**Psycho-Social Environment and HIV/AIDS in India**

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| **Keywords** | **Abstract** |
| HIV/AIDS, Psycho-Social Environment | The present study attempts to review the current state of knowledge on issues relating to the psycho-social environment in which the HIV/AIDS epidemic is breathing in India. A well known but little understood fact is the complex relationship between psycho-social environment and the spread of HIV/AIDS. Information, education and communication efforts and behavioral change strategies about practicing safe sex cannot produce the desirable effect if these efforts are not contextualized within the risk behaviors. In this context some of the social factors are poverty and socio- economic- status, mobility of the Population, HIV Surveillance in injection drug use, young population, evaluation of knowledge and awareness, discrimination and human rights. Depression and other psychological effects were also found in HIV/AIDS patients. So, it is very important for the rehabilitation professionals to recognize the major social and psychological issues that appear at different stages of HIV/AIDS infection. |

In a country where poverty, illiteracy and poor health are rife, the spread of HIV presents a daunting challenge. India is one of the largest and most populated countries in the world with over one billion inhabitants. The acquired immunodeficiency syndrome (AIDS) has become the most serious infectious disease in contemporary history. According to National AIDS control Organization of India, the prevalence of AIDS in India in 2013 was 0.27, which is down from 0.41 in 2002.While the National AIDS Control Organization estimated that 2.39 million people live with HIV/AIDS in India in 2008–09.The last decade has seen a 50% decline in the number of new HIV infections. According to more recent National AIDS Control Organization data, India has demonstrated an overall reduction of 57 percent in estimated annual new HIV infections (among adult population) from 0.274 million in 2000 to 0.116 million in 2011, and the estimated number of people living with HIV was 2.08 million in 2011 (Hindustan Times 2011).

The spread of HIV/AIDS in the south Asian region began in the mid 1980s, with the identification of the first case in 1986 in Chennai , India. Although, the infection was initially viewed as being primarily concentrated among people practicing high-risk behaviour, by the late 1990s it became evident that the transmission of HIV/AIDS among several subgroups of the general population in India was increasing, in some cases, with great speed.

**Indian HIV/AIDS epidemic**

HIV prevalence in India doubled over the last some years, resulting in India having the highest number of HIV infections in the world- an estimated 3.9 million. In Andhra Pradesh, Tamil Nadu, Karnataka, Maharastra, Manipur and Nagaland, HIV prevalence has reached over 1 percent among women attending antenatal clinics. In most other parts of the country, the overall levels of HIV are still low, though male migration; adverse gender norms and weak infrastructure make almost all states vulnerable to the rapid spread of the infection. Eight-nine per cent of the reported HIV Cases are in the sexually active and economically productive age group of 18-40 years. Over 50 per cent of all new infections take place among young adults below the age of 25 years. Twenty-one per cent of new HIV infections are among women – a majority of who do not have any other risk factors than being married to their husbands. Eighty- three per-cent of HIV infections in the reported cases of AIDS are through sexual transmission, 2 percent through perinatal transmission, 4 per cent through injecting drug use, another 4 per cent through blood transfusion and blood product infusion, and the remaining 7 per cent is categorized as ‘other’. As per [UNDP](http://en.wikipedia.org/wiki/UNDP)'s 2010 report, India had 2.395 million people living with HIV at the end of 2009, up from 2.27 million in 2008. Adult prevalence also rose from 0.29% in 2008 to 0.31% in 2009(Hindustan Times 2010). It can be summarized as four sets of factors strongly influenced the course of the emerging HIV/AIDS epidemic in different parts of India- Sexual contacts, Mother to child transmission, contaminated blood and patterns of injection drug use. These factors are aggravated due to several psychological and social factors.

**Psycho-social environment & HIV/AIDS**

A well known but little understood fact is the complex relationship between psycho-social environments and the spread of HIV/AIDS. It is essential to support those suffering from HIV/AIDS, both psychologically and socially and help them to develop better coping skills (NACO 2010 & Satpathy & Shaukat 1997).

**Social Factors**

**Poverty and socio- economic status -** The poor and uneducated in a society are more likely to contract sexually transmitted diseases and other infections since they are deprived of the right to information on risk behavior , are too illiterate to understand prevention messages and have less access to quality services. Socio-economic status (SES) status often determines access to HIV treatment. Research indicates that up to 45 percent of people living with HIV are unemployed (Rabkin, McElhiney, Ferrando, Van Gorp, & Lin, 2004). Patients of lower SES with HIV have increased morbidity and mortality rates. Research suggests a correlation between low SES and earlier death from HIV/AIDS (Cunningham, Wilcockson, Campion , Lunnon , Perry, 2005). Accordingly, individuals of higher SES levels experience slower progression of HIV infection (Schechter, Hogg, Aylward, Craib, Le & Montaner, 1994).

**Mobility of the Population-**Population mobility is a key factor in the spread of HIV in India. Limited employment opportunities force people to move from rural to urban arise, from one state to another and from one country to another. There are over 180 million migrant worker in India (Hira et al 1998), many of who are single man or man who live apart from there wife’s and families. Recent study conduct in Wazirpur Industrial Areas, near new Delhi, reports high prevalence of paid multi-partner sex and low condoms use among industrial worker, many of who were away from their families (Singh 1999).HIV infection among workers in two industrial units in Mumbai was found to be 3 per cent and 2.5 per cent respectively in 1996 (Hira et al. 1998)

**Male to Male Sex-** Male to male sex is morally prescribed behavior, forcing men who have sex with men (MSM) underground. Study among relatively small sample of MSM in Mumbai in the early 1990s recorded level of HIV infection ranging between three and 15 per cent (Nag,1996) However because homosexuality is socially un expectable in India, many of these men are married or have regular female partners. As per recent data of HSS 2010-11, Chattisgarh (15 %), Nagaland (13.58%) and Maharashtra (13%) have the highest HIV prevalence among MSM. In one study among truck drivers, between a third and half of the respondent said that they had oral or anal sex with other men, and that also had sex with women (Rao, Nag, Mishra & Dey 1994).

**HIV Surveillance in Injection Drug Use-** Sharing of injecting equipment is potentially a major rout for HIV transmission, as evidenced by the extremely high prevalence of HIV in north-east India and in some of the major cities. Infection has also been known to spread to the non-injecting sexual partners of IDUs; some 1.25 per cent of pregnant women tested positive in Manipur in 1998 (Shourie 2000). Injecting drugs with contaminated injecting equipment is the main risk factor for HIV infection in the north‐east (especially in the states of Manipur, Mizoram and Nagaland), and features increasingly in the epidemics of major cities elsewhere, including in Chennai, Mumbai and New Delhi ( MAP 2005, NACO 2005) and in the state of Punjab. Products injected include legal pharmaceuticals (e.g. buprenorphine, pentazocine and diazepam), in addition to heroin.

**Young Population-** India has a large population of young people – about 400 million below the age of 18 years. Studies and field experience provide evidence of the early onset of sexual activity and the low level of awareness among young people (Pelto, Joshi & Verma 2000). Young people are also more vulnerable to HIV by certain taboos, ideologies and social norms. This is particularly the case when young people are denied knowledge and skills on sexual and reproductive matters, barred from reproductive health services, including HIV prevention and STD care and counseling, and ostracized if attracted to the same sex. Coleman and Hagell (2007) conducted a study in which they found that young adults very well understand the risks involved in their behaviors but they tend to ignore the risks when the immediate benefits of their behavior are highly attracted. They rely on the beliefs that HIV won’t happen to them. Many Indian researchers have found that young males are at high risk of HIV infections (Verma, Pulerwitz, J., & Mahendra 2008, Verme, 2007). From the estimation 3.1 million people infected with HIV in India (UNAIDS, 2009), approximately one-third of HIV infections are believed to occur among young men below the age of 30 years (NACO, 2009).

**Evaluation of Knowledge and awareness -** A few in- depth studies have confirmed that while knowledge depends on a number of Socio-cultural factors such as age, marital status and state of origin (Basu, Gupta and Krishna1995). The young, unmarried male from Delhi, for example, was much more correctly informed than his more conservative, older, married counterparts from other parts of northern India. Regarding source of information,NFHS-2 showed that television was most important source of information about AIDS among ever-married women.

**Discrimination and Human Rights**- Discrimination against and the denial of human rights to women, children marginalized population, such as street children, female sex workers, sexual minority populations, and men who have sex with men have resulted in their lack of access to information and acceptable services. In a judgments made public, the court also said that hospitals could not be charged with violating medical ethics when they disclosed the HIV+ status of an infected individual to a person he or she intended to marry (Mudur 1998).

Other studies have also covered different social issues. Some of them are: Social consequences (Mawar, et al., 2005; Kumarasamyet al., 2007 –family effect), Gender effect (AIDS care, 2011), Quality of life and finance (Finn & Sarangi, 2008; Longmire-Avitalet al., 2012), Comparison withleprosy (Stevelink, Van Brakel, & Augustine, 2011), Role of community (Nayak and Panda, 2012), Social capital (Sivaramm Zelaya and SriKrishnan, 2009) –voluntarism, community participation, social networks to support, Knowledge in HIV issues (Bradelyet. al., 2011), Family support (Kumarasamyet al., 2007), NGOs and funding (Kapilashrami& McPake, 2012).

**Psychological factors**

The infection with Human Immuno-deficiency Virus (HIV) and the subsequent development of Acquired Immuno-deficiency syndrome (AIDS) are often associated with various psychological problems. Most patients with serious, progressive illness confront a range of psychological challenges, including the prospect of real and anticipated losses, worsening quality of life, the fear of physical decline and death, and coping with uncertainty. Because of the risk of transmission, Behaviour Change Communication (BCC) strategies are adopted for changing the sexual behaviour and reduction of substance use, However, these are not easily modifiable (NACO 2010 & Satpathy & Shaukat 1997 &Remien & Rabkin 2001). Several studies have examined HIV pandemic in India, covering different aspects. Some of them are: Stigma (Sivaram, et. al., 2009; Bharat, 2011) Depression and psychological effects (Charles, et al., 2012; Aggarwal, 2008). Hingar, A., Sharma, P.L. and Paliwal, Vismita (2013), stated that the Human immunodeficiency virus has a large psychological physical and social impact on infected individuals and their families. Stigmatization worsens this impact, it hinders the prevention and treatment of HIV and hampers social support and HIV disclosure. The families most affected by HIV are characterized by low socioeconomic status, which includes such groups as tribal community, drug users, migrants and asylum seekers. Primary and secondary HIV prevention needs to be promoted, which means educating people about HIV, providing materials for its prevention, providing access to treatment and providing programmers that reduce both the short and long term physical, psychological and social harm it causes in adults and children. Specific prevention efforts should be directed at the group of people below 30 years of age.

**Conclusion**

In the view of the evidences cited, social as well as psychosocial environment showed great influence in the spread of HIV/AIDS in Indian society, the fact remains that HIV/AIDS infection is both a social as well as psychosocial issue. In this context some of the social factors are poverty and socio- economic status, mobility of the Population, HIV Surveillance in injection drug use, young population, evaluation of knowledge and awareness, discrimination and human rights .It was noted that majority of the participants with HIV/AIDS were rejected by their friends and relatives when they came to know about the disease. Depression and other psychological effects were also found in HIV/AIDS patients. So, it can be concluded that in order to provide the most effective care, it is very important for the rehabilitation professionals to recognize the major social and psychological issues that appear at different stages of HIV/AIDS infection.

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