CHAPTER V
DISCUSSION ON MAIN FINDINGS

The purpose of the study was to measure the quality of life and social support of HIV positive women. This is assessed in relationship to general health condition and other socio-economic factors. This chapter examines the findings in the context of the general hypothesis set in the beginning of the study and also looks at the possible reasons for the findings while relating them to earlier research and theoretical works. It also presents the interpretation of the findings.

5.1.1 Basic Characteristics of the Respondents

Average age of the respondents was 33 years (SD of +/- 4.6) years age ranging from minimum of 22 yrs to maximum of 45 yrs. The majority of the respondents (95.6%) women belonged to the age group 20-40 yrs an important socio-demographic cohort and economically the most productive age group and potential participants in the National development. This age structure is very similar to the profile of HIV infected individual in the country (NACO 2007) and which is observed in other studies also (. A. C. Gielen, K. A. et al 2001, Mohana rani 2011) 4.4% of women belonged to the age group of more than 40 yrs.

Of the 204 women 65% of them were living in urban areas and 35% lived in urban fringes. There was a history of migration immediately after HIV detection. 32% of the women had migrated to Chennai for treatment purpose and to hide their identity. Because in rural areas still HIV is a socially constructed illness, and has great bearing on an individual’s behavior. Stigma and isolation of individuals are quite common. There fore among the women who were affected by HIV, 32% of them had migrated to Chennai for treatment purposes and to get rid of ostracism.

Among 204 respondents (67.2%) declared that they were literate and attended formal schooling out of that 25% of them had learned up to primary level 21% of them had attended secondary schooling, 19% of the respondents had learned up to +2 , 3% were graduates. 32.8% were illiterate.
36% of the respondents were married women living with the husband. The researcher had come across among married women 12% women were living with their second husband, either because the first husband had died or they had separated and subsequently married and settled in Chennai. 46% of the women were widows. It was found that those respondents who had lost their husbands stated that their spouse had died due to opportunistic infection. 4 of the spouses had committed suicide. However no death was recorded under AIDS infection. It was visible from the data that HIV/AIDS gave women widowhood status. 18% were separated. It was revealed that their husbands had run away when HIV was detected for them.

81% of the respondents were Hindus, 17.5% Christians, and 1.5% were Muslims. While looking into the community profile of the respondents all most all of them were from the marginalized community, 63% declared that they belonged to Scheduled caste and 37% of them were from backward communities. Similar findings have been recorded by (Sakthi S 2010) Illness affects every body. It does not choose people from specific community. However in this study all most all the respondents were from the marginalized communities. This is a significant finding because economic status plays a major role in the treatment adherence.

Regarding economic status, the first variable taken for study was the working status of the respondent. 81.8% of the women were working in various capacities. Out of that 76.4% of them were working in an unorganized sector right from construction coolies to domestic helpers in houses. 5.4 % self employed. Respondents’ average monthly income was Rs 2500 (S.D- Rs 1853) ranging minimum of Rs 1000 to maximum of Rs 8000/-. 42% of the respondents had income below Rs 3000/ per month and 58% of the women had family income above Rs 3000/ per month mean total family income was 4661.76 (S.D- Rs 2012.47) minimum of Rs 1000 to maximum of Rs 10,000/ as a family income.

43% of the respondents were living in their own house and rests of them 57% were living in a rented house. 35% of the respondents lived in thatched huts and 65% of them lived in concrete houses. To know whether there was any association between ownership position and living area, x2 test was conducted. The test result revealed
that there was an association between the living area and the ownership of house. (p = <.001)

Regarding type of family, 33.8% of the respondents lived in nuclear families 9.3% of them living in joint families around 49.5% of the respondents were women heading households. The women lived with their unmarried children. HIV infection had a devastating affect in the family structure. 94% of them were having small family. The family size was 4 and below, where as 6% of them had family which had more than 5 members. Regarding number of children the mean number of children was 2 (S.D-1), minimum of 1 child to maximum of 5 children very rarely, few women had more than 2 children. As far as HIV status of family was concerned 35% of the respondents’ children were infected with the disease.

5.1.2 HIV Related Information:

Out of 204 respondents 25% of the samples were a symptomatic, i.e., free from major symptoms 45% of them were symptomatic. As the immune system fails, symptoms develop. Initially many of the symptoms were mild, but as the immune system deteriorated the symptoms worsened. In this study majority of them had severe physical health issues. The third group comprising of 30% had developed full blown AIDS. As the immune system becomes more and more damaged the individual may develop increasingly severe opportunistic infections leading eventually to an AIDS diagnosis. Usually for this group the cd4 cell count is less than 200. Many of them had severed opportunistic disease like cancer, T.B, swollen body, severe diarrhea and prominent skin lesions.

61% of them were diagnosed for HIV less than five years, 35% were living with the disease for more than 5 years and less than 10 yrs. 4% of the sample had HIV status for more than 10 yrs. These women have been visiting Voluntary organizations that were working for HIV patients. So they had clear awareness regarding the disease and were able to maintain their health status with food and nutrition. They maintained their Cd4 count with frequent medical check ups and took regular food and medicine on time. Similar findings have been presented by A. C. Gielen, et al 2001.
Regarding HIV diagnosis and their after effect, 50% were worried about the disease status; their worry was not about their health status, rather about their children's status. 20% were shocked about it 8% had fears and 3% were denied, 20% showed no reaction. They were neither aware of the seriousness of the disease nor the consequences of the illness. Only 11% feel guilty, 34% of them feel guilty sometimes and 55% felt they never had guilt feelings.

88.7% got infected because of heterosexual relations with the husband having HIV. Similar findings were observed in various studies by (Majumdar B. 2004, Srikanth et al., 1997, George et al 1997, Sud A, Dutta U, et al; 2002, NACO – 2007)

5.2.1 Awareness Level

76.5% had heard about the term HIV/AIDs and knew that it as a disease, but they were not aware of more than the term and the negative connotation associated with the term, until they were diagnosed for HIV positive. Similar findings were observed by (Sudha B. Yadav et.al 2011. Thilagavathy Subramaniam 2007.) During discussion it was found that 53% of the respondents came to know about a disease called HIV/AIDS after coming to General Hospital for their husbands treatment purpose, 24 % heard about this term through the media and they had a vague understanding that it was because of illegal sexual relations with multiple partners, 18% got to know through NGOs attached to hospitals. They did not want to discuss this with anybody. Except 29.4% rest of them were not aware of its mode of transmission. They had lot of misconceptions towards the spread of the disease. In spite of the vigorous awareness, the information regarding HIV had not reached the concerned section of the society Similar findings were reported by (Subramnaian T, Gupte MD 2007), (Reshmi et al 2012)

To find whether any association prevailed between knowledge regarding mode of spread and literacy level, X2 tests was conducted. The result revealed that no association was found between these two. May be it was associated with attitude and the value system of the said society than the level of literacy, which needs further probe. (P= <.147)
5.3.1 General Health condition/Mental Health:

The analysis of data on GHQ 28 reveals that 60 to 70% of the respondents had identified one or more somatic problems ranging from not feeling good to feeling of tightness or pressure in head, clearly indicating the “somatic caseness”. Minimum of 60% to maximum of 70% of the respondents had identified one or more of the stated question as worse than the previous condition. Similar findings were observed by (Kermode et al. (2008)). Most functional symptoms were transient, but a sizeable minority became persistent. Persistent symptoms were often multiple and disabling and were described as functional syndromes which hindered their normal routine life.

India has committed to meet the Millennium Development goals, yet in the 11th Five year Plan women and children continue to be in disadvantageous status, and victims of all sorts of violence. Gender disparity in all walks of life right from education, employment, work participation, and wage disparity, has had a cumulative effect in creating health inequality. Women’s health has always been given secondary importance in the family in spite of her primary role. Right from consumption of food to personal care, her needs have been always pushed back and other members in the family have been given care and importance. As a result women neglect their health care, fail to fulfill their basic requirements, ignoring their personal hygiene and social status. Unless they got severe sickness they always ignored their bodily symptoms and did their routine work slowly, similarly in this study the positive women were engaged in physical work. Though frequent somatic problems hindered their routine, till they continued to do their regular routine work at home. They abstained from wage work frequently which hindered their economic progress.

The presence of anxiety/insomnia among the study group was around 52%-60%. 50% of the respondents faced social dysfunction. Frequent illness affected their routine life. They were not able to discuss their problem with anybody and to seek medical treatment immediately. HIV is a stigmatized disease and majority of them had not disclosed their HIV status due to fear of rejection. Hence they were denied the opportunity to seek medical access and utilization. This finding contradicts Parson’s theory of the Sick Role. When ever a family member gets sick, it is called social
deviation, and they are expected to get treated by a medical practitioner. The entire family members give them rest and help them to recover. Forced rest is guaranteed by the social system. However in the case of HIV positive women, access and utilization of health care is denied because of the social construction of the disease.

Regarding the domain of depression 12 to 21% of the respondent had some sort of depression because of the disease. 15.7% of the sample had extreme depression as they even had an idea of taking away their life, many times. This can not be ignored. In spite of individual and family counseling they lost their emotional balance. Frequent illnesses, indefinite stay in the hospital, and subsequent worry about their children were some of the reasons identified during discussion. 21% felt they were worthless because of severe sickness. Similar findings were observed by (Ahuja, Parkar, and Yeolekar, 1998). 19% felt life was entirely hopeless. 12% felt life was not worth living 12% felt they were nervous and could not do anything. 12% wished they were dead and away from it all. 15.7% of the sample had extreme depression to the extent of wanting to commit suicide. Similar findings were observed by (Shankar Das and George S. Leibowitzb 2010, Bernatsky, S, Souza. R and De Jong K 2011)

From the General Health condition scale it could be inferred that majority of the HIV women had (60%) somatic problem anxiety/insomnia and social dysfunction. Similar findings were reported by (Kermode et al. 2008) Severe mental depression was observed among 15.7%. The progression of disease had induced physical health problems which were hindering the normal routine work of the HIV positive women. Their capacity to work had diminished due to ill health, which affected the economic and social fabric of their life.. They had constant worry about the future of their children and economic burden rather than about their health status.

To find out the relation between duration of the disease and general health condition, the highest scorers in the GHQ scale were categorized as case group in each domain and others were as a non case. Non parametric test was done. The statistical results revealed that there was an association between number of years of patient having HIV status and the presence of somatic disorder x2 =4.656 and p value is (P = <.036).
Whereas the duration of the disease was not significant in other domains like the presence of Anxiety and Insomnia, social dysfunction and mental depression.

After studying combination of variables and its association, the researcher was interested to find out the influence of other variables on GHQ. In order to find out that linear regression was done. The regression results revealed that there was a positive influence between membership in positive women’s net work, social support and Respondents’ income in deciding the general health condition. The Central Role of Flexible Resources for SES Inequalities in Health (Link and Phelan 1995) theory was supporting this finding, that income will decide the health status and health care behavior of the individual which is similar in this study. However widow hood and longevity of the disease and increase in cd4 count were negatively related.

Symptoms occur across the trajectory of HIV disease and can diminish the quality of life of women living with the virus. Untreated symptoms may also influence medication adherence and lead to complications of HIV and coexisting illnesses. Symptom management can address these concerns. A variety of self-care approaches should be incorporated into any plan of treatment, which ideally should be based on a partnership between the woman with HIV and her health-care providers.

5.3.2. Social Support:

Social support given by their family, friends and co-workers provide physical and emotional balance for an individual who is ailing from long term disease. It occurs through an interactive process. As rates of infection increase in women, understanding the impact of HIV/AIDS on women has become important. However, many women were able to counteract these outcomes by surrounding themselves with those who can provide various forms of support.

To assess the social support given to HIV positive women, the Duke-UNC Functional Social Support Questionnaire (FSSQ) was administered. The questions included whether they have somebody to bother in all these areas, right from caring, showing love, discuss their problems, financial help, taking them out, help during crisis situation etc. The descriptive results revealed that on an average 42% of the respondents had good social support while around 21 to 23% of the respondents got
moderate social support but would like to have more. Around one third of the respondents ranging from 33% to 39% did not receive any support. The respondents got functional support from their maternal relatives. Mostly the mother was the pillar of support, followed by their sisters. They extended help right from assisting household work, care giving, taking care of the children during treatment time etc., this finding was supported by (Kallichman SC et al 2003) Both structural and functional help were given by maternal family members only. That was one of the reasons the positive women left their family of procreation and joined family of origin.

5.3.3 Social Support and Relationship with other variables:

Social support is associated with community living, so family, peer group; work environment; neighborhood, and any other network relationship play a role in deciding the effectiveness of the social support and social relationship. Though the HIV positive women get comparatively less social support, it is necessary to find out the type of relation which is extending the help. Hence higher level statistics were done to assess the association of social support with other variables.

To assess that, marital status, type of family and membership in network organization were taken as independent variables and social support was taken as dependent variable. Non parametric x2 test was commuted to know the association. The test results revealed that there was an association between type of family, marital status, and social support. As far as memberships in positive women net work were concerned, except three questions the rest were not associated.

The study inferred that type of family plays a major role in enhancing the social support followed by marital status. The similar findings were reported by Youth Susan Abramowitz, et al (2009), Though there was an association between membership in Positive Women network and social support it did not have a strong association with all parameters because it was an outside agency meant for giving confidence to fight against the challenges. It did not guarantee instrumental and emotional support like primary group relations.
Social support is an important predictor variable for quality of life. Many Western studies proved that there was a positive co-relation between social support and quality of life. Hence this study aimed to find out the association between these two variables. The $x^2$ test was computed. The test result revealed that there was a positive association between social support and quality of life. $X^2$ value 43.119, d.f= 2, $p=<.000$ similar finding were observed by Swindle, Susan et al (1999)

The present study has considered membership in positive women net work as one group and non member as another group. To find out the difference in mean social support among these groups one way ANOVA Test was computed. The test results revealed that there was no difference in social support between these two groups. The membership in positive women net work did not make any difference in social support. Women who had membership in the positive women network had better outlook towards HIV issues. It had guided her to face the challenges posed by the disease. For few women especially those who did not have any support during regular meetings they had developed friendship among themselves which enhanced some sort of social support. But when it comes to functional help it was the family which was taking care of the people rather than the outside agencies. The positive women network organization had removed myths related to the HIV/AIDS disease among the members and given confidence to tackle the challenges. But when the questions of who helps you in a crisis situation, the respondents were immediately associating with their kith and kin rather with Positive women net work. When the help was denied to them they felt they did not have any body to support, but failed to identify this outside organization as a support system.

After analyzing various variables and their role in social support the researcher was interested to find out the level of influence of each variable on social support. To find the same linear regression was done considering social support as dependent variable and structural support systems as an independent variable. The regression analysis indicates that variables like marital status, living with husband, type of family and total family members all found to be strongly related to Social support. No of infected children and women headed family were negatively related.
The standardized beta coefficients indicated that for every one unit change in marital status there will be a .33 change in social support. Likewise a one unit change in living with husband will result in .277 change in good social support, a one unit change in women headed residence result in -.236 negative influence on Social support. A one unit change in number of infected children -0.162 will have negative influences on social support. The study concludes that social support was a major dependent and predictor variable for quality of life. Social support was influenced by type of family, marital status or women living with husband, family income, and total family members were some of the positive predictors of the variable. Women headed family, and presence of infected children were having negative influence on the social support.

The study infers that the most important variable which decides the Social support was family and marital status. The study concludes that social support plays an important role in enhancing the quality of life of the individual. The support can be in any form either instrumental or emotional. The presence of kith and kin or the close relatives play a major role in disease management and building confidence among HIV positive women. The positive women living in the family fold expressed good poise than the women living alone.

5.3.4 Quality of Life:

The HIV/AIDS disease has changed individual lifestyles and quality of life. Empirical evidence shows that as the HIV disease progresses, quality of life deteriorates (Bourgoyne & Saunders, 2001; PLWHA face physiological, physical, psychological, and socio-cultural problems that are caused by four factors; all of which affect the quality of life. These four factors are (a) symptoms of the virus, (b) increased availability of drugs that prolong life, (c) side effects of antiretroviral therapy, and (d) opportunistic infections (Cook et al., 2004; Corless, Nicholas, Davis, & McGibbon, 2005; Portillo et al., 2005; Reynolds, 2004).

HIV/AIDS causes personal misery, interferes with day-to-day functioning of life and affects personal relationships. It is very significant to find ways to mitigate these issues and enhance the quality of life of HIV positive women. Now quality of life has
become an important outcome criterion. Especially in chronic disorders with no complete recovery, the improvement of quality of life is an important treatment goal. This study addresses the quality of life of HIV positive women.

WHO definition of quality of life highlights the view that quality of life is subjective, includes both positive and negative facets of life and is multi-dimensional (WHOQOL Group, 1995a). Quality of life is a broad concept affected in a complex way by the person’s physical health, psychological state, and level of independence, social relationships, personal beliefs and relationships to salient features of their environment (WHOQOL, 1998b).

WHOQOL–BREF is an instrument used to assess the perceived quality of life of long diseased patient. It has 26 questions in 5 point scale. The answers range from very poor to very good. If a patient scores more in the scale it means he has better quality of life. The questionnaire has four domains, Physical, Psychological, Environmental and Social relations. There is a question on the overall quality of life from subject point of view also.

The study aimed to find out the overall quality of life of the respondents. The descriptive analysis revealed that 42% of them had good quality of life 33% had moderate, 25% had poor quality of life.

The next pace of the study is to find out separately under various domains how the outcome is distributed. The first parameter chosen was physical domain which had questions related to the occurrence of physical pain, need of medical treatment to run routine life, energy level, how well are they able to go around, good sleep, ability to perform daily activity and satisfaction of their capacity of work. All these seven questions were considered for finding the physical health status from the respondents point of view.

The high total score indicates the good physical domain and low score indicates the low quality of life in the physical side. Total Score with below 14 is considered as having poor physical quality of life and the scores ranging from 15 to 21 reveals that
they had neither satisfied nor dissatisfied on their physical health, score above 21 reveals that they had good health.

Physical health plays a major role in the quality of life of a person. When the person is physically fit then they can participate in the developmental activities of the family. Otherwise they may not be in a position to generate income for their survival due to frequent illness. Hence physical health is an important parameter to decide the quality of life of an individual. To know the role of physical domain on quality of life, the study data was analyzed which revealed that around 39% felt that they were fine with little physical problems and they were able to manage 29% felt that this hindered the quality of life. 32% were not having much physical ailment. Similar findings were reported and physical symptom hindered their well being. (Angela Hudson et al 2003)

5.3.5 Psychological Domain and Quality of Life:

The second domain taken for analysis was Psychological variables which comprises of 6 questions ranging from enjoyment, to life being meaning full, ability to concentrate, accepting bodily appearance, satisfaction of self, any negative feelings like depression, anxiety. The descriptive data analysis revealed that 23% had psychological problems. 41% stated that it was neither good nor bad. 36% felt they were psychologically feeling good. As far as the concept of health is concerned it includes both physical and mental health. Overall inferences about this parameter was concerned that 73% of the respondents were having balanced mental health to face the challenges posed by this deadly diseases.

5.3.6 Social Relationship and Quality of Life.

People need to have a sense of belonging and acceptance. They need to love and be loved. In the absence of such belongings, individuals become susceptible to loneliness, anxiety, and depression. When an individual is not able to physically and emotionally, relate to self and others, quality of life will be affected. Hence social relationships play a major role in the healthy recovery of an individual from illness. If at all at least they will have secured feeling in the presence of others. So the study intends to find out the social relationship of HIV women.
The third domain has 3 questions related to social relationship. The analysis from the collected data revealed that 33% did not have good social support; 41% felt neither good nor bad, 26% of the respondents reported good support from their friends and personal relationship.

As HIV is associated with risky behavior the infected person was not able to disclose the status to outsiders because of stigmatization and alienation. In this study around 59% of the respondents had disclosed their status to their kith and kin. It was found during discussion that respondents’ spouse had opportunistic infection due to HIV. Subsequently their wives were screened for HIV test by the hospital authorities. The positive results were disclosed to their relatives during their husband’s treatment period. The patient living above 5 yrs with the HIV status had undergone the trauma of separation / alienation. Subsequently they had migrated to Chennai for treatment purpose and to escape from the stigma. So majority of them were not having good social relationship. It was only mothers (24%) who gave emotional support to the HIV positive women. Few cases (7.4%) maternal sisters were giving functional support to them. During hospitalization caring for the positive women, taking care of the children, monetary help etc. was done by their sisters. Information regarding rights and to deal with outside issues, positive women network helped their members i.e. 40% of the respondents.

5.3.7 Environment and Quality of Life:

The last domain was environment. Environment domain was an individual’s perception of financial ability, safety of physical and home environment, and accessibility to both health and social services. Money plays a major role in meeting the daily needs of an individual. The socio-economic status of the individual decides the health status, physical safety and security of an individual. Mostly the environment where they live is decided by the income they earn.

According to Fundamental cause theory the flexible resources that are central, operate at both the individual and contextual levels. At the individual level, flexible resources
can be conceptualized as the “cause of causes” or the “risk of risks” that shape individual health behaviors by influencing whether people know about, have access to, can afford and receive social support for their efforts to engage in health-enhancing or health-protective behaviors. In addition, resources shape access to broad contexts that vary dramatically in associated risk profiles and protective factors. For example, a person with many resources can afford to live in a high SES neighborhood, where neighbors are also of a high standing and where, collectively, enormous clout is exerted to ensure that crime, noise, violence, pollution, and traffic, are minimized, and that the best health-care facilities, parks, playgrounds, and food stores are located close by.

Once a person has used SES-related resources to position themselves to an advantaged neighborhood, a host of health-enhancing circumstances comes along as a package deal. Similarly, a person who uses educational credentials to procure a high-status occupation, inherits a package deal that is more likely to include excellent health benefits and less likely to involve dangerous conditions and toxic exposures. In these circumstances, the person benefits in numerous ways that do not depend fully on their own initiative or ability to personally construct a healthy situation; it is an “add on” benefit operative at the contextual level. (Source: Jo C. Phelan and Bruce G. Link, 1995) It is also vital to have accessibility to good quality health and social care that provide opportunities for acquiring new information and skills.

Environment plays a major role in determining one’s health status. Eight question were on that which was pertinent to assess whether they had safe residential place, healthy physical environment, opportunity to leisure activity, adequate money, conditions of the living place, access to health service, transport facilities etc. The researcher found majority of the respondents 64% were living in urban slums. The reason for settling in urban slums was affordability. Since they worked for the unorganized sector their income permitted them to choose and live in urban slums. As far overall environment was concerned, out of 204 respondents, 19% of the respondents were unhappy with the environment but they felt no other choice for them because of their low income. They were forced to stay in a particular place with
little facilities 41% took the mid position neither happy nor unhappy, around 40% felt that they had good environment around them.

With in the overall environment there were 8 variables included. Regarding the dwelling status 29% were not happy with their living place, 33% were neither happy nor unhappy, and 38% were satisfied with their living place. As regards availability of information 40% of the respondents felt no information was available to them. 36% said a moderate amount of information available 24% felt they got adequate information. About transport facilities 33.3% were unhappy 33.3% had no particular opinion 33.3% respondents felt satisfied with transportation. Accessing to health services 26% were not satisfied, 32% were satisfied 42% were very satisfied with the health services.

Regarding leisure time activities 43% had no such activity, 31% had a moderate amount of activity 26% felt they had good leisure time activities in their place of residence. Regarding the financial position out of 204 respondents, 58% felt that they did not have adequate economy to meet their needs. 26% moderate amount that was enough to meet their basic needs, 16% felt they were satisfied with their income.

5.3.8 Quality of life and other variables:

Quality of life is a broad area which will be influenced by many parameters and it is the dependent variable as far this study was concerned. The present study had taken various other variables as independent variable and vigorous statistical tests were done. The study had identified an array of socio economic variables, HIV positive status and net work variables as Independent variables. Social support, general health conditions and quality of life were dependent variables.

Quality of life of an individual is not just decided by one’s general health status but other socio-economic and psychosocial factors play a role. HIV has become more chronic in nature due to the introduction of antiretroviral therapy. Various researches showed that HIV patients experience a decline in quality of life due to factors other than disease stage and physical condition. Considering such factors and their
influence helps to address the multidimensional issues related to quality of life in these patients.

5.3.9 Type of Family and Quality of life:

The first factor taken for analysis was type of family and their role in the quality of life, x² test was conducted to know the association between the nature of family and quality of life. The test results revealed that there was an association between type of family and quality of life. The respondents living with their family members expressed having good quality of life. Women headed family expressed poor quality of life, because of poor support system during crisis situation. More over they were burdened with children. It became a double responsibility for them to take care of the children and to meet the family demands with their physical ailments. (X² = 19.452, df= 6, p value= <.003)

5.3.10 Marital status and Quality of Life:

The next parameter chosen was marital status and the respondents stand regarding their quality of life. Many researches (Naveet Wig et al 2006) had proved that there was a positive correlation between social relationship and quality of life. As marital status gives way for good bonding among couple and their family which in turn enhances the social relationship, it was considered as an important independent variable. The association test revealed that there was an association between marital status and quality of life. X² = 11.693, p value < .02. Under the institution of marriage a good bonding between the spouses encouraged a good familial relation. It is not only between man and woman. It is between two families. The support system extended, beyond the marital ties. The secondary and tertiary kin relationship gave a moral support to the couple. In spite of global recession, India was able to withstand the economic crisis. It is because of the family unit which gives social security to its members.
5.3.11 Presence of HIV infected children and the Quality of Life of the Respondents:

The next variable taken for test was presence of HIV infected children and the quality of life of the respondents. Person’s quality of life can be influenced by the presence of children. If they have HIV infected children they may constantly worry about the status of the children and feel guilty because of spreading the disease to their children. The presence of infected children in the family has strong association with the outcome variable that is quality of life. The study was interested to find out whether any association existed between quality of life and the presence of HIV infected children. The test results reveal that there was a strong association between these two variables. (X² = 22.736 and P value <.001) The study infers that with out HIV positive children quality of life is better.

5.3.12 Infected Family Members and Quality of Life:

Similarly Number of infected family members will have a great bearing on the quality of life of the respondents. More number of infected people in the family may increase the health expenses. Frequent illness among family members will increase the work load of the women who have already been suffering with HIV positive status. Since she has been the caretaker of the entire family, more number of people with HIV infection can cause dangerous consequences. Frequent illness among family member cause huge loss of money in seeking medical care. Supporting and caring the family pushes her health status at the end. A higher proportion of women depend on self-care, home remedies or traditional methods of relief. Community based studies have shown that one reason for higher morbidity rates among women was the lower incidence of medical treatment for women than men. (Dandekar 1975, Keilmann and Taylor 1983) (Somu Kundu 2010) Due to sickness the family members abstained from works which resulted in a reduced family economy. This in turn affected the social fabric. Women’s access to health care services was intervened by gendered experience. Gender bias prevented three out of four girls who were ill enough to require hospitalization from receiving the care they need.
HIV positive women always feel tired and fatigued due to physical or psychological reasons which affected their routine work and thereby their economic status. The number of family members infected had a role in the quality of life of an individual. The association test between the presence of number of infected persons and quality of life reveals that there was a statistically significant association between good quality of life and less or no infected family members. (P. value < .037)

5.3.13 Income Level and Quality of Life:

Income of the respondent plays a major role in building confidence and social esteem and it gives independency and empowerment to women. In this study majority (82%) of the women were working. Either voluntarily or forced due to economic necessity

To know whether any association existed between income of the respondents, family income and the quality of life the x2 test was conducted and the test results revealed that there was an association between income and quality of life of the respondents. X2 value was 18.737 and (P value <.001.) Similarly total family income was positively associated with the quality of life x2 = 14.017 and P value < 0.007. So the income and quality of life had a relationship which was supporting the theory given by Link and Phelan (1995) called the fundamental cause theory on health inequalities. This theory explains that the socio economic status of an individual decides the health status of the family. If they had money power and knowledge they would have chosen best care for their health. Therefore SES ie Socio Economic Status is the fundamental cause of health inequalities.

5.3.14 HIV Stages and Quality of life:

HIV/AIDS is a persistent illness. When people are first infected with HIV; they show no obvious symptoms for a long period of time. This period is called asymptomatic period. Free from major symptoms which means the patient detected for HIV positive need not have symptoms typically associated with HIV like frequent fever, fatigue, headache, weight loss, etc. The next stage is symptomatic. As the immune system fails, symptoms develop. Initially many of the symptoms are mild, but as the immune system deteriorates the symptoms worsen. The third stage is developing with AIDS
disease. As the immune system becomes more and more damaged the individual may develop increasingly severe opportunistic infections like T.B, skin problem, diarrhea and cancers, leading eventually to an AIDS diagnosis.

HIV stages had a great bearing on quality of life of the patient. Each stage indicates the progression of the disease. When it is advancing the patient may not be healthy, normal and may fail to do their work and completely dependent on others. The uniqueness of this illness is that the patient cannot get back to normalcy. Once the disease has progressed it means that their health has deteriorated. Hence there is a relation between HIV stage and quality of life. To find out whether it is true, HIV status and quality of life was taken for statistical test. The results revealed that there was an association between HIV stage and quality of life of the respondents x2 result was 21.729, and P value = <.0001. The HIV positive people can prolong the onset of the progression of the disease by having good self care behavior like healthy diet; supplemented with vitamins, adequate sleep, and exercise and stress management which can result in better physical health, mental health and overall quality of life.

5.3.15 Duration of HIV Status and Quality of Life:

HIV progresses over a period of time. The time and the severity differ from person to person. HIV infection had a drastic effect on the over all structure of the family. It affects health status, economic condition and social fabric of the family. Hence number of years one had HIV will affect their quality of life. X2 test was done to ascertain the association between HIV status and quality of life. The test results revealed that there was an association between number of year’s disease status and quality of life of the respondents (X2=9.267 and P value <.01)

5.3.16 Role of Positive Women Network and Quality of Life:

During field visits the researcher observed a group of women living alone with their children. They were very enthusiastic, participatory and were having good coping strategies, in spite of their severe illness. It was found that those segments composed of women who had membership in positive women’s network. It is an All India Women’s net work which works for the welfare of the HIV/AIDS women. The membership is voluntary. They support each other and create a sense of belonging
among the group. During the interview they had given positive outlook about life and quality of life. So the study intends to look at the parameter and see whether there were differences in quality of life and general health condition among women who had membership in positive women’s net work and not having membership. The total mean scores of the various domains of quality of life, total score of general health condition and social support was obtained. To find the differences in means, t-test was conducted. The result revealed that there was a significant difference in all four domains – physical, psychological, social, environment domain, quality of life and total general health condition of the respondents.

5.3.17 Difference between Duration of Disease and Quality of Life:

Similarly duration of the disease was an independent variable which had strong influence on the quality of life. HIV had become a chronic illness after the introduction of antiretroviral therapy. The only problem was the social stigma and other socio-economic conditions of the respondents and coping up of the disease. Duration of the disease gave a strong scope and balanced mind set for the individual to face the challenges posed by the disease in spite of the progression of the disease.

To know whether any differences existed in quality of life and general health condition among the patients who have been surviving for long duration and the one who has been recently detected for HIV, t-test was computed. The statistical test revealed that there was a significant difference between number of years with the disease status and the quality of life in all four domains. There was significant difference in means scores of overall general health conditions and duration of the disease. Social support was not significantly different.

5.3.18 Difference in Quality of Life among the Presence and Absence of Infected Children:

Presences of infected children play a significant role in deciding the quality of life. The presence and absence of infected children were considered as two groups and dependent variables were general health condition total score, physical, psychological, social, environment and social support scores. The difference in mean was calculated
for both the groups. The t-test was statistically significant among social, environment domain and social support. In rest of the domain it was found not significant. There was no difference between these two groups.

5.3.19 Difference in Quality of Life, Social Support, GH condition among Different Marital status:

The present study aims at finding out the difference of means among the married women, widow, and separated women and their quality of life, general health condition and social support of these groups. The t-test result revealed that there was a significant difference between marital status and total general health condition, quality of life social domain and environment domain and total social support which revealed that social relationship played a major role in the treatment and coping strategies. Though the study had not concentrated on the coping mechanism the social and environment domain scores indicated that the presence of social support plays a major role in the quality of life of the respondents.

5.3.20 Difference in Quality of Life, General Health Condition, Social Support and HIV Stages:

The next parameter chosen was HIV stages; HIV is a peculiar disease. The onset of the disease is not known to the individual. There are no outward symptoms too. So in many cases the diseases would have set long time back and it is reported only after the clinical test. By that time the disease would had progressed to the next stage. This had influence on the quality of life of the patient.

The disease status was identified based on the clinical symptoms and cd4 count accordingly classified as asymptomatic, symptomatic, and progress to AIDS condition. These groups were considered as an independent variable and various domains of quality of life, social support and general health condition total means score were compared. The test result revealed that there was difference between HIV status and quality of life in all four domains and general health condition. GHQ total score P = <0.0001, Quality of Life physical p = <.001, psychological domain p=<0.001, social domain p<0.001, environment p=.001 and social support = .227
Finally the study aimed at how quality of life was influenced by various parameters. The researcher had identified few variables correlated, through Spearman’s correlation. In the socio economic category, income, number of person infected in the family, type of family, marital status and in HIV related information duration of disease; HIV stages, cd4 count etc were identified as correlated.

The co-relation test revealed that there was a positive co-relation between cd4 count and quality of life, and the physical, psychological, social and environment domains of quality of life. Clean and safe environment guarantees good physical quality of life. There was strong correlation between physical and psychological quality of life. Family income had a strong correlation with quality of life in all domain and social support.

Linear regression analysis was done with parameters which were identified as correlated in the correlation test. Those parameters which were significant in the linear model were taken for multilevel regression analysis.

After finding the relationship with various variables, the researcher was interested to find out the influence of each variable on the dependent variable. To assess that regression analysis was done taking variables which were correlated. Independent variables Socio-economic status, HIV related information. Intermediary variables are social support and general health condition and quality of life as a dependent variable. Regression model was applied. Out of so many demographic and socio economic variables marital status, Longevity of the disease, membership in positive women network, cd4 count and social support were found to be positively influencing and total general health status was found to be negatively influencing. This means if GHQ was bad quality of life was also bad.

After identifying important influential variables for the outcome, to know the individual effect multivariate regression analysis was done. The earlier regression models were bi-variate and they identified individual predictors of QOL. It was important to know whether there was a combination of the independent variables that
could significantly predict QOL. Stepwise multiple regressions were performed to
determine the best predictors of Quality of Life among the key independent variables.
All the variables that individually emerged as significant predictors of QOL were
entered into the regression model. Of the six variables entered, all reached the
criterion for entry into the final regression equation. According to the final model, 64
per cent of the variance in QOL was explained by the linear combination of the
variables GHQ, CD4 count, marital status, membership in positive women net work
and social support signifying a large effect. This combination of variables
significantly predicted participation level, $F (3,200) = 24.1$, $p =<.000$, with all these
variables significantly contributing to the prediction. The beta weights are presented
in .The resulting regression equation for prediction of QOL by the select independent
variables was:

\[
\text{QOL} = 86.378 - 0.74 \text{(GHQ)} + 0.01 \text{(CD4 count)} + 7.25 \text{(Marital status)} - 6.28 \text{(No association membership)} + 0.30 \text{(social support)}
\]

The standardized beta coefficients indicated that for every one unit change in GHQ
there will be a - .54 change in QOL. It was negatively related. It means if general
health condition was bad one unit change will negatively influence -.54 change in
quality of life. Likewise a one unit change in CD4 count will result in corresponding
change of .20 in QOL, a good cd4 count will influence the quality of life. A one unit
change in marital status will result in .18 changes in QOL, a one unit change in non-
membership in association will result in -.17 changes in QOL and a one unit change in
social support will result in .16 changes in QOL. Among the independent variables,
GHQ contributed most to predicting QOL.

The study infers that most important variable which decides the quality of life of the
patient was General health condition, Cd4 count and the presence of strong social
support.
The research study was based on ten hypotheses: The verification of the hypothesis is explained below:

1. The first hypothesis stated was: There is no relationship between the respondents’ disclosure status and their quality of life: The X2 test result revealed that there is no association between quality of life and disclosure status. (X2= 0.744, P value = <0.689). The HIV positive women have a great dilemma to reveal her status to others because of fear of rejection and discrimination. 59% had disclosed their status and 41% had not disclosed their status. As far quality of life is concerned 74% of the disclosed group agreed for moderate to good quality of life and the not disclosed group 78% agreed for moderate to good quality of life and the association test was not statistically significant. The study infers that there is no association between disclosure and quality of life.

2. There is no relation between membership in positive women network and physical health of the respondents: (r = .604) the study infers that there is a positive correlation between membership in network organization and somatic condition. At least it gives courage to manage their health issues. 40% of the HIV positive women were members of the positive women network and 60% were non members. 84% of the positive women network members felt that they were physically good their physical symptom was not disturbing their routine where as among the nonmember 61% felt they were fine. The correlation test was significant.

3. There is no relationship between membership in positive women network and psychological well being of the respondent: (r = .178) among positive network member the psychological well being was 78% and among non members 77% and not statistically significant.

4. There is no relationship between duration of disease and quality of life of the respondents. The test results revealed that there was an association between number of years of disease status and quality of life of the respondents
(X2=9.267 and P <.01). The study infers that the longevity of the disease had given confidence and coping skill to the patients to manage the disease.

5. There is no relationship between No of children and quality of life of the respondents the study was interested to find out whether any association existed between quality of life and the presence of infected children. The test results reveal that there was a strong association between these two variables. (X2 = 22.736 and P value <.001) The study infers with out HIV positive children quality of life is better.

6. There is no relation between place of residence and quality of life of the respondent: X2 test revealed that there was an association between place of residence and quality of life (X2= 6.335, p= 0.042) 65% of the positive women live in urban slums and 35% in urban fringe. As far quality of life was concerned 85% of the urban fringe reported that they had good quality of life, the statistical test revealed that there was an association between settlement pattern and quality of life. The study infers that positive women who settled in urban fringes reported better quality of life than those in urban area (P=<0.042).

7. There is no relation between number of years of disease status and general health condition of the respondent: To find out the relationship between duration of the disease and general health condition, the highest scorer in the GHQ scale were categorized as case group in each domain and others were as a non case. A non parametric test result revealed that there was an association between number of years patients having HIV status and the presence of somatic disorder x2 =4.656 (P = <.036). To know the association between duration of disease and the presence of Anxiety and Insomnia the X2 test result indicated there was no significant association between no. of years disease status and Anxiety (X2 =0.174 and p value is (P = <.768) Social dysfunction. X2 value 0.404, (p=<0.525) and depression X2 value 3.204, P value = <.073. The study infers that longevity of HIV status there is a progression in the status of the disease which was reflected in the physical domain which was associated. In the other domain, it was not associated with the duration of disease. It was assumed that it
varies from patient to patient depending on the family, issues and support rather than longevity of the disease.

8. There is no difference between membership in positive women network and general health condition. The t-test result reveals that there was a difference between overall general health condition and membership in positive women’s network. (GHQ t value 2.737, p = .007).

9. There is no difference between membership in positive women’s network and social support and quality of life. The t-test result reveals that there was no difference between positive women network membership and social support (p=0.391) where as there was difference in being member of positive women network and quality of life in all four domain and over all quality of life also, quality of life physical domain (t value = 5.531, P value = .0001), (QOL psychological domain t – 3.259, p= <0.001), QOL social domain (t = 3.109, p= <0.002), QOL environment (t = 5.910, p= <0.000), Social support (t -.860, p = 0.391).

10. There is no relation between respondent socio-economic status and quality of life. To know the association between income of the respondent, and quality of life, x2 test was conducted and the test results revealed that there was an association between income and quality of life of the respondents. X2 value was 18.737 and (P value <.001.) Similarly total family income was positively associated with the quality of life (x2 = 14.017 and P value < 0.007).

In summary this research has discussed the issues related to HIV positive women especially the quality of life, social support and general health condition. The issues are dealt separately and discussed with other related variables like demographic factors and socio-economic and HIV infection related perspectives. After having discussed the significant findings in this chapter, the researcher will present the suggestions and areas for further research and a Sociological Model of Group Work Intervention for empowering women living with HIV in the concluding chapter.