

CHAPTER – II

REVIEW OF RELATED LITERATURE

Chapter Two

Review of literature

The main purpose of review of related literature is analytical review of the various resources. In every field of research, the research worker needs to acquire comprehensive information about what has been done in the particular area from which he/she intends to take up problem for research. So, review cannot be for mere completion but for reference.

This chapter presents an overview of the available literature on HIV/AIDS in general and studies related to HIV/AIDS affected widows in particular. The lack of proper awareness and knowledge regarding HIV/AIDS and condition of socio economic may leave a large section of population especially widows who are a headed in the family. Keeping in mind, the studies discussed in this section primarily focus on socio economic conditions, knowledge kinds of treatment they received, sources and types of support, stigma and discrimination and plan for the livelihood for children. The literature also includes the various interventions undertaken worldwide and in India to tackle the problem of HIV/AIDS.

Studies Related to HIV in the General Population:

There are few Indian studies of social responses to the HIV epidemic. Societal reactions to people with AIDS have been negative. For example 36 per cent of respondents in one earlier studies felt it would be better if infected individuals killed themselves; the same percentage believed that infected people deserved their fate (Ambati, Ambati and Rao, 1997)

Furthermore, in this same study, 34 per cent of respondents said they would not associate with people with AIDS while about 1/5 stated that AIDS was a punishment from God.

A study on the female street workers in Nigeria by Oyefara (2005) revealed a huge difference between general awareness and the practical perceptions of the disease. Many of the respondents were highly ignorant about the various modes of HIV/AIDS transmission and had mistaken beliefs about HIV/AIDS which had significant negative effects on their risk behavior making them more vulnerable to conduct the virus.

Bollinger, Cooper-Arnold & Stover (2004) studied the relation of key HIV/AIDS prevention services to changes in behavior among different risk groups like intravenous drugs users and men who have sex with men and described the gaps that exist in the literature. The study showed that there was gap in the knowledge, although research evaluating HIV/AIDS interventions was available. This was because lack of pre-intervention data and inadequate control groups disqualified a number of such studies. In other cases, evaluations of interventions were not undertaken, as in the case of programs focused on such high-risk groups as intravenous drugs users and men who have sex with men. The study suggested that rigorous and well controlled evaluation studies must be designed and carried out so that the results may be used to inform future analyses and program design.

A survey of 500 Turkish university students, knowledge, attitude, sexual behavior and perceptions of risk related HIV/AIDS (Cok, Gray & Ersever, 2001) revealed a moderate level of knowledge about the transmission, symptomology and prevention of HIV. The students had significant misconceptions regarding HIV/AIDS. Students' attitudes toward people with HIV/AIDS were contradictory showing both accepting views depending, in part, on their personal involvement with an HIV positive person. One third of the participants who reported sexual

activity also described limited safer sexual behaviors. The perceptions of students of their personal risk of contracting HIV were low regardless of their sexual activity. The study recommended HIV/AIDS education for Turkish university students.

Gray, Devadas, Vijayalakshmi & Kamalanathan (1999) examined the knowledge, attitudes, beliefs of Hindu students from a government women's college of South India, towards people with AIDS. The sample consisted of four hundred female students at a government funded Women's university in Southern India who participated in a survey research project. Results indicated that a majority of the participants learned about HIV/AIDS from reading material while some learned about HIV/AIDS from school classes, and only a few learnt from family members. Thirty – nine percent had never communicated to anyone about HIV/AIDS. The results indicated that the majority of Indian women in this study did not know about explicit sexual behaviors which transmitted the virus. The study suggested the need to increase educational efforts at the university to address the multiple psychosocial issues related to HIV/AIDS.

Agha (2000) examined the level of risk of acquiring sexually transmitted infections among truck drivers and their helpers in Pakistan. Quantitative, self reported, sexual behavior data 300 randomly selected long distance truck drivers and the helpers. Qualitative information was gathered through conversations with drivers. The findings show that multiple sexual partnerships with men and women were common among truckers. Awareness of AIDS and knowledge of sexual transmission of HIV was high. However, most truckers did not believe that AIDS existed in Pakistan. Nor were they aware that condoms were an effective way of preventing HIV transmission. Knowledge of the risks associated with unprotected sex was low among truckers, who considered themselves vulnerable to sexually transmitted infections

because of their self- perception of being moral persons. The study suggested campaigns to increase risk awareness to emphasize the importance of condoms use and interpersonal communities as STI/HIV prevention methods.

At human level, the financial burden of HIV/AIDS is at least 30% greater than deaths from other causes, because it affects the most productive age group (young adults), and because the costs of medication and caring for the sick are staggering and can be prolonged. The psychological stress that is a direct consequence of the impact of HIV/AIDS on individuals and families can compromise school and work performance, family relationships, and the capacity to take care of children, and may also culminate in risk behavior such as alcohol and drug abuse and in unsafe sexual behavior (Coombe, 2002).

Studies Related to Socio-economic Condition:

There is a strong association between poverty and ill health. Wealthier countries and wealthier individuals enjoy better health as measured by a variety of indicators such as life expectancy or incidence of diseases. Many researchers have had the same expectation about AIDS, which has often been described as a “disease of Poverty”

Research studies tend to show that income lost as a result of death due to AIDS- related illnesses is usually the most important economic loss, since those that die from AIDS related illnesses are generally in the most productive years of their life. The economic impact of the AIDS epidemic is most significant at the level of family and community especially among the poor and marginalized groups rather than at national, macro-levels particularly in South Asia (UNDP:2003)

A study on the socio economic impact of HIV/AIDS in people living with HIV/AIDS and their families was conducted in 4 states including Manipur ,Maharashtra , Delhi and Tamil Nadu in 2003(ILO project). It

was found that respondents were earning Rs.3, 200 per month on average. The HIV related increase in expenditure and decrease in income has led to an overall increase of debts among respondents.

Stigma and discrimination contribute to the socioeconomic vulnerability PLWHA. Early job loss, lost days due to illness and lack of insurance or benefits create increasingly difficult economic circumstances for individual and households (Mahal, 2004).

The most direct impact is through the inability of the infected person to participate in income generating work. The impact is especially devastating because most PLWHA are in their prime productive years. The presence of a person in the HHs who does not contribute to HHs expenses for a long period of time constitutes significant burden. This burden is heightened by medical costs if the person is sick (Ankrah, 1994; McGrath et.al 1994) not only because cost of care are extremely high in this disease (Ankrah, 1994; Nag, 1996b; Schopper and Walley 1992), but also because under the present economic scenario, the family is seen as a alternative to providing care and bearing the costs if it is possible no matter however exorbitant.

Barnett and Blaikie's (1992) study shows the major economic impacts to be loss of income earning opportunities; diversion of productive labor time of still healthy family members to caring for the sick; diversion of cash to medical expenses; diversion of food resources and money for funeral ceremonies; withdrawal of children from school to reduce cash expenditure and increase available labor time and provide care; and altered patterns of consumption and production by HHs received orphans from other HHs which no longer have adults capable of caring for and looking after children.

When the breadwinner dies, households face the problem of limited food to meet consumption requirements. Rugalena (1998) in Tanzania, Sauerbon et.al. (1995) in Burkino, Faso and Barnett

et.al.(1995) in rural Uganda , found that some households cut back the numbers of meals when faced with food shortages.

Women's access to health care is limited due to their low status in society and household, arising from illiteracy, economic dependence on men and structures of patriarchy (Cehat, 2001, Sasendran Pallikadavathi, 2003, UNDP, 2003). The low economic and social status of women and their limited access to healthcare have profound implication on HIV epidemic.

In terms of economic conditions by Basanta, Ramamani and Shalabh (2006) in the comparative study of the income of widow households with that of the other HIV households, it found that those HIV Widows households seem worse off than the remaining HIV household. It also can be seen that nearly half of the HIV widow Households belong to the lowest income category and because of this, the average income of the widow households is much less than that of the remaining households in both the urban as well as the rural sample. This could be viewed as the direct impact of the death of a bread winner in the widow households.

Sauerbon et.al (1996) in rural Burkina Faso, SAFAIDS (in press) in rural Zambia, and Barnett et.al (1995) in Uganda, found that rural households that cannot meet their food requirement, or obtain cash, through agricultural production undertake a range of income generating activities such as selling firewood, brewing millet beer, selling livestock, building fences, handicraft, tailoring and petty trade to supplement their income.

Throughout history the family, or in economic parlance the households, has formed the crucial social and economic unit on which most human societies have been base. The extended family as safety net is still by far the most effective community response to the AIDS crisis (Mukoyogo and William, 1991). Literature reveals that affected households in need of

food send their children to live with relatives; Sauerbon et.al(1996) in Burkina Faso, SAFAIDS(1998) in rural Zambia , Barnett et.al (1995) in Uganda , Lwihula(1998) in Kagera region, Tanzania , Rugalema(1998), Drinkwater(1993) in Zambia, Kwaramba(1997) in Zimbabwe and SAFAIDS(in press) in Zambia .

Relatives will then be responsible for meeting the children's food requirement. However, these studies did not probe into the types of relatives, or the length of time the children stayed with those relatives. Relatives and friends may provide both moral and material support to the sick on the assumption of future reciprocation. Preparation of food, work on land or overseeing livestock will be done by another family member or neighbor in addition to their own task. Over time, the ability of families and social networks to absorb these demands will decrease as more adults die young of HIV/AIDS.

More households were found to be headed by AIDS widows. Widows with dependent children become entrenched in poverty as a result of the socio-economic pressures related to HIV/AIDS. Stigmatization compounded their situation further, as assistance from the extended family and the community, the main safety net, was served (FAO, 2001).

There is a significant increase in the percentage of unemployed people living with HIV/AIDS after being detected positive – from 2.3 to 8.5 per cent. The aggregate impact is around 11.8 per cent of the current households' income of all HIV households. However, the loss of income for those households that experienced withdrawal of the PLWHA from the labor force is very severe. Wage laborers are the hardest hit. (NCAERT, UNDP& NACO 2004-05).

Loss of income, health care costs, illness, and deaths among the young in the prime of their life due to AIDS are found to push households into a state of crisis and dissolution among children and the

elderly (Yuan, J. et.al 2002). Reports on the socio-economic impact of the HIV/AIDS epidemic have shown that HIV/AIDS morbidity and mortality reduce labor availability and efficiency and thus affect agricultural productivity (Fox, et.al, 2004).

In an analysis of the economic impact as it affected a group of individuals who were HIV positive , it was found that treatment costs were very high relative to income between 10 and 30 per cent of the annual income of an individual might be spent on treatment of illnesses alone .The highest expenditure on health was incurred on medicines . An analysis of factors affecting the probability of the impact revealed that younger individuals, males, individuals with lower income, those with at least one child, and those with at least one illness were more vulnerable to the impact. The occurrence of at least one illness increased the probability of the impact by 87 per cent. Males had a 34 percent higher probability of the impact than females, and those with at least one child had a 36 percent higher probability of the impact.(The Looming Epidemic (1995).

Coyaji(1994), Lal and Thakur(1995) revealed the higher impact of HIV/AIDS in women in developing countries that stereotypes related to HIV /AIDS have meant that women are either blamed for the spread of the disease or not recognized as potential patients with the disease. The consequences can be delayed diagnosis and treatment, stigmatization, loss of income and violation of human rights .The social and psychological burdens are greater for women than men in a similar situation. These include problems related to pregnancy and motherhood, rejection as a marital partner, loss of security and income, and a greater demand on them to cope with the effects of the epidemic, both by law, people and professionals. Women's low socio-economic status and lack of power frequently make it difficult for them to undertake prevention measures.

Several studies note that the AIDS epidemic has led a significant proportion of sufferers to return to their parents home just before they die (Pambazuka/population council), led urban migrants in some countries to return to their rural villages (Toupousis and du Guerny 1999); that the costs of AIDS are borne by households and public sector (Muwanga 2002), and that there is huge impact at the level of individuals and households, and their communities (AIDS Infothek 2000:5).

Loss of human capital is also the focus of an article by Cohen (2002) writing for the ILO about the negative impacts of AIDS in Malawi and Botswana, measuring impacts especially on education and health. Haacker (2002) also observes effects on labor supply, pension funds, public education, particularly the increased demands on the health sector in southern Africa, noting that HIV/AIDS impacts on human capital affects mainly per capita incomes.

Socio-economic condition, gender inequality play a major role in the rising incidence of HIV/AIDS in the North-east and the rest of the country, concluded at the joint meet organized by IGNOU and Don Bosco Institute Guwahati (Dec 2007).

Several studies note that the AIDS epidemic has led a significant proportion of sufferers to return to their parents home (Pambazuka /Population Council), has led migrants in some countries to return to their rural villages (Toupousis and du Gurney) that the costs of AIDS are borne by households and the public sector(Muwanga2002) and that there is huge impacts at the level of individuals and households and their communities (AIDS Infothek 2000) This was echoed in *The Economist* (1997), which also stated , however that in spite of the fact that the most victims of AIDS are in the prime of their working lives, there has been little impact on the overall economy , speculating that plentiful labour means one family 's misfortune is another's opportunity.

HIV can impact the income composition of affected households. In South Africa, for example, a recent study found that affected households were more dependent on no employment sources of income (consisting primarily of government grants) and a lower proportion of their income was derived from employment than non-affected households. Affected households face higher dependency ratios, are more subjected to morbidity and mortality and face higher unemployment levels (Gow and Desmond, 2007).

Knowledge and Attitudes:

Factors that influence citizen to be more knowledgeable about HIV/AIDS include illiteracy, media access, language, culture, religion, geographical terrain, education, gender etc. knowledge is what person knows, the facts information skills, understanding that one has gained. It is the state of being informed about something (Longmann, 1991).

Knowledge on HIV/AIDS was reported to have increased as a result of information available to the community from a numbers of sources. This includes radio, newspapers, posters, workshops, churches and mosques, health centre. The other sources of information included community health workers, person living with HIV/AIDS, and religious gathering in churches and mosques. (MISR, 2003).

“Most communication specialist believed that awareness precedes the development of attitude on a particular issue” (Atkin, Friemuth; 1989). Media can also influence people’s attitudes in accepting the HIV/AIDS messages. However, it is important that the campaigns are acceptable to the target audiences. Mass media can “raise the informal level about a topic significantly, especially if people can find the information useful with their existing attitude.”(Scanlon1990).

Negative responses and attitudes towards people living with HIV/AIDS are strongly linked to people’s perception of the cases of AIDS

, routes of transmission, and their level of knowledge about AIDS and HIV .In most societies, AIDS is associated with groups whose social and sexual behavior does not meet public approval. Thus, homosexual and sex workers are easily labeled and stigmatized (Herek and Glunt, 1988).

Mass media can be used to improve awareness and knowledge to stimulate interpersonal communication and to recruit others in the HIV/AIDS awareness. The success of awareness campaigns by utilizing the media depends very much on the innovative approach of the campaigns designed that will be acceptable to the target audience (Atkin & Rice, 1989).Lack of knowledge about HIV/AIDS can possibly hinder the HIV/AIDS awareness campaigns.

Chatterjee, N (1999) conducted a study in Mumbai to assess knowledge about AIDS amongst married women. The study found that nearly 67% of the 350 women surveyed had heard of AIDS. Three fourths of these women had heard of AIDS through media and only 6% through newspaper.

Kyrychenko.P, Kohler.C & Sathia.K (2006) study on the mode of transmission. It was found that 80.6% respondents had knowledge that HIV/AIDS get transmitted through sexual contact; 55.2% had knowledge about sharing injections. Only 14.9% to 35.8% had knowledge that HIV/AIDS get transmitted from infected mother to baby during breast feeding and during in the pre-test. The findings of the study showed that education intervention played an important role in increasing knowledge about HIV/AIDS which can be supported by the study.

A study by Naik et.al. (2005) on the knowledge, attitude, and practices regarding sexuality, HIV/AIDS and other STDs amongst tribal communities living in southern region of Karnataka revealed very low knowledge, awareness and information regarding HIV/AIDS. High prevalence of behavioral risk factors, coupled with ignorance, and inadequate health infrastructure contributed to the spread of the

disease. Women were reported to be particularly vulnerable to contract the disease. The study suggested the formulation of effective, culture sensitive and appropriate intervention programs to combat the spread of HIV/AIDS in the tribal population.

In a descriptive and comparative study, Collica (2002) investigated the levels of knowledge of HIV/AIDS, self-reported leading to an increased risk for HIV infection, and perception of future behavior modification among adult female inmates in the AIDS Counseling and Education (ACE) Program at Bedford Hills Correctional Facility in New York State. This program was peer-led inmate program rendering HIV/AIDS education to approximately 6,000 women yearly. The program provided individual counseling, HIV testing, outreach services, support groups, annual events, professional trainings, discharge planning/case management, and important follow-up services when the women were released. The study covered three sets of HIV workshops on a sample size of 35 women for the pre-test and 27 women for the post-test.

The analyses showed a statistically significant increase in knowledge following the workshops. Comparison made between groups determined which participants benefited the most from ACE's program. Many women were not taking this disease seriously if it had not "hit home".

The study evolved the need for more education for women with male partners to curtail acts of risky behavior and to acquire skills for negotiating safer sex with their partner(s). Implementation of more advanced HIV classes including various types of kinesthetic learning techniques (e.g. role plays, assertiveness, and communication) was suggested. Follow-up services to assist in implementing behavioral change were recommended. Comprehensive education including additional components such as testing, counseling community referrals, support groups, and so forth was suggested. Individual counseling was

suggested for women engaged in high- risk behaviors (i.e., drug use, unprotected sexual activity, and prostitution) and who had higher levels of knowledge but lower perceptions of risk than other types of women, to uncover the deeply ingrained beliefs that caused them to engage in high-risk drug and/or sexual activities. The study suggested that future studies should focus on the women who do obtain follow-up services after completion of the workshops to see if there was a reduction in risky behaviors. These women should continue to be studied even after they return back to the community to see if a continuum of services affected behavior modification.

Negative responses and attitudes toward people living with HIV/AIDS are strongly linked to general levels of knowledge about HIV/AIDS, in particular to causes of AIDS and routes of HIV transmission. In most societies, AIDS is associated with groups whose social and sexual behavior does not meet with public approval. In the study of Ambati, Ambati and Rao (1997) 60 per cent of respondents believed that only gay men, prostitute and drugs users can get AIDS.

Attitudes about people with AIDS: People have various negative attitudes towards those infected with AIDS. Ignorance and public misconception about the disease have led to many of these attitudes. Despite efforts by many in the health professions to educate the public about AIDS in the disease process, transmission routes and prevention, people are still ignorant. Ignorance, homophobia, hysteria and fear of contagion are all behind the prejudices and discrimination aimed towards people with AIDS. Witt (1990:127), however, argues that ignorance is not the main cause of negative attitudes. Individual predisposition such as homophobia; attitudes towards homosexuals and authoritarianism also influence them.

Health Vision and Research (2005a) studied the awareness, knowledge, attitude and behavior of Injecting Drugs Users in West

Bengal (India) with regards to STI/HIV/AIDS. The study revealed that both male and female IDUs had low knowledge regarding HIV transmission and symptoms for sexually transmitted diseases (STD). Also, 73 per cent respondents reported of being arrested and out of this 62 per cent respondents were jailed. The study recommended inclusion of risk perception and risk reduction in strategies to reduce risk of HIV transmission.

Mahal, A (2004), The HIV epidemic affects people in the prime of their lives with adverse impacts on life expectancy, the productivity of the labor force and households incomes. It has not always been possible to measure the economic impacts of AIDS empirically with a reasonable degree of precisions. Moreover, while there is some evidence of negative individual household and firm level impact, empirical evidence on the impacts at the sectoral and national levels is still weak. While purely humanitarian consideration may be relevant in supporting investment in HIV/AIDS intervention they may not always appear to be so for finance minister and planners in developing countries. To justify spending more on policies to address HIV/AIDS in a regime of tight resource constraint, it is sometimes important to justify investments in AIDS prevention and treatment as being more critical relative to other investment. To the extent that HIV/AIDS has a tremendous adverse impact on economic indicators and other socially desirable goals of society, policy action may be desirable preferably early in the epidemic rather than later.

Acharya(1994) in his studies have shown that women and children are the worst- affected segment of the population. The impact of AIDS on women is not just a matter of number but also their multiple roles in the family and society .The low status of women within the family and society makes them particularly susceptible to HIV infection.

NACO (2006b) also opines that women are; in fact have more risk of getting infected because of their increased vulnerability. It is,

therefore, important that women should have more access to information about HIV/AIDS. But it is a major problem for India for the Indian society is controlled by strong traditional values.

Treatment, Care and Support:

Although a lot of people living with HIV/AIDS groups are coming up with the help of NGOs supported by government bodies, there is still lack of comprehensive social support system. The traditional social support does not support, to some extent, the women living with HIV/AIDS.

In the majority of developing countries, families are the primary care-giver to sick members. There is a clear evidence of the important role that the family can play in providing support and care to people living with HIV/AIDS (World Bank, 1997; Warwick et.al, 1998; Aggleton & Warwick, 1999). However, not all family response is always positive. Infected and affected family members may still be stigmatized and discriminated against by the family and home.

Women because of their care giving role were allowed to stay in their in-law's home while the husband was alive and after his demise, they were made to leave. One woman was made to leave even during the husband's lifetime in order not to tax HH resources when the husband was going to die. Women who were allowed to stay on as widows were on terms dictated by the husband's HH, making them vulnerable. Only in one in-law's household was the wife seen as the household responsibility and given all care support (Bharat, S., Aggleton, P., et al.1999).

Employer-sponsored insurance schemes providing medical assistance and pensions for employees have come under increasing pressure in countries that have been seriously affected by HIV/AIDS.

Some employees have used this pressure to deny employment to people living with HIV/AIDS (Whiteside, 1993).

Health-care providers, who are also members of the general community, are likely to elicit similar prejudicial and fearful reactions to HIV/AIDS infected persons as members of the community. The resultant effects of negative attitudes include poor patient management, with people being in urgent need of treatment, care and support. This, in turn, could affect their morale, self-esteem and self determination to live quality lives devoid of stigma, fear, repression and discrimination (Adebajo.et.al, 2003).

An Indian study (Bharat, 1996) found that, although a majority of those who had shared their HIV status with their families received care and support, it was largely men rather than women who qualified for such care. Forms of discrimination against woman with HIV included being refused shelter, being denied a share of households property; being denied access to treatment and care; and being blamed for a husband's HIV diagnosis, especially when the diagnosis was made soon after marriage. Other factors influencing whether people received support included the quality of past familial relationships, age, economic and educational status and the apparent or suspected source of infection.

According to the literature,(Hunter&Williamson,1997); Barnett & Blaikie(1992);Sauerbonet.al(1996);Donahue(1998),different community initiatives have sprung up to support and mitigate the impact of HIV/AIDS. Reviewed studies show that people affected by HIV/AIDS receive help principally from family, neighbors, community, institution and local informal organization. The World Bank Kagera(1999), study in Tanzania found that families who lost breadwinner through AIDS reported that 90 per cent of their materials and other assistance come from family and community groups such as saving clubs and burial

societies. Only 10 per cent of assistance was supplied by NGOs and other agencies.

Madembo (1997) in Zimbabwe, and Rugalena (1998) in Tanzania, found that burial societies are established indigenous social support organization that provides mutual assistance to members in rural areas in the event of death and illness. They offer a measure of financial security in the event of bereavement and also cater to some of other social needs of their members. As part of the package, burial society members also devote part of their time to assisting the bereaved by cultivating their fields.

Barnett and Blaikie (1992) found that informal women's counseling groups and in prompter meetings had sprung up, where women assist each other in the plantations, caring for the sick and receiving the care giver. Neighborhood women will appear unannounced to weed and trim the bananas garden of a woman who is ill. They have persuaded the local resistance councils to solicit outside help for the orphans and have assumed the responsibility of caring for them in their homes. Informal counseling sessions enable women to share their experiences and concerns and 'keep them sane'. There is a need for public space for women since it is felt that most of the public space available belongs to men.

Family support is a one way flow of care from non diseased members to the disease-afflicted person. In most chronic diseases, especially in HIV/AIDS, the family as a whole is in need of care. The family often keeps the problem a secret from the community. There are extreme precautions taken to guard the HIV status of the person (Mc Grath et.al, 1993).Consequently, the family copes by itself suffering emotional stresses and strains. Support is thus requested for the family as a unit to enable it to function adequately in the face of HIV/AIDS epidemic. Few efforts have been made to appreciate the problem facing

families, and significant others (Kelly and Sykes, 1989; Koehn, 1987; Grief and Porembski, 1988) presumably because of the focus on the individual with HIV/AIDS and on the care taking context.

The Family's care giving capacity may be better if there are adequate social support networks and /or institutional support (Green, 1993). Not only the family, but the community may also come forward with help of such people. The perception of the "housewife" as an "Innocent victim" of her husband's sexual conduct may however not be as simple in developing societies. For the husband's family, the wife may be seen as a burden and denied care and support both as sick person and as a survivor. Jackson and Civic (1994) reported that maternal extended families are beginning to play a greater support role for the widow and her children.

O'Donnell's (1992) study which examines the support provided to the PLWHA by the family needs to be more supportive in whatever way appropriate, since the positive person's AIDS fatigue makes little things overwhelming efforts.

Seeley et.al, (1994) study in Uganda goes a step further, looking at the role of the extended family in supporting the family of a PLWHA. It is commonly assumed that the extended family in developing countries provides support to its members, especially the sick, the aged and children. As a result, the care of PLWHA is seen as falling within the sphere of extended family care, and the extended family is considered to be a national strength. However, Seeley's research found that the extended family often refuses to help PLWHA, their caregivers and their families, on grounds of poverty and other family responsibilities.

A study by MacNeil et.al. (1999) reveals that care and support for people who have HIV positive status show the reduction of risk and enable others to protect. Linsk, Nathan, Poindexter, Cynthia and Cannon (2000) also show that aging family members who provide extension

support to people with HIV/AIDS while paying minimal attention to their own needs.

A study by Kupek et.al(1999) reveals that hospital service costs were significantly higher for the infected people lacking educational qualification and employment where for community cost they reveal that disease stage, transmission category, social and economic factors, support from partners significantly is associated with the community cost. As disease progresses, heterosexual transmission, less social and economic opportunity and no support from partners show increase in community cost.

Kumari R (1989) found that survival strategies adopted by female-headed varied according to the resource base, mainly land, and the socio-cultural milieu they belonged to. The study concludes that female-headed household's fails to utilize the resources to the extent a male-headed household could due to a weak support structure for widows as well as lack of support from kith and kin.

A study done by Kripa Foundation (2001) has justified many IDUs who have died from HIV symptomatic diseases have left behind their wives and children. The socio-economic conditions of this targeted participants and prevailing social stigma attached with the illness prevents them from attending to even the much required basic health care. The availability of Anti-retroviral therapies is helpful to a limited few due to its cost factor.

Studies Related to Stigma and Discrimination:

Stigma, discrimination and social marginalization are causes of HIV risk and Vulnerability, and consequences of being HIV-positive. Human beings are inherently social animals, and their physical and psychological health is damaged when they are isolated and cut off from their social group (Jenkins & Sarkar, 2007).

De Bruyn (1999) identified 5 factors contributing to HIV/AIDS related Stigma.

- The fact that HIV/AIDS is a life threatening disease
- The fact that people are afraid of contracting HIV
- The disease's association with behavior (such as sex between men and injecting drug use) that are already stigmatized in many societies.
- The fact that PLWHA are often thought of as being responsible for having contracted the disease.
- Religious or moral beliefs that lead some people to conclude that having HIV/AIDS is the result of a moral fault (such as promiscuity or 'deviant' sex) that deserves punishment.

Stigma and discrimination, both real and perceived, may also arise from a variety of community level responses to HIV/AIDS. The harassing and scapegoating of individuals suspected of being infected or of belonging to a particular group has been widely reported. It is often stimulated by the need to blame and punish and can, in extreme circumstances, extend to acts of violence and murder (Nardi & Bolton, 1991).

Fear of discrimination also motivates the infected people to exclude themselves from their social networks and in some cases from sexual relationships as well as making them lonely and isolated (Bharat, 1996). Fear of public disclosure and consequent social discrimination also prevents people from litigating and challenging their right to treatment and employment (Lawyers collective HIV/AIDS Unit, Mumbai, personal communication; Malcolm et al. 1998).

Family responses to relatives are heavily influenced by community perceptions of the disease. Families that include an individual with HIV may fear isolation and ostracism within the community (McGrath et al.,

1993; Warwick et al, 1998; Bharat and Aggleton, 1999). Consequently, they may try to conceal an HIV diagnosis, which, in turn, may cause considerable stress and depression within the family (Bharat and Aggleton, 1999). For most people living with HIV/AIDS in India maintain such secrecy that, the epidemic is not socially visible. Given this secrecy and invisibility, it would appear that there have been relatively few actual instances of community-based discriminatory responses. However, stigmatization and discrimination may arise when an individual identifies as HIV- positive is seen as a source of infection to others, or when the physical appearance of someone with AIDS produces revulsion or fear. By contrast, a person who is known to have HIV, but whose behavior or appearance is 'non- threatening", is sometimes tolerated and may even be offered support in the community (Bharat, 1996). Nevertheless, misconceptions about how HIV is transmitted continue to fuel discrimination. Community -based care, which provides psychological, social, medical and nursing support to HIV- infected persons and their families, is seen by many medical countries as the only realistic approach to cope with the crisis (HIV/AIDS care at the institutional, Community and Home level, SEARO publications on HIV/AIDS, WHO, 2001).

Maharashtra study states the household level impact of HIV, which indicated that the family had been supportive towards the people living with HIV/AIDS. However, fearing stigma and discrimination, only a small percentage of them have revealed their HIV status in the community and at the workplace. It is evident that women face greater discrimination within families, even though they take care of their sick husbands (Bharat, S., et al 1996). Sometimes they are also forced to take up a job apart from attending to household chores , even when they might themselves be ailing. The levels of their knowledge and awareness about

the disease are so low that it becomes difficult for them to take care of themselves (NCEART, UNDP, and NACO 2004-05).

A study on stigma in Ethiopia, Tanzania and Zambia has unearthed six major findings (Adapted from ICRW, 2002):

- People are largely unaware that their attitudes and actions are stigmatizing. Respondents spoke of the importance of not stigmatizing PLHA, but at least the same time they said that they were “promiscuous”, “indulge in immoral behavior”, or “deserve what they got”, and they have been “punished by God for their sins”.
- Some languages have no word for stigma as opposed to discrimination. Language is central to how stigma is expressed, through words used by individuals, the media, and in educational materials. For instance, in Tanzania, PLHA are often referred to as *maiti inayotmbea* (walking corpse) and healthy looking PLHA as *nyambizi* (submarine).
- Knowledge and fear interact in unexpected ways that allow stigma and discrimination to persist. People maintain both correct and incorrect knowledge for example even when people know how HIV is transmitted, they still fear casual contact. People who do not understand the differences between HIV and AIDS equate an HIV positive test result with imminent death and they may shun HIV positive people for this reason.
- Sex, mortality, shame and blame are closely related to HIV related stigma. HIV is usually associated with identified “high risk|” groups; sexually active young girls, merchants, truckers, sex workers, bar ladies. These groups have often been seen to have brought shame to their families and communities.
- Ideally, HIV positive individuals should feel able to disclose their status, but current attitudes toward HIV/ADS make it difficult to

do in these countries .Rather, people often try to infer HIV status through changes in behavior, symptoms and weight loss.

- Widespread care and support for PLHA coexists, or believing PLHA are worthless

Stigma attaches itself strongly to women because of negative assumption made about sexual risk behavior even when a woman has not engaged in any – and its association with HIV. A recent four city study in India found that while almost 90 per cent of HIV positive women were infected by their husbands, they faced more stigma and discrimination than men and were often blamed for their husband's illnesses. Women living with their husband's family frequently faced expulsion if the husband died and many had trouble finding anyone to care for them when they themselves became ill. (ILO, 2003).

In a study of social reaction to people with AIDS in India, 36 per cent respondents felt that it would be better if infected individual killed themselves and the same percentage believed that infected people deserved their fate. Nearly 34 per cent said that they would not associate with people with AIDS and about a fifth stated that AIDS as a punishment from God. (Ambati & Ambati and Rao, 1997).

A study (The socio economic impact of HIV/AIDS in India, 2006) found that 25% of people living with HIV/AIDS were denied medical treatment on the basis of their HIV Positive status. Evidence of stigma was rampant in the work place, with 74% of employees not disclosing their status to their employees for fear of being discriminated against (UNDP 2006).The remaining 26% who did disclose their status, 10% of them reported to have faced prejudice as a result. People who have or are suspected of having HIV may be turned away from health care services, denied housing and employment and shunned by friends and colleagues.

Bharat (1996) writes, Discrimination against HIV positive women included:

- Being thrown out of the house:

In most cases, after the death of the son, parents refused to take responsibility for their well being of their daughter-in-law and asked her to leave. She either had to return to her birth family or was forced to support herself. Some women who were thrown out of their marital homes were not welcome in their birth homes either. Being HIV positive therefore translated as being homeless.

- Being denied access to care and treatment.
- Being blamed for the husband's HIV positive status, especially when the diagnosis was made after marriage. Quality of the infected individual's relationship with his family also determined whether he/she could receive support.

In societies with cultural system that place greater emphasis on individualism, HIV/AIDS may be perceived as the result of personal irresponsibility, and thus individuals are blamed for contracting the infection (Kegeles. et.al (1989).In contrast, in societies where cultural systems place greater emphasis on collectivism, HIV/AIDS may be perceived as bringing shame on the family and community.(Panos,1990; Warwick et.al.1998).

UNAIDS (2004) reports that the forms of Stigma and Discrimination faced by the people with HIV/AIDS are multiple and complex with the most burden on women. Research conducted in India and Uganda shows that women with HIV/AIDS are doubly stigmatized, as Person living with HIV/AIDS and as women.

The way in which HIV/AIDS related stigma and discrimination are manifested in individuals depends on family and social support and the degree to which people are able to be open about such issues as their sexuality as well as their sero-status. In contexts where HIV/AIDS is highly stigmatized, HIV/AIDS related Stigma and discrimination may cause individuals to isolate themselves to the extent that they no longer feel part of civil society and are unable to gain access to the services and support they need (Daniel and Parker 1993). This has been called internalized stigma. In extreme cases, this has led to premature death through suicide (Gilmore and Somerville 1994; Hasan, Farag and Elkerdawi 1994).

News reports indicate that a large majority of the general public, including health care professionals hold negative and adverse attitudes toward HIV/AIDS patients who are subjected to discrimination and humiliation or even denied treatment(AIDS-India e-Forum,20& 22 November,2003;Singh and Maliya, 1994;The Hindustan Times, 15 Oct 2003).On 3 October,2003, Gita Bhawan Hospital in Indore issued a policy statement advising doctors to not provide treatment to HIV patients(The Hindustan Times, 15 October 2003).

Stigma and Discrimination Affect Women:

In a feeling of stigmatization common to most HIV positive, women face several unique problems. They may, for example, experience feelings of extreme isolation, reproductive concerns and fears or guilt about transmitting the virus to their children. Positive women face rejection, loss of security and their role of mothers, daughters, wives or sisters (Buckingham and rehm, 1987; Chachkes, 1987; Waxler, 1989)

Women are biologically more vulnerable to HIV/AIDS, and more likely to contract infections from their male partners. The combination of their sexuality and gender disadvantage in terms of cultural, economic

and social factors place them more at risk of infection from men (Aneikwu, 2002). Women tend to experience greater stigma and discrimination than men, more likely to experience its harshest and most damaging forms, and have fewer resources for coping with it (Ogden & Nyblade, 2005; Hong, Van Anh, & Ogden, 2004; Bond, et.al, 2003; Castle, 2004; Nyblade, et.al, 2003). Given the stigma and discrimination HIV, it is likely that gaining access to HIV drugs will be even more difficult for women and girls, particularly where drugs will be even more difficult for women and girls, particularly where drugs are not provided free of charge or where there is lack of confidentiality (Health and Human Rights, 2005). Violence is a severe consequence of stigma faced principally by women (Parish, et.al, 2004; Lary, et.al, 2004; Koenig, et.al, 2004).

Understanding of Well-being of Children Affected with HIV/AIDS;

A study done by Mark Loudon et.al, Barriers to services for children with HIV positive parents, (UNICEF) 2007) has revealed some of the psychosocial problems faced by children who are affected with HIV/AIDS. The study brings out some key issues related to children affected with HIV/AIDS (Mark Loudon et.al, 2007). The children with HIV/AIDS are low esteemed, guilty, and anxious and fearful about rejection from society. There are social exclusions in the school and at the community level gatherings; so child has no friend and social support in the time of difficulties. Children were denied love, warmth, and hug by relative, friends and even by their own parents due to fear of HIV infection. It has lead the children to loneliness, demoralized, depressed, hatred.

Children of affected parents, being neglected in terms of the disruption of a relation with the most significant others or as a result of death, undergo severe trauma before the death of their parents as well as

the continued suffering from maternal deprivation of infants who survive their mothers. When parents die many young people find themselves with insufficient schooling and poor employment prospects. (Ankrah, 1994).

Children affected by AIDS are those children under 18 with additional vulnerabilities and disadvantages due to HIV and AIDS, including:

- Having parents who are HIV infected or suffering from AIDS.
- Leading or living in child-headed households.
- Living in families that are caring for orphans or other additional family members due to AIDS.
- Living in communities severely devastated by HIV and AIDS.
- Being orphaned due to AIDS (maternal, paternal or both).
- Living with HIV since birth.
- Having been newly infected with HIV.
- Being especially vulnerable and at risk of HIV infection due to lack of economic or gendered power in the face of the epidemic. (UNAIDS IATT on Education. 2008).

A large qualitative study in India (Loudon et al, 2007) of children affected by HIV (with an HIV-positive parent or orphaned by AIDS) reported that stigma was one of the major reasons for dropping out of school. In focus groups of 281 pre-adolescents (aged 9–12), 295 adolescents (1–17), 487 care givers, and 441 heads of households, children reported that ostracism and humiliation by their peers were their major concerns. Young children reported losing interest in their studies, becoming depressed, and dropping out of school because of taunts by peers. All the adult caregivers reported that stigma and discrimination by teachers was the major educational barrier. Some caregivers reported that children with HIV-positive parents had been denied school admission. Moreover, the study reported key informant

interviews with more than 300 service providers where 43% reported being aware of the exclusion of HIV affected children for services related to well-being, 29% were aware of exclusion related to education, and 41% were aware of exclusion within the health sector.

Loss of home, dropping out of school, separation from siblings and friends, increased workload and social isolation may all affect negatively current and future mental health growth. (Makame,V., et al. 2002). Existing studies of children's reactions suggest that they tend to show internalizing rather than externalizing symptoms to response to such impacts-depression, anxiety and with-drawl as opposed to aggression and other forms of anti-social behaviour (Sengendo, J., Nambi, J., et.al.1997).

A study by eminent HIV/AIDS expert on children G.,Foster & J.,Williamson highlights the fact that the health of the children affected by HIV/AIDS is compromised due to lack of proper care and supervision at home , may suffer from malnutrition and may not have access to available health services , although no studies have yet demonstrated increased mortality and morbidity among affected children compared to unaffected control groups. He further suggested that the safety nets of families and communities are still sufficiently intact to protect the majority of children from the most extreme effects of the epidemic (Foster,G., Williamson,J.,et al.2000).

The economic and social effects of HIV/AIDS on children include Malnutrition, poverty, neglect, migration, and homelessness .Psychological effects are depression, guilt, and fear, possibly leading to long term mental problems. The combination of these effects compromises children's access to an adequate standard of living , health and education and increase their vulnerability to a wide range of consequences, including illiteracy, poverty, child labour, sexual and

other forms of exploitation, HIV infection, and unemployment in adulthood(Geoff Foster, et al 2006).

A study by Mehra, J (2000) on impact of HIV/AIDS on children in Manipur found that the affected families had discontinued sending the children to school. Older children had to drop out of school for providing economic support to their families. The mothers faced the problems of choice whether they should feed the healthy children or buy medicines for their infected child. Infected children were denied treatment at the state and districts hospitals.

A study by Rajkumar,V(2000) on HIV/AIDS and Children, found that poverty, early initiation to work and discontinuation of education , the ability of children to relate to HIV/AIDS, gender, lack of access to youth, friends and health services etc. were factors related to the increase in AIDS cases among children. Maharashtra has the highest number of persons reported to have developed AIDS in India, and the highest percentage of women who have tested positive in antenatal clinics. Overall impact of the infection observed was that children were forced to discontinue their education due to the financial drain of medical bills. The number of families that are headed by widows is increasing along with the number of orphaned children. Where parents are ill or have died, there was increased load on the extended family, and those children who did not have support of an extended family were the worst hit. The mortality rate for this group of children is higher due to their frequent medical complications. The problems get more acute when they develop AIDS.

Widow's Context;

Patil (1988) considers widowhood as a change in the status of a woman brought about by the death of the spouse in the marital dyad

which necessitates established of new relations within the family with the kin-group and with community.

Very few published works are available on the topic under study. There is plenty of incidence occurred to the widows related to HIV/AIDS. Moreover, the study has not been taken up as an academic venture by any of the researcher. News reports, Seminar and different Government reports show the case and prevalence of HIV/AIDS affected widows in our country.

HIV widows are fairly young, mostly in the age of 20 to 30 years and their households are economically and socially worse off than the other HIV households. Their household income, availability of amenities as well as ownership of assets and consumer durables is much lower. Further, a higher percentage of widow households are below the poverty line as compared to the others. (UNDP; NACO; NCAER, 2006).

T.N.Kitchlu(1993)observes that in order to overcome the economic hardships after the husband's death, widow seeks to get employment in both organized and unorganized sector. He also finds out that among rural widows, 30.40 per cent faced problem in getting jobs in comparison to 14.29 per cent urban widows who had better educational qualifications .The study further states that 40 percent of the Muslim widows had to face problems in getting jobs in comparison to 12.50 per cent of Hindu widows and 11.76 per cent of Christian widows.

K.V.Edwara Prasad (1998) highlights the problems faced by the destitute widows in accessing to the pension scheme in Tamil Nadu. The problems highlighted by the researcher include lack of easy accessibility to administration, as well as rigid procedures involving eligibility criteria, insensitivity to their needs, difficulty in obtaining information and applying for assistance.

Balwinder Arora (2006) has highlighted the lack of knowledge of a widow regarding husband's business property, as well as social security schemes as some of the major problems afflicting the widows in Punjab.

Baidyanath Saraswati (1985) highlighted that widowhood not only leads to social, cultural, psychological and economic deprivation but also impacts the relationship of widow with her husband's family. Both the family and the widow may be unable to adjust to the death of the male head of the house hold and this is the cause of many widows moving to Kashi or Vrindavan.

Hijam Dinesh (2009), in his paper presentation on Human Rights violations with special reference to PLWHA, has said, that the Widows are mostly thrown out of their home by their in-laws family and again they are not wanted at their parental home due to various reasons, especially, the reason for sharing her parental property.

Karines Bates (1998) in her study in rural Maharashtra has focused on problems of widows in respect of inheritance of property. She argues that widows have very vague knowledge of the law of inheritance and are not aware of the banking procedures as bank accounts are generally operated by their husbands. The problem is further compounded by non-registration of marriage, which enables relatives to question the validity of their claim to inheritance.

Usha Rani (2006) points out the difference in the income and resultant problems of widows in organized and unorganized sectors. They observe that in the organized sector, the widow's salary gets supplemented by the late husband's pension, while those working in unorganized sector have only their salary as the source of income. This income is not sufficient to meet their expenses.

Bridget (2001) Panos AIDS Programme in his paper presentation on 'Widows and AIDS' Redefinition and Challenges concludes that major problem facing widows is the fact that they are so often seen as little

more than victims. There is a need to ensure the intervention targeting widows in their own right. However, if policy makers, NGO's and the media continue to fail to address the causes behind the particular vulnerability of widows, they continue to be discriminated against and fail to recognize the changes that HIV/AIDS is dictating.

Sadek, N (2007), the Special Advisor to UN Secretary General and the special envoy for AIDS in Asia speaks in the context of Feminization of the virus. Global figures show that the percentage of women affected by the virus is increasing. In Asia, the situation is quite alarming with 5.4 million new cases being reported every year.

A Help Age International reports (2000) from Tanzania revealed that some 500 older women, mostly widowed in the context of AIDS, were stoned to death or deliberately killed.

In the Global survey on HIV/AIDS and Person (2000), women face disadvantage and as women, they are discriminated against on the basis of gender.

Singh B.K (2007) 'A report on contextual Analysis Study on HIV/AIDS in Manipur' finds that most of the clients are facing multiple cases relative to HIV, stigma and trauma, lack of psychological supports from the family and community.

Thekka. M (1988) *The Widows Encounter with Problems* says that even though in our society, a widow is taken care of by either her husband's family or by her father's family, she loses her status and importance both in her family and in society. He further opines that in spite of the changes in Indian society, their position has not improved much.

There are few published about the incident, occurring in Manipur, however from the sources of voluntary organization (SASO), through International HIV/AIDS Alliance (IHAA). SHALOM came across that an infected woman was insulted by cutting her hairs in public confirming

that she was infected because of her immoral character. Another widow, an infected with HIV/AIDS returned to her father's house, because after her husband's death, her in-laws abandoned, treated her badly and made her unable to bear and stay any longer at her in-laws house.

In the reports of Assam tribune papers on Manipur Domestic Violence Against Women, the Widow and infected with HIV positive shared the story of how she has been exploited and discriminate by the community (Feb 2008).

North East Network (NEN), a resource directory (2003) reports shows that both men and women with HIV/AIDS are discriminated against within the level of discrimination but violence faced by the women is much higher.

It would be appropriate to refer to the study of Dutta, S (2005) where few cases of discriminated reported through some cases of glaring discrimination and inhuman treatment and indignities towards the HIV positive patient. The relevant cases are mentioned below.

A housewife with HIV has been driven out of her family by the family members under the fear of social ostracism. Even her husband demanded compensation from his father – in – laws.

In another case that happened in a village in Midnapore district West Bengal, a widow and her son infected with HIV were thrown out of their house. The widow contracted the disease through her husband who died 2 years ago. Not only that, she is deprived of property and assets due to them in the joint family. They now live in the thatched hut in bamboo grove in one corner of the village.

A widow in Orissa Ganjam District was burnt to death by her in-laws. According to police, her husband had died of AIDS and the couple's two children also died successively after they inherited the HIV virus at birth.

The study conducted by National Council of Applied Economic Research (NCAER) with support from the National AIDS Control Organisation (NACO) and United Nations Development Programme (UNDP) 2004 on socio economic impact of HIV and AIDS in Manipur found out that about 43%of the HIV Households have either borrowed or liquidated their assets to cope with increased financial burden. It also found that poor among the HIV households are under serious constraints in attempting to meet their consumption expenditure.

In the paper presentation by Sr.Lizy on social support and stigma towards people living with HIV/AIDS in Kerela found out that among the families of PLWHA , communication and cohesion are affected, which may indirectly affect their family interaction . Most of the families do not receive adequate support which needs immediate attention. It is also reported that the respondents experienced discrimination from various sources i.e from their partner, sibling, their own children, relatives, friends and neighbours. They experienced discrimination from various settings such as health care setting, work place and co-workers, from public gatherings and functions.

In the Paper Presentation by Dr.Pranali Patil and Dr.Keshao Patila on the “Etiology of HIV/AIDS among Women in Nagpur city”, it was found out that almost all the women got infection through their husband. They were infected at the age of 22 years and above and in two cases after ten years of marriage when they are above 35 years of their age. Moreover, due to HIV/AIDS, all the women are discriminated by the society.

May(2000)refers to the “time poverty” experienced by women which is the result of the long hours women spend on their reproductive roles- collecting fire woods, water, child care, cooking and cleaning to the detriment of their own well-being.

Bangkim,C, in his presentation says that majority of the widows have no source of income. They are either wage earners in the market areas or doing small petty business. They face tremendous psychological trauma beside stigma and discrimination from their relatives and society at large. They are constantly worried about the future of their child's education and health as well as custody after death.

A report from the 'Hindu', Madurai edition 2003 stated that a widow in the state of Andhra Pradesh, who had contracted the virus from her husband, was stoned to death by her relatives and fellow villagers. HIV/AIDS status for a person has varied implications on the life of an individual. The person identified with HIV has to deal with many situations while living with HIV/AIDS. While going through the different experiences the individual experiences various kinds of agony which lead to poor conditions for the individuals. The status of PLWHA's is worsened their experiences of stigma and discrimination at family, community or in various setting.

The studies of Balk, Pathak and Lahiri (1995, 1997) looked at 13 states for which supplementary questions on knowledge of HIV/AIDS were included in NFHS-1. In 13 states considered as a whole, only 17 percent of ever-married women of reproductive age had ever heard of AIDS. This percentage varied from 8 percent in Assam to 85 percent in Mizoram. By residence, it varied from 8 percent in rural areas to 33 percent in urban areas. By education, it varied from 2 percent among illiterate women to 71 percent among women with at least a high school education. By media exposure, it varied from 2 percent among women with no media exposure to 34 percent among those who regularly watch television. Even among those who had heard of AIDS, only about one-fourth had a sound understanding of how the disease is transmitted. Despite low level of awareness and knowledge, the findings indicate a strong positive co-relation between knowledge of AIDS and condom use.

The main policy implications are that the government needs to mount a major public education campaign about HIV/AIDS and to intensively promote condom use among high-risk subgroups. The mass media need, to become much more effective communicators about AIDS. The finding that teachers are rarely a source of HIV/AIDS information suggests that a comprehensive HIV/AIDS-awareness program should include an expanded role for schools. Most important, effective ways to convey HIV/AIDS information to the rural majority and the illiterate must be developed — for example, through new uses of film, health workers, and community meetings.

Given the context of HIV/AIDS situation in Manipur, it can be mentioned that HIV can hit different population or different geographical areas in dissimilar ways, ways that may change over the course of time. It is recognized that the more we learn about the way HIV moves through communities, the more we understand the relationship between HIV spread and other factors like social, economic, political and cultural phenomenon which is rarely simple (UNAIDS/WHO).

A particular concern in Manipur is the growing rate of HIV/AIDS among injecting drug users (IDUs). Indeed, an article published in 2002 reports that “the biggest problem, and the root cause of drug abuse, which is widely prevalent among the population of Manipur is poverty and the near total absence of Industrial development”. The articles illustrate the critical nexus of injecting drug use, HIV/AIDS and poverty: “In Manipur about 72 per cent of HIV/AIDS cases originate from sharing of needles and syringe by injecting drug users (IDUs) (Bhagat, Rasheeda, 2002).

Thomas and Bandopadhyay, M (1999) conducted a study which looks at vulnerabilities of indigenous group in Manipur. This study mentions that civil unrest and other socio economic problems are leading to an increased vulnerability to HIV/AIDS. Women are often the greatest

sufferers in situations of civic unrest, vulnerable to violence and therefore, infection both by insurgents and by security agencies.

From the above mentioned different studies, it appears that lots of studies have been conducted on PLWHA, where it has found the socio economic life and hardship, pattern of discrimination, negligence and the way of life. It was also understood the whether that community is developed or developing; discrimination patterns are the same .The people from poor background faced more economic as well as social hardship. The results of studies on women HIV experience show that it was more critical and difficult to continue their life and tolerate in the society. They were the most vulnerable group among the HIV affected. There seem to be no substantive published literature on widows/children care and studies on North East etc. Hence, there is a gap in the existing literature on this issue and there is a need of conducting studies on widows with special reference to their social life, child management and its care and support from various angles. Thus, this study attempts to fill this gap in the existing literature.