

Knowledge and beliefs about HIV/AIDS among rural women of Udham Singh Nagar

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Abstract

HIV/AIDS is one of the biggest challenge in the medical world, this is because AIDS is life threatening and as of present there is no cure for the disease. The first AIDS case in India was reported in 1986. Since then, the epidemic has steadily grown. The present research was aimed at studying the awareness of HIV/AIDS among rural adolescent girls and married women of Udham Singh District in Uttarakhand. Specifically, the research investigated the role of traditional and cultural societal norms, on the behavioural patterns of rural women. The results of the survey indicate that socio-economic factors, culture and tradition all play a significant role in rural women's perceptions of the HIV/AIDS.

Keywords: Cultural Societal norms, HIV/AIDS, Rural Women

Introduction

The first incident of AIDS was identified in the United States of America in 1981, and since then the epidemic has spread throughout the world, despite the increased biological and epidemiological knowledge about the disease. As of 2013, it is estimated that there were 35 million people worldwide infected with HIV (UNAIDS, 2014). Out of which 50% Proportion of adults living with HIV/AIDS in 2011 were women. Adults here are defined as men and women aged 15 or above.

The extremely large population of India poses a high threat in terms of the rapid spread of HIV infection. In the future, India is estimated to have the most number of HIV infected individuals. The first AIDS case in India was reported in 1986 and since then the epidemic has steadily grown. A brief overview of HIV/AIDS data revealed that in 2006, 5.6 million people were estimated to be living with HIV in India, (UNAIDS, 2006). In 2008, the figure was 2.5 million which equated to a prevalence of 0.3%. While this may seemed a low rate, because of India's large population, it constitutes third in the world in terms of greatest number of people living with HIV. With a population of around a

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billion, a mere 0.1% increase in HIV prevalence would increase the estimated number of people living with HIV by over half a million (UNAIDS, 2008). India has the third largest HIV epidemic in the world. According to UNAIDS (2014) in 2013 HIV prevalence in India was an estimated 0.3%. This figure is small compared to most other middle-income countries but because of India's huge population (1.2 billion) this equates to 2.1 million people living with HIV. In the same year, an estimated 130,000 people died from AIDS-related illnesses. 75% of women testing positive in India have a husband who is a migrant labourer - Since AIDS is life threatening and as of present there is no cure for the disease, attention must therefore focus on the only available measure: alteration of those human behaviours essential to transmission of HIV (Becker and Joseph, 1988). Despite the role of Government and Health agencies in the country in bringing about educational campaigns to the general public on HIV/AIDS, the alarming rate of increased HIV prevalence show that there is a need for an assessment to be conducted to ascertain the existing knowledge, awareness especially among women.

HIV/AIDS - Vulnerability of Women in India

Discrimination against women in India is most evident in the declining sex ratio: from 972 females per 1000 males in 1901 to 933 females per 1000 males in 2001 940 females per 1000 males in 2011. Various studies have revealed that the girl child is deprived of proper nutrition, healthcare and education, given her lower social status in society. The discrimination meted out to women and their increased vulnerability makes women hapless victims of HIV/AIDS. Compared to developed countries, most Indian women were found to be relatively less aware about HIV/AIDS as per a survey conducted by The National Family Health Survey (NFHS) in 2007. According to UNDP nearly 40 percent of HIV-positive people in India were women. 350 of 911 HIV positive patients in Uttarakhand were women, and nearly 30 per cent of them got infected from their husbands (NACO, 2008)

Indian women are easy prey to HIV infection due to various factors, some of them are:

- Women are less likely to be able to negotiate condom use and are more likely to be subjected to non-consensual sex.
- As a majority of women continue to be financially dependent on, and socially inferior to, men, they find themselves unable to refuse sex or insist on condom use.
- The threat of violence and physical abuse undermine women's ability to guard them against the disease.

- Women who are victims of sexual violence are at a higher risk of being exposed to HIV, and the lack of condom use and forced nature of rape makes women more vulnerable to HIV infection

Objectives of the Study

Since statistics have shown that the women are most at risk of HIV/AIDS, this study conducted in year 2015, investigates the extent of women knowledge and the risk factors of the epidemic. For this reason, we evaluated the knowledge, beliefs and behavioural practice about HIV/AIDS amongst rural females in two villages of Udham Singh District in Uttarakhand with the broad aim to understand the social and cultural factors which impact upon HIV/AIDS. Rural females were divided into two categories Adolescent girl and married women. Adolescent girls are sometimes referred as girls and married women as women in the paper. The specific objectives were:

- to ascertain the awareness level of rural women in Udham Singh Nagar on HIV/AIDS;
- to access information needs of rural women on HIV/AIDS

Study Design

The study was intended to generate information on the social and cultural factors impacting women on HIV/AIDS in Udham Singh Nagar. The target population was in the reproductive age of 15-49 years. Two age groups of 15–20 years and 21 years & above were selected to include sexually active adolescents and adult rural women.

Location of the study

A new state of Uttaranchal was carved out of the northern part of the erstwhile Uttar Pradesh of the Himalayan region in November 2000.



It comprises thirteen districts, namely, Uttarkashi, Chamoli, Rudraprayag, Tehri Garhwal, Dehradun, Garhwal, Pithoragarh, Bageshwar, Almora, Chanpawat, Nainital, Udham Singh Nagar and Haridwar.



Udham Singh Nagar is tarai (low lying) region, Haridwar is at the foothills and the rest all are hilly tracts. This district consists of seven Tehsils named Bajpur, Gadarpur, Jaspur, Kashipur, Kichha, Khatima, and Sitarganj. The district is located in the Terai

region, and is part of Kumaon Division. It is bounded on the north by Nainital District, on the northeast by Champawat District, on the east by Nepal, and on the south and west by Uttar Pradesh state. The district was created in October 1995 out of Nainital District, and is named for Udham Singh. As of 2011 it is the third most populous district of Uttarakhand, after Haridwar and Dehradun.

Population & Distribution: The provisional population of the new state, as per 2011 census was 10086292 (0.84 percent population of the country) comprising 5137773 males and 4948519 females. The total area is 53,483 sq.kms and its shares of the land area is 1.69 percent of the country. The density of population per sq.km is 189, with wide variation among the districts. For instance while Udham Singh Nagar is densely populated with 648 per sq.km, districts in Northern part of the state have a low density such as Pithoragarh - 69, Chamoli - 49, and Uttarkashi - 41 per sq. km perhaps due to being situate in hilly terrains.

Sex ratio: According to 2011 census, sex ratio of the state was 965 females per 1000 males which were relatively high as compared to the districts in the plains. The lowest sex ratio was in Haridwar 879, followed by Dehradun 902 while Udham Singh Nagar was 919 per 1000 males. The sex ratio in 0-6 years has declined adversely from 948 (1991) to 909 (2001) to 890 females per 1000 males in 2011 census.

Literacy: The state with 79.63 per cent literates was ahead of average all India literacy rate of 74 per cent. The literacy rate in Udham Singh Nagar was 74.44 percent - 82.48 per cent (male) and 65.73 percent (female) respectively.

Migration: The state also has diverse migration pattern - while Almora and Pithoragarh have a high level of migration, Nainital district has large scale immigration. There are several reasons for the big upsurge in population in the Terai - Bhabar region of the Nainital district. The highly fertile land of Terai generally attracts the people from mountainous regions while big farms and forests draw labourers in large numbers. The establishment in 1962 of Govind Ballabh Pant University of Agriculture and Technology at Pantnagar has also led to human settlement in the contiguous areas.

HIV /AIDS Status in Uttarakhand

The state of Uttarakhand, like other parts of the country, has also fallen prey to the fast spread of AIDS. According to NACO report, since Uttarakhand's creation in November 2000 till December 2008, a total of 1788 HIV positive patients have been detected and out of this, nearly 528 new cases were reported in 2007 alone. Of the 1788 HIV positive patients, 315 of them turned into AIDS cases resulting in 10 deaths. While

the prevalence of HIV positive in Uttarakhand was only 0.8 percent, which was less than the alarming percentage of 1 percent and above, there was still cause for concern because of the large number of youths and men from the state going outside in search of livelihood.

As stated earlier, Uttarakhand has high trends of migration. Some of migrant men indulge in unprotected sex and contract the disease and when they return to their homes in Uttarakhand, they in turn infect their wives who get to know about their condition after several years. In Uttarakhand maximum numbers of HIV positive patients have been reported from the plain areas of Dehradun (944), Nainital (264), Udham Singh (97) and Haridwar districts (114). (NACO 2008).

Data Collection

The data for the study was collected using qualitative research. There are a variety of methods of data collection in qualitative research, including observations, case study and interviews (individual or group). However, some research common methods used particularly in healthcare are interviews and Focus Group Discussions (FGDs).

The data for this study was collected using FGDs to elicit qualitative data from rural women. In addition, Role Play technique was also used as it involves simulation of social interactions in which participants assume and enact described roles within specified situations.

Focus Group Discussion

FGD research technique was used to collect qualitative data from a select group of respondents. For the research focus groups were chosen as this method was ideal for studies that are seeking to explore and understand attitudes and behaviours. The method assumes that an individual's attitudes and beliefs do not form in vacuum. People often need to listen to other's opinions and understandings to form their own. (Hurworth, 1996)

FGDs were used for generating information on collective views, and the meanings that lie behind those views. They were also useful in generating a rich understanding of participants' experiences and beliefs (Morgan, 1997). The questions in FGDs were generally kept simple to promote the participant's expression of their views through the creation of a supportive environment. The format allowed the facilitator the flexibility to explore unanticipated issues as they arise in the discussion. It facilitated freewheeling discussion on issues and allowed the participants to give their views and feedback in a group setting. The group members got to hear what others in the group have to say, which

stimulated them to formulate their opinion on an issue.

Knowledge is socially constructed by people active in the research process, and that researchers should attempt to understand the complex world of lived experience from the point of view of those who live it (Schwandt, 2000).

Focus group gave an opportunity to observe group dynamics and the interaction between the participants. The method helped to establish a flexible and open atmosphere, where participants appeared comfortable with sharing opinions and exploring issues. Participants were given the opportunity to react to others' reactions and build upon that. The focus group provided rich qualitative perspective on the social phenomenon under study. FGD also obtained access to the participants' verbal and non-verbal expressions.

Focus groups can also pose some challenges as well as it was not always easy to find suitable participants to participate in focus groups. The researcher often faced the challenge of adapting the topic of discussion to suit the participant's knowledge and abilities. Furthermore, group interaction, which was on the one hand an advantage, can also pose a challenge in the sense that participants may influence each other's views and opinions. FGD can be directed in a certain direction that may be irrelevant to a study. The researcher addressed to this potential limitation, by continuously directing the focus of the discussion.

FGDs were conducted in two villages with groups of adolescent unmarried and adult married females. Participants were recruited using snowball sampling technique from contacts known to the researcher. Separate groups for married and unmarried women groups were formed for enable freer discussion.

For the two villages selected in each study area, 4 FGDs (two for adolescents and two for adults) were conducted. Thus, a total of 8 FGDs were conducted in each village. The FGDs were used to collect detailed and spontaneous information on issues pertinent to HIV/AIDS in the community such as knowledge of HIV/AIDS, gender dynamics, social cultural factors impacting on HIV/AIDS and general community perceptions, roles and strategies in the fight against HIV/AIDS (Table 1)

Table 1

Questions Template for the FGDs

1. Have you heard of HIV /AIDS? If Yes, what do you know about it?
2. Where have you got this information from (radio , newspapers, Television other)
3. Do you know if there is any difference between HIV and AIDS?
4. Do you know how to protect against HIV?
5. Do you know what a condom is? Have you seen a condom? Do you know how to use it? Do you know where you can buy condoms? Who (husband/wife) can negotiate condom use.
6. Do you know about female condom?
7. Do people have more than one sex partners?
8. Do you talk about HIV in school? If yes, among whom?
9. Would you like to learn about sex in school?

Profile of FGD Group

FGD was conducted in two villages of Udham Singh Nagar in Uttarakhand. Total eight FGDs were carried. Groups were divided into two categories of married women and adolescent unmarried girls.

TABLE 2

Location	Married Adults	Unmarried Adolescents
Shantipuri	20	18
Jawahar Nagar	19	17
Total	39	35

Role Play Technique

Role play as a method was used as it has several qualities that make it a technique

to understand user needs and understanding. The Role-play technique provided spoken data through enactments that approximates real-life performance. Role-play technique was chosen because it allowed the researcher to examine not only the content of the utterance but also its discourse features such as laughter, reluctance, pauses, modulation, tone, stress, turns, moves in an utterance, sequence organization, overlapping, etc. According to Rintell and Mitchell (1989), role-play yield longer and elaborate communicative act data as compared to questionnaires as it allows more negotiation, repetition and avoidance strategies than written questionnaires. Dramatization scenarios created a situated embodied context of Sexually transmitted Diseases, which enhanced the participants' ability to envision needs and find out answers within their cultural context

Although the researcher found the process time consuming as mentioned by Kasper and Dahl (1991) as it required transcribing of plays enacted which was a lengthy process.

According to Sarah Bowman, the practice of role-playing entails three major functions: Scenario building, problem- solving, and skill training.

Scenario building describes the projection of potential future and subsequent conjecture regarding the difficulties, benefits and consequences involved in taking particular set of action. The concept was pioneered by Peter Schwartz in his book *The Art of the Long View*.

Problem-Solving is another function of role-playing. Scenarios place players in difficult situations that often require a high-level of critical analysis for resolution. Players must evaluate the options open to them, such as available resources and potential social reactions to stimuli. Role –playing allows people to find solutions to problems in a safe, low- risk environment.

Skill training focuses that active learning is superior to passive learning. Role playing give an opportunity to attain high level of engagement and interactivity.

In this study, the researcher focused on scenario building and problem solving. Role play was conducted with group of adolescent girls, as they were more interactive and energetic. During role play the group of adolescent girls was divided into two groups.

The researcher focused on scenario building and problem solving.

During role play for problem solving interaction with adolescent girls some solutions were suggested.

In Kumaon *Patri/Chinn/Kundli* plays an important role in fixing the match. The

idea behind the process was to make sure that the boy and girl after marriage will be happy and it will be a successful marriage. Healthy family is also a key for successful and happy marriage, then why not to check pre marital medical records of boy and girl to be sure that you do not get a STD after marriage.

Need for free and open discussion between parents and their children was also highlighted. The role plays give importance to need of taking about sexual knowledge by mother, elder sisters and teachers in open manner came up. They all lack knowledge about sexually transmitted disease and preventions, need for open atmosphere to discuss such issues in family came up. There was demand from younger generation of girls for reliable and comfortable atmosphere to discuss sexual issues.

Findings

Findings from the study indicate that the knowledge and awareness about HIV/AIDS transmission was generally high among adolescent girls due to the fact that in most schools there were lots of HIV/AIDS awareness campaigns and most of them had also participated in functions organised during AIDS day.

Although the knowledge and awareness of HIV/AIDS may be high amongst rural women there were a majority of girls who had misconceptions on the modes of transmission. For example during the FGD, the some girls revealed that they believed HIV could be easily detected by just looking at physical appearance. Although the knowledge of HIV/AIDS was significantly higher in the adolescent girls, findings from the FGD reveal that married women were less able to negotiate safer sex with their partners due to cultural norms of masculinity and femininity which ascribe ideas about normal behaviour for men and women.

Economically dependent women cannot negotiate for safer sex or condom use, and this puts women in a very vulnerable position in terms of HIV infection. Due to the patriarchal nature of the society, a man may have many sexual partners and be bragged for his escapades, but if a woman engages in such behaviour, she will be labelled a deviant or reckless.

Perceived vulnerability was assessed by asking students if they were worried about getting AIDS. More adolescent girls than married females were personally worried about contracting AIDS. There was a belief specially among married women that HIV could only happen from sex workers, the concept of getting HIV from husband was absent. On the other hand it was believed that masculinity could encourage men to have more sexual partners.

Findings of the study were largely dependent on following five areas:

1. Source of Information

Both women and teens recalled learning about HIV/AIDS at school. The main sources of information about HIV/AIDS were the classroom, and television. For many, it was the first place they heard of the disease; for a few it appears to be the only source from which they have received some information during the interaction. Most often they said they learned about HIV/AIDS in school classes. Some felt their education on the topic was adequate and others felt it was not. As one adolescent girl complained, “I think that they should teach it more in schools, because I myself didn’t get that much.” Another participant of Jawahar Nagar explained, “I go to a private school and all they say, have sex out of marriage. They don’t say anything about HIV or AIDS.”

Another significant source of information had been television. Participants pointed to a variety of television programs and public service announcements. A women participant said that, ‘They have been putting a lot about AIDS on TV.’

2. Awareness about HIV/AIDS

All the participants were aware of HIV/AIDS. They were also aware about the three ways from which HIV/AIDS spreads and that by using condoms one can protect themselves from the disease. The source of information was regular media campaigns. However, they did not know the difference between HIV and AIDS and they discussed HIV/AIDS for the first time during research.

Most participants were fairly well-informed about HIV transmission, but there were some important gaps in their knowledge. A handful appears ill-informed. Most of the focus group participants knew that HIV was transmitted through sexual contact and intravenous drug use, or through infected blood. Most of them knew that condoms were the best way to protect oneself from HIV. While most participants had sketchy information about transmission in general, a fair number were not fully informed.

Some of the participants did not understand the most basic facts about HIV/AIDS. For example, one woman did not know that a person can only get HIV from an infected spouse; she was under the impression that just having multiple partners put a person at risk.

The majority of participants said that they were not too concerned about HIV/AIDS on a personal level. When asked the reason of not being personally concerned, some women said it was because they practiced sex within marriage.

'We practice sex within marriage. We cannot get this disease from our husband'

3. Multiple sex partners

Focus group participants described a tendency to associate HIV with extra-marital sex and prostitution. Village women described that HIV cannot be transmitted from their spouses. Another woman described a tendency to associate HIV with commercial sex workers.

'Only those who visit sex worker can get the disease'

But on the other hand all participants accepted that extra marital relationships were prevailing but none of them could relate it to sexually transmitted disease.

All the participants believed that masculinity can encourage men to have more sexual partners.

'Although it is wrong and most men are faithful, but who know?'

The understanding between the links in extra -marital relationships with HIV/AIDS was missing in rural women.

4. Condom usage

Women participants realized that there is no cure for HIV/AIDS; most knew there was no vaccine to prevent HIV/AIDS. They also admitted that they were not using condoms. According to them, in the cultural setting of the village, young women are supposed to be sexually innocent and may therefore be reluctant to carry or suggest using condoms. Since condoms were also associated in many contexts with illicit or extra-marital sex, married women are often powerless to request their partner to wear a condom despite suspecting that he may be having an extra marital affair, for fear of reprisal at the implied accusation of being unfaithful.

None of the participants ever used condoms.

'How can we (Wife) ask our husband's to use condom. Even if we ask them then they will suspect us'

The condoms were never used even as a family planning method. To maintain gap between two children women usually followed natural method of keeping a track of menstrual cycle.

'It's women's job to give birth and rear children hence we should keep a track of our menstrual cycle'

5. Information sharing and HIV/AIDS

Married women do crack sex related jokes in all women's company, but none of them ever talked about HIV/AIDS or discussed any sexually transmitted diseases.

School was a main source of information about sex and AIDS but it had always been superficial. According to adolescent girls boys and girls seem to have different ideas/reasons for having or not having sex. Boys relate to the physical nature of sex, whereas girls relate to the emotional aspects. Teens reported being bored with AIDS education, but suggest needing information that was more relevant for them.

Conclusions

Social and cultural determinants relating to women's position in Indian society directly affect their ability to care for their health. This was especially so in regard to HIV/AIDS. Women's negotiating position with husband was very often undermined by economic dependency. During FGDs it was found that there was severe lack of understanding among women of getting infected by their husbands. They were also not in position to negotiate condom use with in marriage. In the cultural setting of the village, young girls are supposed to be sexually innocent and may therefore be reluctant to carry or suggest using condoms. Since condoms are also associated in many contexts with illicit or extra-marital sex, married women are often powerless to request their partner to wear a condom despite suspecting that he may be having an extra marital affair, for fear of reprisal at the implied accusation of being unfaithful. None of them were aware of female condom

For many men, masculinity was linked with taking risks and being tough, and having more than one sex partner or experiencing sex before marriage. Adolescent girls desire for safe and healthy sexual relationship after marriage and hence during role play suggested to give equal importance to pre medical records as parents give for *Chinn* (Kundali)

There are still critical contextual factors such as poverty, ignorance and gender inequalities that encumber them to continuously practice protective behaviour. For instance, women who are faithful to their husbands may still get infected because they are not in position to negotiate for safe sex even when they know their husbands are engaging in risky sexual practices. Similarly, adolescents and youths who would have wished to get married after an HIV test were unable to do so because of social system. As a result of

their societal roles, women and girls face a number of unique challenges that affect their ability to protect themselves from HIV/AIDS and its overwhelming effects. AIDS feeds on systems of injustice that existed long before HIV/AIDS epidemic and has considerable impact on fairer sex.

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