Available online at http://www.journalijdr.com

IJDR

International Journal of
DEVELOPMENT RESEARCH

ISSN: 2230-9926

International Journal of Development Research
Vol. 06, Issue, 09, pp.9330-9332, September, 2016

Full Length Research Article

IMPACT OF LIVING AREA AND FAMILY ON CHILDREN LIVING WITH HIV/AIDS IN GUNTUR AND WARANGAL DISTRICTS OF ANDHRA PRADESH AND TELANGANA, INDIA

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ARTICLE INFO

Article History:
Received 28th June, 2016
Received in revised form
24th July, 2016
Accepted 09th August, 2016
Published online 30th September, 2016

Key Words:
Guntur, Warangal, HIV/AIDS,
Faith-Based Organizations.

ABSTRACT

In India about 2.40 million (1.93 -3.04 million) people are living with HIV and AIDS. India is the second largest population living with HIV and AIDS. Among the four high prevalent states of India, Andhra Pradesh has the highest number of HIV patients in the country. It accounts for 20 per cent of AIDS patients (5 lakh of the 24 lakh). Guntur is one of the highly HIV burdened district in Andhra Pradesh, having more than 70,000 people living with HIV in the district alone. 357 children who were living in FBOs homes in two districts (Guntur of Andhra Pradesh and Warangal of Telangana State) were identified, interacted and screened. The study found that the impact of HIV/AIDS on children living with HIV/AIDS is more on their health and also their biological growth. Most of the children are orphans with both parents died and rarely with single or both parents.

INTRODUCTION

Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) epidemic threatens the social fabric of the most affected countries. Globally, an estimated 35.3 (32.2–38.8) million people were living with HIV. In Asia and the Pacific in 2012, an estimated 4.9 million [3.7–6.3 million] people were living with HIV (UNAIDS, 2013). Approximately 260,000 children were infected with HIV in low- and middle income countries in 2012 (UNAIDS, 2013). In India 2.1 million people estimated to be living with HIV and AIDS in 2013 (Idele *et al.,* 2014). Andhra Pradesh is one of the highly prevalent states in HIV epidemic and it accounted for 22% of total reported AIDS cases of India (Over, 2004). According to IHAT, (2010) data HIV prevalence in Guntur was 1.2%, and in Warangal 0.8% the districts of Andhra Pradesh. During 2013-2014 Guntur district ranked the highest with 5,195 HIV positive registered cases (including 2,498 female) (Times of India, 2015). There are approximately 36.7 million people currently living with HIV and tens of millions of people have died of AIDS-related causes since the beginning of the epidemic (UNAIDS, 2016).

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Infected and orphaned children are often traumatized and suffer a variety of psychological ordeal. Loss of home, dropping out of school, separation from sibling and friends, increased workload and social isolation may all impact negatively on current and future mental health. Children tend to show internalizing behavior (depression, anxiety and withdrawal) rather than externalizing symptoms (aggression and other forms of antisocial behavior).

MATERIALS AND METHODS

The children homes of FBOs in two districts i.e. Warangal of Telangana State and Guntur of Andhra Pradesh State were identified. A detailed data was collected for 357 children living with HIV/AIDS. In this study purposive sampling method has been adopted to know about the issues, concerns and growth of children living with HIV/AIDs. Primary data was collected from children through the interview schedule. The data from Viswa Karuna Deepam, Assuntha Ashanilayam, Devine Mercy home of Warangal district and St. Ann's Inola Prem Nivasam, St. Alphonsa children home, Swadhaar of Guntur district were collected. Steps were taken to ensure the ethical considerations. The quantitative data was analyzed using Microsoft Excel 2007 software.

RESULTS

Type of area of Respondents

The figure represents the information about the type of area of the respondents.

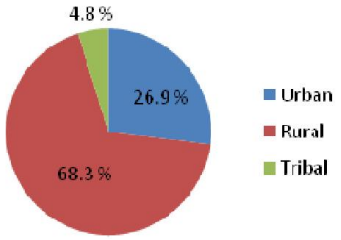

Figure 1. Distribution of the respondents by their type of area

Figure 1, represents the information about the type of area of the respondents. From the data most of the respondents comes from rural area (68.3 %) followed by urban area (26.9 %) and Tribal area (4.8 %).

Place of stay

The figure represents the place of stay of children living with HIV/AIDS in selected centers with or without contact with their own family

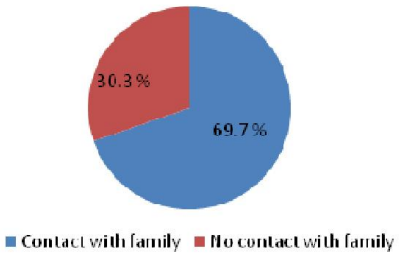

Figure 2. Distribution of the respondents by their place of stay

The data shows the respondents who's living in the center; the majority (69.7 %) of the them having contact with family and 30.3 % of them did not have contact with their own family.

Type of Family

The figure below presents the information about the type of the family of the respondents.

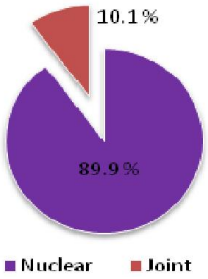

Figure 3. Distribution of the respondents by their type of the family

The data shows that the majority (89.9 %) of the respondents is from the nuclear family and only 10.1 % of the respondents are from joint family.

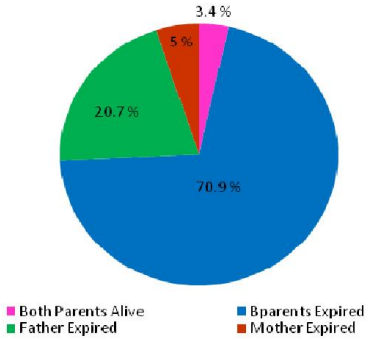

Figure 4. Distribution of the respondents by their Parents survival status

The data shows 70.9 % of the respondents both parents expired, 20.7 % of the respondents father expired, 5.0 % mother expired and 3.4 % respondents both parents were alive.

DISCUSSION

In the present study the area of the respondent shows significant variations. Population from the rural area shows higher percentage (68.3 %) of AIDS when compared to urban (26.9 %) and tribal (4.8%) area. According to Koye *et al.,* 2012, residence of Northwest Ethiopia the Urban children showed 66.5% and Rural children 33.5% HIV infection respectively which is contrast to the present investigation. Majority (66.8%) of HIV/AIDS children from Togo are urban and 33.2% are Semi-rural (Salou *et al*., 2016). Majority (63%) of the respondents are from rural areas while 35 % are from urban areas and the remaining 2 % of the respondents are from the tribal areas. (Abraham, 2013). The data shows that 69.7 % of the respondents stay in a centers but have contact with family and 30.3 % respondents stay in a centers, but did not have contact with their own family. A study reported that among HIV-infected children in India 83% hailed from a rural setting, whereas 43% of the from an urban background (Shet *et al.,* 2009) Vital status of parents of HIV-infected children in Zambia was 72.1% both parents alive, 19.9 % one parent died and 8.0 % both parents died (Van *et al.,*2011). The data shows that 69.7 % of the respondents stay in a centers but have contact with family and 30.3 % respondents stay in a centers, but did not have contact with their own family. The data shows that the majority (89.9 %) of the respondents are from the nuclear family and only 10.1 % of the respondents are from joint family. Majority of the inmates (85%) belonged to nuclear family and the rest 15 % belonged to the joint family (Westat *et al*., 2010). According to Plathottathil *et al.* (2015) in Kerala people of HIV/AIDS are of 86.6% from nuclear family, 12.4% from extended family and 1.0% belonged to joint family. The present data shows for 70.9 % of the respondents' both parents expired, 20.7 % of the respondents' father expired, for 5.0 % mother expired and 3.4 % respondents' both parents were alive. The study differs with the study of Abraham, (2013) who stated in his study that majority 47.1 % of the respondents are double orphans who lost both the

parents, while 36.4 % are paternal orphans who lost fathers. 16.5 % are the maternal orphans who lost only mother and living with their parents. The percentages of both parents expired, father expired, mother expired and both parents alive were 19.0%, 27.3%, 15.7% and 38.0%, respectively (Kikuchi *et al*., 2014). Both parents were alive for 41% of the children, whereas one quarter of the children had lost both parents (Patel *et al*., 2012). The study on HIV-infected children in Uganda Majority (50%) of the children's both parents deceased, 12% mother deceased, 21% father deceased and 17% both parents alive (Bikaako *et al*., 2006). According to Alvarez *et al*. (2012) children in an HIV cohort India for 50.97% of children's both parents were alive, 25.81% father died, 13.71% both parents died and 9.52% mother died. In Northwest Ethiopia for children of HIV/AIDS 55.0% mother and father alive, 23.3 mother died, 8.7 % father died and 13.0% both parents died (Koye *et al*., 2012). According to Sutcliffe *et al.* (2011 a) 76.1 % of the respondents' both parents alive, 18.4 % one parent dead and 5.5 % both parents dead. Sutcliffe,*et al*. (2011 b) reported that for 9.5 % of the respondents' both parents expired, 9.5 % of the respondents' father expired, for 10.0 % mother expired and 71.1 % respondents' both parents were alive. According to Bacha *et al*. (2012) in Ethoiopia for the children infected with HIV for 96 % of children's both parents were alive, 51% either father or mother died, 22.5% both parents died and 22.5% un known about their parents vital status. According to Renner *et al.* (2011) parental living status of both parents alive was 46.8% only one parent alive was 33.9 %, both parents are dead 9.9%, both parents living status was unknown 3.4% and one parent alive and other parent's living status unknown 6.0%.

REFERENCES

Abraham, M. 2013. Situational analysis of children orphaned by AIDS (A Study in Krishna, YSR Kadapa and Karimnagar Districts of Andhra Pradesh). Ph. D. Thesis in Social Work. Faculty of Socialogy, Andhra University, Vishakapatnam (AP) India.

Alvarez-Uria, G., Midde, M., Pakam, R., and Naik, P. K. 2012. Gender differences, routes of transmission, socio-demographic characteristics and prevalence of HIV related infections of adults and children in an HIV cohort from a rural district of India. *Infectious Disease Reports*, 4(1), 19.

Bacha, T., Tilahun, B., and Worku, A. 2012. Predictors of treatment failure and time to detection and switching in HIV-infected Ethiopian children receiving first line anti-retroviral therapy. *BMC Infectious Diseases*, 12 (1), 1.

Bikaako-Kajura, W., Luyirika, E., Purcell, D. W., Downing, J., Kaharuza, F., Mermin, J., Malamba,S., and Bunnell, R. 2006. Disclosure of HIV status and adherence to daily drug regimens among HIV-infected children in Uganda. *AIDS and Behavior*, 10 (1), 85-93.

Idele, P., Gillespie, A., Porth, T., Suzuki, C., Mahy, M., Kasedde, S., and Luo, C. 2014. Epidemiology of HIV and AIDS among adolescents: current status, inequities, and data gaps. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, 66, S144-S153.

India Health Action Trust (IHAT) 2010. HIV/AIDS Situation and Response in Andhra Pradesh: Epidemiological Appraisal Using Data Triangulation. Hyderabad, India: IHAT, NIMS, ICMR. Available:

Kikuchi, K., Poudel, K. C., Muganda, J., Sato, T., Mutabazi, V., Muhayimpundu, R. and Jimba, M. 2014. What makes orphans in Kigali, Rwanda, non-adherent to antiretroviral therapy? Perspectives of their caregivers. *Journal of the International AIDS Society*, *17*(1).

Koye, D. N., Ayele, T. A. and Zeleke, B. M. 2012. Predictors of mortality among children on Antiretroviral Therapy at a referral hospital, Northwest Ethiopia: a retrospective follow up study. *BMC Pediatrics*, 12 (1), 1.

Over, A. M. (Ed.). 2004. *HIV/AIDS treatment and prevention in India: modeling the costs and consequences* (Vol. 1). World Bank Publications.

Patel, A., Trivedi, S. S., Chudasama, R. K., and Patel, P. K. 2012. Effect of antiretroviral therapy on clinical and immunologic disease progression in HIV positive children: One-year follow-up study. *Journal of Family and Community Medicine*, 19 (3), 178.

Plathottathil, M. J., Saibunnisa,B.K., Baladevan, Jayalekha, 2015. Depressive Disorders among People Living with Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome in Kerala, India. *Academic Medical Journal of India*, [S.l.], p. 130-137

Renner ., L., Prin, M., Li, F. Y., Goka, B., Northrup, V., and Paintsil, E. 2011. Time to and Predictors of CD4+ T-Lymphocytes recovery in HIV-infected children initiating Highly Antiretroviral Therapy in Ghana. *AIDS Research and Treatment*, 2011.

Salou, M., Dagnra, A. Y., Butel, C., Vidal, N., Serrano, L., Takassi, E., Konou A.A., Houndenou, S., Dapam, N., Singi-Tokofai, A., Pitche, P., Atakouma, Y., Prince-David, M., Delaporte and peters, M. 2016. High rates of virological failure and drug resistance in perinatally HIV-1-infected children and adolescents receiving lifelong antiretroviral therapy in routine clinics in Togo. *Journal of the International AIDS Society*, 19 (1).

Shet, A., Mehta, S., and Rajagopalan, N. 2009. Anemia and growth failure among HIV-infected children in India: a retrospective analysis. *BMC Pediatr*., 9, 37.

Sutcliffe, C. G., Van Dijk, J. H., Munsanje, B., Hamangaba, F., Siniwymaanzi, P., Thuma, P. E., Moss, W. J. 2011a. Risk factors for pre-treatment mortality among HIV-infected children in rural Zambia: a cohort study. *PloS one*, 6 (12), e29294.

Sutcliffe, C. G., van Dijk, J. H., Munsanje, B., Hamangaba, F., Sinywimaanzi, P., Thuma, P. E., and Moss, W. J. 2011b. Weight and height z-scores improve after initiating ART among HIV-infected children in rural Zambia: a cohort study. *BMC Infectious Diseases*, 11 (1), 1.

Times of India 2015. City News. Guntur tops the list of HIV positive cases in Andhra pradesh by Sribala vadlapati.

UNAIDS 2013. HIV in Asia and the Pacific: Joint United Nations Programme on HIV/AIDS Report, 2013.

UNAIDS. 2016. Global AIDS Update.

Van Dijk, J. H., Sutcliffe, C. G., Munsanje, B., Sinywimaanzi, P., Hamangaba, F., Thuma, P. E., and Moss, W. J. 2011. HIV-infected children in rural Zambia achieve good immunologic and virologic outcomes two years after initiating antiretroviral therapy. *PLoS One*, 6 (4), e19006.

Westat, R., Sorra, J., Famolaro, T., Dyer, M. P. S. N., Khanna, K., and Nelson, D. 2010. *Hospital Survey on Patient Safety Culture:* 2010 *User Comparative Database Report*.

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