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Some Case Studies of AIDS/HIV Patients in India

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Introduction

The present study deals with the mental health of AIDS patients. Therefore it is essential that we should have some clear ideas about the scientific nature of AIDS and mental health. **Human Immunodeficiency Virus Infection / Acquired Immunodeficiency Syndrome (HIV/AIDS)** is a disease of the human immune system caused by infection with human immunodeficiency virus (HIV). During the initial infection, a person may experience a brief period of influenza-like illness. This is typically followed by a prolonged period without symptoms. As the illness progresses, it interferes more and more with the immune system, making the person much more likely to get infections, including opportunistic infections and tumors that do not usually affect people who have working immune systems. HIV is transmitted primarily via unprotected sexual intercourse (including anal and even oral sex), contaminated blood transfusions, hypodermic needles, and from mother to child during pregnancy, delivery, or breastfeeding. Some bodily fluids, such as saliva and tears, do not transmit HIV. Prevention of HIV infection, primarily through safe sex and needle-exchange programs, is a key strategy to control the spread of the disease. There is no cure or vaccine; however, antiretroviral treatment can slow the course of the disease and may lead to a near-normal life expectancy. While antiretroviral treatment reduces the risk of death and complications from the disease, these medications are expensive and may be associated with side effects.

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Acute infection:

The initial period following the contraction of HIV is called acute HIV, primary HIV or acute retroviral syndrome. Many individuals develop an influenza-like illness or a mononucleosis-like illness 2–4 weeks post exposure while others have no significant symptoms. Symptoms occur in 40–90% of cases and most commonly include fever, large tender lymph nodes, throat inflammation, a rash, headache, and/or sores of the mouth and genitals. The rash, which occurs in 20–50% of cases, presents itself on the trunk and is maculopapular, classically. Some people also develop opportunistic infections at this stage. Gastrointestinal symptoms such as nausea, vomiting or diarrhea may occur, as may neurological symptoms of peripheral neuropathy or Guillain-Barre syndrome. The duration of the symptoms varies, but is usually one or two weeks.

Due to their nonspecific character, these symptoms are not often recognized as signs of HIV infection. Even cases that do get seen by a family doctor or a hospital are often misdiagnosed as one of the many common infectious diseases with overlapping symptoms. Thus, it is recommended that HIV be considered in patients presenting an unexplained fever who may have risk factors for the infection.

AIDS in India:

According to a recent study in the British Medical Journal, India has an HIV/AIDS population of approximately 1.4-1.6 million people. According to the United Nations 2011 AIDS report, there has been a 50% decline in the number of new HIV infections in the last 10 years in India. "According to the data released by National AIDS Control Organization NACO, India has demonstrated an overall reduction of 57 percent in estimated annual new Human immunodeficiency virus (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.

The prevalence estimates reported above are suspect. NACO's sentinel survey data indicates over 5.7 million HIV cases in 2001. In 1987 New Delhi announced a National AIDS control Program but that organization spent a substantial amount of time arguing that the AIDS problem in India was overstated.

Despite being home to the world's third-largest population suffering from HIV/AIDS (with South Africa and Nigeria having more), the AIDS prevalence rate in India is lower than in many other countries. In 2007, India's AIDS prevalence rate stood at approximately 0.30%—the 89th highest in the world. The spread of HIV in India is primarily restricted to the southern and north-eastern regions of the country and India has also been praised for its extensive anti-AIDS campaign. The US$2.5 billion National AIDS Control Plan III was set up by India in 2007 and received support from UNAIDS The main factors which have contributed to India's large HIV-infected population are extensive labor migration and low literacy levels in certain rural areas resulting in lack of awareness and gender disparity. The Government of India has also raised concerns about the role of intravenous drug use and prostitution in spreading AIDS, especially in north-east India and certain urban pockets. A recent study published in the British medical journal "The Lancet" in (2006) reported an approximately 30% decline in HIV infections among young women aged 15 to 24 years attending prenatal clinics in selected southern states of India from 2000 to 2004 where the epidemic is thought to be concentrated. The authors cautiously attribute observed declines to increased condom use by men who visit commercial sex workers and cite several pieces of corroborating evidence. Some efforts have been made to tailor educational literature to those with low literacy levels, mainly through local libraries as this is the most readily accessible locus of information for interested parties. Increased awareness regarding the disease and citizen's related rights is in line with the Universal Declaration on Human Rights.

The estimated adult HIV prevalence was 0.32% in 2008 and 0.31% in 2009. The states with high HIV prevalence rates include Manipur (1.40%), Andhra Pradesh (0.90%), Mizoram (0.81%), Nagaland (0.78%), Karnataka (0.63%) and Maharashtra (0.55%).

The adult HIV prevalence in India is declining from estimated level of 0.41% in 2000 through 0.36% in 2006 to 0.31% in 2009. Adult HIV prevalence at a national level has declined notably in many states, but variations still exist across the states. A decreasing trend is also evident in HIV prevalence among the young population of 15–24 years. The estimated number of new annual HIV infections has declined by more than 50% over the past decade.

According to Michel Sidibé, Executive Director of UNAIDS, India's success comes from using an evidence-informed and human rights-based approach that is backed by sustained political leadership and civil society engagement. India must now strive to achieve universal access to HIV prevention, treatment, care and support.

*HIV statistics, 2011 in India					
State	***Antenatal clinic HIV prevalence 2007 (%)***	***STD clinic HIV prevalence 2007 (%)***	***IDU HIV prevalence 2007 (%)***	***MSM HIV prevalence 2007 (%)***	***Female sex worker HIV prevalence 2007 (%)***
A & N Islands	0.25	1.33	...	...	...
Andhra pradesh	1.00	17.20	3.71	17.04	9.74
Arunachal Pradesh	0.00	0.00	0.00	...	...
Assam	0.00	0.50	2.41	2.78	0.44
Bihar	0.25	0.40	0.60	0.00	3.40
Chandigarh	0.25	0.42	8.64	3.60	0.40
Chhattisgarh	0.25	3.33	...	...	1.43
D & N Haveli	0.50	...	...	...	...
Daman & Diu	0.13	...	...	...	...
Delhi	0.25	5.20	10.10	11.73	3.15
Goa	0.18	5.60	...	7.93	...
Gujarat	0.25	2.40	...	8.40	6.53
Haryana	0.13	0.00	0.80	5.39	0.91
Himachal Pradesh	0.00	0.00	...	5.39	0.87
Jammu & Kashmir	0.00	0.20	...	...	...
Jharkhand	0.00	0.40	...	...	1.09
Karnataka	0.50	8.40	2.00	17.60	5.30
Kerala	0.38	1.60	7.85	0.96	0.87
Lakshadweep	0.00	0.00	...	...	0.00
Madhya	0.00	1.72	...	...	0.67

Pradesh					
Maharashtra	0.50	11.62	24.40	11.80	17.91
Manipur	0.75	4.08	17.90	16.4	13.07
Meghalya-	0.00	2.21	4.17	...	...
Mizoram	0.75	7.13	7.53	...	7.20
Nagaland	0.60	3.42	1.91	...	8.91
Orissa	0.00	1.60	7.33	7.37	0.80
Pondicherry	0.00	3.22	...	2.00	1.30
Punjab	0.00	1.60	13.79	1.22	0.65
Rajasthan	0.13	2.00	...	...	4.16
Sikkim	0.09	0.00	0.47	...	0.00
Tamil Nadu	0.25	8.00	16.80	6.60	4.68
Tripura	0.25	0.40	0.00	...	...
Uttar Pradesh	0.00	0.48	1.29	0.40	0.78
Uttaranchal	0.00	0.00	...	...	...
West Bengal	0.00	0.80	7.76	5.61	5.92

**Some areas report an HIV prevalence rate of zero in antenatal clinics. This does not necessarily mean HIV is absent from the area, as some states report the presence of the virus at STD clinics and amongst injecting drug users. In some states and territories the average antenatal HIV prevalence is based on reports from only a small number of clinics.*

History:

In 1986, the first known case of HIV was diagnosed by Dr. Suniti Solmon amongst female sex workers in Chennai. Later that year, sex workers began showing signs of this deadly disease. At that time, foreigners in India were traveling in and out of the country. It is thought that these foreigners were the ones responsible for the first infections. By 1987, about 135 more cases came to light. Among these 14 had already progressed to AIDS. Prevalence in high risk groups reached above 5% by 1990. As per 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.

In 1986, HIV started its epidermis in India, attacking sex workers in Chennai, Tamil Nadu. Setting up HIV screening centers was the first step taken by the government to screen its citizens and the blood bank.

To control the spread of the virus, the Indian government set up the National AIDS Control Programmers in 1987 to co-ordinate national responses such as blood screening and health education.

In 1992, the government set up the National AIDS Control Organization (NACO) to oversee policies and prevention and control programmers' relating to HIV and AIDS and the National AIDS Control Programmers (NACP) for HIV prevention. The State AIDS Control Societies (SACS) was set up in 25 societies and 7 union territories to improving blood safety.

In 1999, the second phase of the National AIDS Control Programmed (NACP II) was introduced to decrease the reach of HIV by promoting behavior change. The prevention of mother-to-child transmission programmed (PMTCT) and the provision of antiretroviral treatment were materialized.

In 2007, the third phase of the National AIDS Control Programmed (NACP III) targeted the high-risk groups, conducted outreach programmers, amongst others. It also decentralized the effort to local levels and non-governmental organizations (NGOs) to provide welfare services to the affected.

Key Words: - *HIV/AIDS, Case Study, Clinical Psychology*

REVIEW OF LITERATURE

A: UNAIDS Inter: Agency test team (IATT) on education published a research paper in 2009. Such research was carried out by IATT for 2010. Global monitoring report on reaching and teaching the most marginalized. The research was carried out with the aim of improving and accelerating the education response to HIV and AIDS. Its specific objectives are to encourage alignment and harmonization within and across agencies to support global and country level actions.

B: In may 2006 a working group of the unaided (IATT) on education was formed to support the main streaming of HIV and AIDS in the G.M.R. IATT administration housed in UNESCO's section of HIV and AIDS in the division for the co-ordination of priorities in education has acted as the agent between IATT and GMR.

C: The team of 2010 GMR on reaching and teaching the most marginal has particular relevance. Children affected by AIDS can face particular challenges in getting educational opportunities ensuring regular school attendance containing their studies. Teachers are given an important responsibility in ensuring that children and young people acquire essential knowledge, skills, and attitudes for HIV prevention.

D: AIDS research alliance help to make HIV/AIDS treatable but 8000people still die of AIDS every day, while millions more with HIV may lose thrill of their lifespan.

As an independent research organization, AIDS research alliance has moved the science forward contributing to the approval of today's HIV/AIDS treatment. AIDS research alliance was the first origination to claim that it is possible to cure HIV/AIDS. Today the world is working to prevent HIV infection. AIDS research alliance is taking steps towards realizing president OBAMA's vision of an "AIDS free generation"

OBJECTIVES

1: Main aim of this study is to know about the patient's emotional stability, adjustment, and self concept regarding their mental health.

2: To know about the patient's present life style.

3: To study and compare the mental health of male patient and female patient.

4: To know the difference between the personality traits of male and female patient.

5: Massage to whole society that all patient of AIDS require more sympathy, co-operation, affection, love, and care.

RESEARCH DESIGN

For present research "MENTAL HEALTH BATTERY OF ARUNKUMAR AND ALPNA SEN GUPTA" was used. From this battery only 70 items were selected for the study, 15 items for emotional stability, 40 for adjustment, and 15 for self-concept. Twenty patients were selected randomly from GODHRA's CIVIL hospital. In this group 10 patients are male and 10 patients are female. When patients came to hospital for treatment, the questionnaire was given to them. All patients answered with full co-operation. Thus data of twenty patients was collected. After that according to MHB the analysis was done. 't' test was used for all case studies.

VARIABLES

In this study patient's illness and present life style are independent variables. Gender of patients is independent variable. Emotional stability, Adjustment, and Self-concept are dependent variables.

RESULT AND DISCUSSION

Result of each patient is indication is separate table. Table wise discussion is done below. Final conclusions and significance of research is show at the end. Case study 1 to 10 is male patients and 11 to 20 are female patients.

MALE PATIENTS:

Case study no.1: SHAIKH MAKBUBHAI		
Traits	**Total Score**	**Patient Score**
Emotional Stability	15	08
Adjustment	40	18
Self-Concept	15	07
*This table indicts that MAKBULBHAI's all score are law in which his adjustment is very poor.		
Case study no.2: RATHOR VIKRAMBHAI		
Traits	**Total Score**	**Patient Score**
Emotional Stability	15	11
Adjustment	40	21
Self-Concept	15	08
*Patient VIKRAMBHAI's score of self-concept is very low. So he is depended on others.		
Case study no.3: MAKVANA VIJAYBHAI		
Traits	**Total Score**	**Patient Score**
Emotional Stability	15	08
Adjustment	40	25
Self-Concept	15	07
*In this table patient's score of emotional stability and self concepts are poor.		
Case study no.4: MAKVANA DHARMESHBHAI		
Traits	**Total Score**	**Patient Score**
Emotional Stability	15	05

Adjustment	40	25
Self-Concept	15	09
*Table no.4 indicates that patient is emotionally disturbed and dependent on others.		
Case study no.5: RATHVA SHANABHAI		
Traits	**Total Score**	**Patient Score**
Emotional Stability	15	07
Adjustment	40	19
Self-Concept	15	07
*These tables clearly mention that patient's mental health is very weak.		
Case study no.6: PATELIA RAMESHBHAI		
Traits	**Total Score**	**Patient Score**
Emotional Stability	15	07
Adjustment	40	18
Self-Concept	15	09
*PATELIA RAMESHBHAI is also disturbed and upset is his life style, which is mentioned in this table.		
Case study no.:7 SAMBHALIWALA RAHENADBHAI		
Traits	**Total Score**	**Patient Score**
Emotional Stability	15	05
Adjustment	40	24
Self-Concept	15	07
*This patient AIDS has affected his emotional balance and his self-concept is also poor.		
Case study no.8: GAMIT SANKETBHAI		
Traits	**Total Score**	**Patient Score**
Emotional Stability	15	06
Adjustment	40	22
Self-Concept	15	09
*This table is also like another table, that patient is emotionally disturbed and depended.		
Case study no.9: TOPIWALA MOHMADBHAI		
Traits	**Total Score**	**Patient Score**

Emotional Stability	15	07
Adjustment	40	19
Self-Concept	15	07
TOPIWALA MOHMADBHAI is also emotionally disturbed and depended.		
Case study no.10: THAKOR TERSHINGBHAI		
Traits	**Total Score**	**Patient Score**
Emotional Stability	15	08
Adjustment	40	18
Self-Concept	15	07
Table no 10 also indicates the same result like another table. This patient is also disturbed in emotionally.		

Female Patients:

Case study no.11: MAKVANA JAYESRIBEN		
Traits	**Total Score**	**Patient Score**
Emotional Stability	15	08
Adjustment	40	20
Self-Concept	15	05
JAYESRIBEN is emotionally disturbed and her self-concept is poor, which is shown this in table.		
Case study no.12: SHEKH RUKHSHARBEN		
Traits	**Total Score**	**Patient Score**
Emotional Stability	15	06
Adjustment	40	23
Self-Concept	15	08
*Here in this table patient is very poor in emotional control and more dependent on others.		
Case study no.13: RATHVA SUKHIBEN		
Traits	**Total Score**	**Patient Score**
Emotional Stability	15	07
Adjustment	40	20
Self-Concept	15	12

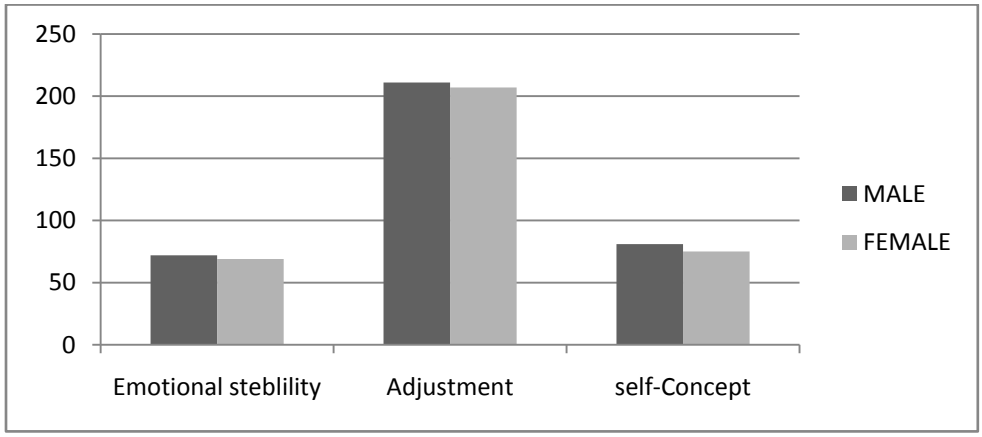
*SUKHIBEN's score is different than others, even though she is emotionally disrobed.		
Case study no.14: THAKOR AMIBEN		
Traits	**Total Score**	**Patient Score**
Emotional Stability	15	07
Adjustment	40	19
Self-Concept	15	06
*Table indicants that AMIBEN is also suffering from bad mental health.		
Case study no.15: PATELIA RAMILABEN		
Traits	**Total Score**	**Patient Score**
Emotional Stability	15	07
Adjustment	40	23
Self-Concept	15	09
*RAMILABEN's emotion and self-concept are very poor.		
Case study no.16: MAKVANA INDUBEN		
Traits	**Total Score**	**Patient Score**
Emotional Stability	15	05
Adjustment	40	18
Self-Concept	15	07
*Patient INDUBEN is also disturbed like other patients.		
Case study no.17: TOPIWALA REHAMATBEN		
Traits	**Total Score**	**Patient Score**
Emotional Stability	15	07
Adjustment	40	19
Self-Concept	15	05
*Patient REHAMATBEN is more dependent on others.		
Case study no.18: RATHOR RAZANBEN		
Traits	**Total Score**	**Patient Score**
Emotional Stability	15	07
Adjustment	40	21
Self-Concept	15	09

*RAZANBEN is suffering from emotional disturbance and dependency.		
Case study no.19: BHIL KAILASHBEN		
Traits	**Total Score**	**Patient Score**
Emotional Stability	15	06
Adjustment	40	27
Self-Concept	15	06
*This table indicates clearly that patient is mal adjusted with her life style.		
Case study no.20: BHIL MANJULABEN		
Traits	**Total Score**	**Patient Score**
Emotional Stability	15	09
Adjustment	40	17
Self-Concept	15	08
*Here is also the same result, which is indicated in other table.		

TABLE OF GENDER DIFFERENCE

Table no.1: Total score of Male and Female AIDS patients. (t value).

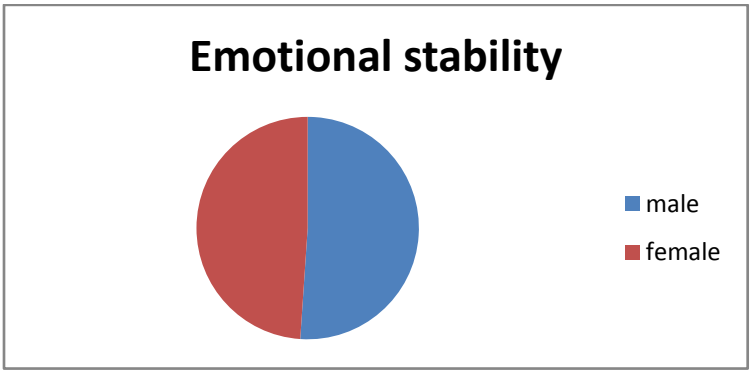
Group	Mean	SD	SEM	T	Standard of difference
Male	36.40	2.76	0.87	0.83	1.18
Female	34.90	5.04	1.59	N.S	



This table indicts that there is no significant difference in mental health of males and females.

Table no.2: Difference of Emotional stability in male and female.

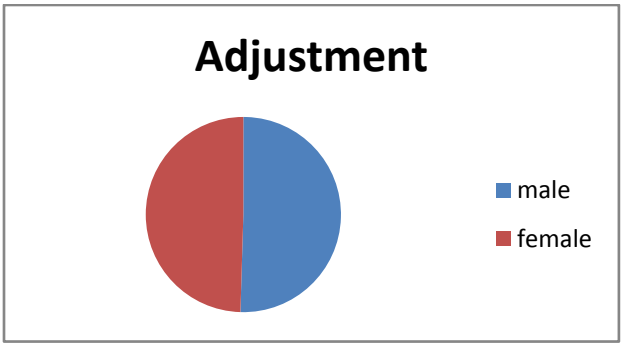
Group	mean	SD	SEM	T	Standard of difference
Male	7.00	1.76	0.56	0.16 N.S	0.657
Female	6.90	1.10	1.35		



There is no much difference in emotional stability of males and females.

Table no.3: difference of Adjustment in males and females.

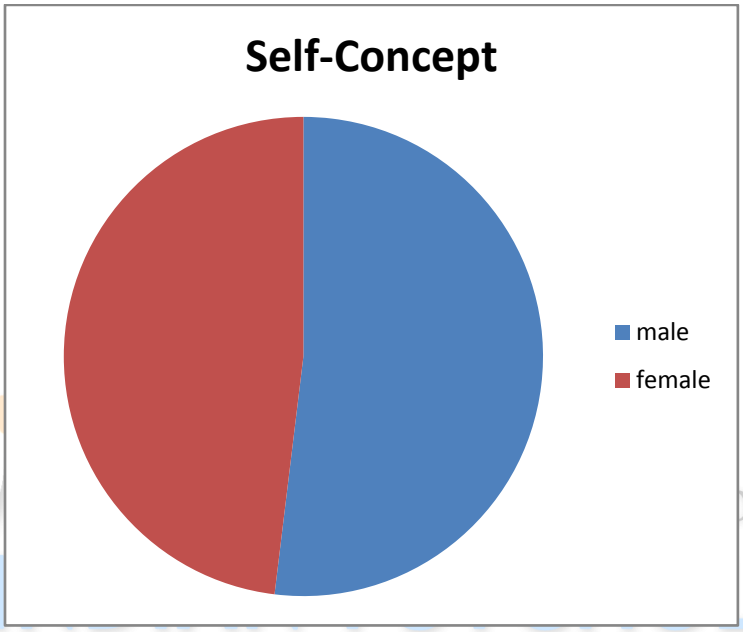
Group	mean	SD	SEM	T	Standard of difference
Male	21.60	3.13	0.99	0.66 N.S	1.360
Female	20.70	2.95	0.93		



This table of adjustment proves that male and females are equal.

Table no.4: Difference of Self-concept in male and female.

Group	mean	SD	SEM	T	Standard of difference
Male	8.50	1.35	0.43	2.90 N.S	0.552
Female	6.90	1.10	0.35		



There is no difference in Self-concept of male and female.

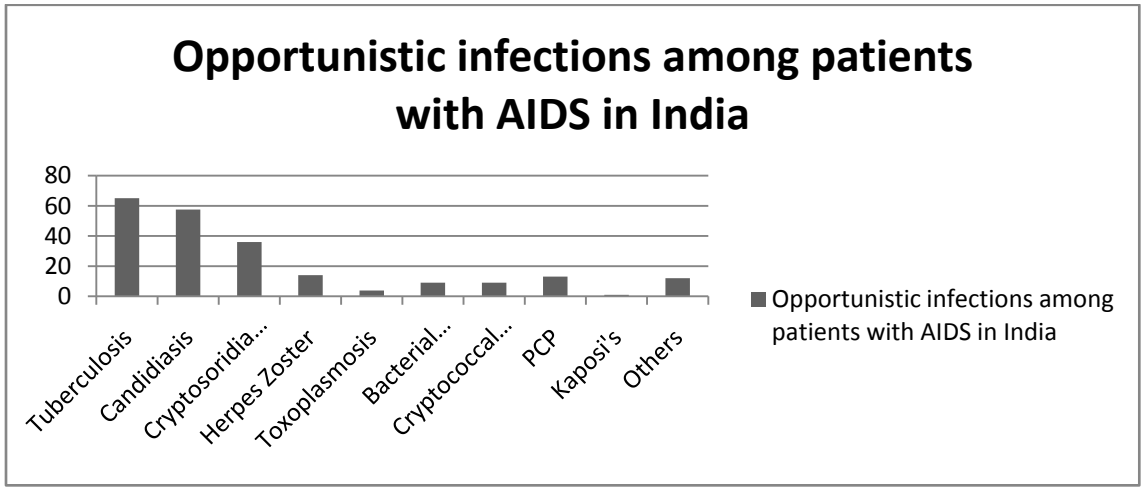
SIGNIFICANCE OF RESEARCH

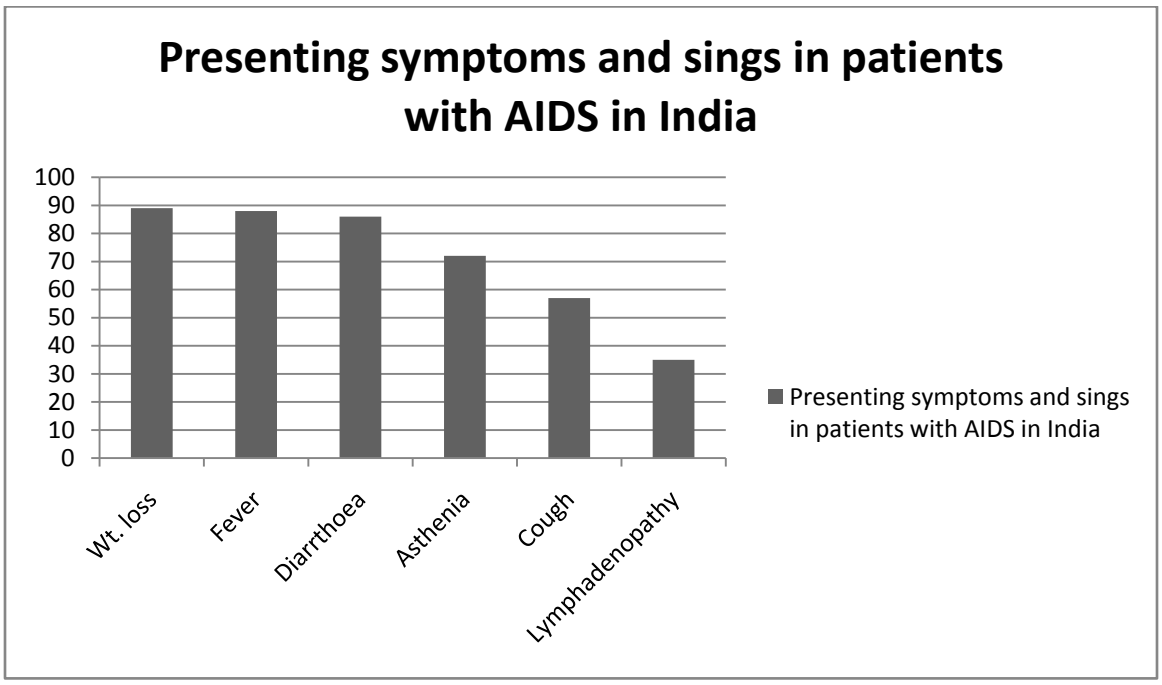
This study of AIDS patients has proved that all the patients are emotionally disturbed and their self-concept is very weak. Their daily life adjustment is normal. All the patients are under the treatment and they take tablet of ART. At present when this study was done they will live more than two to five years.

Final conclusion of this research is that the all patients' mental health is disturbed due to illness. They are more dependent on others. So they always require help, sympathy, love and care. I request the whole society to behave in good manner with all ADIS patients.

At last if we take care properly and consciously, than we will remove this decease from whole world.

*HIV related infections most frequently encountered in India				
Bacterial	**Viral**	**Fungal**	**Parasitic**	**Other illnesses**
Tuberculosis	Herpes simplex virus infection	Candidacies	Cryptosporidiosis	AIDS dementia complex
Bacterial respiratory infections	Oral hairy leukoplakia	Cryptosporidiosis	Microsporidiosis	Invasive cervical cancer
	Varicella zoster virus disease	Pneumocystis jiroveci pneumonia	Isosporiasis	Non-hodgkin lymphoma
Salmonella infection	Cytomegalovirus disease	Penicilliosis	Giardiasisww stongyloides	
	Human papilloma virus infection		Toxoplasmosis	
**Rare infections include those due to Bartonella henselae, Rhodococcus equii, atypical mycobacterioses and human herpesvirus (HHS)-8 infections.*				





2012 UN Report (India):

New HIV cases among adults have declined by half in India since 2000, according to a new UN report which praised India's contribution to AIDS response through manufacture of generic antiretroviral drugs.

Though rate of HIV transmission in Asia is slowing down, at least 1,000 new infections among adults continue to be reported in the continent every day in 2011.

An estimated 360,000 adults were newly infected with HIV in Asia in 2011, considerably fewer than 440,000 estimated for 2001, a new UNAIDS report has said.

"This reflects slowing HIV incidence in the larger epidemics, with seven countries accounting for more than 90 per cent of people (in Asia) living with HIV – China, India, Indonesia, Malaysia, Myanmar, Thailand and Vietnam," the report 'Together We Will End AIDS' said.

The UNAIDS lauded India for doing "particularly well" in halving the number of adults newly infected between 2000 and 2009 and said some smaller countries in Asia like Afghanistan and Philippines are experiencing increases in the number of people acquiring HIV infection.

It said a total 1.7 million people had died across the world due to AIDS related illness. In India, the figure for such deaths stood at 170,000 in 2009. The report says India has contributed enormously to the AIDS response.

"With 80 per cent of these drugs being generics purchased in India, several billion dollars have been saved over the past five years. The country is also committed to new forms of partnership with low-income countries through innovative support mechanisms and South? South cooperation," the UNAIDS report says.

It also points out that India already provides substantial support to neighboring countries and other Asian countries – in 2011, it allocated USD 430 million to 68 projects in Bhutan across key socio-economic sectors, including health, education and capacity-building. In 2011 at Addis Ababa, the Government of India further committed to accelerating technology transfer between its pharmaceutical sector and African manufacturers.

"We want AIDS free Generation…"

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