INTRODUCTION

From time immemorial, though man professes civilization and development, he has always been basically instinctual in his behaviour, especially in his sexuality. In India, though sexual promiscuity is considered a taboo, it is being practiced by most, largely. This has always given rise to social problems like infidelity, pre-marital affairs, divorce, family disintegration, suicide and even murder. Even then, the seriousness of the problem or the necessity to curb such behaviour was not implanted in the minds of human beings due to their weak morals and values. So much took place under cover and almost never came out until the outbreak of this deadly disease - AIDS. AIDS is a unique pandemic. Unlike any other disease, it principally affects the youth and the adult in their productive phase. Since this group of people is also the most contributive towards the economy of any nation, a rise in the number infected with HIV also implied a fall in the productivity of the country. Slowly the vulnerability of acquiring the virus spread from sexually active people to those who were intravenous drug users, blood recipients and patheticallly ignorant infants of infected mothers.

The din of the celebrations of victory over smallpox had barely died when mankind was struck by this deadlier disease and more virulent infection - the Human Immuno Deficiency Virus (HIV) infection. Acquired Immuno-Deficiency Syndrome is the final stage of this viral infection. Within two decades of the first reported case, millions of cases have been so far diagnosed. HIV/AIDS is a multi-faceted issue, which cannot be reduced to medical terminology and factual information alone. HIV/AIDS is very much a human and social problem that cannot be addressed merely as a public and medical issue.

It represents the deadliest emergency and the greatest social, economic and health crisis of modern times. The virus has many allies. Silence and denial have fuelled its transmission. Just as cultural and religious taboos inhibit open discussion about sexual
practices and preferences, including the use of contraceptives, shame and guilt have surrounded this virus that spreads mainly through sexual contact.

HISTORY OF HIV/AIDS

In 1981, the Center for Disease Control (CDC), Atlanta, U.S.A reported for the first time the occurrence of a rare form of pneumonia caused by an ‘opportunistic’ micro-organism called pneumocystis carinii and an opportunistic cancer called kaposi’s sarcoma in otherwise healthy young homosexual men. It appeared that they somehow acquired a form of immuno-deficiency characterized by loss of cellular immunity. Very soon AIDS was reported in U.S.A among intravenous drug addicts. Around the same time, a disease similar to AIDS was also reported from some tropical African countries, Haitian Island and Caribbean islands. Nevertheless, in these countries the disease was primarily showing a heterosexual mode of spread similar to any other common sexually transmitted disease.

Tracing back the history, scientists from San Francisco, based on mathematical analysis using the world’s largest computer, have concluded that the virus that sparked the AIDS pandemic first surfaced in people sometime around 1930, probably in Central Africa. Bette Korber of Los Alamos National Laboratory in New Mexico presented this conclusion. The oldest viral sample discovered to date came from a patient who died in Leopoldville, Congo, in 1959. That 1959 virus was a member of the M class of HIVs-the type responsible for most HIV cases today.

The first patient in South East Asia region was reported from Thailand in 1984. Since then HIV infection has spread rapidly. UNAIDS and WHO estimated that the number of people living with HIV or AIDS at the end of the year 2000 stands at 5.8 million in this region. India is a country which has a name labelled for chastity, morality and cultural heritage. So in the early 1980s, HIV/AIDS was considered to be an alien phenomenon, where people even hesitated to speak of sex. However, the cultural prestige shattered to
pieces in April 1986, when the first case of HIV/AIDS was reported at the Madras Medical College, Chennai.

According to Dr. Prof. C.N. Deivanayagam (Former Superintendent, Government Hospital of Thoracic Medicine, Tambaram Sanatorium), "AIDS entered India through Myanmar and Manipur, from there via Calcutta to Vellore and from Vellore to Namakkal (Salem), and then throughout the country. Myanmar, Laos and Thailand are a tri-junction called the Golden Triangle. Prostitution is rampant in Bangkok. The disease then spread to north of Thailand, Laos, Myanmar and India. Manipur has a high incidence of intravenous drug abusers and so the epidemic spread there rapidly. Many tamilians live in Manipur. Once these travelled back home, it spread here. Namakkal in Tamilnadu, the country's lorry transport hub, saw lorry drivers, cleaners and helpers spreading the disease to all parts of the country."

GLOBAL SCENARIO

"20 years back AIDS was an unknown entity. But now 36.1 million people in the world are living with HIV/AIDS. Of this 34.7 million are adults and women. Children constitute about one and half million. HIV/AIDS has so far claimed 21.8 million lives. Children account for 4.3 million deaths" (UNAIDS, 2000).

Twenty years after the first clinical evidence of acquired immuno-deficiency syndrome was reported, AIDS has become the most devastating disease humankind has ever faced. Since the epidemic began, more than 60 million people have been infected with the virus. HIV/AIDS is now the leading cause of death in sub-Saharan Africa. Worldwide, it is the fourth-biggest killer.

At the end of 2001, an estimated 40 million people globally were living with HIV. In many parts of the developing world, the majority of new infections occur in young adults, with young women especially being vulnerable. About one-third of those currently living with HIV/AIDS are aged 15-24. Most of them do not know that they carry the virus.
Many millions more know nothing or too little about HIV to protect themselves against it.

Eastern Europe and Central Asia – still the fastest-growing epidemic

Eastern Europe - especially the Russian Federation - continues to experience the fastest growing epidemic in the world, with the number of new HIV infections rising steeply. In 2001, there were an estimated 250,000 new infections in this region, bringing to 1 million the number of people living with HIV. Given the high levels of other sexually transmitted infections, and the high rates of injecting drug use among young people, the epidemic looks all set to grow considerably.

Asia and the Pacific – narrowing windows of opportunity

In Asia and the Pacific, an estimated 7.1 million people are now living with HIV/AIDS. The epidemic claimed the lives of 435,000 people in the region in 2001. The apparently low national prevalence rates in many countries in this region are dangerously deceptive. They hide localized epidemics in different areas, including some of the world's most populous countries. There is a serious threat of major, generalized epidemics. But, as Cambodia and Thailand have shown, prompt, large-scale prevention programmes can hold the epidemic at bay. In Cambodia, concerted efforts, driven by strong political leadership and public commitment, lowered HIV prevalence among pregnant women to 2.3% at the end of 2000 - down by almost a third from 1997.

Sub-Saharan Africa – the crisis grows

AIDS killed 2.3 million African people in 2001. The estimated 3.4 million new HIV infections in sub-Saharan Africa in the year 2000 mean that 28.1 million Africans now live with the virus. Without adequate treatment and care, most of them will not survive the next decade. Recent antenatal clinic data show that several parts of southern Africa have now joined Botswana with prevalence rates among pregnant women exceeding
30%. In West Africa, at least five countries are experiencing serious epidemics, with adult HIV prevalence exceeding 5%. However, HIV prevalence among adults continues to fall in Uganda, while there is evidence that prevalence among young people (especially women) is dropping in some parts of the continent.

➢ The Middle East and North Africa – slow but marked spread

In the Middle East and North Africa, the number of people living with HIV totals to 4,40,000. The epidemic's advance is most marked in countries such as Djibouti, Somalia and the Sudan, that are already experiencing complex emergencies. While HIV prevalence continues to be low in most countries in the region, increasing numbers of HIV infections are being detected in several countries, including the Islamic Republic of Iran, the Libyan Arab Jamahiriya and Pakistan.

➢ High-income countries – resurgent epidemic threatens

A larger epidemic also threatens to develop in the high-income countries, where over 75,000 people acquired HIV in 2001, bringing to 1.5 million the total number of people living with HIV/AIDS. Recent advances in treatment and care in these countries are not being consistently matched with enough progress on the prevention front. New evidence of rising HIV infection rates in North America, parts of Europe and Australia is emerging. Unsafe sex, reflected in outbreaks of sexually transmitted infections, and widespread injecting drug use are propelling these epidemics, which, at the same time, are shifting more towards deprived communities.

➢ Latin America and the Caribbean – diverse epidemics

An estimated 1.8 million adults and children are living with HIV in Latin America and the Caribbean - a region that is experiencing diverse epidemics. With an average adult HIV prevalence of approximately 2%, the Caribbean is the second-most affected region in the world. But relatively low national HIV prevalence rates in most South and Central
American countries mask the fact that the epidemic is already firmly lodged among specific population groups. These countries can avert more extensive epidemics by stepping up their responses now.

NATIONAL SCENARIO

HIV was first identified in 1986 in prostitutes in Chennai, and later in intravenous drug users in Manipur state. In the years following the discovery, the general perception was that HIV was largely restricted to prostitutes and truck drivers, and to urban areas in India. Now studies have shown that the virus has entered the general population and that it is rapidly spreading through the rural areas. In fact, rural and urban areas may be affected equally. Indeed, a survey of randomly selected houses in the state of Tamil Nadu found that 2.1% of the adult population living in the countryside had HIV compared to 0.7% of the urban population.

HIV is spreading among the general population in India, mostly in conjugal relationships, through unprotected sex between infected husbands and their uninfected wives. In Pune, a study of nearly 400 women showed that about 14% were infected with HIV and these were women who never had sexual relations with anybody but their husbands. Data from an anonymous counselling / testing centre in Chennai showed that of the 134 women who tested HIV positive from 1994 to 1998, 88% reported a history of only one lifetime sexual partner. Their main risk factor was their husband. The majority of these women were married, dependant on their husband and being in the reproductive age group had the potential to transmit HIV to their babies.

As of July 31, 1999, NACO reported that out of a total cumulated number of 3.29 million persons screened, 87,313 were HIV positive. The seropositive rate per thousand was 24.92. That is, 25 people per thousand screened were HIV positive. Among the states showing the highest seropositive rates per thousand were Manipur (150.0), Maharashtra (110.9), Punjab (43.7), Daman & Diu (32.0), and Goa (31.7). States that were close to the
national average of 24.92 were Himachal Pradesh (26.2), Rajasthan (23.27) and Tamil Nadu (18.6).

According to NACO, as of February 2002, the number of people living with HIV has reached 3.86 million. The actual number of AIDS cases reported to NACO as of October 31, 2000 is 15,606. Of these 15,606 cases, 11,970 were males and 3,636 were females. The most common route of transmission was the sexual route (81.6%). Among these 15,606 AIDS cases the highest number of cases are reported from Tamil Nadu (7,787) and Maharashtra (3,657).

It is worth repeating that the majority of AIDS cases are not recorded. They are either not diagnosed or go unreported. Also, many people with AIDS do not seek medical help and pass away in their homes. While surveillance schemes can pass valuable information, they have their own limitations.

The latest figures of HIV infected /AIDS cases provided by National AIDS Control Organisation (NACO) with state-wise distribution is given in the following page.
**HIV/AIDS Surveillance in India**

*(as reported by NACO)*

*As on 30th April, 2003*

### AIDS CASES IN INDIA:

<table>
<thead>
<tr>
<th></th>
<th>Cumulative</th>
<th>This Month</th>
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</thead>
<tbody>
<tr>
<td>MALES</td>
<td>36606</td>
<td>195</td>
</tr>
<tr>
<td>FEMALES</td>
<td>12590</td>
<td>68</td>
</tr>
<tr>
<td>Total</td>
<td>49196</td>
<td>263</td>
</tr>
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</table>

### RISK / TRANSMISSION CATEGORIES:

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<thead>
<tr>
<th>Category</th>
<th>No. of cases</th>
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<tr>
<td>Sexual</td>
<td>41839</td>
<td>85.05</td>
</tr>
<tr>
<td>Perinatal transmission</td>
<td>1302</td>
<td>2.65</td>
</tr>
<tr>
<td>Blood and blood products</td>
<td>1373</td>
<td>2.79</td>
</tr>
<tr>
<td>Injectable Drug Users</td>
<td>1293</td>
<td>2.63</td>
</tr>
<tr>
<td>History not available</td>
<td>3389</td>
<td>6.89</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
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<td><strong>100.00</strong></td>
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### AGE-WISE DISTRIBUTION:

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<th>Age group</th>
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<tr>
<td>0 - 14 yrs</td>
<td>1145</td>
<td>714</td>
<td>1859</td>
</tr>
<tr>
<td>15 - 29 yrs</td>
<td>11552</td>
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<td>17394</td>
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<tr>
<td>30 - 44 yrs</td>
<td>21070</td>
<td>5317</td>
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<tr>
<td>&gt; 45 yrs</td>
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<td>717</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>36606</strong></td>
<td><strong>12590</strong></td>
<td><strong>49196</strong></td>
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</tbody>
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STATE-WISE DISTRIBUTION:

<table>
<thead>
<tr>
<th>S. No</th>
<th>State / UT</th>
<th>AIDS Cases</th>
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<tbody>
<tr>
<td>1</td>
<td>Andhra Pradesh</td>
<td>3412</td>
</tr>
<tr>
<td>2</td>
<td>Assam</td>
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<tr>
<td>3</td>
<td>Arunachal Pradesh</td>
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<tr>
<td>4</td>
<td>A &amp; N islands</td>
<td>27</td>
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<tr>
<td>5</td>
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<tr>
<td>6</td>
<td>Chandigarh (UT)</td>
<td>683</td>
</tr>
<tr>
<td>7</td>
<td>Delhi</td>
<td>775</td>
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<tr>
<td>8</td>
<td>Daman &amp; Diu</td>
<td>1</td>
</tr>
<tr>
<td>9</td>
<td>Dadra &amp; Nagar Haveli</td>
<td>0</td>
</tr>
<tr>
<td>10</td>
<td>Goa</td>
<td>171</td>
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<tr>
<td>11</td>
<td>Gujarat</td>
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<tr>
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<td>Kerala</td>
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<td>28</td>
<td>Sikkim</td>
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<tr>
<td>29</td>
<td>Tamilnadu</td>
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<td>30</td>
<td>Tripura</td>
<td>6</td>
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<td>31</td>
<td>Uttar Pradesh</td>
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<td>West Bengal</td>
<td>930</td>
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<td>Ahmedabad Mun.Corp.</td>
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<tr>
<td>34</td>
<td>Mumbai Mun.Corp.</td>
<td>2067</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td></td>
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AIDS AS A SOCIAL PROBLEM

The critical feature that distinguishes AIDS from other life threatening and fatal illnesses, such as cancer or TB is that it selectively affects adults in their most active sexual ages, which coincide with their prime productive and reproductive years.

If an adult in a family gets affected with AIDS, the household resources, which he earns, will be reduced, and medical expenses increases. Reduced income in turn threatens food supply, the ability to pay for the education or health of surviving family members, and the ability to invest in productive inputs. AIDS threatens more than the capability of a household to function as an economic unit; the entire social fabric of the family gets disrupted or dissolved. The loss of either or both parents leaves behind dependants, both the very young and the elderly who may have been relying on their children for support in old age.

The HIV infection enters the family through the infected partner to the ignorant partner, and affects the newly born infant from the infected mother. Thus, the entire family gets disrupted.

Excessive absenteeism from school or work, because of sickness of self or significant others, results in the loss of productivity. The responsibility of caring for the elders and the orphaned children is shouldered by the governmental and non-governmental organizations.

As heterosexual contact becomes increasingly the predominant mode of transmission world wide, women and children will become more vulnerable, both as potential AIDS casualties and survivors. Another cause of deep concern is the children who are not infected with HIV, but whose parents are. Often the responsibility to support these children falls on the unwilling extended family members or on elderly grandparents with little means of financial or physical support. Another issue of growing concern is the inability of widows and children to acquire rights to the property after the death of the
male head of the household. Without access to any decent means of income, widows and children may be forced to petty theft and commercial sex work, a vicious cycle that could contribute to the increased rates of HIV infection.

Apart from the personal struggles for survival, the persons who are infected with HIV undergo social ostracism. HIV first presented itself as an infection of sexually promiscuous people and IV drug users. It immediately was enveloped in stigma. Even now the stigma prevails which acts as a barrier for the society to stretch its helping hands to the needy infected.

WOMEN AND HIV/AIDS

Though women of these days have made great strides towards equality with men, they are still being termed and treated as the weaker sex. Though, at present they do have some control over their economic, social and personal lives, for millions of others these are still a remote dream. These are the women who are likely to be the most vulnerable to infection with HIV.

"The HIV epidemic is driven by men", says Calle Almedal, a senior official with the joint United Nations AIDS programme (UNAIDS). It is confirmed by statistical analysis of the disease. Worldwide women may be more affected by the consequences of HIV/AIDS, but it is the sexual and drug taking behaviour of a large minority of men, which enables the virus to spread.

The proportion of women among those infected has been rising inexorably, so that, on a global scale, women accounted for 43% of all infected people in 1998. The risk is increasing for women in developed and developing countries alike. Consequently the number of infants who acquire HIV from their infected mothers before or during birth or from breast-feeding has also been rising dramatically. Globally, one in ten of those who became newly infected during 1998 was a child under the age of 15 years.
CHILDREN AND HIV/AIDS

HIV infection is predicted to become a major cause of death among children, yet the pandemic is still perceived as largely an adult issue. When parents have AIDS the effect on their children is cumulative and not easy to see at first. These children receive less nutrition, have to leave school, assume adult responsibilities, face the trauma of the death of their parents, or carry the stigma of being labelled AIDS orphans. The first descriptions of this illness in children were reported in 1982. Every day an estimated 1000 children become infected with HIV, mostly in the developing countries. In 1996, 4 lakh children under 15 became infected with HIV. UNAIDS estimated that a total of 2.6 million children worldwide had been infected with HIV by the end of 1996.

STATEMENT OF THE PROBLEM

Women are not only the main caregivers of the family but are also largely responsible for food production, labor and rearing children. They act as the backbone of the family, supporting the entire system and providing care to all its members. When HIV enters a family, it is the woman who gets affected the most, even more than the infected person himself. The burden of the entire family is shouldered by the woman if her husband contracts AIDS and it gets even more heavier if she too has contracted it. The sudden loss or decrease in the family’s income, the stress of taking care of the husband’s illness, her own diminishing health condition and the threat of sudden death of a loved one becomes an impossible burden to bear. However, the man gets all the attention and care that he needs, irrespective of her HIV status. Moreover, the psychological trauma increases in a woman when she discovers that one or more of her children have been infected by AIDS through mother to child transmission. Guilt combined with a feeling of inability to combat the situation causes a major setback in a woman’s life.

Women go through a lot of physical as well as psychological stress due to HIV and AIDS. Taking care of infected children could be the worst part of the crisis. Since children have a low immune capacity they are prone to fall ill more often and recover
very late. Her illness develops rapidly when combined with all this stress. The support that she willingly provides her husband is rarely reciprocated. When a man falls sick it only affects the financial status of the family. But when a woman falls ill it disrupts the entire network of schedules, since she is the one responsible for all the household chores, the preparation of food for the entire family, taking care of the children and the elders in the family.

Though the woman is the pivot of any family, it is she, who gets ostracised and sometimes even disowned, when it comes to socially stigmatised issues and diseases. As a wife, she stays with her husband till his / her death and as a mother she nurtures and protects her children till her last breath. Therefore, it is important to analyze the role of a woman as an infected wife and / or an infected mother who takes on extra care and burden to rear the infected as well the healthy children with or without the necessary support systems. The role of a mother is given more importance since the children often survive the parents when they are not infected and to provide for their future within a short span of a sick life usually a traumatic time for the mother, especially when she has girl children. Even when one or more children die before the mother due to AIDS, it often leaves a spell of guilt and low esteem for her as she allows herself to be blamed more than their father.

The study is designed to investigate the problems of HIV infected mothers with special reference to the upbringing of children. There are plenty of research studies on women, but there is no study related to the problems of HIV infected mothers in the upbringing of their children or any other similar study that has been conducted in Chennai. The study aims to throw light on that particular issue and provide with hypothesis for further extensive research. The study attempts to describe the health status of a mother, her socio-economic status and the social support available to the mother in the context of upbringing her children. The study also explains how the mother strives to provide care to her children and the extent to which she is able to provide the basic needs for her children.
SIGNIFICANCE OF THE STUDY

Children are the future of every country. It is therefore, very crucial to nurture, socialize and educate them for the future prospects of the family, the society and the country, at large. All these responsibilities are the sole efforts of the mother of the child in most families, especially in the Indian context. However with the advent of HIV/AIDS, this has not only been hindered but also often rendered impossible among the middle and poor class families. Women who have become prey to the disease are overburdened and stressed, especially when they have passed on the virus to their children. The physical and psychological stress of a sick person plays an important role in the treatment process and in turn his or her life span. Therefore, it is important to study the woman as an infected mother so as to analyze the increased difficulties in child rearing, which is very crucial not only for the family but also for the society. The study will surely help in formulating or redefining existing support systems for the infected mothers with special reference to child rearing and providing for the overall care and development of the children, irrespective of their HIV status.

OBJECTIVES OF THE STUDY

➢ General Objective:
(a) To study the problems of HIV infected mothers with special reference to the upbringing of their children.

➢ Specific Objectives:
(a) To study the socio-economic status of the HIV infected mothers.
(b) To study the demographic profile of the HIV infected mothers.
(c) To study the health status of the HIV infected mothers.
(d) To study the HIV status of the children of the HIV infected mothers.
(e) To study the ability of the HIV infected mothers to provide basic care and support needs for the children.
(f) To study the support systems available to the HIV infected mothers in the upbringing of children.

RESEARCH QUESTIONS

This study seeks to answer the following questions:

(a) Is there any specific difference, in the problems faced by the HIV infected mother woman with reference to the HIV status of the children?

(b) Does the HIV infected woman specifically lack anything in child rearing, with specific reference to her HIV status?

(c) Do the HIV infected woman or her children face any kind of ostracism, which affects the development of the children?

(d) Are the HIV negative children affected in any way due to the HIV status of the others in the family?

(e) Does the HIV positive woman face any specific problems in rearing the HIV positive and the HIV negative children under the same roof?

(f) Is the availability or unavailability of necessary support systems affecting the upbringing of the children?

RESEARCH DESIGN

The researcher attempts to portray accurately the existing problems of HIV infected women with special reference to the upbringing of children. The purpose of the research was to describe socio-economic conditions, demographic, family and health profile of HIV infected mothers and their problems related towards the upbringing of their children. Hence the researcher has chosen Descriptive design for the research purpose.
SAMPLING DESIGN

Sampling Technique:

The sampling technique adopted by the researcher is purposive sampling technique (Non-probability sampling method). The researcher interviewed the respondents who were admitted in the female ward, Government Hospital of Thoracic Medicine, Tambaram Sanatorium between the time period of March 2001 and October 2001.

Sample Size:

The number of respondents covered in this Study is 120.

Criteria for sample selection:

The criteria for selection of respondents are:

i. The respondent should be HIV positive women with children belonging to the age group of 14 years or below. The children may or may not be HIV positive.

ii. Their (the women's) HIV status must have been confirmed by the western blot test.

iii. They should be getting in-patient treatment at the Government Hospital of Thoracic Medicine, Tambaram Sanatorium.

iv. They should be willing to participate in this study.

SOURCE OF DATA

The primary source of data was the HIV infected mothers, admitted in Government Hospital of Thoracic Medicine, Tambaram Sanatorium.

The secondary source of data comprised of Books, Journals, Periodicals, Doctors, Health Care Workers and Social workers from the field.
TOOL OF DATA-COLLECTION

The tool of data-collection is the interview schedule. The tool was prepared by the researcher specially for this Study. The tool was validated through Expert Validation Method. The tool was also pre-tested.

*Components of the tool of data collection:*

The interview schedule had about 80 questions and had both open-ended and close-ended questions. Though most of the questions were close-ended, certain questions were open-ended so as to get an in-depth understanding of the issue studied.

The tool consisted of six parts as follows: (i) Socio-economic status, (ii) family profile, (iii) health profile, (iv) details of children, (v) ability of HIV infected mothers to provide basic care and support needs for the children and (vi) support systems.

i. The component on Socio-economic status helps us to elicit information on domicile, income, occupation, financial soundness of the respondents etc.

ii. The Family Profile enables us to understand the marital status, type of family and extent of role conflicts in the family.

iii. The health profile gives an insight into the year of testing, reason for testing, the nature of other ailments (in terms of frequency and treatment), prevalence of opportunistic infections, treatment pattern, medical expenses incurred on self, spouse and children, diet habits etc.

iv. The component on Children's profile provides details on the number of children per respondent, the age of the children, the HIV status of the children, relationship between siblings, relationship between mother and child etc.
v. The component on ability to provide basic care and support needs is based on the UNICEF's declared Rights for Children (1989).

vi. The last component - Support Systems - elicits details on the network of support available to the respondents through various governmental, non-governmental organizations and the family.

PRE-TESTING OF THE TOOL OF DATA COLLECTION

The interview schedule was pre-tested during November 2000 among 24 respondents (i.e., 20% of sample size); a few changes were made as required to enhance the clarity of the tool.

FIELD OF STUDY

The field of study chosen by the researcher is the Government Hospital of Thoracic Medicine, Tambaram Sanatorium. The hospital which caters to patients suffering from Tuberculosis and other chest diseases has been chosen for treating HIV infected /AIDS patients in 1993, by the Government of Tamil Nadu. The hospital has the distinction of being Asia's largest care center for treating HIV / AIDS patients.

The hospital consists of six wards for the HIV infected / AIDS patients, among which three are for men, two for women and one for children. The hospital receives patients from all over Tamil Nadu, borders of Andhra Pradesh and also from Mumbai. During the time of study, Approximately 115 infected women were admitted as inpatients, 250 men were treated in the male wards and 12 in the children's ward. The hospital renders HIV screening and counselling, in-patient services, blood bank services, rehabilitation services and patient-relatives' care sheds for the welfare of patients.

Thus the research is set in the Indian sub-continent.
ACTUAL COLLECTION OF DATA

The data for the said study were collected by the researcher between March and October 2001 at Government Hospital for Thoracic Medicine, Tambaram Santorium, Chennai. The respondents were assured of confidentiality of responses and respondents prior to the collection of data.

**Difficulties encountered at the time of data collection:**

The researcher was more than a researcher at the time of the research. She had to play the role of a social worker too. Often, she had to bail out respondents from depression by counselling them and by instilling in them a positive outlook on life. Such instances made the data collection process very time-consuming. Besides, the researcher had to confront reluctance on the part of the respondents. Not all respondents were forthcoming with their responses at the first instance. In addition to the above, the conditions prevailing in the hospital imposed health constraints on the researcher too.

DATA ANALYSIS AND INTERPRETATION

The data collected were analysed electronically using Statistical Package for Social Sciences (SPSS, Version 10.0). Statistical test (chi-square test) was applied to test the significance of relationship between select variables. Select data have been diagrammatically represented. Qualitative data have been incorporated at appropriate places.

CLARIFICATION OF TERMS

The following operational definitions are provided to ensure uniformity and understanding of the terms throughout the study.
Chapter - I

> HIV infected mothers
Mothers who are HIV positive and having children below 14 years of age who are either positive or negative.

> Support system
The support available to the HIV infected mother from parents, relatives, neighbours, Governmental and non-governmental organizations.

> Children
Children born to the HIV infected mothers and belonging to the age group of 14 and below 14 years, who are either HIV positive or negative.

> Basic care and Support needs
The basic care and support needs include nutrition, parental care, recreation, education, and medical care. The constituents of basic care and support needs have been derived from the Declaration of the Rights of the Child (1989) as given by the United Nations Children’s Fund (UNICEF).

> Family
The term family refers to the basic unit in society having as its nucleus two or more adults living together and cooperating in the care and rearing of their own children.

The types of families covered in this study were:

- Joint Family - where the infected couples or separated/widowed women stay along with their parents/in-laws and children.
- Nuclear Family - where the infected couples are staying on their own with their children.
- Single Headed Family - where the infected mother (separated/widowed) stays alone with her children.
Role Conflict

Role Conflict refers to the incompatibility between the spouses as well as the members of the family, which disrupts the upbringing of children.

LIMITATIONS OF THE STUDY

i. As the data were collected from women who were admitted in the Government Hospital of Thoracic Medicine, majority of them are from rural areas among whom most of them were illiterates and were much ignorant about their HIV status.

ii. As HIV/AIDS is a sensitive issue, the response from the respondents are candor and vague and might not accurately reflect the opinions of all members of the included population.

iii. As the study employs non-probability sampling technique, the study may suffer from the demerits of the said technique.

iv. The data were collected in a hospital setting where patients were admitted for treatment and when they were sick. Hence, the responses may suffer from human bias and prejudice.

CHAPTERISATION

➢ Chapter I titled 'Introduction and Research Methodology' has been presented as the introduction to the research study and the methodology adopted.

➢ Chapter II - 'Review of Relevant Literature' - contains the review of related literature and research related to the problem being investigated.

➢ The results of analysis and findings that emerge from the study are contained in Chapters III to VI.
• Chapter - III gives the socio-economic and family profile of the respondents.
• Chapter - IV gives the health profile of the respondents.
• Chapter - V gives the children’s profile and respondents’ ability to provide basic care and support needs.
• Chapter - VI gives details on the support systems.

▷ Chapter 7 gives the conclusions and suggestions based on the study.

▷ This is followed by select bibliography.

▷ A copy of the tool of data collection and select case studies are enclosed in the appendices.
CHAPTER - II

REVIEW OF RELEVANT LITERATURE