HIV has become truly an international epidemic; HIV infection is now common in India. The epidemic has reached to all spectrum including women and children. Women are facing the distressing impact of HIV/AIDS world over. Women in India are already economically, culturally and socially deprived; lacking access to treatment, financial support and education. They lack the power to take decisions at every level; be it their individual lives or their families. They are denied the opportunity of participating equally within the community and are subjected to castigatory laws, norms and practices exercising control over their bodies and sexual relations.

Women affected with HIV/AIDS face discrimination and isolation not only due to the stigma associated with the disease but also due to the existing gender inequalities and marginalization. In most cases women get infected due to contact which is often not with in their control. Infection from the spouse is unavoidable thereby pushing women to become victims of HIV. Due to their vulnerable status both the family and in the community women is often denied access to treatment and is made to feel guilty for having acquired the infection. Due to delay in treatment her health status deteriorates thereby making her increasingly difficult for her to go for work. Abandonment and rejection are common problems faced by HIV affected women. Discrimination, poverty, gender based violence, patriarchal system, conservative culture and traditional norms, and attitude towards parent hood are the important factors that fuel the epidemic.

The study focuses on issues concerning their livelihood, family life, stigma and discrimination and health related issues, the study was conducted with the help of a Nongovernmental organization called Nalamdana. The research design of the study is descriptive cum explanatory.
Data was collected through both primary and secondary sources. Primary data was collected using structured interview schedule method from the HIV positive women who attended the meetings in the net work organization. Secondary data was collected from various external sources such as books, magazines, newspapers, internet, and journals. It served as a guideline based on which the study was tuned. Field source of information is collected from the social workers and community animators from Nalnadana. The inclusion criteria adopted was women 18 years and above with HIV positive status hailing from in and around Chennai region, and willingness to participate in the study.

Appropriate statistical tools have been used to assess the information gathered through structured interview schedule and standardized scales.

The study group comprised of 204 HIV positive women whose average age was 33.3 yrs (SD 4.6) year’s age ranging from minimum of 22 yrs to maximum of 45 yrs. 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 workers in houses. Out of 204 respondents 25% of the samples were a symptomatic. 45% of them were symptomatic. 30% - had developed AIDS. There was an association between number of years HIV and the HIV stage. 88.7% got infected through heterosexual relations. 76% were not taking medicine regularly.

76.5% had heard about the term HIV/AIDs and knew it as a disease, but they were not aware of more then the term and the negative connotation associated with the term, until they were diagnosed as HIV positive. Except 29.4 % rest of them were not aware of its mode of transmission, and had misconceptions about the mode of spread.

The General Health condition scale infers that 60% of the HIV women had somatic, anxiety/insomnia and social dysfunction problems. 21% had depression and 15.7% had severed depression. There was positive influence between member ship in positive women net work, social support and Respondent income in deciding the
general health condition, where as widow hood, longevity of the disease and increase in cd4 count were negatively related.

42% of the respondents had good social support while around 20 to 23% of the respondent got some 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. There were 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 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 are some of the positive predictor of the variable. Women headed family, presence of infected children were having negative influence on the social support. 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 but the presence of kith and kin or the close relatives play a major role in disease management and building confidence among positive women.

The study aimed to find out the overall stand of the respondents towards perceived quality life. The descriptive analysis revealed that around 42% of them had good quality of life, 33% had moderate, 25% poor quality of life. There was a positive correlation between cd4 count and quality of life, and physical, psychological, social and environment domain of quality of life. The clean and safe environment guarantees good physical quality of life. There was strong correlation between physical and psychological quality of life. When the patients were physically fit, they felt emotionally better. Family income had a strong correlation with quality of life in all domains and social support.
The standardized beta coefficients indicate 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 the most important variables which decides the quality of life of the patient was General health condition, Cd4 count and the presence of strong social support. The solution lies in the process of empowering such vulnerable women through support networks.