

TREATMENT SEEKING BEHAVIOUR AMONG THE RURAL WIDOWS LIVING WITH HIV/AIDS

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Abstract

Health is a core value, which is cherished by the organised behaviour of human beings. It is one of the socio-cultural factors that determine the status of any individual. The stigma attached HIV infection has created panic among the persons living with HIV (PLHIV). This study analysed the socio-economic contour of the widows living with HIV to understand their condition and their treatment seeking behaviour with specific reference to adherence of antiretroviral therapy (ART). Descriptive design was employed to study the treatment seeking behaviour of the widows living with HIV. Qualitative technique such as focus group discussion was conducted. The WLHIV have easy accessibility to health care from the health institutions but the economic burden on the take off their time and responsibility to drift away from regular maintenance of their health. The NGOs working with the WLHIV have not initiated sustainable livelihood programme for them. Though they are in self-help groups, they are not given privilege in promoting viable income generation programmes. The NGOs need to concentrate to enable the WLHIV to enhance their economic status, which would ultimately increase their treatment seeking behaviour.

Key words: HIV/AIDS, WLHIV, NGO, ART, Treatment seeking behaviour

INTRODUCTION

India is one of the largest and thickly populated countries and the home for approximately 2.5 million (2-3.1 million with 0.36% prevalence) HIV infected population in 2007 compared to 5.2 million in 2006 (NACO 2007). In a country where poverty, illiteracy and poor health are the crucial social problems, the spread of HIV/AIDS has initiated a great challenge to the nation. Even though India has made significant progress in the past several decades in improving the health and well-being of the people, the country continues to bear the heavy burden of both communicable and non-communicable diseases.

Health is a core value, which is cherished by the organised behaviour of human beings. It is one of the socio-cultural factors that determine the status of any individual. The stigma attached HIV infection has created panic among the persons living with HIV (PLHIV). They are conditioned to a state of health maintenance to have a better quality of life. If they fail to do so then they have severe health repercussion that eventually deteriorates their life. This further have rippling consequences on the families, the worst affected are the women and children. In rural cultural context, the women are treated as secondary citizens in the society, but the case even worse for the widows living with HIV (WLHIV). In many families, they become the heads of the family, who are in the compelling state to nurture the children and other family members. Those who belong to poor socio-economic status, are trapped in the vicious circle of poverty, violence, exploitation and abuses (Amita Chudgar, 2010, cited in William, et al., 2013).

Samet, et al., (2003) conducted a cross-sectional study on HIV-positive men and women with a history of alcohol consumption. The result showed that the individuals, who drink alcohol at the time of receiving highly active anti-retro viral therapy (HAART), have lower CD4 counts and higher viral load than those, who did not consume alcohol. They observed no association between heavy alcohol consumption and CD4 counts or viral load among patients receiving anti-retro-viral therapy. However, alcohol consumption was connected with lower CD4 counts among patients not receiving antiretroviral therapies. Parsons, et al., (2005) pointed out that a positive relationship between the amount of alcohol consumption and viral load. Greater alcohol consumption was associated with higher viral load among HIV positive men.

Sivaram, et al., (2008) in their study on behaviours of male patrons of wine shops found that Over 85% reported using alcohol at least 10 days a month i.e. 17% reported drinking everyday. During a typical drinking day, 49% reported consuming five or more drinks. Alcohol use before sex was reported by 89% of respondents. Unprotected sex with non-regular partners was significantly higher among unmarried men, those who reported

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irregular income, who used alcohol before sex and who have higher numbers of sexual partners. Solomon, et al., (2008) observed that women scored significantly lower than men in psychosocial well-being from the period prior to care, at enrollment, and at 6 months; women reported significantly higher levels of partner satisfaction at 6 months.

Jintana, Anna and Vinod (2000) have found that the people who attributed persons losing weight, having fever and cough as AIDS rather than TB. This caused delay in seeking care and non-adherence to TB treatment in some patients who suspected they have AIDS and feared AIDS detection. Most HIV-negative TB patients were also suspected by their relatives and neighbours of having AIDS. Most participants, except HIV-positive females, believed TB to be curable. Kalichman (1999) investigated the continued sexual risk behaviour among 203 HIV-positive men and 129 HIV-positive women recruited from infectious disease clinics and AIDS service agencies. The outcomes showed that 42% of men and 42% of women reported at least one occasion of unprotected anal or vaginal intercourse in the preceding six months. Unprotected intercourse frequently occurred outside of long-term relationships and with partners who were not known to be HIV-infected.

Sexual behaviors among heterosexual persons living with HIV (PLHIV) in India, was investigated. The results showed that one third of men and one fourth of women reported inconsistent condom use with regular sexual partners. Facilitators of condom use with regular partners included a feeling of personal responsibility to protect the health of the partner, desire to prevent acquisition and/or transmission of sexually transmitted infections, and the belief that condoms are needed for antiretroviral therapy to be effective (Chakrapani, Newman, Shunmugam, & Dubrow, 2010). Raj, et al., (2011) described sex risk behaviors of HIV-infected female sex workers (FSWs) and HIV-infected male clients of FSWs. Among males, a greater number of transactional sex partners was associated with more unprotected transactional sex episodes, and any unprotected transactional sex was associated with higher odds of self-reported STI in the past year. For women, risky transactional sex behaviors were not associated with condom non-use, and unprotected sex was negatively associated with STI.

Pronyk, Makhubele, Hargreaves and et al., (2001) examined the health seeking behaviour among hospitalised tuberculosis patients. Patients more often presented initially to public hospitals (41%) or clinics (31%) than to spiritual/traditional healers (15%) or private general practitioners (13%). Total delay was shorter amongst those presenting to hospitals than those presenting to clinics, with a significantly smaller proportion of the total delay attributable to the health service providers. Lwin (2011) explored that the increase in highest education level and wealth was found to be significantly associated with the high HIV related knowledge, have comprehensive knowledge, have HIV related positive attitudes, have accepting attitudes towards PLHA and HIV related less risky behaviors.

Ahmed, Tomson, Petzold, & Kabir (2005) there was no major differences in health-seeking behaviour between elderly people and younger adults. On an average about 35% (405/1169) of those who reported having been ill during the previous 15 days in both age groups chose self-care/self-treatment. A household's poverty status emerged as a major determinant of health-seeking behaviour. Traditional healers (THs) were sometimes preferred over health facilities (HFs) because of familiarity, trust, accessibility, expense, payment plans, and the perceived cause, nature and severity of the illness, e.g. only THs were believed to successfully treat bewitchment. Some people, particularly young girls, delayed or avoided seeking treatment for STIs for fear of stigma. Most STIs were attributed to natural causes, but AIDS was sometimes attributed to witchcraft. Locally available biomedical care of people with AIDS-like symptoms consisted of basic treatment of opportunistic infections. (Plummer, et al., 2006).

Wig, Lekshmi, Hemraj and et al., (2006) in their study observed that there was a significant difference of quality of life in the physical domain between asymptomatic patients (14.6) and patients with AIDS (10.43) defining illnesses and asymptomatic and early symptomatic (12) patients. Ramachandani, et al., (2007) revealed that major barriers to taking ART were cost (33%), lack of knowledge of ART (41%), and deferral by physician (30%). More than half of all public and private patients have not heard of CD4 (57%) or viral load testing (80%), and even fewer have received these tests (32% and 11%, respectively).

Increasingly older adults are being diagnosed with HIV/AIDS. In 2002, UNAIDS indicated that 13 aspects of quality of life (QoL) were poorer for older adults, but only sparse, inconsistent cross-cultural evidence is available. Moreover, older people reported greater dependency on medication. However, older HIV adults have better QoL than expected on 11 dimensions; negative feelings, social inclusion, and several environmental and spiritual facets. This highlights the extent of poor QoL in younger adults. (Skevington, 2012).

OBJECTIVES OF THE STUDY

This study was conducted to observe the socio-economic contour of the widows living with HIV to understand their condition in general and more specific to know their treatment seeking behaviour with specific reference to adherence of antiretroviral therapy (ART).

MATERIALS AND METHODS

Descriptive design was employed to study the treatment seeking behaviour of the widows living with HIV. Qualitative technique such as focus group discussion was conducted. Two focus group discussions were conducted in two packets of Madurai district. In each focus group discussion, minimum 11 women were present. The NGOs working with the PLHIV helped in conducting the focus group discussions in the month of January 2013. The participant widows were from rural areas and in the productive age group of 19 to 45 years and who had shown no inhibition in disclosing their HIV identity.

MAJOR OBSERVATIONS

All the widows participated in the discussion are engaged as agricultural labourers and having income below Rs.3000 per month.

- Some of the women feel satisfying to some extent about HIV post-test counseling. Some of the women were silent and unrevealing about the post-test counseling.
- The WLHIV make frequent visit to ART centre but at times lack of family support prevent some of the WLHIV to make frequent visit to ART centre. Those who failed to go to ART centre regularly feel that they are disinclined to go to ART centre due to fear of HIV disclosure to others. But they continued to go to ART centre after the counseling provided by the programme staff, which removed their self-stigma.
- The WLHIV who are registered under On-ART healthy state after ART consumption. Earlier some WLHIV in On-ART didn't adhere to ART suspecting that it has side effects but after the visits of the health programme personnel, they have understood about the ART course and its health effects, which resulted in continuation of their ART medication.
- The WLHIV in Pre-ART test CD4 count once in 3 months, but those failed to do so due to lack of family support.
- The Community Care Centre (CCC) is the chief health care institution for the WLHIV to avail treatment for OI. But they have satisfaction on treatment to a moderate level. They suggested the State should provide the CCC with adequate infrastructure and medical equipments to render quality health care services for PLHIV.
- The WLHIV are burdened with economic pressure to maintain their family, especially their children, after the demise of their spouse. They are not respected in the in-laws house. The driving force to care their health is their children because they feel that after their death the children would be left out without proper care and support, so till their maturity the survival is must.
- The neighbours and relatives have questioned the WLHIV why they are taking medicines, which is ART medicine, so sometimes they avoid consuming the medicine, particularly during festivals and rituals.
- The grown up children suspect the consumption of ART drugs, this also create a fear among the WLHIV, who at times discontinue the ART medication.
- The programme staff in HIV/AIDS care and prevention is the external force that motivates them to maintain their health for having better quality of life.
- Irregular income sources from the work, is the threatening factor that at times retards them accessing to better health care.
- The WLHIV are able to disclose their HIV identity in their HIV infected community but they still have problem in mingling with others who don't know their HIV status.

CONCLUSION

The WLHIV have easy accessibility to health care from the health institutions but the economic burden on the take off their time and responsibility to drift away from regular maintenance of their health. The NGOs working with the WLHIV have not initiated sustainable livelihood programme for them. Though they are in self-

help groups, they are not given privilege in promoting viable income generation programmes. The NGOs need to concentrate to enable the WLHIV to enhance their economic status, which would ultimately increase their treatment seeking behaviour. More over Professional social workers along with health personnel functioning with PLHIV; have to upkeep the Pre-ART patients in the Pre- ART status itself in such a way that they need to be given effective counseling.

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