© Journal of the Indian Academy of Applied Psychology,
April 2008, Vol. 34, Special Issue, 90-100.

Mental Disposition of Commercial Sex Workers (CSWs) With HIV/AIDS

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Heterosexual contact is the main mode of transmission of HIV/AIDS across the globe and Commercial Sex Workers (CSWs) are considered to be one of the main carriers of the disease. The disease might spread fast if discrimination is not minimized and good quality condoms are not made available free of cost for CSWs, not in paper but in practice. The broad objective of the study was to understand the mental disposition of the CSWs with HIV/AIDS; motivating factors for blood testing; nature of care and support services received by them after identification of the disease and to suggest viable and comprehensive rehabilitative measures. In order to achieve the objective of the study, a group of 26 CSWs with HIV/AIDS was covered. For collection of data semi-structured questionnaire, Beck Hopelessness Questionnaire, in-depth interview and case study methods were adapted. Findings revealed that most of the CSWs had been suffering from depression. Blood testing for ascertaining HIV status was mostly voluntary and severe health problems caused by the disease were the main motivating factors for majority of the CSWs (68.2 per cent), followed by persuasion by the health workers (18.8 per cent). Out of a total of 26 CSWs with HIV/AIDS, only six had taken anti-retroviral therapy. About half of the CSWs experienced social discrimination following the detection of the disease within the family and/or in social life while about one-third reported discrimination in the health centers, which affected the quality of services. The findings of the present study suggested comprehensive rehabilitation programme for the CSWs with HIV/AIDS along with alternative sources of earning, which will encourage CSWs to come forward for voluntary blood testing and thereby reducing the secondary transmission of the disease.

Keywords: Mental Disposition, HIV/AIDS, Social Discrimination

India is one amongst the most populated countries in the world, with a population over one billion. In 2006 UNAIDS estimated that there were 5.6 million people living with HIV in India (Source: UNAIDS Report, 2006). However, National AIDS Control Organization (NACO) disputed this estimate, and claimed that the actual figure to be lower (Source: NACO Estimation, April 2006). In 2007, using a more effective surveillance system, UNAIDS and NACO agreed on a new estimate - between 2 million and 3.6 million people living with HIV. This puts India behind South Africa and Nigeria in numbers living with HIV (Source: UNAIDS, July 6, 2007).

As on August 2006, the total number of AIDS cases reported to NACO was 124,995. Of which 29.0% were women and 36.0% were under the age of 30. These figures are an underestimation of the actual situation since a large number of AIDS cases go unreported (Source: NACO Monthly Updates on AIDS, August, 2006).

Overall, around 0.36% of India's population is living with HIV (Source: UNAIDS, July 6, 2007). However, the main mode of transmission is heterosexual contact. Commercial sex workers (CSWs) are regarded as one among the prime transmitters of the disease. In India there are about 8 - 12 lakhs CSWs. In order to create awareness among the CSWs about the disease and to strengthen their bargaining capacity while dealing with the customers a number of intervention programmes have been undertaken in different parts of the country and their experience is mixed.

HIV/AIDS Scenario in West Bengal:

The rate of incidence of HIV infection is on the rise in West Bengal. The total number of HIV positive cases in West Bengal is more than 5200 while the number of full blown AIDS cases in the state is 2379.

In 1986 the first HIV patient was detected in West Bengal. The West Bengal State AIDS Prevention and Control Society (WBSAPCS) was established in 1998 for combating the epidemic in West Bengal. The mission of the WBSAPCS is to provide catalytic leadership, a coordinated and concerted effort towards HIV/AIDS prevention, care and support by utilizing Government and Non-government agencies in a partnership involving appropriate strategies and principles. Its aim is to empower people to be able to make informed choices through a combination of appropriate communication and provision of quality services.

Contributory Factors Sustaining the Epidemic in West Bengal:

The geographical location of West Bengal makes the State vulnerable to the HIV epidemic since the State has a large hinterland compromising States like U.P., Bihar, Sikkim, Assam and the North East, and large borders with Nepal, Bhutan and Bangladesh. The large number of industries and services in the State serve as a major source of attraction migrating labourers from the neighbouring states. Added to these there are seven national highways, which support a huge volume of mobile population across the entire West Bengal. There are also the two ports at Kolkata and Haldia, from where people from all over the World visit. In fact, nearly 3-5 million people migrate into West Bengal for seasonal employment every year. Of them, majority are single and largely responsible for sustaining the State's huge sex industry of nearly 1, 00,000 sex workers, the largest in India (Source: Countering HIV/ AIDS in West Bengal, WBSAPCS, 2002).

Impact of the Disease:

Infection with HIV/AIDS brings unprecedented problems for the person, irrespective of background. A person suffering from HIV/AIDS undergoes severe psychological stress and feels loss of hope regarding the future, including employment, family life, health and self-esteem (Hedge et al., 1992). Death phobia is also prominent among them. These people are often stigmatized, rejected and isolated especially in the developing countries (Blendon & Donelan, 1988; Cerandall & Coleman, 1992; Gilmore and Somerville, 1994). This discrimination often puts them under tremendous mental pressure, which may often result in suicide (Rabkin et al., 1993; Gala et al., 1992). During this period they need empathy and mental support to cope with the stressful situation. In this regard, caregivers and the family members can play a vital role.

Many intense, negative psychological reactions have been reported in people with HIV disease - the most common reactions being anxiety and depression (King, 1989; Hedge et al., 1992). Schneider et al., (1991) and Slater and Depue (1981) have reported that potential suicide risk of people with HIV infection is high at all times. Although one can foresee the problems encountered by

the CSWs after getting the infection, very few studies attempted to systematically document the problems encountered by the CSWs in terms of psychological, social and economic problems..

The broad objective of the study was to understand the mental disposition of the CSWs with HIV/AIDS; motivating factors for blood testing; nature of care and support services received by them after identification of the disease, and to suggest viable and comprehensive rehabilitative measures.

Method

Sample:

The present study was confined to Kolkata and it covered 26 female CSWs with HIV/AIDS and they were selected from the govt. and non-govt. health centers following incidental sampling technique.

Tools:

The study tools, which were used in achieving the objectives include:

- Semi-structured Questionnaire
- Hopelessness Scale - a standardized psychological test
- In-depth Interview
- Case study

Problems Encountered and Limitations:

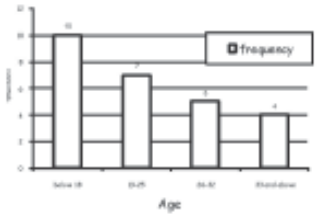
It was very difficult to identify the CSWs with HIV/AIDS and more so because some of the NGOS directly working with them did not extend their cooperation although they were ensured about the ethical issues to be considered while collecting data from the subjects. The sample size of the present study was small since it was difficult to identify the CSWs with HIV/AIDS and also the non-cooperation of some of the NGOs. Another study with larger sample is suggested

Results

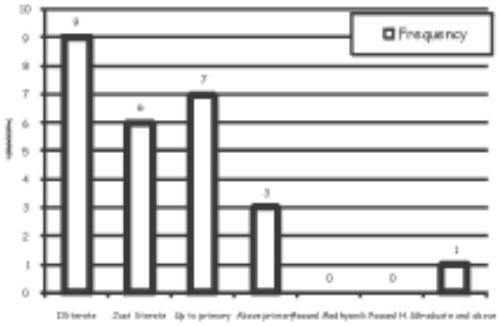
Profile of CSWs:

Most of the CSWs with HIV/AIDS (10/26, 38.5 %) covered in the study were minor i.e., below 18 years of age while 26.9, 19.2 and 15.3 per cent of them belonged to 19 - 25, 26 - 32 and 33 and above age groups respectively (Figure 1).

Fig.1: Age distribution of CSWs with HIV/AIDS



So far as educational background is concerned, 34.6 per cent were illiterate i.e., they could neither read nor write their names, while 23.1 per cent were just literate and 26.9 per cent studied up to primary level. The rest studied above primary level while only one of them was a graduate.



During the study most of the CSWs were under the in house intervention programmes run by the NGOs and some had come from home for treatment and counseling in the Govt. Health centres. As a result, majority of them did not have any direct source of income. However, a secondary source of information reported that some of them were still continuing with the profession, especially those who were not under any intervention programme. Interestingly, none of them admitted the same during interview. The said

observation has been corroborated by some of the social activists and law enforcement personnel. The issue requires immediate attention of health policy makers.

Poverty was the main reason for pushing the subjects into this profession, followed by disloyal promise of marriage, separation and/ or marital discord. Out of 14 married women, four stated that their husbands forced them to entertain the friends and known person of their husband. But none of them experienced group sex.

Every woman has a desire to have a husband. After coming into this profession three women had developed a personal relation with a customer and they agreed to have a steady relation and thought of living an informal conjugal life. They developed a sort of emotional attachment. They dreamt even of raising a family with them. The so called informal husband of those CSWs hardly objected them to continue with this profession and they used to entertain other clients too.

Mental Disposition:

Through in-depth interview an effort was made to understand the first reaction of the CSWs. The first reaction of most of the CSWs when they came to know about the disease was shock, followed by a mental break down, anxiety, feeling of depression i.e., their future status and survival.

The Hopelessness Scale disclosed that the Majority of the CSWs with HIV/AIDS covered in the study had been suffering from depression. The mean score of depression as found out through Hopelessness Scale was 11.88. Qualitative data collected through case study corroborate the same findings. Motivating Factors for Blood Testing and Effectiveness of Pre and Post Blood Test Counseling as Perceived by the CSWs: In most of the cases (15/26, 57.7 per cent) the infection was detected within the last one year while for 4 and 7 CSW, it was detected two years back and more than two years also. Blood testing for ascertaining HIV status was mostly voluntary in case of 84.6 per cent CSWs while it was forceful in case of remaining 15.4 per cent CSWs.

Severe health problems caused by the disease were the main motivating factors for majority of the CSWs (68.2 per cent) for undergoing voluntary blood testing for HIV status. For the 18.8 per cent the motivators were the health workers. Two of them were self-motivated. As per National AIDS Control Organisation (NACO) guidelines pre and post blood test counseling are mandatory. But in case of the CSWs covered in the study, 38.5 per cent (10/26) and 50.0 per cent (13/26) did not undergo pre and post blood test counseling. Among the CSWs who underwent pre blood test counseling, majority (69.0 per cent) of them were happy with the same while rest 31.2 per cent were not happy. However, in case of post blood test counseling more number of CSWs reported it was beneficial. About one-fifth stated that it was not beneficial.

A good number of CSWs with HIV/AIDS (46.2 per cent, 12/26) did their periodic health check up for ascertaining CD-4 Cell count and Viral Load while the rest did not do the same. Most of them bore the expenses for the same while only two CSWs received support from NGOs for the same.

Quality of Treatment, Care and Other Support Services

Out of a total of 26 CSWs with HIV/AIDS, only 6 got anti-retroviral therapy in Calcutta Medical College. But two of them could not state exactly when they had taken the same. However, the rest had been taking it for the last one-year. When asked who bore the cost, one stated it was an NGO bearing partially, while the rest five borrowed money from others.

The nature of support and care services availed by 80.8 per cent CSWs with HIV/AIDS

includes mostly free medicine for asymptomatic diseases, counseling, periodic blood testing, shelter and free food. The CSWs who attended the health center for counseling had been receiving the same for the last one year and majority of them held good impression about the behaviour and caring of counselors. They were satisfied with the type and quality of treatment they received from those counselors.

Experience of Living with HIV/AIDS and Social Discrimination:

After detection of the disease the CSWs had both positive and negative experiences in terms of interpersonal relationship. Few of them had positive experience as their husbands and/or other family members extended mental support and they never felt depressed. On the contrary, few had negative experiences like

- 'Rejection by the family member'
- 'No treatment for this disease as stated by one of the family members after knowing the status which depressed the CSW further.'
- 'Neighbours reduced social interaction'

In most of the cases married CSWs disclosed the test results to their husbands and children only, while unmarried ones disclosed the same to their parents. About half of the husbands and children were not supportive while few parents became angry although they did not express it verbally. Unfortunately, the co-workers were not that supportive as expected, as stated by few. A few of them did not disclose the status of blood to outsiders.

In the health centers 34.6 per cent (9/26) experienced discrimination at the time of blood testing, admission in the Hospital and during stay in the ward.

***Table 1:* Experience of Discrimination in the Health Center**

Experience of discrimination	F	P
▪ Yes	9	34.6
▪ No	17	34.6
If yes, when? (N=9)		
▪ At the time of blood testing	2	22.2
▪ At the time of admission in hospital	2	22.2
▪ Care in the ward	4	44.4
▪ Confidentiality of report	-	
▪ Others	1	3.8
Experience with medical staff who knew about the HIV status		
▪ Did not experience discrimination	13	50
▪ Discriminated	4	15.4
▪ Did not attend properly	-	
▪ Did not behave properly	2	7.7
▪ Behaved properly	4	15.4

However, most of the CSWs stated that they were provided with all sorts of medical facilities except anti-retroviral therapy as made available in case of other patients. Mostly they were discriminated by ward boys, nurses and other support staff. About 19.2 per cent (5/26) CSWs felt that discriminatory attitude of the health service providers affected the quality of services especially in dealing with CSWs with HIV/AIDS. Most of the CSWs were of the opinion that awareness programme in this regard should be taken up in order to sensitize the health service providers about the mode of transmission of the disease. Such an approach could perhaps reduce the discrimination in the health centers only.

In the study, 12/26 CSWs with HIV/AIDS (i.e., 46.2 per cent) were contacted in different NGOs who were under intervention and/or rehabilitation programme and the rest were contacted in the outdoor of the Govt. Hospitals. Regarding the source of livelihood, after detection of the disease, about half of them did not disclose anything clearly. About

one-third stated that they had been continuing with the profession for about six months with precautionary measures without disclosing their HIV status i.e., used condoms while entertaining the clients while the rest one-third clearly stated that they did not entertain any more clients after detection of the disease.

As a response to the question whether it was ethical to inform the client about the disease and/or discontinue earning as a CSW, most of them agreed with it to be ethical. But at the same time they asked the researchers to show them alternate sources of earning.

It is quite likely that a good number of them are still continuing with the profession with or without condoms. However, it depends upon the situation i.e., if the client insists to have sex without condoms they were professionally bound to do it, as they could not disclose the HIV status out of a fear of losing the clients and/or fear of boycott by the clients. Hard reality to a large number of CSWs was the absence of a second option for survival. Hence, they were compelled to continue with this profession despite knowing the further risk of getting the infection and/or spreading the same as reported by most.

Findings of Case Studies:

Case study is the best approach to understand the various dimensions of a problem. In order to understand the over all problems encountered by the CSWs with HIV/AIDS detailed case study of 10 CSWs were prepared, analysed and finally presented two case studies in the following section for understanding the overall problems faced by them. However, analysis of case studies revealed that the CSWs with HIV/AIDS faced the problems, which are presented in chart-1:

Chart I: Problems Encountered by the CSWs with HIV/AIDS

Psychological	Physical	Social	Economic
▪ Depression	▪ Fever ▪ Diarrhoea	▪ Discrimination in the Health Centre ▪ Hatred and of family members	▪ Unable to maintain self discrimination and bear family expenses.
▪ Loneliness, feeling of insecurity	▪ Loss of weight ▪ Anemic ▪ Skin rash		▪ Persistent stringency in family environment.
▪ Anxiety ▪ Fear of rejection ▪ Lack of family support			▪ Poverty leads to continuation of profession

Case 1: Kabita, 16 years, illiterate, born and brought in rural Bengal was working as a child prostitute for two years. Her father was a psychiatric patient and that is why mother used to run the family of five members working as a domestic assistant. Poor financial condition compelled Kabita to earn money otherwise. One day she came in interaction of a person who offered her a job in Kolkata city. First, that person used her sexually and finally sold her to a brothel. Initially, she did not want to entertain the clients thinking of morality but then the pimps withdraw food and even water for one/two days and locked her in a room. When she asked for water and food she was given the same mixing some addictive substance with food so that she could not resist any more to entertain the clients. Gradually she was made dependent on some substances and accepted the profession as means for survival. After two years of being in this profession she got HIV infection since a good number of clients had sexual intercourse with

her, forcefully without condoms. During the two years period of time, no health workers visited her and/or extended any support or advice. Afterwards some health problems compelled her to go for blood testing, which she did in the School of Tropical Medicine and was found to be HIV positive. After detection of the disease she became very nervous and depressed as she was told that this is a dreaded disease by one of the health service providers. She received both pre and post blood test counseling. But she was not happy the way she was handled/counseled. Even now her knowledge about the various aspects of the disease is very poor. At present she has contact with her family members but they do not want to maintain regular contact. Currently she is staying in a Home and attending a vocational training on tailoring.

Case 2: Anamika, aged 15, came from a poor joint family. She did not get any education and had to work as a domestic assistant to support her family. Unable to tolerate such financial crisis she went to Mumbai with a group of two other girls of her village in search of a better job as guided by an elderly person. Later she realized that she was a victim of false promise. In Mumbai she was engaged in sex trade. After a police raid she was rescued from there and was brought to Liluah Home in West Bengal. From there she was sent to the School of Tropical Medicine, where she was confirmed to be a HIV+ patient. Then she was sent to Sanlaap-an NGO for vocational rehabiliation. She is expressive by nature and spoke confidently about her future. She doesn't want to continue as a sex worker rather she prefers to earn her livelihood as a domestic assistant. After detection of the disease she was subjected to discrimination in regards to interpersonal relationship. Currently she has fallen victim to major depression as she has come to know that HIV is not a curable disease.

Discussion

India is one of the worst affected countries by HIV/AIDS. Heterosexual contact happens to be the most prevalent mode of transmission of the HIV virus throughout the world and it is not astonishing that India also has its share in it. From a study it has been reported that HIV/AIDS has already spread among general population and from urban to rural areas (Misra et al., 1998). In this regard, CSWs might have a good contribution. In India CSWs suffer from various psychosocial problems along with financial insecurity, especially in their later lives. When CSWs get HIV/AIDS, they are in a miserable condition. In fact, it is very difficult for them to survive, as there is no social support system for them and literally no arrangement for money for treatment and medication in addition to discrimination.

Recent studies reveal that, AIDS related attitudes have certain specific dimensions; the first labeled as Coercion/Compassion, which includes judgments about the extent to which AIDS is viewed as highly contagious and requiring containment, through coercion, if necessary. It also includes attributions of blame to people with AIDS. The second dimension, Pragmatism/Moralism, includes judgments about the extent to which AIDS is viewed as controllable through research, public education and governmental sponsorship of behavior-change programs.

Under the given circumstances, the necessity was felt to carry out an in-depth study to understand the mental disposition of the CSWs with HIV/AIDS; motivating factors for blood testing; nature of care and support services received by them after identification of the disease and to suggest viable and comprehensive rehabilitative measures.

The study covered 26 CSWs with HIV/AIDS. The most alarming findings are that, more than one third CSW with HIV/AIDS were minor and most of them entered the

profession under compulsion, i.e. poverty. Some of them were victims of circumstances like disloyal promise of marriage, separation and/or marital discord. Though not large in number, more than one-third of the sample had entered this profession about four years back; among them ten have got children.

After detection of the disease all the CSWs were in miserable financial condition. As they were either under intervention programmes and/or undergoing medication, they were unable to earn money and support their livelihood. More so, 16 had got dependent members in their family. Some of the CSWs who were not under direct intervention programmes might be carrying out with the profession as well for sheer survival. When enquired about the source of livelihood, half of them did not clearly specify anything. However, about one-third admitted that they continued with this profession for about six months with precautionary measures without having disclosed their HIV status to their clients. Although they did not disclose the same during intervention, in-depth interview with them has revealed the fact. Informal discussion with some of the NGO personnel within the HIV intervention programme and the senior police officials of Criminal Investigation Department supported the above findings.

So far as the care and treatment is concerned, only six CSWs with HIV/AIDS could take anti-retroviral therapy. Of them only one got support from an organization, while the rest depended on money borrowed from other sources. Some of them, nearly 81.0 per cent did receive some of the free services, free medicine for asymptomatic diseases, counseling, periodic blood testing, shelter and free food. Findings reveal that severe health problems caused by the disease were the main reasons for undergoing blood testing for ascertaining HIV status. Among the sample studied, unfortunately, more than one-third and half did not receive pre and post blood test counseling respectively. Among the remaining two-third who received pre blood test counseling, one-third was not satisfied with the quality of the counseling they received. It could be because of individual differences of counselors. Some counselors are more efficient and sensitive to the problems of the clients and that is why the CSWs who met those counselors were happy and benefited while some were not that efficient and sensitive.

However the CSWs who received post blood test counseling, majority of them were happy. In order to understand the mental disposition of CSWs with HIV/AIDS, the Beck Hopelessness Scale was administered. It was found that majority of the CSWs had been suffering from depression. So far as addiction behavior is concerned, majority of the CSWs were addicted to some substances and they did it to earn minimum money for livelihood for entertaining more client. Their hard life conditions compelled them to do so.

Discrimination is also alarmingly common in the health care sector. Negative attitudes from health care staff have generated anxiety and fear among many people living with HIV and AIDS. As a result, many prefer to keep their status secret. It is not surprising that among a majority of HIV positive people, AIDS-related fear and anxiety, and at times denial of their HIV status, can be traced to the traumatic experiences in health care settings.

Although social discrimination is less as compared to the beginning of the pandemic, it is not non-existent till date. CSWs covered in the study had both positive and negative experiences with respect to social discrimination in personal life as well as in health center. Fortunately about half received mental support from the family members, while the rest had negative experiences, i.e. rejection and/or avoidance. It is important to note here that most of the CSWs did not disclose the HIV status to

outsider and/or to the co-workers. A similar study by Bharat (1999) has revealed that sharing the HIV status with the co-workers has resulted in avoidance or restricted social behavior. Those who had disclosed their HIV status faced resistance from management and very often from their colleagues too (Bharat 1999). Two other important areas of discrimination and stigmatization identified in the same study are those of children's education and life insurance policy. The school is also a setting for discriminating the children of HIV positive parents or those who are HIV positive. In a few institutions in Mumbai, destitute children were tested for HIV at the time of admission to the institute and when found positive they were either segregated to an isolated room or transferred to an NGO with shelter programme for these children (Deb, 2006; Bharat, 1999).

About one-third of the CSWs covered in the study experienced discrimination in the health centers at the time of blood testing, admission and during their stay in the ward. Still ward boys, nurses and other support staff discriminated HIV/AIDS patient in the health centers. However, they did not experience discrimination in terms of medicinal facilities. The predominant outcomes at the individual level were fear leading to secrecy of one's HIV status and self imposed isolation and social withdrawal. Depression, anxiety and sense of helplessness were common. Many harbor suicidal tendencies. Many patients delay or avoid taking treatment till the time they can, harming themselves in the process (Bharat, 1999).

A 2006 study found that 25.0% of people living with HIV in India had been refused medical treatment on the basis of their HIV-positive status. It also found strong evidence of stigma in the workplace, with 74.0% of employees not disclosing their status to their employees for fear of discrimination. Of the 26.0% who did disclose their status, 10.0% reported having faced prejudice as a result (Source: UNDP, 2006).

Herek and Capitanio (1993) have found that African Americans were more likely than Whites to stigmatize response; they overestimate the risk of casual contact but were less likely to feel negatively towards the persons with AIDS (PWA). Overall, females were less likely to hold negative personal feelings towards PWAs.

African Americans were more likely than Whites to express distrust towards doctors and scientists concerning HIV transmission through casual contact, to believe that AIDS is being used as a form of genocide against minority groups, and to believe that information about AIDS is being withheld from the public (Herek and Capitanio, 1994).

Conclusion

In fine, it may be stated that majority of the CSWs had been suffering from depression. Blood testing for ascertaining HIV status was mostly voluntary and severe health problems caused by the disease were the main motivating factors for majority of the CSWs followed by persuasion by the health workers. Although medical and other services like free medicine for asymptomatic diseases, periodic blood testing, shelter and free food were available for most, only six had taken anti-retroviral therapy for which only one received financial support from an NGO. More than one-third and half did not receive pre and post blood test counseling, respectively, which should have been mandatory in the Integrated Counselling and Testing Centre (ICTC).

About half of the CSWs experienced social discrimination while about one-third was subjected to discrimination in the health centers mostly by the ward boys, nurses and other support staff. From secondary sources it was found that a good number of CSWs with HIV/AIDS still continue the profession with or without condoms.

Proposed Rehabilitative Measures

The fundamental and indispensable needs of the CSWs with HIV/AIDS could be classified into following groups and they should be made available for their overall rehabilitation and empowerment:

- Medical i.e., free periodic health check up, free blood testing and anti-retroviral therapy since majority of the CSWs are very poor and lack social support.
- Economic i.e., arrangement of meaningful vocational training for alternate source of earning and assisting them to start something providing information about various sources of financial support.
- Psychological i.e., individual and group counseling to restore their mental strength.
- Social i.e., minimization of social discrimination through awareness programmes.
- Support for up-bringing and education for the children of CSWs.
- Awareness among CSWS about HIV/ AIDS, their Rights and Govt. Welfare programmes
- Strengthening network of all NGOs, religious, law enforcement and government organizations to facilitate assistance to CSWs with HIV/AIDS
- CSWs with HIV/AIDS could be used by the NGOs as peer group educators, which will serve three purposes. First, this approach will give them alternate source of earning. Second, acceptability of the CSWs with HIV/AIDS will be much higher among other CSWs and they can become an effective peer group educator. Third, secondary transmission of the disease could be prevention.

This apart, the following issues need attention of funding agencies:

Success of any intervention programme depends largely upon professional capacity of the organization involved in the intervention programme along with their honesty and integrity in delivering care and support services i.e., what they proposed in the proposal followed the same guide lines while implementing the programme. First hand experience of the researchers raise question about the said issue i.e., is professional expertise available in the NGO and do they deliver services they proposed in the proposal? Therefore, there is a need to look into this issue and carrying our periodic in-depth evaluation of the activities of the NGOs involved in intervention programme, irrespective of its size and banner for effective utilization of resources.

Secondly, there is a need to improve the monitoring system of NGO activities by the State AIDS Control Society through clear measurable indicators.

Thirdly, since there is no medicine for complete cure of the disease, counseling is considered to be one of the best approaches for modification of risk behaviour. Therefore, the counselors need skill and for which they undergo training. For training of the counselors a training curricula has been developed by a group of National Level Experts in India under the banner of NACO and WHO. Unfortunately, most of the people who act as trainers at the state level are mostly inexperienced. This issue demands immediate attention of the authorities of NACO.

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Received: December 11, 2007
Revision received: February 28, 2008
Accepted: March 12, 2008

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