MARITAL ADJUSTMENT IN RURAL WOMEN IDENTIFIED WITH HIV/AIDS AND UNDERGOING ANTI RETRO VIRAL DRUG THERAPY

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Abstract

Since ‘Human Immunodeficiency Virus’ (HIV) was first reported, ‘Acquired Immunodeficiency Syndrome (AIDS) has now become a major public health issue all over the country. The typical rural Indian woman is often a hapless victim of this deadly disease infected by her philandering spouse. There is growing evidence that the pandemic is spreading into the country’s rural areas, wherein marital relationships and gender equations are generally on a different platform as compared to those in towns and large cities. It is one thing to know about the disease and quite another thing to be guaranteed a protected sex life. Against this background, this study chose to investigate into nature or characteristics of reported marital adjustment in rural women identified with HIV/AIDS and undergoing anti retro viral drug therapy. This study uses a cross sectional small group survey design to elicit details on marital adjustment in the target population. Data collection involved the use of two tools: (a) Demographic Profile Sheet; and, (b) Ten Item Marital Adjustment Inventory (Singh, 1987). On the whole, results show that the rural Indian women respondents identified or diagnosed as affected by HIV/AIDS have qualitatively an attitude on marital adjustment which falls in the interpretable range of ‘More than Least Favorable’. Significant differences are seen in their scores on marital adjustment in relation to their age, non-nuclear type of family backgrounds, higher SES, and type of occupation. However, associated variables like route of infection, ongoing stage of their affliction and their educational status do not emerge as significant in their report on marital adjustment. These findings are presented and discussed along with their implications for the ongoing social-cultural movement advocacy and empowerment of affected rural women in raising their voice against HIV/AIDS in the country.

Keywords: HIV/AIDS – Rural Women – Marital Adjustment - ARVT.

Introduction

Since 1986, when the first case of Human Immunodeficiency Virus (HIV) was reported in India, Acquired Immunodeficiency Syndrome (AIDS) has now become a major public health issue (Maniar, 2000; Pais, 1996). The Indian National AIDS Control Organization estimates 2.31 million HIV cases in the country for 2007 with significant variations across the states (NACO, 2007). There are clearly identified low risk
groups (like housewives, college students or teenagers) (Jejeebhoy, 1998; Apte, 1997; Singh et al., 1997) and high risk groups (like sex workers or intravenous drug users) (Newmann et al., 2000).

Infected husbands form the main source of infection for housewives (George et al., 1997). Thus, the route of transmission via sex workers and long distance truck drivers has slowly penetrated and endangered marital sexual relationships (Bryan, Jeffrey and Joseph, 2001; Venkaraman and Sarada, 2001; Rao et al., 1999; Singh and Malaviya, 1994).

There is growing evidence that the pandemic is spreading into rural areas of the country, wherein marital relationships and gender equations are generally on a different platform as compared to those in towns and larger cities. Since women have little say or autonomy in rural areas, HIV poses a greater burden on infected rural women, than in their men or similar women folk from urban areas. Further, rural women have different needs, impacts and consequences of the disease. Additional factors like lack of knowledge about HIV and its prevention, age, illiteracy, nature of family system or available supports places the average rural women in greater jeopardy. In a related survey, it was reported that only 30% of a population of over 90,000 married women in reproductive age from rural areas were aware of HIV (NACO, 2007); but reported that they could not do much about it.

It is one thing to have awareness or knowledge (even though it may be incomplete) and it is quite another thing that the available information guarantees women to lead a protected sex life (Sharma et al., 1997). Sexual behaviors are central to any marital relationship. In the traditional Indian settings, by and large, people have conservative attitudes towards sex. On many occasions, it is a taboo subject for open or public discussion (Bang et al., 1989). An understanding of sexuality and gender based power relations within the marital context is an important issue of reproductive health (Balmer et al., 1995; Dixon-Muller, 1993). Female sexuality is seen as needed to be channeled into marriage at an early age in the rural Indian culture.

The traditional Indian ideal or stereotype is marital fidelity, premartial chastity, submission and near total absence of homosexuality in women although these notions are now changing under the influence of mass media, increased mobility and late age of marriage (Nag, 1996; Savara and Shridhar, 1996). There are reports to believe that unlike in Africa (Boerma et al., 2002), for example, HIV/AIDS maybe higher in rural India than in urban areas (Banerjee, Deaton and Duflo, 2004; Bang et al., 1989). This may be because such cases go under reported and are kept secret. Or it may be that awareness is higher in urban areas and rural women may not be culturally in a position to refuse sexual relations with their infected husband. Many rural uneducated women (this is true of urban educated women also) may have little or no control over choice in marriage (Singh and Samara, 1996), abstinence (Sharma, Sujay and Sharma, 1998) or condom use at home or about the extra marital activities of their husbands (Bhattacharjee et al., 2000; Bharat and Aggleton, 1999). Many times, their basic right to safe motherhood is deprived or infringed (Baylies, 2001). These cultural and economic inequities...
increase the vulnerability of rural women (Dube, 1997). Against this background, this study attempts to investigate the nature or characteristics of marital adjustment in rural women identified with HIV/AIDS and undergoing anti retro viral drug therapy.

Methodology
The present study makes use of a cross sectional small group survey design to elicit information on the self reported nature or characteristics marital adjustment in rural women identified with HIV/AIDS and undergoing anti retro viral drug therapy.

Participants
The sample in the present investigation comprised of 60 rural women identified or diagnosed as affected by HIV/AIDS and those who were regularly attending as out patients in the Department of ART Clinics at Krishna Raja Hospital, Mysore Medical College, Mysore, Karnataka, as well as those who visited the VCTC in the districts of Mysore and Chamrajnagar, Karnataka, during April-December, 2009.

Procedure
After obtaining informed permission from competent authorities, participating subjects and by following the ethical guidelines stipulated for such research activities (Venkatesan, 2009), data collection involved individual interview of 60 target women respondents using a semi-structured questionnaire in their native tongue. The interviews were carried out in a quiet, undisturbed, private and confidential milieu. Wherein women respondents were unwilling to discuss related issues with the male investigator, a female interviewer was used to ease interpersonal communication and data collection. Home visits and interviews were not undertaken because of the risk of a breach in confidentiality. On an average, each interview took about half an hour. Some respondents, especially, women who were recently widowed, became distressed, wept, or tended to remain silent at certain points during the interviewing process. Such situations were handled tactfully by not precipitating greater grief or distress in the subjects. Where ever possible, an alternative line of questioning was adopted for the remainder of the interview. The areas or topics covered in the questionnaire or interview schedule included demographic details, age, number of years of marriage and those related to interpersonal relationships and adjustment with their husband as perceived by the infected sample of women in this study (Helitzer-Allen, Makhambera and Wangel, 1994).

Operational Definitions
Marital adjustment as operationally defined in this study refers to ‘sexual satisfaction, verbal and non-verbal communication’. Marital satisfaction, different from marital adjustment, refers to ones level of agreement, liking and approval towards ones own marriage. It is an attitude of greater or lesser favorability towards ones own marital relationship. It is a measurement on the perception of ones marriage by means of an attitude scale which is at the same time objective uncontaminated by marital conventionalization and social desirability; and, which could also provide items that would reflect attitudinal change likely to occur as a result of marital intervention. Some well known marital adjustment scales, inventories or measures available for use are: ‘The Locke Wallace Marital Adjustment Test’ (1959)(Cocoran and Fischer, 1987), ‘The Dyadic Adjustment
Scale' (Spanier, 1976), 'The Kansas Marital Satisfaction Scale' (Schumm et al., 1986), 'Marital Satisfaction Scale' (Fowers and Olson, 1993), 'The Comprehensive Marital Satisfaction Scale' (Blum and Mehrabian, 1999; Arthur, Frazier and Bowden, 1981), 'Marital Adjustment Inventory' (Singh, 1987) and others.

**Tools & Materials**

The two tools used in this study are:

- **Demographic Profile:**
  This tool was developed for the purpose of this study to elicit details of the respondents on their current age, the age or years of their marriage, number and ages of children, the family housing standards, etc.

- **Marital Adjustment Inventory:**
  The 10-item Marital Adjustment Inventory (Singh, 1987) developed on the basis of factor analysis was used for data collection in this study. This tool comprises of two forms A and B separately to be filled about the husband by the wives or about the wife by their husband respectively. However, in this study, only the form containing ten statements to be answered by the wives was used. The procedure of administration for this inventory involved the respondents to answer each of ten statements as either 'yes' or 'no'. After giving the direction of their response as consent for "yes" (+ sign) or "no" (- sign); they were also expected to circle any number between +1 to +10 or -1 to -10 to indicate the strength of their response by circling the number which best explained their opinion towards the issue. The rating scale ranges from +10 (most favorable) to +10 (least favorable). All doubtful situations were to be avoided. The specific items in the inventory included statements on the kind or amount of freedom given to their husbands, regarding upkeep of the homes, preparation of menus, intellectual participation or grasp on their business or occupational activities, sharing of leisure and recreation time or matters of common interests, relationships with his friends and relatives, dressing and appearance according to his tastes or likings, etc. Scoring for individual respondents for each item on this scale involves the corresponding integer (+) or (-) the number for 'Most Favorable' (10), 'Significantly Favorable' (9), 'More than Slightly Favorable' (8), 'Slightly Favorable' (7), 'Just Favorable' (6), 'Favorable' (5), 'Definitely Favorable' (4), 'Comparatively Favorable' (3), 'More than Least Favorable' (2) and 'Least Favorable' (1) respectively. Thus, higher scores on this scale for an individual respondent indicates attitudes towards favorable direction as low scores denote less favorable valence. The maximum possible score for the most favorable attitude on this scale is +100 and the minimum score for the most unfavorable attitude towards marital adjustment of an individual respondent on this scale is -100. The scale has been shown to have a coefficient of reliability for the general population to the order of 0.94. The discriminate validity of the instrument to separate the lower and upper fifteen percent of the persons in a distribution of scores has been demonstrated.

**Results & Discussion**

The marital adjustment score (by considering their integers) as derived for the overall sample of 60 rural women respondents identified or diagnosed as affected by HIV/AIDS is 1384 out of a maximum-minimum possible score range between +/- 6000 (N: 60; Score: 1384; Mean: 23.07) for all the ten items on this scale. This implies that qualitatively their
attitude falls in the interpretable range of ‘More than Least Favorable’ for the whole group.

When these overall trends are analyzed in terms of age variable, it is seen that respondent rural women in age 30-35 years (N: 14; Score: 110; Mean: 7.86) show least marital adjustment scores followed by women in age range 20-25 years (N: 11; Score: 212; Mean: 19.28), those above 35 years (N: 12; Score: 330; Mean: 27.50) and last by women between 25-30 years (N: 23; Score: 732; Mean: 31.83) respectively. Therefore, age of the rural women appears to be significant variable influencing their report of more or less marital adjustment in this sample (f: 3.29; p: 0.03). Studies have linked several psychosocial determinants like flexibility, dyadic consensus, interest sharing between the married couple, and higher standard of living as correlated with women reports on their positive marital adjustment (Kitamura et al, 2006). Others have connected perceived emotional intelligence, or the mediating role of personality and social desirability in marital adjustment (Joshi and Thingujam, 2009). Still others have found factors like loneliness (Demir and Fisliolu, 1999), sexual satisfaction, verbal and non verbal communication, expressiveness (Lamke, 1989) as well as demographic variables like age and number of years of marriage (Tucker and Horowitz, 1981) as critical in marital adjustment for women.

With regard to education variable, all levels of the rural women respondents in this sample report similar trend of marital adjustment irrespective of their illiteracy (N: 15; Score: 449; Mean: 29.93), education up to primary level (N: 9; Score: 205; Mean: 22.78), middle school level (N: 8; Score: 64; Mean: 8.00) and/or high school level (N: 28; Score: 669; Mean: 23.89) (f: 1.88; p: 0.15). There are indications to show that Indian women tend to generally report adequate marital adjustment and positive subjective wellbeing irrespective of their occupation and/or levels of education (Nathawat and Mathur, 1993) as also otherwise (Dubey, 1999). These findings have implications for the ongoing social-cultural movements, advocacy and empowerment of rural women in raising their voice against HIV/AIDS (Kishore and Gupta, 2004; Hawkes and Santhya, 2002). Moreover knowledge or awareness about the disease condition in the rural Indian women does not appear to automatically translate into positive social action (Pallikadavath, Jayachandran and Stones, 2003; Hirve and Sathe, 1999; Kunte et al, 1999).

The type of family background of the rural women respondents in this study emerges as a significant variable in their report on marital adjustment depending upon whether they hail from nuclear (N: 40; Score: 1148; Mean: 28.70) or non-nuclear settings (N: 20; Score: 236; Mean: 11.80). There is greater marital maladjustment reported by HIV/AIDS affected rural women from non-nuclear type of family milieu than women from nuclear families (f: 1.4699; p: 0.002). These trends are in consonance with similar findings on greater psychological depression, dissatisfaction in life and mental health issues in rural Indian women from such family backgrounds (Patil, Somasundaram and Goyal, 2002; Patel and Oommen, 1999).

Likewise, the type of occupation held by the rural respondent women in this study also surfaces as significant variable in their report on marital adjustment depending on whether they are skilled (N:}
The women respondents from high income groups (N: 33; Score: 980; Mean: 29.70) show statistically significant differences by reporting higher scores on marital adjustment compared to their counterparts from low income groups (N: 27; Score: 404; Mean: 14.96)(f: 3.256; p: <0.012). A few studies have reported the presence or prevalence of sexual harassment and domestic violence in families with husbands afflicted by HIV/AIDS (Khan et al, 1992). This gives the predilection especially for affected rural women from low income groups to reflect lower marital adjustments (Kumar et al, 1995) in contrast to their counterparts from urban settlements (Nayar and Chawla, 1996). The route of infection for HIV/AIDS either sexual (N: 48; Score: 810; Mean: 16.87) and/or non-sexual (N: 12; Score: 574; Mean: 47.83) does not surface as an influential variable for determining marital adjustment in this study (f: 0.5785; p: 0.577). Available literature suggests that spread of HIV to rural women is mostly from their infected husbands and/or their irregular use of condoms to ensure safe sex (George et al, 1997). Despite this observation, the typical rural Indian infected woman offers neither resistance nor reports of severe marital maladjustment in the companionship of the infected or risky spouse.

Data was analyzed based on stage of the infection ranging between I-IV. For the rural women respondents in stage IV (N: 8; Score: 74; Mean: 9.25), the marital adjustment scores are the least compared to women in stage I (N: 13; Score: 205; Mean: 15.77), stage II (N: 26; Score: 681; Mean: 26.19), and stage III (N: 13; Score: 424; Mean: 32.62). Even though these differences on the basis of stage of infection are not statistically significant (f: 2.58; p: 0.6861), there are differences based on the level or type of ARV treatments being taken by the infected respondents of rural women (f: 4.15; p: 0.013). The highest marital adjustment being reported by infected rural women who are at ARV IV (N: 2; Score: 77; Mean: 38.5), followed by those women who are at ARV II (N: 4; Score: 146; Mean: 36.5), ARV I (N: 43; Score: 1028; Mean: 23.91), and ARV III (N: 11; Score: 133; Mean: 12.09) respectively.

**Item Analysis**

At another level, an analysis on the 10-item Marital Adjustment Scale showed that majority of the respondents gave negative markings to item seven and nine related to questions like ‘Do you not care in dressing according to the likes or dislikes of your husband?’, ‘Do you not care about the interests of your husband and so be an hindrance to him during leisure hours?’, etc. In related studies, it was reported that women can impose authority within the husband’s household only after she gives birth to a live child, particularly a son. Her status in the family rises with the number of healthy children that she gives birth for the family (Karve, 1965). In patrilocal societies the status of
widows in the family is low (Dreze and Sen, 2002). Dubé (1997) notes the husband’s exclusive right over the wife’s sexuality is unquestioned. Women have no power to make men use barrier contraceptive methods, such as, the condom which could prevent both pregnancy and sexually transmitted infections (Sharma, Sujay and Sharma, 1998).

In sum, the present study has highlighted the adverse position and predicament of a typical Indian rural woman afflicted by HIV/AIDS and undergoing anti retro viral drug therapy. The derived profile of an affected typical rural Indian woman as one who, irrespective of her knowledge or awareness about HIV/AIDS in the spouse, is monogamous, uncomplaining, adjusting, accepting of the spouses’ vapid sexual behaviors, etc. (Flanigan et al, 2000). These findings have tremendous implications for the ongoing social-cultural movement on advocacy and empowerment of affected rural women in raising their voice against HIV/AIDS in the country.

References:


Boerma, J.T., Urassa, M., Nnko, S., Ng’weshemi, J., Isingo, R., Zaba, B. and Mwaluko, G. (2002). Socio-demographic context of the AIDS epidemic in a rural area in Tanzania with a focus on people’s mobility and marriage. Sexually
Transmitted Infections. 78. 197-I105 Suppl.1.


Knowledge and Opinion Preferences on HIV/AIDS in Affected Rural Women Undergoing Antiretro Viral drug Therapy

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The present study uses a cross sectional small group (n: 60) survey design to determine the extent of knowledge and opinion about HIV/AIDS in infected rural women on anti retro viral drug therapy. After a review of available ‘knowledge-opinion scales’, a 30-item two-part inventory to measure ‘knowledge’ (Part A) and ‘opinion’ (Part B) was exclusively developed for use in this study with subsection for eliciting personal-social demographic details of each respondent. Open ended non-directive interview techniques were supplemented during data collection. Results show a mean knowledge score of 7.53 (SD: 2.00) out of 15. It is seen that ‘high economic status’ and ‘joint type of family’ background significantly influence high ‘knowledge’ scores (p<0.05); while other socio-demographic variables are not significant in determining their knowledge status on or about HIV/ AIDS (p>0.05). With regard to ‘opinion’ component, statistically significant inter-item respondent difference across all studied socio-demographic variables (p<0.05) indicate heterogeneity in their views. This suggests the need for common agenda on facts or figures about HIV/AIDS that must be delivered for the affected women from rural areas. A content analysis of individual items reveals sparse knowledge on or about their disease combined with a strong sense of reserve, reticence and reluctance to discuss openly on a subject matter which is viewed as personal, intimate and tabooed. These trends are presented and discussed against the backdrop of an already relegated social status of the typical rural Indian women afflicted with the double disadvantage of having a deadly disease.

Keywords: HIV/AIDS Knowledge, Rural Women, Opinion Preferences, ARVT

When HIV/AIDS was first reported in 1980s, the initial impression was that it is the disease of homosexuals, drug abusers, or those who receive infected blood transfusions or blood products. It is now clear that the malady is prevalent even in heterosexuals, women as well as children (Newman et al, 2000). Recent reports on prevalence for AIDS indicate a dip by almost half compared to figures from earlier years (UNAIDS, 2009). Although some consolation the challenge posed by the disease has not dwindled. As on 31st August, 2007, the number of patients on official registers across ART centers, inter-sector partners, and others was close to over a lakh. The country's adult AIDS prevalence rate is now estimated at 0.36 % measuring around 2.5 million. The number of people living with HIV/AIDS in India continues to be largest in the world after South Africa and Nigeria. The situation in the country continues to be grim despite being under control (NACO, 2010). Women are under greater risk than men for contracting this deadly disease. Their prevalence rates are 0.29 % compared to 0.43 % for Indian males. This means that for
every 100 people living with HIV/AIDS, there are 61 men and 39 women. Certain age
groups (15-49) are reported to have high
rates of prevalence (88.7%). Young women
are getting infected more rapidly than elder
ones (Steinbrook, 2007; Ruxrungtham, Brown
& Phanuphak, 2004).

There are many studies on knowledge,
attitudes, information, opinions, or perception
of risk about the illness in various target
groups, such as, teachers-school/college
students (Merakou et al, 2002; Brook, 1999;
Brook et al, 1994; Holtzman et al, 1994; Brown
& Fritz, 1988), infected patients (Benotsch
et al, 2003; Pinkerton et al, 2003), incarcerated
adolescents (Di Clemente et al, 1991), adolescent
mothers (Brown et al, 1998), youth (Eaton & Flischer, 2000), urban-
rural inhabitants (Rich, Holmes & Hodges,
1996; Sikand, Fischer & Friedman, 1996) and
members of the general public (Leili, Elham
& Farhkhondeh, 2008) across continents
(Peltzer & Promtussananon, 2005; Kraenik &
Wangel, 1990), countries (Ayranci, 2005;
Tavoosi et al, 2004; Montazeri, 1995; Green
et al, 1991) and communities all the world
over (Pattullo et al, 1994). Pinkerton et al
(2003), for example, examined HIV/AIDS
knowledge, attitudes towards condoms, and
sources of information about HIV in 200 male
and 200 female Russian STD clinic patients
to discover substantial knowledge deficits on
AIDS and HIV transmission. Mc Daniel et al
(1995) surveyed knowledge and attitudes
about HIV and AIDS among medical students
using a 25-item survey schedule to find mean
score on knowledge scale as 6.25 (SD = 1.63)
out of 10. Factor analysis suggested three
major groupings of medical students with
regard to attitudes. The largest group had
generally positive attitudes about patients with
HIV/ AIDS; two subgroups reported feeling
uncomfortable with homosexual behavior and
with HIV seropositive clients or while taking a patient’s
sexual history.

Related studies on knowledge-attitude
on HIV/AIDS in India have focussed on
teacher-school/ college students in various
parts of the country (Lal et al, 2008; Bhalla
et al, 2005; Ganguli et al, 2002; Chatterjee
et al, 2001; Agarwal et al 1999; Sodhi and
Mehta, 1997; Aggarwal and Kumar, 1996).
Others have targeted general rural
populations (Chuttani, Gupta and Chaturvedi,
1999). There is dearth of studies on rural
infected women and those undergoing
treatment. A community survey of women in
rural Tamil Nadu using qualitative techniques
to elicit their understanding about HIV/AIDS
found that about 28 % of the women
respondents had not heard about the
disease. This appalling lack of information
combined even for other details like, causes,
signs or symptoms, and prevention
(Subramanian, Ezhi & Gupte, 2004).

Research on HIV/AIDS in India continues to
grapple on known risk groups like sex
workers, STI clinic attendees, homosexuals,
transgenders and long distance truck drivers
from urban areas. The affected rural women
are ignored. Many knowledge-attitude
surveys in west have used standardized tools
and instruments, structured interview
schedules, checklists, inventories, or formal
questionnaires (Easpada et al, 2009; Carey
and Schroder, 2002; Basen-Engquist et al,
1999; Froman, Owen and Daisy, 1991; Kelly
that respondents show less knowledge when
assessed with open-ended rather than set
choice questions, suggesting low levels of
spontaneous memory for AIDS information. A
challenge for investigators addressing rural
Indian women is their abject illiteracy, inability
to respond to survey instruments or paper-
pencil tests. To overcome this issue,
Palikadavath et al (2005a) used in-depth
personal interviews and focus group
discussions to collect experiences of testing

and treatment, the social impact of living with HIV and differential impact on women and men. Many women were not allowed to take decisions about their bodies, use contraception, adopt a given style of living or even answer to questions posed by field investigators without the prior permission of their husbands or other elders in the family (Sharma, Sujay and Sharma, George et al, 1997). Against this backdrop, the present investigation seeks to determine the extent of knowledge that rural infected women hold about HIV/AIDS, its nature, course, characteristics, prevalence, and route of transmission, prevention and treatment. This objective is coupled with another part of this study which seeks to elicit their opinion preferences related to the disease, stigma or discrimination attached with it.

Based on a comprehensive review of the above mentioned 'knowledge-attitude scales'; and also by taking into account the local cultural factors regarding gender and sexuality, a 30-item two-part inventory to measure 'Knowledge' (Part A) and 'Opinion' (Part B) was exclusively developed for use in this study on the sample of 60 rural women affected by HIV/AIDS and regularly attending as out patients for ART. The inventory also had a section for eliciting personal, social demographic details of each respondent, such as, age, marital status, educational qualifications, occupation, income, type of family, status of the HIV infection, route of transmission and clinical stage. Along with the twin inventory, an open ended non-directive interview was also used in this study. To establish face and content validity for the inventory, an initial draft of the instrument was distributed to an experienced multidisciplinary team of health professionals working in a general hospital. Their critical appraisal allowed revision for clarity and reliability. The first 15 items of the tool assessed general 'knowledge' about transmission, contagion, epidemiology, and medical treatment of HIV/AIDS. Responses to these items were 'right/true', 'wrong/false' or 'cannot say/don't know'. The remaining 15 items were 'opinion' statements scored on a 3-point scale, ranging from 'agree', 'disagree' and 'no opinion/cannot say'.

Thereafter, for the main study on larger sample, the frequencies for each of the 30 items were determined. In addition, an overall 'knowledge score' and 'opinion score' was computed by giving each respondent 1 point for each of the knowledge items that was answered correctly, and counting 'don't know/cannot say' as incorrect response. The possible range for knowledge scale score was from 0 to 15 for any single individual respondent. Higher the score indicated superior knowledge. The questionnaire was pre-tested in a local language and to establish 2-week test retest reliability measure on a sample of 15 participants (not a part of the main sample) from different sub-populations of the rural areas. After analyzing the data, Cronbach's alpha was calculated to assess internal consistency of the questions. Alpha coefficients were found to be 0.81 and 0.75 for 'knowledge' and 'opinion' on HIV/AIDS respectively. The test retest reliability coefficient was measured at 0.83. Responses to all items were converted to a number score indicating the magnitude of correct responses. The SPSS version 18.0 was used to enter and analyze the data on a personal computer. Obtained data was analyzed by frequency and non-parametric statistics such as t tests, chi-square and Kruskal-Wallis test. The measure for statistical significance was established a priori as P: <0.05.

Operational Terms

'Knowledge' as operationally defined in this study refers to 'a theoretical or practical familiarity, awareness or understanding of the subject matter pertaining to HIV/AIDS including the sum totality of facts, figures, and information gained by experience'.
Responses to 'knowledge' questions were subsumed as 'right', 'wrong' and/or 'cannot say'. 'Opinion' was defined as 'a message, expression, personal belief, sentiment or judgment about something that is not founded on proof or certainty'. It is a subjective statement or thought about an issue or topic and is the result of feeling, emotion or interpretation of facts. The 'opinion' responses to statements must be viewed as 'agree', 'disagree' and/or 'cannot say', rather than as 'right' or 'wrong'.

**Method**

**Participants:**

The sample in the present investigation comprised of 60 rural women identified/diagnosed as affected by HIV/AIDS and those who were regularly attending as out patients in Department of ART Clinics at Krishna Raja Hospital, Mysore Medical College, Mysore, Karnataka, as well as those who visited VCTC in the districts of Mysore and Chamrajnagar, Karnataka, during April-December, 2009.

**Tools:**

HIV-Knowledge Questionnaire-18 (Carey and Schrodter, 2002): The original questionnaire is psychometrically strong and contains 45 items. It has been truncated into a small set of 18 items with a selected representative domain of items requiring to be responded as 'true/right', 'false/wrong' or 'cannot say'. The reliability analyses of the HIV-KQ indicate that it is internally consistent (alpha: 0.91) and stable over 1- (r: 0.83), 2- (r: 0.91), and 12-week (r: 0.90) intervals. Sample items are: 'Coughing and sneezing do not spread HIV', 'A person can get HIV by sharing a glass of water with someone who has HIV', 'Pulling out the penis before a man climaxes keeps a woman from getting HIV during sex', 'A woman can get HIV if she has anal sex', 'Showering or washing one's genital/private parts after sex keeps a person from getting HIV', etc. Espada et al (2009) describe the development, factor structure, reliability and validity of another multidimensional scale to measure HIV/AIDS-related knowledge for adolescents (HIV/AIDS Knowledge Scale, HIV-KS). The final version of this 10 item scale is distributed across three major factors: (1) HIV oral transmission, (2) HIV effects, and (3) other HIV transmission methods. The HIV-KS is invariant across gender and age and shows good validity and internal reliability. It is shown to be a capable and parsimonious self-report scale for assessing main aspects of HIV/AIDS-related knowledge for adolescents.

**AIDS Attitude Scale (AAS)** (Froman, Owen & Daisy, 1991): It is a 6-point Likert scale that can be used with various subjects to identify people's attitudes towards HIV/AIDS. The scale allows the researcher to classify subjects as having either empathy or avoidance towards people with HIV/AIDS, depending on their agreement or disagreement with the item statement. The range of scores is 1 for "strongly disagree" to 6 for "strongly agree". Seven items deal with empathy, while 14 items deal with avoidance. The scale has a high degree of validity and reliability in its original form. This instrument has been used in different cultural settings. Experts have agreed upon its content and face validity. The test-retest reliability is reported as r: 0.82, which is acceptable for an attitude scale. Kelly et al (1989) describe the construction of another standardized 40-item test of AIDS risk behavior knowledge and presents data on the validity, reliability, and psychometric characteristics of the measure in addition to norms for several populations.

**Procedure**

By following the ethical guidelines stipulated for such research activities (Venkatesan, 2009), the field work for the present investigation comprised of individually interviewing target respondents using semi-structured questionnaires in the native tongue. The interviews were carried
out in a quiet, undisturbed, private and confidential milieu after obtaining the informed consent of the respondents. Wherein women respondents were unwilling to discuss related issues with male investigator, a female interviewer was present to ease inter-personal communication and data collection. Home visits and interviews were not undertaken because of the risk of a breach of confidentiality. On an average, each interview took about half an hour. Some respondents, especially, women recently widowed or others as well, became distressed, wept, or tended to remain silent sometimes at certain points of the interviewing process. Under such circumstances, the situations were handled tactfully by not precipitating greater grief or distress; and where possible, by taking an alternative line of questioning for the remainder of the interview. The areas or topics covered in the questionnaire or interview schedule included demographic details, their current knowledge and opinion on or about various aspects of the HIV/AIDS illness.

Results and Discussion

Results of the present study with respect to knowledge and opinion on HIV/AIDS by affected rural women respondents are presented and discussed sequentially under the following three sections/ headings: (a) Analysis of ‘Knowledge’; (b) Analysis of ‘Opinion Preferences’; and, (c) ‘Individual Item/Content Analysis’ respectively.

(a) Analysis of ‘Knowledge’

On the whole, the rural women respondents in the present sample (N = 60) earn a mean score of 7.53 (SD = 2.00) out of 15 on the ‘knowledge’ component of the administered questionnaire (Table 1). Against this point of reference, when various individual personal and socio-demographic parameters are studied, it is seen that only ‘economic status’ and ‘type of family’ are the two variables which significantly influence the ‘knowledge’ scores of these women (p<0.05).

The rural women from low socio-economic status groups (N= 32; Mean: 6.43; SD=1.89) show comparatively lower ‘knowledge’ scores about HIV/AIDS as compared to similar women from higher socio-economic status groups (N= 17; Mean= 7.21; SD= 5.27)(F= 3.18139; p=0.049). Likewise, the HIV/AIDS affected rural women from ‘joint family’ backgrounds (N=20; Mean=7.85; SD=2.06) show better ‘knowledge’ about their disease than their counterparts from ‘nuclear family’ backgrounds (N=40; Mean=6.37; SD=1.90) (t=2.3921; df=58; SEM=0.535; p = 0.200).

Other socio-demographic variables like education, occupation, age, clinical stage of the disease/therapy, or route of transmission are not significant variables in influencing the knowledge status of the infected rural women in the sample of this study (p>0.05).

In a related investigation, Pallikadavath et al (2005b) studied the socio-cultural and reproductive health correlates of knowledge about AIDS among rural women using multivariate analysis of 1998-99 National Family Health Survey (NFHS) data from Maharashtra and Tamilnadu. Their analysis used multiple logistic regression to investigate the rural women’s knowledge of AIDS, of whether the disease can be avoided, and of effective means of protection. Although 47 % of all rural women in Maharashtra were aware of AIDS/HIV, only about 28 % knew that one can avoid it and only about 16 % possessed correct knowledge about its transmission. In Tamilnadu, where overall 82 % of rural women were aware of AIDS/HIV, about 71 % knew that one can avoid the disease; and, only 31 % of them had correct knowledge about its transmission. In both states, women from socially and economically backward groups had lower awareness about AIDS/HIV and of ways to avoid getting the disease. Associations with socio-cultural and reproductive variables and impact of contact with family planning services differed in the two states.
Table 1. Distribution of Mean and SD for 'Knowledge Scores' in Rural Women in relation to different variables

<table>
<thead>
<tr>
<th>NO</th>
<th>VARIABLE</th>
<th>N</th>
<th>MAX</th>
<th>ACTUAL</th>
<th>MEAN</th>
<th>SD</th>
<th>PROBABILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>ARV THERAPY</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>ARV I &amp; II</td>
<td>47</td>
<td>705</td>
<td>356</td>
<td>6.67</td>
<td>2.20</td>
<td>T: 0.3911; DF: 58; SEM: 0.639; p: 0.69072; NS</td>
</tr>
<tr>
<td></td>
<td>ARV III &amp; IV</td>
<td>13</td>
<td>166</td>
<td>96</td>
<td>6.92</td>
<td>1.26</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>MONTLY INCOME LOW</td>
<td>39</td>
<td>495</td>
<td>254</td>
<td>6.75</td>
<td>2.20</td>
<td>T: 0.1776; DF: 58; SEM: 0.593; p: 0.85986; NS</td>
</tr>
<tr>
<td></td>
<td>HIGH</td>
<td>21</td>
<td>405</td>
<td>198</td>
<td>8.85</td>
<td>1.93</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>EDUCATION</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>NIL</td>
<td>15</td>
<td>225</td>
<td>114</td>
<td>6.13</td>
<td>2.06</td>
<td>Variation Between: 5.97; Variation Within: 2.03; F: 2.94; p: 0.05; NS</td>
</tr>
<tr>
<td></td>
<td>SCHOOL</td>
<td>17</td>
<td>255</td>
<td>128</td>
<td>6.44</td>
<td>2.12</td>
<td></td>
</tr>
<tr>
<td></td>
<td>COLLEGE</td>
<td>28</td>
<td>420</td>
<td>210</td>
<td>7.16</td>
<td>1.96</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>AGE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>BELOW 20</td>
<td>36</td>
<td>540</td>
<td>279</td>
<td>6.94</td>
<td>1.73</td>
<td>T: 0.3615; DF: 58; SEM: 0.626; p: 0.7190; NS</td>
</tr>
<tr>
<td></td>
<td>ABOVE 30</td>
<td>24</td>
<td>360</td>
<td>173</td>
<td>6.79</td>
<td>2.34</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>ECONOMIC STATUS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>LOW</td>
<td>32</td>
<td>480</td>
<td>245</td>
<td>6.43</td>
<td>1.89</td>
<td>Variation Between: 6.44; Variation Within: 2.56; 158; F: 3.1613; p: 0.04949; NS</td>
</tr>
<tr>
<td></td>
<td>MIDDLE</td>
<td>17</td>
<td>255</td>
<td>122</td>
<td>7.21</td>
<td>2.27</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HIGH</td>
<td>11</td>
<td>165</td>
<td>85</td>
<td>7.54</td>
<td>1.75</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>FAMILY</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>JOINT</td>
<td>20</td>
<td>300</td>
<td>306</td>
<td>7.65</td>
<td>2.06</td>
<td>T: 2.3921; DF: 58; SEM: 0.836; p: 0.0220; NS</td>
</tr>
<tr>
<td></td>
<td>NUCLEAR</td>
<td>40</td>
<td>600</td>
<td>146</td>
<td>6.37</td>
<td>1.96</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>ROUTE OF TRANSMISSION</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SEXUAL</td>
<td>48</td>
<td>720</td>
<td>357</td>
<td>6.70</td>
<td>2.05</td>
<td>T: 0.6991; DF: 58; SEM: 0.658; p: 0.4873; NS</td>
</tr>
<tr>
<td></td>
<td>NON</td>
<td>12</td>
<td>180</td>
<td>95</td>
<td>7.16</td>
<td>1.99</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>OCCUPATION</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SKILLED</td>
<td>16</td>
<td>240</td>
<td>339</td>
<td>7.43</td>
<td>2.06</td>
<td>T: 1.4835; DF: 58; SEM: 0.585; p: 0.1433; NS</td>
</tr>
<tr>
<td></td>
<td>UN SKILLED</td>
<td>44</td>
<td>660</td>
<td>113</td>
<td>6.58</td>
<td>1.99</td>
<td></td>
</tr>
</tbody>
</table>

Table 3. Actual Test Statements in 'Knowledge-Opinion Scale'

<table>
<thead>
<tr>
<th>KNOWLEDGE INVENTORY</th>
<th>R</th>
<th>W</th>
<th>CS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>STD's are curable, but there is no cure for HIV/AIDS</td>
<td>R</td>
<td>W</td>
</tr>
<tr>
<td>2</td>
<td>A person infected with HIV/AIDS can be recognized by their looks</td>
<td>R</td>
<td>W</td>
</tr>
<tr>
<td>3</td>
<td>People with AIDS die of any illness</td>
<td>R</td>
<td>W</td>
</tr>
<tr>
<td>4</td>
<td>HIV/AIDS can be avoided through PPTCT program</td>
<td>R</td>
<td>W</td>
</tr>
<tr>
<td>5</td>
<td>People with AIDS should be made to live far away from others</td>
<td>R</td>
<td>W</td>
</tr>
<tr>
<td>6</td>
<td>One can get HIV by hugging or touching a person who has HIV/AIDS</td>
<td>R</td>
<td>W</td>
</tr>
<tr>
<td>7</td>
<td>HIV is transmitted through semen, vaginal fluids and blood</td>
<td>R</td>
<td>W</td>
</tr>
<tr>
<td>8</td>
<td>Multiple sexual partners increase the risk of infection for HIV/STDs</td>
<td>R</td>
<td>W</td>
</tr>
<tr>
<td>9</td>
<td>A person can get HIV infection by donating blood</td>
<td>R</td>
<td>W</td>
</tr>
<tr>
<td>10</td>
<td>One can get HIV even if he/she has sex only once with an infected person</td>
<td>R</td>
<td>W</td>
</tr>
<tr>
<td>11</td>
<td>Use of condom reduces the risk of HIV/AIDS</td>
<td>R</td>
<td>W</td>
</tr>
<tr>
<td>12</td>
<td>Breast feeding by infected mother spreads HIV/AIDS</td>
<td>R</td>
<td>W</td>
</tr>
<tr>
<td>13</td>
<td>An AIDS patient should not to be allowed to donate blood</td>
<td>R</td>
<td>W</td>
</tr>
<tr>
<td>14</td>
<td>HIV/AIDS virus is detected through blood test</td>
<td>R</td>
<td>W</td>
</tr>
<tr>
<td>15</td>
<td>Gonorrhea is a Sexually Transmitted Disease (STD)</td>
<td>R</td>
<td>W</td>
</tr>
</tbody>
</table>

(KEY: R-Right; W-Wrong; CS-Can't Say)
Table 2A. Distribution of Mean and SD for ‘Opinion Preferences’ in Rural Women in relation to different variables

<table>
<thead>
<tr>
<th>Qno</th>
<th>General (N=40)</th>
<th>AP Phases</th>
<th>Illiteracy (N=35)</th>
<th>NCC (N=30)</th>
<th>Aged (N=30)</th>
<th>Lo (N=30)</th>
<th>H (N=30)</th>
<th>Income</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3.13 (3.2)</td>
<td>3.24 (3.1)</td>
<td>3.02 (2.9)</td>
<td>3.19 (3.0)</td>
<td>3.11 (3.0)</td>
<td>3.06 (3.0)</td>
<td>3.15 (3.0)</td>
<td>3.10 (3.0)</td>
<td>3.20 (3.0)</td>
</tr>
<tr>
<td>2</td>
<td>3.02 (2.9)</td>
<td>3.24 (3.1)</td>
<td>3.17 (3.0)</td>
<td>3.19 (3.0)</td>
<td>3.11 (3.0)</td>
<td>3.15 (3.0)</td>
<td>3.15 (3.0)</td>
<td>3.10 (3.0)</td>
<td>3.20 (3.0)</td>
</tr>
<tr>
<td>3</td>
<td>3.19 (3.0)</td>
<td>3.11 (3.0)</td>
<td>3.06 (3.0)</td>
<td>3.15 (3.0)</td>
<td>3.10 (3.0)</td>
<td>3.20 (3.0)</td>
<td>3.15 (3.0)</td>
<td>3.10 (3.0)</td>
<td>3.20 (3.0)</td>
</tr>
<tr>
<td>4</td>
<td>3.11 (3.0)</td>
<td>3.06 (3.0)</td>
<td>3.15 (3.0)</td>
<td>3.20 (3.0)</td>
<td>3.10 (3.0)</td>
<td>3.10 (3.0)</td>
<td>3.20 (3.0)</td>
<td>3.10 (3.0)</td>
<td>3.20 (3.0)</td>
</tr>
</tbody>
</table>

Table 2B. Distribution of Mean and SD for ‘Opinion Preferences’ in Rural Women in relation to different variables

<table>
<thead>
<tr>
<th>Qno</th>
<th>Skill (N=40)</th>
<th>Unskilled (N=40)</th>
<th>Sexual (N=35)</th>
<th>Non-Sexual (N=30)</th>
<th>All (N=30)</th>
<th>School (N=30)</th>
<th>College (N=30)</th>
<th>Stages (N=40)</th>
<th>Stage (N=40)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3.02 (3.0)</td>
<td>2.94 (2.9)</td>
<td>3.20 (3.1)</td>
<td>3.15 (3.0)</td>
<td>3.15 (3.0)</td>
<td>3.10 (3.0)</td>
<td>3.10 (3.0)</td>
<td>3.15 (3.0)</td>
<td>3.15 (3.0)</td>
</tr>
<tr>
<td>2</td>
<td>3.19 (3.0)</td>
<td>3.06 (3.0)</td>
<td>3.20 (3.0)</td>
<td>3.15 (3.0)</td>
<td>3.15 (3.0)</td>
<td>3.10 (3.0)</td>
<td>3.10 (3.0)</td>
<td>3.15 (3.0)</td>
<td>3.15 (3.0)</td>
</tr>
<tr>
<td>3</td>
<td>3.11 (3.0)</td>
<td>3.06 (3.0)</td>
<td>3.15 (3.0)</td>
<td>3.20 (3.0)</td>
<td>3.15 (3.0)</td>
<td>3.10 (3.0)</td>
<td>3.10 (3.0)</td>
<td>3.15 (3.0)</td>
<td>3.15 (3.0)</td>
</tr>
<tr>
<td>4</td>
<td>3.02 (3.0)</td>
<td>3.19 (3.0)</td>
<td>3.06 (3.0)</td>
<td>3.20 (3.0)</td>
<td>3.15 (3.0)</td>
<td>3.10 (3.0)</td>
<td>3.10 (3.0)</td>
<td>3.15 (3.0)</td>
<td>3.15 (3.0)</td>
</tr>
</tbody>
</table>

(Sources: A-D, C-S, CS-Can't Say)
(b) Analysis of ‘Opinion Preferences’:

For the overall sample (N=60), it was seen that there is a statistically significant differences within the group of rural women respondents across each or all of 15 statements under ‘opinion preferences’ (H=12.73; df=2; p=0.001). Similar inter item respondent differences are also found in relation to personal and socio-demographic variables like rural women from lower age groups (< 30 years), both low and high income groups, those from joint family background alone, those involved in skilled and unskilled occupations, and those from all levels of education. In short, opinions vary across the whole sample of female rural respondents (p<0.05). This heterogeneity of ‘opinion preferences’ beckon attention towards a common agenda on facts or figures about HIV/AIDS that is needed for affected women from rural areas in our country (Table 2A and 2B).

(c) Individual Item/Content Analysis:

An analysis of responses on individual items show greatest unawareness on statements like ‘People with AIDS should be made to live far away from others’ (Item #5; N=60; Right: 46; Wrong: 9; Can’t Say: 5). There are doubts on or about statements like ‘a person can get HIV infection by donating blood’ (Item #9; N: 60; Right: 15; Wrong: 25; Can’t Say: 20). There is belief that ‘HIV is transmitted through semen, vaginal fluids and blood’ (Item #7; N=60; Right=12; Wrong=43; Can’t Say=5). A content analysis of individual statements under ‘opinion’ inventory reveals greatest agreement for items like ‘During initial stage of the HIV/AIDS infection, a person does not exhibit any symptoms’ (Item #7; N=53 out of 60), followed by items on ‘It is embarrassing for parents to teach about sex to teenagers’ (Item #10; N=51 out of 60), and that ‘HIV/AIDS is the punishment given by God’ (Item #3; N=49 out of 60), etc. It is noted that a sizeable section of the women respondents in this study are undecided on statements like ‘Sex education helps to control STDs’ (Item# 8; N=51 out of 60), and ‘Open discussion on sex related matters is harmful to society’ (Item# 9; N=50 out of 60) (Table 3).

During this survey, it was noticed that the respondent rural women with HIV/AIDS have sparse information about the disease that has affected them. They are in dark or have misconceptions on the possibilities for a person to contract HIV infection by donating blood, or through semen, vaginal fluids and blood or that a person infected with HIV/AIDS can be recognized by their looks. Despite efforts by the field investigator/s, there was no knowledge or opinion expressed on key issues whether the infection can occur through other commonly apprehended routes of transmission, such as, contact with sweat or tears, coughs or sneezes; insect bites; sharing facilities like swimming pools, telephones, toilets, saunas or hot tubs with HIV-infected people. Similar explorations on knowledge and beliefs on other frequently feared routes of transmission by kissing or whether they come through sharing the same utensils, food from the same bowl, drinking water from the same cup or glass, or sharing towels, bedding, razors, tooth brushes, etc. were not openly responded. Further, there are often questions people ask or discuss whether using two condoms protect one from AIDS than using one condom, or whether a person can still get infected if one has sex with HIV positive person even after sterilization, or whether masturbation can transmit or give rise to HIV/AIDS, or whether HIV/AIDS is hereditary and so on. The respondents of the present study were too inhibited to get into such intricate or intimate details on these commonly held notions, frequently asked questions, or doubts in the people.

Further, with regards their opinion preferences, the studied sample of women affected by HIV/AIDS show greater agreement for statements like ‘It is embarrassing for
parents to teach about sex to teenagers’. There is a streak of moral-religious dilemma whether their quandary is the consequence of the punishment given by god. This predicament is typically reflected as indecision or vacillation with regards to statements on ‘sex education to help control STDs’, or about having ‘open discussions on sex related matters is harmful to society’. It is evident that there are no linkages between knowledge or awareness and held opinion preferences about HIV/AIDS in this sample as also suggested elsewhere (Morton, 1986).

Although intended as exploratory, it must be admitted that the statements included in the ‘opinion’ inventory of the present study is only tentative. It cannot be construed as all-inclusive or exhaustive. There is scope, for example, to explore on use of condoms or certain aphrodisiacs, multiple partnership sex, coitus with animals, virgins or disabled, or about sex on certain auspicious or inauspicious days, oral/anal sex, etc which are customarily linked as ‘cures’ for HIV/AIDS. They have not been admittedly not included, elicited or reported even informally by the rural women respondents during the data collection in this study.

Conclusion

In conclusion, the objective study of knowledge, opinion, information, attitudes and/or perceptions of various segments of population including various groups of affected individuals themselves must be viewed as an important, needed, periodic, continuing and dynamic research exercise. It cannot and must not be viewed as single-time or solitary activity. Rather, the findings are to be closely interwoven with action plans and programs directed towards enabling attitude changes, dispensing of accurate information and positive opinion formation to the target groups of individuals. Moreover, the spread of the epidemic to rural areas presents a need to actively disseminate AIDS related knowledge for health protection.

References


Received: December 8, 2010
Revision received: January 12, 2011
Accepted: April 13, 2011

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