

PSYCHIATRIC MORBIDITIES IN PEOPLE LIVING WITH HIV/AIDS-A CASE STUDY OF GUJARAT

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Abstract

Despite all the medical advances we have made in treatment of HIV infection the psychiatric care of the patients of persons' with HIV and AIDS remained one of the most challenging aspects of medical care. The review of antecedent literature showed a paucity of information and evidence of psychiatric morbidities amongst PLWHAS. Nevertheless, such studies were confined to South India only. Considering this as a pivot the researcher decided to undertake one such piece of research in Gujarat. The main objectives of the research undertaken were, to study the presence of psychiatric morbidities like anxiety, depression and suicide ideation in People Living with HIV/AIDS (PLWHAS), to study their self esteem and to explore the association between HIV positive status and psychiatric morbidities with reference to age, gender, occupation, habitat and religion. The dependent variables in the study were presence of anxiety, depression, suicide ideation, quality of life and self-esteem in PLWHAS. The dependent variables were HIV positive status, age, sex, caste, rule of residence and education.

Sample of the study was collected from four major districts of Gujarat namely Ahmedabad, Rajkot, Surat and Vadodara. The methodology consisted of both quantitative and qualitative methods. Data was collected using standardized tools like Interview Schedule, Beck Depression Inventory (BDI), Positive and Negative Suicide Ideation Scale (PANSI), Clinical Anxiety Scale (CAS) and World Health Organisation Quality of Life instrument (WHOQOL). Data was analysed using Frequency, Percentage Tables, Chi square and Correlation.

Important findings revealed that anxiety score of the respondents was comparatively high according to which 69.9% fell in the category of severe anxiety. Similarly with regards to depression 52.2% i.e. 153 respondents fell in the category of severe depression while 14.7% of the respondents' i.e. 43 of them were in need of medication. This finding was alarming. Above 50% of the respondents had suicide ideation which also calls for suitable interventions. The analysis suggested that the overall Quality of Life revealed that only 2.4% of respondents had a high score, while the rest were either in moderate or low categories. With regards to medical care almost all worried about their health conditions and medical care. Among the four districts which were taken as sample by the researcher it is observed that Ahmedabad has the highest number of HIV positive patients. Majority of the respondents belonged to the age group of 30 to 39 years. This age is the most productive age in an individual's life time. Being infected at this age makes it difficult to be socially, economically as well as reproductively successful. Belonging to a Social Work profession the researcher developed intervention modalities which could be used at different stages of infection and thereby help HIV infected people to lead a normal and purposeful life.

Keywords: Psychiatric morbidities, HIV/AIDS, India, Gujarat and depression

INTRODUCTION

We have lived with HIV for almost a century now. It is a complex phenomenon that raises sensitive issues regarding sex and sexuality, gender and economic inequalities and socially tabooed behaviour such as injecting drugs and homosexuality.¹ Recognised as an emerging disease only in the early 1980's, AIDS is one of the most talked about disease on the globe. During the 80's HIV/AIDS was confined to certain well-defined population groups such as commercial sex workers, gay men and haemophiliacs. Threatening, it continues to spread disproportionately fast in most countries and is likely to persist well into 21st century. Despite the impressive reduction in morbidity and mortality related to HIV infection, and due to the consequent increase in life expectancy gained, important physical, psychosocial and psychiatric repercussions of this disease are expected to become more relevant. For these reasons, a multidisciplinary approach, with several specialties involved in counselling and treatment, become relevant in HIV/AIDS. From the beginning of this disease up to the present time, the psychosocial aspects as well as psychological/psychiatric disorders affecting HIV-infected individuals have become a major concern for professionals taking care of these patients.

HIV/AIDS AND MILLENNIUM DEVELOPMENT GOALS²

In September 2010, world leaders met for the High Level Plenary Meeting on "Millennium Development Goals"(MGDs Summit)The MGDs Summit took place with great fanfare ,attracting close to 140 heads of State and government, as well as leaders from civil society foundations and the private sector. It launched important aid initiatives and generated unprecedented agreement by Member States on the importance of human rights in efforts to achieve the Millennium Development Goals (MDGs).The MDGs comprise eight time bound ,measureable human development goals, with eighteen agreed targets and forty-eight indicators. Examples of which are:

- between 1990 and 2015 ,halving the proportion of people suffering hunger and living on less than USD 1 per day;
- achieving universal primary education halting and beginning to reverse HIV/AIDS by 2015; and
- reducing by three quarters the maternal mortality ratio.

Inspite of HIV/AIDS being one of the important areas of concern in the MDGs Eastern Europe and Central Asia remain the only regions where incidence is increasing.

Globally, there are still five new infections for every two people put on ARVs.

Prevention of mother-to-child transmission - According to the UN World Health Organization's (WHO) 2009 report, Towards Universal Access, the 20 countries with the highest burden of HIV among pregnant women have scaled up HIV counselling and testing to at least 75 percent of their antenatal care facilities. In 2008, 45 percent of pregnant women living with HIV in low- and middle-income countries received ARVs to prevent HIV transmission to their infants - up from just 10 percent in 2004.

HIV-related maternal and child mortality - In 2008, 9 percent of all maternal deaths in sub-Saharan Africa were HIV related, according to a new report, Trends in Maternal Mortality: 1990-2008 by WHO and the UN Children's Fund, UNICEF. The report notes that there is evidence that women with HIV infection have a higher risk of maternal death.

Access to prevention of mother-to-child-transmission (PMTCT) improves outcomes for children as well, with studies showing that in KwaZulu Natal, South Africa, child mortality declined by 34 percent following improvement in PMTCT. According to UNICEF, HIV is one of four diseases that accounted for 43 percent of all deaths in children under five worldwide in 2008.

Condom availability and use - Globally, condom use has doubled over the past five years, according to UNAIDS. An estimated 13 billion condoms per year will be needed by 2015 to help halt the spread of HIV, but only four condoms were available for every adult male of reproductive age in sub-Saharan Africa. Female condoms are even less accessible. According to the UN Population Fund, UNFPA, in 2009, one female condom was distributed for every 36 women worldwide. Condom use remains low in many high prevalence countries.

New prevention technologies - The first positive results from a microbicide trial have injected fresh hope

¹ M.S.Usha, "Women and AIDS in India ", "Womens Link, April 2001

² "How do you solve half a century bloodshed in Colombia", The Gurdian, April 2017

into efforts to halt the spread of the virus; the gel, containing the ARV Tenofovir, was found to be 39 percent effective in reducing a woman's risk of becoming infected with HIV.

"Treatment 2.0" also promises benefits for prevention, with evidence showing that people on ARV treatment are much less likely to transmit the virus. A Thai vaccine trial completed in 2009 also provided the first evidence that a vaccine can provide some protection against HIV.

Several trials are under way to test the efficacy of pre-exposure prophylaxis (PrEP) whereby HIV-negative people take a single ARV drug or a combination of drugs with the hope that it will lower their risk of infection if exposed to HIV. Male circumcision, proven to reduce men's risk of infection through sexual intercourse by up to 60 percent, is being rolled out in several countries.

Tuberculosis - TB remains a major cause of death for people living with HIV. WHO estimates that in 2008, there were 1.4 million TB cases among people living with HIV and over 500,000 deaths. Drug-resistant TB is on the rise in several countries, but diagnosis remains very low. TB research remains under-funded and the most widely used TB diagnostics are over 100 years old. For many co-infected patients in the developing world, late diagnosis leads to death.

The authors of a recent article published in medical journal "The Lancet" argue that TB control is crucial to achieving the MDGs, given its link to HIV mortality as well as maternal and child mortality. Recent developments such as a new drug to treat TB and rapid, more accurate TB tests could lead to improvements in the diagnosis and management of the highly infectious disease.

THE HISTORY OF AIDS IN INDIA³

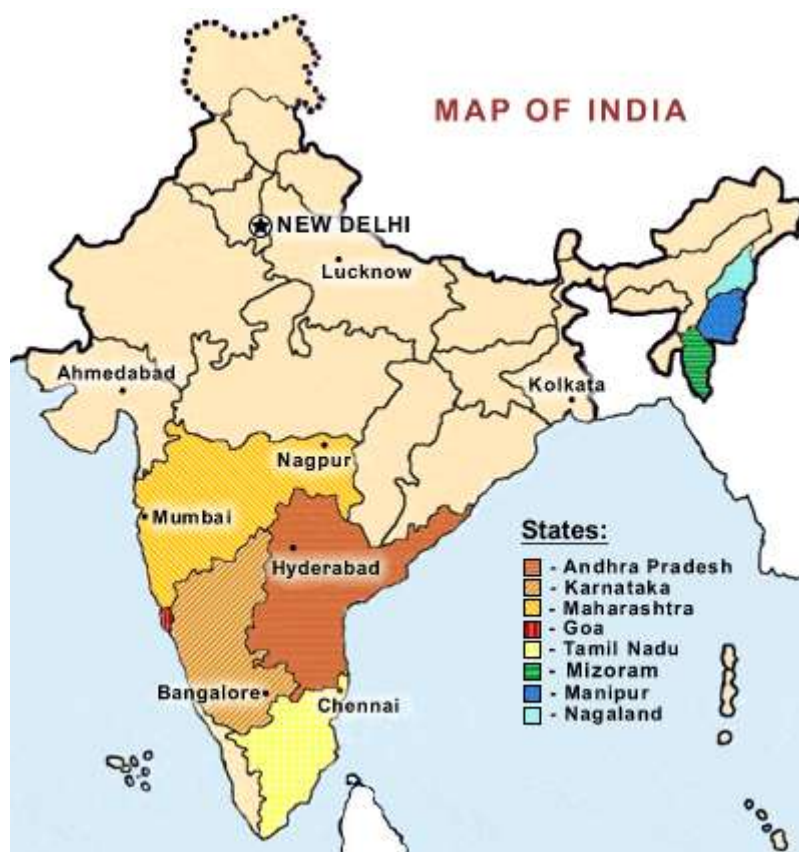
According to the United Nations, the Asia Pacific regions where more than seven million people are living with HIV/AIDS could become the epicentre of the global AIDS pandemic in the next decade, with China and India the worlds, two most populous nations facing a potential AIDS catastrophe. According to India's National AIDS Control Organization (NACO), HIV/AIDS is no longer confined to specific groups or urban areas but is steadily spreading into the wider population and rural areas.

At the beginning of 1986, despite over 20,000 reported AIDS cases worldwide, India had not reported cases of HIV or AIDS. This was recognition, though, that this would not be the case for long and concerns were raised about how India would cope once HIV and AIDS cases started to emerge. One report published in a medical journal in January 1986, stated:

"Unlike developed countries India lacks the scientific laboratories, research facilities, equipment and medical personnel to deal with HIV/AIDS epidemic. In addition factors such as cultural taboos against discussion of sexual practices, poor co-ordination between local health authorities and their communities, widespread poverty and malnutrition and a lack of capacity to test and store blood would severely hinder the ability of the government to control AIDS if the disease did become widespread." Later in the year, India's first cases of HIV were diagnosed among sex workers in Chennai, Tamil Nadu. It was noted that contact with foreign visitors had played a role in initial infections among sex workers, and as HIV screening centres were set up across the country there were calls for visitors to be screened for HIV. Gradually these calls subsided as more attention was paid to ensuring that HIV screening was carried out in blood banks".

In 1987, National AIDS Control Programme (NACP) was launched to co-ordinate national responses. Its activities covered surveillance blood screening and health education. By the end of 1987, out of 52,907 who had been tested, around 135 people were found to be HIV positive and 14 had AIDS. Most of these initial cases had occurred through heterosexual sex, but at the end of the 1980's a rapid spread of HIV was observed among injecting drug users in Manipur, Mizoram, and Nagaland- three north-eastern States of India bordering Myanmar (Burma).

³ An overview of HIV/AIDS In India (www.avert.org/aidsindia.htm)



In 1998 one author wrote: "HIV infection is now common in India; exactly its prevalence is not known but it can be said without any fear of being wrong that infection is widespread.... It is spreading rapidly into those segments that society in India does not recognize as being at risk".

THE HIV SCENARIO IN GUJARAT⁴

Gujarat is one of the highly industrially developed states in the country. Being an industrialized state, migration of labourers from various parts of the country is very high. Mobility and migration of people make them more vulnerable as a result of separation of spouse and release of social sanctions leading to high-risk sexual practices and consequently may contract HIV, which in turn is carried to their spouse and to their children. On one hand with the increase in urbanization most of the societies are in transition, young population is under less social restraint. On the other hand, lower literacy level of rural women especially in the state; local customs and traditions make a woman more vulnerable to the infection. A large number of women suffer from Reproductive Tract Infections (RTIs), which are mainly due to poor sexual hygiene especially during menstruation and sexually transmitted infections from their spouse.

In Gujarat the first AIDS patient was diagnosed in 1986. Gujarat came into middle level prevalence as early as 1994 along with Tamil Nadu due to high vulnerability of the state. However, still Gujarat state is in middle level, whereas Tamil Nadu and other states like Maharashtra, Andhra Pradesh, Karnataka, Manipur and Nagaland went into high prevalence. To respond to the menace of HIV in the state, State AIDS Cell (SAC) was created in December 1992, for implementation of phase I of National AIDS Control Programme. The implementation of the Programme was done by the State AIDS Control Organization and the approval of the State empowered committee constituted for the purpose of the state level. With a view to ensure speedy and effective implementation of the programme through inter-sector co-ordination for AIDS prevention, and also to involve NGOs, the state AIDS Empowered Committee decided to convert the existing State AIDS Cell into a registered society. Government of India had also decided to constitute AIDS Control Society for effective implementation of the programme, especially in the second phase beginning from April 1999. Since then National AIDS Control Programme is being implemented through States AIDS Control Society.

⁴ www.GSACS online

PSYCHIATRIC COMPLEXITIES ASSOCIATED WITH AIDS⁵

Despite all the medical advances we have made in the treatment of HIV infection, the psychiatric care of persons with HIV and AIDS remained one of the most challenging aspects of medical care. Mental health programmes are a necessity to all comprehensive HIV clinics and in private practices. Persons with HIV have underlying mental health issues and conditions. Whether it is substance abuse, mood disorders or psychosis individuals with these issues need evaluation by a skilled mental health specialist. Perhaps the most challenging issue to address is the aetiology of the psychiatric manifestation. Was it pre-existing but undiagnosed? Is it due to HIV or could the therapies themselves be contributing? Are there other infectious or organic reasons for this behaviour? Being HIV infected could result in psychiatric disorders as psychological consequences of the infection or because of the effect of the HIV virus in the brain. Disorders may be as varied as depression, post-traumatic stress disorder, AIDS phobia, grief and the whole gamut of cognitive disorders. Apart from the more obvious impact of HIV on mental health, there are several ways in which HIV infection and psychiatric disorders are linked.

- ⁶HIV infection owing to its malignant course and the associated stigma often results in emotional reactions of a serious nature among those infected.
- HIV has direct effects on the brain that may lead to neuro-cognitive disturbances, psychosis or behavioural changes.
- Opportunistic neurological and systematic infections and their treatment may lead to neuro-psychiatric problems.
- Some of the drugs used in HAART (Highly Active Antiretroviral Therapy) are known to be associated with psychiatric side effects.
- Persons with severe mental illness are known to be vulnerable to HIV infection and there are various management concerns in this population.
- Substance abuse and HIV are linked in direct ways (intravenous drug use) and in indirect ways by their influence on sexual behaviour.
- Treatment adherence and course of illness have been found to be influenced by emotional factors and substance use.

The above description indicates the complexities of the link between psychiatric syndromes and HIV infection. In a given individual, more than one of these factors might be involved thus leading to complex clinical manifestations and requiring a multipronged approach in assessment and management of the problem.

RESEARCH DESIGN

In the present study the investigator has undertaken cross-sectional design (one shot design). A cross sectional design slices a sample of the population (at one time). The focus in a cross-sectional survey is on description- describing the characteristics of a population or the differences among two or more population. Cross-sectional designs can also be used to assess inter-relationships among variables within a population. These types of designs can be especially be useful in epidemiology, the study of the incidence and prevalence of disease in a population. Incidence refers to the number of new cases of a disorder reported during a specific time period. Prevalence is the frequency of a disorder in a particular population. Lastly, cross sectional designs are ideally suited to the descriptive and predictive functions.

RATIONALE

The review of literature and relevant studies showed that there is a paucity of information and evidence of psychiatric morbidities amongst PLWHAs. Such studies were conducted in India also, but were confined only in Southern India, and were concentrated only on mental health per se. Hence keeping this fact as a pivot the researcher has decided to undertake one such study in Gujarat. With the help of this study mental health specialists can help in the prevention and treatment of several complications of HIV infection. They can identify and modify behavioural factors related to the acquisition of the infection or affecting the course of the disease. They can help describe the significance and inner consequences of HIV/AIDS diagnosis. They

⁵ Cohen.M.A and Gorman.J.M.(ed)Comprehensive Textbook of AIDS Psychiatry.

⁶ Chandra,P.S, " HIV and Psychiatric Disorders", Indian Journal of Medical Research,2005,Volume 121,pages 451-467

can determine the usefulness of interventions aimed to alleviate the psychiatric implications of these aspects. The study can help in integration of mental health into HIV/AIDS initiatives and programmes in the country. Primary health care providers including HIV counsellors' can be trained to recognise and treat common mental disorders and refer patients to specialized services when needed. HIV can be integrated into mental health services. Such a study can help in relevant guidance, continued advocacy and monitoring of actual levels of coverage of interventions for mental health and HIV/AIDS in our country.

OBJECTIVES OF STUDY

1. To study the presence of psychiatric morbidities like anxiety, depression and suicide ideation in PLWHA.
2. To study the Quality of Life in PLWHA.
3. To study the self esteem of PLWHA.
4. To explore the association between HIV positive status and psychiatric morbidity with reference to age, gender, occupation, habitat and religion.

VARIABLES

Considering the present investigation, the following are the dependent and independent variables.

Dependent Variables:

The dependent (DV) is defined as one about which the investigator makes a prediction. Hence in this study the dependent variable will be the presence of anxiety, depression, suicide ideation, quality of life and self esteem among PLWHAs.

Independent Variables:

The independent variable is defined as one which is manipulated, measured and selected by the experimenter for the purpose of producing observable changes in the behavioural measure or dependent variable (DV). Underwood calls dependent variables as the stimulus variables and independent variables as the response variables. In this study the independent variables will be HIV positive status, age, sex, marital status, caste, rule of residence and educational qualifications

RESEARCH QUESTION

- i. Are HIV positive people prone to psychiatric morbidities?
- ii. What are different psychiatric morbidities that HIV/AIDS positive people have?

Sampling frame: In order to collect the data a list of total cases of HIV positive cases in 2009-2010 was obtained from Gujarat AIDS Control Society (GSACS) which gave the number of HIV positive cases in all four major urban cities of Gujarat viz: Ahmedabad, Baroda, Rajkot and Surat. The investigator then drew the percentage of cases to be drawn from each city.

DATA COLLECTION PROCEDURE

Universe: Gujarat.

Sampling Procedure: Newly HIV Positive Cases Detected in 2009-2010 at ICTCs

Steps of Data Collection:

Inclusion criteria for selection: Males and females above 18 years of age. HIV sero positive individuals

Consent Form

A consent form was developed for the present study. This is a written consent form which elicited information that the respondents have agreed to be part of the study. Prior to the admission of all parameters, the willingness of the subjects was ascertained and they were made to sign a consent form. The purpose of the study was explained, confidentiality was assured and the consenting process was properly followed.

As HIV/AIDS is still a sensitive topic in the Indian context conducting an in-depth research in the said topic requires a great deal of challenges. For a smooth flow in all the technical aspects permission was taken from the relevant authorities for the same. The researcher personally met the authorities at Gujarat State AIDS Control Society (GSACS) and explained the purpose and nature of a research proposal to them and sought

their consent and permission.

Ethical issues and approval

An ethical committee was formed at the university level comprising experts from medical field, social science research, members of HIV positive network, professors and members of NGOs. Ethical issues were deliberated by them. Their views were incorporated in the questionnaires and the selection of tools. After seeking their approval, the researcher proceeded further. The researcher sought permission from the superintendent of the civil hospital from where data was collected. Once the tools were finalised a pre study on a small sample was conducted using the tools selected to figure if they were suited to meet the study's requirement. Once the researcher began approaching the patients at the Antiretroviral therapy (ART) centre of Civil Hospital, Baroda it was observed that the members of the HIV positive network also attended the ART centre on a regular basis. Hence rapport was established with them too and data was collected from the positive network too.

DATA ANALYSIS

1. Frequency Percentage Tables: This was to find out the responses in each variable that have been considered for the study.
2. Chi Square: Chi square was applied to develop an association between socio-demographic variables (age, education, religion, occupation, sex, habitat etc) and dependent variables like: depression, anxiety, self-esteem, quality of life and suicidal ideation.
3. Correlation: We have developed a correlation to observe the relationship between measuring (dependent) variables.

RESULTS AND IMPORTANT FINDINGS

1. The clinical anxiety score of the respondents is comparatively high according to which 69.9% fall in the category of severe anxiety.
2. Similarly with regards to depression 52.2% i.e. 153 respondents are in the category of severe depression while 14.7% of the respondents i.e. 43 of them need medicine for depression. This finding is alarming.
3. Contrary to the previous data 143 respondents (48.8%) had a high general self esteem. 69.3% i.e. 203 respondents had a very high social self-esteem, 268 respondents i.e. 91.5% had a high personal self-esteem.
4. Almost 52 percent of the respondents had suicide ideation some of the time or a good part of the time which also calls for suitable interventions.
5. The overall quality of life score revealed that only 2.4 percent have a high score on quality of life, while the rest were either in moderate or low categories. Looking in the sub-items of Quality of Life i.e. sex life only 20% are satisfied, only 7.5% respondents worry very little about their financial condition while remaining 83% have moderate to high level of anxiety about financial matters. With regards to guilt 58.4% respondents are at the higher score and 28% are at the moderate level.
6. With reference to medical care almost all worried about their health conditions and medical care.
7. Amongst the four districts which are taken as sample by the researcher, it is observed that Ahmedabad has the highest number of HIV/AIDS patients. The reason can be the available business possibilities there. Surat, which stands third was expected to have the highest number of HIV positive cases due to its proximity to Mumbai, more migrant population and large number of workers due to the textile and diamond cutting industries.
8. Majority of the respondents i.e. 129 belonged to the age group of 30 to 39 years. This age is the most productive age in an individual's life time. Being HIV infected at this age makes it difficult to be socially, economically and reproductively successful.
9. HIV is often considered to be affecting only the marginalised groups of the society, but in this study it was found that even the business class was infected by it.
10. It is often assumed that people being infected with HIV live alone and lack familial support and due to loneliness they indulge in high risk behaviour, but this piece of research revealed that maximum respondents lived with their family and still were HIV positive.

11. Many respondents were found having Tuberculosis which is said to be a supplement of HIV due to the weakened immune system.
12. Barrier contraceptive methods were used by majority respondents and condom was most widely used.
13. In view of stigma, majority of the respondents faced a problem at the family level which is quite strange, because family is an institution which should give the necessary support and care to individual in terms of crises.
14. Majority of the respondents attended social gatherings and functions after discovering they are HIV positive. This indicates that their social life was not disturbed much after HIV infection. This finding further reflects the lack of guilt conscious among the respondents.
15. With regards to the spread and knowledge of HIV infection, media is said to have a very prominent role. Majority facts related to HIV infection were known to the respondents through media like television. Second important source was the health care provider.
16. With reference to the spread of HIV information was adequate but with reference to prevention respondents were not very sure of.
17. Lastly, respondents were also aware of the most recent development about the Antiretroviral Therapy which can help cure AIDS to some extent

The data collected thus reveals various eye opening facts which we as laymen are unaware of. It was assumed that amongst all the four districts Surat would have the maximum number of HIV positive cases, due to its proximity with Bombay and the penetration of migrant population coming from other parts of the country, but the data available from Gujarat Aids Control Society (GSACS) showed that it was Ahmedabad which had the highest number of HIV positive cases followed by Rajkot, Vadodara and Surat.

The data suggests that maximum number of respondents belonged to the age group of 25 to 40 years. This age group is considered productive in all respects i.e. when an individual aspires to be financially stable, reproductively functional and educationally sound. If at this age an individual is infected with HIV his future is definitely challenged which in turn is a great loss to the nation as a whole. Not only this but through the entire course of data collection the researcher observed that most of the HIV infected people were married and had children who were also infected and belonged to urban areas. The medical facilities were easily available and accessible.

According to the data collected it was observed that respondents primarily complained of continuous cough, fever and weakness. Due to the stigma attached to HIV infection disclosure to one's spouse was not very common as there exists a fear of separation, being abandoned and divorce. In view of the present measures that can help combat HIV infection informing the spouse or knowing the HIV positive status of one's spouse proves to be effective and helpful. In contrast to the earlier mention where most of the individuals were unaware of their spouse's HIV status, data reveals that when the HIV positive status was known to the family members they were sympathetic and caring towards the respondents. Surprisingly though it was assumed that the respondents would have faced problem in their interaction with the paramedical staff, the findings suggests that they were treated with courtesy and support. After knowing their HIV status many individuals did not attend any social functions.

On one hand, media had a great impact in creating awareness and spreading knowledge about HIV among the masses, but on the other the role of the health care providers and the paramedical staff like the social workers and the service providers is not well defined and understood in our country. Majority of the respondents either did not know or were unwilling to answer the question whether HIV can be prevented or not. This is an alarming fact brought to light as it suggests the unsafe sexual practices observed by the respondents.

The data also suggests that the sample under study exhibited certain psychiatric complications. Majority of the PLWHAs' experienced severe anxiety and depression which was high enough to be treated. Findings from studies examining the relationship between social support and well-being amongst PLWHAs' suggest that support is a key predictor of quality of life, positive coping, higher levels of life satisfaction and positive self esteem. In this study very few respondents had a high level of quality of life. Health and medical care were a matter of concern to the respondents.

In terms of general psychiatric management patients with AIDS who are most severely ill pose perplexing problems. The problems though severe / fewer are familiar to mental health professionals. For instance, a prominent psychiatric problem is depression. This depression is not simply normal grief response to having a

fatal illness, but rather a pathological process characterized by alienation, irrational guilt, diminished self-esteem and at times pronounced suicidal ideations. These symptoms are related to conscious and unconscious conflicts about the way in which the disease was acquired and what it means to the particular patient. Psychotherapy, antidepressant medication and precautions to prevent suicide may all be necessary.

The psychiatric interventions for patients suffering from dementia are similar to those for the general management of mental disorders. We as social workers can help these patients establish structure in their daily living, set limits appropriate to the patients current capacities, reduce self destructive or impulsive acts and help the patient with financial matters. Some AIDS patients may remain unreasonably hopeful about recovery despite of the presence of their fatal illness. At times the denial becomes so extreme that it interferes with the patients receiving palliative care and often refuses to practice risk-reducing behaviour. In such cases denial must be confronted and treatment be instituted.

It was observed throughout the course of data-collection that psychological problems (coping with death in a young adult, disfigurement, physical weakness and pain) posed by HIV infection are offshoots of psychosocial stressors that are more particular to AIDS epidemic. These include ostracism by family and friends etc, unsupportive social network, paucity of facilities, funding and health care providers. In addition most of these people realize they are not only infected but also infectious.

As trained social workers in mental health field with a basic knowledge of HIV/AIDS we can provide the support, psychotherapy to treat the anxiety, grief, depression, alienation and avoidance behaviour experienced by these patients.

Through cost-efficient self-help and government funding is available, it has not reached at all places and also it is not applicable for all. Some individuals have unique problems or are too concerned about confidentiality to participate into a group process. Moreover in certain places public and private organizations are often sluggish in responding to the psychosocial needs of these individuals.

The efficacy and cost-effectiveness of various psychosocial interventions should be assessed for sero-positive and sero-negative population, for those with psycho-pathological reactions to having AIDS and for those who are not in high risk groups (e.g. family, friends, caretakers, the general public).

Educational material should be developed for use with those psychosocially stressed by AIDS related disorders.

The impact of psychosocial intervention risk individuals should be measured to determine which groups are preferable targets of effort to limit the spread of HIV.

Psychiatric staff must be enabled to assess patient's mental status.

Additional funding should be provided for sufficient chronic care facilities, partial hospitalization outpatient units and home care to meet the psychosocial requirements of those with HIV related disorders and to provide the additional staffing and support in existing facilities because of the unique psychosocial requirements of patients with HIV related disorders.

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REFERENCE LIST

1. Cohen. M.A and Gorman.J.M.(ed) Comprehensive Textbook of AIDS Psychiatry.
2. Chandra,P.S, " HIV and Psychiatric Disorders", Indian Journal of Medical Research,2005,Volume 121,pages 451-467
3. M.S.Usha, "Women and AIDS in India ", "Womens Link, April 2001

4. "How do you solve half a century bloodshed in Colombia", The Gurdian, April 2017

5. www.GSACS online

6. An overview of HIV/AIDS in India (www.avert.org/aidsindia.htm)