7.1 Introduction

India is known as a land of customs, traditions, an ancient history and bright culture. We could not imagine that this land would get affected by HIV/AIDS in the forthcoming years. But after 1986 the imagination turned out to be true. Now this disease has become a challenge towards the field of health. Even after struggling for over 20 years and more, we are unable to suppress this deadly disease, and still government with the help of people is trying to eradicate the same. But the results are not satisfactory and the disease has become a major problem towards mankind. When we explored the depth of this disease with the root we were unable to differentiate the root cause; either the affected person or the common man.

There is a need of awareness in the minds of youths and common man about this deadly disease HIV/AIDS. Overall, to avoid or to control the spread of HIV/AIDS further, the disciplinary steps, advices and the suggestions are necessary to be followed by each and every citizen of the nation, just as his/her rights by cooperating with the affected person, his/her surrounding, family and with the society and even to avoid the false beliefs towards HIV/AIDS. It also requires proper coordination. Apart from the awareness, there is an utter necessity of the control over the spread of HIV/AIDS and the hospitality towards the affected person in today's generation.

Various issues related to the PLHA especially psychosocial issues have been discussed in this study. Each individual is different in the society and requirements of the individuals are different. Though it is very difficult to provide the individual based services, but the effort should be made to develop the integrated service packages
on the need basis. The services should be integrated and need to be applicable and useful to majority including the minority communities in the society.

The psychosocial support to the PLHA is need of the hour at every stage by the individuals, spouse, family members, caregivers and community as whole and has been pointed in this study. The people and personnel working in the field of health need to change their attitude towards the HIV/AIDS infected people. There is a need for reducing the gap between the HIV infected and health professionals. This has to be done by the concerned authorities over and over again. By doing so the services especially the psychosocial support can be provided in a better way.

The present ongoing programmes should be evaluated in time and the learnings should be shared in time to improve the performance of the programmes. By executing the learnings of the programme the HIV infected people can be accessible to the better services in the society.

Overall this study highlights the need for understanding the psychosocial issues of the HIV infected and develop the strategies and programs and an honest effort is required to implement the developed programmes.

Following were the main findings, suggestions of the study.

7.2 Main findings of the Study

Part-A Demographic Profile

1. Among the total respondents majority i.e.23.63% were in the age group of 29 to 33 followed by 24 to 28 years age group (20.90%).

2. Only 23.30 % of the respondents were illiterates and remaining respondents educational qualification was from primary level to graduation.
3. In this study majority of respondents were from Hindu religion (76.90%) followed by the Muslim (17.60%) and the Christian (5.50%).

4. The majority of respondents were housewives (33.00%) followed by the business profession (18.50%).

5. Among the total respondents 71.80% were married and 14.20% were Widow or Widower.

6. The majority of the respondents were married at the age of 22 to 25 (56.96%) followed by 18 to 21 years of age group (24.54%).

7. The 38.18% of the respondents were not having annual income and 36.36% respondents had the annual income of Rs.5000 to 17000/- and 40.60% of the respondents were having the family annual income of Rs.5000 to 17000/-. In 61.81% of the cases only respondents were the earning members in the family.

8. Majority (71.50%) of the respondents belonged to nuclear families.

9. The 71.63% of the respondents were having one to three dependents followed by 21.63% not having any dependents.

10. In 60.60% of the cases the respondent himself/herself was the head of the family.

11. various habits were found with the respondents.

12. There was drastic change in the living status of the respondents before and after the HIV infection. The 40.30% were living with the spouse and children before HIV infection and after HIV infection it had come down to 26.36%.

**Part -B, Health Background**

1. The majority i.e. 58.40% of the respondents underwent HIV test followed by the Doctor's suggestion.
2. 87.90% of the respondents were tested at VCTC followed by the 8.18% were tested at VCTC and private hospitals.

3. After knowing the HIV positive test the 35.20% were shocked and 23.60% were shocked and accepted the reality.

4. 49.09% of the respondents were infected due to unprotected sex and followed by the 19.69% were infected by their infected partners.

5. At the time of interview 38.50% were on ART treatment and 38.50% were not on any treatment.

6. The majority i.e. 39.09% have the satisfaction on the Government treatment and there was less belief on other department treatments.

7. The majority 41.20% had disclosed their HIV status to their spouse followed by the disclosure to their parents (25.50%).

8. The HIV infection was disclosed to the infected in slow process. About 38.20% of them came to know the status after a month and 27.60% were disclosed after a week.

9. The majority i.e. 61.81% had respondents on the HIV status of the spouse and 24.54% were non reactive on the spouse HIV status.

Part-C, Economic and Social implications

1. The major expense of the respondents were medical treatment and hospitalization (28.18%) followed by the food and travel.

2. The hospital expenses were managed in different ways by the respondents. The 23.00% were depending on the family members and 22.72% were managing by mixed efforts and 19.69% respondents were managing by their savings.

3. There was mixed response from the family members of the infected. About 36.36% of the respondents’ family members were supportive and accepted the infected 26.36% were also
supportive, accepted and also caring. About 21.081% of the respondents got discriminated and negligent response from the family members. About the friends’ response to their HIV status the majority of the respondents (58.20%) did not respond on that.

4. The respondents’ working place was an important component and 77.00% of the respondents had answered to this question.

5. About 31.20% of the respondents agreed that their family was discriminated and stigmatized in the society and 68.80% of them said no.

**Part-D, Details of Psychosocial Problems**

1. In the individual psychosocial problems 87.87% of the respondents faced the loneliness problem and 53.93% of respondents reported loss of self esteem in the society. Around 29.69% of respondents explained the individual psychosocial problem of sexual desire.

2. Fear of illness and death problem came out in the study as a major health related psychosocial problem among the respondents that is 75.45% percent. Followed by worries about life span problem 64.84% of them were also reported.

3. When the livelihood psychosocial problems of the respondents were concerned, half of the respondents (52.12%) were evident for the problem of loss of income. Around 46.96% of respondents showed the concern in the problem of dependents.

4. Family related psychosocial problem was experienced by the total respondents and it was evident that most of them had worried about future of the spouse and children which was 63.93% and followed half of them reported problem of status of family in the society i.e. 52.42 percent.

5. Loss of prestige (79.09%) in the society problem was reported as one of the major problems in the stigma and discrimination
related psychosocial problem. The problem Stigma and discrimination from the family member, health care provider and community (23.63%) had taken equal place and this evident was proved as the problem of stigma and discrimination related issues in the PLHAs day to day life.

Part-E, Counselling and Support System details

1. Counselling is one the significant treatment components and in this case 80.90% of the respondents were ongoing the counseling sessions.

2. The majority of the respondents agreed that the counselling sessions were helpful and 93.30% of the respondents agreed that after attending the counselling sessions their life style had changed.

3. After attending the counselling sessions majority (93.30%) respondents were living healthy life style.

4. About 76.10% of the respondents were having the membership to the network and majority were getting support from the network.

5. The majority of the respondents (68.18%) were aware of the safe sex practices and 68.00% were using the condoms.

6. The respondents strongly felt that the HIV test is to be made mandatory (67.57%).
7.3 Conclusion

Maximum number (44.50%) of infected individuals fall under the age group of 24 to 33 years of age during which the individuals are sexually active and are in reproductive age. The considerable number of young adult were also infected which may be due to the fact that they did not have proper sex education.

The study shows that there is no correlation between HIV prevalence and literacy rate. Hence, maximum number of educated respondents (76.70%) were also infected owing to the fact that they had very poor or no knowledge about safe sex practices and sexual health, since about (92.00%) of the respondents were not having safe sex practices. Hence, these people need to get sexual education which they still think to be tabooed. Though there are lot of programmes related to sex education and health which constitute of condom use, HIV prevention education, trainings etc., there is still need to see that these people have really understood its importance and if yes, to what extent they are practically applying the knowledge.

Though the study shows no correlation between occupation and HIV infection considerable number of respondents fall under the business category (18.50%). Hence, it can be inferred that most of the times the business people who are out on a business tour and hence in order to reduce their burnout they go in for sexual pleasure after finishing their get-together party or alcoholic consumption. This makes them more vulnerable to the infection because they may not take necessary precautions before entering into such sexual acts.

Due to rapid progression of the HIV infection many of the respondents have lost their spouse leading them to become widow/widower (14.20%). This status paves way to innumerable social and economic milieu.

The study showed that maximum number of respondents fall below poverty line (17.57%) and hence they are more vulnerable to
face economic crisis because most of them have only one earning member with many dependents. Apart from this the earning members were also posing various bad habits like alcoholism, chewing of tobacco, smoking etc.

According to the study, majority of the respondents were infected through having unprotected sex (85.14%) with unknown, multiple partners and with risk behaviour. But they came to know about their HIV status when they were referred to VCTC through doctors’ suggestions hence they were already in symptomatic stage which showed that the disease had progressed considerably. At this stage the viral load was more and they were practicing unsafe sexual activities which made their spouse more vulnerable to the disease.

Majority of the infected individuals in the study expressed shock (35.20%) when they came to know about their HIV status. Apart from that considerable number of spouses of these individuals were also diagnosed as having HIV (61.81%) infection followed by this, quite a large amount (38.20%) of gap was seen in disclosing their HIV status to their spouses and parents due to the ill-consequences they may face within the family and community.

It was evident from the study that major expenses of the infected individual was on medical treatment (28.18%), hospitalization (28.18%), food and travel (28.18%). These expenses were met with the help of family members and sometimes by using their savings (19.69%). Though majority of the family members of the infected individual were supportive and caring (36.36%) considerable number of them were discriminated and neglected the family members (21.08%). However, majority of the respondents did not disclose their HIV status to their friends, neighbours and at working place. The respondents’ status was known indirectly, through someone else where in, they had to face the problem of stigma and discrimination in the society.
In the present study psychosocial problems of the respondents are studied at the various levels like the individual, livelihood, family related and at the society level. Innumerable psychosocial problems were experienced by the respondents due to the HIV status. Among them the major individual problems faced were related to loneliness (87.17%) and loss of self esteem (53.93%). This had a major impact on routine activities in their life. Apart from this the respondents also expressed fear of illness and death and were also extremely worried about their life span.

Psychosocial problems related to livelihood also had remarkable impact on the HIV infected individuals. The major concern here was found to be loss of income (52.12%) and problem of fulfilling the needs of their dependents. This lead to severe stress, worries and burden which the respondents had already had due to the infection.

Future of the spouse, children (63.93%) and status of the family (52.42%) in the society was found to be the major concern to the respondents as far as family related psychosocial problems were concerned. The impact on family was more because majority of them were living in nuclear family (71.50%). Hence, they were denied of support from other family members that could be seen among the joint families.

Inspite of experiencing the above said psychosocial problems, the respondents also had to face problems in the society due to their HIV status. Loss of prestige (79.09%), stigma and discrimination by the family members (23.63%), health care providers (23.63%) and community people (23.63%) were also seen. This aggrieved the already existing psychosocial distress. Due to such indifferent behaviour of the people in the society the respondents became desperate and were helpless in availing the existing medical, counselling and care and support services.

The counselling services provided by the government hospitals and support centres proved to be satisfactory. Owing to the fact that
majority of the respondents’ counselling sessions were still going on (80.90%). This was due to the fact that these sessions helped PLHA in changing their lifestyle (93.30%) in more constructive way.

Due to the repeated counselling and information exchange at the ART centre and support centres maximum number of PLHA were aware of safer sex practice and the use of condoms regularly (68.18%). The study also showed that majority of the PLHA were willing to join the positive network and avail the existing services (76.10%). They also opined that it was an added advantage to see their life in more positive way by joining the positive networks.

Considering all the above psychosocial problems faced by PLHA they opined that HIV testing should be made mandatory before marriage (67.57%). This shows the severity of the psychological and social impact faced by the PLHA.

Thus the study strongly depicts the psychosocial correlation of persons living with HIV AIDS.

7.4 Suggestions

1. In order to curb the prevalence of HIV among the young adults it is important to provide appropriate sex education and moral education during adolescence which may have deep behavioural impact on the young adults.

2. Though the infected individuals are literate it is important to assess the knowledge of sex education and their attitudes towards sex behaviour. This can be made more effective through addressing these issues and also involving sexual partners/spouse.

3. From past two decades India has been utilizing huge funds for the prevention, control and care in HIV programmes but there is no proper data related to widow/widower and such data can be made useful in designing and implementing programmes for reducing negative social and economic impact on them.
4. To reduce the economic crises faced by the infected persons families, it becomes necessary to implement such programs which enhances their economic status. This can be done by providing trainings in income generation activities like dairy farming, tailoring, food packet preparations, electronic repairs and handicrafts etc. Such type of programs should support not only to the infected individual but also to other eligible family members because if the infected persons fall ill frequently the other family may carry out such activities in his/her absence.

5. By early diagnosis of HIV infection the vulnerability of spouses and unknown partners getting infected may be reduced because at the early stage the viral load is less and infected person may be educated with safe sex practices. Hence, in order to increase voluntarism in getting HIV test done, more and more awareness programs relating to HIV transmission, sexual health and safe sex practices, should be promoted at grass-root level to higher level.

6. The core issues like acceptance of HIV positive result, disclosure and partner testing need to be addressed skillfully by the service provider at ICTC and ART especially the counsellors who are trained at that level and should be ensured that they make use of these skills and tools to solve the above said issues.

7. In order to reduce stigma and discrimination towards the infected individual by the family members, neighbour, friends, workplace and service providers it becomes important to strengthen the HIV positive network and create volunteers who can develop good linkages with service care providers, family and community, so that misconceptions regarding the infection and infected persons may be reduced drastically. It is also important to educate the infected person regarding his/her rights. This can be done by reframing and improving existing services for PLHA.
8. The psychosocial problems of the PLHA can be addressed at various levels. At the service provider level the counselling sessions should focus on client centered aspects. This can be done by identifying the needs of the PLHA, prioritising them and providing appropriate options to solve their problems. This can be done more effective by periodic training and capacity building of the counsellor at ICTC, ART and other care and support service centres. The counsellor should also be provided with scientific psychosocial assessment tools in assessing the degree of psychological problem of the PLHA.

9. Since most of the ART centres in the government hospital do not possess sufficient psychiatric services, the existing services need to be improved and new psychiatric services should be established where they are not present especially at the peripheral level.

10. There should be an integrated approach with the Health department to solve the problem of the infection in our society.

11. There is a need for commitment from individual, family, community, society, government and political leaders in promoting awareness of HIV/AIDS among the general public.

12. There is a need to develop documentation related to psychosocial help provided to PLWHA.

13. To develop a friendly nature (homely atmosphere) among the care providers to reduce psychosocial sufferings.

14. To provide hostel facilities for orphans/OVC CLHA in all districts to support the psychosocial needs of the child, parents and family members.

15. To provide some reservation percentage in government and private sectors for improving PLHA economic status and as well as standard of living.
16. To strengthen female intervention programmes in this perspective, provide counselling services by the same gender counsellors, for effective involvement of women in counselling and treatment services and psychosocial support.

17. To ensure partner treatment and counselling for implementation of effective treatment, psychosocial support and safer sex practices.

7.5 Area for Further Research

The verification of the various conclusions that are drawn from the analysis of the data show that social reality is not so simple as empirical evidence appears. The results of the above study above point out that there is a need for further research in the area of HIV/AIDS particularly on the psychosocial issues related to the PLHA to evolve realistic and valid indicators for developing the policy towards the HIV/AIDS infected.

Applied research is needed to examine at length the nature and magnitude of linkages between the psychosocial issues and life of the PLHA.

The further research can be done in the following areas.

- Psychosocial problems among the discordant couples.
- Psychosocial and economic impact among the HIV infected widow and widowers.
- Psychosocial barriers related to safer sex practices among the HIV infected individuals.
- Psychosocial support to PLWHA issues and challenges.
- Psychosocial problems among the target intervention population (MSM, FSW).
- Evaluation of effectiveness of counselling services in redressing psychosocial of PLWHA.