	1624	1334	2958	10.05	10.6	10.29
7	2008-09	20876	11169	20876	1770	1396	3166	8.5	12.5	9.9
8	2009-10	28503	19921	48424	1759	1390	3149	6.2	7	6.5
9	2010-11	41391	26733	68124	1895	1430	3325	4.6	5.3	4.8

Source: Source: Annual Reports of Andhra Pradesh State AIDS Control Society-2002-03 to 2010-2011.

It can be inferred from the table 2 that the number of males and females who are coming forward for testing HIV test is gradually increasing. But the total number of males and females diagnosed as positive is also increasing in the district. The percentage male positivity is decreasing gradually. But it is not evenly distributed in case of females. The total percentage of positivity is gradually decreasing. It means that the governmental voluntary association's efforts in reducing the percentage of HIV positive cases proved somewhat fruitful.

Table—3

Year Wise Age wise Non ANC clients tested & found positive from April 2002 to March 2011 in Chittoor district

Years	Tested							Positive						
	<14	15-19	20-24	25-29	30-39	40-49	50+	<14	15-19	20-24	25-29	30-39	40-49	50+
2002-03	102	296	949	790	801	447	302	24	11	90	188	226	111	38
2003-04	189	866	2586	1869	1986	959	630	41	20	208	366	536	211	70
2004-05	256	793	2756	2324	2845	1366	845	58	15	229	395	679	284	123
2005-06	405	629	2682	2700	3464	1749	973	86	20	262	552	904	379	125
2006-07	728	1788	6671	6099	6409	3305	1950	153	33	274	665	1179	566	196
2007-	728	1788	6671	6099	6409	3305	1951	153	33	274	665	1179	566	196

08														
2008-09	695	1802	5893	6364	5993	3108	1859	123	51	201	596	1098	530	183
2009-10	719	2586	7962	6323	6543	3896	2153	119	32	202	534	987	495	171
2010-11	1528	5412	9856	6438	7896	5814	2105	13	39	29	41	36	24	12

Source: Annual Reports of Andhra Pradesh State AIDS Control Society-2002-03 to 2010-2011.

It is evident from the table 3 that the number of teenage children who undergone testing in Chittoor districts increasing year by year in 2002-03, 102 children below 14 years were tested. By 2007-08 it went up to 728 on the other hand the children in the age group of 15-19 years is 296 in 2002-03 and it gone up to 1778 by 2007-08. In the same the number cases fund positive is also gradually increasing year by year in cast under 14 and 15-19 age groups. The same is the case in case of all other groups. The overall data makes it clear that the incidence of HIV positive cases in the district is increasing at alarming rate.

CONCLUSION

The district has a considerably large size of a local network of FSWs, their clients and MSM-T. A substantial proportion of the female PLHIV above age 15 years are either widowed, divorced or separated. HIV positivity among the walkin males tested in ICTCs has been declining, indicating that a large number of low-risk individuals are being tested. On the other hand, a substantial proportion of HRGs have been reporting that they have undergone HIV test, possibly in private laboratories. Thus the number of individuals who are tested HIV positive could be greater than the number indicated by the ICTCs.

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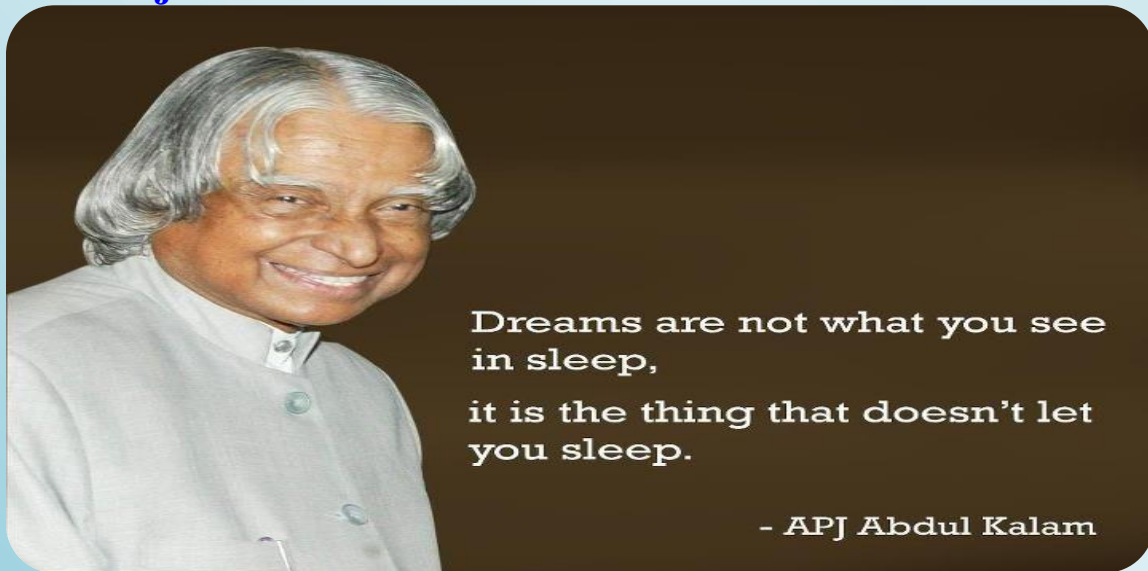
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Dreams are not what you see
in sleep,
it is the thing that doesn't let
you sleep.

- APJ Abdul Kalam