CHAPTER - I

INTRODUCTION

“In that mission, how we fare in the fight against AIDS is crucial. Halting the spread is not only a Millennium Development Goal in itself; it is a prerequisite for reaching most of the others. That is why the fight against AIDS may be the great challenge of our age and our generation. Only if we meet this challenge can we succeed in our other efforts to build a humane, healthy and equitable world.”

Secretary-General Kofi Annan, General Assembly High Level Meeting on HIV/AIDS, in New York, on June 2nd, 2005

1.1 MDGs AND HIV/AIDS

The Millennium Development Goals are intertwined. Without achieving substantive progress towards the HIV-specific Goal 6, few other Goals are likely to be reached; likewise, without integration and significant progress towards most other goals being made, Goal 6 will probably not be achieved. Stopping infections, saving lives and improving the quality of life of people living with HIV have always been at the heart of the global AIDS response. AIDS impacts negatively on all the other MDGs. It affects poverty outcomes (MDG 1) and impedes universal access to education (MDG 2) – especially in countries with high prevalence rates. It also has forceful consequences on maternal and child health, since the HIV infection increases the frequency of obstetrical and neonatal problems. The successes and continuing challenges serve as catalysts for continued action.

The vital importance of HIV/AIDS within the global development agenda has been recognized in the sixth MDG, which is to halt and begin to reverse the spread of HIV/AIDS by 2015. However, not only is reversing the spread of HIV/AIDS a goal in itself, but there are also close linkages between the HIV/AIDS epidemic and other MDGs. It is clear that the achievement of all the MDGs depends in part on progress in turning around the HIV/AIDS epidemic, while success in the response to the epidemic
will not be possible without the achievement of the other MDGs. The countries where the incidence of HIV/AIDS had increased tremendously, have witnessed a collapse of social and economic sustainability. The linkages further demonstrate the close relationship between HIV and human development, as well as the pressing need for broad-based multi-sectoral responses.

1.1.1 Linkages between HIV/AIDS and the other MDGs:

1. Eradicate extreme poverty and hunger

The loss of productive capacity among families affected by HIV/AIDs has a major impact on economic growth, food production and nutritional well being (in the hardest-hit countries, economic growth has fallen by 4 percent and labour productivity has been cut by up to 50 percent).

2. Achieve universal primary education

The quality of education services and teaching is affected because of higher absenteeism among teachers due to illness. More school children are caring for their sick parents and such responsibilities force them to drop out of school. AIDS-related illness eats into family budgets, making it more difficult to pay for school.

3. Promote gender equality and empower women

Girls are more likely to be kept out of school to provide care, or when resources are limited. Women take on the greater burden of caring and face greater economic insecurity when wage earners fall ill. While gender equity, both social and economic, is a critical factor in reducing risk, HIV/AIDS exacerbates gender inequalities and burden on women.

4. Reduce child mortality

Infant and child mortality will continue to increase for the next decade, and possibly longer, due to parent-to-child HIV infection.
5. Improve maternal health

HIV/AIDS is increasingly a cause of death among mothers.

6. Ensure environmental sustainability

Illness, increased labour demands for caring for patients, and lost labour reduce time for fetching water, especially for women. Human resource losses and costs in water supply services affect delivery and increase the cost of services to households.

7. Develop a global partnership for development

HIV/AIDS continues to place additional resource burdens on developing countries.

1.2 GENDER ASPECTS OF HIV/AIDS

In countries where HIV transmission occurs predominantly through heterosexual sex, as is now increasingly the case everywhere, women are more likely than men to be infected. Gender relations and gender inequalities play a major role in this context of the spread of HIV/AIDS. Adequate understanding of gender-related determinants that shape vulnerability to HIV infection is, therefore, fundamental for addressing health care and treatment strategies.

Two aspects of this question need to be considered. On one hand, as the percentage of women living with HIV is increasing among the total number of HIV/AIDS victims, actions focused on women as a part of SRH services become increasingly important. On the other hand, the mechanisms accounting for HIV infection among women involve specific Gender problems and vulnerability that are different from those encountered among other groups.

AIDS evokes negative reactions – denial, shame, fear, anger, prejudice, in-equity and discrimination these manifest themselves in interpersonal and group relationships. The widows of HIV infected men are treated in a negative way and regarded by others as
being flawed, incapable and morally degenerate or undesirable. A widow of HIV infected man fears that her family and relatives will reject her if she is HIV positive. This practice and outcropping of stigma, naturally discourages testing for HIV, as a result neither individuals nor their relations have the basic information that they need to fight the epidemic.

The percentage of women living with HIV and AIDS varies significantly between different regions of the world. According to an NCAER (2006) report titled ‘Gender Impact of HIV and AIDS in India’, biological, societal and economic factors make women and young girls more vulnerable to the epidemic. The report reveals that the low status of women, poverty, early marriage, trafficking, and sex work, lack of education and gender discrimination are factors responsible for the increasing vulnerability of women and girls to HIV infection. There are a number of factors—biological, socio-cultural and economic— which make women and young girls more vulnerable to HIV and AIDS. Women are at a biological disadvantage of contracting the virus as HIV is more easily transmitted to a female body as compared to men. In sub-Saharan Africa, young women in 15-24 age groups were 2.5 times more likely to be infected as compared to men of the same age group. Gender inequality and poverty are responsible for the spread as well as disproportionate impact of the epidemic on women. The gender inequalities get reflected in the sexual relations between husband and wife. In India, women do not have the right to decide and negotiate safe sex and ask men to use condoms. There is also lack of availability of female-controlled HIV preventive methods. Cultural norms and attitudes condoning multiple sexual partners for men, and their pre- or post-marital sexual relationships increase women’s risk of getting infected with the virus (UNDP 2006). AIDS has affected millions of women worldwide. Elizabeth Glaser, Gugu Dlamini and Rebekka Armstrong are a few of the many women who have become publicly known for their personal stories in the fight against HIV and AIDS.
1.3 FEMINIZATION OF HIV-AIDS

The spread of the disease has been the result of highly unequal gender relations and also affects men and women differently. Women shoulder the increased burden of care within the household and the community, in addition to their domestic work and economic responsibilities. This increased care or the disease itself lessens the ability of women to work in the formal, informal or agricultural sectors, leading to a further loss of income, reduction in child care and food security. In cases where the male members of the household stop earning or die of AIDS, the women are left to provide for the rest of the family, and this can include being pushed into the sex trade. Finally, women are often blamed for their families and their own sickness, and are ostracized by the extended family and community, leading to their bearing the social and psychological burden of the disease as well. “This epidemic unfortunately remains an epidemic of women”, said Michel Sidibé, Executive Director of UNAID and it sums up the cause and effect of HIV/AIDS and women. The AIDS epidemic has had a unique impact on women, which has been exacerbated by their role within society and their biological vulnerability to HIV infection.

Generally women are at a greater risk of heterosexual transmission of HIV. Biologically women are twice more likely to become infected with HIV through unprotected heterosexual intercourse than men. In many countries women are less likely to be able to negotiate condom use and are more likely to be subjected to non-consensual sex. Additionally, millions of women have been indirectly affected by the HIV and AIDS epidemic. Women’s childbearing role means that they have to contend with issues such as mother-to-child transmission of HIV. The responsibility of caring for AIDS patients and orphans is also an issue that has a greater effect on women.

The number of women living with HIV and AIDS in Asia varies greatly between different countries, and in places largely affected by the epidemic, such as India, the numbers vary between different states. Although women are often perceived to be at low risk of HIV infection because it is not common to have more than one lifetime sexual
partner, a great number of women are put at risk of HIV infection as a result of their husbands having unprotected sex outside of marriage or injecting drugs. It has been estimated that 90% of women living with HIV in Asia were infected by their husband or long-term partners.

The burden of HIV/AIDS has to be borne by women more as compared to men--

**Responsibility of care:** Caring for ill parents, children or husbands is unpaid and can increase a person’s workload by up to a third. Women often struggle to bring in an income while providing care and therefore many families affected by AIDS suffer from increasing poverty. In some areas of sub-Saharan Africa where a family’s livelihood relies on growing and maintaining crops, the death of farmers can lead to famine. The care of family members who fall sick because of HIV / AIDS add existing burden of domestic and economic duties. Coping with her HIV status and looking after her child burden, which she has to manage along with her own health as social vulnerabilities.

**Inequalities within the family:** In some societies, women have fewer rights within sexual relationships and the family. Often men make the majority of decisions, such as whom they will marry and whether they will have more than one sexual partner. This power imbalance means that it can be more difficult for women to protect themselves from getting infected with HIV. For example, a woman may not be able to insist on the use of a condom if her husband is the one who makes the decisions. Marriage does not always protect a woman from becoming infected with HIV. Many new infections occur within marriage or long-term relationships as a result of unfaithful partners. In a number of societies, a man having more than one sexual partner is seen as the norm.
**Women’s inheritance and property rights:** In many countries around the world, women do not have the same property rights as men. Especially in sub-Saharan Africa, property is typically owned by men and even when married, women still do not have as many property rights as their husbands. Inheritance rights are just as discriminatory, as when a husband dies, his property often goes to his side of the family and not to his wife. The denial of a woman’s inheritance and property rights can increase her vulnerability to HIV. Not being able to own property means that women have limited economic stability. This can lead to an increased risk of sexual exploitation and violence, as women may have to endure abusive relationships or resort to informal sex work for economic survival.

**Loss of income:** As care of the sick of dying takes women’s time, or a woman becomes sick herself, she may be forced to abandon work in formal or informal sectors, with consequent reduction in family income and food security. Lack of time and resources, sickness and exhaustion may lead to the neglect of children.

**Economic support of the family:** Women are more likely to be blamed for becoming HIV positive, even if they have led monogamous lives, and promiscuous partners are infected them. Their husbands who visit sex workers or are intravenous drug users infect many women. Women’s economic dependence on men, violence against women and the greater acceptability of male promiscuity combine to leave women at particularly high risk for HIV infection. In addition, women have to take the responsibility in the absence of their husbands or due to their sickness.

With loss of income as result of illness or death of an earning member, women are often to support the family and children in whatever they can. This may include using sex as one of the few avenues of economic responsibilities to resource the response to the degree that their means permit support open to her. Increasingly, countries with heavy HIV burdens are assuming their domestic expenditure is the largest source of HIV financing globally today, accounting for 52% of resources for the HIV response in low- and middle income countries. Improving financing for the global response will require
ongoing efforts to mobilize domestic resources among countries that appear to be under-investing in the HIV response, increasing the efficient use of funds for HIV and other related health and development programmes, and increasing external aid in a global environment of constrained resources.

**Stigmatization:** Stigma is expressed in language. Since the beginning of the epidemic, the powerful metaphors associating HIV death, guilt, punishment, crime, horror and ‘otherness’ have compounded stigmatization. It is often the women who are blamed for their husband and for their child falling sick, as well as being railed for her own infection, leading to rejection and expulsion by the family and community. AIDS-related stigma and discrimination refers to prejudice, negative attitudes, abuse and maltreatment directed at people living with HIV and AIDS. The consequences of stigma and discrimination are wide-ranging: being shunned by family, peers and the wider community, poor treatment in healthcare and education settings, an erosion of rights, psychological damage, and a negative effect on the success of HIV testing and treatment.

### 1.4 GLOBAL SCENARIO OF HIV/AIDS

Since 1999, the year in which it is thought that the epidemic peaked, globally, the number of new infections has fallen by 19%. Of the estimated 15 million people living with HIV in low- and middle-income countries who need treatment today, 5.2 million have access, translating into fewer AIDS-related deaths. For the estimated 33.3 million people living with HIV after nearly 30 years into a very complex epidemic, the gains are real but still fragile. Future progress will depend heavily on the joint efforts of everyone involved in the HIV response.

Slightly more than half of all people living with HIV are women and girls. In sub-Saharan Africa, more women than men are living with HIV, and young women aged 15–24 years are as much as eight times more likely than men to be HIV positive. Protecting women and girls from HIV means protecting against gender based violence and promoting economic independence from older men. Therefore, human rights are no
longer considered peripheral to the AIDS response. Today, the vast majorities of countries (89%) explicitly acknowledge or address human rights in their national AIDS strategies, with 92% of countries reporting that they have programmes in place to reduce HIV-related stigma and discrimination. At the same time, however, criminalization of people living with HIV still presents significant challenges to the AIDS response. More than 80 countries across the world have laws against same-sex behaviour, and the free travel of people living with HIV is restricted in 51 countries, territories and areas. Such laws are not only discriminatory and unjust—they also drive HIV underground and inhibit efforts to expand access to life-saving HIV prevention, treatment, care and support.

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 is that of young men. Besides for 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.

**Table-1.1: Estimated number of people living with HIV/AIDS the world.**

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<thead>
<tr>
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<th>ESTIMATE</th>
<th>RANGE</th>
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</thead>
<tbody>
<tr>
<td>People living with HIV/AIDS</td>
<td>34 million</td>
<td>31.6-35.2 million</td>
</tr>
<tr>
<td>Proportion of adults living with HIV/AIDS who were women (%)</td>
<td>50</td>
<td>47-53</td>
</tr>
<tr>
<td>Children living with HIV/AIDS</td>
<td>3.4 million</td>
<td>3.0-3.8 million</td>
</tr>
<tr>
<td>People newly infected with HIV</td>
<td>2.7 million</td>
<td>2.4-2.9 million</td>
</tr>
<tr>
<td>Children newly infected with HIV</td>
<td>390,000</td>
<td>340,000-450,000</td>
</tr>
<tr>
<td>AIDS deaths</td>
<td>1.8 million</td>
<td>1.6-1.9 million</td>
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*Source: Statistics published by UNAIDS in November 2010.*
Building social coalitions to reduce vulnerability to HIV infection supports individuals and strengthens communities. Safeguarding the health of mothers and infants and optimizing infant feeding provides a strong basis for the growth of new generations. Investing in health care and social support systems, working to eliminate violence against women and girls and promote gender equality and working to end stigma and discrimination against people living with HIV and members of other marginalized groups help to provide social environments that are effective against the spread of HIV and promote more general mental and physical well-being. And in providing HIV-specific services with an awareness of other health and social issues and forging appropriate linkages, the response to HIV can make an important contribution to global health.

1.5 HIV/AIDS IN INDIAN CONTEXT

The number of adults living with HIV and AIDS in India is estimated to be 2.3 million, of which 38 percent are women. As HIV transmission in India is largely through heterosexual contact, the infection rate for women is increasing, and the low economic and social status of women continues to be a barrier to preventing new infections.

Though India is a country with low HIV prevalence, it has the third largest number of people living with HIV/AIDS. HIV epidemic in India is concentrated in nature. The HIV prevalence among the High Risk Groups, i.e., Female Sex Workers, Injecting Drug Users, Men who have Sex with Men and Transgender is about 20 times higher than the general population. Most infections occur through heterosexual transmission. However, in certain regions, injecting drug users, men who have sex with men and single male migrants are contributing to the spread of HIV epidemic.

At the beginning of 1986, despite over 20,000 reported AIDS cases worldwide, India had no reported cases of HIV or AIDS. A report, published in a medical journal in January 1986, stated: “Unlike developed countries, India lacks the scientific laboratories, research facilities, equipment, and medical personnel to deal with an AIDS epidemic. In addition, factors such as cultural taboos against discussion of sexual practices, poor coordination
between local health authorities and their communities, widespread poverty and malnutrition, and a lack of capacity to test and store blood would severely hinder the ability of the Government to control AIDS if the disease did become widespread.”

Later in the year, India’s first cases of HIV were diagnosed among sex workers in Chennai, Tamil Nadu. It was noted that contact with foreign visitors had played a role in initial infections among sex workers, and as HIV, screening centres were set up across the country there were calls for visitors to be screened for HIV. Gradually, these calls subsided as more attention was paid to ensuring that HIV screening was carried out in blood banks.

In 1987, a National AIDS Control Programme was launched to co-ordinate national responses. Its activities covered surveillance, blood screening, and health education. By the end of 1987, out of 52,907 who had been tested, around 135 people were found to be HIV positive and 14 had AIDS. Most of these initial cases had occurred through heterosexual sex, but at the end of the 1980s a rapid spread of HIV was observed among injecting drug users (IDUs) in Manipur, Mizoram and Nagaland - three north-eastern states of India bordering Myanmar. (Panda S. 2002)

At the beginning of the 1990s, as infection rates continued to rise, responses were strengthened. In 1992 the government set up NACO (the National AIDS Control Organisation), to oversee the formulation of policies, prevention work and control programmes relating to HIV and AIDS. In the same year, the government launched a Strategic Plan for HIV prevention. This plan established the administrative and technical basis for programme management and set up State AIDS bodies in 25 states and 7 union territories. It was able to make a number of important improvements in HIV prevention such as improving blood safety. By this stage, cases of HIV infection had been reported in every state of the country. Throughout the 1990s, it was clear that although individual states and cities had separate epidemics, HIV had spread to the general population. Increasingly, cases of infection were observed among people that had previously been seen as ‘low-risk’, such as housewives and richer members of society. In 1998, one
author wrote: “HIV infection is now common in India; exactly what the prevalence is not really known, but it can be stated without any fear of being wrong that infection is widespread… it is spreading rapidly into those segments that society in India does not recognize the risk. AIDS is coming out of the closet.” (Nath, 1998)

In 2001, the government adopted the National AIDS Prevention and Control Policy. HIV had now spread extensively throughout the country. In 1990, there had been tens of thousands of people living with HIV in India; by 2000, this had risen to millions. In 2006, UNAIDS estimated that there were 5.6 million people living with HIV in India, which indicated that there were more people with HIV in India than in any other country in the world. In 2007, following the first survey of HIV among the general population, UNAIDS and NACO agreed on a new estimate – between 2 million and 3.1 million people living with HIV. The national HIV prevalence rose dramatically in the early years of the epidemic, but a study released at the beginning of 2006, suggested that the HIV infection rate has recently fallen in southern India, the region that has been hit hardest by AIDS. In addition, NACO released figures in 2008 suggesting that the number of people living with HIV has declined.

Adult HIV prevalence among men is 0.36%, while among women is 0.25%. India is one of the largest and most populated countries in the world, with over one billion inhabitants. Yet due to its large population, over 2.4 million Indians, 880,000 of them women, are estimated to be living with HIV - the third largest number in the world, after South Africa and Nigeria (NACO, 2010).

1.6 HIV/AIDS IN MANIPUR

The lower Himalayan ranges at the far eastern border of India cradle the beautiful green fertile valley of Manipur. Manipur is bounded by Nagaland in the north, Burma in the east, Mizoram in the south and Assam in the west. The people of Manipur are a mixture of tribal groups of Tibeto-Burmese background, sharing languages and origins more in common with western China and Burma than the rest of India. But proximity to the
Golden Triangle has a high price. Manipur is one of three epicentres of the HIV/AIDS epidemic in India. Best known are the huge urban centres of Bombay and Madras where the virus is passed on via heterosexual activity, especially the thriving commercial sex industries. In sparsely populated Manipur transmission is mainly associated with the sharing of needles by injecting drug users. In Manipur the pure Burmese heroin costs around one Australian dollar. It is easily and readily available throughout the state, which shares a 352-km-long border with Burma where much of the world’s heroin is produced.

As per details from Census 2011, Manipur has population of 27.21 Lakh, an increase from figure of 22.94 Lakh in 2001 census. Total population of Manipur as per 2011 census is 2,721,756 of which male and female are 1,369,764 and 1,351,992 respectively. The HIV/AIDS pandemic has been changing human lives and the shape of society for more than one decade in Manipur. The first HIV (Human Immune Deficiency Virus) positive case in Manipur was reported in February 1990 per the blood samples among a cluster of six injecting drug users (IDUs). As from September 1986 to January 2011, a total 31256 positive cases were found out of these 10109 are females cases and out of 31256 positive cases 4724 were found as AIDS cases and 3381 are males and 1343 are females and out of these 4724 AIDS cases 658 were deaths, among these 658 cases 528 are males and 130 are females was reported by the epidemiological analyses of HIV/AIDS in Manipur.

Manipur is one of the six high HIV/AIDS prevalence states of the country. According to MACS (November 2012), the state has 38,016 people infected with HIV, including 10,109 women and 2,578 children. Manipur with hardly 0.2% of India’s population is contributing nearly 8% of India’s total HIV positive cases. Estimated cases of HIV positives among the general population in the state are around 40,000. Though the prevalence rate among injecting drug users is more than 42% in Manipur, the rate has reached to alarming through other routes.
Fig. 1.1 Map indicating the districts in Manipur state in North East India
As the HIV/AIDS epidemic in Manipur has penetrated into the general population from the Injecting Drug Users through sexual route, the situation among the women and children has become alarming. The infection has now spread to the female sexual partners of IDUs and their children. This is not surprising as women are particularly vulnerable to HIV infection and other sexually transmitted infections/diseases because of biological and socio-cultural factors including economic, educational and legal discrimination and unequal gender relations. We are now beginning to see waves and waves of HIV epidemic among women and children. Similarly, the prevalence rate among pregnant women has been on the higher side, 0.8% in 1994, 1.32% in 1997, 2.70% in 1999, 2.04% in 2001, 1.34% in 2003, 1.67% in 2004, 1.3% in 2005 and 1.4% in 2006. The trend is not stabilized. Today feminization of the epidemic could see in Manipur with the increasing transmission of the virus through sexual route. HIV transmission between spouses has become a more prominent cause of new infection in Manipur.

1.7 WIDOWS IN INDIAN CULTURE

Traditionally, in Indian families widows were seen as liability. Indian society is more dominated by religious superstitions and cultural practices wherein a widow is deemed as a bad omen and forced to live a lonely and a depressed life. In India, there is often an elaborate ceremony during the funeral of a widow's husband, including smashing the bangles, removing the bindi, colorful attire, and widows are made to wear white clothes (colour of mourning). Traditionally, in India Sati was a popular practice, where the newly widowed woman would throw her body onto her husband's burning funeral pyre and immolate herself. A woman existence was marked merely by her husband’s physical presence. Widow Remarriage was simply out of question. Other visible norms included, not wearing of jewellery, coloured clothes, forced shaving of heads, they were treated inhumanly to an extent that even their shadows were considered bad luck. They lived life in extreme poverty, often seeing begging or singing at temples for a measly meal. Many of the younger widows were forced into prostitution.
However, in modern-day culture the norms for clothing have gradually changed and given way to coloured clothing in a widow’s life. Sati practice has been banned in India for more than a century now. The ban began under British rule and is much owed to the persistence of the social reformer Ram Mohan Roy, who asserted that ‘Sati’ was a means of showing status rather than a universal ritual in India, and said, “there are other ways of doing it than by burning wives.” Certain matrilineal communities, the most notable being the Nairs from Kerala, not only allow, but encourage widow remarriage. In these societies, children retain the family name of the mother, and women were permitted to divorce and remarry if they wished.

Consequently, with this traditional mindset in the Indian society, entering into widowhood is more hazardous, painful and humiliating to women because of the discrimination, the ritual sanctions of the society against the widows. With the result, in India widows not only suffer with social and economic sanctions but also face many psychological consequences, loneliness and in many cases deprivation causing emotional disturbances and imbalance. For centuries, they have been ill treated facing deprivation, poor economic status, lack of social support, poor health, denial of human rights to food, shelter and clothing, and discrimination in relation to work, dignity and participation in the community life.

There were more than 40 million widows in India in 2011, the country with largest widow population in the world. Every fourth household in India has a widow. While a public outcry does occur from time to time when the social marginalization of a widow takes a sensational form such as that of sati, there is a striking lack of public concern for the deprivation experienced by millions of widows on day-to-day basis. The helplessness that is often associated with it has an influence on their health and well-being. India ranks highest in the world, in the incidence of widowhood.
1.7.1 PROBLEMS OF WIDOWS AFFECTED BY HIV/AIDS

Many young women who are widowed by unforeseen circumstances are reeling under meager earnings on daily basis. As our society is firmly based on traditional customs and norms has adversely affected to widows who are living in scrimpy earnings. The condition is rather severe to women who have been left behind by husband that succumbed to HIV/AIDS.

Widowhood presents a myriad of economic, social and psychological problems, particularly in the first year or so after the death of the spouse. A major problem for both sexes is economic hardship. When the husband was the principal breadwinner, his widow is now deprived of his income and the nucleus of the family is destroyed (Fasoranti et al, 2007).

The women, who had been completely neglected, oppressed, violated and invisible, struggling to survive and above all their voices are the most unheard are the widows of HIV/AIDS patients who are affected with HIV/AIDS. Discrimination against widows and HIV/AIDS are interrelated in two ways: HIV/AIDS significantly adds to the burden of the already inferior status of widows. At the same time, this economic, social and political inferiority makes widows (and women in general) more vulnerable to HIV infection. It is a vicious circle of discrimination and poverty.

Information addressing the situation of widows in general often focuses on the older woman, whilst in fact HIV/AIDS has created a generation of young widows. These young widows, frequently with young children, face the burden of discrimination on two counts, the loss of their husband and the disease.

Of the 245 million widows worldwide, almost 50% live in devastating poverty, and China, India and Indonesia alone account for over one third of these vulnerable women. That vulnerability is even more pronounced for those who are HIV positive, whose deceased spouse was HIV positive, and elderly widows caring for grandchildren orphaned by HIV (Loomba Foundation, 2010)
In rural domains the conditions of the widows remain the same where the society look down upon them as ill-omened in social and religious gatherings whereas the situation of their counterparts in urban regions are rather relax. Imposition of social sanction to them has negative implications in their day today livelihood that survive on limited resources. Many of them fallen prey to easy earnings which are regarded as socially outrageous professions in our society.

Troubles & problems start emerging soon after the husband’s death. HIV widows not only bear the grief of their husbands’ death and economic repercussions, but also have to face the stigma of being HIV. They have to take care of their health as well as that of their children, many of whom are HIV positive themselves. HIV-positive widows face double the stigma and are discriminated against by both their family as well as society at large.

**Economic deprivation:** The HIV widows face deprivation due to the economic disadvantages. The burden of HIV widowhood is not same with that of ordinary widow. The poverty that follows the loss of the income as a result of illness, loss of breadwinner and the HIV infection and lack of necessary qualifications or skills to make living can push them into demoralizing panic. Almost all HIV widows face problems related to money, findings job because of their inexperience in dealing with financial matters and their lack of occupational skills, expenditure on illness of their children and as well as for themselves.

**Familial and social deprivation:** The death of husband represents the cessation of a woman’s social existence and the end of her personhood. The death of the husband marks a dramatic shift in the perception of the community towards the HIV widow. Feared and hated, she must thenceforth be confined to the ‘dark spaces’ where she is inaccessible. Goals of life also change with position. She often misses the familial roles played by her husband such as sex-partner, caretaker and companion. For most traditional oriented women, the basic self-identity is the role of a mother, she loses even that due to her illness. It compels her to be dependent on others as a connecting link between herself and
the public sphere. Thus, she is forced into a life of colourlessness’, hopelessness and loneliness.

**Legally marginalized:** Unaware of HIV widows right and incapable of asserting herself, effects on the legal rights. There is no specific legislation either protecting or infringing upon the rights of HIV widows make. However, the constitution provides certain fundamental rights including the right to equality and non discrimination, right to life and liberty as well as privacy, which are pertinent in the context of HIV widows. Though there is lack of protective legislation, many national strategies state that people living with HIV/AIDS (PLWHA) are entitled to fundamental human rights and freedom. The HIV widows see themselves as having a right to their husbands land and property.

**Lack of support:** Very few government and non-government organization view HIV widows as special category with individual problems and special status. Social support for HIV widows differs from community and from caste to caste depending on social practices, norms regarding inheritance, remarriage and the styles of caste governance.

**Psychological impact:** The pain of being widowed is great enough in most of the circumstances but for a widow affected by HIV/AIDS, the additional psychological burden is particularly great. They may be blamed for the death of their husband or they feel guilt at having survived, irrespective of who transmitted the infection. HIV widows experience many of the emotional responses identified in people facing a terminal illness. They commonly go through an initial stage of denial, in which they do not accept of having the disease or deny is possible consequences. They may also suffer psychological distress as a result of the many physical, social, and economic effects of the disease on their lives.

**Stigma and discrimination**

Stigma was defined by the UNAIDS Inter country Team for East and Southern Africa, Tanzania, (June 2001) as “an act of identifying, labeling, or attributing undesirable qualities targeted towards those who are perceived as being shamefully different and
deviant from the social ideal” and as “an attribute that is significantly discrediting (and is) used to set the affected persons or groups apart from the normalized social order.” Discrimination can be defined as “an action or treatment based on the stigma and directed toward the stigmatized” and as “sanction, harassment, and violence based on infection or association with HIV/AIDS.” It can be simply stated that stigma is the attitude, and discrimination is the act. Acting through discrimination, denial, and shame, stigmatization is an impediment to HIV prevention and treatment efforts.

HIV/AIDS-related stigma refers to all unfavourable attitudes and beliefs directed toward people living with HIV/AIDS (PLWHA) or those perceived to be infected, and toward their significant others and loved ones, close associates, social groups, and communities. Herek, 1999 said that the HIV/AIDS epidemic has created new opportunities for the manifestation of stigma. The disease’s characteristics are similar to those of other ailments that commonly evoke stigma: the cause is perceived to be the bearer’s responsibility even though it often may not be the case; it is incurable; it is infectious and can cause others harm.

HIV/AIDS-related stigma and discrimination is a “process of devaluation” of people either living with or associated with HIV and AIDS, according to UNAIDS. Discrimination follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status. Discrimination occurs when a distinction is made about a person that results in him or her being treated unfairly and unjustly on the basis of belonging, or being perceived to belong, to a particular group (UNAIDS 2003).

Gossip and rumors focus on speculation about whether a person has HIV, usually because of visible signs of illness or association with “high risk” groups. Once a person is assumed HIV-positive, people often speculate about how he or she contracted HIV. Gossip was reported to be one of the most significant forms of stigma, particularly for HIV affected widows.
Other forms of verbal stigma include expressions of blame and shame, often through scolding or judgmental statements like “they got what they deserved.” People living with HIV and AIDS are blamed for becoming infected with HIV through their “irresponsible” and “selfish” behavior; bringing shame to themselves, their families and the community; and becoming a burden to the family.

1.8 WIDOWS IN MANIPUR:

Despite their significant contribution in the realm of economy and culture, however due to the existence of patriarchal, patrilineal, and patrilocal social system, discrimination against women is quite a common practice. The life of widows in Manipur is difficult. After the death of her husband, she is condemned and has to live a life of forced austerity. Also widows are not totally segregated from participating in social and religious practices but their visible appearance in performance of certain social and auspicious occasions are not encouraged. For instance, during marriage ceremony in Manipuri culture, some valuable items are given to the bride as a token of love from bridegroom’s parents on the wedding day. These items are kept inside the traditional baskets which are made out of bamboo and are called “Phiruk” and “Phingaruk”. These items are carried in a row which is led by a woman who is known as “JatraPubi”, (JatraPubi is the lady who leads the marriage procession of the bridegroom’s party in the traditional Manipuri wedding ceremonies), this woman should be a mother who bear a first male child, but a widow who is the mother of first male child cannot carry it as they are scorned as objects of ill luck. In fact, their presence during auspicious and ceremonial occasions is least desired. They are discouraged from attending any festival and joyful celebrations. They can attend only the funeral functions. Widows are not supposed to wear luxurious jewellery and colorful dresses. They have to wear ‘pungou-phanek’ (light reddish-white, a traditional dress) white ‘chadar’ and black ‘chandan (chandan or sandalwood paste or a paste made out of yellow clay, used to decorate the nose, forehead and throat with fine lines) while other women can use any colour i.e. white or yellow ‘chandan’) in order to differentiate their identity. They cannot perform in the ‘Laiharaoba’ ritual. Laiharaoba’ is celebrated...
in the honour of the sylvan deities known as Umang Lai; the festival represents the worship of traditional deities and ancestors. A number of dances by both men and women are performed before the ancient divinities. It is held annually from five days to one month. Widow remarriage is also very rare among the Manipuris.

1.9 SUPPORT AVAILABLE TO HIV/AIDS AFFECTED WOMEN

Government/non-government agencies and organisations have been implementing intervention programmes (counseling, condom promotion, medical check-ups, needle and syringe exchange programmes) among vulnerable groups like IDUs, Men having Sex with Men (MSM), sex workers, truck drivers etc. They also organise prevention/awareness programmes for youth, community leaders, teachers, security enforcement personnel etc. Those infected by HIV/AIDS are given medicines for the various infections that come with HIV, and home-based care is available for bedridden people living with HIV/AIDS. The Indian government is committed to preventing HIV infection, and it has greatly expanded its efforts to prevent the disease since 1997. Most service providers in Manipur facilitate Self Help Groups (SHGs) for widows of IDUs. SHGs comprising 25-30 members are often the only support system women have. The members share needs and issues, network with related agencies, hold training and income-generation programmes for embroidery, knitting, block printing, tailoring, making preservatives etc. Significantly, most existing programmes are either funded by foreign agencies or by the Manipur State AIDS Control Society which releases funding from the National AIDS Control Organisation (NACO). Population Foundation of India along with NACO provided care and support services for PLWHAS, while the (NACO) looked after the antiretroviral treatment (ART) at the public health facilities. From April 1, 2004, anti-retroviral treatment is being provided free of cost at government hospitals in six high prevalence states of Tamil Nadu, Andhra Pradesh, Maharashtra, Karnataka, Manipur, Nagaland and Delhi. At present, ART is provided free of cost in all the state of the country.
1.10 SIGNIFICANCE OF THE STUDY

Manipur is the first state in the country to have adopted AIDS policy in 1986 and the formation of the Manipur AIDS Control Society (MACS) in 1998. However in the beginning of the epidemic injecting drug users (hereafter IDUs) are infected with HIV in large but this epidemic is now no longer confined to the IDUs but has spread to normal people especially to the spouses of the injecting drugs users and their children. Most injecting drug users are men; an estimated 40 percent are married and death rates have been high in the last five years, consequently the number of widows of IDUs has increased.

Widows of HIV infected men have more difficult life than to that of the ordinary widows. They are outcast (ostracized) by family, friends, relatives and society. Major factors that inhibit her position are ignorance, powerlessness and vulnerability. The emotional problem they faced had seriously affected the widows’ health status. Stress due to the HIV infection, loss of husband and the resulting socio-economic problems wreck the health of many HIV widows. The social, economic and development consequences of HIV/AIDS in Manipur in the near future will be very grim unless an immediate planning is started from now onwards. Though, there is no substantial project or steps were taken up to rehabilitate the HIV/AIDS widows and their children who were the actual victims of this dreaded disease.

Therefore, this study was planned to document the problems faced by the widows of HIV infected men in depth and to offer suggestions based on their coping strategies to create opportunities for them to live their life with dignity and provide sustenance for their dependents. This study will also benefit to the NGOs, Government and policy planners for provide services as per the requirements of women affected by HIV/AIDS.
1.11 OBJECTIVES OF THE STUDY

General objective

The general objective of the study is to gain insights into the living conditions of widows of HIV infected men. It is an attempt to document their lived experiences of HIV affected women.

Specific Objectives

The following objectives were adopted to carry out the present investigation:

1. To understand the influence of the death of HIV positive men on the socio-economic condition of the family and specially their wives.
2. To understand the difference in coping mechanism adopted by women who are HIV positive and HIV negative themselves.
3. To understand the differences in meeting the demands of the family adopted by the working and non working widows of HIV positive husbands.
4. To study the support system available to the widows of HIV infected men.

1.12 OPERATIONAL DEFINITIONS

- HIV Affected Widows:
  All the women respondents under the study were HIV affected. They themselves were either HIV positive or HIV negative.

- Coping mechanism:
  Coping mechanisms are the methods adopted by the families to their needs. The coping mechanism could differ owing to their---
  a) their own HIV positive or HIV negative status.
  b) their working status before and the after the death of the husband.
  c) living arrangement that is whatever they live with parent’s family, in-laws family or independently.
• **Support System:**
  Support system available has been studied in context of familial support and services available through government and non-government programmes.

• **Household assets:**
  Items possessed by the families were used as a criterion to assess their socio-economic status. To assess the differences, the household items were classified into three different categories.
  a) **Low prestige items:** The low prestige items were iron, wooden cupboard, cycle, radio, and a bed to sleep.
  b) **Medium prestige items:** Along with low prestige items, at least 2-3 items of the following T.V.(Big/colour), gas stove, tape recorder, pressure cooker, motor cycle, ceiling fan & stand fan, refrigerator, washing machine, juicer-mixer-grinder, VCD/DVD player.
  c) **High prestige items:** Along with medium prestige items, at least 2-3 items of the following T.V in each room, computer/laptop, four wheeler, digital cameras, geyser, electric water purifier, air conditioner and microwave oven.

1.13 LIMITATIONS

The study was limited to

- Two districts of Manipur that is Imphal East and Imphal west.
- Only those NGOs who provide services for both HIV positive and HIV negative women were included in the study.