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Empowering Women Victims of HIV & AIDS Pandemic in Andhra Pradesh: India

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Abstract: The paper is limited to the problems and issues related to the heterosexual transmission of HIV because that has been the considered in detail with its investigation work. It has been focused that heterosexual transmission is one of the aspects of the epidemic, since the most recent statistics show that heterosexual transmission of HIV remains by far the most common mode of transmission in India and globally. In general the focus of International Women's Day 2013, global leaders and social scientists joined the call for equal rights and equal opportunities for all women. Though women's achievements focused and reviewed, it is to remember / realise that many challenges still remain and that women's empowerment can mean the difference between life and death. As emphasised by Gaeta Rao Gupta ICRW, US 2012 that it was known for at least a decade that gender and sexuality are significant factors in the sexual transmission of HIV, and also elaborated that they also influence treatment, care, and support. Both terms, nevertheless, continue to remain misunderstood and inappropriately used. Further has been focused that Gender is not a synonym for sex. It refers to the widely shared expectations and norms within a society about appropriate male and female behaviour, characteristics, and roles. It is a social and cultural construct that differentiates women from men and defines the ways in which women and men interact with each other. The outcome of the study indicates, that three overarching themes are revealed through the women's stories: 1) the empowerment and resiliency demonstrated by the participants; 2) the need for cultural competency in a society that continues to stigmatize HIV-positive women; and, 3) the need for a more systematic and holistic approach within society when it comes to education, learning, and healing.

Keywords: Heterosexual transmission, empowerment, education, information Technology, Adopting skills, services, Technical knowhow and Social vaccination.

1. INTRODUCTION

This qualitative research study focuses explicitly on understanding the experiences and perceptions of women living with HIV/AIDS. Stigmatizing attitudes and language have serious impacts upon the lives of HIV-positive women. Current research indicates that there are many factors associated with women being at higher risk for infection and lower physical and mental health, such as race, socio-economic conditions, isolation, oppression and violence, family history, substance abuse, discrimination, and often the responsibilities of childrearing. Material was collected using semi-structured, open-ended questioning conversations with the participants. Most of the studies express the problems and concerns related to the people who are living with HIV & AIDS. Only a very few studies are convey the social, economical and emotional feelings of the women living with HIV & AIDS to the society. Very few in the society is thinking about the infected women and their mental condition and their economical status. So through this study is

to explore the feelings of the infected women regarding stigma & discrimination, family economic conditions and emotional factors which are compelling them to death sometimes in order to identify and distinguish different areas and strategies where the society can empower the HIV and AIDS victims.

2. WOMEN AND HIV/AIDS

Examining the situation of women and the HIV epidemic provides the basis for understanding the link between the epidemic and women's rights issues. Generally, the epidemic has largely flourished in the most affected regions because women and girls have limited means and power to protect themselves—and vulnerability to HIV results from the lack of power of individuals and communities to reduce or manage their risk of exposure to HIV infection. Once infected, women and girls have limited means and power to access the care and support they need. HIV/AIDS vulnerability is gender-biased and mediated by factors that are largely out of women's control. These factors include gender-based violence, imbalance in sexual power relations, unequal access to rights, discriminatory laws and policies, traditional norms and practices, poverty, and poor access to services. For very vulnerable subpopulations of women such as sex workers, their level of vulnerability is increased by being women as well as by engaging in an economic activity that exposes them to greater social, sexual, and physical abuse and to increased risk of HIV infection.

3. GLOBAL SCENARIO OF HIV / AIDS

As per the latest statistics of UNAIDS on World AIDS Day report 2012, worldwide, women constitute more than half of all people living with HIV/AIDS. Among young people aged 15-24, the HIV prevalence rate for young women twice that of young men. Besides the women in their reproductive years (15-49) , HIV/AIDS is the leading cause of death. The statistics of the global HIV and AIDS epidemic were published by UNAIDS, WHO and UNICEF in November 2011, and refer to the end of 2010.

The number of people living with HIV rose from around 8 million in 1990 to 34 million by the end of 2010 and proportion of women is in the order of 47 to 53%.By the end of 2009 ,there are 15.9 million Women living with HIV/AIDS around the Globe. Where in it was reported in the resent statistics related to 'Asia and the Pacific', nearly 372,000 people became newly infected in 2011, bringing the total number of people living with HIV/AIDS there to nearly 5 million. AIDS claimed an estimated 310,000 lives in the region in 2011.

5. THE INDIAN CONTEXT: SITUATIONAL ANALYSIS:

NACO 2008, GoI report has emphasised that , in India, experts point out that there is no one single epidemic. Instead there are numerous sub-epidemics which are localized in nature reflecting the diverse socio-cultural reality of the country. Some significant structural and socio-economic factors serve to exacerbate the existing vulnerabilities to

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Table: 1

	Estimate	Range
People living with HIV/AIDS in 2010	34 million	31.6-35.2 million
Proportion of adults living with HIV/AIDS in 2010 who were women (%)	50	47-53
Children living with HIV/AIDS in 2010	3.4 million	3.0-3.8 million
People newly infected with HIV in 2010	2.7 million	2.4-2.9 million
Children newly infected with HIV in 2010	390,000	340,000-450,000
AIDS deaths in 2010	1.8 million	1.6-1.9 million

Source: Statistics published by UNAIDS in November 2010, referring to the end of 2009.

Table: 2

	Estimate	Range
People living with HIV/AIDS in 2009	33.3 million	31.4-35.3 million
Adults living with HIV/AIDS in 2009	30.8 million	29.2-32.6 million
Women living with HIV/AIDS in 2009	15.9 million	14.8-17.2 million
Children living with HIV/AIDS in 2009	2.5 million	1.6-3.4 million
People newly infected with HIV in 2009	2.6 million	2.3-2.8 million
Adults newly infected with HIV in 2009	2.2 million	2.0-2.4 million
AIDS deaths in 2009	1.8 million	1.6-2.1 million
Orphans (0-17) due to AIDS in 2009	16.6 million	14.4-18.8 million

Source: Statistics published by UNAIDS in November 2010, referring to the end of 2009.

HIV infection:

- High poverty levels, with more than 35 percent of the population living below the poverty line;
- skewed gender relations
- Large scale migration
- Low levels of literacy
- Unsafe mobility
- Lack of awareness
- Cultural myths, misconceptions, silence and resulting stigma regarding sex, sexuality and HIV
- Commercial sex and unprotected sex with multiple concurrent partners
- Male resistance to condom use
- High prevalence of sexually transmitted infections

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- Low status of women, resulting in inability to negotiate safer sex
- Women's limited control over and access to economic resources

Since the detection of the first case in Chennai in 1985, the epidemic has spread to all parts of the country from urban to rural areas, infecting the most marginalized especially the poor women, and has moved out to general population from High Risk Groups. Among the high risk groups, the infection rate is as high as 7.23 percent among Injecting Drug Users (IDUs), while it is 7.41 percent and 5.06 percent among Men who have Sex with Men (MSM) and Female Sex Workers (FSWs), respectively

6. STRATEGIES AND AREAS OF EMPOWERMENT

From the study it has been projected that the following ten distinct areas to be focused as it is essential and crucial for empowerment of women victims of HIV/AIDS. 1. Information; 2.Education; 3.Adopting skills; 4.Access to services; 5. Technical knowhow; 6.Economic resources; 7. Social vaccination; 8. Involvement or opportunity to have a voice in decision-making at all levels. 9. Employment; and 10. Accesses to Health care centres.

Thus, to empower women we must:

- Educate women. Give them the information they need about their bodies and sex. Information is power and women have the right to receive it.
- Give women the skills they need to use a condom. Make them condom literate. Provide skills training on communication about sex and foster inter-partner communication.
- Improve women's access to economic resources. Ensure that they have property and inheritance rights, have access to credit, receive equal pay for equal work, have the financial, marketing and business skills necessary to help their businesses grow, have access to the agricultural extension services to ensure the highest yield from their land, have access to formal sector employment, and are protected in the informal sector from exploitation and abuse.
- Ensure that women have access to health services and that they have HIV and STI prevention technologies that they can control, such as the female condom and microbicides. And support the development of an AIDS vaccine that is safe, effective, and accessible to women and young girls.
- Increase social support for women who are struggling to change existing gender norms by giving them opportunities to meet in groups, visibly in communities; by strengthening local women's organizations and providing them with adequate resources; and by promoting sexual and family responsibility among boys and men.
- Move the topic of violence against women from the private sphere to the public sphere. This is not a personal issue it is a gross violation of women's rights and is has significant negative implications for the health of communities and for economic development.
- And, to give women a voice, provide them with the opportunity to create a group identity separate from that of the family because for many women the family is of-

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ten the social institution that enforces strict adherence to traditional gender norms; and promote women's decision-making at the household, community, and national level by promoting women's leadership and participation.

7. INCLUSIVENESS AND STRENGTHEN THE POSITION OF WOMEN

- Support business opportunities for women, particularly those most at risk populations, widows and women living with HIV and AIDS.
- Promote female-owned business in supply chains and in public-private dialogue.
- Provide technical assistance and training to community and industry networks on enhancing participation of women, especially those at-risk, widows and infected women in the workforce.
- Develop financial literacy programs tailored to age, gender, marital status and context.
- Strengthen provision of support services such as crèches and day care centers as well as redressal systems that promote an enabling environment for women at work.
- Facilitate access of appropriate government programs for women's empowerment. Build capacities of the community to monitor implementation of the programs

8. VULNERABILITY

The most disturbing form of male power, violence against women, contributes both directly and indirectly to women's vulnerability to HIV. In population-based studies conducted worldwide, anywhere from 10 to over 50 percent of women report physical assault by an intimate partner. And one-third to one-half of physically abused women also report sexual coercion (Heise, Ellsberg, and Gottemoeller 1999).

9. POWER IMBALANCE AND HIV/AIDS

In addition to increasing the vulnerability of women and men to HIV, the power imbalance that defines gender relations and sexual interactions also affects women's access to and use of services and treatments.

10. OVERCOMING INEQUALITY

To effectively address the intersection between HIV/AIDS and gender and sexuality requires that interventions should, at the very least, not reinforce damaging gender and sexual stereotypes. Many of our past and, unfortunately, some of our current efforts, have fostered a predatory, violent, irresponsible image of male sexuality and portrayed women as powerless victims or as repositories of infection. This poster, in which a sex worker is portrayed as a skeleton, bringing the risk of death to potential clients, is an example of the latter which, from experience we can predict, probably succeeded in doing little

other than stigmatizing sex workers, thereby increasing their vulnerability to infection and violence .

11. GENDER-SENSITIVE APPROACHES

Efforts to integrate STD treatment services with family planning services to help women access such services without fear of social censure is another example of such an approach. We know that such pragmatic approaches to programming are useful and necessary because they respond to a felt need and often significantly improve women's access to protection, treatment, or care. But by themselves they do little to change the larger contextual issues that lie at the root of women's vulnerability to HIV. In other words, they are necessary, even essential, but not sufficient to fundamentally alter the balance of power in gender relations.

12. TRANSFORMATIVE APPROACHES

Far too many women are still powerless against the threat of HIV, especially in sub-Saharan Africa, where women and girls represent about 60% of HIV infections. AIDS is the leading killer of women of reproductive age worldwide. Current HIV prevention strategies such as condoms, although effective, are not practical for women who cannot persuade their husbands or partners to use them, who want children or who are at risk for violence. Women still lack an effective way to protect themselves against HIV.

13. CONCLUSION

Health care professionals who have lost many patients to HIV/AIDS begin to suffer because they have inadequate time to grieve or deal with their losses. Like their patients, they display many of the symptoms of the stages of grief (denial, anger, guilt, bargaining, depression, and acceptance). However, as they experience loss after loss, the stages become intermingled. They have not worked through one loss before another occurs. Loss of multiple patients can lead to complicated and ongoing grief and can prevent the health care worker from processing the thoughts, feelings, and responses to patients in healthful and helpful ways. Over time, the unacknowledged sadness, anger, and guilt can become compressed and result in cynicism and decreased ability to invest emotionally in patients. It is painful to acknowledge the feelings associated with seeing patients suffer and die, so the professional becomes more hardened and expresses less sensitivity and sympathy for the needs of the next patient.

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