ABSTRACT

WOMEN LIVING WITH HIV/AIDS AND THEIR LIVELIHOOD STRATEGIES IN IMPHAL, MANIPUR

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CHAPTER I

INTRODUCTION

The present study attempts to comprehend the status of Women Living with HIV/AIDS (WLHA) and their livelihood strategies in Imphal, Manipur.

Manipur is one of the states, located in North eastern part of India with its capital city, Imphal at the latitude of 23.50N-25.30N and longitude 93.40E-94.30E. It is a beautiful place surrounded by nine hills on all side with a small oval shaped valley at the centre. Manipur is christened with alternative names such as Kangleipak or Sanaleibak. It is surrounded by Nagaland to the north, Mizoram to the south and Assam to the west, Myanmar lies to its east.

The geographical area of the state is 22,327 square kilometers (8,621 sq. kms.) which constitutes 0.7% of the total land surface of India. The total population of the state is 28.56 lakhs including 14.39 lakhs of males and 14.17 lakhs of females (Census, 2011). The state is divided into two tracts viz. the hills and the valley. The hill embraces 5 districts i.e. Senapati, Tamenglong, Churachanpur, Chandel and Ukhrul and the valley encompasses 4 districts i.e. Imphal East, Imphal West, Bishnupur and Thoubal. The folks residing include the Meitei, Kuki, Naga, and Pangal, who speak Sino-Tibetan dialect.

Since more than 2,500 CE, Manipur has been at the crossways of the Asian economic and cultural exchange. It has been linked with Indian subcontinent to Southeast Asia, allowing migration of populaces, cultures and religions. It has also evidence several wars, including fighting during World War II. Manipur is one among those states where HIV prevalence rate is very high. HIV transmission in the State is commonly through infection of Injecting Drug Users (IDU's). The main causes of drug abuse in the State are due to the closeness of 'Golden Triangle" in Myanmar which has been the heart of main opium poppy cultivation since 19th century.

1.1 Overview of Concepts

The developing trend of HIV/AIDS has been set up in every nook and corner of the globe. In 1981, an unusual cluster of Pneumocystis Carinii pneumonia (PCP) and Kaposi's sarcoma has been reported from Centres for Disease Control and Prevention (CDCP) among gay men in United States of America. These were the first reported cases

of AIDS in the world. The appearances of virus in gay community lead to the belief that immune-deficiency was confined only to homosexuals and the physicians named it as Gay Related Immune Deficiency (GRID), but similar cases were started to appear among blood transfusion recipients. Again alike cases were reported from amongst women and children in Africa. It became evident that the disease was cause by a micro-organism transmissible through blood and sex and named it Acquired Immune-deficiency syndrome (AIDS). In 1983, a virus was insulated from a patient with AIDS and accepted as a retrovirus. In later years World Health Organisation (WHO) named it as Human Immune deficiency Virus (HIV).

HIV is a member of a cluster of viruses called retroviruses. These viruses cannot grow without energy and nutrient supplied by a host cell. There are two types of HIV viz. HIV 1 and HIV 2. These two viruses belong to same family of retroviruses, but differ in their genetic character. In 1983, HIV 1 was first discovered in France and appears to be more widespread in Europe and America. HIV 2 was first discovered in Africa in 1986 and is more confined in West Africa. HIV 1 is more responsible for the global pandemic while HIV 2 is less easily transmitted. Both HIV 1 and HIV 2 lead to AIDS and they have been detected in India.

HIV is a virus whereas AIDS is a collection of illnesses and is therefore a condition which starts when the immune system becomes very weak that it cannot fight any other infection which gets into the body from outside. AIDS does not immediately follow after the detection of the HIV and there is a period of at least five to seven years between the catching of the infection and the AIDS condition (Varma, 2010:43).

HIV can be transferred from one person to another by various activities such as:

1) Unprotected sexual intercourse
2) Direct blood contact, including injection drug needles, blood transfusions, accidents in health care settings or certain blood products
3) Mother to baby (before or during birth, or through breast milk)

The battle against HIV/AIDS has been acute all over the world. HIV have infected and affected millions of people all over the globe in spite of their age. The stigma and discrimination faced especially by the women has been upsetting. Women infected with the disease need special protection. The discrimination against women has been found

universally not only in the social sphere but also in political, economic and spiritual spheres. Women battling with HIV/AIDS especially those belonging to the downtrodden section of the society face dilemma to earn their livelihood. The situation was much graver for widow whose husband died of HIV/AIDS and was far shoddier if they were already infected by the virus.

In India, different women's movement has been involved but it was limited to the fight against female foeticide neglecting its agenda on fight against HIV/AIDS. It is extremely important to give a voice to the women who are infected with the virus and bring necessary changes to the outlook of the society with collective action (Varma, 2012).

1.2 Trends of HIV/AIDS Epidemic

AIDS began to appear around the 'global village' in the early 1980s. International scientific institutions and new organisations quickly created a place for AIDS in the global imaginary i.e. from the heart of Africa and gay bathhouses in San Francisco to the back street of Southeast Asia and poverty-stricken neighbourhoods in the United States (Patton, 2002). Millions of people all over the world are newly infected every year by this disease. In this day and age, HIV/AIDS has been the burning issue in health sector. Till now there have been no vaccines that can purely cure HIV/AIDS. The only way to effectively control the level of HIV in the body would be by taking Anti- retro viral therapy (ART or ARV). In 2012, a report from UNAIDS stated that there were total 34.4 million PLWHA all over the world and out of this 2.1 million were children and the remaining were adults both males and females, and 2.5 million were newly infected with the virus.

In India, the first case of HIV was diagnosed by Dr. Suniti Solmon among female sex worker (FSW) in Chennai in 1986. The spread of HIV in India was primarily restricted to the Southern and North- eastern region of the country. The main factors which have contributed to India's large HIV-infected population were extensive labour migration and low literacy levels in certain rural areas resulting in lack of awareness and gender disparity, Injecting drug users (IDU's) and prostitution. To control the spread of the virus, the Indian Government set up the National AIDS Control Programme in 1987 to co-ordinate national responses to the disease. To overlook the problem Indian Government has set up State AIDS Control Societies (SACS) in different states. In 2006,

approximately 2.5 million were PLWHA in India with a national adult HIV prevalence of 0.36 per cent (Varma, 2012:34).

In north eastern states the first case of HIV were reported in Manipur in 1989 among Injecting Drug Users (IDU's). HIV/AIDS epidemic became grave in 1990s in Manipur. The cause of frightening number of HIV rate in state was because of the easy access to the transit route of drugs across the border with Myanmar, growing unemployment among youth adding with highly westernized lifestyle, general frustration, family complications, pleasure seeking, lack of societal control, poor health services, lack of political will and social unrest. Manipur were among those six high HIV/AIDS prevalence states in India. According to NACO, Manipur stands at 3rd rank among the HIV positive high prevalence states which come next to Maharashtra and Tamil Nadu (Census, 2011).

In 2014-15, total number of 8,39,650 people blood samples were screened and out of 5,072 people were found positive in the state and 2,163 people had died of AIDS. Table 1 shows the annual trend of HIV/AIDS surveillance in Manipur.

Table 1

Trend of HIV/AIDS Surveillance of Manipur (in numbers)

Year	Blood samples screened	HIV positive cases	AIDS cases	Deaths due to AIDS
(1)	(2)	(3)	(4)	(5)
2008-2009	59,467	2,451	_	_
2009-2010	83,836	3,041	_	_
2010-2011	90,406	3,130	_	_
2011-2012	95,756	2,282	_	_
2012-2013	1,09,450	1,910	_	_
2013-2014	59,771	1,016	_	_
2014-2015	8,39,650	45,072	_	2,163

Source: Manipur State AIDS Control Society, Imphal (Census 2011)

In Manipur, HIV positive cases were identified in every district. District-wise, Imphal has reported highest number of HIV positive cases. Next to Imphal, Thoubal district has identified the second highest HIV prevalence. The capital city, Imphal was significantly concentrated with maximum HIV positive. Among different districts in Manipur, Tamenglong reported lowest HIV positive case. As the epidemic was spreading into common folk from IDU's through sexual route, the condition among women and children has become frightening day by day. The infection has now spreading to the female sexual partners of IDUs and their kids (Census, 2011).

Table 2

District-wise number of HIV positive cases (Sero-Surveillance in Manipur)

District	2005-2006		2006-2007		2007-2008	
	Blood Sample screened	HIV Positive cases	Blood Sample screened	HIV Positive cases	Blood Sample screened	HIV Positive cases
(1)	(2)	(3)	(4)	(5)	(6)	(7)
Senapati	617	131	2212	202	4087	232
Tamenglong	439	14	740	3	2240	9
Churachanpur	1324	264	3249	347	3924	384
Bishnupur	2136	192	4469	234	5551	143
Thoubal	2721	257	7230	365	7855	421
Imphal West & Imphal East	8276	1122	16643	1415	18836	1153
Ukhrul	1104	260	2485	437	3102	295
Chandel	629	172	1001	155	2148	285
TOTAL	**17246**	**2412**	**38029**	**3190**	**47743**	**2922**

Source: Directorate of Health Services, Govt. of Manipur, 2016.

1.3 Women Living with HIV/AIDS

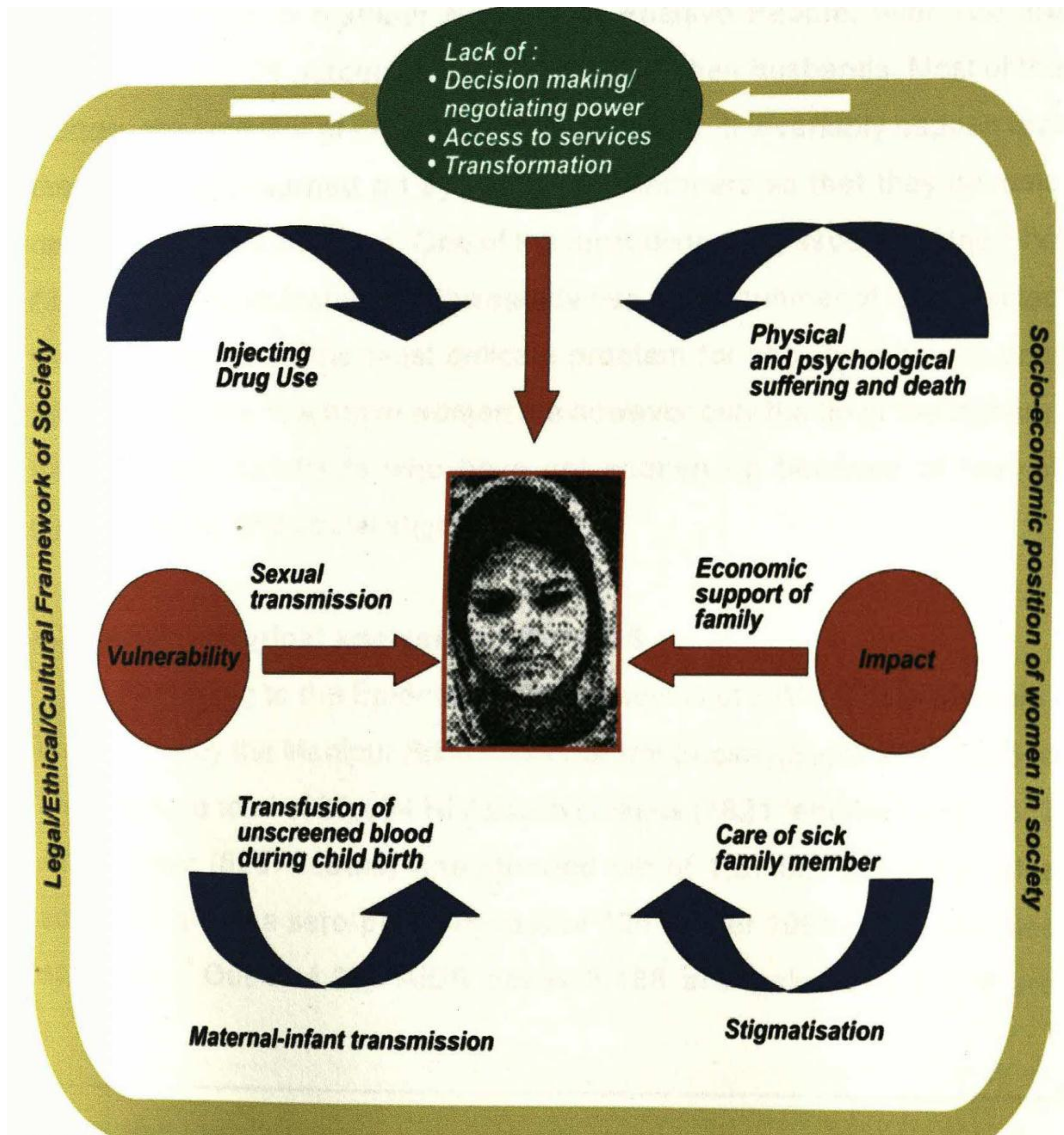
Women living with HIV/AIDS are that woman who has detected HIV antibodies in their body. Women are especially vulnerable to HIV infection and sexually transmitted diseases due to biological and socio cultural factors counting economic, educational and legal discrimination and imbalanced gender relations. WLHA could not even participate in social gatherings of their locality. Once society becomes aware of their status they were treated as outcaste and their future seems to be lifeless life. After the death of their husband, many widows lose everything in the family and treated as countless deprived family members. The path to be a companion of the society was likely to be half shutter. Even though they are aware of the legal notions to fight for their rights they did not claim it because of the fear of societal stigma and custom.

Feminist theory or feminism express about the equality of men and women in the society. Its main focus is on the critical analysis of gender disparity highlighting the problem of discrimination, objectification (especially sexual objectification), oppression, patriarchy, stereotyping, art history and contemporary art and aesthetics. It also expressed their view regarding the socio political theory and those harmful practices which purpose is to free women section from the male superiority and exploitation. According to N. Abercrombie, "Feminism is a doctrine suggesting that women are systematically disadvantaged in modern society and advocating equal opportunities for men and women."

The issue related with HIV infected women has been raised in different international conferences on women empowerment as well as on HIV/AIDS. Dignitaries like Bill and Melinda Gates, Bill Clinton, Richard Gere and many others have steered the concerned about feminization of HIV/AIDS but so far women's movement have not been able to reach at its grass roots level. The rhetoric of women's right on HIV/AIDS has been confined so far to the speech given by well-known personal only (Varma, 2012:96). According to a report from United Nation Development Programme (UNDP) women are particularly vulnerable to HIV infection and sexually transmitted diseases due to certain factors. The following figure shows the centrality of women in HIV/AIDS epidemic.

Figure 1

The centrality of women in the HIV/AIDS epidemic



Source: Gopen Moses, Dialogue, Vol. 9, 2007

1.4 Poverty

The core concept of poverty is mainly related with income. It is a multi-dimensional problem, whether it is at global, national or community level. According to World Development Report (2000), "*Poverty is pronounced deprivation in well-being*". It is defined by a poverty line, i.e. the minimum income needed by an individual to meet its minimum basic needs. Millions of people across the globe are living below the poverty line therefore Millennium Development Goal (MDG) makes its indicators for first goal eradication of extreme poverty and hunger.

Poverty increases risk behaviours to HIV infection among women. Very less scope on employment and education prevent women from empowerment, creating a favourable condition for spreading of HIV infection in national scale, restrict financial development and educational opportunities, and also lesser access to health care and employment (Rodrigo & Rajapakse, 2010:10).

The causes of poverty vary by its gender, age, culture and other social and economic contexts. It results not only from the lack of one thing but from cluster of interlocking many factors. Women are particularly very vulnerable towards poverty because of the societal cultural norms and legal restrictions that limit their access to various resources and decision-making power.

1.5 Gender

Gender refers to the socially constructed differences between males and females that are learned and deeply rooted in every culture. Gender is changeable over period and has extensive variations both within and between cultures. Gender defines the roles, responsibilities, opportunities, privileges, expectations and limitations for males and females in any culture (Inter Agency Standing Committee, 2005).

According to World Health Organisation (WHO), *"Gender is a socially constructed role, behaviour, activities and attributes that a particular society considers appropriate for men and women".* The distinctive role and behaviour assigned to both the gender create gender inequalities i.e. differences between men and women that systematically support one group.

Gender is not a natural process that stems from the body; it is a socially constructed activity. It refers to the traditionally accepted categories of masculinity/femininity centred upon the biological division. Masculinity is defined as being independent, assertive and aggressive (Eagly & Steffen, 1984; Eagly, 1987). Femininity is defined as being nurturing, sensitive and emotional (Slavkin & Straight, 2000; Bem, 1981).

1.6 Sustainable Livelihood Framework

Sustainable livelihood is a concept which makes its attempt to understand the conventional definitions and approaches to poverty eradication. The idea of Sustainable Development was first introduced by Brundtland Commission on Environment and Development and further the concept was expanded by United Nations Conference on Environment and Development in 1992 especially in the realm of Agenda 21, which stood its stand on the achievement of sustainable livelihoods as an expansive goal of poverty eradication.

According to Chambers and Conway (1992:7-8),"*A livelihood comprises the capabilities, assets (stores, resources, claims and access) and activities required for a means of living: a livelihood is sustainable which can cope with and recover from stress and shocks, maintain or enhance its capabilities and assets, and provide sustainable livelihood opportunities for the next generation; and which contributes net benefits to other livelihoods at the local and global levels and in the long and short term*".

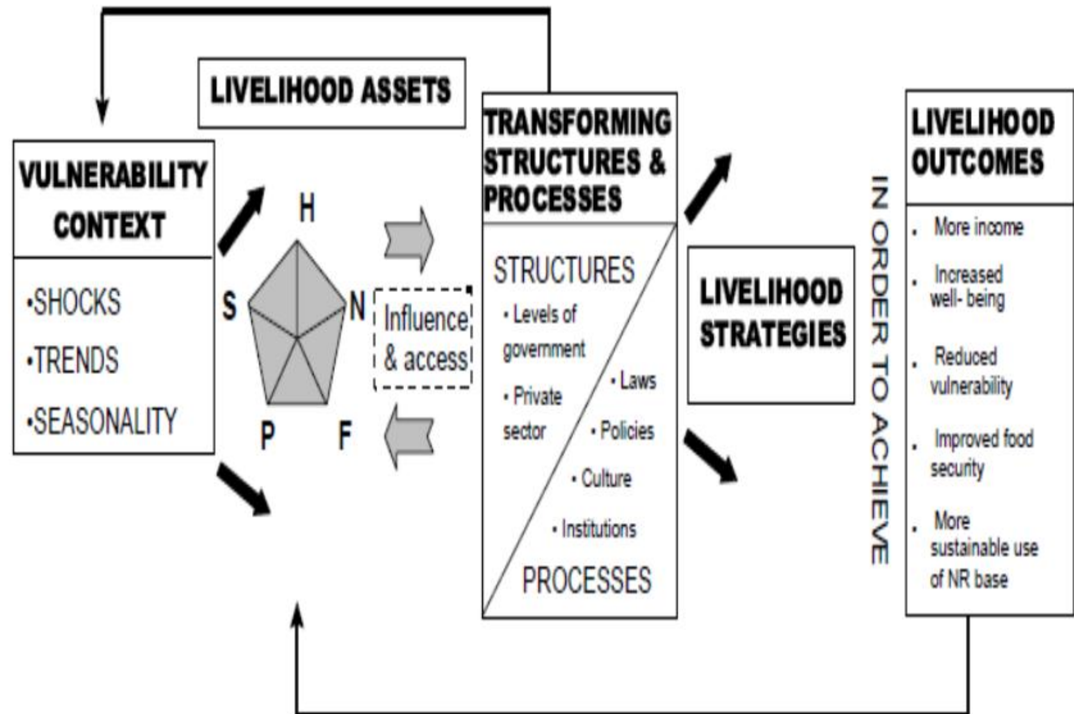
Generally, livelihood means a "way of living" but in development perspective livelihood means the mode people make a daily living. In short livelihood means "making a living". To make a way of living people mainly depend on income or income generating factors which includes aspects of food security (the ability to feed oneself and one's family), providing a home, health, security (reduced vulnerability to climatic, economic or political shocks, etc.), sustainability (the ability to continue to make a satisfactory living) and power (the ability to control one's own destiny), etc.

UK Department for International Development's (DFID) has the biggest aim of elimination of poverty in poorer countries. According to DFID, there are six main principles of livelihood approaches that can apply on poverty-focused development activity. They are: a) People-centred, b) Responsive and participatory, c) Multi-level, d)

Conducted in partnership, e) Sustainable and f) Dynamic (Ashley and Carney, 1999). The framework for livelihood analysis and its support to the design and management of intervention can be seen in figure below. The figure was design by DFID.

Figure 2

Sustainable livelihood framework



Source: Department for International Development's, 1999

To get in depth understanding of DFID's Sustainable Livelihood Framework, it is important to have a dynamic examination of the five components of the livelihood framework and their close relationship with each other. These components are vulnerability context, livelihood assets, institutions, policies and processes, livelihood strategies and livelihood outcomes

1) Vulnerability context refers the external environment in which people live and it includes trends, shocks, seasonality, over which people have limited or no control thereby influencing people 's livelihoods and their availability of assets. But it will be wrong to assume all the trends and seasonality as negative. Human being faces vulnerability when they counter harmful threat or shock with insufficient capacity to react efficiently.

2) Livelihood assets are the fundamental portion of the SLF within the vulnerability context. To achieve one's livelihood goals, people need a range of assets. Five types of assets defined in SLF are:

a) Natural capital: Natural resources such as land, forests, water, pastures, wildlife, biodiversity and wider environmental resources.
b) Physical capital: Privately owned assets such as houses, farm animals, tools, machinery, and vehicles; publicly owned economic infrastructure such as roads, transport, water, energy, communications and electricity supply; and social infrastructure such as schools and hospitals.
c) Financial capital: Cash income and savings, readily convertible liquid, supply of credit, remittances, pensions and wages.
d) Human capital: Health, nutrition levels, educational standards and skills, knowledge and ability to pursue, influence and work.
e) Social capital: The set of social relationships on which people can draw to expand livelihoods options: e.g., kinship, friendship, patron-client relations, relationships of trust, reciprocal arrangements, membership of formal groups, membership of organisations that provide loans, grants and other forms of insurance.

3) Institutions, policies and processes within the SLF form people's livelihoods. They perform their work at all levels and spheres i.e. from the household to the international level and from the most private to most public. They also have straight influence upon people own decision i.e. whether or not people have a feeling of inclusion and rights over resources.

4) Livelihood strategies are the blend of activities and choices that people undertake in order to accomplish their livelihood goals (including productive activities, investment strategies, reproductive choices, etc.). Livelihood approaches will try to recognize the strategies followed and factors behind people's decision making; to highlight the optimistic aspects of these strategies and mitigate against restraints. Farming, fishing, migration, business and self- employment are some of the examples of livelihood strategies. Livelihood strategies directly depend on asset status and policies, institutions and processes.

5) Livelihood outcomes are the outputs of livelihood strategies. Some good examples of livelihood outcomes are more income, improved food security, a feeling of

inclusion, physical security and peace, a secure job, shelter, good health, and a feeling of self-esteem.

1.7 Statement of the problem

Manipur has registered very high number of PLWHA. District wise, Imphal has the highest rate of PLWHA prevalence. Women were particularly vulnerable to HIV infection and other sexually transmitted diseases because of biological and socio-cultural factors. Nowadays, AIDS has not only the health, political or security crisis for women; it has been increasingly recognized as a livelihood crisis. The study aims at learning the vulnerability context that WLHA face in their day to day life to earn livelihood by using Sustainable Livelihood Framework (SLF- DFID, 1999). Considering world scenario, PLWHA chose to hide their status as coping mechanism to survive in the society since society already tag them as stigmatized group they keep their status hidden to protect themselves from the ill treatment. Majority WLHA chose negative internal coping strategy to lead a normal life in the society creating more problems to their health and threat to their life.

The study examined the livelihood strategies that WLHA adopt to make their livelihood. HIV/AIDS affect the most productive age groups i.e. person in the age of 15-50 years. According to International Labour Organization (ILO), the age group most severely affected by the virus was 25-35 years for females and 30-40 years for males (ILO, 2005). WLHA grieves lots of disadvantage and the problem was more when she became a widow. To support the family, they were forced to choose different hard working job which paid very low wage. Keeping in view of the issues faced by PLWHA, the study tries to understand vulnerability context and identifies the relationship between livelihood assets and strategies among WLHA. The present study further offers the suggestions for devising suitable intervention strategies to promote sustainable livelihood among the WLHA in north east of India.

1.8 Objectives

The objectives of the present study are as follows:

1. To understand the vulnerability context of WLHA;
2. To study the demographic profile of the WLHA in Imphal;

3. To assess the patterns of livelihood assets of WLHA;

4. To probe into the livelihood strategies of WLHA and;

5. To determine the relationship between livelihood assets and strategies among WLHA.

1.9 Chapter Scheme

The study is organised into following five chapters:

Chapter I: Introduction

Chapter II: Review of literature

Chapter III: Methodology

Chapter IV: Results and discussion

Chapter V: Conclusion and suggestions

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Trends of HIV/AIDS Epidemic

AIDS began to appear around the 'global village' in the early 1980s. Millions of people all over the world are newly infected every year by this disease. In this day and age, HIV/AIDS has been the burning issue in health sector. Till now there have been no vaccines that can purely cure HIV/AIDS. The only way to effectively control the level of HIV in the body would be by taking Anti- retro viral therapy (ART or ARV). In 2012, a report from UNAIDS stated that there were total 34.4 million PLWHA all over the world and out of this 2.1 million were children and the remaining were adults both males and females, and 2.5 million were newly infected with the virus.

In India, the first case of HIV was diagnosed by Dr. Suniti Solmon among female sex worker (FSW) in Chennai in 1986. The main factors which have contributed to India's large HIV-infected population were extensive labour migration and low literacy levels in certain rural areas resulting in lack of awareness and gender disparity, Injecting drug users (IDU's) and prostitution. To control the spread of the virus, the Indian Government set up the National AIDS Control Programme in 1987 to co-ordinate national responses to the disease.

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have five main components and they are vulnerability context, livelihood assets, institutions, policies and processes, livelihood strategies and livelihood outcomes.

OVERVIEW OF LITERATURE

Review of literature is a vital and important chapter in research as it highlights the literature related to selected field of study. It helps the researcher to understand the theoretical background of the study area thoroughly and identify the suitable dimension of the present study. Also it gives the idea of commonality or differences of diverse studies and the research gaps in the present study. It also helps to understand the appropriate methodology, research designs, methods of measuring concepts and techniques of analysis. It furthermore highlights the core importance of selected study area thus helping one to conduct a systematic study. The review of literature in present study includes diverse studies done by various researchers across the country as well as in the globe.

WLHA and their Livelihood strategies

Since time immemorial women were fighting for their rights which everyone was entitle to bear simply as a human being. Looking at the condition of women in Indian society, they were dominated by the men mostly due to our patriarchal system. But when the responsibility to look after their family comes women also takes full responsibility as their men counterpart does. Women were oppressed and look down by the society in terms of deprived by education, decision making and economic independence. They were always placed in vulnerable situation in every sphere of their lives. As she grows older and older her responsibility increases in the society, as women, mother etc. HIV/AIDS affect the livelihood of WLHA as the opportunities and possibilities available to them were snatched from them due to their positive status.

Ansell et. al (2016) conducted a study on AIDS affected young people's access to livelihood assets and skills in two southern African countries i.e. Malawi and Lesotho by employing SLF. It was found that Southern Africa suffers from world's highest adult HIV prevalence rates (UNAIDS, 2014). The epidemic affects the structures and processes of young people's livelihood assets. The researcher suggested that access to reliable information about livelihood opportunities were crucial both at broad and specific job opportunities levels.

According to Manipur State AIDS Control Society (MSACS), HIV/AIDS has been one of highly misunderstood and stigmatised disease in the state. Lamkang, Joshi & Singh (2016) carried a cross sectional descriptive study to assess and understand knowledge, attitude, behaviour and practice towards HIV/AIDS using random sampling in Chandel district, Manipur, India. The study found that the main causes of stigmatisation and misconception against HIV/AIDS and PLWHA in the region were due to the reliability of localities on socio-cultural and religious misconstructions over medical facts.

Laar et. al (2015) conducted a study on coping strategies of HIV affected households in Ghana. The study found that the main source of income in the region adopted by PLWHA household were petty trading, cash crop production, skilled trade and casual labour. The multiple coping strategies adopted by PLWHA household in the region were limiting portion size, reducing intake of meals per day, relying on less expensive foods, begging, eating outside and harvesting immature crop.

Pascoe et al (2015) conducted a research on poverty, food insufficiency and HIV infection and sexual behaviour among young rural Zimbabwean women. The relationship between poverty and HIV infection in sub-Saharan Africa were complex and has been the topic of discussion for recent years. The scenario of HIV prevalence among populations has change from the urban wealthy into impoverished and more rural populations (Mishra et. al, 2007; Wojcicki JM, 2005; Dodoo FN, Zulu EM & Ezeh AC, 2007; Johnson & Way, 2006; Hargreaves et. al, 2008; Hargreaves & Glynn, 2002). The need for economic support sometimes drive young female into early marriage and pose them in difficult situation to choose safer sex. Food insufficiency was also one of the reasons for women to choose high risk behaviours (Weiser et. al, 2011; Weiser et. al, 2007; Miller et. al, 2010).

Kerr (2015) analysed the effect of HIV/AIDS on food security and livelihoods in Sub-Saharan Africa. The book reveals that though AIDS creates many unwanted social condition such as increasing poverty, decreasing food production among population, the region has been neglecting the topic. The book effectively provides variation that existed in social dynamics at the individual, household and community levels.

Udobong R et. al (2015) conducted a study on the relationship between family support and coping strategy of women living with HIV/AIDS in Calabar. The study shows that there were noteworthy relationship between favourable social attitude and

coping strategy of WLHA in the region. The better the social condition the more the WLHA cope with the problem of the disease. The coping strategies of WLHA in the region are boost through favourable social attitude, proper and adequate care giving and proper exposure to communication.

Dam R (2013) conducted a study on experiences and livelihood strategies of poor people living with HIV/AIDS in Kolkata, India. The study brings out the substantial differences men and women living with HIV/AIDS experience regarding their illness and the impact on their day to day life. The research found that NGOs were one of the most helpful supports that help PLWHA to cope with their daily needs preventing them from becoming more susceptible and disadvantaged.

Women are economically, culturally and socially disadvantaged group in our society imposing several blockages to the access of treatment, financial support and education. Devi KM (2013) explore different situation they have been facing from various quarter in the society particularly stigma and discrimination. The study found that women have less access to job, low status in work place than men, and large number of women is subject to mental, emotional and physical cruelty making them more prone to HIV/AIDS. Further the study also identifies the unbearable condition WLHA face in their day to day life but also various steps government has undertaken to stop the disease.

Statement of the problem

Manipur has registered very high number of PLWHA. District wise, Imphal has the highest rate of PLWHA prevalence. Women were particularly vulnerable to HIV infection and other sexually transmitted diseases because of biological and socio-cultural factors. Nowadays, AIDS has not only the health, political or security crisis for women; it has been increasingly recognized as a livelihood crisis. The study aims at learning the vulnerability context that WLHA face in their day to day life to earn livelihood by using Sustainable Livelihood Framework (SLF- DFID, 1999). Considering world scenario, PLWHA chose to hide their status as coping mechanism to survive in the society since society already tag them as stigmatized group they keep their status hidden to protect themselves from the ill treatment. Majority WLHA chose negative internal coping strategy to lead a normal life in the society creating more problems to their health and threat to their life.

The study examined the livelihood strategies that WLHA adopt to make their livelihood. HIV/AIDS affect the most productive age groups i.e. person in the age of 15-50 years. According to International Labour Organization (ILO), the age group most severely affected by the virus was 25-35 years for females and 30-40 years for males (ILO, 2005). WLHA grieves lots of disadvantage and the problem was more when she became a widow. To support the family, they were forced to choose different hard working job which paid very low wage. Keeping in view of the issues faced by PLWHA, the study tries to understand vulnerability context and identifies the relationship between livelihood assets and strategies among WLHA. The present study further offers the suggestions for devising suitable intervention strategies to promote sustainable livelihood among the WLHA in north east of India.

Objectives of the study

- To understand the vulnerability context of WLHA;
- To study the demographic profile of the WLHA in Imphal;
- To assess the patterns of livelihood assets of WLHA;
- To probe into the livelihood strategies of WLHA;
- To determine the relationship between livelihood assets and strategies among WLHA.

Profile of the Study Area

The study was conducted among individual WLHA residing in core and peripheral area of Imphal district, Manipur. The respondents were within the age group of 18-50 years and the data was collected through MNP+ which is located at Yaiskul in Imphal East district.

Imphal is the capital city of the Indian state of Manipur. According to 2011 census, the total population residing in the district was 264,986 of which 128,931 were males and 136,055 were females. The city of Imphal has been divided into two parts i.e. Imphal East and Imphal West. Imphal district has its own core and peripheral contours. Since a high percentage of HIV+ cases were reported from Imphal district i.e. Imphal East and Imphal West, Imphal were taken up for the proposed study. So, individual WLHA within the age of 18-50 years residing in both the core and peripheral area from

the two districts were selected for the universe of the study and approached through MNP+ (NGO) personnel.

Manipur Network of Positive People (MNP+)

Manipur Network of Positive People (MNP+) is a state level community based Non-government Organisation established on 7th September, 1997 by five ex Injecting Drug Users (IDUs) who were living with HIV. The NGO is situated in Yaiskul Hiruhanba Leikai, Imphal East. It is a self-support group which help infected and affected people living with HIV/AIDS (PLWHA) and help them to overcome constraints and limitations and bring overall improvement especially in their lives and society in general. The organisation is registered under the Society Registration Act of 1989 on 14th December 1998 with the regd No. 62/M/SR of 1998 and registered under the FRCA 1976 and the number is- 194130232. The organisation works hand in hand with various other NGOs and CBOs operating in the field of HIV/AIDS. The main objectives of the organisation are: to facilitate and improve access to treatment for PLWHA, to provide access to information to PLWHA, to promote and protect the human rights of PLWHA, to promote involvement of PLWHA at all levels of decision making, to promote social acceptance of PLWHA and to end stigma and discrimination, to provide opportunities for networking for PLWHA.

Study Design

The study attempts to assess the patterns of livelihood adopted by WLHA in core and peripheral area of Imphal districts and analysed the livelihood strategies embraced by them. The study was cross-sectional in nature. To achieve the objectives of the study, exploratory research design was adopted. The study was based on both qualitative and quantitative approaches.

Sampling

The researcher identified 900 WLHA registered in the MNP+ including Imphal East and Imphal West districts. The selection of study unit was employed by using stratified disproportionate random sampling method. The samples were stratified on the basis of WLHA residing in core and peripheral areas considering their age group from 18 to 50 years of Imphal, Manipur. The samples were drawn at random disproportionately 80 in Imphal East and 80 in Imphal West districts respectively.

Ethical Considerations

- Prior permission was taken from the NGOs to carry out the interviews with WLHA.
- Respondents profile was made anonymous to respect their confidentiality.
- Informed consent was obtained from the WLHA before the interview was conducted.

Tools used for Data Collection

A structured interview schedule with both open ended and close ended questions was used for data collection. The primary data was collected from WLHA within the age of 18-50 years residing in core and peripheral area of Imphal East and Imphal West. In-depth case study with five WLHA and two focus group discussions (FGD) with 10 WLHA in each session from two districts was conducted.

Secondary data were collected from books, journals, articles, newspapers, NGO pamphlets, magazines, websites, etc.

Data Analysis and Interpretation

The quantitative data collected through interview schedule was processed through Microsoft excel and analysed with the help of SPSS package. Apart from these, simple percentages, cross tabulation and correlation were calculated for the analysis of data.

MAJOR FINDINGS

The major findings of the study are highlighted and divided into sections with its sub sections.

Profile of the respondents

The findings in the present study reveals that majority of the respondents in both the districts were from periphery area. The epidemic of HIV/AIDS knows no boundaries and prevalent in all the sections of women in society. Majority of the respondents belongs to the age group of 41-50 years while 18-30 years were the least number. The findings also indicated that majority of the Imphal valley was dominated by Hindus. Their education profile indicates that in both the districts respondents who studied till matriculate were the highest. Occupation plays an important role in supporting one's

livelihood. The majority of the respondents in both the districts were engaged in low paying job which required hard work. And half of the respondents in both the districts have monthly income between Rs. 2000-5000. The time period of the occupation for respondents in both the districts was highest who works for 2-5 years. Almost half of the respondents in both the districts have household who were headed by respondent herself and their annual income lies between Rs.50000-100000. More than half of the respondents in both the districts live under poverty line and belongs to economically deprived sections.

Marriage is regarded as a sacred bond for every living human being but this sacred bond has become the very means for resentment for the respondents. The findings reveal that majority of the HIV transmission takes place within the sanctity of marriage. Majority of the respondents in both the districts belongs to nuclear family and they have small and medium size families which comprises 1-6 family members. The findings further reveal that majority of the respondents in both the districts belongs to stable family and almost half of the respondent's household were headed by their husband. Almost half of the respondents in both the districts inherent the house from their elders. Majority of the respondent's family have land of their own and half of the respondent's family own below ½ acre of land. The findings also show that majority of the respondents in both the districts does not possess any property by their name and the reason behind it were due to the belief of family members that they would not live a long and healthy life

Vulnerability context of WLHA

The findings indicated that vast majority respondents choose hospital as their first time illness detection place since confidentiality to reveal their identity were kept secret and majority of the respondents in both the districts were living with the virus with more than six years which means they have very high chances of catching of AIDS (Varma, 2014). Majority of the respondents decided to go for HIV testing since their partner was infected by the virus. Majority of the respondents started to seek treatment due to their low CD4 count.

The findings further reveal that majority respondents have the chance to participate in the decision making of their household which in turn build the situation to bear equal trouble for running household and taking care of the aged and children. Majority of the respondents in both the districts have less than four family members

infected by the virus. Majority household in both the districts have one or more than one family member who was dependent on the respondent. Being an earning member the respondents enjoyed the privileges of financial independence and participation in decision making though they were not fully satisfied with their present social status.

Violence is a physical force unlawfully used toward a person's causing damage or injury. Majority in both the districts faced mental abuse, domestic violence and physical violence due to financial problem, being WLHA, husband alcoholic problem and unemployment were also supplementing in their life. However, there were no such cases of gender and sexual violence among the respondents in both the districts.

Patterns of livelihood assets of WLHA

The study reveals that majority of the respondents in both the districts faced economic challenges in meeting their daily expenses and providing better education for their children. Majority of the respondents in both the districts spend their expenditure in buying food and children education; and least was spend in buying cloths. Majority of the respondents received economic support from friends/family member/NGO/Government and the reason to get such support were to meet their daily expenses of the household. Majority of respondents in both the districts got care and support benefits from other organisations.

The findings revealed that almost half of the respondents in both the districts were engaged in other low income generating activities in addition to their main source of income to run their household. Majority of respondent's family member was engaged in income generating activities however half of the respondents have very poor cooperation of human resources in the family. Majority of respondent's main causes for challenges in household was due to financial problem.

Majority of the respondents in both the districts have skills of weaving and least skills of food processing and very least number of respondents has exposure to skills development program.

The findings further revealed that majority of the respondents in both the districts have good impressions from social networks and majority respondents belongs to one or other agency in the community. Majority of the respondents in both the districts got the same treatment as they were before infected by the virus from family and friends.

Majority of the respondents in both the districts were not at all affected by the perception of the community regarding their household. Vast majority of respondents in both the districts felt that support of religious groups/networks was good for their household and they did not feel excluded from associations in neighbourhood. Vast majority of respondents in both the districts own mobile phone for communication.

Livelihood strategies of WLHA

The study revealed that hundred per cent of the respondents in both the districts were affected by the virus and it was found that three fifth of the respondents have huge effect of illness on family. Majority of the respondents in both the districts have exposed their HIV status to everyone.

The findings also indicated that majority of respondents in both the districts cannot do hard manual work after their diagnosis. To cope with their livelihood majority of respondents adopted borrowing money from friends, working hard, starting petty business, selling belonging and help from extended family to sustain their household. Two fifth of the respondents in both the districts faced challenges due to the loss of loved ones and to cope with the situation most of them adopted embracing positive beliefs and spending time with close friends.

The findings further revealed that vast majority of respondents in both the districts received support from Government, extended family and NGO besides their family. Vast majority of respondents in both the districts received medical and counselling support from NGO or Government organisations. Vast majority of respondents in both the districts got help from NGO in the form of moral, physical, mental, medical, education, nutrition and financial support.

The correlation that was found in the study were the more WLHA spend their money on treating their illness, the more WLHA faced problem in providing food and shelter to their family. And the more WLHA unable to provide shelter and treat illness, the more WLHA have to work hard for their livelihood. It shows that to support their household WLHA have to involve them in hard working job which paid very less money. The analysis clearly depict that the respondents living conditions were very poor and pathetic in terms of shelter, food and treatment.

Another finding was that the more WLHA involved in semi-skilled work, the more WLHA have to struggle to earn their livelihood. The skills that WLHA possess were time consuming and need huge effort but to support their family WLHA engaged into such activities. Also the more WLHA link with social networks the better their support system. Social network help WLHA to build self-confidence and also to channel with other people in the community. Social network not only help them to socialise with people, it also help them in supporting their livelihood. Further, It shows that when WLHA were not having good physical capital and coping strategies.

CONCLUSION

In this current era, AIDS has been increasingly recognized as a livelihood crisis. The virus shows its huge impact on the lives of WLHA. Most of the women became the victim of the virus after they enter wedlock. HIV/AIDS affect the livelihood of WLHA as the opportunities and possibilities available to them are snatch from them due to their positive status. To support their family, they indulge themselves in hard working job which pay less money. Engagement of WLHA in such low paying job leads to financial dishevels which strongly affect their day to day existence. The main reason for facing problem in their household was due to financial constraint. WLHA spend most of their household expenditure on buying food, buying medicine and paying for their children's education. As a woman they have to look after their family member and take responsibility on guiding their children to lead a good lifestyle. To lead a healthy and meaningful life they choose different positive coping mechanisms such as optimistic planning and social networking with members of the community either HIV (+) or HIV (-).

SUGGESTIONS

HIV/AIDS is a very sensitive issue and those who are affected with virus should be handled with love, care and affection. Women battling with HIV/AIDS especially those belonging to the downtrodden section of the society face dilemma to earn their livelihood.

- Spreading awareness and sensitizing women about HIV/AIDS is very important since most of the HIV transmission took place within the sanctity of marriage. Most of the women become the victim of this virus at very young age because of

their husband/spouse/partner enticed them into marriage without informing them about their illness.

- Education plays an important role in choosing one's occupation. The current research found that most of the respondents studied till matriculate hence posing hindrances in taking well paid job. So providing and making them access to proper education is essential step in helping them sustain their livelihood.
- Social networks play an important part in socializing and interacting them with other people in community whether HIV $^{(+)}$ or HIV $^{(-)}$. Expanding social network will boost self-confidence for respondents and help them overcome their difficulties.
- Poverty is the main causes of financial constraint in respondent's livelihood. The study found that maximum respondents face problem in providing proper education to their children. So, the NGOs and GOs need to make special provision which focus on PLWHA children education and help them flourish in their respective chosen field.
- Social workers can play a significant role in sensitizing WLHA about various schemes and programmes which are especially available for poorest of the poor families so that they can get accessed to the services available for them.
- Health is one of the important aspects of WLHA in sustaining their livelihood. Most of the respondents in the present study have low CD4 count. Therefore they cannot indulge themselves in hard manual work. So, acknowledging their needs the policy maker should include strategy which promote livelihood for WLHA.
- From the study, the Karl Pearson co-efficient test show that the respondents living condition were very poor and pathetic in terms of shelter, food and treatment. Moreover, financial capital, human capital, social capital and physical capital were showing significant relationships towards unhealthy living conditions for their livelihood. Therefore, the sustainable livelihood framework would be applied in order to promote and strengthen for the betterment of WLHA.
- Livelihood assets and livelihood strategies vary according to one's habitation. The present study focus on livelihood of WLHA residing in plain areas only so further research can be conducted on livelihood of PLWHA residing in hilly areas of Manipur and also compared the difference between two areas.

CHAPTER II

REVIEW OF LITERATURE

Review of literature is a vital and important chapter in research as it highlights the literature related to selected field of study. It helps the researcher to understand the theoretical background of the study area thoroughly and identify the suitable dimension of the present study. Also it gives the idea of commonality or differences of diverse studies and the research gaps in the present study. It also helps to understand the appropriate methodology, research designs, methods of measuring concepts and techniques of analysis. It furthermore highlights the core importance of selected study area thus helping one to conduct a systematic study. The review of literature in present study includes diverse studies done by various researchers across the country as well as in the globe.

2.1 WLHA and their Livelihood strategies

Since time immemorial women were fighting for their rights which everyone was entitle to bear simply as a human being. Looking at the condition of women in Indian society, they were dominated by the men mostly due to our patriarchal system. But when the responsibility to look after their family comes women also takes full responsibility as their men counterpart does. Women were oppressed and look down by the society in terms of deprived by education, decision making and economic independence. They were always placed in vulnerable situation in every sphere of their lives. As she grows older and older her responsibility increases in the society, as women, mother etc. HIV/AIDS affect the livelihood of WLHA as the opportunities and possibilities available to them were snatched from them due to their positive status.

2.2 Vulnerability context of WLHA

According to Manipur State AIDS Control Society (MSACS), HIV/AIDS has been one of highly misunderstood and stigmatised disease in the state. Lamkang, Joshi & Singh (2016) carried a cross sectional descriptive study to assess and understand knowledge, attitude, behaviour and practice towards HIV/AIDS using random sampling in Chandel district, Manipur, India. The study was performed with 100 non-HIV participant using semi-structure interview. The study found that the main causes of stigmatisation and misconception against HIV/AIDS and PLWHA in the region were due

to the reliability of localities on socio-cultural and religious misconstructions over medical facts. The study advises that the socio-religious leaders need to be properly sensitised about the disease because they play an important role in influencing the perception and behaviour of localities towards HIV/AIDS.

Batte et. al (2015) conducted a study on disclosure of HIV test results by women to their partners among slum dwellers in Kampala, Uganda. Disclosure of HIV sero-status of pregnant women to their sexual partners was the key to prevention of HIV transmission to partners and unborn baby (Medley A, Garcia-Moreno C, McGill S & Maman S, 2004). WLHA who disclose their HIV status during ANC received more financial and emotional support, freedom to use their HIV drugs before the person they disclose to and freedom to choose feeding option for her unborn baby. The disclosure of HIV status also places them to certain vulnerabilities such as facing discrimination and stigma from neighbours, friends and relatives (Joge et. al, 2013). Reduced in social support, blame for testing without partner's consent and separation or divorce were other outcomes for disclosure of their HIV status. Such negative impact for their disclosure of HIV status affects the livelihood of WLHA.

Hancock, Myezwa & Carpenter (2015) conducted a study on disability and living with HIV in South Africa. From many years HIV has been one of the most challenging issues of health sector in southern Africa. Free access to lifesaving antiretroviral treatment (ART) has increased in the region over the last ten years. Through access to ART, AIDS related deaths have declined and life expectancy and quality of life in the region have improved (Nixon SA, Hanass-Hancock J, Whiteside A & Barnett T, 2011; Deeks SG, Lewin SR & Havlir DV, 2013). But long term living with HIV comes with different forms of disabilities and HIV related co-morbidities (Deeks SG, Lewin SR & Havlir DV, 2013; Banks LM, Zuurmon M, Ferrana R & Kuper H, 2014; Hanass-Hancock J, Regondi I, Egeraat Lv & Nixon S, 2013). As the HIV epidemic progresses into a chronic illness, rehabilitation interventions must become a part of the standard package of care and support in the region and it is not only to prevent or mitigate disability, but also to enable people on ART to build livelihoods and live a life with the greatest possible function and wellness.

Paudel and Baral (2015) conducted a study on WLHA who were battling with stigma, discrimination, denial and their coping with HIV/AIDS by using online databases

through the library search engine (NORA) at Northumbria University. Women has increasingly place at the higher risk of getting infected with HIV due to their biological susceptibility, low socio-economic status, dominant sexual practice of males and epidemiological factors (Pratt RJ, 1998; Campbell C, 1999; De Bruyn M, 1992). Women vulnerability to coerced sex both in marital and non-marital rape, sexual abuse in and outside the family makes very difficult for them to protect themselves from STIs including HIV infection (Vetten L & Bhana K, 2001; Pratt RJ, 1998). WLHA bears 'triple jeopardy' in the society as person infected with HIV, as mothers of child and as carers of partners, parents or orphans with AIDS (Campbell C, 1999). Millions of WLHA have been rejected from their family, friends and partners and thousands have lost their lives and thousands have been unable to live their life (Berer M & Ray M, 1993; Dane B, 2002; Marcenko MO & Semost L, 1999).

The stigma faced by WLHA were associated with rejection from friends and family, society, feelings of uncertainty and loss, low self-esteem, fear, anxiety, depression and suicidal ideation (Green L, Ardon C & Catalan J, 2000; Heath J & Roadway MR, 1999; Crossley M, 1998). Coping with HIV/AIDS related stigma and discrimination has always been a difficult task for women. The needs and concerns for WLHA can be best addressed with support groups (Marcenko MO & Semost L, 1999). Support groups offer supportive environment for WLHA to express their suppressed feelings in the company with other HIV positive women. Support groups also provide sharing strategies for securely disclosing their HIV status, builds a network of friends to socialise with and provide emotional support (Lennon-Dearing R, 2008; Siebert MJ & Dorfman WL, 1995). Gray (1999) in their study argued that support groups empowered WLHA and helps them to improve their life both in physical and emotional ways.

Kerr (2015) analysed the effect of HIV/AIDS on food security and livelihoods in Sub-Saharan Africa. The book reveals that though AIDS creates many unwanted social condition such as increasing poverty, decreasing food production among population, the region has been neglecting the topic. Many scholars have conducted numerous studies in the region on the relationship between HIV/AIDS, food security and livelihoods (e.g., Gillespie 1989; Rugalema 2000; Kalipeni et. al, 2004; Niehof 2004; Peters et. al, 2008). The author has given special focus on Eastern and Southern Africa in the study because of their high rates in HIV/AIDS. The author has pointed out that in order to get in-depth understanding of the epidemic and its interactions with rural livelihoods; one has to

examine the specific local context. The book effectively provides variation that existed in social dynamics at the individual, household and community levels.

Suresh et. al (2014) conducted a retrospective cross sectional record based study on the socio-demographic characteristics, family status, mode of transmission and clinical characteristic of HIV/AIDS patient's attending ART centre at MGM Hospital, Warangal district, Andhra Pradesh, India. The study selected 139 HIV+ patients out of which 106 were males and 33 were females. The study found that high prevalence of HIV was found in the age group of 31-40 years and their main mode of transmission is through heterosexual mode. Majority of patients were labourers and married, having annual income less than Rs. 25,000 and they were neglected by other family members.

Chitra L, Jayalakshmi L & Vinod R (2014) has carried a study on stigma of WLHA in Coimbatore district, Tamil Nadu, India with 43 WLHA. By using standardised Berger scale four domains of stigma i.e. personalized stigma, disclosure stigma, negative self-image and public attitude stigma were calculated. A high level of stigma was found for disclosure stigma and least was found for negative self-image. The study shows that financial stability and higher socioeconomic status among WLHA decreases the possibility of abandonment by their partner and family that leads to the increasing rate of disclosure of their status.

Blessed NO and Ogbalu AI (2013) made a clinical based study on experience of HIV-related stigma by PLWHA based on gender in Owerri, Imo States, Nigeria. The study found that stigma related with HIV was universal but stigma faced by each individual differs. The study identified four forms of stigma experience by PLWHA i.e. internalized stigma, disclosure stigma, public attitude stigma and negative self-image stigma. The study were conducted with 1552 HIV positive person including 626 males and 926 females by using purposive sample and Berger stigma survey questionnaire. The study further found that both males and females experience stigma but internalized, disclosure and negative self-image stigma faced by females is higher than males thereby making significant difference on gender. The study proposes various recommendations to protect the rights of HIV positive women.

Women are economically, culturally and socially disadvantaged group in our society imposing several blockages to the access of treatment, financial support and education. Devi KM (2013) explore different situation they have been facing from

various quarter in the society particularly stigma and discrimination. India has the third largest HIV positive cases in the world and the rise of women infected with the virus continue to increases than that of men. Women have less access to job, low status in work place than men, and large number of women is subject to mental, emotional and physical cruelty making them more prone to HIV/AIDS. Further the study not only identifies the unbearable condition WLHA face in their day to day life but also various steps government has undertaken to stop the disease.

The study by Ramjee G and Daniels B (2013) found that in sub-Saharan Africa women bear huge burden of HIV epidemic. In 2011, 92 per cent of pregnant WLHA were residing in the region. Several factors contributing to the heart wrenching scenario among women is due to biological, social, behavioural, cultural, economic and structural norms prevailing in the region. In Africa, the dominant patriarchal culture and norms worsens the inferiority of women and their distinct health status. Women are not considered as important and their sexual decision making were neglected and they were not allow to express their sexuality (Duffy L, 2005; Buve A, Bishikwabo-Nsarhaza K & Mutangadura G, 2002). The deterioration of education, health and other social services causes a loss of opportunities for HIV prevention among women (Buve A, Bishikwabo-Nsarhaza K & Mutangadura G, 2002).

Institutionalized economic disparity makes women to financially dependent on men creating unfavourable condition for them to keep away from the reach of money, land and other resources and also more likely to practice transactional sex, less likely to negotiate sex safe or condom use with a partner and more vulnerable to violence (UNAIDS, 2013; Ackermann L & Klerk GW, 2002; Pettifor AE et. al, 2004; Gupta GR, 2002; Leclerc-Madlala, 2008).

Dangmei T (2011) conducted a study on lived experiences of women living with AIDS in Manipur, India. The study was cross cultural and conducted among WLHA in the state. She discussed numerous difficulties faced by them in the society regarding their status and the overwhelming need to cope with the experience of stigma. AIDS related stigma is one of the negative outcomes they face in the form of violations of social, economic and political rights, including access to health care. She found that most widow after their death choose orphan home as their children safety net.

A study on HIV+ pregnant women in Churachanpur district, Manipur was conducted with 250 WLHA, 115 being pregnant women at the time of interview and 135 already delivered were selected using interview schedule, focus group discussion and in-depth interviews. Laltlinzo G (2011) in their study assessed the knowledge on various experiences faced by HIV+ pregnant women in the district that will help policy makers and health sector service provider to notify their condition and help them to improve their reproductive choices, health care and well-being. The study further specifies their socio-economic background, worries and concern and also strength and limitation of the prevailing services for them.

The study also found that married HIV+ women in the child bearing age group were very vulnerable because of their low status in society and also their belonging to low income group household. Further, the study reveals that most of the respondents were illiterate or lesser educated making them more prone to economic insecurity and discrimination. The study also found the important role play by PPTCT programme in prevention of caring for pregnant women.

A study by Devi RL (2010) on assessment of HIV+ widows in Imphal districts of Manipur with main emphasis on problem of HIV+ widows regarding their background, family relationship, health care, urban and rural setting, self-perception were conducted. The study were led with 226 HIV+ widows of IDUs, 94 HIV+ widows from Imphal East and 132 HIV+ widows from Imphal West district belonging to urban and rural area using interview schedule and SMSP. The study identified different problematic areas of the rural and urban HIV+ widows. The study further reveals that majority of the respondents got married between the age of 20-25 years and majority number of widows have an educational qualification of under-matric and as per occupation was concerned the most respondents were self-employed. Maximum number of widows belongs to a very low income level which makes “seeking help from others” and “praying to almighty” their coping strategies with difficulties.

Varma (2010) had analysed the HIV pandemic in India from the gender perspective. He reviews the status of women in India regarding their effect by HIV epidemic. The book brings out various hindrances among women infected and affected by HIV face in the society. There were widespread rejection, stigma, discrimination and hatred towards the HIV infected and affected women in the society making them more

vulnerable in accessing health care, counselling, policy and programme specially made for them. The study makes an attempt to point out universal issues related with HIV positive women and give recommendation to improve all-inclusive policies and plans of action for their development.

Arrehag L et. al (2006) conducted a study on the impact of HIV/AIDS on the economy, livelihoods and poverty in Malawi. The authors pointed out numerous factors liable for the high prevalence of HIV/AIDS. Gender disparity, demotion of women in sexual relation, harmful traditional practices were among the dynamic forces for the spread of disease. The rates of HIV prevalence was higher among women as compared with men and compared with cities the prevalence rate were much higher in rural area. The study found that HIV/AIDS hits the most productive age group giving negative impact on supply of labour.

The cultural aspect of the spread of HIV/AIDS continues in Africa (Merten and Haller, 2006). In the context of HIV/AIDS, women's sexual behaviour was the core concern (Lugalla et. al, 2004). In the past, practices such as widow inheritance, compensatory adultery and arranged extra marital relationships for women (lubambo) have been accepted in Kafue Flats of Zambia (Smith & Dale, 1968). Local health and development professional's belief that such traditions were responsible for occurrence of sex trades and spreading of HIV in the region. Merten and Haller, (2006) in their study discuss that traditional institutions were responsible for the spread of HIV/AIDS in Kafue Flats. The study found that female fish traders was the main host of spreading HIV in the region and point out that fish for sex exchanges were not traditions but an economic opportunity choose by fish trader in conditions of poverty and changing livelihood.

A research on HIV/AIDS in Manipur was conducted by Irengbam R (2005). The study explores the demographic scenario, institutional responses and status of PLWHA in the state. The study used 200 respondents from five NGOs using questionnaire, snowballing sampling method and in-depth interview. The study found that mode of transmission in the state was mostly due to IDUs and the seropositivity rate among IDU was 58.52 per cent (MSACS, 2001). The study reported that Imphal district has the highest number of HIV positive cases followed by Thoubal district and the least number of HIV positive cases were from Tamenglong district in the state (MSACS, 2001). A response from policy makers shows that majority of drug abuser was heroin users in the

state and mostly they were from broken family. The study further found that most of the HIV infected person was from low middle class family.

Gostin (2003) thoroughly examined the major social, political, economic and ethical issues related with the disease in the globe. The study found that women and girls were especially vulnerable to the disease. Women may be deprived from her credits, distribution networks or land rights if her husband abandon her or dies. Therefore improving the status and strengthening of their social, political and economic rights would allow them to protect themselves not only from HIV/AIDS but also from other health threats.

HIV/AIDS has been truly a global epidemic and the impact of disease was rampant throughout the world affecting health, communities, and countries economic structures (Gostin, 2003). Ninety per cent of PLWHA live in developing countries (UNAIDS & World Bank, 1999) which can least meet the expense of the sickness, death and loss of productivity related with the epidemic. Across the globe, African continent has experienced the worse impact of the disease. The epic tragedy of HIV/AIDS in Africa and other regions in the world was intensified by simultaneous catastrophes of famine and armed conflict (Annan KA, 2002). The pandemic destroys the families and social networks, lessening economic growth and creates a destructive environment for the future. HIV/AIDS generates poverty, sense of vulnerability and hopelessness to the infected and affected people. United States of America has declared HIV/AIDS as national security threat (Gellman B, 2000).

2.3 Patterns of Livelihood assets of WLHA

Ansell et. al (2016) conducted a study on AIDS affected young people's access to livelihood assets and skills in two southern African countries i.e. Malawi and Lesotho by employing SLF. The researchers employed "New Variant Famine" hypothesis in their study. The hypothesis suggested that AIDS were responsible for food insecurity in southern Africa. Southern Africa suffers from world's highest adult HIV prevalence rates (UNAIDS, 2014). de Waal and Whiteside (2003) has suggested four drivers for food scarcity: changing dependency patterns, loss of assets and skills, an increased burden of care and the vicious interaction between AIDS and malnutrition. Among the four drivers, second driver has the most likely chances to threaten young people long-term food security. AIDS reduces young people's access to assets and skills in various ways. For

example, when the parents of young children die in family, the children sold their livestock and equipment to fund medical and funeral costs for their parents (Kimaryo et. al, 2003; Munthali and Ali, 2000). The epidemic affects the structures and processes of young people's livelihood assets. The researcher suggested that access to reliable information about livelihood opportunities were crucial both at broad and specific job opportunities levels.

Pascoe et. al (2015) conducted a research on poverty, food insufficiency and HIV infection and sexual behaviour among young rural Zimbabwean women. The relationship between poverty and HIV infection in sub-Saharan Africa were complex and has been the topic of discussion for recent years. The scenario of HIV prevalence among populations has change from the urban wealthy into impoverished and more rural populations (Mishra et. al, 2007; Wojcicki JM, 2005; Dodoo FN, Zulu EM & Ezeh AC, 2007; Johnson & Way, 2006; Hargreaves et. al, 2008; Hargreaves & Glynn, 2002). The need for economic support sometimes drive young female into early marriage and pose them in difficult situation to choose safer sex. Food insufficiency was also one of the reasons for women to choose high risk behaviours (Weiser et. al, 2011; Weiser et. al, 2007; Miller et. al, 2010). Among young rural Zimbabwean women, indicators of lower socio-economic status were associated with lower educational attainment, earlier marriage, higher rates of symptoms of depression and anxiety and suicidal ideation. Poverty has been associated with many factors which drive HIV risk behaviours. Many researcher have a notion that 'HIV is a disease caused by poverty' (Gillespie S, Kadiyala S & Greener R, 2007; Piot P, Greener R & Russell S, 2007; Shelton JD, Cassell MM & Adetunji J, 2005).

Winniefred N (2015) explored the livelihood of female headed household in Namuwongo slum of Kampala, the capital city of Uganda. The result for female headed household was due to male migration, death of male partners, conflicts and separation and divorce, etc (Chant, 1997; Horrell & Krishnan, 2007; O'laughlin, 1998). Several studies show that women took help from their relatives as a survival strategy (Lokshin et. al, 2000; Ruwanpura, 2003). A study in the cities of Boston, Chicago, Charleston and San Antonio in USA revealed that many single mothers opted extra part time job for the survival of their families (Edin & Lein, 1997). In Zimbabwe, HIV/AIDS changed the structures of household and main reason behind was HIV/AIDS related deaths of male partners (Horrell & Krishnan, 2007). To access proper health care and nutrition, HIV+ female headed household often sold their property (Kanyamurwa & Ampek, 2007).

Winniefred N (2015) in the study further found that to secure human capital female headed household have given more priority to medical care and children education and for natural capital they opted farming as their survival strategy. To secure financial capital they involved in petty trade, casual labour, brewing of alcohol and renting house to generate income. To transform the livelihood of female headed household NGOs and social networks were big help.

The right to livelihood was fundamental to both men and women around the world. It was the right to enjoy a dignified life. Above all, it was the right that is embraced by women around the globe, who often face obstacles to livelihood and pursue equal opportunities to grasp their rights (PWESCR, 2011). At World Social Forum, the issues related with the emerging definitions of right to livelihood has been discussed and broken down into three categories: a) the right to food and issues related with food such as food security, food sovereignty and food production including agriculture and seeds; b) access to and ownership and control over natural resources like land, water and forests; and c) issues related to markets, a space to trade both goods and services, and recognition of the fact that participation in markets requires education, skills and credit (PWESCR, 2009). Right to livelihood was particularly important for women ability to realise other rights.

Rodrigo C and Rajapakse S (2010) in their study found that women in some societies were more vulnerable and place at disadvantage segment as compared with others because of extreme poverty, submissive gender norms limiting freedom, higher prevalence of violence and very few privileges in terms of employment and education. Giving preference to HIV in developing world, it was reasonable to conclude that HIV has been the disease of poorer countries but it would be important to analyse the dynamic of relationship between poverty and HIV. Mishra et. al (2007) report on national survey of eight sub-Saharan countries show that as the wealth increase, HIV positivity increase. Poverty prevents female children from accessing education therefore limiting their employment opportunity in future (Coker AL & Richter DL, 1998).

The positive impact of education in minimising HIV risk behaviour has been illustrated in many parts of the world and especially Africa. Many interventions have shown that educated female benefit more than educated male in minimising risk behaviour and gaining knowledge (Gavin et. al, 2006). HIV itself has been a cause of

poverty for those affected by HIV. HIV can disturb household economy in two ways i.e. direct costs including attributable to drugs, illness related issues, funerals; and indirect costs including loss of work, loss of productivity of both caregivers and patients, loss of productivity due to untimely death. Wyss K, Hutton G & N'Diekhor Y (2004); Kumarasamy N et. al, (2007) studies shown that direct costs due to drug related expenditure disturb household economy more than indirect costs.

Yadav S (2010) made a cross sectional study based on PLWHA on perceived social support, hope and quality of life in Nepal. The study selected 160 HIV infected persons getting treatment, care and support from eight community based NGOs. WHO (QOL)-26 tool, Sarason's social support questionnaire were used for the study. The study found that non family support network was greater than family support network. Harris and Larsen (2007) suggest that non family members like health workers, counsellor, volunteers and friends play an important role in providing information and tangible support for livelihood and treatment of PLWHA. The study further implies that social support has great impact on all the realms of hope and quality of life. Furthermore, the study found that socio-cultural factors may affect the social support, hope and quality of life in WLHA.

Parker et. al (2009) conducted a study on HIV/AIDS epidemic looms economic, social and environmental sustainability throughout the sub-Saharan Africa. The study was qualitative nature and explored the relationships between HIV/AIDS, labour availability, agricultural productivity, household resources, food consumption and health related issues in rural south-eastern Uganda. The study state that there were increase in widow and orphan headed households because of the disease. Due to illness there were shortage of labour, degradation of household resources, loss of land tenure and assets and also changes in agricultural productions and practices particularly for widows and orphans. The study further highlights the possible downward spiral of livelihood deprivation for HIV/AIDS affected household.

Alemu A and Bezabih T (2008) explored the impacts of HIV/AIDS on households affected by HIV/AIDS in rural Ethiopia. The study adopted SLF developed by DFID and conducted in four regions of rural Ethiopia i.e. Tigray, Amhara, Oromiya and Southern Nations, Nationalities and Peoples' Region (SNNPR). The study covered total of 1245 households in which 620 household were affected by HIV/AIDS and remaining 625 were

non HIV/AIDS affected household. Questionnaires, interviews and community focus group discussion were held to get in-depth information for the severity of coping strategies adopted by household in each region.

The study in Alemu A and Bezabih T (2008) found that AIDS affect the quantity and quality of productive labour in each four region of rural Ethiopia. In the study, it was found that most of the household spend their expenditure on buying food items. Female headed households have better dietary diversity as compared with male headed households. The study further highlights various coping strategies employed by the household such as consumption strategies, expenditure strategies, income strategies and migration strategies and it was found that most of the household affected by HIV/AIDS adopt negative consumption related coping strategies such as skipping meals.

Berg E and Ndlela M (2008) conducted a study on the impact of HIV/AIDS on rural livelihood in Swaziland with special emphasis on women. The study gives main emphasis on exploring the implications of HIV/AIDS on rural livelihoods and special importance was given to the prevailing gender gaps in the region. HIV/AIDS has been the major threat to rural livelihood, human security and more specifically to the livelihood of women. HIV/AIDS continues to be a devastating crisis showing its deep impacts on social, cultural and economic aspect of the nation. The epidemic has been responsible for the declining life expectancy, domestic household income and labour in the society. The epidemic affects the most productive group in the society i.e. between 15-50 years of age.

Studies have shown that the rate of HIV/AIDS among women was indeed higher than men in the Swazi society and the main reason contributing to such disheartening gap were due to cultural practices prevalent in the society. The major cultural practices that magnify women's vulnerability to HIV/AIDS in the society were Sitsembu (Polygamy), Kungena (wife inheritance), Kuhlanta (a younger sister having children with her infertile sister's husband), Bunganwa (having multiple female partners), Kujuma (occasional short term or overnight visits between unmarried lovers) and Kulamuta (having sexual relations with the younger sisters of one's wife). In Swazi society, the effects of HIV/AIDS were felt in all levels in the form of many deaths in families, increased number of orphans, loss of labour and huge loss on resources.

A report from United Nations World Food Programme (2008) analysed the impact of HIV/AIDS on the infected or affected person by the virus using sustainable livelihood

framework. Sustainable livelihood in the context of HIV/AIDS points out that illness and deaths because of AIDS have both immediate and long term impact on household and communities vulnerability to food security. The report further bring out that livelihood assets are often negatively impacted by AIDS and livelihood strategies are usually adapted in response to HIV/AIDS but the strategies can barely avoid the increase in poverty and food insecurity leading to increase in HIV/AIDS vulnerability.

Several studies that adopted SLF found that HIV/AIDS had noteworthy impacts on all capital assets. HIV/AIDS erodes human capital as it lessens labour and decreases productivity in the household. It further affects financial capital by providing less income and more expenses and impact on social capital was huge as it pushed social institutions and customs. For natural and physical capital, HIV/AIDS affects their land tenure rights creating changes in land use pattern and neglecting productive and common property assets (Harvey, 2004).

Masanjala (2006) conducted a study on nexus between poverty and HIV/AIDS in Africa using sustainable livelihood framework. The study found that the effect of AIDS on livelihood outcomes is deep and diverse. The study further found that the most immediate impact of HIV falls on human capital therefore generating new poverty in HIV affected households owing total credit to the illness. AIDS epidemic also negatively impact financial capital of household creating people to used their savings, borrow money, take additional debt at penal rates of interest or searching for additional source of income (Koestle, 2002). The study also found that AIDS induced transformation may not only worsen pre-existing gender inequalities but the loss of breadwinner may result in the dissolution of the entire household. In rural Africa, vulnerability context includes the lack or small size of land holdings, reliance on rain-fed subsistence agriculture and seasonality of income and reliance on a narrow range of income sources (Ellis and Alderman, 2002; Ellis, 1998; McDonagh, 2002). The study illustrates that although AIDS may not be a disease of poor but the determinants of the epidemic go far beyond individual choice and some extents of being poor increase risk and vulnerability to HIV.

Seeley J (2002) conducted a study on the HIV/AIDS epidemic with special reference to livelihood framework. The study shows the overall impact of the epidemic on livelihood of PLWHA. The study highlighted the effect of epidemic on financial, economic, social and physical capital of people infected and affected by the disease.

HIV/AIDS touched every sphere of livelihood framework. The author stressed that PLWHA not only deal with their illness but they too also have to maintain and support their livelihood. In major parts of the world, caring for people living with AIDS related illness were the unpaid and compulsory work for women. The study further highlighted the impact of the disease on the lives of PLWHA and the author has given its view on improving the policies of HIV/AIDS related health aspects on local, regional and national levels.

2.4 Livelihood strategies of WLHA

Laar et. al (2015) conducted a study on coping strategies of HIV affected households in Ghana. HIV disrupts the livelihoods of infected person as they often lose their ability to work and generate income (Ivers et. al, 2009). The relationship between HIV and food insecurity often causes individuals and households to adopt negative, undesired, unsustainable and irreversible coping strategies (Oldewage-Theron WH, Dicks EG & Napier CE, 2006; Ivers & Cullen, 2011). Strategies often adopted by PLWHA include saling assets, drop-outs of children from school, migrating and engaging in transactional sex (Gillespie S & Kadiyala S, 2005; Ivers et. al, 2009; Gillespie S, 2008). The study found that the main source of income in the region adopted by PLWHA household were petty trading, cash crop production, skilled trade and casual labour. The multiple coping strategies adopted by PLWHA household in the region were limiting portion size, reducing intake of meals per day, relying on less expensive foods, begging, eating outside and harvesting immature crop.

Udobong R et. al (2015) conducted a study on the relationship between family support and coping strategy of women living with HIV/AIDS in Calabar. The study used questionnaire, focus group discussion and in depth interview techniques among 160 randomly selected WLHA. The study highlights that at the end of 2012, there were estimated 52% WLHA residing in low and middle income countries (UNAIDS, 2013). Women were especially vulnerable to the virus because of certain factors such as biology of the virus, anatomy of the female genital tract and socio-cultural traditions. Traditional practices such as polygyny that was prevalent in the region increases the exposure of virus among women. The study shows that there were noteworthy relationship between favourable social attitude and coping strategy of WLHA in the region. The better the social condition the more the WLHA cope with the problem of the disease. Furthermore,

there were significant relation found between effective communication (exposure to information) and coping strategy of WLHA. Exposures to information improve social interaction and support women to cope successfully with the virus. The coping strategies of WLHA in the region are boost through favourable social attitude, proper and adequate care giving and proper exposure to communication.

Dam R (2013) conducted a study on experiences and livelihood strategies of poor people living with HIV/AIDS in Kolkata, India. The study was based on the urban area poor PLWHA. The study found that most studies conducted so far on household livelihood strategies concentrated on rural area somewhat bypassing urban contexts, especially in urban India. India accounts for half of the Asia's HIV epidemic, with an estimated 2.4 million PLWH at the end of 2010 (UNAIDS, 2011). Semi structured interview were used to collect data from 59 men and women living with HIV/AIDS in Kolkata. In the study, coping strategies can be classified into two groups such as 'Positive external coping' and 'Negative internal coping'. To lead a healthy and meaningful life PLWHA choose different coping mechanisms including 'Positive external coping' such as dealing with stigma, optimistic planning and social networking with members of the HIV community and 'Negative internal coping' such as secrecy, negative rumination and self-isolation (Jenkins & Guarnaccia, 2003). Commonly, PLWHA prefer keeping their status secret as coping strategy to be accepted as a member of their society causing them more vulnerable and impoverished towards their livelihood (Thomas, 2006; Greeff et. al, 2008). The study brings out the substantial differences men and women living with HIV/AIDS experience regarding their illness and the impact on their day to day life. The research found that NGOs were one of the most helpful support that help PLWHA to cope with their daily needs preventing them from becoming more susceptible and disadvantaged.

Depression was common among PLWHA and played a key role in deteriorating HIV related outcomes, including AIDS related death (Tsai et. al, 2012). Current research has found that food insecurity, defined as having uncertain or limited availability of nutritionally adequate food or as being unable to procure food in socially acceptable ways (Anderson, 1990), may be consider as a risk factor for depression that can be modified to increase HIV outcomes.

Numerous cross sectional studies have identified a link between food insecurity and depression among PLWHA (Anema et. al, 2011; Vogenthaler et. al, 2011; Wu et. al, 2008). Especially for those women who engaged in subsistence livelihoods to support their household (Quisumbing et. al, 1995), food insecurity may be even more strongly associated with depressed mood than other psychosocial stressors.

Several coping strategies in times of food insecurity can place people at higher risk of receiving HIV infection. For example, women and girls may choose transactional sex if it is the only income generating option left for them (Donnell, 2004). In Mozambique, women switch their occupation from agricultural production to petty trading activities and a child-headed household coping by renting out an unused hut (Petty et. al, 2004).

Aziz and Smith (2011) conducted a study on challenges and successes in linking HIV infected women to care in United States. In USA, the Latino and black persons were disproportionately affected by HIV infection. Women account for 27% of new HIV infections in the region and the majority mode of transmission were through heterosexual mode. The major drivers of HIV infection among women of colour in the region include complex behavioural, cultural and environmental factors. Black and Hispanic women were more likely to live in environment with higher rates of poverty, crime, incarceration and illicit drug use than white women. The study suggested certain strategies for HIV infected women to improve the linkages to HIV care which include increased community awareness of HIV, increased HIV testing in general and high prevalence environment in particular and aggressive direct linkage to HIV care clinics.

Logie et. al (2011) analysed the effect of HIV infection among marginalised WLHA in five cities across Ontario, Canada. The study explores various experiences of stigma and coping strategies adopted by WLHA. The study highlights connection of stigma across micro, meso and macro levels i.e. HIV-related stigma; sexism and gender discrimination; racism; homophobia and trans phobia; and sex work stigma. The study further reveals various coping strategies adopted by WLHA that support them to cope with the stress and positive living. The coping strategies at various levels include resilience (micro), social networks (meso) and challenging stigma (macro).

Resilient coping strategy includes personality and attitudinal traits like tenacity, optimism, and problem solving in tough situations, and was associated with positive

psychological outcomes (Taylor & Stanton, 2007; Sinclair & Wallston, 2004). Social networks strategy includes interacting with other people. Challenging stigma strategy includes women empowerment and engagement of WLHA in fighting for equal rights. The study generally highlights the complex system of intersectional stigma that requires manifold strategies to promote health parity for WLHA.

HIV prevention strategies have historically focused on changes in individual behaviour and so far very little success were achieved in reducing HIV risk among young women and girls (ICRW, 2010). Several studies suggest that economic factors contribute to girls and young women HIV risk and vulnerability both at household and individual level (Hallman, 2005; Turmen, 2003; Weissman et. al, 2006). Dworkin and Blankenship, (2009) in their study suggest that economic strategies in some extent may improve social, economic and health outcomes among women. Economic empowerment strategies were gradually being adopted into HIV/AIDS programme focusing on girls and young women, as well as orphans and vulnerable children (Glennerster and Takavarasha, 2010).

The relationships between economic status and HIV status have been complex. High risk sexual behaviour was often associated with economic inequality between males and females. Economic inequality was the only one dimension of vulnerability to HIV among girls and women (ICRW, 2010). Economic empowerment has been recognised as one of the promising strategies for overcoming vulnerability among girls and women.

Empowerment has been defined as multi-dimensional, long term process with two important components: a) resources that embrace not only financial and productive assets but opportunities and capabilities, and social networks and other environmental factors; and b) agency or ability to act in one’s own best interest (Malhotra & Schuler, 2005). Economic empowerment has been one of the strategies that can enhance individual and community level resilience to HIV/AIDS.

A report from UNAIDS (2010) on the Global AIDS Epidemic highlights that efforts to promote universal access to HIV prevention, treatment, care and support services need a sharper focus on women and girls. New UNAIDS strategy (2011-2015) stresses that meeting the needs of HIV+ women and girls and calling for zero tolerance for gender based violence has important impact on advancing global progress toward universal access to HIV prevention, treatment, care and support and to control the spread of HIV, therefore backing Millennium Development Goals to achieved its target by 2015.

Globally, HIV/AIDS has been the leading cause of death among women of reproductive age within 15-49 years (UNAIDS, 2010).

Curry J et. al (2006) in their study found that HIV/AIDS has a severe impact on food security affecting availability, stability, access and utilization. According to Food and Agriculture Organisation (FAO), HIV has been a determining and consequence factor of food insecurity. HIV/AIDS impact household affecting food security and livelihood. . The study has been conducted in three African countries i.e. Namibia, Uganda and Zambia and identifies vulnerable households and document changes in resource availability, household labour force, livelihood strategies, coping strategies and food security status. HIV/AIDS affect the lives of women and girl child due to gender inequality and traditional gender roles (Wiegers, 2004). The traditional role of women implies that women in addition to earning a livelihood were also responsible for looking after PLWHA and orphans in the household.

Mehta and Gupta (2006) analysed the impact of HIV/AIDS, coping strategies and care on women. The study found that coping mechanisms of household affected by HIV/AIDS in sub-Saharan Africa include borrowing of money from friends and relatives; short term relief through aided organisations; substitution with cheaper commodities; reduction in consumption of food and other expenditure like education; making girl child to drop out from school; sending away children to live with relatives; marrying second time; migration, taking loans, selling assets and using savings; reducing investment, self-employment; and selling essential income generating devices.

Studies conducted in different states of India exposed that the poor household affected by HIV/AIDS had adopted various coping mechanisms such as selling assets, taking loans, vending and taking the girls child out of school to care and maintain the family (Mukhopadhyay et. al, 2001).

Rashid, Langworthy and Aradhyula (2006) suggested that choosing a set of coping strategies was governed by a number of factors comprising the types of crisis face by the households and the options available to them. Poor households risk their future income generating capacity to sustain their current food consumption. The study examined the coping strategies adopted by rural households in Bangladesh. The study indicates that the choice of coping strategies was influenced by diversity and stability of household income sources.

For the majority of people affected by HIV/AIDS around the world, agriculture was their main source of livelihood (IFPRI, 2005). Millions of men, women, boys and girls residing in rural areas depend on agricultural product as it gives food security, livelihood and income generation strategies (CIDA, 2005; ICAD, 2005). Based on this, Canadian International Development Agency (CIDA) draft Strategic Directions Paper on Health and Nutrition recognizing agricultural development as key for Africa, especially for the promotion of the welfare of women who depend on agricultural production. According to FAO (2000), in Namibia losing livestock immediately impacts women and/or children because she loses her food security bank, potential draught power, fertilizer and source of income.

The key factor driving HIV/AIDS epidemic was gender inequality because it creates unequal social and economic power making women and girls more vulnerable than men and boys. The lower status and limited livelihood opportunities often force women and girls to choose transactional sex for food or a way of survival. Unequal intra household decision making power, divisions of labour, resource and services access and control have strong effects on women's and girl's food, nutrition and livelihood security.

Declining economy and the effects of HIV/AIDS epidemic have impoverished numerous numbers of people into permanent poverty (Nkurunziza & Rakodi, 2005). The study highlighted short term coping strategies, livelihood strategies and socio political relationship in poor urban household in Kenya and Zambia. *Coping strategies may be defined as "short-term responses to unusual food stress" and adaptation as "coping strategies which have become permanently incorporated into the normal cycle of activities".* Some studies have discussed that livelihood may be more multifarious in urban areas than rural areas (Rakodi, 1999; Chambers, 1995). Generally, urban areas were more culturally diverse and socially fragmented but present better economic opportunities. HIV/AIDS plagued individual production capabilities due to illness, stress, depression and eventual death.

National Council of Applied Economic Research (NCAER), National AIDS Control Organisation (NACO) and United Nations Development Programme (UNDP) conducted study on "Socio economic impact of HIV/AIDS in Manipur" in 2004-2005 in 6 districts of Manipur. Interview was conducted among 270 PLWHA households and 761 non HIV households from both rural and urban areas. The study found that poverty hit

severely on income and employment both in urban and rural PLWHA household and people residing in rural area prefer to hide their HIV status as one of the coping mechanisms.

Drimie S (2002) highlights the key issues surrounding the impact of HIV/AIDS on land particularly at the rural household in Southern and Eastern Africa. The study was concentrated in Kenya, Lesotho and South Africa. According to Balyamujara et. al (2000), poverty has been connected with the spread of HIV infection in three ways: a) deep rooted structural poverty arising from gender imbalance, unequal land possession, ethnic and geographical isolation and low access to services; b) developmental poverty produced by unregulated socio-economic and demographic changes; and c) poverty arise from war, civil unrest, social disruption and refugees (Walker, 2002).

Millions of people sell sex because of lack of opportunities to earn a livelihood for themselves and their household. People whose livelihood strategies expose them to a high risk of infection were due to destitution and unable to take HIV infection seriously (Collins and Rau, 2001). HIV/AIDS exacerbate social, economic and cultural inequalities which define the status of women in society (IFAD, 2001).

Several studies have shown that HIV/AIDS first affects the well-being of households through sickness and demise of family members, which in turn leads to the diversion of resources from savings and investments into care (Cohen, 1993; HSRC, 2001; Rugalema, 1999). Balyamujura et. al (2000) have recognized three household coping strategies identified by UNAIDS (1999) to cope with HIV/AIDS i.e. a) strategies aimed at improving food security; b) strategies aimed at raising & supplementing income to maintain household expenditure patterns; and c) strategies aimed at alleviating the loss of income.

Munthali A C (2002) conducted a study on adaptive strategies and coping mechanisms of families and communities affected by HIV/AIDS in Malawi. The rate of HIV/AIDS in Malawi is overwhelming. The study examined that death of young and economically productive member deprives social security in the family. To deal with the pressing impacts of HIV/AIDS people choose early marriages, re-marriage by widow, school dropout, help from extended family, casual labour and piece work, small scale sales and community based organisations as their coping strategies.

Keeping in view of the above discussion the researcher makes an attempt to fill the gaps of various problem faced by WLHA on their day to day lives and the coping mechanisms adopted by them to cope with the disease and the preventive possibility that they embrace to protect themselves from impoverishment and also to maintain their wellbeing. Globally, half of the world population reside in urban areas and majority of the prevalence rate of HIV were reported from urban areas, but most of the studies conducted so far related with livelihood strategies among PLWHA have been conducted on rural areas. So, addressing the gap the present study explore the livelihood strategy and coping mechanism among WLHA in Imphal, capital of Manipur by using the sustainable development frame work model (DFID, 1999).

In this chapter an attempt has been made to critically review and analyse the literature related with the study topic. The next chapter will present the methodological aspects.

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CHAPTER III

METHODOLOGY

The previous chapter critically analysed copious literature related with the topic globally, nationally and state wise and brings out the major research gaps within. In the present chapter, study design, pilot study, profile of the study area, sampling, sources of data collection, tools of data collection, operational definitions and limitations are discussed.

3.1 Profile of the Study Area

The study was conducted among individual WLHA residing in core and peripheral area of Imphal district, Manipur. The respondents were within the age group of 18-50 years and the data was collected through MNP+ which is located at Yaiskul in Imphal East district.

3.1.1 Imphal

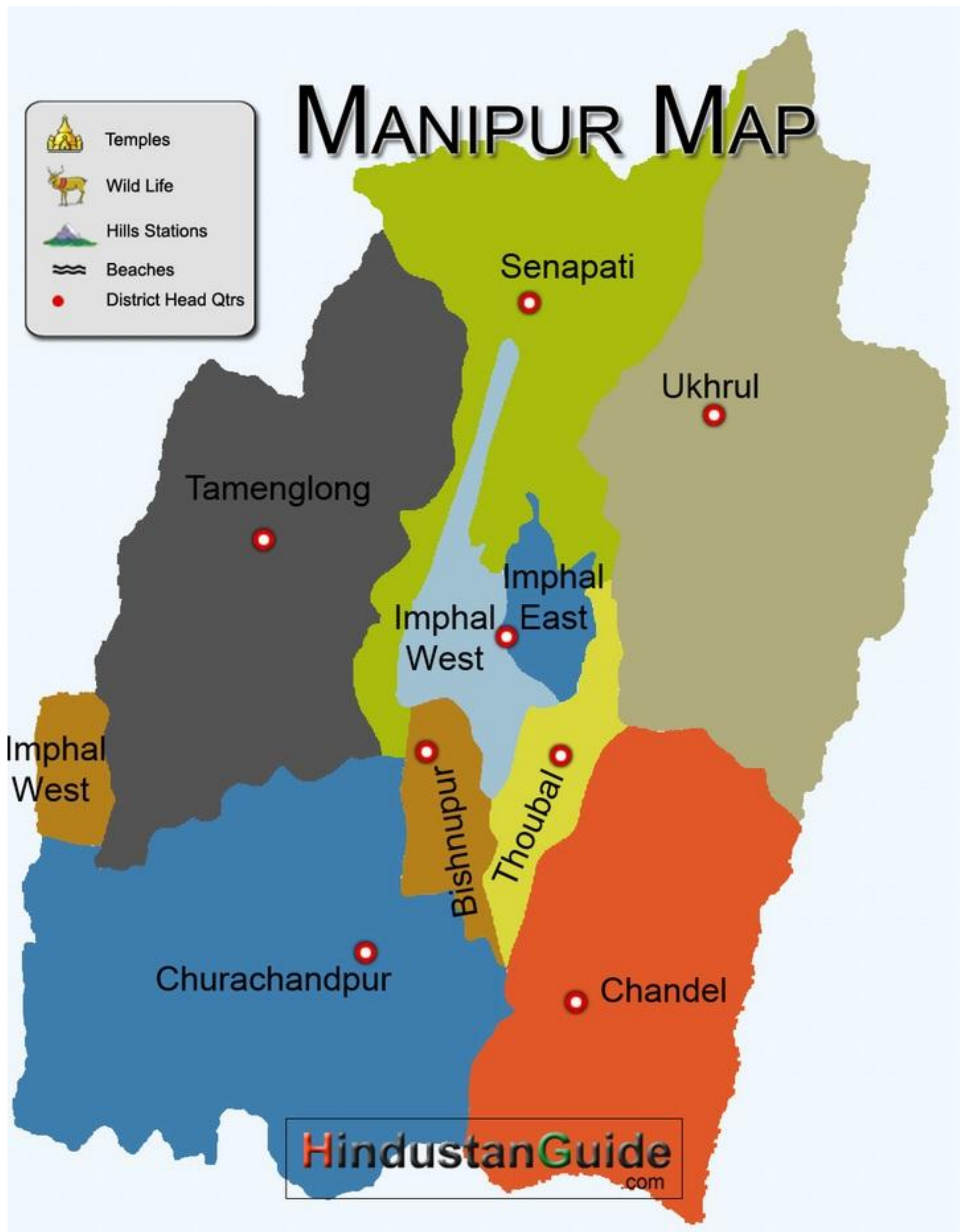
Imphal is the capital city of the Indian state of Manipur. According to 2011 census, the total population residing in the district was 264,986 of which 128,931 were males and 136,055 were females. The city of Imphal has been divided into two parts i.e. Imphal East and Imphal West. Imphal district has its own core and peripheral contours. Since a high percentage of HIV+ cases were reported from Imphal district i.e. Imphal East and Imphal West, Imphal were taken up for the proposed study. So, individual WLHA within the age of 18-50 years residing in both the core and peripheral area from the two districts were selected for the universe of the study and approached through MNP+ (NGO) personnel.

3.1.2 Manipur Network of Positive People (MNP+)

Manipur Network of Positive People (MNP+) is a state level community based Non-government Organisation established on 7th September, 1997 by five ex Injecting Drug Users (IDUs) who were living with HIV. The NGO is situated in Yaiskul Hiruhanba Leikai, Imphal East. It is a self-support group which help infected and affected people living with HIV/AIDS (PLWHA) and help them to overcome constraints and limitations and bring overall improvement especially in their lives and society in general.

Figure 3

Map of Manipur



The organisation is registered under the Society Registration Act of 1989 on 14th December 1998 with the regd No. 62/M/SR of 1998 and registered under the FRCA 1976

and the number is- 194130232. The organisation works hand in hand with various other NGOs and CBOs operating in the field of HIV/AIDS.

The organisation has six strategic objectives to fulfil their goal in refining the quality of life of PLWHA in the state. They are:

1) To facilitate and improve access to treatment for PLWHA.
2) To provide access to information to PLWHA.
3) To promote and protect the human rights of PLWHA.
4) To promote involvement of PLWHA at all levels of decision making.
5) To promote social acceptance of PLWHA and to end stigma and discrimination.
6) To provide opportunities for networking for PLWHA.

MNP+ has been running different project under their supervision for the upliftment of the condition of PLWHA in different areas of state. The majority priority areas of the network are:

1) Women and gender issues
2) Access to treatment care and support
3) Capacity building and organisational development of PLWHA network
4) Partnership building with key stakeholders
5) Role of PLWHA in prevention
6) Addressing stigma and discrimination through advocacy
7) Positive IDU access to treatment

3.2 Pilot Study

A pilot study was first conducted among ten WLHA in core and peripheral area of Imphal district. WLHA was approached through Manipur Network of Positive People (MNP+, an NGO). Pre-testing of interview schedule was first conducted to make sure that the tool used for the study was clear and appropriate. The research tools were further amended giving importance to the identified gaps before using them for the final data collection for the study.

3.3 Study Design

The study attempts to assess the patterns of livelihood adopted by WLHA in core and peripheral area of Imphal districts and analysed the livelihood strategies embraced by

them. The study was cross-sectional in nature. To achieve the objectives of the study, exploratory research design was adopted.

3.4 Sampling

The researcher identified 900 WLHA registered in the MNP+ including Imphal East and Imphal West districts. The selection of study unit was employed by using stratified disproportionate random sampling method. The samples were stratified on the basis of WLHA residing in core and peripheral areas considering their age group from 18 to 50 years of Imphal, Manipur. The samples were drawn at random disproportionately 80 in Imphal East and 80 in Imphal West districts respectively.

3.4.1 Ethical Considerations

- Prior permission was taken from the NGOs to carry out the interviews with WLHA.
- Respondents profile was made anonymous to respect their confidentiality.
- Informed consent was obtained from the WLHA before the interview was conducted.

3.5 Sources of Data Collection

The study was based on both qualitative and quantitative approaches. The primary data was collected from WLHA within the age of 18-50 years residing in core and peripheral area of Imphal East and Imphal West. In-depth case study with five WLHA and two focus group discussions (FGD) with 10 WLHA in each session from two districts was conducted.

Secondary data were collected from books, journals, articles, newspapers, NGO pamphlets, magazines, websites, etc.

3.6 Tools for Data Collection

A structured interview schedule with both open ended and close ended questions was used for data collection. The interview schedule contains different interrelated questions which offer information on the demographic profile, vulnerability context, patterns of livelihood assets and livelihood strategies of WLHA.

The primary data were collected directly from WLHA by taking prior appointment and considering suitable timing via NGO personnel. The NGO personnel were involved whole the time when the researcher was collecting data making all the process easy. The respondents were informed about the content and purpose of the study. The utmost importance was given to the confidentiality of the respondents to remain their profile anonymous. Voluntary participation and oral consent of the respondents was taken to contribute in the study.

The respondents were interviewed at their homes, common gathering place (especially home of HIV positive woman) or a secluded room in the NGO office. The researcher with the help of interview schedule, in-depth case study and FGD gathered information related with respondents livelihood.

The interview schedule was divided into four sub-sections. The first sections brief about the profile of the respondents and comprise total twenty three questions. The second sections contain eleven questions and provide information on the vulnerability context of the respondents. Further the third sections comprise eighteen questions and provide information on patterns of livelihood assets of the respondents. And lastly, the fourth sections encompass twelve questions and provide information on various livelihood strategies adopted by the respondents.

Operational definitions

Women living with HIV/AIDS

Women living with HIV/AIDS are that woman who has detected HIV antibodies in their body.

Livelihood

Livelihood comprises the capabilities, assets (stores, resources, claims and access) and activities required for a means of living: a livelihood is sustainable which can cope with and recover from stress and shocks, maintain or enhance its capabilities and assets, and provide sustainable livelihood opportunities for the next generation; and which contributes net benefits to other livelihoods at the local and global levels and in the long and short term". (Chambers and Conway, 1992)

Livelihood strategies

Livelihood strategies are the blend of activities and choices that people undertake in order to accomplish their livelihood goals.

3.7 Data Processing and Analysis

The quantitative data collected through interview schedule was processed through Microsoft excel and analysed with the help of SPSS package. The qualitative data was processed with the use of transcript and has been presented in the form of reports.

3.8 Limitations of the Study

The researcher witnesses certain limitations while collecting data. Firstly, as the respondents were WLHA it was very important to respect the confidentiality and remain their profile anonymous. Secondly, the researcher was extremely cautious about the respondent's state of mind because HIV is a sensitive issue and stigma, violence and discrimination go hand in hand with the epidemic. Thirdly, it was very difficult to arrange meeting to interact with WLHA as majority of the respondents in the study belong to lower class and practice semi-skilled work and petty business to earn their livelihood.

3.9 Case Study of Women Living With HIV/AIDS in Imphal District

A Meitei woman of 44-year-old, widow voiced her journey till now expressing anger and frustration towards her late husband for transferring the virus to her and her children. To make a living for their family, she started petty business with her elder son who was also HIV+. As a breadwinner of the house, she has to take all the responsibility for the family as well as look after their children and take the entire burden. Being a HIV + woman, she faces mental abuse and discrimination from her in-laws and society. She said,

> *After my husband died I was suspicious of being positive so I tested and when I got my result I felt hurt and betray. To some extent I console myself because I have a family to look after but when my elder son was confirmed HIV positive, I was devastated and crushed.* (Hail from Imphal West)

A 34-year-old Meitei widow stated her life experience and struggle to survive as a HIV+ widow with one son (also HIV+) in the community and her dreadful life journey

till now. As she was only 8th standard passed and also from poor family, she has very little option to choose a well-paid job. Although she knows weaving and embroidery she cannot do it because it was very tiresome and as her CD4+ count was very low she cannot indulge herself in such kind of activity so she opened a small shop from her parents help to make her living. She faces domestic violence, untouchability and mental abuse from her in-laws after her husband died and main reason for such abuse was financial problem and being a HIV+ woman. She said,

> *My husband never reveals his HIV+ status to me. When I was pregnant with my first child I have to run few test and at that time I confirm my HIV+ status. I was furious with my husband for not telling me but I was helpless and hopeless because "damage was already done". Now my innocent son has to bear his father sin. (Hail from Imphal West)*

A Naga woman, a young widow of 39 years expressed the vulnerability and abuse she faces from her mother-in-law after the dead of her husband. After her husband dead she becomes the breadwinner of the family and has to look after her 5 children (2 being HIV+). Being a Seasonal employment makes her very difficult to run the family. She faces domestic, physical and mental abuse from her in-laws regularly. To support her family she sold her belonging and also borrows money from her friends at the time of need. She said,

> *My husband death devastated me and while I was still mourning my loss, my mother-in-law assaulted me call me with different ill name. Church member are the only lifeline for me. They console me when I face assault from my mother-in-law. Being a widow and mother of 2 HIV+ children make me very vulnerable. (Hail from Imphal East)*

A 43-year-old Meitei widow expressed her struggle with life and how she manages her family after her husband died. To run her family she does weaving and tailoring but the money was not sufficient enough to meet the daily expenses and give her children better education. To cope with her financial problem she borrows money from her friends at the time of need and pays them back when she has money. As she belongs to a joint family, her in-laws understand about her HIV+ status and help her time to time but her sister-in-law now and then abuse her verbally for being a HIV+ woman and they do not give importance to her opinion. She said,

Dead of my husband was a big blow to me. My huge moral support comes from NGO and without the help of NGO I could not think I would survive as HIV+ woman in the society. After coming to NGO, I realized I was not the only woman with this deadly virus. Woman like me were also there and they were surviving so "why could not I?"(Hail from Imphal East)

A 40-year-old Kuki woman shared her experience being a HIV+ woman and different obstacles she had faced to earn a living. To earn a living she ran small vegetable shop in the market and her husband was a local transport worker. She got infected from her husband but the amount of discrimination she faced as compared with her husband was too heart breaking. The people who used to mingle with her stop interacting and would not ask her to join the public gathering and during those phase of her life NGO personnel came as a life saver. She said,

My friends who used to be very close start neglected me and would not invite me in social gathering and I was totally outcast but during those rough time NGO personnel welcome me and give moral, mental and physical support. My life will be forever indebted to them. (Hail from Imphal East)

Findings

From the case studies, it was found that WLHA were the victim of the virus after they entered wedlock. Their positive status forced many hurdles in earning livelihood. To support their family, they indulged themselves in hard working job which pay less money and no recognition. The main reasons for facing problems in their household were due to the spouse and in-laws, financial constraints, stigma and discrimination, violence, etc. in the society. On the other hand, the condition of WLHA becomes even worse when they become a widow. In order to overcome the challenges faced by them, they received support from NGOs.

3.10 Focus Group Discussion

Focus Group Discussion (FGD) was used to understand the patterns of livelihood, source of income generating activities and coping strategies for Women Living with HIV/AIDS in Imphal districts. The topic of discussion was "Livelihood pattern and coping strategies of WLHA". During the discussion each respondent were encouraged to express their opinion and their opinion were noted down by the researcher. The

discussion was set for 1 ½ hour and 10 WLHA (Imphal West) and 10 WLHA (Imphal East) from core and periphery area at the age of 18-50 years were selected. Topic related with their income generating activities like saving, household expenditure and coping strategies were discussed.

Findings

From the group discussion conducted, it was found that majority of the women were engaged in low paying job mostly semi-skilled work and petty business which makes them very difficult to manage their household and also further making them more and more vulnerable to lead a vigorous lifestyle. Engagement of WLHA in such low paying job leads to financial dishevels which strongly affect their day to day existence. Besides, they were trying to save some money for their own children future education but they were unable to save some money due to high cost of living and bound to spent more money for their treatment as well. Apart from their main source of income they hardly manage to involve in other income generating activities and even if they engaged in other activities all were petty job which make very meagre.

WLHA spend most of their household expenditure on buying food, buying medicine and paying for their children's education. As a woman they have to look after their family member and take responsibility on guiding their children to lead a good lifestyle. They were fully engaged in all the activities to run their family.

In focus group discussion, it was found that coping strategies for WLHA to maintain their livelihood were support from family member, borrowing money from friends, working hard, selling belongings, praying to Almighty God and starting petty business. Adoption of such strategies was due to the financial constraint and poverty. Poverty was the main cause of vulnerability towards their livelihood. The coping strategies of the respondents solely depend on the occupation and other income generating activities which they adopted.

The next chapter presents the results and discussions of the present study.

Figure 4

FOCUS GROUP DISCUSSION (Imphal West)

Sl. No.	Occupation	Household expenditure	Other source of income	Livelihood coping strategies
1	Service (Govt./Pvt)	a)Buying food b)Children education	a)Nil	a)Working hard
2	Semi-skilled work	a)Buying medicine	a)Nil	a) Borrow money from friends
3	Petty business/small shop/self-employed	a)Buying medicine	a)Nil	a)Petty business
4	Semi-skilled work	a)Buying medicine	a)Nil	a)Borrow money from friends a)Help from brother
5	Petty business/small shop/self-employed	a)Buying food	a)Nil	a)Petty business b)Support from children
6	Petty business/small shop/self-employed	a)Buying food b)Buying medicine c)Children education	a)Agricultural labour	a)Working hard
7	Petty business/small shop/self-employed	a)Buying food	a)Agricultural labour	a)Working hard b)Petty business
8	Service (Govt./Pvt)	a)Children education	a)Petty business	a)Pray to god b)Petty business
9	Petty business/small shop/self-employed	a)Children education b)House rent	a)Semi-skilled work b)Agricultural work	a)Working hard b)Petty business
10	Seasonal employment	a)Buying food b)Children education	a)Agricultural labour	a)Borrow money from friends b)Working hard c)Petty business

Source: 10th June 2016

Figure 5

FOCUS GROUP DISCUSSION (Imphal East)

Sl. No.	Occupation	Household expenditure	Other source of income	Livelihood coping strategies
1	Petty business	a)Buying food b)Buying medicine	a) Semi-skilled work	a)Petty business b)Working hard
2	Petty business/small shop/self-employed	a)Buying food b)Buying medicine	a)Agricultural labour	a)Working hard
3	Petty business/small shop/self-employed	a)Buying food b)Children education	a)Nil	a)Borrow money from friends b)Petty business
4	Semi-skilled work	a)Buying medicine	a)Tailoring	a)Help from in-laws
5	Seasonal employment	a)Buying food	a)Nil	a)Borrow money from friends
6	Semi-skilled work	a)Buying food	a)Nil	a)Children drop out from school
7	Semi-skilled work	a)Buying food b)Buying medicine c)Children education	a)Tailoring	a)Borrow money from friends
8	Seasonal employment	a)Buying food b)Buying medicine	a)Agricultural cultivation	a)Working hard b)Borrow money from friends
9	Petty business/small shop/self-employed	a)Buying medicine b)Children education	a)Semi-skilled work	a)Petty business
10	Seasonal employment	a)Children education	a) Petty business	a)Borrow money from friends b)Selling belongings c) Petty business

Source: 21st June 2016

CHAPTER IV

RESULTS AND DISCUSSION

In this present chapter an attempt has been made to present the results and discussion of the data that have been collected from the respondents through interview schedule. The information gathered from the respondents were analysed on the basis of the objectives of the present study. The data were analysed quantitatively. The chapter has been presented in different sections and sub-sections.

4.1 Profile of the respondents

The profile of the respondents are divided into three sections viz., personal characteristics, familial characteristics and landholding and housing patterns of the respondents.

4.1.1 Personal characteristics

The table 4.1 shows the personal characteristics of the respondents. The personal characteristics are divided into eight sub-sections and include locality, age, religion, educational qualification, occupation, monthly income, time period of occupation and socio-economic status.

As regards to locality, it has been divided into core and periphery areas. Less than half of the respondents (46.9%) were from core areas and more than half of the respondents (53.1%) were from peripheral areas. The table shows that majority of the respondents were from periphery area in both the districts.

Age is an important variable in order to understand the prevalence of HIV/AIDS among the WLHA. Among the respondents the age range from 18-30 years cover less than one tenth (8.8%) and 31-40 years cover more than two fifth (44.4%) and other 41-50 years cover less than half (46.9%). The mean age of respondents from Imphal East was 39.78 while the mean age of respondents from Imphal West was 39.53. The table shows that in both the districts majority of the respondents were belonged to the age group of 41-50 years while 18-30 years of age group were the least number of HIV+ cases in both the districts.

The epidemic of HIV/AIDS knows no boundaries and it was prevalent in all the sections of women in society. The findings indicated that from both the districts three fourth (74.4%) respondents belong to Hindu and less than one tenth (2.5%) belong to Muslim and less than one fourth (23.1%) belong to Christian. The table shows that majority of the Imphal valley are dominated by Hindus.

Education is one of the factors that are closely connected with respondent's occupation. Education creates the environment for receiving proper economic security for the respondents. In the table 4.1 educational qualification reveals that less than one tenth (6.2%) of the respondents from Imphal East district were illiterate and there were no illiterate respondents from Imphal West district. One fifth (20%) in Imphal East and one eighth (12.5%) of the respondents from Imphal West district studied till lower primary level. One fourth (25%) in Imphal East district and little less than one fourth (23.8%) in Imphal West district studied up-to upper primary level. One third (35%) in Imphal East district and little more than one fourth (28.8%) of the respondents in Imphal West district studied reached matriculation. One tenth (10%) in Imphal East district and little more than one fifth (22.5%) in Imphal West district were Intermediate. Less than one tenth (3.8%) in Imphal East district and one eighth (12.5%) in Imphal West district were Graduate and above. The table reveals that from both the districts respondents who studied till matriculation were the highest. The main reason for not pursuing higher education is due to the financial problem in the family.

Occupation plays an important role in supporting one's livelihood. One fifth (20%) of the respondents from Imphal East district and more than one fourth (28.8%) in Imphal West district were engaged in seasonal employment. 'Seasonal employment' refers to temporary or short term job. Less than one third (30%) in Imphal East district and little more than one fifth (22.5%) were engaged in semi-skilled work. 'Semi-skilled work' refers to those works that required limited skills. Less than one tenth (7.5%) in Imphal East district and less than one fifth (17.5%) in Imphal West district were engaged in Service (Govt. /Pvt.). Less than one tenth (1.2%) in Imphal West district were engaged in agricultural labour/cultivation/landholding while no one in Imphal East district were engaged in such activities. Two fifth (40%) in Imphal East district and more than one fourth (29%) in Imphal West district were engaged in petty business/small shop/self-employed. The remaining less than one tenth (2.5%) in Imphal East district were engaged in skilled work while no one from Imphal East district were engaged in skilled work.

'Skilled work' refers to those works that required special training. The table shows that majority of the respondents were engaged in low paying job which required hard work.

The respondent's monthly income was divided into six sub-sections. More than half (51.2%) of the respondents from both the districts Imphal East (56.2%) and Imphal West (46.2%) have monthly income between Rs.2001-5000. The respondents monthly income Below Rs.2000 were one sixth (17.5%), Rs.5001-10000 were one seventh (14.4%), Rs.10001-30000 (3.1%) & Rs.30001-above were less than one tenth and the respondents who have no income at all were one eighth (12.5%) from both the districts. The table shows that majority of the respondents monthly income were below Rs.10000. The respondents who do not have monthly income at all were either dependent on husband or siblings or family member for their livelihood. The mean monthly income for respondents from Imphal East was 2.40 while the mean monthly income for respondents from Imphal West was 2.74. The table shows that half of the respondents have monthly income between Rs.2000-5000. Engaging in low paying job create complication in sustaining their livelihood.

The time period of the occupation was highest who works for 2-5 years (33.1%) which comprised Imphal East (40%) and Imphal West (26.2%) and followed by 6-10 years (25.6%). The lowest was 31 years-above (0.6%) from both the districts. The remaining little more than one fifth (23.1%) of the respondents from both the districts was not applicable since they were not engaged in any paying job.

The socio-economic status of the respondents revealed that more than half (55%) of the respondents belong to BPL which comprises Imphal East district (42.5%) and Imphal West district (67.5%), one fourth (25%) belong to AAY, less than one tenth (0.6%) to APL and those who does not belong to any category were one fifth (19.4%) in both the districts. The table shows that more than half of the respondents from both the districts live under poverty line and belongs to economically deprived sections.

Table 4.1

Profile of the Respondents

Sl.No.	Characteristics	Domicile		
		Imphal East n=80	Imphal West n=80	Total N=160
1	**Locality**			
	Core	35	40	75
		43.8%	50%	46.9%
	Periphery	45	40	85
		56.2%	50%	53.1%
2	**Age**			
	18-30 years	6	8	14
		7.5%	10%	8.8%
	31-40 years	37	34	71
		46.2%	42.5%	44.4%
	41-50 years	37	38	75
		46.2%	47.5%	46.9%
	Mean ± S.D	39.78±6.071	39.53±6.775	39.65±6.41
3	**Religion**			
	Hindu	54	65	119
		67.5%	81.2%	74.4%
	Muslim	1	3	4
		1.2%	3.8%	2.5%
	Christian	25	12	37
		31.2%	15%	23.1%
4	**Education**			
	Illiterate	5	0	5
		6.2%	0%	3.1%
	Lower primary (1-5)	16	10	26
		20%	12.5%	16.2%
	Upper primary (6-8)	20	19	39
		25%	23.8%	24.4%
	Matriculate (9-10)	28	23	51
		35%	28.8%	31.9%
	Intermediate	8	18	26
		10%	22.5%	16.2%
	Graduate & above	3	10	13
		3.8%	12.5%	8.1%

5	**Occupation**			
	Seasonal employee	16	23	39
		20%	28.8%	24.4%
	Semi-skilled worker	24	18	42
		30%	22.5%	26.2%
	Service (Govt./Private)	6	14	20
		7.5%	17.5%	12.5%
	Agricultural labour	0	1	1
		0%	1.20%	0.6%
	Agriculture	0	1	1
		0%	1.2%	0.6%
	Self employed	32	23	55
		40%	29%	34%
	Skilled worker	2	0	2
		2.5%	0%	1.2%
6	**Monthly Income (Rs.)**			
	Below 2000	14	14	28
		17.5%	17.5%	17.5%
	2001-5000	45	37	82
		56.2%	46.2%	51.2%
	5001-10000	12	11	23
		15%	13.8%	14.4%
	10001-30000	1	4	5
		1.2%	5%	3.1%
	30001-above	0	2	2
		0%	2.5%	1.2%
	N/A	8	12	20
		10%	15%	12.5%
	Mean ± S.D	2.40±1.356	2.74±1.621	2.57±1.499
7	**Time period**			
	1 month-1 year	5	7	12
		6.2%	8.8%	7.5%
	2-5 years	32	21	53
		40%	26.2%	33.1%
	6-10 years	20	21	41
		25%	26.2%	25.6%
	11-20 years	4	6	10
		5%	7.5%	6.2%
	21-30 years	4	2	6
		5%	2.5%	3.8%
	31 years & above	1	0	1
		1.2%	0%	0.6%

	N/A	14	23	37
		17.5%	28.8%	23.1%
8	**Socio-economic status**			
	APL	1	0	1
		1.2%	0%	0.6%
	BPL	34	54	88
		42.5%	67.5%	55%
	AAY	26	14	40
		32.5%	17.5%	25%
	No category	19	12	31
		23.8%	15%	19.4%

Source: Computed

4.1.2 Familial characteristics of the respondents

The familial characteristics of the respondents are divided into seven sub-sections viz., marital status, type of family, size of family, form of family, head of family, main earner of family and annual income of family (see table 4.2).

Marriage is regarded as a sacred bond for every married human being but this sacred bond has become the very means for discrimination and stigma for the respondents. The findings indicated that two fifth (40%) of the respondents in Imphal East district and less than three fourth (71.2%) in Imphal West district were married. Less than half (48.8%) in Imphal East district and one fourth (25%) in Imphal West district were widow. One ninth (11.2%) in Imphal East district and 2.5 per cent in Imphal West district were divorcee. The remaining 1.2 per cent in Imphal West district was single. The table shows that majority of the HIV transmission takes place within the sanctity of marriage.

The type of family was divided into two type's viz., nuclear and joint family. Findings indicated that four fifth (80.6%) of the respondents which comprises Imphal East district (80%) and Imphal West district (81.2%) have nuclear family and remaining one fifth (19.4%) from both the districts have joint family. The table displays the impact of modernisation on family as majority of the respondents belongs to nuclear family.

The size of the family has been categorised into small, medium and large families. More than two fifth (43.8%) of the respondents in Imphal East district and two fifth (40%) in Imphal West district belong to small size families. Less than two fifth (38.8%) in Imphal East district and more than two fifth (43.8%) in Imphal West district belong to

medium size families. The remaining less than one fifth (17.5%) in Imphal East district and one sixth (16.2%) in Imphal West district belong to large families. The table shows that majority of the household have small and medium families which comprises 1-6 family members.

The form of family has been divided into three type's viz., stable, broken and rebuilt step. More than four fifth (83.8%) of the respondents in Imphal East district and nine tenth (91.2%) in Imphal East district belong to stable families. One sixth (16.2%) in Imphal East district and less than one tenth (7.5%) in Imphal West district belong to broken families. The remaining only one respondent in Imphal West district belongs to rebuilt step family. The family structure reveals that even though the respondents were infected by the incurable disease they keep their family intact and struggle to lead a normal life.

The presence of patriarchal system in our society can be seen in the head of the household. The findings revealed that one third (33.8%) of the respondents in Imphal East district and more than half (57.5%) in Imphal West district household were headed by the respondent husband. Little less than half (46.2%) in Imphal East district and little more than one fourth (27.5%) in Imphal West district household were headed by respondent herself. Less than one tenth (7.5%) in Imphal East district and one eighth (13.8%) in Imphal West district household were headed by their in-laws. The remaining one eighth (12.5%) in Imphal East district and 1.2 per cent in Imphal West district household were headed by their parents. The table reveals that almost half of the respondent's household were headed by their husband. The household who were headed by the respondents herself were because they were either widows or their husband was seriously ill.

The respondents not only struggle through their malady to survive but also struggle to earn the daily wages to support their family. More than half (56.2%) of the respondents in Imphal East district and two fifth (40%) in Imphal West district were the main earner of their respective family. Little less than one fourth (23.8) in Imphal East district and more than half (56.2%) in Imphal West district household main earner were respondents husband. Less than one tenth (4.4%) from both the districts main earner were their in-laws. One tenth (10%) of the respondents in Imphal East district main earner were their parents and remaining were their children (2.5%) and Brother (2.5%). While in

Table 4.2

Familial Characteristics of the Respondents

Sl.No.	Characteristics	Domicile		
		Imphal East n=80	**Imphal West n=80**	**Total N=160**
1	**Marital status**			
	Single	0	1	1
		0%	1.2%	0.6%
	Married	32	57	89
		40%	71.2%	55.6%
	Widow	39	20	59
		48.8%	25%	36.9%
	Divorcee	9	2	11
		11.2%	2.5%	6.9%
2	**Type of family**			
	Nuclear	64	65	129
		80%	81.2%	80.6%
	Joint	16	15	31
		20%	18.8%	19.4%
3	**Size of family**			
	Small	35	32	67
		43.8%	40%	41.9%
	Medium	31	35	66
		38.8%	43.8%	41.2%
	Large	14	13	27
		17.5%	16.2%	16.9%
4	**Form of family**			
	Stable	67	73	140
		83.8%	91.2%	87.5%
	Broken	13	6	19
		16.2%	7.5%	11.9%
	Rebuilt step	0	1	1
		0.0%	1.2%	0.6%
5	**Head of family**			
	Herself	37	22	59
		46.2%	27.5%	36.9%
	Husband	27	46	73
		33.8%	57.5%	45.6%
	In-laws	6	11	17
		7.5%	13.8%	10.6%
	Parents	10	1	11
		12.5%	1.2%	6.9%

6	**Main earner of family**			
	Herself	45	32	77
		56.2%	40%	48.1%
	Husband	19	45	64
		23.8%	56.2%	40%
	In-laws	4	3	7
		5%	3.8%	4.4%
	Parents	8	0	8
		10%	0%	5%
	Children	2	0	2
		2.5%	0%	1.2%
	Brother	2	0	2
		2.5%	0%	1.2%
7	**Annual income of family**			
	Below 50000	27	18	45
		33.8%	22.5%	28.1%
	50000-100000	34	42	76
		42.5%	52.5%	47.5%
	100001 & above	19	20	39
		23.8%	25%	24.4%

Source: Computed

Imphal West district there were no household whose main earner was either their parents or children or brother. The table indicates that almost half of the respondents from both the districts have household who were headed by respondent herself.

The findings indicated the annual income of the respondent family. One third (33.8%) of the respondents in Imphal East district and more than two fifth (22.5%) in Imphal West district have below Rs.50000 annual family income. More than two fifth (42.5%) of the respondents in Imphal East district and more than half (52.5%) in Imphal West district have Rs. 50000-100000 annual family income. While more than one fifth (23.8%) of the respondents in Imphal East district and one fourth (25%) in Imphal West district have Rs.100001 & above annual family income. The table shows that almost half of the respondent’s household have annual income of Rs.50000-100000 which is followed by below Rs.50000. Majority of the respondents belong to low income group which immensely affect their livelihood.

4.1.3 Respondents housing and landholding patterns by domicile

The table 4.3 presents the housing and landholding patterns of respondents with regards to their respective domicile and divided into six sub-sections viz., type of house,

ownership of house, land possession, acre of land, possession of property from family and reason for not possessing family property.

The findings revealed that three fifth (60.6%) of the respondents which comprises Imphal East district (58.8%) and Imphal West district (62.5%) live in kaccha house, less than one third (30.6%) in semi pucca house and less than one tenth (8.8%) of the respondents from both the districts live in pucca house. The table shows that more than half of the respondents live in kaccha house and very least live in pucca house. Further, the table shows that majority of the respondents have poor financial condition.

The table indicated that less than half (45.6%) of the respondents house which comprises Imphal East district (46.2%) and Imphal West district (45%) were inherited from their elders, more than one fourth (28.1%) which comprises Imphal East district (22.5%) and Imphal West district (33.8%) have their own house and one eighth have rented house (13.8%) and house jointly owned by siblings (12.5%). The table shows that almost half of the respondents inherent their house from elders and those respondents who were living in rented house were either outcast by their family or were currently building their home.

Land possession shows that more than nine tenth (91.2%) of the respondents which comprises Imphal East district (95%) and Imphal West district (87.5%) possess land and the remaining less than one tenth (8.8%) from both the districts do not have any land possession. The table shows that majority of the respondents family have land of their own.

The acre of land possess by family reveals that more than half (53.8%) of the respondents in Imphal East district and less than half (46.2%) of the respondents in Imphal West district own below ½ acre of land. While more than one fourth (27.5%) in Imphal East district and more than one third (37.5%) of the respondents in Imphal West district were not accurate about their family landholding. Less than one tenth in Imphal East district own 1acre of land (7.5%) & above 1 acre of land (6.2%) and Imphal West district above 1 acre of land (3.8%). The remaining 8.8 per cent from both the districts were not applicable since their family were not entitled with any property. The table shows that half of the respondent's family own below ½ acre of land.

Table 4.3

Respondents Housing and Landholding Patterns by Domicile

Sl. No.	Characteristics	Domicile		
		Imphal East n=80	**Imphal West n=80**	**Total N=160**
1	**Type of house**			
	Pucca	9	5	14
		11.2%	6.2%	8.8%
	Kaccha	47	50	97
		58.8%	62.5%	60.6%
	Semi pucca	24	25	49
		30%	31.2%	30.6%
2	**Ownership of house**			
	Rented	13	9	22
		16.2%	11.2%	13.8%
	Own	18	27	45
		22.5%	33.8%	28.1%
	Inherent from elders	37	36	73
		46.2%	45%	45.6%
	Jointly owned by siblings	12	8	20
		15%	10%	12.5%
3	**Land possession**			
	Yes	76	70	146
		95%	87.5%	91.2%
	No	4	10	14
		5%	12.5%	8.8%
4	**Acre of land**			
	Below 1/2 acre	43	37	80
		53.8%	46.2%	50%
	1 acre	6	0	6
		7.5%	0%	3.8%
	Above 1 acre	5	3	8
		6.2%	3.8%	5%
	Not accurate	22	30	52
		27.5%	37.5%	32.5%
	N/A	4	10	14
		5%	12.5%	8.8%

5	Family Property			
	Yes	27	19	46
		33.8%	23.8%	28.8%
	No	50	51	101
		62.5%	63.8%	63.1%
	N/A	3	10	13
		3.8%	12.5%	8.1%
6	**Reasons for not possessing family property**			
	My husband own it	23	40	63
		28.8%	50%	39.4%
	My parents own it	16	2	18
		20%	2.5%	11.2%
	Still not divided the property yet	10	10	20
		12.5%	12.5%	12.5%
	N/A	31	28	59
		38.8%	35%	36.9%

Source: Computed

In Indian society, women enjoyed very limited freedom in accessing property rights despite many Act passed by the Government. The scenario of women regarding their property rights are heart wrenching. Possession of property from family shows that less than two third of the respondents from both the districts which comprises Imphal East district (62.5%) and Imphal West district (63.8%) have no property in their name. While one third (33.8%) in Imphal East district and less than one fourth (23.8%) in Imphal West district have property of their own. The remaining 8.1 per cent respondents from both the districts are not applicable since they were either living with their parents or brothers or in rented house. The table shows that majority of the respondents do not possess any property by their name.

Regarding the reason for not possessing family property in their name, it was observed that little more than one fourth (28.8%) in Imphal East district and half of the respondents (50%) in Imphal West district have husband as the property owner. One fifth (20%) in Imphal East district and less than one tenth (2.5%) of the respondents in Imphal West district have parents as the property owner. One eighth of the respondents from Imphal East district (12.5%) and Imphal West district (12.5%) have no property in their name since their family have not divided the property yet. The remaining more than one third (36.9%) of the respondents from both the districts were not applicable since they have no property of their own. The table shows that family member does not want to

share their property with the respondents due to the belief that they would not live a long and healthy life. Women are the last options when inheritance of the property comes.

4.2 Vulnerability context of WLHA

The Vulnerability context of WLHA are divided into five sections viz., respondents vulnerability context in terms of illness by age, respondents vulnerability context in terms of illness by age and marital status, respondents vulnerability context with household and society by age, respondents privileges being WLHA, violence faced by respondents.

4.2.1 Respondents vulnerability context in terms of illness by age

The table 4.4 shows the respondents vulnerability context in terms of illness by age and divided into four sub-sections viz., period of diagnosis, first time detection of illness, treatment and reason for not seeking treatment.

Time period of diagnosis explain the number of days respondents live with virus. Respondents within the age of 18-30 years have more than one third (35.7%) 6-10 years and 2-5 years period of diagnosis, more than one-fifth (21.4%) have 1 month-1 year and less than one tenth have 16 years & above period of diagnosis. While respondents within 31-40 years have two fifth (40.8%) 6-10 years period of diagnosis, one fourth have (25.4%) 2-5 years, one sixth have 16 years & above (16.9%) and 11-15 years (14.1%) and remaining less than one tenth have 1 month-1 year (2.8%) period of diagnosis. Further, respondents within 41-50 years have half (50.7%) 6-10 years diagnosis period, one sixth have 11-15 years (16%), 16 years & above (14.7%) and 2-5 years (13.3%) and remaining (5.3%) have 1 month-1 year period of diagnosis. The table shows that majority of the respondents were living with the virus with more than six years. It means that the respondents were prone to AIDS.

Table 4.4

Respondents Vulnerability Context in Terms of Illness by Age

Sl. No.	Characteristics	Age in years			
		18-30 n=14	31-40 n=71	41-50 n=75	Total N=160
1	**Period of Diagnosis**				
	1 month-1 year	3	2	4	9
		21.4%	2.8%	5.3%	5.6%
	2-5 years	5	18	10	33
		35.7%	25.4%	13.3%	20.6%
	6-10 years	5	29	38	72
		35.7%	40.8%	50.7%	45%
	11-15 years	0	10	12	22
		0%	14.1%	16%	13.8%
	16 years & above	1	12	11	24
		7.1%	16.9%	14.7%	15%
2	**First time Detection of Illness**				
	Hospital	14	70	72	156
		100%	98.6%	96%	97.5%
	NGO	0	1	1	2
		0%	1.4%	1.3%	1.2%
	Health Centre	0	0	2	2
		0%	0%	2.7%	1.2%
3	**Treatment**				
	Low CD4 count	10	50	63	123
		71.4%	70.4%	84%	76.9%
	Precaution	1	6	4	11
		7.1%	8.5%	5.3%	6.9%
	Frequent sickness	2	9	5	16
		14.3%	12.7%	6.7%	10%
	N/A	1	6	3	10
		7.1%	8.5%	4%	6.2%
4	**Reason for not seeking treatment**				
	High CD4 count	1	6	3	10
		7.1%	8.5%	4%	6.2%
	Others	0	1	0	1
		0%	1%	0%	1%
	N/A	13	64	72	149
		92.9%	90.1%	96%	93.1%

Source: Computed

Regarding place of detection for illness, only fourteen respondents within 18-30 years choose hospital, vast majority (98.6%) respondents within 31-40 years choose hospital and remaining (1.4%) choose NGO, vast majority (96%) of the respondents within 41-50 years choose hospital and less than one tenth choose health centre (2.7%) and NGO (1.3%). Majority of the respondents (97.5%) choose hospital as their first time illness detection place. The table shows that hospital were the most fitting option for the respondents since confidentiality to reveal their identity were kept secret.

Regarding treatment, respondents within 18-30 years have less than three fourth (71.4%) low CD4 count, one seventh (14.3%) frequent sickness, less than one tenth (7.1%) as a precaution and the remaining (7.1%) are not applicable. While respondents within 31-40 years have more than two third (70.4%) low CD4 count, one eighth (12.7%) frequent sickness, less than one tenth (8.5%) precaution and remaining (8.5%) are not applicable. Further, the respondents within 41-50 years have more than four fifth (84%) low CD4 count, less than one tenth frequent sickness (6.7%), precaution (5.3%) and the remaining (4%) are not applicable. The table shows that low CD4 count was the main reason for the respondents to seek treatment. The CD4 count for normal healthy women is between 500 and 1500 per cubic millimetre of blood. To lead a long and healthy life one has to maintain their CD4 count. If the CD4 count are low than there are high chances to catch various illness easily.

As regard to reason for not seeking treatment, less than one-tenth (6.2%) of the respondents have not started seeking treatment since their CD4 count was high and the remaining vast majority (93.1%) have already started seeking treatment.

4.2.2 Respondents vulnerability context in terms of illness by age and marital status

The table 4.5 shows the respondents reason for HIV testing and divided into seven sub-sections viz., my partner were infected by the virus, my partner had died of AIDS, he had used and/or was consuming injectable drugs, mother to child, illness, pregnancy and blood transfusion.

The main mode of HIV transmission in the state is through IDUs. The IDUs after marriage transfer the virus to their partner/spouse. The evidence of such scenario are clearly reflected among respondents in the below table 4.5. Half (50%) of the respondents within 18-30 years decided to go for HIV testing because their partner were infected by

the virus, more than one fourth (28.6%) pregnancy, one seventh (14.3%) partner had died of AIDS and remaining less than one tenth (7.1%) mother to child. While less than two third (64.8%) respondents within 31-40 years decided for HIV testing since their partner were infected by the virus, one seventh (14.1%) partner had died of AIDS, one ninth (11.3%) pregnancy and remaining less than one tenth illness (8.5%) and partner had used/or was consuming injectable drugs (1.4%). Further, more than half (54.7%) respondents within 41-50 years decided for HIV testing since their partner were infected by the virus, one fifth illness (20%) & partner had died of AIDS (18.7%), less than one tenth blood transfusion (2.7%), partner had used/or was consuming injectable drugs (2.7%) and pregnancy (1.3%). The table shows that respondents decided to go for HIV testing since their partner were either infected by the virus/partner had died of AIDS/partner had used or was consuming injectable drugs/Mother to child/illness/pregnancy/blood transfusion.

HIV transmission among respondents was found within the sanctity of marriage. The finding indicated that only one respondent who was single decided to go for HIV testing since their partner was infected by the virus. Two third (64%) of the respondents who were married decided to go for HIV testing since their partner were infected by the virus, one sixth (16.9%) illness, one tenth (10.1%) pregnancy and less than one tenth partner had died of AIDS (3.4%), partner had used/or was consuming injectable drugs (3.4%), mother to child (1.1%), blood transfusion (1.1%). While half (49.2%) of the respondents who were widow decided to go for HIV testing since their partner were infected by the virus. Less than two fifth (37.3%) partner had died of AIDS, less than one tenth illness (8.5%), pregnancy (3.4%) and blood transfusion (1.1%). Further, two third (63.6%) of the respondents who were divorcee decided to go for HIV testing since their partner were infected by the virus. One fifth (18.2%) pregnancy, less than one tenth illness (9.1%), partner had died of AIDS (9.1%). The table shows that vast majority of the respondents got infected with the virus after marriage only. The sacred bond of marriage has become the bond of humiliation for the infected women. Women are already vulnerable sections of society but being infected with HIV put them in uncompromising situation.

Table 4.5

Respondents Vulnerability in Terms of Illness by Age and Marital Status

Sl. No.	Characteristics	Age in years				Marital Status				
		18-30 n=14	**31-40 n=71**	**41-50 n=75**	**Total N=160**	**Single n=1**	**Married n=89**	**Widow n=59**	**Divorcee n=11**	**Total N=160**
I	**Reason for HIV testing**									
1	My partner were infected by the virus	7	46	41	94	1	57	29	7	94
		50%	64.8%	54.7%	58.8%	100%	64%	49.2%	63.6%	58.8%
2	My partner had died of AIDS	2	10	14	26	0	3	22	1	26
		14.3%	14.1%	18.7%	16.2%	0%	3.4%	37.3%	9.1%	16.2%
3	He had used and/or was consuming injectable drugs	0	1	2	3	0	3	0	0	3
		0%	1.4%	2.7%	1.9%	0%	3.4%	0%	0%	1.9%
4	Mother to child	1	0	0	1	0	1	0	0	1
		7.1%	0%	0%	0.6%	0%	1.1%	0%	0%	0.6%
5	Illness	0	6	15	21	0	15	5	1	21
		0%	8.5%	20%	13.1%	0%	16.9%	8.5%	9.1%	13.1%
6	Pregnancy	4	8	1	13	0	9	2	2	13
		28.6%	11.3%	1.3%	8.1%	0%	10.1%	3.4%	18.2%	8.1%
7	Blood transfusion	0	0	2	2	0	1	1	0	2
		0%	0%	2.7%	1.2%	0%	1.1%	1.7%	0%	1.2%

Source: Computed

4.2.3 Respondents vulnerability context with household and society by age

The table 4.6 shows the respondents vulnerability context with household and society by age and divided into four sub-sections namely family, participation in decision making, number of dependents family and opinion.

Being infected with the virus is a big dilemma for the respondents. Adding to their grief there were some household whose family members were infected by the virus. The respondents within 18-30 years have more than two fifth (42.9%) less than two family members who were living with the virus, more than two fifth (42.9%) by less than four and remaining less than one fifth (14.3%) by more than four family members living with the virus. While two third (69%) of the respondents within 31-40 years have less than

four family members who were living with the virus, less than one third (29.6%) by less than two and less than one tenth (1.4%) by more than four family members living with the virus. Almost half (48%) of the respondents within 41-50 years have less than four family members who were living with the virus, less than half (46.7%) and remaining less than one tenth (5.3%) with more than four family members living with the virus. The table shows that more than half of the respondents have less than four family member infected by the virus.

As regard to participation in decision making, less than three fourth (71.4%) of the respondents within 18-30 years have always participated in decision making of the family, one seventh (14.3%) often participate, less than one tenth rarely participate (7.1%) and never participate (7.1%). While more than four fifth (88.7%) respondents within 31-40 years have always participate in decision making in the family, less than one tenth often participate (9.1%) and occasionally participate (1.4%). Majority (88%) of the respondents within 41-50 years have always participate in decision making of the family, less than one tenth often participate (6.7%), occasionally participate (2.7%) and rarely participate (2.7%). The table shows that majority of the respondents in the age group of 31-40 years have participated in the decision making in their households which in turn build the situation to bear equal trouble for running the households and taking care of the aged and their children.

The table 4.6 revealed the number of dependents in family. Less than three fifth (57.1%) of the respondents within 18-30 years have one family member dependent, more than one fifth (21.4%) of the respondents have more than 2 dependents, less than one seventh (14.3%) have two dependents and remaining less than one tenth (7.1%) have no one to look after them. More than one third (36.6%) respondents within 31-40 years have more than 2 family members dependent, more than one fourth (26.8%) have two, one fifth (21.1%) have one and one seventh (15.5%) have no one to look after them. While two fifth (41.3%) respondents within 41-50 years have more than 2 family members dependent on the respondents, less than one third (30.7%) have two, one fifth (21.3%) have one and less than one tenth (6.7%) have no one to look after them. The table shows that majority household have one or more than one family member who was dependent on the respondent.

Table 4.6

Respondents Vulnerability Context with Household and Society by Age

Sl. No.	Characteristics	Age			
		18-30 yrs n=14	31-40 yrs n=71	41-50 yrs n=75	Total N=160
1	**Family**				
	Less than 2	6	21	35	62
		42.9%	29.6%	46.7%	38.8%
	Less than 4	6	49	36	91
		42.9%	69%	48%	56.9%
	More than 4	2	1	4	7
		14.3%	1.4%	5.3%	4.4%
2	**Participation in decision making**				
	Never participate	1	0	0	1
		7.1%	0%	0%	0.6%
	Rarely participate	1	0	2	3
		7.1%	0%	2.7%	1.9%
	Occasionally participate	0	1	2	3
		0%	1.4%	2.7%	1.9%
	Often participate	2	7	5	14
		14.3%	9.9%	6.7%	8.8%
	Always participate	10	63	66	139
		71.4%	88.7%	88%	86.9%
3	**No of dependents in family**				
	One	8	15	16	39
		57.1%	21.1%	21.3%	24.4%
	Two	2	19	23	44
		14.3%	26.8%	30.7%	27.5%
	More than 2	3	26	31	60
		21.4%	36.6%	41.3%	37.5%
	No one	1	11	5	17
		7.1%	15.5%	6.7%	10.6%
4	**Opinion**				
	Dissatisfied	6	15	19	40
		42.9%	21.1%	25.3%	25%
	Somewhat dissatisfied	0	5	2	7
		0%	7%	2.7%	4.4%
	Neither satisfied nor dissatisfied	1	12	10	23
		7.1%	16.9%	13.3%	14.4%
	Somewhat satisfied	2	11	18	31
		14.3%	15.5%	24%	19.4%
	Satisfied	5	28	26	59
		35.7%	39.4%	34.7%	36.9%

Source: Computed

Regarding opinion, it was divided into five sub-sections. The condition of women in every society is far beyond satisfaction. The vulnerability of women is customary in each culture. WLHA lead a rather disgruntle lifestyle as they are made the focal point of responsibility and duty for their ailing family members. The table shows that little more than two fifth (42.9%) respondents within 18-30 years were dissatisfied with the present status that they are enjoying in the society, more than one third (35.7%) were satisfied, one seventh (14.3%) were somewhat satisfied and less than one tenth (7.1%) neither satisfied nor dissatisfied. While two fifth (39.4%) respondents within 31-40 years were satisfied with the present status that they are enjoying in the society, one fifth (21.1%) dissatisfied, one sixth neither satisfied nor dissatisfied (16.9%) & somewhat satisfied (15.5%) and less than one tenth (7%) somewhat dissatisfied. Further, one third (34.7%) respondents within 41-50 years were satisfied with the present status that they are enjoying in the society, one fourth dissatisfied (25.3%) & somewhat satisfied (24%), one eighth (13.3%) neither satisfied nor dissatisfied and remaining less than one tenth (2.7%) somewhat dissatisfied. The data reveals that majority of the respondents were not fully satisfied with their present social status.

4.2.4 Respondents privileges being WLHA

HIV/AIDS affect women in every sphere. Making themselves financially independent is one of the key steps which can bring a tiny assistance in their already overburden deprived social status. Being an earning member in the family create the condition for respondent to contribute in decision making and also create environment to get respect from the society.

Table 4.7

Respondent's privileges being WLHA

Sl. No.	Privileges	Frequency N=160	Per cent
1	Financial independence	115	71.9
2	Participate in decision making	83	51.9
3	Respectable place in society	11	6.9
4	Reduction in household chores	2	1.2
5	Able to mingle with other HIV (-) people	1	0.6

Source: Computed

Regarding the privileges being WLHA earner, more than two third (71.9%) enjoyed financial independence, more than half (51.9%) take part in decision making of their family and remaining less than one tenth enjoyed respectable place in society (6.9%), reduction in household chores (1.2%) and able to mingle with other HIV (-) people (0.6%). The table shows that being earning women, the respondents enjoyed the privileges of financial independence and participation in decision making.

4.2.5 Violence faced by respondents

Violence is a physical force unlawfully used toward a person's causing damage or injury. Violence can be used in diverse forms. It has its different unpleasant faces. More than one fourth (30%) of the respondents faced mental abuse and little less than one fifth (18.8%) faced domestic violence and remaining less than one tenth (6.2%) faced physical violence. Common form of violence prevalent among respondents was mental abuse, domestic violence and physical violence. There were no such cases of gender and sexual violence among the respondents. Majority of the respondents faced different form of violence either from their family member or partner or localites. Respondents were look down and mentally abuse by their family member/close friends/society for being HIV positive.

Table 4.8

Violence faced by respondents

Sl. No.	Characteristics	Frequency N=160	Per cent
I	**Violence**		
1	Mental abuse	48	30
2	Domestic violence	30	18.8
3	Physical violence	10	6.2
4	Gender violence	0	0
5	Sexual violence	0	0
II	**Reasons for violence**		
1	Being HIV+ woman	55	34.4
2	Financial problem	18	11.2
3	Husband alcoholic	14	8.7
4	Unemployment	1	0.6

Source: Computed

Violence is prevalent in every nook and corner of the world in different faces. Women are very susceptible in receiving violence from their family member/partner/close

relative/society. The main reasons for facing violence among respondents were due to financial problem, being HIV+ woman and unemployment. More than one third (34.4%) of the respondents faced violence due to their HIV status. Being WLHA makes the respondents prone in receiving violence. Their very positive status brought afflictions to themselves. One ninth (11.2%) of the respondents face due to financial problem, less than one tenth (8.7%) faced due to husband alcoholic problem and only one respondent (0.6%) faced violence due to unemployment. Financial constraint is one of the factors for respondents in receiving violence from their partner.

4.3 Patterns of livelihood assets of WLHA

The patterns of livelihood assets of WLHA are divided into five sections viz., respondents livelihood assets with financial capital by age, sources of income in family**,** respondents livelihood assets with human capital by age, respondents livelihood assets with physical capital by age, respondents livelihood assets with social capital by age.

4.3.1 Respondents livelihood assets with financial capital by age

The respondent's livelihood assets with financial capital by age are divided into four sub-sections viz., economic challenges, expenditure, economic support and reason for economic support.

As regard to economic challenges, vast majority (92.9%) of the respondents within the age of 18-30 years faced economic challenges in meeting their daily expenses, one fifth (21.4%) in providing adequate food, one third (35.7%) in providing better education for their children, no one in providing shelter and less than one tenth (7.1%) in getting treatment for their illness. While more than three fourth (77.5%) of the respondents within the age of 31-40 years faced economic challenges in meeting their daily expenses, one ninth (11.3%) in providing adequate food, two third (66.2%) in providing better education for their children, less than one tenth (7%) in providing shelter and one fifth (19.7%) in getting treatment for their illness. Further, four fifth (80%) of the respondents within the age of 41-50 years faced economic challenges in meeting their daily expenses, one sixth (16%) in providing adequate food, less than two third (62.7%) in providing better education for their children, less than one tenth (4%) in providing shelter and one eighth (12%) in getting treatment for their illness. The table shows that

majority of the respondents faced economic challenges in meeting their daily expenses and providing better education for their children.

Expenditure states to an amount of money spent on certain goods or services. More than three fourth (78.6%) of the respondents within the age of 18-30 years spend their expenditure in buying food, one fifth (21.4%) in buying cloths, two third (64.3%) in buying medicine, no one on house rent and half (50%) in providing children education. While more than four fifth (83.1%) of the respondents within the age of 31-40 years spend their expenditure in buying food, less than one tenth (7%) in buying cloths, two fifth (40.8%) in buying medicine, one seventh (14.1%) in house rent and three fourth (76.1%) in providing children education. Further, two third (68%) of the respondents within the age of 41-50 years spend their expenditure in buying food, less than one tenth (9.3%) in buying cloths, two fifth (42.7%) in buying medicine, one eighth (13.3%) in house rent and two third (66.7%) in providing children education. The table shows that majority of the respondents spend their expenditure in buying food and children education however least were spend in buying cloths.

Economic support is an important factor to sustain one's livelihood. More than one third (35.7%) of the respondents within the age of 18-30 years received economic support while remaining two third (64.3%) of the respondents do not received any economic support. While three fifth (59.2%) of the respondents within the age of 31-40 years received economic support while remaining two fifth (40.8%) of the respondents do not received any economic support. Further, more than half (54.7%) of the respondents within the age of 41-50 years received economic support while remaining more than two fifth (45.3%) of the respondents do not received any economic support. The table shows that more than half of the respondents received economic support from friends/family member/NGO/Government.

Regarding reason for economic support, one third (35.7%) of the respondents within the age of 18-30 years got economic support from family member/friends/NGO/Government to meet their daily expenses only. While less than one tenth of the respondents within the age of 31-40 years got economic support from family member/friends/NGO/Government to have sufficient food (9.9%) and meeting daily health care (4.2%), one fifth (18.3%) to access education for children and more than half (56.3%) in meeting daily expenses. Further, less than one tenth of the respondents within

Table 4.9

Respondents Livelihood Assets with Financial Capital by Age

Sl. No.	Characteristics	Distortions	Age			
			18-30 yrs n=14	31-40 yrs n=71	41-50 yrs n=75	Total N=160
I	**Economic challenges**					
1	Inability to meet daily expenses	Yes	13	55	60	128
			92.9%	77.5%	80%	80%
2	Inability to provide adequate food	Yes	3	8	12	23
			21.4%	11.3%	16%	14.4%
3	Inability to access better education for children	Yes	5	47	47	99
			35.7%	66.2%	62.7%	61.9%
4	Inability to provide shelter	Yes	0	5	3	8
			0%	7%	4%	5%
5	Unable to treat illness	Yes	1	14	9	24
			7.1%	19.7%	12%	15%
II	**Expenditure**					
1	Buying food	Yes	11	59	51	121
			78.6%	83.1%	68%	75.6%
2	Buying cloths	Yes	3	5	7	15
			21.4%	7.0%	9.3%	9.4%
3	Buying medicine	Yes	9	29	32	70
			64.3%	40.8%	42.7%	43.8%
4	House rent	Yes	0	10	10	20
			0%	14.1%	13.3%	12.5%
5	Children education	Yes	7	54	50	111
			50%	76.1%	66.7%	69.4%
III	**Economic support**	Yes	5	42	41	88
			35.7%	59.2%	54.7%	55%
IV	**Reason for economic support**					
1	To have sufficient food	Yes	0	7	4	11
			0%	9.9%	5.3%	6.9%
2	To meet daily health care	Yes	0	3	3	6
			0%	4.2%	4%	3.8%
3	To access education	Yes	0	13	11	24
			0%	18.3%	14.7%	15%
4	To meet daily expenses	Yes	5	40	35	80
			35.7%	56.3%	46.7%	50%

Source: Computed

the age of 41-50 years got economic support from family member/friends/NGO/Government to have sufficient food (5.3%) and meeting daily

health care (4%), one seventh (14.7%) to access education for children and less than half (46.7%) in meeting daily expenses. The table shows that majority of the respondent's reason to get economic support from family member/friends/NGO/Government was to meet daily expenses of their household.

4.3.2 Sources of income in family

The table 4.10 shows sources of income in family. Earning play an important share in maintaining one's household. Less than one tenth (7.1%) of the respondents within the age of 18-30 years were engaged in semi-skilled work other than their main source of income, one seventh (14.3%) in agricultural labour, no one in petty business/small shop and remaining more than three fourth (78.6%) of the respondents were not applicable since they were not engaged in other activity in addition to their main source of income. While more than one fifth (22.5%) of the respondents within the age of 31-40 years were engaged in semi-skilled work other than their main source of income, one sixth (16.9%) in agricultural labour, little less than one fifth (18.3%) in petty business/small shop and remaining more than two fifth (42.3%) of the respondents were not applicable since they were not engaged in other activity in addition to their main source of income. Further, more than one fifth (22.7%) of the respondents within the age of 41-50 years were engaged in semi-skilled work other than their main source of income, less than one tenth (8%) in agricultural labour, one tenth (10.7%) in petty business/small shop and remaining more than half (58.7%) of the respondents were not applicable since they were not engaged in other activity in addition to their main source of income. The table shows that almost half of the respondents were engaged in other low income generating activities in addition to their main source of income to run their household.

Involvement of respondents family earning are shown in below table and categorised into six types. Respondents within the age of 18-30 years have one seventh (14.3%) family member who were engaged in semi-skilled work, less than one tenth (7.1%) in agricultural labour, one fifth (21.4%) in agricultural cultivation, again one fifth (21.4%) in petty business/small shop, zero per cent in local transport work (auto/bus driver), less than one tenth (7.1%) in service (Pvt./Govt.) and the remaining more than one fourth (28.6%) were not applicable since they were not engaged in any activity. Respondents within the age of 31-40 years have less than one tenth (5.6%) family member who were engaged in semi-skilled work, less than one tenth (2.8%) in

agricultural labour, one fifth (19.7%) in agricultural cultivation, again one fifth (19.7%) in petty business/small shop, 1.4 per cent in local transport work (auto/bus driver), one seventh (14.7%) in service (Pvt./Govt.) and the remaining more than one third (36.6%) were not applicable since they were not engaged in any activity. Respondents within the age of 41-50 years have less than one tenth (5.3%) family member who were engaged in semi-skilled work, less than one tenth (4%) in agricultural labour, one eighth (12%) in agricultural cultivation, one sixth (16%) in petty business/small shop, less than one tenth (4%) in local transport work (auto/bus driver), one seventh (14.7%) in service (Pvt./Govt.) and remaining more than one fifth (44%) were not applicable since they were not engaged in any activity.

Table 4.10

Sources of income in family

Sl. No.	Characteristics	Age			
		18-30 yrs n=14	31-40 yrs n=71	41-50 yrs n=75	Total N=160
I	**Other source of earning**				
1	Semi-skilled work	1	16	17	34
		7.1%	22.5%	22.7%	21.2%
2	Agricultural labour	2	12	6	20
		14.3%	16.9%	8%	12.5%
3	Petty business/Small shop	0	13	8	21
		0%	18.3%	10.7%	13.1%
4	N/A	11	30	44	85
		78.6%	42.3%	58.7%	53.1%
II	**Involvement of family in earning**				
1	Semi-skilled work	2	4	4	10
		14.3%	5.6%	5.3%	6.2%
2	Agricultural labourer	1	2	3	6
		7.1%	2.8%	4%	3.8%
3	Agricultural cultivation	3	14	9	26
		21.4%	19.7%	12%	16.2%
4	Petty business/Small shop	3	14	12	29
		21.4%	19.7%	16%	18.1%
5	Local transport work (Auto/Bus driver)	0	1	3	4
		0%	1.4%	4%	2.5%
6	Service (Pvt/Govt)	1	10	11	22
		7.1%	14.1%	14.7%	13.8%
7	N/A	4	26	33	63
		28.6%	36.6%	44%	39.4%

Source: Computed

The table shows that majority number of respondent’s family member was engaged in income generating activities to run their household.

4.3.3 Respondents livelihood assets with human capital by age

The respondent’s livelihood assets with human capital by age are divided into three sub-sections viz., respondents exposure to skill development program, respondent’s skills for their livelihood and respondents cooperation of human resources in family.

The table 4.11 shows respondents exposure to skill development program. Less than one tenth (7.1%) of the respondents within the age of 18-30 years were exposed to skill development program. While one sixth (16.9%) of the respondents within the age of 31-40 years were exposed to skill development program. And Further, less than one fourth (22.7%) of the respondents within the age of 41-50 years were exposed to skill development program. The table shows that very least respondents have exposure to skills development program.

Skill is an ability to perform an activity or job. Less than one tenth (7.1%) of the respondents within the age of 18-30 years have skills of embroidery, no one within these age group have knitting, handloom and handicraft, food processing and tailoring skills, two fifth (42.9%) have weaving and one third have harvesting crop skills. While one fifth (19.7%) of the respondents within the age of 31-40 years have skills of embroidery, less than one tenth have knitting (2.8%), handloom and handicraft (4.2%) and tailoring (8.5%) skills, no one have food processing skill, more than two fifth (43.7%) have weaving and one third (33.8%) have harvesting crop skills. Further, one fifth (22.7%) of the respondents within the age of 41-50 years have skills of embroidery, less than one tenth have knitting (1.3%), food processing (1.3%) and tailoring (8%) skills, one tenth (10.7%) have handloom and handicraft skills, more than half (56%) have weaving and one fourth (26.7%) have harvesting crop skills. The table shows that majority of the respondents have skills of weaving and least skills of food processing.

Human resource is an important factor in contributing support to run the household. More than two fifth (42.9%) of the respondents within the age of 18-30 years have very poor cooperation of human resources in family, one fifth (21.4%) have poor, again one fifth (21.4%) have medium and remaining one seventh (14.3%) have good cooperation of human resource on their household. Half of the respondents (50.7%)

within the age of 31-40 years have very poor cooperation of human resources in family, one fourth (25.4%) have poor, one eighth (12.7%) have medium and remaining one ninth (11.3%) have good cooperation of human resources in family. Little less than half (48%) of the respondents within the age of 41-50 years have very poor cooperation of human resource, one fifth (21.3%) have poor, less than one fifth (18.7%) have medium and remaining one eighth (12%) have good cooperation of human resources in family. The table shows that almost half of the respondents have very poor cooperation of human resources in the family.

Table 4.11

Respondents Livelihood Assets with Human Capital by Age

Sl. No.	Characteristics	Distortions	Age			
			18-30 yrs n=14	31-40 yrs n=71	41-50 yrs n=75	Total N=160
I	**Exposure to skill development program**	Yes	1	12	17	30
			7.1%	16.9%	22.7%	18.8%
II	**Skills**					
1	Embroidery	Yes	1	14	17	32
			7.1%	19.7%	22.7%	20%
2	Knitting	Yes	0	2	1	3
			0%	2.8%	1.3%	1.9%
3	Handloom & Handicraft	Yes	0	3	8	11
			0%	4.2%	10.7%	6.9%
4	Food processing	Yes	0	0	1	1
			0%	0%	1.3%	0.6%
5	Weaving	Yes	6	31	42	79
			42.9%	43.7%	56%	49.4%
6	Harvesting crop.	Yes	5	24	20	49
			35.7%	33.8%	26.7%	30.6%
7	Tailoring	Yes	0	6	6	12
			0%	8.5%	8%	7.5%
III	**Cooperation**					
1	Very poor		6	36	36	78
			42.9%	50.7%	48%	48.8%
2	Poor		3	18	16	37
			21.4%	25.4%	21.3%	23.1%
3	Medium		3	9	14	26
			21.4%	12.7%	18.7%	16.2%
4	Good		2	8	9	19
			14.3%	11.3%	12%	11.9%

Source: Computed

4.3.4 Respondents Livelihood Assets with Physical Capital by Age

The table 4.12 shows the respondent's livelihood assets with physical capital by age. Vast majority (92.9%) of the respondents within the age of 18-30 years own mobile phone for communication. Cent per cent (98.6%) of the respondents within the age of 31-40 years own mobile phone for communication. And vast majority (92%) of the respondents within the age of 41-50 years own mobile phone for communication. The table shows that vast majority of the respondents own mobile phone for communication.

Table 4.12

Respondents owning of mobile phone

Sl. No.	Mobile phone	Age			
		18-30 yrs n=14	**31-40 yrs n=71**	**41-50 yrs n=75**	**Total N=160**
1	Yes	13	70	69	152
		92.9%	98.6%	92%	95%
	No	1	1	6	8
		7.1%	1.4%	8%	5%

Source: Computed

4.3.5 Respondents pattern of livelihood assets on social capital by age

The respondent's livelihood assets with social capital by age are divided into three sub-sections viz., social networks, relationship and perception.

A social network is a web of social interactions and individual relationships. More than one fourth (28.6%) of the respondents within the age of 18-30 years have bad impressions from social networks, half (50%) of the respondents have good, one fifth (21.4%) have tolerable and no one within 18-30 years have experience worse impression from social networks. While one eighth (12.7%) of the respondents within the age of 31-40 years have bad impressions from social networks, more than two third (69%) have good, little less than one sixth (15.5%) have tolerable and remaining less than one tenth (2.8%) have worse impression from social networks. Further, one eighth (12%) of the respondents within the age of 41-50 years have bad impressions from social networks, little more than two third (68%) have good, less than one fifth (17.3%) have tolerable and remaining less than one tenth (2.7%) have worse impression from social networks. The table shows that majority of the respondents have good impressions from social networks.

As regards to relationship, more than half of the respondents (57.1%) within the age of 18-30 years faced discrimination from family and friends due to their HIV status, more than one fourth (28.6%) got the same treatment as they were before infected by the virus and one seventh (14.3%) faced stigma, while there was no case for not accepting them in gathering. Less than one tenth (2.8%) of the respondents within the age of 31-40 years were not accepted in gathering, one fourth (25.4%) faced discrimination, two third (66.2%) got the same treatment as they were before infected by the virus and less than one tenth (5.6%) faced stigma. Less than two fifth (38.7%) of the respondents within the age of 41-50 years faced discrimination, more than half (56%) got the same treatment as they were before infected by the virus, less than one tenth (5.3%) faced stigma while there was no case for not accepting them in gathering. The table shows that majority of the respondents got the same treatment as they were before infected by the virus from family and friends.

Perception is the way in which one's think about or understand someone/something. Less than three fourth (71.4%) of the respondents within the age of 18-30 years felt that the perception of the community regarding their household does not affect them at all, little more than one fourth (28.6%) have felt little while no one within these age group felt huge effect. While four fifth (80.3%) of the respondents within the age of 31-40 years felt that the perception of the community regarding their household does not affect them at all, One sixth (16.9%) felt little and less than one tenth (2.8%) felt huge effect. Further, four fifth (80%) of the respondents within the age of 41-50 years felt that the perception of the community regarding their household does not affect them at all, one eighth (13.3%) felt little and less than one tenth (6.7%) felt huge effect. The table shows that vast majority of the respondents were not at all affected by the perception of the community regarding their household.

Table 4.13

Respondents pattern of livelihood assets on social capital by age

Sl. No.	Characteristics	Age			
		18-30 yrs n=14	31-40 yrs n=71	41-50 yrs n=75	Total N=160
I	**Social networks**				
1	Bad	4	9	9	22
		28.6%	12.7%	12%	13.8%
2	Good	7	49	51	107
		50%	69%	68%	66.9%
3	Tolerable	3	11	13	27
		21.4%	15.5%	17.3%	16.9%
4	Worse	0	2	2	4
		0%	2.8%	2.7%	2.5%
II	**Relationship**				
1	Won't accept me in gathering	0	2	0	2
		0%	2.8%	0%	1.2%
2	Discrimination	8	18	29	55
		57.1%	25.4%	38.7%	34.4%
3	Accept me as i am before	4	47	42	93
		28.6%	66.2%	56%	58.1%
4	Stigma	2	4	4	10
		14.3%	5.6%	5.3%	6.2%
III	**Perception**				
1	Not at all	10	57	60	127
		71.4%	80.3%	80%	79.4%
2	Little	4	12	10	26
		28.6%	16.9%	13.3%	16.2%
3	Huge	0	2	5	7
		0%	2.8%	6.7%	4.4%

Source: Computed

4.3.6 Member in social networks in their neighbourhood

The respondents member in social networks in their neighbourhood are divided into five sub-sections viz., agency, support of religious groups, feeling of exclusion, assistance from other organisation and challenges.

The agency are categorised into three types namely, meirapaibi, marup and SHG. Meirapaibi (women torch holder) is a women’s relationship specially established to fight against civil rights violations at the community level. More than one fourth (28.6%) of the

respondents within the age of 18-30 years belongs to meirapaibi (women torch holder), less than four fifth (78.6%) to marup (lottery) and one seventh (14.3%) to SHG. Less than half (45.1%) of the respondents within the age of 31-40 years belongs to meirapaibi (women torch holder), four fifth (78.9%) to marup (lottery) and one fourth (25.4%) to SHG. More than half (54.7%) of the respondents within the age of 41-50 years belongs to meirapaibi (women torch holder), three fifth (61.3%) to marup (lottery) and more than one third (36%) to SHG. The table shows that majority of the respondents belongs to one or other agency in the community.

As regards to support of religious groups, more than four fifth (85.7%) of the respondents within the age of 18-30 years felt that religious groups/networks were good for their household. While vast majority (95.8%) of the respondents within the age of 31-40 years also felt that religious groups/networks were good for their household. Further, vast majority (96%) of the respondents within the age of 41-50 years felt that religious groups/networks were good for their household. The table shows that vast majority of the respondents felt that support of religious groups/networks were good for their household.

Regarding feeling of exclusion, one seventh (14.3%) of the respondents within the age of 18-30 years felt excluded from relationships in neighbourhood. There were no such cases found within the age of 31-40 years of respondents. While less than one tenth (4%) of the respondents within the age of 41-50 years felt excluded from relationships in neighbourhood. The study shows that least respondents were excluded from relationships in their neighbourhood. The table shows that majority of the respondents was not excluded from relationships in neighbourhood.

The assistance/support from other organisation are divided into five types namely, food assistance, financial assistance, SHG, education and care & support. More than one fourth (28.6%) of the respondents within the age of 18-30 years got food assistance from other organisations, less than one tenth (7.1%) got financial assistance, no one within these age group got SHG and education benefit, nine tenth (92.9%) got care and support benefit. While one third (32.4%) of the respondents within the age of 31-40 years got food assistance from other organisations, one eighth (12.7%) got financial assistance, less than one tenth (3%) got SHG and one ninth (11.3%) got education benefit, nine tenth (90.1%) got care and support benefit. Further, more than one fifth (22.7%) of the

Table 4.14

Member in social networks in their neighbourhood

Sl. No.	Characteristics	Distortions	Age			
			18-30 yrs n=14	**31-40 yrs n=71**	**41-50 yrs n=75**	**Total N=160**
I	**Agency**					
1	Meirapaibi	Yes	4	32	41	77
			28.6%	45.1%	54.7%	48.1%
2	Marup (lottery)	Yes	11	56	46	113
			78.6%	78.9%	61.3%	70.6%
3	SHG	Yes	2	18	27	47
			14.3%	25.4%	36%	29.4%
II	**Support of Religious groups**	Yes	12	68	72	152
			85.7%	95.8%	96%	95%
III	**Feeling of exclusion**	Yes	2	0	3	5
			14.3%	0%	4%	3.1%
IV	**Assistance from other organisation**					
1	Food assistance	Yes	4	23	17	44
			28.6%	32.4%	22.7%	27.5%
2	Financial assistance	Yes	1	9	18	28
			7.1%	12.7%	24%	17.5%
3	SHG	Yes	0	2	6	8
			0%	2.8%	8%	5%
4	Education	Yes	0	8	10	18
			0%	11.3%	13.3%	11.2%
5	Care & support	Yes	13	64	65	142
			92.9%	90.1%	86.7%	88.8%
V	**Challenges**					
1	Stigma	Yes	2	4	10	16
			14.3%	5.6%	13.3%	10%
2	Unemployment	Yes	5	26	18	49
			35.7%	36.6%	24%	30.6%
3	Financial problem	Yes	13	64	69	146
			92.9%	90.1%	92%	91.2%
4	Discrimination	Yes	6	14	23	43
			42.9%	19.7%	30.7%	26.9%
5	Illness	Yes	0	0	2	2
			0%	0%	2.7%	1.2%
6	Alcoholism	Yes	0	1	1	2
			0%	1.4%	1.3%	1.2%
7	Child education	Yes	3	12	12	27
			21.4%	16.9%	16%	16.9%
8	Both parents HIV+	Yes	0	0	1	1
			0%	0%	1.3%	0.6%

9	Husband dead	Yes	0	1	2	3
			0%	1.4%	2.7%	1.9%

Source: Computed

respondents within the age of 41-50 years got food assistance from other organisations, one fourth (24%) got financial assistance, less than one tenth (8%) got SHG and one eighth (13.3%) got education benefit, less than nine tenth (86.7%) got care and support benefit. The table shows that vast majority number of respondents got care and support benefits from other organisations.

The respondent's causes of challenges in household are categorised into nine types. One seventh (14.3%) of the respondents within the age of 18-30 years causes of challenges in household were stigma, one third (35.7%) were unemployment, more than nine tenth (92.9%) were financial problem, two fifth (42.9%) were discrimination, one fifth (21.4%) were child education and no one from illness, alcoholism, both parents HIV+ and husband dead. Less than one tenth of the respondents within the age of 31-40 years causes of challenges in household were stigma (5.6%), alcoholism (1.4%) and husband dead (1.4%), less than two fifth (36.6%) were unemployment, nine tenth (90.1%) were financial problem, one fifth (19.7%) were discrimination, one sixth (16.9%) were child education and no one from illness and both parents HIV+. Almost one seventh (13.3%) of the respondents within the age of 41-50 years causes of challenges in household were stigma, one fourth (24%) were unemployment, more than nine tenth (92%) were financial problem, one third (30.7%) were discrimination, one sixth (16%) were child education and less than one tenth illness (2.7%), alcoholism (1.3%), both parents HIV+ (1.3%), husband dead (2.7%). The table shows that majority of the respondent's main causes of challenges in household was due to financial problem.

4.4 Livelihood strategies of WLHA

The livelihood strategies of WLHA are divided into three sections viz., respondent's impact on livelihood strategies with family and friends by age, respondent's livelihood strategies by age and respondent's assistance from NGOs by age.

4.4.1 Respondent's impact on livelihood strategies with family and friends by age

The respondents impact on livelihood strategies with family and friends by age are divided into three sub-sections viz., status, family and friends.

As regards to status, cent per cent (100%) of the respondents within the age of 18-30 years shows impact of HIV status on livelihood. Vast majority (98.6%) of the respondents within the age of 31-40 years also shows impact of HIV status on livelihood. And again cent per cent (100%) of the respondents within the age of 41-50 years shows impact of HIV status on livelihood. The table shows that cent per cent of the respondents were affected by their status.

Family is a group of people who are related to each other. Family is a social institution and the members are dependent on each other. More than one fourth (28.6%) of the respondents within the age of 18-30 years have no effect on family from the illness, one seventh (14.3%) have mild, more than half of the respondents (57.1%) have huge and zero per cent for everything. While one ninth (11.3%) of the respondents within the age of 31-40 years have no effect on family from the illness, one fifth (21.1%) have mild, two third (67.6%) have huge and zero per cent for everything. Further, less than one fifth (18.7%) of the respondents within the age of 41-50 years have no effect on family from the illness, almost one fourth (24%) have mild, more than half (56%) have huge and less than one tenth (1.3%) have everything. The table shows that majority of the respondents have huge effect of illness on family.

Regarding friends, little more than one third (35.7%) of the respondents within the age of 18-30 years have exposed their status to 1-10 people in the community, less than one tenth (7.1%) to 1-50 people, half of the respondents (50%) to everyone, less than one tenth (7.1%) were not applicable and no one within these age group exposed their status to 1-20 people, half of the community and lots of people but HIV+ only. Less than one tenth (7%) of the respondents within the age of 31-40 years have exposed their status to 1-10 people in the community, less than one fifth (18.3%) to 1-20 people, less than one tenth to 1-50 people (5.6%) and half of the community (2.8%), three fifth (60.6%) to everyone and less than one tenth (5.6%) were not applicable and no one within these age group exposed their status to lots of people but HIV+ only. Less than one seventh (13.3%) of the respondents within the age of 41-50 years have exposed their status to 1-10 people in the community, less than one fifth (17.3%) to 1-20 people, less than one tenth to 1-50 people (4%), half of the community (4%) & lots of people but HIV+ only (2.7%), more than half of the respondents (54.7%) to everyone and less than one tenth (4%) were not applicable. The table shows that majority of the respondents have exposed their HIV status to everyone.

Table 4.15

Respondent's impact on livelihood strategies with family and friends by age

Sl. No.	Characteristics	Age			
		18-30 yrs n=14	**31-40 yrs n=71**	**41-50 yrs n=75**	**Total N=160**
1	**Status**				
	Yes	14	70	75	159
		100%	98.6%	100%	99.4%
	No	0	1	0	1
		0%	1.4%	0%	0.6%
2	**Family**				
	Nothing change	4	8	14	26
		28.6%	11.3%	18.7%	16.2%
	Mild	2	15	18	35
		14.3%	21.1%	24%	21.9%
	Huge	8	48	42	98
		57.1%	67.6%	56%	61.2%
	Everything	0	0	1	1
		0%	0%	1.3%	0.6%
3	**Friends**				
	1-10 people	5	5	10	20
		35.7%	7%	13.3%	12.5%
	1-20 people	0	13	13	26
		0%	18.3%	17.3%	16.2%
	1-50 people	1	4	3	8
		7.1%	5.6%	4%	5%
	Half of community	0	2	3	5
		0%	2.8%	4%	3.1%
	Everyone	7	43	41	91
		50%	60.6%	54.7%	56.9%
	N/A	1	4	3	8
		7.1%	5.6%	4%	5%
	Lots of people but HIV+ only	0	0	2	2
		0%	0%	2.7%	1.2%

Source: Computed

4.4.2 Respondent's livelihood strategies by age

The respondents livelihood strategies by age are divided into four sub-sections viz., pre diagnosis, coping with livelihood, challenges due to loss of loved one and coping with challenges.

With regard to post diagnosis activities of the respondents, two third (64.3%) of the respondents within the age of 18-30 years cannot do hard manual work after their

diagnosis, two fifth (42.9%) cannot support their family and children, one fifth (21.4%) cannot do daily wage earning and no one have problem in attending social gathering. Less than one tenth (5.6%) of the respondents within the age of 31-40 years cannot attend social gathering after their diagnosis, less than nine tenth (88.7%) cannot do hard manual work, less than half (46.5%) cannot support their family and children, less than one tenth (9.9%) cannot do daily wage earning. Less than one tenth (8%) of the respondents within the age of 41-50 years cannot attend social gathering after their diagnosis, four fifth (82.7%) cannot do hard manual work, less than half (46.7%) cannot support their family and children, one seventh (13.3%) cannot do daily wage earning. The table shows that majority of the respondents cannot do hard manual work after their diagnosis.

Coping refers to facing or dealing with responsibilities, problem or difficulties in a given situation. The respondents coping with livelihood are categorised into fourteen types. More than half (57.1%) of the respondents within the age of 18-30 years adopted the coping strategies of loan from friends to maintain their livelihood, less than one tenth adopted children drop out from school (7.1%) and selling their belongings (7.1%), more than one fourth adopted working hard for livelihood (28.6%) and help from extended family (28.6%), more than half (57.1%) adopted starting petty business, no one within these age group adopted reduced expenditure on food, reduced expenditure on health care, support from NGOs, praying to Almighty God, help from son, help from in-laws, loan from bank and help from neighbour. While more than half (52.1%) of the respondents within the age of 31-40 years adopted the coping strategies of loan from friends to maintain their livelihood, less than one tenth adopted reduced expenditure on health care (1.4%), support from NGOs (7%), selling their belongings (4.2%), praying to Almighty God (5.6%), help from in-laws (1.4%), loan from bank (1.4%) and help from neighbour (2.8%), two fifth (42.3%) adopted working hard for livelihood, half (49.3%) adopted starting petty business, almost one fourth (23.9%) adopted help from extended family and no one within these age group adopted reduced expenditure on food, children drop out from school and help from son. Further, one third (36%) of the respondents within the age of 41-50 years adopted the coping strategies of loan from friends to maintain their livelihood, less than one tenth adopted support from NGOs (8%), children drop out from school (4%), selling their belongings (6.7%), praying to Almighty God (1.3%), help from son (4%) and help from in-laws (1.3%), one third (33.3%) adopted working hard for livelihood, two fifth (42.7%) adopted starting petty business, more than

one fourth (28%) adopted help from extended family, no one within these age group adopted reduced expenditure on food, reduced expenditure on health care, loan from bank and help from neighbour. The table below shows that majority of the respondents adopted coping strategies of taking loan from friends, working hard for livelihood, starting petty business and help from extended family to sustain their livelihood.

Regarding challenges due to loss of loved one, one fifth (21.4%) of the respondents within the age of 18-30 years faced challenges due to loss of their loved one. While one third (33.8%) of the respondents within the age of 31-40 years faced challenges due to loss of their loved one. And further, more than two fifth (45.3%) of the respondents within the age of 41-50 years faced challenges due to loss of their loved one. The table shows that two fifth of the respondents faced challenges due to the loss of loved ones.

The coping with challenges of the respondents are categorised into four types namely, self-isolation, spending time with close friends, consulting counsellor and embrace positive beliefs. Less than one tenth of the respondents within the age of 18-30 years adopted self-isolation (7.1%), spending time with close friends (7.1%) and consulting counsellor (7.1%) as the coping strategies for the loss of their loved ones, one seventh (14.3%) adopted embrace positive beliefs. While one ninth (11.3%) of the respondents within the age of 31-40 years adopted spending time with close friends as the coping strategies for the loss of their loved ones, less than one tenth (7%) adopted consulting counsellor, one fourth (23.9%) adopted embrace positive beliefs and no one within these age group adopted self-isolation. Further, one fifth (20%) of the respondents within the age of 41-50 years adopted spending time with close friends as the coping strategies for the loss of their loved ones, less than one tenth (5.3%) adopted consulting counsellor, one third (32%) adopted embrace positive beliefs and no one within these age group adopted self-isolation. The table shows that most of the respondents adopted coping strategies of embracing positive beliefs and spending time with close friends for the loss of their loved ones.

Table 4.16

Respondent's livelihood strategies by age

Sl. No.	Characteristics	Distortions	Age			
			18-30 yrs n=14	31-40 yrs n=71	41-50 yrs n=75	Total N=160
I	**Pre diagnosis**					
1	Attending social gathering	Yes	0	4	6	10
			0%	5.6%	8.0%	6.2%
2	Hard manual work	Yes	9	63	62	134
			64.3%	88.7%	82.7%	83.8%
3	Supporting family & children	Yes	6	33	35	74
			42.9%	46.5%	46.7%	46.2%
4	Daily wage earning	Yes	3	7	10	20
			21.4%	9.9%	13.3%	12.5%
II	**Coping with livelihood**					
1	Reduced expenditure on food	Yes	0	0	0	0
			0%	0%	0%	0%
2	Reduced expenditure on health care	Yes	0	1	0	1
			0%	1.4%	0%	0.6%
3	Borrow money from friends	Yes	8	37	27	72
			57.1%	52.1%	36%	45.0%
4	Seek support from NGOs	Yes	0	5	6	11
			0%	7%	8%	6.9%
5	Children drop out from school	Yes	1	0	3	4
			7.1%	0%	4%	2.5%
6	Working hard	Yes	4	30	25	59
			28.6%	42.3%	33.3%	36.9%
7	Selling belonging	Yes	1	3	5	9
			7.1%	4.2%	6.7%	5.6%
8	Starting petty business	Yes	8	35	32	75
			57.1%	49.3%	42.7%	46.9%
9	Praying to Almighty God	Yes	0	4	1	5
			0%	5.6%	1.3%	3.1%
10	Help from extended family	Yes	4	17	21	42
			28.6%	23.9%	28%	26.2%
11	Help from son	Yes	0	0	3	3
			0%	0%	4%	1.9%
12	Help from in-laws	Yes	0	1	1	2
			0%	1.4%	1.3%	1.2%
13	Loan from bank	Yes	0	1	0	1
			0%	1.4%	0%	0.6%
14	Help from neighbour	Yes	0	2	0	2
			0%	2.8%	0%	1.2%

III	Challenges due to the loss of your loved one	Yes	3	24	34	61
IV	Coping with challenges					
1	Self-isolation	Yes	1	0	0	1
			7.1%	0%	0%	0.6%
2	Spending time with close friends	Yes	1	8	15	24
			7.1%	11.3%	20%	15%
3	Consulting counsellor	Yes	1	5	4	10
			7.1%	7%	5.3%	6.2%
4	Embrace positive beliefs	Yes	2	17	24	43
			14.3%	23.9%	32%	26.9%

Source: Computed

4.4.3 Respondent's assistance from NGOs by age

The respondents assistance from NGOs by age are divided into five sections viz., support other than family, support from NGOs and GOs, reason for seeking support from NGOs and GOs, extent of help from NGO and aspect of help from NGO.

The table 4.17 shows the respondents support other than family. Less than one tenth (7.1%) of the respondents within the age of 18-30 years received support from neighbours besides their family, one seventh (14.3%) from friends, two fifth from extended family (42.9%) and NGO (42.9%), vast majority (92.9%) received from Government assistance. While one ninth (11.3%) of the respondents within the age of 31-40 years received support from neighbours besides their family, more than one fifth (22.5%) from friends, three fifth (62%) from extended family, more than half (54.9%) from NGO and almost cent per cent (98.6%) received from Government assistance. Further, less than one tenth (8%) of the respondents within the age of 41-50 years received support from neighbours besides their family, one fifth (21.3%) from friends, less than three fourth (72%) from extended family, three fifth (62.7%) from NGO and vast majority (96%) received from Government assistance. The table shows that vast majority of the respondents received support from Government, extended family and NGO besides their family.

As regards to support from NGOs and GOs, one third (35.7%) of the respondents within the age of 18-30 years received food assistance from NGO or Government organisations to supports their livelihood, vast majority (92.9%) received medical support, vast majority (92.9%) received counselling, one fifth (21.4%) received financial

support and no one within these age group received education and empowerment support. While one third (33.8%) of the respondents within the age of 31-40 years received food assistance from NGO or Governments organisation to supports their livelihood, vast majority (94.4%) received medical support, vast majority (94.4%) received counselling, less than one tenth received education support (9.9%) & empowerment support (9.9%) and two fifth (43.7%) received financial support. Further, one fourth (25.3%) of the respondents within the age of 41-50 years received food assistance from NGO or Government organisations to supports their livelihood, more than vast majority (97.3%) received medical support, more than nine tenth (97.3%) received counselling, one eighth (12%) received education, less than one tenth (2.7%) received empowerment and two fifth (38.7%) received financial support. The table shows that vast majority of the respondents received medical and counselling support from NGO or Government organisations.

Regarding reason for seeking support from NGOs and GOs, one seventh of the respondents within the age of 18-30 years seek support from NGOs and Government organisations due to hide their status (14.3%), financial crisis (14.3%) & unemployment (14.3%), one fifth (21.1%) seek support due to unable to manage household by themselves, more than one fourth (28.6%) due to poor health, one third (35.7%) due to get care & support and no one within these age group seek support due to want to live long, want to live with my children, child education, approached made by NGO worker and want to mingle with other HIV+ people. Less than one tenth of the respondents within the age of 31-40 years seek support from NGOs and Government organisations due to hide their status (7%), unable to manage household by themselves (9.9%), unemployment (2.8%), want to live long (1.4%), want to live with my children (1.4%), child education (1.4%), approached made by NGO worker (8.5%) & want to mingle with other HIV+ people (1.4%), one fifth (21.1%) due to financial crisis, one fourth (26.8%) due to poor health and more than half (52.1%) due to get care and support. Less than one tenth of the respondents within the age of 41-50 years seek support from NGOs and Government organisations due to hide their status (4%), unable to manage household by themselves (9.3%), unemployment (4%), want to live long (1.3%), want to live with my children (2.7%), approached made by NGO worker (2.7%) & want to mingle with other HIV+ people (2.7%), one sixth (16%) due to financial crisis, one third (32%) due to poor health, almost half (49.3%) due to get care and support and no one within these age group

Table 4.17

Respondent's assistance from NGOs by age

Sl. No.	Characteristics	Distortions	Age			
			18-30 yrs n=14	31-40 yrs n=71	41-50 yrs n=75	Total N=160
I	**Support other than family**					
1	Neighbours	Yes	1	8	6	15
			7.1%	11.3%	8%	9.4%
2	Friends	Yes	2	16	16	34
			14.3%	22.5%	21.3%	21.2%
3	Extended family	Yes	6	44	54	104
			42.9%	62%	72%	65%
4	NGO	Yes	6	39	47	92
			42.9%	54.9%	62.7%	57.5%
5	Government assistance	Yes	13	70	72	155
			92.9%	98.6%	96%	96.9%
II	**Support from NGOs and GOs**					
1	Food	Yes	5	24	19	48
			35.7%	33.8%	25.3%	30%
2	Medical support	Yes	13	67	73	153
			92.9%	94.4%	97.3%	95.6%
3	Counselling	Yes	13	67	73	153
			92.9%	94.4%	97.3%	95.6%
4	Education	Yes	0	7	9	16
			0%	9.9%	12%	10%
5	Empowerment	Yes	0	7	2	9
			0%	9.9%	2.7%	5.6%
6	Financial support	Yes	3	31	29	63
			21.4%	43.7%	38.7%	39.4%
III	**Reason for seeking support from NGOs and GOs**					
1	To hide the status	Yes	2	5	3	10
			14.3%	7%	4%	6.2%
2	Unable to manage household by themselves	Yes	3	7	7	17
			21.4%	9.9%	9.3%	10.6%
3	Financial crisis	Yes	2	15	12	29
			14.3%	21.1%	16%	18.1%
4	Poor health	Yes	4	19	24	47
			28.6%	26.8%	32%	29.4%
5	Unemployment	Yes	2	2	3	7
			14.3%	2.8%	4%	4.4%
6	To get care & support	Yes	5	37	37	79
			35.7%	52.1%	49.3%	49.4%
7	Want to live long	Yes	0	1	1	2
			0%	1.4%	1.3%	1.2%

8	Want to live with my children	Yes	0	1	2	3
			0%	1.4%	2.7%	1.9%
9	Child education	Yes	0	1	0	1
			0%	1.4%	0%	0.6%
10	Approached made by NGO worker	Yes	0	6	2	8
			0%	8.5%	2.7%	5%
11	Want to mingle with other HIV+ people	Yes	0	1	2	3
			0%	1.4%	2.7%	1.9%
IV	**Extent of help from NGO**					
1	Very little		3	14	21	38
			21.4%	19.7%	28%	23.8%
2	Little		7	33	27	67
			50%	46.5%	36%	41.9%
3	Huge		4	24	26	54
			28.6%	33.8%	34.7%	33.8%
4	Only help		0	0	1	1
			0%	0%	1.3%	0.6%
V	**Aspect of help from NGO**					
1	Moral support	Yes	12	57	65	134
			85.7%	80.3%	86.7%	83.8%
2	Physical support	Yes	0	2	1	3
			0%	2.8%	1.3%	1.9%
3	Mental support	Yes	3	14	15	32
			21.4%	19.7%	20%	20%
4	Legal support	Yes	2	1	1	4
			14.3%	1.4%	1.3%	2.5%
5	Medical support	Yes	1	7	5	13
			7.1%	9.9%	6.7%	8.1%
6	Nutrition support	Yes	1	7	7	15
			7.1%	9.9%	9.3%	9.4%
7	Education support	Yes	0	5	4	9
			0%	7%	5.3%	5.6%
8	Financial support	Yes	0	8	6	14
			0%	11.3%	8%	8.8%

Source: Computed

seek support due to child education. The table shows that half of the respondent's reason to seek support from NGOs and Government organisations were due to get care and support.

The extent of help from NGO is divided into four categories: very little, little, huge and only help. One fifth (21.4%) of the respondents within the age of 18-30 years got very little support from NGO, half (50%) got little, little more than one fourth

(28.6%) got huge and zero case for only help. While one fifth (19.7%) of the respondents within the age of 31-40 years got very little support from NGO, less than half (46.5%) got little, one third (33.8%) got huge and again zero case for only help. Further, more than one fourth (28%) of the respondents within the age of 41-50 years got very little support from NGO, less than two fifth (36%) got little, one third (34.7%) got huge and less than one tenth (1.3%) shows only help. The table shows that majority of the respondents got help from NGO.

Regarding aspects of help from NGO, more than four fifth (85.7%) of the respondents within the age of 18-30 years got moral support from NGO, one fifth (21.4%) got mental support, one seventh (14.3%) got legal support, less than one tenth got medical support (7.1%), nutrition support (7.1%) and no one within these age group got physical support, education support and financial support. While four fifth (80.3%) of the respondents within the age of 31-40 years got moral support from NGO, less than one tenth got physical support (2.8%), legal support (1.4%), medical support (9.9%), nutrition support (9.9%), education support (7%), one fifth (19.7%) got mental support and one ninth (11.3%) got financial support. Less than nine tenth (86.7%) of the respondents within the age of 41-50 years got moral support from NGO, less than one tenth got physical support (1.3%), legal support (1.3%), medical support (6.7%), nutrition support (9.3%), education support (5.3%), financial support (8%) and one fifth (20%) got mental support. The table shows that vast majority of the respondents got moral support from NGO.

4.5 Relationship between livelihood assets and strategies among WLHA

The relationship between livelihood assets and strategies among WLHA are divided into four sections viz., correlation of financial capital and coping strategies, correlation of human capital and coping strategies, correlation of physical capital and coping strategies and correlation of social capital and coping strategies.

4.5.1 Correlation of financial capital and coping strategies

The table 4.18 shows the correlation of financial capital and coping strategies, to find out the associations Karl Pearson co-efficient test was applied. It was found that there was a relationship between inability to provide shelter and inability to provide adequate food (.233) at 0.01 level of significance. There was also relationship between

unable to treat illness and inability to provide adequate food (.277) at 0.01 level of significance. In financial capital and coping strategies, there was relationship between unable to treat illness and inability to provide shelter (.385) at 0.01 level of significance. And also there was a relationship between working hard for livelihood and inability to provide shelter (.181) at 0.05 level of significance in. Further, relationship between working hard for livelihood and unable to treat illness (.223) at 0.01 level of significance (see table 4.18).

It was also found that there was negative relationship between selling their belongings and working hard for livelihood (-.187), starting petty business and support from NGOs (-.156), help from extended family and loan from friends (-.197) & help from extended family and starting petty business (-.190) at 0.05 level of significance (see table 4.18)

Analysis of results shows that there was positive relationship between unable to treat illness and inability to provide adequate food & inability to provide shelter. The more WLHA spend their money on treating their illness, the more WLHA faced problem in providing food and shelter to their family. And the more WLHA unable to provide shelter and treat illness, the more WLHA have to work hard for their livelihood. Hence, from the analysis the correlation clearly depict that the respondents living conditions were very poor and pathetic in terms of shelter, food and treatment.

There was negative relationship between working hard for livelihood and selling their belongings. It shows that when WLHA started working hard for livelihood they stop selling their belongings. The study also shows that when WLHA started petty business they stop asking for help from NGOs and when WLHA took help from their extended family they stop asking for loan from friends. Further, the data revealed that WLHA have some resistance in their livelihood.

4.5.2 Correlation of human capital and coping strategies

To examine the relationship between human capital and coping strategies, Karl Pearson co-efficient test was used. There was a relationship between knitting and embroidery (.161) at 0.05 and also there was relationship between working hard for livelihood and harvesting crop (.363) at 0.01 level. Further, there was relationship

between starting petty business and weaving (.275) at 0.01 level of significance (see table 4.19).

It was also found that there was negative relationship between harvesting crop and embroidery (-.231) at 0.01 level. Further, the study reveals that there was negative relationship between tailoring and weaving (-.186), working hard for livelihood and embroidery (-.155), working hard for livelihood and weaving (-.159), selling their belongings and harvesting crop (-.162), selling their belongings and working hard for livelihood (-.187), starting petty business and support from NGOs (-.156), help from extended family and loan from friends (-.197) and help from extended family and starting petty business (-.190) at 0.05 level of significance (see table 4.19).

Analysis of results show that there was a positive relationship between knitting and embroidery and also revealed that the more WLHA involved in semi-skilled work.

There was also negative relationship between working hard for livelihood and weaving. It shows that when WLHA engaged them in hard work they decrease their involvement in embroidery and weaving. It was also found that when WLHA engaged in harvesting crop that tend to affect their weaving.

4.5.3 Correlation of physical capital and coping strategies

The table 4.20 shows the correlation of physical capital and coping strategies. It was found that there was negative correlation between working hard for livelihood and mobile phone (-.175), selling their belongings and working hard for livelihood (-.187), starting petty business and support from NGOs (-.156), help from extended family and loan from friends (-.197) and help from extended family and starting petty business (-.190) at 0.05 level of significance (see table 4.20).

Analysis shows that there was a negative relationship between physical capital and coping strategies. It shows that when WLHA were not having good physical capital and coping strategies.

4.5.4 Correlation of social capital and coping strategies

The table 4.21 shows the correlation of social capital and coping strategies in Pearson's correlation. There was relationship between loan from friends and support from religious group (.196) at 0.05 level of significance (see table 4.21).

It was also found that there was negative correlation between support from religious group and marup (-.167), selling their belongings and working hard for livelihood (-.187), starting petty business and support from NGOs (-.156), help from extended family and loan from friends (-.197) & help from extended and starting petty business (-.190) at 0.05 level of significance (see table 4.21).

Analysis shows that there was positive relationship between loan from friends and support from religious group. It revealed that the more WLHA link with social networks the better their support system. There was also negative relationship found between marup and support from religious group. It shows that the more WLHA engaged in marup, the less they asked support from religious group.

The above chapter, results and discussion were presented based on the objectives of the study. The next chapter presents the conclusion and suggestions of the present study.

CHAPTER V

CONCLUSION AND SUGGESTIONS

The present chapter briefly draws out the conclusion and suggestions of the study. The findings of the present study highlighted and divided into sections with its sub sections.

5.1 Summary

The purpose of the present study is to understand the vulnerability context of WLHA and identifies the relationship between livelihood assets and strategies among WLHA in Imphal, Manipur by using Sustainable Livelihood Framework.

The study explores livelihood vulnerabilities, assets and strategies of WLHA in both Imphal East and Imphal West district. Manipur stands at 3rd rank among the HIV positive high prevalence states (Census 2011). The main causes of frightening number of HIV rate in state was because of the easy access to the transit route of drugs across the border with Myanmar, growing unemployment among youth adding with westernized lifestyle, general frustration, family complications, pleasure seeking, lack of societal control, poor health services, lack of political will and social unrest. Among the districts of Manipur, Imphal has reported highest number of HIV positive cases. The virus has spread to the significant number of female sexual partners of IDUs and their kids (Census, 2011). Women are especially vulnerable to HIV infection and sexually transmitted diseases due to biological and socio cultural factors counting economic, educational and legal discrimination and imbalanced gender relations. WLHA grieves lots of disadvantage and the problem was more when she became a widow. To support the family, they were forced to choose different hard working job which paid very low wage. In this current era, AIDS has been increasingly recognized as a livelihood crisis. The present research provides an overview of evidence about the status of WLHA and their livelihood strategies in Imphal, Manipur.

The study was cross sectional in nature and exploratory in design. A total of 160 WLHA between the ages of 18-50 years were selected for the study. The study was based on primary data collected through qualitative and quantitative methods. The secondary data were collected from books, journals, newspapers, magazines, websites, NGO

pamphlets, articles, etc. quantitative data was collected from WLHA by using interview schedule. The data collected were analysed with the help of SPSS and presented in the form of single frequency tables, cross tables and correlation for interpretation.

The objectives of the study were to understand the vulnerability context of WLHA, the demographic profile of the WLHA in Imphal district, to assess the patterns of livelihood assets of WLHA, to probe into the livelihood strategies of WLHA and to determine the relationship between livelihood assets and strategies among WLHA.

The researcher observed the following major findings:-

5.1.1 Profile of the respondents

The findings in the present study revealed that majority of the respondents in both the districts were from periphery area. The epidemic of HIV/AIDS knows no boundaries and prevalent in all the sections of women in society. Majority of the respondents belongs to the age group of 41-50 years while 18-30 years were the least number. The findings also indicated that majority of the Imphal valley was dominated by Hindus. Their education profile indicates that in both the districts respondents who studied till matriculate were the highest. Occupation plays an important role in supporting one's livelihood. The majority of the respondents in both the districts were engaged in low paying job which required hard work. And half of the respondents in both the districts have monthly income between Rs.2000-5000. The time period of the occupation for respondents in both the districts was highest who works for 2-5 years. Almost half of the respondents in both the districts have household who were headed by respondent herself and their annual income lies between Rs.50000-100000. More than half of the respondents in both the districts live under poverty line and belongs to economically deprived sections.

Marriage is regarded as a sacred bond for every living human being but this sacred bond has become the very means for resentment for the respondents. The findings revealed that majority of the HIV transmission takes place within the sanctity of marriage. Majority of the respondents in both the districts belongs to nuclear family and they have small and medium size families which comprises 1-6 family members. The findings further reveal that majority of the respondents in both the districts belongs to stable family and almost half of the respondent's household were headed by their husband.

Almost half of the respondents in both the districts inherent the house from their elders. Majority of the respondent's family have land of their own and half of the respondent's family own below ½ acre of land. The findings also show that majority of the respondents in both the districts does not possess any property by their name and the reason behind it were due to the belief of family members that they would not live a long and healthy life.

5.1.2 Vulnerability context of WLHA

The findings indicated that majority of the respondents choose hospital as their first time illness detection place since confidentiality to reveal their identity were kept secret and more than half of the respondents in both the districts were living with the virus with more than six years which means they have very high chances of catching of AIDS (Varma, 2014). Majority of the respondents decided to go for HIV testing since their partner was infected by the virus. Majority of the respondents started to seek treatment due to their low CD4 count.

The findings further reveal that majority of the respondents have the chance to participate in the decision making of their household which in turn build the situation to bear equal trouble for running household and taking care of the aged and children. More than half of the respondents in both the districts have less than four family members infected by the virus. Majority household in both the districts have one or more than one family member who was dependent on the respondent. Being an earning member the respondents enjoyed the privileges of financial independence and participation in decision making though they were not fully satisfied with their present social status.

Violence is a physical force unlawfully used toward a person's causing damage or injury. Half of the respondents in both the districts faced mental abuse, domestic violence and physical violence due to financial problem, being WLHA, husband alcoholic problem and unemployment were also supplementing in their life. However, there were no such cases of gender and sexual violence among the respondents in both the districts.

5.1.3 Patterns of livelihood assets of WLHA

The study reveals that majority of the respondents in both the districts faced economic challenges in meeting their daily expenses and providing better education for their children. Majority of the respondents in both the districts spend their expenditure in buying food and children education; and least was spend in buying cloths. More than half

of the respondents received economic support from friends/family member/NGO/Government and the reason to get such support were to meet their daily expenses of the household. Majority number of respondents in both the districts got care and support benefits from other organisations.

The findings revealed that almost half of the respondents in both the districts were engaged in other low income generating activities in addition to their main source of income to run their household. Majority number of respondent's family member was engaged in income generating activities however half of the respondents have very poor cooperation of human resources in the family. Majority of respondent's main causes for challenges in household was due to financial problem.

Half of the respondents in both the districts have skills of weaving and least skills of food processing and very least number of respondents has exposure to skills development program.

The findings further revealed that two third of the respondents in both the districts have good impressions from social networks and majority respondents belongs to one or other agency in the community. More than half of the respondents in both the districts got the same treatment as they were before infected by the virus from family and friends. Majority of the respondents in both the districts were not at all affected by the perception of the community regarding their household. Vast majority of respondents in both the districts felt that support of religious groups/networks was good for their household and they did not feel excluded from associations in neighbourhood. Vast majority of respondents in both the districts own mobile phone for communication.

5.1.4 Livelihood strategies of WLHA

The study revealed that hundred per cent of the respondents in both the districts were affected by the virus and it was found that three fifth of the respondents have huge effect of illness on family. More than half of the respondents in both the districts have exposed their HIV status to everyone.

The findings also indicated that majority of the respondents in both the districts cannot do hard manual work after their diagnosis. To cope with their livelihood majority of the respondents adopted borrowing money from friends, working hard, starting petty business, selling belonging and help from extended family to sustain their household.

Two fifth of the respondents in both the districts faced challenges due to the loss of loved ones and to cope with the situation most of them adopted embracing positive beliefs and spending time with close friends.

The findings further revealed that majority of the respondents in both the districts received support from Government, extended family and NGO besides their family. Majority of the respondents in both the districts received medical and counselling support from NGO or Government organisations. Majority of the respondents in both the districts got help from NGO in the form of moral, physical, mental, medical, education, nutrition and financial support.

The correlation that was found in the study were the more WLHA spend their money on treating their illness, the more WLHA faced problem in providing food and shelter to their family. And the more WLHA unable to provide shelter and treat illness, the more WLHA have to work hard for their livelihood. It shows that to support their household WLHA have to involve them in hard working job which paid very less money. Another finding was that the more WLHA involved in semi-skilled work, the more WLHA have to struggle to earn their livelihood. The skills that WLHA possess were time consuming and need huge effort but to support their family WLHA engaged into such activities. Also the more WLHA link with social networks the better their support system. Social network help WLHA to build self-confidence and also to channel with other people in the community. Social network not only help them to socialise with people, it also help them in supporting their livelihood. Further, it shows that when WLHA own mobile phone they decrease working hard for livelihood.

5.2 Conclusion

In this current era, AIDS has been increasingly recognized as a livelihood crisis. The virus shows its huge impact on the lives of WLHA. Most of the women became the victim of the virus after they enter wedlock. HIV/AIDS affect the livelihood of WLHA as the opportunities and possibilities available to them are snatch from them due to their positive status. To support their family, they indulge themselves in hard working job which pay less money. Engagement of WLHA in such low paying job leads to financial dishevels which strongly affect their day to day existence. The main reason for facing problem in their household was due to financial constraint.

WLHA spend most of their household expenditure on buying food, buying medicine and paying for their children's education. As a woman they have to look after their family member and take responsibility on guiding their children to lead a good lifestyle. To lead a healthy and meaningful life they choose different positive coping mechanisms such as optimistic planning and social networking with members of the community either HIV (+) or HIV (-).

5.3 Suggestions

HIV/AIDS is a very sensitive issue and those who are affected with virus should be handled with love, care and affection. Women battling with HIV/AIDS especially those belonging to the downtrodden section of the society face dilemma to earn their livelihood.

- Spreading awareness and sensitizing women about HIV/AIDS is very important since most of the HIV transmission took place within the sanctity of marriage. Most of the women become the victim of this virus at very young age because of their husband/spouse/partner enticed them into marriage without informing them about their illness.
- Education plays an important role in choosing one's occupation. The current research found that most of the respondents studied till matriculate hence posing hindrances in taking well paid job. So providing and making them access to proper education is essential step in helping them sustain their livelihood.
- Social networks play an important part in socializing and interacting them with other people in community whether HIV $^{(+)}$ or HIV $^{(-)}$. Expanding social network will boost self-confidence for respondents and help them overcome their difficulties.
- Poverty is the main causes of financial constraint in respondent's livelihood. The study found that maximum respondents face problem in providing proper education to their children. So, the NGOs and GOs need to make special provision which focus on PLWHA children education and help them flourish in their respective chosen field.
- Social workers can play a significant role in sensitizing WLHA about various schemes and programmes which are especially available for poorest of the poor families so that they can get accessed to the services available for them.

- Health is one of the important aspects of WLHA in sustaining their livelihood. Most of the respondents in the present study have low CD4 count. Therefore they cannot indulge themselves in hard manual work. So, acknowledging their needs the policy maker should include strategy which promote livelihood for WLHA.
- From the study, the Karl Pearson co-efficient test show that the respondents living condition were very poor and pathetic in terms of shelter, food and treatment. Moreover, financial capital, human capital, social capital and physical capital were showing significant relationships towards unhealthy living conditions for their livelihood. Therefore, the sustainable livelihood framework would be applied in order to promote and strengthen for the betterment of WLHA.
- Livelihood assets and livelihood strategies vary according to one's habitation. The present study focus on livelihood of WLHA residing in plain areas only so further research can be conducted on livelihood of PLWHA residing in hilly areas of Manipur and also compared the difference between two areas.

MIZORAM UNIVERSITY

DECEMBER, 2016

DECLARATION

I, Thokchom Valentina Devi, hereby declare that the subject matter of this dissertation is the record of work done by me, that the contents of this dissertation did not form bias of the award of any previous degree to me or to the best of my knowledge, to anybody else; and that the dissertation has not been submitted by me for any research degree in any other University/institution.

This is being submitted to the Mizoram University for the degree of **Master of Philosophy in Social Work Department.**

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CERTIFICATE

This is to certify that the dissertation **"Women Living with HIV/AIDS and their Livelihood Strategies in Imphal, Manipur"** submitted by Thokchom Valentina Devi for the award of Master of Philosophy in Social Work is carried out under my guidance and incorporates the student's bonafide research and this has not been submitted for award of any degree in this or any other university or institution of learning.

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LIST OF ABBREVATIONS

AIDS	: Acquired Immunodeficiency Virus
ANC	: Antenatal Care
ART	: Anti-retroviral Therapy
CBOs	: Community Based Organisation
CDCP	: Centers for Disease Control and Prevention
CIDA	: Canada International Development Agency
DFID	: Department for International Development
FAO	: Food and Agriculture Organisation
FGD	: Focus Group Discussion
FRCA	: Foreign Contribution Regulation Act
FSW	: Female Sex Worker
GOs	: Government Organisations
GRID	: Gay Related Immune Deficiency
HIV	: Human Immunodeficiency Virus
IASC	: Inter Agency Standing Committee
ICAD	: International Coalition on AIDS and Development
ICRW	: International Centre for Research on Women
IDU	: Injecting Drug User
IFAD	: International Fund for Agricultural Development

IFPRI : International Food Policy Research Institute

ILO : International Labour Organisation

MDG : Millennium Development Goal

MNP+ : Manipur Network of Positive People

MSACS : Manipur State AIDS Control Society

NACO : National AIDS Control Organisation

NCAER : National Council of Applied Economic Research

NGO : Non-Government Organisation

PCP : Pneumocystis Carinii pneumonia

PLWHA : People Living With HIV/AIDS

PPTCT : Prevention of Parents to Child Transmission

PWESCR : Programme on Women's Economic, Social and Cultural Rights

SACS : State AIDS Control Societies

SLF : Sustainable Livelihood Framework

SMSP : Software Maintenance and Support Plan

SNNPR : Southern Nations, Nationalities and Peoples' Region

UNAIDS : United Nations Programme on HIV/AIDS

UNDP : United Nation Development Programme

UNDP : United Nations Development Programme

UNWFP : United Nations World Food Programme

WDR : World Development Report

WHO	: World Health Organisation
WLHA	: Women Living with HIV/AIDS

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WOMEN LIVING WITH HIV/AIDS AND THEIR LIVELIHOOD STRATEGIES IN IMPHAL, MANIPUR

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INTERVIEW SCHEDULE

(Confidential and for research purpose only)

Schedule No____________ **Date**: __________

I. Profile of the Respondent

1.	Name	**:**	
2.	Domicile	**:**	1.Imphal West ☐ 2.Imphal East ☐
3.	Locality	**:**	1.Core ☐ 2.Periphery ☐
4.	Age	**:**	1.18-30 years ☐ 2.31-40 years ☐ 3.41-50 years ☐
5.	Religion:	**:**	1. Hindu ☐ 2. Muslim ☐ 3. Christian ☐ 4. Others ☐
6.	Maritalstatus	**:**	1. Single ☐ 2. Married ☐ 3. Widow ☐ 4.Divorcee ☐
7.	Type of family	**:**	1.Nuclear ☐ 2.Joint ☐
8.	Size of family	**:**	1.Small ☐ 2.Medium ☐ 3.Large ☐
9.	Form of family	**:**	1.Stable ☐ 2.Broken ☐ 3.Rebuilt step ☐
10.	Head of family	**:**	1.Herself ☐ 2.Husband ☐ 3.In-laws ☐ 4.Parents ☐

11.	Educational qualification	**:**	1. Illiterate ☐ 2.Lower primary (1-5) ☐ 3.Upperprimary (6-8) ☐ 4.Matriculate (9-10) ☐ 5. Intermediate ☐ 6.Graduate & above ☐
12.	Occupation	**:**	1.Seasonal employee ☐ 2.Semi-skilledworker ☐ 3.Service(Govt./Private) ☐ 4.Agricultural labour ☐ 5.Agricultural cultivation/landholding ☐ 6.Petty business/small shop/self-employed ☐ 7.Skilled worker ☐
13.	Monthly income of Respondent	**:**	1.Below 2000 ☐ 2.2001-5000 ☐ 3.5001-10000 ☐ 4.10001-30000 ☐ 5.30001-above ☐ 6.N/A ☐
14.	Time period of occupation	**:**	1. 1 month-1 year ☐ 2.2-5 years ☐ 3.6-10 years ☐ 4.11-20 years ☐ 5.21-30 years ☐ 6.31 years & above ☐ 7.N/A ☐
15.	Main earner of family	**:**	1.Herself ☐ 2.Husband ☐ 3.In-laws ☐ 4.Parents ☐ 5.Children ☐ 6.Brother ☐
16.	Annual income of family	**:**	1.Below 50,000 ☐ 2.50,000-1,00,000 ☐ 3.Above 1,00,000 ☐
17.	Type of house	**:**	1. Pucca ☐ 2.Kaccha ☐ 3. Semi Pucca ☐
18.	Ownership of house	**:**	1. Rented ☐ 2.Own ☐

			3.Inherent from elders ☐ 4. Jointly owned by siblings ☐ 5.None ☐
19.	Socio-economic status	:	1.APL ☐ 2.BPL ☐ 3.AAY ☐ 4.No category ☐
20.	Does your family have land?	:	1. Yes ☐ 2. No ☐
21.	If yes means, how much acre of land.	:	1. Below ½ acre ☐ 2.1 acre ☐ 3.Above 1 acre ☐ 4.Not accurate ☐ 5.N/A ☐
22.	Did they give any property to you?	:	1. Yes ☐ 2. No ☐
23.	If no means why?	:	1.My husband own it ☐ 2.My parents own it ☐ 3.Still not divided the property yet ☐ 4.N/A ☐

II. Vulnerability context of WLHA

24. How long you have been diagnosed with HIV/AIDS?

1. 1 month-1 years 2. 2-5 years 3. 6-10 years
4. 11-15 years 5. 16 years & above

25. Where have you been diagnosed the disease first time?

1. Hospital 2. NGO 3. Health Camp 4. Health Centre

26. What made you to decide to go for HIV testing?

1. My partner were infected by the virus
2. My partner had died of AIDS
3. He had used and/or was consuming injectable drugs
4. Mother to child
5. Illness
6. Pregnancy
7. Blood transfusion
8. Sex work
9. Others

27. Have you sought treatment for the illness?

1. Yes, what made you seek treatment for it?
2. No, what are the reasons?

28. How many people within the household are infected with HIV/AIDS?

1. Less than 2 2. Less than 4 3. More than 4

29. What is your share of participation in decision making process of your family?

1. Never participate 2. Rarely participate 3.Occasionally participate 4. Often participate 5. Always participate

30. How many people in your household are dependents on you?

1.1 2. 2 3. More than 2 4.No one

31. As a positive woman, what is your opinion of present-day status in the society?

1. Dissatisfied 2. Somewhat dissatisfied
3. Neither satisfied nor dissatisfied 4. Somewhat satisfied
5. Satisfied

32. What are the privileges that being a WLHA earner give to you?

1. Participate in decision making 2. Respectable place in society
3. Able to mingle with other HIV (–) ve people
4. Reduction in household chores
5. Financial independence 6. Others

33. Have you faced any types of violence?

1. If yes, please specify
   a. Domestic violence b. Gender violence
   c. Sexual violence d. Physical violence
   e. Mental abuse f. Others
2. No

34. What are the reasons for facing such kind of violence?

1. Financial problem 2. Being HIV+ woman
3. Unemployment 4. Others

III. Patterns of livelihood assets of WLHA

35. What are the economic challenges that you have faced to manage your household as WLHA?

1. Inability to meet daily expenses 2. Inability to provide adequate food
3. Inability to access better education for children 4. Inability to provide shelter
5. Unable to treat illness 6. Others

36. What is the cooperation of human resources on the household?

1. Very Poor 2. Poor 3. Medium 4. Good

37. How you spend your expenditure?

1. Buying food 2. Buying Cloths 3. Buying Medicine
4. House Rent 5. Children education 6. Others

38. Do you receive any economic support from anywhere else?

1. Yes 2. No

39. What are the reasons for receiving such support?

1. To have sufficient food 2. To meet daily health care
3. To access education 4. To meet daily expenses
5. Others

40. What is the impression of Social networks on the household?

1. Bad 2. Good 3. Tolerable 4. Worse

41. Is there any change in the relationship or behavior from your family members and friends after identifying positive?

1. Cut all ties 2. Won't accept me in gathering
3. Won't ask to join ceremony 4. Discrimination
5. Accept me as I am before 6. Others

42. Do you belong to any social networks in your neighborhood?

1. Meira paibi (woman torch light holder) 2. Marup (Lottery)
3. SHG 4. Others

43. Do you feel that any of the religious groups and other networks is good for your household?

1. Yes 2. No

44. Do you ever feel excluded in some associations in the neighborhood that you think are important for the household?

1. Yes 2. No

45. Are you a member of Non-Government organizations' and do you receive any sort of help that contributes to your livelihood from any of the organizations'?

1. Food assistance 2. Financial assistance 3. SHG
4. Education 5. Care & support 6. Others

46. Does the perception of the community about your household affect you?

1. Not at all 2. Little 3. Huge

47. What are the skills that you have that have helped you achieve the livelihood of your household?

1. Embroidery 2. Knitting 3. Handloom & Handicraft
4. Food processing 5. Weaving 6. Harvesting crop
7. Tailoring 8. Others

48. Are you into any programs for skill development?

1. Yes 2. No

49. What are the causes of the challenges you face in your household?

1. Stigma 2. Unemployment 3. Financial problem
4. Discrimination 5. Others (specify)

50. Do you engage in other activities in addition to your main source of income to maintain the livelihoods of the household?

1. If yes, what is it? 2. No

51. Do your children and other members of the household involved in any activity to help the family?

1. If yes, what is it 2. No

52. Do you own any mobile phone for communication?

1. Yes 2. No

IV. Livelihood strategies of WLHA.

53. Do your friends within the community know about your HIV/AIDS status?

1. Yes, how many? 2. No

54. What aspects of your life and the lives of people within the household has the illness had an effect?

1. Nothing change 2.Mild 3.Huge 4.Everything

55. What are the things that you did before diagnosis that you cannot do since your diagnosis?

1. Attending social gathering
2. Hard manual work
3. Supporting family and children
4. Daily wage earning
5. Others

56. Does your HIV status affect your livelihood?

1. Yes 2. No

57. How do you cope with your household livelihood

1. Reduced expenditure on food
2. Reduced expenditure on health care
3. Loan from friends
4. Support from NGO's
5. Dropping out from school
6. Working hard for livelihood
7. Selling their belongings
8. Starting petty business
9. Praying to Almighty God
10. Others (specify)

58. Do you face any challenges due to the loss of your loved one?

1. Yes 2. No

59. If yes, how do you cope with such challenges?

1. Self-isolation
2. Spending time with close friends.
3. Consulting counsellor
4. Embrace positive beliefs
5. Others

60. Have you received any support beside your family?

1. Neighbours
2. Friends
3. Extended family
4. NGO
5. Government assistance

61. What kind of assistance you get from NGO or Government Organisations that supports your livelihood?

1. Food
2. Medical support
3. Counselling
4. Education
5. Empowerment
6. Financial support
7. Others

62. What made you decide in going to seek support for your livelihoods from NGO's and Government Organisations in the first place?

1. To hide the status
2. Unable to manage household by themselves
3. Financial crisis
4. Poor health
5. Unemployment
6. To get care and support
7. Others (specify)

63. How helpful is it (NGO) to your household?

1. Very Little
2. Little
3. Huge
4. Only help.

64. In which aspect is it helpful?

1. Moral support
2. Physical support
3. Mental support
4. Legal support
5. Others (specify)

CASE STUDY

Topic: WLHA and their livelihood strategies in Imphal, Manipur

(Dear Respondent, the information gathered from you is highly confidential and purely academic in nature and will used only for research purpose. Thank you for your valuable participation).

Date: ________________

1. Name
2. Domicile
3. Age
4. Religion
5. Marital status
6. Type of family
7. Form of family
8. Head of family
9. Educational qualification
10. Occupation
11. Monthly income of respondents
12. Socio-economic status
13. What are the difficulties you have face as a HIV+ woman?

14. What are the major challenges you have faced to manage your livelihood?

15. What are the skills that you have that support your livelihood?

16. Do you get any assistance from anyone that helps your livelihood?

17. What are the coping strategies that you adopt to support your livelihood?

PARTICULARS OF THE CANDIDATE

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DEPARTMENT	: Social Work
TITLE OF DESSERTATION	: Women Living with HIV/AIDS and their livelihood strategies in Imphal, Manipur
DATE OF PAYMENT OF ADMISSION	: 15th August, 2015
COMMENCEMENT OF SECOND SEMESTER	: 18th February, 2016
1. BOARD OF PROFESSIONAL STUDIES	: 13th April, 2016
2. SCHOOL BOARD	: 22nd April, 2016
3. REGISTRATION NO. & DATE	: MZU/M.Phil./344 of 22.04.2016
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Details of Educational Qualification

Sl. No.	Class	Subject	Board/University	Percentage	Division
1	HSLC	-	BOSEM	50.1	Second
2	HSSLC	Science	COHSEM	59	Second
3	Bachelor of Arts	English, Sociology, Political Science	HNB Garhwal University	60.2	First
4	Master of Social Work	Social Work	Panjab University	66.9	First

Working Experience

1. Worked as a voluntary teacher for the slum children in "**Don Bosco Navjeevan Society**", Sec-24, Chandigarh from 7th Nov 2009 to 27th Feb 2010.
2. Summer internship in "**Impulse NGO Network**" SHILLONG from 1st to 30th Jun 2010. Work engaged are: conducted interview of the coal exporters in Meghalaya and its export markets, transcriptions of audio and video interviewed of child labourers and other target population working in the coal mines of Jaintia Hills District, Meghalaya, following up with corporate, under CSR (Corporate Social Responsibility Initiative) with different business agencies to support the publishing of the Newsletter "Beneath the Surface", and assisted in documentation of the information of CYCI Loan applicants.
3. Worked as an intern in **YUVSATTA (NGO)** for 4 months i.e. 3rd Aug 2010 to 30th Nov 2010 on HIV/AIDS Project for Female sex workers in Bapu Dham Colony. Area of intervention at this project is promoting healthy lifestyle, blood testing, medical check-ups and condom promotions amongst the targeted area.
4. Done Short-Term Training in the Dept. of Psychiatry at "**Government Medical College and Hospital**", Sec-32, Chandigarh for a period of 40 days from 22nd Mar to 30th Apr 2011. Work engaged are conducted counselling for psychiatric patient at psychiatric ward, attending Medical camp at different places of Chandigarh, help out patients who come at OPD, help out disabled persons and children at RIGIONAL INSTITUTE OF MENTALLY HANDICAPPED, HALF WAY HOME and UMEED.
5. Summer Block-Placement in "**Ambuja Cement Foundation-Bathinda Unit**" for the period of 40 days from 5th June to 15th July 2011. Details of activities undertaken are conducted a study on Ambuja Gyan Deep Kendras (a non-formal education programme in urban slums) and suggested improvements to make programme more effective, formed a Self Help Group of females of urban slums, formed two Self Help Group of rural women in Behmandeewana village.
6. Worked as a lecturer at "**College of Social Work**" Manipur from Feb 2012 to June 2015.

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Registration No. & Date: MZU/M.Phil./344 of 22.04.2016

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CHAPTER I

INTRODUCTION

CHAPTER II

REVIEW OF LITERATURE

CHAPTER III

METHODOLOGY

CHAPTER IV

RESULTS AND DISCUSSION

CHAPTER V

CONCLUSION AND SUGGESTIONS

APPENDICES

Table 4.18

Correlation matrix: Financial capital and coping strategies

Variables	IMDE[1]	IPAF[2]	IABEC[3]	IPS[4]	UTI[5]	LFF[6]	SFN[7]	WHL[8]	SB[9]	SPB[10]	HEF[11]
IMDE[1]	1										
IPAF[2]	-0.018	1									
IABEC[3]	-0.039	-0.008	1								
IPS[4]	-0.029	**.233****	0.003	1							
UTI[5]	0.035	**.277****	-0.031	**.385****	1						
LFF[6]	0.075	0.131	0.038	0.02	0.007	1					
SFN[7]	0.074	0.029	0.061	-0.1	-0.05	0.05	1				
WHL[8]	0.091	0.093	0.147	**.181***	**.223****	-0.12	-0	1			
SB[9]	-0.081	-0.023	-0.032	0.07	-0.03	-0.06	0.041	**-.187***	1		
SPB[10]	-0.063	0.151	0.041	-0.1	-0.01	-0.12	**-.156***	-0.1	-0.07	1	
HEF[11]	-0.128	-0.042	0.059	0.06	-0.01	**-.197***	-0.05	0.015	-0.08	**-.190***	1

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

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[1] Inability to meet daily expenses
[2] Inability to provide adequate food
[3] Inability to access better education for children
[4] Inability to provide shelter
[5] Unable to treat illness
[6] Loan from friends
[7] Support from NGOs
[8] Working hard for livelihood
[9] Selling their belongings
[10] Starting petty business
[11] Help from extended family

Table 4.19

Correlation matrix: Human capital and coping strategies

Variables	E[12]	K[13]	H&H[14]	FP[15]	W[16]	HC[17]	T[18]	LFF[6]	SFN[7]	WHL[8]	SB[9]	SPB[10]	HEF[11]
E[12]	1												
K[13]	**.161***	1											
H&H[14]	0.111	-0.038	1										
FP[15]	-0.04	-0.011	-0.022	1									
W[16]	-0.119	-0.044	0.028	-0.078	1								
HC[17]	**-.231****	-0.092	-0.073	-0.053	-0.059	1							
T[18]	0.095	-0.039	0.016	-0.023	**-.186***	-0.138	1						
LFF[6]	-0.075	-0.032	-0.047	-0.072	0.036	0.08	-0.114	1					
SFN[7]	-0.012	-0.038	-0.074	-0.022	-0.071	0.034	0.016	0.052	1				
WHL[8]	**-.155***	-0.01	-0.003	0.104	**-.159***	**.363****	-0.119	-0.118	-0	1			
SB[9]	0.081	-0.034	0.041	-0.019	0.139	**-.162***	-0.07	-0.057	0.041	**-.187***	1		
SPB[10]	-0.031	-0.13	0.141	-0.074	**.275****	0.137	-0.125	-0.12	**-.156***	-0.095	-0.07	1	
HEF[11]	0.128	0.127	-0.05	-0.047	-0.021	-0.057	0.046	**-.197***	-0.05	0.015	-0.08	**-.190***	1

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

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[12] Embroidery
[13] Knitting
[14] Handloom & Handicraft
[15] Food processing
[16] Weaving
[17] Harvesting crop
[18] Tailoring

Table 4.20

Correlation matrix: Physical capital and coping strategies

Variables	MP[19]	LFF[6]	SFN[7]	WHL[8]	SB[9]	SPB[10]	HEF[11]
MP[19]	1						
LFF[6]	0.081	1					
SFN[7]	0.051	0.052	1				
WHL[8]	**-.175***	-0.118	-0.003	1			
SB[9]	-0.056	-0.057	0.041	**-.187***	1		
SPB[10]	-0.101	-0.12	**-.156***	-0.095	-0.066	1	
HEF[11]	0.059	**-.197***	-0.05	0.015	-0.084	**-.190***	1

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

[19] Mobile phone

Table 4.21

Correlation matrix: Social capital and coping strategies

Variables	M[20]	ML[21]	SHG[22]	SRG[23]	LFF[6]	SFN[7]	WHL[8]	SB[9]	SPB[10]	HEF[11]
M[20]	1									
ML[21]	0.127	1								
SHG[22]	0.038	0.085	1							
SRG[23]	0.123	**-.167***	0.04	1						
LFF[6]	0.059	-0.134	-0.03	**.196***	1					
SFN[7]	0.035	-0.096	-0.07	-0.062	0.052	1				
WHL[8]	0.068	0.038	-0.01	0.003	-0.12	-0	1			
SB[9]	-0.018	-0.081	0.08	-0.056	-0.06	0.041	**-.187***	1		
SPB[10]	0.148	0.111	0.08	0.014	-0.12	**-.156***	-0.095	-0.1	1	
HEF[11]	0.022	0.042	-0.04	-0.072	**-.197***	-0.05	0.015	-0.1	**-.190***	1

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

[20] Meirapaibi (Woman torch light holder)
[21] Marup (Lottery)
[22] Self Help Group
[23] Support from religious group