International Journal of Research in Social Sciences
Vol. 10 Issue 03, March 2020
ISSN: 2249-2496 Impact Factor: 7.081
Journal Homepage: http://www.ijmra.us, Email: editorijmie@gmail.com
Double-Blind Peer Reviewed Refereed Open Access International Journal - Included in the International Serial Directories Indexed & Listed at: Ulrich's Periodicals Directory ©, U.S.A., Open J-Gate as well as in Cabell's Directories of Publishing Opportunities, U.S.A

A SOCIOLOGICAL STUDY ON UNMARRIED WOMEN LIVING WITH HIV/AIDS

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ABSTRACT:

Acquired immunodeficiency syndrome (AIDS) is a chronic, potentially life-threatening condition caused by the human immunodeficiency virus (HIV). By damaging our immune system, HIV interferes with your body's ability to fight the organisms that cause disease. Women living with HIV/AIDS, in particular, have been positioned as a latent source of infection, and have captivated culpability and blame leading to a highly stigmatized and discriminated life. Despite the situation, women and their particular concerns have largely been ignored in HIV/AIDS. Women living with HIV/AIDS experiences of being rejected , shunned and treated differently by physicians, family and close friends. However, youths still have a mixture of correct and incorrect HIV/AIDS knowledge of transmission routes and prevention strategies. In this study the researchers used observation and case study method to analyses the problems faced by the unmarried women living with HIV/AIDS. This study took place in Chennai at Rajiv Gandhi Government Hospital. We spent 7 weeks on this field. This approach was appropriate as it is descriptive, and it attempts to take hold of things as they appear and interpretive. This study aims to examine and analyze the feelings, experience and perception of nutrition and health status of affected women and misconception spread among them and problems faced by the unmarried women living with HIV/AIDS. This paper assesses the women living with HIV/AIDS, particularly, unmarried women living with HIV/AIDS, unmarried women injecting drugs and their family structure, because family is the most important socializing agent for youths and family/peer communication about sexuality and accurate knowledge of transmission routes and prevention strategies.

1. INTRODUCTION:

India has the third largest HIV epidemic in the world, with 2.1 million people living with HIV. In 2017, 79% of people living with HIV in India were aware of their status. HIV positive women are significantly more likely to be diagnosed, compared to HIV positive men (87% vs. 68%). This is due to the number of women testing for HIV through preventing mother to child transmission(PMTCT) services. According to WHO, 17.4 million women were living with HIV worldwide in 2014 constituting 51% of all adults living with HIV. 35 fortunately, from 2001 to 2013, the annual number of new HIV infections has declined by 38% globally, followed by a significant decline in AIDS- related deaths. Women in many regions have been disproportionately affected by HIV. Today, women constitute more than half of all people living with HIV and AIDS related illnesses remain the leading cause of death for women aged between 15 to 49. Young women (aged 15-24), and adolescent girls (aged 10-19) in particular, account for a disproportionate number of new HIV infections. In 2017, 7,000 adolescent girls and young women became HIV positive . This is a far higher rate than new infections among young men, with young women twice as likely to acquire HIV as their male peers. In 2019, 19.6 million girls and women living with HIV. Girls and women make up more than half of the 37.9 million people living with HIV. Ending AIDS by 2030 requires that we address girls' and women's diverse roles by putting them at the centre of the response.

HIV/AIDS and WOMEN:

HIV/AIDS is now recognized as a disease that affects women as well as men. Women are increasingly at high risk of becoming HIV positive due to biological vulnerabilities, low socio-economic status, dominant sexual practice of males and epidemiological factors. Men are more efficient at transmitting HIV to women than women are to men, and women are biologically more vulnerable to HIV infection than men. As the receptive partner, a women has a larger mucosal surface exposed during sexual intercourse. In addition, semen contains a higher volume and cervical secretions. The risk of being infected with HIV during unprotected sex is two or four times greater for a women than for a man. Women often have little power or control over decisions relating to the sexual behavior of there partners, such as condom use and safer sex, and over access to primary prevention information. Women are also vulnerable to coerced sex including marital rape, sexual abuse in and outside the family. This sexual subordination of women makes it difficult for them to protect themselves from sexually transmitted infections (STIs), including HIV infections.

Why are women and girls particularly at risk of HIV?

HIV disproportionately affects women and girls because of their unequal cultural, social and economic status in society. Intimate partner violence, inequitable laws and harmful traditional practices reinforce unequal power dynamics between men and women, with young women particularly disadvantaged. HIV is not only driven by gender inequality, but it also entrenches gender inequality, leaving women more vulnerable to its impact.

What factors put women at risk for HIV?

HIV is spread through the blood, pre-seminal fluids, semen, vaginal fluids, rectal fluids, or breast milk of a person who has HIV. In the United States, the main risk factors for HIV transmission are the same for women as for men:

.Having anal or vaginal sex with a person who has HIV without using a condom or taking medicines to prevent or treat HIV.

. Sharing injection drug equipment such as needles, with a person who has HIV.

Several factors can increase the risk of HIV infection in women. For example, during vaginal sex without a condom, HIV passes more easily from a man to a womenthan from a women to a man. Age-related thinning and dryness of the vagina may also increase the risk of HIV infection in older women. A women's risk of HIV infection can also increase if her partner engages in high-risk behaviors, such as injection drug use or having sex with other partners without using condoms.

WOMEN: HIV/AIDS, Stigma, Discrimination and Denial:

Life for HIV infected women is never easy; they manifest profound physical and psychological consequences. Women bear a 'triple jeopardy' impact of HIV/AIDS: as person infected with HIV as mothers of child, and as careers of partners, parents or orphans with AIDS. Women living with HIV/AIDS (WLHA) are at particularly high risk of living painful, shameful life of exclusion. Millions have been rejected from their family, friends and partners, thousands have lost their lives and thousands have been unable to live their life. In spite of the burden of disease the world is paying less attention to the issues raised by WLHA. Their voices remain unheard. Since it was first identified, HIV/AIDS has been linked with 'sexual misbehavior' and 'promiscuity' contributing to the high level of stigma and discrimination associated with it. Women are often even more susceptible to the stigma associated with HIV/AIDS and are frequently referred to as 'vectors', 'diseased' and 'prostitute'. Discrimination for women can dispirit them from seeking vital medical and psychological care they need during the illness. HIV stigma in women is associated with

rejection from friends and family, society, feeling of uncertainty and loss, low self-esteem, fear, anxiety, depression and even suicidal ideation.

Young Women's lack of access to healthcare:

In many settings, where SRH and HIV services exist, they are primarily for married women with children and do not meet the specific needs of unmarried young women and adolescent girls. Healthcare provides often lack the training and skills to deliver youth-friendly services and do not fully understand laws around the age of consent.

In 45 countries, organizations cannot legally provides SRH and HIV services to people under 18 without parental consent. In some countries, doing this is an offence linked to encouraging 'prostitution' or the trafficking of minors. Some national laws also require healthcare providers to report underage sex or activities such as drug use among adolescents. Closely related to this is the fining, taken from evidence gathered in 28 sub-Saharan Africa countries, that 52% of adolescent girls and young women in rural areas and 47% in urban areas are unable to make decisions about their own health.

As a result of age restrictions, in Kenya, Rwanda and Senegal, over 70% of unmarried sexually active girls aged 15 to 19 have not had their contraception needs met. This is despite the fact that i sub-Saharan Africaaround half of young women living in urban areas will have been pregnant by the time they reach 18. young people, and young unmarried young women were too ashamed or afraid to ask for help. Research into attitudes towards sexual and reproductive health among adolescent girls in Ghana found varying degrees of negative social and community norms, attitudes and beliefs about adolescent girls tended to endorse these stigmatizing attitudes, and also observed or experienced SRH-related stigma regularly. Adolescent girls and young women belonging to groups most affected by HIV are also negatively affected by laws that criminalize injecting drug use, sex work and homosexuality.

Civil Society's role and HIV in INDIA:

India is often described as the world's largest democracy. It boasts an active and vibrant civil society, with over three million civil society organizations (CSOs) and social movements. This is typified by the involvement of CSOs in India's HIV response, including a strong presence of networks and organizations led by at-risk communities. The decriminalization of homosexuality in 2018, following a prolonged rights activists and CSOs, shows the collective strength of these groups.

HIV education and approach to sex education:

Increasing awareness among the general population and key affected populations about HIV prevention is a central focus of NACP IV. However, as of 2017, only 22% of young women (aged 15-24) and 32% of young men knew how to prevent HIV. This is reflected in the wider population, as only one fifth of women and one third if men (aged15-49) had comprehensive knowledge of HIV and AIDS.

A number of innovative program are being implemented to increase awareness of HIV testing, prevention and treatment. These include the use of folk media to reach people in remote and rural locations, particularly those that are 'media dark' (places where there is very limited or no electricity source and therefore no television). This involves folk troupes being selected and trained on standardized scripts who then give performances in villages.

The Adolescence Education Program (AEP) was operating in 55,000 schools in 2017/ 2018. The Program helps adolescence cope with negative peer pressure and improve awareness on sexual health and HIV. Around 12,000 Red Ribbon Clubs also operate in India. These are linked to schools and universities and are driven by young ambassadors and peer educators who help other young people access HIV information and also serve to reduce HIV-related stigma.

People Who Inject Drugs (PWID) and Harm reduction for people who inject and use drugs:

In 2016, 1.7 million people in India were estimate to inject drugs. HIV prevalence among this group is high, with injecting drug use the major route of HIV transmission in India's north-eastern states. In 2017, 6.3% of people who inject drugs were thought to be living with HIV, of whom half(50%) were aware of their status prevalence various between locations, standing at 12.1% in manipur,10% in Mizoram, and 3.2% in Nagaland . In 2018 study analyzed unsafe injecting and sexual risk behaviors among around 20,000 Indian men who inject drugs. Results suggest that beginning drug use at age 25 or above, engagement in drug use for longer, injecting three times or more per day, sharing needles and syringes, and self-reported sexually transmitted diseases were all linked to an increased likelihood of HIV infection. HIV prevention efforts in the northeast of the country have been effective in reducing the number of new infections. However, there is evidence that the number of PWID is growing. In addition, evidence of higher HIV prevalence among sub-populations of PWID is also emerging. For Instance, in 2015 study found prevalence to be more than three times higher among women who inject drugs than men.

People who inject drugs can take precautions against becoming infected with HIV by using sterile injecting equipment(including needles and syringes) for each injection, and not sharing drug-using equipment and drug solutions. Treatment of drug dependence, in particular, opioids substitution therapy for people dependent on opioids, also helps to reduce the risk of HIV transmission and support adherence it HIV treatment. A comprehensive package of HIV prevention and treatment interventions for people who inject drugs includes:

- Needle and Syringes Program;
- Opioid substitution therapy for people dependent on opioids, and other evidence-based drug dependence treatment;
- HIV testing and counseling;
- HIV treatment and care;
- Risk-reduction information and education, and provision of naloxone to prevent opioid overdose;
- Access to condoms; and
- Management of STIs, TB and Viral hepatitis. .

WHO RESPONSE:

The sixty-ninth World Health Assembly endorsed a new " Global health sector strategy on HIV for 2016-2021". The strategy includes five strategic directions that guide priority actions by countries and by WHO over six years.

The strategic directions are:

- Information for focused action (know your epidemic and response)
- Interventions for impact (covering the range of services needed)
- Delivering for equity(covering the populations in need of services)
- Financing for sustainability(covering the costs of services)
- Innovation for acceleration(looking towards the future).

WHO is a cosponsor of the Joint United Nations Program on AIDS (UNAIDS). Within UNAIDS, WHO leads activities on HIV treatment and care, and HIV and TB co-infection, and jointly coordinates the work on elimination of MTCT of HIV with UNICEF.
Sociology has contributed in various ways to the understanding and control of HIV/AIDS infection. Studies of sexual networks of transmission were crucial foridentifying the virus in 1982. Sociology has also informed national and large-scale studies of sexual and drug-taking behavior, both KABP(Knowledge, Attitudes, Behavior and Practices), and the more innovative and qualitative research that is necessary to monitor the prevalence and incidence of high-risk behavior and risk-taking activity. Theories of risk-taking have also developed from early reliance on the Health Belief Model to contextual and strategic aspects and the study of collective and community response.
Health sociology, as a discipline, is a pertinent tool for the study of HIV. One of the reasons for the emergence of this discipline is the crisis of medicine, not as a science, but as a model of social practice.

2. REVIEW OF LITERATURE

Off our Backs 18(1988) Public attention focused on disease over the last two decades has dominated concern and overshadowed potential risks of other STDs. Fear and panic about HIV disease have brought into the foreground misconceptions people hold about women's role in the spread of STD. Women especially women who work in the sex industry- are regarded as a reservoir of disease, when women are actually more likely to contract the virus from men than men are from women. Sex workers have been leaders in education about the practice of safer sex. Increased risk of transmission of HIV disease in sex workers is more a function of workers and customers use of shared needles in intravenous drug use.
Vaughan (1990) In Africa, high rates of HIV and STD infection have often been attributed to the 'unbridled promiscuity' of black women, so that prevention activities become such a means of controlling their sexuality.
Lawless et al (1996) Asfeminist schools theorized when the epidemic began, "It is the sexually transmissible nature of HIV that transforms sexuality into something highly stigmatized and fraught with panic".
Lawless et al (1996) provides one of the earliest empirical examples of intersectional feminist theorizing on sexuality among women living with HIV, although they do not explicitly use of this term. Based on the narrative accounts of 24 hetero sexual women with HIV in Australia, researches illuminated how women's sexual pleasure and safety was undermined by violence, gender norms and both subtle and overt messages from care providers that their sexuality was contaminated and a threat to the public.
Carole Campbell (1999) draws a clear connection between women's risk of HIV/AIDS, compared with men, HIV infected women face unequal access to care and unequal quality of care. Campbell makes a compelling case that social institutions such health care and the media have created barriers for women by failing to take into account the differences between men and women in terms of social roles, status, and power.
Although HIV/AIDS stigma is general, women are more vulnerable than men. Campbell (1999) called this experience the jeopardy impact of HIV/AIDS on a person infected with HIV, as mother of a child, and career of the partner, and parents or orphans with AIDS.
De La Rosa, 2002; De La Rosa & White, 2001; Marin, 2003 Poverty is often linked to negative health outcomes in Latino populations, such as increased drug use and a sense of hopelessness that may result in a lack of concern for one's self and increased vulnerability to behavior that might put them at risk for HIV.

L Ackermann, GW Klrek- Health care for women international (2002) The degree to which women are able to control various aspects of their sexual lives is clearly a critical question for health promotion and the prevention of AIDS. It is evidence that social factors such as the high rate of rape, the unfavorable economic position of women, and the inability to insist on condom usage to negotiate the timing of sex and conditions under which it occurs. They are thus rendered powerless to protect themselves against HIV infection.

De La Rosa, (2002) Acculturation has become increasingly important for understanding a variety of social and health behaviors of immigrant populations. Samanie & Gonzales, (1999) The acculturation is positively correlated with social and health problems, such as delinquency, violence, alcohol abuse and dependency and mental health. Dixon et al, (2001); Saul et al, (2000) Education level, employment, and socioeconomic status, rather than acculturation, are more accurate predictions of the ability of some younger Latina subpopulations to negotiate safe sex.

Turmen, T (2003) When exposed to the virus through heterosexual contact, women are more likely to contract the virus than men. Transmission is at least 2 to 4 times as efficient in women as in men.

Coleman, 2003; Poindexter & Keigher, 2004 Seniors comprise about 11% of reported AIDS cases for seniors nationwide, and the percentage has increased steadily over time. Centers For Disease Control, 2003 has estimated that there was a 72 % increases between 2000 and 2003, in the numbered of people over 55 living with HIV/AIDS.

S C Kalichman, LC Simbayi and Taylor& Francis (2004) Sexual violence is associated with women's risks for HIV infection. The current study investigated factors related to risks for sexually transmitted infections (STIs), including HIV, among south Africanwomen with a history of sexual assault. An anonymous street intercept survey of women living in an African township in the western cape, South Africa assessed demographic characteristic, history of sexual assault, HIV risk behaviors, substance use and non-sexual relationship abuse.

Keigher, Stevens & Plach,(2004) " Women are the fastest growing population infected with HIV. They succumb to AIDS faster than men". Wingood (2003) In 1986, women accounted for less than 7% of AIDS cases. By 1999, 23% of AIDS cases and almost one-third of new HIV cases wrer women. Mack & Bland, 1999; Savasta, 2004) In turn, poor health can speed conversion from HIV to AIDS, as well as comprehensive the disease trajectory. This process is particularly true of older women(coleyman, 2003; Emlet& Farkes,2002; Nokes et al ,2000; Strombach & Levy, 1998).

Sandelowski et al (2004) In a meta-synthesis of 93 reports of research studies, examined the issue of stigma and discrimination in women living with HIV/AIDS. While only 16 of 93 reports reviewed were specifically focused on stigma, their study revealed that for women, living with HIV/AIDS meant living with panic, and the painful effects of stigmatization and discrimination including social rejection, denial, even violence within family and community.

WHO(2006) has identified five core aspects of sexual and reproductive health that are essential in accelerating progress towards meeting internationally agreed targets: 1) improving antenatal, delivery, postpartum and newborn care; 2) providing high-quality services for family planning, including infertility services; 3) eliminating unsafe abortion 4) combating sexually transmitted infections (STIs), including HIV, reproductive tract infections (RTIs), cancer and other gynecologicalmorbidities; and 5) promoting sexual health.

Taylor and Davis (2006) heath care providers such as family doctors, nurses and counselors also have a role to play in initiating conversation around sexuality during post-

test counseling and annual check-ups, as well as offering shame-free support for challenges that may be distressing to women.

Yanqiu Rachel Zhou (2008) Women in china are increasingly affected by HIV/AIDS. Current AIDS studies have examined the HIV risks faced by this gender group, paying inadequate attention to women's actual experiences with the disease. Based on a qualitative study on illness experiences of HIV infected people, this article examines the interaction between HIV/AIDA and gender roles in the Chinese context. HIV infection has created a conflict between women's intention to fulfill their conception of "womanhood" and a decreased ability to do so, which, in turn, has adversely affected their self-perceptions and well-being.

In a review, sociologistScrambler (2009) showed that HIV stigma trajectory through four phases including at risk (pre-stigma and the worried), diagnosis (confronting an altered identity), latent (living between health and illness), and manifest (passage to social and physical death).

Saad A Khan, Jayanthy Moorthy, Syed Shahzad Hasan (2012) In Malaysia, during 2004 the number of individuals infected with HIV and the number of AIDS cases reported were 6,427 and 1,148 respectively and in 2005, 6,120 were infected by HIV and 1,221 of AIDS cases were reported. The number of PLWHA reached a cumulative total of 87,710 by 2009, the most recent figure in 2011 has reached up to a cumulative figure of 79,855. The large number of PLWHA- although it is slightly decreasing- requires more attention to improve the quality of life of the individuals diagnosed with the disease as HIV/AIDS affects both physical and psychological health.

Celeste Watkins-Hayes(2014); Annual Review of Sociology: This review focuses on three topics that have dominated the sociological literature on HIV/AIDS in the United States: a) the demographics of the epidemic and the dynamics of structural-, neighborhood-, and individual- level risk; b) the lived experiences of HIV- positive people; and c) the collective response to HIV/AIDS through community based services, political activism and social movements, and public policy.

According to WHO, 17.4 million women were living with HIV worldwide in 2014 constituting 51% of all adults living with HIV. 35 fortunately, from 2001 to 2013, the annual number of new HIV infections has declined by 38% globally, followed by a significant decline in AIDS- related deaths.

V. Paudel and K. Baral(2015) (WLHA) Life for HIV infected women in never easy; they manifest profound physical and psychological consequences. Women bear a 'triple jeopardy' impact of HIV/AIDS: as person infected with HIV as mothers of child, and as careers of partners, parents or orphans with AIDS. Women living with HIV/AIDS are at particularly high risk of living a painful, shameful life of exclusion.

A review conducted by Paudel and Baral (2015) showed five themes with regarded to this experience including 1) disclosure, 2) stigma and discrimination, 3) internalized stigma, 4) rejected, shunned, and treated differently by physicians, family and close friends, 5) support group act as among the best interventions for stigma and discrimination.

WHO(2019): WHO has revised its guidance on contraceptive use to reflect new evidence that women at risk of HIV can use any form of reversible contraception, including progestogen- only inject able, implants and intrauterine devices, without an increased risk of HIV infection. However, as these contraceptive methods do not protect against HIV and other sexually transmitted infections, the guidelines emphasizes that correct and consistent use of condoms should beused where there is a risk of STIs, including HIV.

3.OBJECTIVES OF THE STUDY:

- To study the socio-economic status of the unmarried women living with HIV/AIDS.
- To find the nutrition and health status of unmarried women living with HIV/AIDS.
- To find misconception spread among them andbring out the problems faced by unmarried women living with HIV/AIDS.

4. RESEARCH METHODOLOGY:

The study has made use of various anthropological methods like collection of primary data through observation and case study. The study has also made use of secondary data collected from various sources like libraries, online databases through the library search. Databases were searched with the help of key words and local NGO sectors working on the people affected by HIV/AIDS.

Systematic thinking and consistent rigor were put in to bring about an appropriate methodology for the study that would fulfill the objectives of the study. To grasp their life experience through the lens of the identification of the problems they face and their survival and qualitative data seemed inevitable approach to undertake. Case study method were applied in the field of investigation in that particular place with an intention to find out the problems faced by the unmarried women living with HIV/AIDS.

The research has done in Rajiv Gandhi Government Hospital at Chennai; the respondents were taken under the study through simple random sampling method. It comes under descriptive method. The researchers has spent long time to get the information from respondents because they were unmarried women. The researchers has restricted to very small sample because of limited time and also the scope of the study is limited.

5. RESULTS AND ANALYSIS:

Case-1

The respondent name is Kumari. her current age is 29. She is B.A History incomplete. The respondent knows about her health status while she studying 2nd year of college. After that, she was stop her studies. The respondent stayed in private hostel with few friends for her college studies, in that time one of her friend got addicted in drug injection so that, she forced the respondent to inject the drug. The respondent didn’t knows about the seriousness of the drug injection, the respondent put the drug injection because of her friends’ compulsion. After 4 to 5 months back she got allergy like small swelling in her body so that, she went to hospital for check up. The respondent gave her blood to test according to the doctor advice after took the blood test, the doctor conform her HIV positive. After heard that, the respondent was shocked and totally broke and even she was confused how she got HIV positive. The respondent thought this is because of inject the drug so that, the respondent said about her health status to her friend. At that time the respondent's friend also got afraid and then she also went to hospital for her check up. After she finished her checkup she also got positive in HIV. Through the injection only the respondent got this HIV positive. After that the respondent was stop her studies and went to her native. The respondent's father passed away while she is studying 5th std. After that, she is taken care by her mother and the elder brother. The respondent's mother works as a domestic help and her elder brother is also as a mechanic and her brother got married.

The respondent revealed about her health status to the family. Her mother and brother beat her when they heard that and then brother's wife spread this to the relatives and neighbors. After her relatives learned that she had HIV, none of them associated with her. Some relatives learned that it is not transmitted easily, some of them resumed their relationships. However, some still do not come over to her home. The relations have left

her, even her brother and brother's wife besides her mother. No one looks at her except her mother.

The respondent went to private hospital for further treatment and check up. "Once she went to a private hospital, when the doctor understood she have HIV, the doctor pushed her chair back and said do not move. She was so annoyed". Wherever she went to her treatment, when the physicians learned about her health status, the physician is not ready to check her.

Due to the problems mentioned above and such as neglected by relatives, brother and brother's wife, being alone and feeling of guilt, were faced with a problem called "self stigma". The respondent experienced this stigma. This stigma is related to the relationship of affected with her selves, her soul, her body and her potentials, which leads to negative feelings include shame, and whining, hopelessness, self-blame, self-deprivation, low self-esteem, depression, suicidal thoughts, marital refusal and other related emotions.

After that, the respondent stop going to private hospitals and private clinics and even she don't like to live in her native place so that, she moved to Chennai with her mother's permission and staying private hostel with the help of her friend and joined in super market for her further expense and then, few days later the respondent feeling very tired and she can't do her daily works so that, she went to government hospital for her treatment. In government hospital, the physician referred the ART Tablet (AntiretroviralTherapy) after taking that tablet, the respondent feeling normal and the respondent proffered to the NGO who working for the HIV/AIDS affected people by the government health sector so that, she went to that NGO and taking counseling, after she joined in that NGO they giving more support to her. through the NGO's counseling and support, the respondent got new energy and she left her suicidal thought and she got hope in her life. The respondent having idea to complete her study and become a good personality in the society. She hopes to settle in her life with happiness and her life is going smoothly.

Case-2

The respondent's name is Reeta. Her current age is 32. Her birth place is Chennai. She completed B.Tech. She workingin IT Company. She affected by HIV in the age of 30. Through the sexual intercourse with the co-workers and their friends. The respondent diagnosed her disease in the age of 30 itself and her disease diagnosed by the physician in the private health sector. The respondent felt very restless and she cannot do her daily works and even she felt too much irritation and itchingness in her vaginal part and also she had a menstrual cycle problem so that only, she went to hospital, the physician checked her and said this vaginal infection called BV(Bacterial Vaginosis), BV is a condition caused by changes in the amount of certain types of bacteria found in the vagina. BV is more common in women living with HIV. BV is called as STD (sexually transmitteddisease) so that, the doctor said to take blood test. After took the test , the physician conformed she was affected by HIV. The respondent having drinkinghabitsalso. She drunk and having sexual intercourse with her male co-workers without any precautions like condom. This is the only reason, the respondent affected by HIV through her sexual partner.
The respondent took treatment in private health sector for first 6 months but they treating very bad so that, the respondent stop going to private hospital and she went to government health sector for the further treatment. In the government health sector and health policymakers treating her in the very good manner and they giving proper counseling about the HIV/AIDS. The doctor said that, the counting of the virus is increased more in her blood so that, the doctor preferred the ART tablet to the respondent. The respondent

taking ART tablet daily in a correct time. Now she is feeling normal. The respondent taking tablet without knowing to her family, because the respondent not yet reveals her health status to the family. The respondent said " my family compelling me to get marriage but i refusing past 1 and half years so that, i am having plan to reveal about my health status to my family because they compelling very often to get the marriage and even i am having plan to get marry my friend, we loving each other and he very well know about my health status and he is also affected

This is all because of bad companionship and cultural disaster is one of the main reason of this situation. The respondent realized her mistake and she hopes to settle in her life with happiness.

6. CONCLUSION:

Unmarried women living with HIV/AIDS can be seen in many major cities, especially in developing countries and may be subject to abuse and neglect. Overall, Indian's HIV epidemic is slowly down. Between 2010 and 2017 new infections declined by 27% and AIDS-related deaths more than halved, falling by 56%. However, in 2017, new infections increased to 88,000 from 80,000 and AIDS- related deaths increased to 69,000 from 62,000.[UNAIDS(2017), UNAIDS data 2017].

Unmarried women living with HIV/AIDS are faced with certain psychological pressures, and it is reacquired to reduce discrimination and inequality against them. Alongside social attention, social work support and psychological counseling are suggested for these patients. In addition, health policy makers should pay more attention to this issue. The most discrimination happened in the health sector because these people can hide their problems in other parts of the society. However, they were trained that they should inform their healthcare team about their disease. They are a chaste women, not a prostitute. This feeling of stigma and the likely label of prostitution as well as the social discrimination that follows make these people sensitive to the term HIV/AIDS. It exposes them to severe psycho-social pressures, making them hide their diagnosed disease. In addition to this social stigma, self-stigma is another experience of these people. They feel guilty and hopeless and pose limitations to themselves in their close relationship with their parents.

Based on the findings of our study, supporting such people seems to be a social responsibility of our health policy makers. Reduction of discrimination in health sectors alongside psychological and social work consultation is suggested for these patients.

Non-governmental organization plays a vital role for the women living with HIV/AIDS in the society. Non- governmental organizations providing support and proper counseling for the women living with HIV/AIDS. These kind of NGOs are serving for the up liftmen of women living with HIV/AIDS in our society. Women living with HIV/AIDS get benefits and get helps from the Non-governmental organizations. NGO is one of the effective agencies which promote the welfare of the women living with HIV/AIDS in this society. The cultural disaster is one of the main reason, the respondents comes in affected with HIV and the respondents' bad companionship is also main causes to be changed her life. In order to reduce this, unmarried women living with HIV/AIDS to be considered as an important factor in our society. HIV and sex education plays a major role in handling such issues in the society. Proper counseling initiatives should be taken for unmarried women living with HIV/AIDS by NGO's and other organizations. Unmarried women living with HIV/AIDS should react in times of any problem faced by them. They should be culturally assisted by the society, so that the respondents ready to come out and ready to lead a happy life.

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