CHAPTER-I
INTRODUCTION

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CHAPTER-I

INTRODUCTION

1.0 Introduction

Health is one of the essential and very important aspects in developing countries like India. The health sector requires a multi sectoral approach in which the health service has a major role to play in enhancing good health of the community. After independence India put forth various health related programmes in the Five Year Plans, which was accelerated more in the past few decades.

India is a country with rich culture and social background and the assumption was that the country will not have diseases like HIV/AIDS. But the international devil called HIV/AIDS was detected in 1986 and the dreams and assumptions were spoiled. The HIV/AIDS has spoiled the Indian dream and concept of safe life of human beings. Since HIV/AIDS is a bio-medical problem, it also has socio economic and psychological impacts on the individuals. HIV/AIDS is a challenge to the society and has led to rumors and false beliefs about diseases. In India 84 percent (World Bank, 2007) reported HIV cases were transmitted through sexual routes and remaining either through blood and blood products and transmission from infected pregnant woman to her child.

Once when HIV/AIDS is detected in individuals, s/he will start thinking that the death is nearing. The clients will become depressed because of no cent percent cure and also it is attached with stigma and discrimination in the society. The HIV/AIDS is more among the productive age group (18-49) and once when HIV/AIDS is detected in individuals, there are possibilities of occurrence of other opportunistic infections in the process and it may lead to the death of the client after being infected by HIV within 10-15 years. Thus it has an impact on the social life, education of the children and on the economic conditions of the client's family.
India initiated Anti Retroviral Treatment (ART) in 2004 and its purpose was to prolong the life and help them to lead a natural life. But due to lack of proper follow up with the clients it has remained as a challenge among the Persons Living with HIV/AIDS (PLWHA). ART treatment has its own side effects and deficiency of care and treatment facilities. The entire treatment of ART is to lead a positive life, behaviour modification, change of attitudes and depends totally on counselling service and support of the family and community. But in the present scenario the workload in ART centers is very high and it leads to doubt about the quality of counselling available to the clients.

The condition of the women and children who have been infected by the HIV/AIDS is really pathetic and the number of their group suffering has been increasing day by day. As per the Karnataka State AIDS Prevention Society (KSAPS) Bangalore report (March 2003 December 2004), in India 89% of the reported cases were in the sexually active and economically productive age group at 18-40 years. Over 50% all new infections took place among the young adults below 25 years. About “21% of new infections were among women. The majority of them did not have any other risk factors other than being married to their husbands”1.

It was an issue which needed to be looked into with serious concern by all the concerned Governments, individuals, like minded organizations and the community.

To improve the quality of life of the PLWHA they need quality food consumptions, safer sex practices and regular follow up to hospitals. But in our present conditions it is difficult to fulfill the basic needs of the PLWHA.

Therefore its impact on the client’s economic status, family, social acceptance and psychological problems etc, needs to be studied.

1 Karnataka State AIDS prevention Society, Bangalore, March 2002, and December 2004, Printed Book on Karnataka Meet the Challenges of HIV/AIDS.
in depth. These conditions compel us to think regarding prevention and protection from HIV/AIDS.

Therefore there is need for research on these issues. The problems related to the impact of HIV/AIDS on the individuals need to be analyzed. The researcher intends to work on psychosocial correlation of HIV/AIDS persons in Karnataka.

Before we go on to the psychosocial correlations of HIV/AIDS it becomes important for us to know about some basic facts about HIV/AIDS.

1.1 HIV/AIDS

1.1.1 What is HIV and AIDS?

H: Human; means not found in any other living creatures.
I: Immunodeficiency; destroys the immune or defense system of the body.
V: Virus; a type of germ.

So HIV means Human Immunodeficiency Virus. Now let us know what AIDS is.

A: Acquired; means got and not caught i.e. not born with
I: Immuno: Immune or body’s defense system which fights germs like bacteria and virus.
D: Deficiency; not functioning to the appropriate degree, malfunctioning.
S: Syndrome: Group of signs or symptoms.

Hence HIV is a virus which may cause AIDS, AIDS is acquired, not hereditary. HIV is an incurable infection.

Immune system is an important component of the human body because it defends the body from bacteria, fungi and viruses which cause illness. White Blood Cells (WBC) are the most important part of the immune system. Here in this case HIV virus destroys the WBCs which fight against the deadly germs. As the WBC count in the body
comes down, that person becomes more prone to various diseases and infections.

Once the person is infected with HIV, S/he is called HIV positive. HIV positive person may not have AIDS. It may take 6 months to 10 years or more for progression to AIDS.

1.1.2 Classification of HIV

Since HIV mutates very often it is highly variable virus, hence there are different strains of HIV even within the body of a single infected person.

There are two types of HIV - HIV-1 and HIV-2. The most predominant virus world wide is HIV-1 and HIV-2 type is rarely seen but is concentrated in West Africa. It is also shown that HIV-2 is less easily transmitted and is a very slow progress as compared to HIV-1. Hence the period between initial infection and illness is longer in case of HIV-2.

From the above diagram it can be seen that HIV-1 can be classified into 3 groups, group M (major group), group O (Outlier group) and group N (New group) (www.avert.org). More than 90% of
the infections around the world belong to group M. Group O appears only in the West Central Africa and group N is found only in Cameroon but extremely rare at other places.

1.2 Signs and Symptoms

It is seen that some people experience the signs and symptoms of HIV as soon as they become infected but some at the later stage; probably after many years. These signs and symptoms include fever, headache, fatigue, nausea, and diarrhoea. Enlarged lymph nodes (on neck, armpits and groin). However these signs and symptoms are common to normal individuals also hence, the only way to know if you are carrying the infection is to get tested for HIV.

The later stage signs and symptoms of HIV/AIDS are given by Centre for Disease Control (CDC) Washington which are as follows: Rapid weight loss, dry cough, recurring fever, profound and unexplained fatigue, swollen lymph glands in the armpits, groin, or neck, diarrhoea for more than a week, white spots or unusual blemishes on the tongue, in the mouth, or in the throat, pneumonia, memory loss, depression and other neurological disorders.

1.3 Modes of Transmission

HIV is transmitted mainly through 4 routes viz.

1. Having unsafe sex (without using condom) with an infected person.

2. Sharing needles and/or syringes with the infected person.

3. Transfusion of infected blood or blood clotting factors to the normal person.

4. Infected mother may transfer the virus to the baby before or during birth or after birth through breast feeding.
Many state and local health departments have thoroughly investigated and no additional routes of transmission have been recorded.

1.4 Types of HIV Tests

There are two categories of tests namely screening tests and confirmatory tests. These two types of tests can give accurate and reliable diagnosis of HIV infection.

Screening tests are used for initial testing which are helpful in testing large numbers of samples at less cost. However, screening tests are not as specific as confirmatory tests.

The most common screening tests are Enzyme Linked Immunoabsorbent Assay (ELISA). This test measures antibodies to HIV.

Once the result is positive in the screening test then s/he will be advised for confirmatory test. Among the confirmatory tests the Western blot test is considered as a standard measure. This test also measures antibodies to HIV.

There is another type of test called Rapid Serologic tests which provide results in less than 30 min. These tests also measure antibodies to HIV. Most commonly used test is the comb test. Most of the rapid tests include kits that consist of all necessary supplies.

1.4.1 Window period

The window period is another important stage in the diagnosis of HIV/AIDS, which represents the period between the time of initial infection with HIV and the time when HIV antibodies can be detected in the blood stream. During this period, HIV replicates in the blood and lymph nodes; patients are highly infectious and may be symptomatic, but their blood test will result negative for HIV antibody. The window period can last up to 12 weeks and may vary between assays using different methodologies.
1.5. HIV/AIDS: Karnataka scenario

Karnataka is one of the high prevalence states in India. AIDS prevention and control measures were initiated in the state during 1997. First AIDS surveillance center was established in the dept. of microbiology at Victoria Hospital Bangalore Medical College under the technical guidance of Indian Council of Medical Research (ICMR). The first HIV sero positive individual was detected in the state during 1988 and the first AIDS case was also reported during the same year.

In Karnataka the state AIDS cell was established in the Director of Health & Family Welfare services during May 1992 (NACO, 2006). The Karnataka State AIDS Prevention Society was established in the year of 1999. Karnataka State AIDS Prevention Society is a registered body under the Government of Karnataka to look after HIV/AIDS programmes in the state. The second phase of the National AIDS Control project was launched in December 1999 with World Bank support.

The objectives of the AIDS control project phase 2 in Karnataka 1999-2004 were

1. To reduce the spread of HIV infection in the state
2. To strengthen the state's capacity to respond to HIV/AIDS on long term basis.

To meet out these goals they started intervention among the high risk groups started with involvement of NGOs and condom promotion. To strengthen the existing STD clinic, ICE, Blood safety, voluntary counselling and testing center, PPTCT, care and support, school AIDS programme, commercial sex workers programme activities were implemented.

According to HIV Sentinel Surveillance, Karnataka is one of the four large states in South India with a relatively advanced HIV epidemic, with the adult HIV prevalence in several districts exceeding
one percent for the past nine years. As a part of the National AIDS Control Program (NACP) of the National AIDS Control Organization (NACO), Karnataka has been conducting the HIV Sentinel Surveillance since 1998. Surveillance is carried out annually by testing for HIV at designated sentinel sites.

Surveillance testing for infection is conducted among populations at higher risk, represented by patients at sexually transmitted disease (STD) clinics, intravenous drug users (IDUs) who often share needles, female sex workers (FSWs), and men who have sex with men (MSM). Populations at low risk are represented by women attending antenatal clinics (ANCs). Pregnant women attending antenatal clinics are assumed to have the same risk of sexual transmission of HIV as any other sexually active general population. The prevalence among ANC attendees in 2007 was 0.9 percent. This is close to the NFHS III estimate of 0.69 percent in 2006 (HIV in Karnataka, 2007).
Table No. 1.1

<table>
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<th>Type of surveillance site</th>
<th>2003</th>
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<th>2006</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>No of Sites</td>
<td>% +ve</td>
<td>No of Sites</td>
<td>% +ve</td>
<td>No of Sites</td>
</tr>
<tr>
<td>Antenatal clinics</td>
<td></td>
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<td></td>
<td></td>
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<td>District Hospitals</td>
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<td>27</td>
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<td>27</td>
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<td>27</td>
<td>1.6</td>
<td>27</td>
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<td>1.5</td>
<td>54</td>
<td>1.5</td>
<td>54</td>
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<tr>
<td>Antenatal clinics (ages 15-24)</td>
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<td>1</td>
<td>3.3</td>
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<tr>
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<td>7</td>
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<td>7</td>
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<tr>
<td>Female sex workers</td>
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<td>14.4</td>
<td>1</td>
<td>21.6</td>
<td>1</td>
</tr>
<tr>
<td>IDUs</td>
<td>1</td>
<td>2.8</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>MSM</td>
<td>1</td>
<td>10.8</td>
<td>1</td>
<td>10.0</td>
<td>1</td>
</tr>
<tr>
<td>Tuberculosis centres</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>12.5</td>
<td>1</td>
</tr>
</tbody>
</table>


- Evidence of decline in adult HIV prevalence in the state – from 1.5% among ANC attendees in 2003 to less than 1% (0.9%) in 2007
- HIV prevalence among FSWs, their clients, MSM and TG was approximately 10-fold higher than in general population
- As in most of India, HIV transmission occurs in localized sexual network of highly vulnerable populations including FSWs, their clients, MSM and TG.
1.6 KSAPS important programmes

- Targeted Interventions for High Risk Groups
  The Targeted interventions aim to interrupt HIV transmission among highly vulnerable populations like sex workers, men who have sex with men (MSM) population, mobile populations, prisoners, and youth etc. A multi-pronged strategy was adopted including behavioral change communication, counselling, treatment for STI, provision of condom, provision of enabling environment, etc. One of the most important components of the NACP-3, was that Karnataka Health Promoting Trust (KHPT) implemented these activities in 16 districts and in remaining districts KSAPS implemented programme through NGOs. The peer worker groups were formed for effective implementation of prevention of HIV/AIDS infections among these groups.

- Controlling of Sexual Transmitted Infections (STIs)
  Around 4%-6% of the population suffers from sexual transmitted infections (STIs) every year. An individual with STI is 8-10 times more vulnerable to contract HIV. Prevention of STI as a key strategy, to reduce spread of HIV, the National Venereal Disease Control Programme was merged with the National AIDS Control programme in 1992. Syphilis, chancroid, donovanosis, genital herpes, gonorrhoea, candidacies are some of the common STIs. Through a network of STD clinics and syndromic case management the programme seeks to control STI. About 206 STD clinics are functioning in the State (NACO – 40, State Funded- 166). 17 NGOs supported by KSAPS provide STI services to clients. Family Health Awareness Campaign (FHAC) is implemented to enhance health seeking behaviour and treatment access of people with STI and RTI from general population. Stress on Education, counselling, risk assessment counselling, condom promotion, partner notification and completion of treatment issues are implemented to prevent further infection of HIV/AIDS.
• **Condom Promotion**

In sexual route of transmission of HIV, infected only through semen, vaginal fluid or blood to enter the vagina/anus of the sexual partner and therefore constant, correct use condom is only way for protection from the HIV infection. Promotion of condom activity related education demonstration and free supply of condoms distribution are being done in all HIV/AIDS related programmes in Karnataka. At present male condom is available everywhere because female condom is more expensive than male condom and unacceptable by many women and men (HIV Counselling Module, 2006). Around 50 Condom Vending Machines were installed in Nirmal toilets of Bangalore; 1205 condom vending machines installed throughout the state. Condoms sold through Condom Vending Machines were 20.94 lakhs (2006-07).

• **Blood Safety**

The Blood safety programme is banging with a healthy blood donor. Blood is one of the most important and valuable elements in medical field. In India blood safety programme is monitoring through NACO. In Karnataka 156 Blood Banks, 29 component separation units and 35 Blood Storage Centers were established and 14 centers were identified as regional blood transfusion centers. Out of 156 Blood Banks in the state 57 were in Bangalore. In 3 districts Koppal, Gadag, Chamarajnagar had no Blood Banks but Blood transfusion centers were established.

• **HIV-TB co-infection**

Tuberculosis is one of the most common opportunistic infections in the HIV/AIDS. In India it was estimated that around 60% of HIV positive persons will develop tuberculosis in their life time. Around 18 lakh people develop TB every year and each day 20000 people get infected with tuberculosis bacillus, 5000 people will develop the TB diseases. "Approximately 30% of HIV-infected, smear positive
TB patients die within 12 months of starting treatment, and about 25% of those who complete treatment will die during the next 12 months". To prevent tuberculosis they implemented tuberculosis eradication programme in Karnataka through dept of health and family welfare.

- **Integrated counselling and testing center (ICTC)**

  'Integrated counselling and testing center is a place where a person is counselled and tested for HIV, on his own free will or as advised by a medical provider'.

**The main functions of ICTC are**

- Early detection of HIV.
- Provision of basic information on modes of transmission and prevention of HIV/AIDS
- Promoting behavioural change and reducing vulnerability.
- Link people with other HIV prevention, care and treatment services

In Karnataka first VCTC was started at Victoria Hospital in 1999. Thereafter VCTC was started in 6 Medical Colleges. In 2002-03 it was started at all district Hospitals and today there are 55 World Bank funded VCTCs in state. There are 364 combined VCTC/PPTCT centers in the state at Taluk Level & 6 VCTCs at TB Sanitorium.

ICTC were set up in the government health facility such as a medical college, district hospital, sub district hospital, community health centre (CHC) or a 24-hour primary health centre (PHC) which caters to a population of 30,000 to 40,000 with minimum 30 bedded provision Hospitals /Conducting 50 deliveries in the month/TB sanitorium.

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### Total Number of ICTCs

<table>
<thead>
<tr>
<th>Service</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusive ICTC</td>
<td>61</td>
</tr>
<tr>
<td>Exclusive PPTCT</td>
<td>82</td>
</tr>
<tr>
<td>ICTC Combined</td>
<td>364</td>
</tr>
<tr>
<td>ICTC HIV-TB</td>
<td>58</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>565</strong>*</td>
</tr>
</tbody>
</table>

*As per NACP-III guidelines all the above mentioned centers merged as only ICTC.

ICTC is main entry point of the HIV prevention and control. A prevention, pretest, post test, follow-up, ART, family counselling, HIV testing, condom promotion, HIV-TB coordination, and referral linkages with various activities are the main services of the ICTCs.

### PPTCT services

In India prevention of parents to child transmission of HIV programme was started in December 2002. PPTCT services were provided through the antenatal clinics of Medical College Hospitals both private and government and through District Hospitals/Maternity Hospitals. Vani Vilas Hospital is the Center of Excellence for PPTCT services in the country. In Karnataka PPTCT programme was implemented in all 565 ICTCs and strengthened and up graded into primary health centers. In this programme single dose nevirapine 200 mg tablet will be administered to the HIV positive mother during the labor and single dose nevirapine syrup 2mg per kg body weight will be administered to the baby within 72 hours after birth. In PPTCT antenatal care, group education, pre test counselling, HIV testing, post test counselling, to make plan for institutional delivery, administration of nevirapine to mother and baby, feeding counselling and followups upto 18 months are the main activities.
• **Care and Support**

Care and Support for people living with HIV/AIDS is a cornerstone of prevention efforts. NGOs and faith-based organizations run 33 care and support centers in the Karnataka state. The main objective of the care and support center is to give psychosocial support and ART adherence. Medical treatment, in patient care, counseling, nutrition support, guardian counseling, outreach activities are the main functions of the care and support center.

• **Antiretroviral Therapy (ART)**

Karnataka ART centers were established in Bowring Hospital, K. R. Hospital, Mysore, KIMS, Hubli and VIMS, Bellary in 2004, with an aim to provide free ART for 1,00,000 people living with HIV/AIDS by the end of 2007. Free ART is provided through Government Medical Colleges and through district hospitals. Today all districts have ART centers. As per NACO guidelines (NACP-III, 2006-2011) they planned to start 63 ART link centers in high prevalence districts.

ART is not a cure for HIV, but suppresses the virus and improves the immune system in the PLWHAs. In ART programme adherence is one of the big challenges for the success of the treatment. ART side effects, psychosocial support, nutrition, regular follow-up, health and hygiene activities and family support are very important issues in ART.

• **Physical Report**

KSAPS conducted following number of programmes to prevent, protect and control of HIV/AIDS in Karnataka by end of 2007.

- No. of High Schools covered - 8122
- No. of Nodal Teachers - 15392
- No. of Children (in lakhs) - 2267937
- No. of Head Masters/Principals- 964
District AIDS Prevention and Control Units

For the effective implementation of HIV/AIDS activities at the district level KSAPS established District AIDS prevention and control units in all 29 districts as per the National AIDS programme III guidelines. District programme officer, district supervisor and supporting staff were appointed for the development of supervision and monitoring and reporting activities to prevent and control HIV/AIDS epidemic. The main goal of the DAPCU is to merge HIV/AIDS activities in National Rural Health Mission before 2012.

The above mentioned are the main activities explained for the understanding of the current HIV/AIDS programmes in the Karnataka state.

1.7 Psychosocial problems among persons living with HIV/AIDS

Psychosocial support has been defined “as an ongoing process of meeting emotional, social, mental and spiritual needs, all of which are considered essential elements of meaningful and positive human development”4

Psychosocial support addresses the psychological and social problems of HIV infected individuals, their partners, families and caregivers5. HIV/AIDS has many physical effects, but perhaps some of its most profound effects are on the psychological, social, and

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4 www.ovcsupport.net/sw2355usp. International HIV/AIDS Alliance
economic health of the PLWHA, his or her loved ones, and the community.

The HIV/AIDS has an impact on the psychosocial aspects of the infected person. A wide range of personal experiences are encountered by the client by the subsequent progression of the disease. Since man is a social being he has to face a variety of reactions from his family members, employers, co-workers, etc.

As there are stages of HIV in medical terms, so also there are psychosocial stages in the disease progression viz.,

- Pre-HIV testing – here there is a possibility of being infected.
- Post HIV testing – there is a knowledge of being sero positive, asymptomatic stage with stable CD4 count.
- The stage of falling CD4 count with or without symptoms with increasing viral load.
- Severe medical illness or AIDS, there is deteriorating physical and mental functioning.
- Restored feeling at well being with change in attitude regarding future due to treatment.

Hence People with HIV/AIDS must deal with strong emotional issues. Each of these stages can include a variety of emotional responses such as fear, shame, loss, grief, anger, depression, feelings of dependency, and hope (Anita Leal-Idrogo, 1997).

Fear and shame may prevent the client from seeking support from others, or getting help from the AIDS organizations or counsellors. Fear that others will find out about their previous risk behaviours and HIV infection (Michael W. Ross, 2007). Fear may arise due to the unpredictable nature of the disease which in turn aggravate depression symptoms, feeling of hopelessness, frustration and being overwhelmed. Fear among co-workers, friends and relatives of being
infected or the person’s death pull themselves away leaving the client in deep sense of isolation and loss.

HIV/AIDS infection is further complicated by the stigma related to the transmission of HIV infection (i.e., sexual activity and intravenous drug use). Due to disclosure fears and stigma associated with HIV/AIDS, many families isolate themselves from their extended family and communities to protect themselves and their children from maltreatment (Lauriann Tomaszeski, 2001). The client may also experience loss that is loss of lovers, partner, family, friends, co-workers, mobility, strength, weight, appetite, Physical activeness, focus of control, social role, income, employment, housing, etc due to this stigma.

Anger may be induced simultaneously at several targets. The diseased persons may blame themselves or the persons they think who gave them the HIV infection. Some may even blame God (TB/HIV Training Module, 2005) for getting infected, anger on their family for not able to do anything, at society for their rejection, for failing to find the cure. Again the need to stay in control can sometimes produce behaviors such as quarreling, arguing, complaining or being demanding.

The feeling of depression is also experienced by the clients due to HIV infection. Mood disturbances may occur after the diagnosis of HIV infection (NACO Training Module, 2006). The symptoms include disturbance in sleep, appetite changes, withdrawal from all activity, failure to find pleasure in favourite activities, difficulty in concentration. If this is not resolved it may lead to substance abuse or attempted suicide.

Feelings of dependency also arise due to the disability caused by physical and mental illness. Dependency brings threat to autonomy, privacy, control, independence etc. Hence the person may
ask for accommodation because of change in identity, feelings of shame, not waiting to feel different or pitied.

However it can be seen that all emotional responses to HIV/AIDS are not negative, the primary task of the client is to maintain hope.

Apart from this emotional stress the clients may also experience scepticism, confusion, surviving guilt, daring to be hopeful, post traumatic stress disorder, numbness, dizziness and uncertainty.

Again the psychosocial competence is comprised of 3 variables viz.,

- Coping style – refers to the way a person approaches management of their life challenges. It comprises of their thought process, self talk, emotional management, behavioural efforts to tolerate, reduce or master.

- Self efficiency – That is belief in one’s sense of control, one’s ability to perform some action or to control one’s behaviour or environment.

- Self-Esteem – includes a person’s sense of self, of their competence, and their acceptability to others. In case of HIV infected person low self esteem persons are not self protecting from others. Due to stigma, guilt, loss of good physique, loss of roles, work, social network the self esteem of the infected person would be threatened (Anita Leal-Indrogo, 1997).

Therefore there is a need for research on these issues. The problems related to the impact of HIV/AIDS on the individuals need to be analyzed. The researcher intends to work on psychosocial correlation of HIV/AIDS persons in Karnataka

1.8 Need for the Study

A review of literature in the area of psychosocial correlation of persons living with HIV/AIDS shows that, there is no much research done in this area. Especially in India it is important to find out the
psychosocial needs of the persons living with HIV/AIDS because it is the second largest country with HIV epidemic in the world.

This study needs to be done because of the following reasons:

• To find out the details of the psychosocial correlation of the persons living with HIV/AIDS.

• To suggest better ways to address the psychosocial needs of persons living with HIV/AIDS.

• To understand & suggest measures which may help to make HIV/AIDS related activities become more effective and sustainable in our country.

The study attempts to bring about a need based approach document based on an empirical evaluation study undertaken in 2 districts of Karnataka State.

Conclusion

In this chapter an effort is made to have a glance over the details of the topic and its related background. This helps to understand the status of the disease and its impact in the society. With this background the details of the studies conducted on par or related to this study will be reviewed in the next chapter.