Psychosocial Aspects of HIV/AIDS: Adults

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Objectives
1. Understand the complexity of factors that affect the life of an HIV-infected adult.
2. Evaluate and identify means of reducing the personal and socioeconomic effects of HIV/AIDS.
3. Identify and describe appropriate resources for care and support.
4. Identify how caring for people with HIV/AIDS affects health care providers.
5. Identify sources of stigma and discrimination and discuss ways of educing their negative effects on patients and health care workers.

Introduction
HIV as an illness affects the person first and foremost at the biological level in the form of an aggressive virus that compromises immunity. Every illness experience represents a unique and dramatic negative experience for the patient; it is associated with a profound and authentic psychological engagement of patients themselves and the significant people in their lives.

Psychologists conceptualize the disease developing based not only on an individual relationship with the nature and the aggressiveness of the viral subtype but also on the psychological response of the person, their experience with other pathologies, and their personality traits. For example, Kalichman et al. provide evidence that patients with personality disorders are at higher risk for HIV exposure than those diagnosed with only clinical symptoms because these patients display little confidence in their ability to enact safer sexual practices, little commitment to condom use, and higher anxiety associated with risk of contracting HIV.

Several studies have found that a substantial proportion of the chronically mentally ill report engaging in HIV risk behaviors. HIV infection adds stress to the already compromised coping skills of the mentally ill, while mental illness itself may increase the risk behavior and thus predispose the affected person to HIV.

HIV-infected adults live in a social and cultural environment, and the economic and political conditions of the state that they live in directly affect these people. In this complex context there are specific developmental stages that all adults, regardless of their HIV status, tend to go through. Developmental psychology described these stages decades ago, and we should consider them when we want to understand the effect of HIV on an adults’ lives and their movement toward achievement of life tasks (Vignette 1). HIV can affect an adult while he or she is forming a couple and developing a sense of intimacy and...
trust, or while becoming a parent and moving toward a different life stage: parenthood. For a certain period the illness can take away the person's ability to work and keep a job, thereby affecting the sense of productivity, self-control, and security of daily life. Redefining identity through the condition of HIV can be a big challenge because it can come in deep contradiction with life goals and plans. Sexuality is important during adulthood; however, having a sexually transmitted disease that is not curable will affect dynamics and form of sexual life. Having HIV can affect other social relationships because infected adults need to make decisions regarding levels of HIV diagnosis disclosure. Within the developmental stages of the adult, Ross et al. have also noted that the individual infected with HIV will move through personal psychological stages of response to finding out that he or she is infected. These stages tend to mirror Kübler-Ross's stages of death and dying because HIV/AIDS is still seen as a threat to life; however, with the stigma associated with both AIDS and sexuality, it also contains aspects of adapting to, and protecting information about, a stigmatized identity (Vignette 2).

The individual HIV illness, even if it is subjectively experienced as unique and isolating, always happens in the context of the HIV epidemic. The face of the HIV epidemic may look different from country to country or even between rural and urban areas (Vignette 3). However, the epidemic of HIV is more deeply seated than the person’s body. Barnett (2002) notes that “an epidemic reveals many of the fractures, stresses, and strains in a society”; among these, one can enumerate long-term historical and societal structural inequalities and inequities (poverty, inequities in distribution of income and wealth, polarization by social class, levels of social justice, education, ethnicity) or other aspects such as social order and social cohesion, which may be affected by war or migration or similar social and physical dislocations. “The HIV/AIDS epidemic did not just happen. There are social, economic, and cultural reasons why such events occur” (Vignette 4).

When assisting and working with an HIV infected patient, health care providers must consider the preceding aspects. The HIV infection may, depending on context, be seen to a greater or lesser extent as a “lifestyle disease,” depending on the perceived mode of transmission. But becoming HIV infected and coping with the disease is not totally the individual's

### Vignette 1: Developmental stages in adulthood
(Vaillant, 1977)

- Age of establishment (20-30 years): moving from under the parents’ dominance to autonomy, finding a spouse, raising children, developing and deepening friendships
- Age of consolidation (25-35 years): doing what has to be done, consolidating career, strengthening marriage, not questioning goals
- Age of transition (~40 years): leaving the compulsive busywork of occupational apprenticeship to examine the inner world

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<td>4a: “Coming out” to significant others</td>
<td>Testing others’ reactions and bargaining, stress displacement, need to be loved</td>
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<td>4b: Looking for other HIV positives</td>
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<td>4c: Special status</td>
<td>Turning alienation into a unique advantage, difference becomes special, needed by others</td>
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<td>Group commitment and cohesiveness, feeling of community</td>
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<td>Stage 5: Acceptance</td>
<td>Integrated HIV status into self-identity, balance between altruism and self, coming to terms with condition</td>
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### Vignette 2: Developmental stages of HIV disease in adulthood
(Ross, Tebble, and Viliunas, 1977)

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### Vignette 3: Types of epidemics

- Nascent epidemics: HIV less than 5% in one or more subpopulations with high-risk behavior
- Concentrated epidemics: more than 5% in one or more subpopulations with high-risk behaviors but less than 5% in antenatal clinics
- Generalized: HIV spread from the original subpopulation; prevalence in antenatal clinics more than 5%
Stigma, Discrimination, and HIV

Probably the single most important factor in producing and extending the negative psychosocial effect of HIV and AIDS is stigma. Consequently, actions to reduce or protect against stigma may be the most significant step that can be taken to improve the psychosocial well-being of people with HIV/AIDS. Stigma can be defined as “an act of identifying, labeling, or attributing undesirable qualities targeted towards those who are perceived as being shamefully different and deviant from the social ideal” and as “an attribute that is significantly discrediting (and is) used to set the affected persons or groups apart from the normalized social order.” (Definitions from UNAIDS Intercountry Team for East and Southern Africa [D. Miller, Stigma and HIV/AIDS in Africa: setting the operational research agenda], Tanzania, June 2001.)

Discrimination can be defined as “an action or treatment based on the stigma and directed toward the stigmatized” and as “sanction, harassment, scapegoating, and violence based on infection or association with HIV/AIDS.” Stated more simply: stigma is the attitude, and discrimination is the act. Acting through discrimination, denial, and shame, stigmatization is an impediment to HIV prevention and treatment efforts. A broader definition of stigma argues that the concept can be understood only in relation to notions of power and domination. Power and control exerted over the devalued group create social inequality and result in the social exclusion of people with the stigmatized disease.

Vignette 4: Determinants of HIV epidemic
(Barnett et al., 2000)

- Biology: virus subtypes, stage of infection, presence of other sexually transmitted diseases, patient’s sex, circumcision
- Behavior: rate of partner change, prevalence of concurrent partners, sexual mixing patterns, sexual practices and condom use, breast feeding
- Microenvironment: mobility, urbanization, access to health care, levels of violence, women’s rights and status
- Macroenvironment: wealth, income distribution, culture, religion, governance

People with HIV/AIDS are stigmatized and discriminated against for many reasons, including the following:
- HIV is a slow, incurable disease that eventually results in suffering and death.
- Many people regard HIV as a death sentence.
- The public often poorly understands how HIV is transmitted and is irrationally afraid of acquiring HIV from people infected with it.
- HIV transmission is often associated with violations of social mores regarding proper sexual relationships, so people with HIV are associated with having done something “bad.” For example, in some cultures, people believe that a woman becomes infected with HIV because she has violated the mourning period after her husband died.
- Therapeutic protocols are lacking for anti-HIV medications that could control the spread of the epidemic and prolong lives.

Stigma prevents people from talking about and acknowledging HIV as a major cause of illness and death. Stigma prevents HIV-infected people from seeking counseling, obtaining medical and psychosocial care, and taking preventive measures to avoid infecting others. Prevention behaviors are also stigmatized, and people are reluctant to introduce behaviors that could associate them with the virus, such as use of condoms, certain medications, and infant formula when appropriate. A woman with HIV might want her partner to use a condom but might be reluctant to ask because of the stigma associated with the suggestion of HIV risk.

If one family member exhibits signs and symptoms of HIV, the entire family may face rejection and even violence from the community. The loss of social support results in isolation for the family, which may also fear loss of employment, denial of school admission, or denial of adequate housing. Stigma can attach to children of HIV-infected parents and to orphans whose parents died of AIDS. Globally, the AIDS epidemic has robbed 15 million children (12 million in sub-Saharan Africa) of one or both parents. Children may be ostracized at school if it is known that they have an HIV-infected family member, and HIV-infected children may be denied school services for fear that they might spread the virus through casual contact.
Stigma and discrimination also occur in the health care setting. Sometimes HIV-infected patients are denied appropriate care or are segregated from the general hospital population. Health care workers may selectively use universal precautions only with HIV-infected patients. Reasons may include a lack of medical resources, but health care workers’ ignorance and stigmatization of HIV can also be factors. A survey of 1000 physicians and nurses in West Africa in 2002 found that 20% of them felt that HIV-infected patients had behaved immorally and deserved their fate. Oftentimes health care workers who help patients with HIV may also be stigmatized because of their association with the virus.

Statistics indicate that close to 75% of the global HIV/AIDS caseload occurs in Africa. As in other places, stigma associated with HIV/AIDS in Africa involves attributions of other stigmatized behavior, such as homosexual acts among young men. Homosexuality is highly stigmatized and is even illegal in many parts of Africa and Asia. People often blame outside forces, such as foreigners or the devil, for HIV/AIDS. Stigma may even lead to violence against those blamed for introducing the disease. In 2003, schoolchildren in Ghana staged a demonstration to demand that all tourists be required to get HIV tests. Most societies stigmatize sex workers (prostitutes), who are an integral part of the spread of HIV. Stigma and discrimination prevent sex workers from playing a larger role in the fight against HIV/AIDS.

Anal sex is also widely stigmatized, independent of its association with HIV infection. Anal sex is a more common practice in Africa than previously thought: in a 2004 survey in South Africa, male-male sex accounted for 7% of sexual practices, and heterosexual anal intercourse is a common form of birth control. Stigma may cause people not to talk about risk behaviors and risk reduction. By association with HIV, stigma may also attach to HIV prevention methods, such as the use of condoms, and thus prevent HIV risk reduction among the uninfected.

Social dislocation carries with it not only additional risks of infection but also the stigma associated with being a foreigner or outsider. Many refugees may have contracted HIV in their own countries before seeking refuge elsewhere. Warring groups in Sudan, Congo, Uganda, and Rwanda have raped thousands of women and girls, putting them at high risk of contracting HIV. Among an estimated 250,000 rape survivors, up to 67% might be living with HIV.

Sex education may also be stigmatized, perhaps in the belief that it can contribute to sexual activity. As a result, young people may lack information to prevent the spread of HIV. Research shows that many girls in Africa contract HIV during their first sexual encounter. Remarkably, 8% of women surveyed reported having sex before the age of 13 years, and 15% said that they had sex before their first menstrual period. Only 27% reported using a condom during their first sexual experience. In areas of high HIV prevalence, infection during early sexual encounters is likely.

Most routes of HIV transmission are not exclusively associated with “immoral” behaviors. But such behaviors are attributed to those infected, thus doubly stigmatizing them—through infection and through attribution. Prevention efforts are also stigmatized through their association with HIV; the attribution is that those trying to protect themselves must be infected. Stigma is thus associated not only with psychosocial distress but also with a reduction in prevention efforts and practices. We must minimize the effects of stigmatization to improve prevention and treatment efforts. Because HIV/AIDS stigma is a social and cultural phenomenon of the entire community and not simply the result of individual actions, attempts to reduce stigma must address the community rather than focus on individuals.

Health care professionals must be aware of the stigma faced by their HIV-positive patients and must be scrupulous in protecting their patients’ confidentiality. At the same time, providers can take steps to reduce the effects of stigma on their patients. By promoting disclosure of a positive HIV test result to the patient’s family or spouse, health care providers can help build a support system for the patient and educate family members about HIV. They should provide supportive counseling to patients, caregivers, and fellow health care providers to reduce the stressful effects of stigma. Finally, all providers should regularly examine their personal values as they relate to caring for people with HIV/AIDS.

**Psychosocial Effects of HIV on the Individual**

Even if stigma is minimized, an incurable and often fatal disease requires enormous psychosocial adjustments. People diagnosed with HIV experience many of the emotional responses identified in people facing a terminal illness. They commonly go through an initial stage of denial, in which they do not acknowledge having...
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the disease or deny its likely consequences. HIV threatens a person’s life, goals, expectations, and significant relationships; no wonder that many people are reluctant to admit their diagnosis or their risk of infection. People who subject themselves to high-risk situations or behaviors commonly deny that they are at risk of HIV infection. They often avoid testing, and if they are tested, they avoid following up on results, as if avoiding a clinical diagnosis might prevent the disease. To battle HIV successfully, people must have some level of acceptance of the disease so that they can seek counseling, social support, and medical care.

Individual Reactions to Disclosure of HIV Diagnosis in Adults

Change, adaptation, and evolution are principles of life. Having a disease is discouraging, growth inhibiting, and fosters hopelessness and helplessness. Often denial and regression are the first processes that take place in the psychological life of persons newly disclosed to.

The level of distress felt by a person as a result of disclosure of HIV diagnosis may depend on the following:
- Method of acquiring the infection
- Personality characteristics and lifestyle
- Degree of support available
- Knowledge of and experience with AIDS-related issues
- Accessibility to HAART (highly active antiretroviral therapy)
- Self-evaluated risk of exposure to HIV

Many psychosocial reactions might appear (e.g., anxiety, depression, guilt, body image disturbance, social isolation, and ambivalence), and for many the HIV diagnosis is at least a highly stressful event, if not a traumatic one. On the basis of case histories in Australian men infected with HIV, Ross et al. (Vignette 2) have offered a model of the progress of psychological response. Although these data were based on responses of men having sex with men in the 1980s, clinical experience has suggested that these broad stages may categorize the response to being informed of infection in other people with HIV infection. However, there is a crucial interaction between the stigma of HIV and the progression through stages. Where stigma is high, people may be unlikely to progress into the fourth stage, because any self-exposure would lead to isolation and stigmatization. Progression through these stages is possible only to the extent that there is sufficient communication about HIV to make a common support grouping of people with HIV possible, and so they may be appropriate only to more Western and individualistic cultures where stigma management may be easier.

The nature and quality of disclosure are critical to preventing trauma. If the disclosure is blunt and aggressive (or has not been sought through voluntary testing), it can become an overwhelming and intrusive event that will affect the long-term psychological balance.

Although appreciating what is normal and what is pathologic is difficult when we talk about life-changing bad news, there are different types of reactions to stress and trauma:
- Normal (fear, fury, denial, depression, withdrawal)
- Neurotic (exaggerated reactions such as panic, extreme avoidance behaviors, and impairment

HIV is an illness that affects the whole family.
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of ability to love and work; patients can express emotional distress and attitudes toward illness

- Psychotic (depressive symptoms and depressive disorders are among the most common psychiatric sequelae of HIV infection)
- Psychosomatic (low ability to verbally express distress; focused on the disease of an organ)

Chronicity of HIV Infection as a Subjective Experience

From a psychological point of view, the disease is a period of many questions, self-explorations, and anxious expectations. All these can lead to new symptoms that can be structured in a second disease (e.g., secondary morbid state, a mental disorder) or an increase of somatic symptomatology through psychogenic factors that are activated by the awareness of the disease (e.g., hypertension). Health psychology suggests that mental mechanisms are geared toward maintenance or reestablishment of the overall health of an individual.

For antiretroviral therapy availability, one can consider HIV to be more a chronic disease. Whereas patients tend to consider any acute disease as an exterior, accidental, and transitional circumstance in one’s life, they often perceive a chronic disease as being developed from within, as being part of the body (this creates a paradoxical situation, because the conflict comes from wanting to avoid something that is inside and by this very nature it is a state that cannot be avoided).

The long-term progression of HIV, doubled by the uncertainties related to the disease prognosis, enhances these feelings. All these factors reinforce the anxiety felt by the patient with chronic disease (versus the trust that one experiences for an acute condition).

Depression may be common among people with HIV, especially as they adjust to the fact that they are no longer the healthy people they once thought they were. Adjustment to HIV is affected by the lack of hope that comes from a person’s inability to access or benefit from treatment and the anticipated rejection and need for secrecy because of HIV-associated stigma. Seeing many others become ill and experience alienation before succumbing to AIDS increases fear and depression. Suicidal impulses appear as complications of depression and failure to find significance and meaning in a life with HIV. However, suicidal behavior is not particularly common. A 20-year longitudinal study in a Romanian hospital showed that a somatic affection with serious risk for life does not increase suicidal impulses; instead, it is correlated with a tendency to overcome obstacles to survive.

Psychological Issues through Progression of HIV/AIDS

The issues facing HIV-positive people vary in accordance with the disease process, including whether the disease is symptomatic. In a study monitoring 80 homosexual men with HIV/AIDS for 15 years, Nilsson Schönnesson and Ross noted common themes that emerged at different points in the disease process. They found that HIV is a threat not only to people’s physical survival but also to their psychological survival. Early in the disease, people often see themselves as being “persecuted” by the virus—an external, alien, bad object. At later stages, physical and psychological anxieties and fears about death are common.

As the disease progresses, control (or power) issues emerge as patients face increasing loss of physical control. Self-efficacy and active involvement in their health can increase people’s sense of being in control and reduce their risk of feeling helpless. But hope may alternate with despair. Nilsson Schönnesson and Ross found that existential issues invariably emerged in response to threats to physical and psychological survival. Patients’ sense of the meaning of life may be shattered, and they will need to reconstruct new meanings that incorporate HIV. For some, this process may include personal and spiritual growth, with HIV as an impetus to do something with their life or for their family. Existential isolation—a fear of being rejected or abandoned—may lead to anxiety and depression. For many, the existential issues involve spirituality, often manifesting as a rediscovery of religion if the person has a history of religiosity. For such people, religious belief systems may be a major source of psychosocial support and consolation.

At the beginning of the disease process, issues of death tend to be dealt with indirectly as fears of psychological death. At the severe symptomatic stage of AIDS, patients experience these issues as much more direct concerns related to physical death. Views of the persecutory nature of HIV change over time. Initial bewilderment turns to fear as the disease becomes more severe. Denial is most typical in the early stages of infection. Control issues are more salient in the asymptomatic and mild symptomatic
stages, and helplessness and hopelessness are most concentrated in the severe symptomatic and terminal phases of AIDS. Thus, one can characterize HIV disease as producing four major psychological concerns:

1. existential and spiritual issues,
2. a perception of HIV as a threat or persecutor,
3. feelings of vulnerability and loss of control, and
4. death-related concerns.

These concerns emerged from a longitudinal study of a Western, gay population, but the same issues and stages of dealing with HIV would probably emerge in non-Western countries.

Other psychological mechanisms that one is likely to encounter during different stages of the HIV progression include the following:

1. Denial (total refusal of acknowledging the truth of HIV infection), which can be cognitive, emotional, or behavioral. It is common in the initial shock-numbness-disbelief stage and is usually short term/rarely pathologic, taking years to manifest.

2. Splitting (always present, to a lesser or greater extent because it allows some degree of dissociation and denial). Clients appear with a nonchalant, hapless attitude toward HIV status. This comes in contrast with at least one intense feeling—beyond the usual expected intensity—that the client displays toward some other problems such as school problems/grades or relationship conflicts. (See **Vignette 5**.)

3. Projecting “bad” parts of self associated with illness (influenced by internalized stigma). The self-concept is altered: I am bad, I am without control, I anticipate failure in all my endeavors. All these cognitions create high levels of doubt and uncertainty regarding identity and self-effectiveness. “Magic” thinking and acting can replace more rational and common-sense practices—for example, when patients are looking for quasimedical cures. Persons are making constant efforts to seclude their felt badness from the rest of the world.

4. Limitation of the ability to process and integrate symbols (Greek: “to put together”) and our ability to operate with them holds a critical role in adapting to conflicting situations and mediates the healing process. It is about reframing and finding a new, positive meaning in difficult, existential issues.

**Vignette 5: Splitting examples**

- Patient unable to discuss HIV (taboo subject); patients find countless ways of avoiding or diverting the answer to a direct HIV-related question.
- Splitting may appear in relation to sexuality ("sex, badness, and death are associated in a fixed constellation" [Cartwright, 2002]).
  For example:
  - I will never have sex or marry.
  - I am not interested in boys/girls.
  - I do not spend time with school peers because they are all thinking only about sex (disgusting).

"Through symbols, human beings are trying to integrate everything into a system, to reduce the multiplicity to a unique and more transparent situation.”

—Mircea Eliade, 1992

**Finding Meaning and Mediating Successful Adaptation to a Life with HIV**

Professionals need to be able to recognize the aforementioned processes and help patients overcome denial and splitting, improve self-esteem, and restore the symbolic function of mind. The final goal is to assist the person to recognize the unpleasant reality of the disease while keeping hope and goals in life, to offer a safe mode of expressing fury and fear while keeping the love and support of significant ones, and finally integrating the disease into the self-concept. However, Ross et al. and Nilsson Schönnesson and Ross note that with successive health crises, people may regress briefly to earlier stages as they adapt to new health circumstances.

Professional counselors, social workers, health care workers, clergy, trained volunteers, friends, and family play crucial roles in providing psychosocial support. One of the first steps in providing adequate assistance for people with HIV is to ensure that the helper is thoroughly aware of and comfortable with the facts about HIV transmission. If helpers feel personally at risk from HIV-infected patients, they will convey those feelings to the patients, who will then feel even more isolated than before. Counselors need to educate themselves about HIV to adequately counsel people with HIV. Individual and supportive counseling can help patients come to terms with their HIV diagnosis and with how it will affect all aspects of their lives. Patient education should include information about how HIV is transmitted and should
give the patient some idea of common physical and emotional responses to HIV. This type of education can help patients anticipate and plan for these experiences.

Professionals can also help patients assess controllability of HIV-related stressors and to design adaptive coping mechanisms. For example, the therapeutic focus can be on developing a problem-focused coping response when the stressor is controllable, whereas an uncontrollable stressor should focus interventions on finding, defining, and redefining meaning (Vignette 6).

Vignette 6: Meaning- versus problem-focused coping

- Meaning-focused coping refers to a positive reappraisal even if a stressor cannot be readily alleviated or changed.
- Problem-focused coping has the greatest effect on self-reported depressive symptoms when stressors are controllable (e.g., seeking information).

One useful tool to use is the self-report scale “Meaning of illness questionnaire” that helps evaluate illness-related meaning appraisals in five domains:
- Impact (Has this illness negatively affected how you live your day-to-day life?)
- Type of stress (Would you describe this illness as a loss?)
- Degree of stress (Are you pleased with the way you are handling stress?)
- Challenge, positive attitude, motivation, hope (Would you describe this illness as a challenge?)
- Nonanticipated vulnerability (Was this illness expected before the doctor told you?)

This tool can provide insight to both the patient and the professional that offers assistance on how the person subjectively experiences the illness, and it can be the starting point in designing a successful intervention plan.

Improved quality of life and successful adaptation to life challenges are the main goals of psychosocial intervention plans. These are developed by multidisciplinary teams, taking into consideration the many factors presented in the beginning of this chapter and their dynamics.

The general goal is then elaborated into more concrete objectives connected with designed interventions and anticipated outcomes. The interventions of the multidisciplinary team might focus on the following areas:
- Improved physical well-being
- Reduction or control of stigma and discrimination
- Improved access to health care
- Improved access to social support
- Activation of internal resources

Heckman (2003) presents the logic model of the preceding factors (Figure 1) that should be the goals of psychosocial interventions to ensure a good quality of life and the best possible successful adaptation to the HIV diagnosis and life with HIV for affected adults. The process depends on how each individual activates, combines, and uses different resources available, both internal and external. (See Vignette 7.)

Figure 1. Model of factors influencing quality of life of HIV-infected persons.

Vignette 7: Resources activated for successful adaptation to HIV

Internal resources:
- Cognitive reappraisal of a situation
- Realistic perception of current life events
- Strong self-concept and self-esteem
- Self-control and self-efficacy
- Positive appraisal of the future

External resources:
- Access to medical care
- Family and social support network
- Therapeutic alliance with the care team
- Psychotherapeutic and psychopharmacological support
- Support with issues regarding confidentiality
- Access to social services
Group counseling can also play an important role by allowing individuals with HIV to share experiences with one another. However, this approach is usually not a good idea until the person has been able to accept the diagnosis enough to come to the group and communicate honestly. Group support can help patients cope with their emotional responses to HIV on the basis of accurate information, shared experiences, empathetic listening, and assistance with problem solving. Counseling and support can help people with HIV share their feelings about secrecy and stigma and consider how these influence their emotional and physical health. Counseling and support can also help people consider how their own behaviors can promote health and well-being, such as seeking resources for adequate nutrition, shelter, proper medical follow-up, adequate sleep, and management of stress and anxiety.

Supporting the spiritual needs of HIV-infected people and their families is a critical component of good care and support. Patients with AIDS report significantly lower levels of spiritual well-being than do patients with cancer and other terminal illnesses. They also report greater feelings of loneliness, fewer support systems, and less satisfaction with the support systems that they have. Support from spiritual leaders who are significant to the patient helps the patient and family cope with the existential and intrapersonal questions raised by a life-threatening illness and with regrets that the person may feel about past actions, relationships, or experiences. Traditional healers, often the first care providers sought out by patients, can also be a source of support. When traditional healers and other medical providers work together and have a shared understanding of the goals of care, patients with HIV benefit. One can engender hope in terminally ill patients by controlling symptoms, encouraging relationships, assisting patients with practical needs, affirming their value, and helping them review their life experiences and personal worth positively.

**Types of Psychosocial Interventions for Adults**

All the preceding issues presented have stressed the complexity and variability of unique constellations of psychosocial factors that come together in the life of each patient. Good care can be provided through structured psychosocial services that involve a multidisciplinary team.

One key principle before designing any intervention that will address a specific need of our patient is to always involve the client in the design of his intervention plan and prioritize issues together.

The multidisciplinary team should have clear standards of care and intervention that will guide their actions (Figure 2). Clients might have different needs, starting with the need for information or legal support with respect to rights and responsibilities; continuing with need for know-how on accessing services available; and ending with needs for developing practical skills to improve adherence, disclose diagnosis to other parties, or change a specific life situation.

Support can be either intensive or nonintensive and usually comes in one of the following forms:

- Counseling
- Education
- Practical support and assistance
- Psychotherapy and psychiatric support

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**Figure 2. General design of guiding procedures for multidisciplinary team interventions’ plan**

- Initial evaluation
- Establish needs and level of support required
- Define objective, type of intervention, expected changes, involved parties
- Implement support action
- Obtain feedback and document impact
Counseling can be linked with many aspects, such as HIV testing and support for adaptation to the new status, promoting a healthy lifestyle (e.g., adherence to antiretroviral therapy, behavioral changes), decisions regarding current conflicting emotional situations, and confidentiality and its limits. It can be an individual process, but involving the couple or working with family members or in a group format might also be required.

Education includes several components, such as sexual education, education about HIV infection and opportunistic infections, and education about the legal framework that the patient should be aware of. It can also focus on, for example, developing parenting and nutritional skills for those caring for HIV-infected newborns and teaching nursing skills for caregivers of the terminally ill. Educational approaches can take a variety of forms, starting with professional guided education and ending with self-education based on printed materials or mediated by a peer educator.

However, situations often require practical support and assistance. Such interventions include providing free condoms, temporarily helping with transportation fares or medication, helping the patient to represent himself at different institutions to access his legal rights, or simply paying home visits for follow-up.

Because HIV infection is a chronic condition, the follow-up and monitoring of a patient does not end, even if he or she might not need intensive support at one time. Health care workers should have ongoing evaluations and keep track of changes that might negatively affect the person.

**Psychosocial Effects of HIV on the Family**

HIV affects the whole family, not only the infected individual. When one member of a family has HIV, often there are others who are as yet undiagnosed. When HIV infects one partner in a relationship, both partners are affected. The infection may indicate that sex or other risk behavior has occurred outside the relationship, but even if the infection predated the relationship, both partners will be involved in the emotional trauma of the discovery. Ideally, the couple should openly discuss sensitive matters such as condom use, sexual fidelity, and childbearing. This step does not always happen. Regardless of his or her own risk behavior, the undiagnosed partner may express anger and violence toward the person who has been diagnosed. The diagnosis of HIV infection in a child usually indicates the presence of the virus in the mother. The father and other siblings may carry the infection as well.

Cultural, social, biological, and economic pressures make women more vulnerable to HIV infection than men. In some areas, the high prevalence of rape puts some women at risk of acquiring HIV. In others, older men who may be infected with HIV pressure teenagers into sexual relationships. Women are often economically dependent on men and unable to negotiate safer-sex practices, including condom use. Women are usually the primary caregivers for their families and may have little support from others when they are ill themselves. As more people receive care for HIV/AIDS in their own homes or the homes of others, health care workers must keep in mind that HIV-infected women are likely to care for everyone else in the family, often to the detriment of the women’s own health. Households led by women also face greater economic difficulties and have fewer supports.

Strengthening the family structure is especially important because of the tremendous stress that HIV puts on family systems. Besides caring for ill relatives and for orphans, families are often beset by economic and social problems as well as the grief that accompanies the loss of family and friends. They may benefit from group or family counseling, including counseling about their desire to have a family, perhaps the need to prevent unwanted pregnancies, and negotiation of risk-reduction practices such as condom use. Individuals may need training in assertiveness and how to communicate their needs. Remember also the more basic needs that the family is facing: food, shelter, and dwindling finances.

A common issue in counseling is who should be told of a person’s HIV status and how and when the matter should be communicated. One approach is to educate the infected person about how HIV progresses. While the person is still asymptomatic, he or she should consider whom to tell about the infection before the illness begins to manifest itself. A counselor can help the patient identify family members and friends who are supportive and will be open to education regarding HIV. A related issue is disclosure to a sexual partner or spouse. Partner notification programs may help patients who want to tell their partners but do not feel comfortable doing so. Some patients may opt not to tell people with whom they live because they fear losing their home and family support. The reaction of a partner or other family member could
be violent. At times, it may be possible to give alternative explanations for changed behavior, such as wanting to use condoms to avoid pregnancy. In societies where a man’s virility and a woman’s worth are measured by how many children they have, this approach may be more difficult.

**Socioeconomic Effects of HIV/AIDS**

HIV/AIDS affects the economic well-being of families, businesses, and societies in many ways. When people become ill and die, society loses not only those people but also their productive potential. They no longer hold jobs, manufacture goods, provide services, or support their families. Families lose their breadwinners; the nation loses people who contribute to the well-being of society.

As families use their time and money to care for ill members, their energies are diverted from working to provide income or farming to provide food. Not only the present but also the future is affected, as family members discontinue education because of the financial needs of the family. Even burying the dead makes life more difficult for families and society. Funerals are costly, and people miss days from work to attend the rituals. The epidemic’s high death toll is producing cultural changes. In some communities with high rates of HIV infection, cemeteries have become overcrowded, creating pressure to accept practices not previously sanctioned by religious and cultural authorities, such as cremation. Funerals are a visible, potentially numbing reminder to all that a deadly disease threatens their survival.

HIV threatens workplace productivity because of deaths, absenteeism due to illness and funeral attendance, and lower productivity of sick or newly hired replacement workers. Other increased costs to the business sector include expenses for insurance and medical care for sick employees, which must be weighed against the cost of having to train new employees if more experienced employees become sick because of inadequate health care.

At the societal level, economic growth in many nations is lagging because so many skilled and experienced workers have died of AIDS. High unemployment and high rates of infection among skilled workers bode ill for countries’ ability to keep social supports intact. Studies of teachers and health care workers, for example, indicate that many in those professions have been infected with HIV. Society faces the challenges of having many of its productive members sick or dying, leaving few people to care for children and the elderly. In many countries, the number of people affected by HIV/AIDS is overburdening health care and social support resources.

The effect of HIV/AIDS on broader indicators of development, such as life expectancy, has been profound. In the 1950s, a child born in southern Africa had a life expectancy of 44 years. By the early 1990s, that figure had risen to almost 60 years. But life expectancy is expected to drop to 45 years between 2005 and 2010 because of the toll that AIDS has taken. Poor households are being pushed deeper into poverty. The effects of the AIDS epidemic will be felt for generations, because so many children are being deprived of adequate nurturing, nutrition, education, and good role models.

In sub-Saharan African countries such as Malawi, Mozambique, Tanzania, Uganda, and Zambia, determinants of long-term growth show sharp declines as a result of the AIDS pandemic. In South Africa, the gross domestic product is projected to decline by 17% between 2002 and 2010.

Frail economies, weak institutions, declining standards of living, and reduced social and governmental capacities indicate that the effect of HIV/AIDS on the future of African societies will be devastating. The assault on countries’ most productive segment, with the resultant undermining of their tax base and their ability to finance such critical infrastructure as health and education, are certain to hamper sustained economic, cultural, and societal development.

A United Nations Development Programme study carried out between 1980 and 1992 confirms the scale of the setback to human development by HIV/AIDS. The average loss of human development progress because of AIDS was estimated at 10 years in Zambia; 8 years in Tanzania; 7 years in Rwanda; 6 years in the Central African Republic; and 3-5 years in Burundi, Kenya, Malawi, Uganda, and Zimbabwe. Because the severity of the AIDS epidemic in sub-Saharan Africa has increased significantly since 1992, subsequent losses in human development are probably even greater.

Reduced productivity in important sectors of the economy feeds into economic instability, which in turn
can undermine a country’s political stability. Civil unrest and war create social dislocation, refugees, and rape, fueling a vicious cycle whose hallmark is an increased incidence of HIV/AIDS.

**Effects of HIV on the Societal Level**

HIV places enormous and varied stresses on the political, cultural, and religious fabric of society. Among issues that become critical are the availability of health care, social supports for orphans and caregivers, legal rights and responsibilities of people with HIV, and the response of religious and cultural systems to the needs of their members who are infected with or affected by HIV/AIDS. Political instability may be exacerbated by growing frustration with the government’s inability to stop or slow the epidemic or to respond effectively to the needs created by it. Increased poverty and social inequality may encourage conflict and crime. How these critical issues are resolved will determine society’s survival and viability.

The effects will be most obvious in the area of health care as the need for services increases. Providing treatment for HIV/AIDS and the illnesses that accompany the infection is expensive. Often governments must choose between providing treatment and funding prevention programs. The choices are not easy.

Education systems face shortages as teachers become ill and die. A rare public-sector assessment commissioned by the Government of the Kingdom of Swaziland estimated that the country would have to train 13,000 teachers between 2003 and 2011, compared to 5,093 if no AIDS epidemic existed. Schools also must deal with significant numbers of infected and affected children with psychological, social, and economic problems caused by the epidemic. Enrollment rates in institutions of higher education may drop because fewer children live to adulthood.

**Societal Interventions**

Because of the complex effects of HIV/AIDS on the individual, family, community, and society, interventions on many levels are needed to mitigate the effect of the epidemic. Some interventions are targeted at individuals with or at risk of HIV, whereas others are aimed at the larger community. Their objective is prevention of HIV and reduction of societal factors that increase the risk of infection. Protecting the human rights of vulnerable members of society, who are often hardest hit by any health problem, is another important step in mitigating the effects of HIV. Destigmatization of HIV and legal protection from discrimination and physical harm of people with HIV are important because of the broad effects that stigma and fear have on prevention and treatment efforts.

Role modeling is an effective way to encourage behavior change, as for HIV testing in Siaya, Kenya. When three members of parliament took the lead by offering to be tested in public, many people joined them. The three parliament members later called on fellow legislators and civic leaders to follow suit and take the lead in motivating other districts to join in this voluntary counseling and testing initiative. Leading figures who discuss their HIV infection in public may also make a major contribution to reducing stigma.

Many projects try to help patients and families with basic needs and income generation. Reduction of poverty and improvement of the overall health of the population are important objectives in the fight against HIV/AIDS. Nongovernmental organizations and community-based organizations, often in conjunction with the government, are carrying out considerable work at the local level toward these objectives. Approaches range from institutionalized care to home-based care for terminally ill patients to training for lay counselors. To be successful, home-care interventions must be supported with structured programs from the health-service delivery system. Poor families without such basic resources as clean water and adequate food are likely to need extra training and resources to care for a sick family member at home. Health care providers should assess each family’s needs for support when making a home-care plan. Many families may benefit from simple support, such as a friendly visit, a referral for food assistance, latex gloves, or advice to improve caregiving skills. Families also need contact information, such as phone numbers or addresses, in the event of a problem or emergency.

On a larger scale, public and private industry policies regarding HIV and HIV prevention should be evaluated on an ongoing basis to examine their effects on the lives and health of the population. Advocacy for policies ensuring confidentiality of HIV status, access to medical care, and protection from discrimination are likely to help more people with HIV meet their physical and social
needs. Education and advocacy within religious and cultural groups, and support from these groups, help patients and families living with HIV. Governments and nongovernmental organizations must devote resources to advocacy for increased attention to HIV prevention and the need for medications, medical care, and psychosocial and cultural support for individuals, families, and communities living with the virus.

**Prevention of Transmission**

People who find out that they have HIV may feel powerless against the virus. But they are not powerless to prevent its spread. The pandemic’s growth depends on an infected person who transmits the infection and an uninfected person who receives it. To slow the epidemic, people who are infected must be educated to avoid transmitting it. Thus, on diagnosis and during subsequent visits, prevention information needs to be provided and reinforced. As part of this reinforcement, a health care provider might emphasize that despite their infection, patients still have some control over where the epidemic goes in their community and a responsibility not to become another link in the chain of transmission. This emphasis will need to be balanced against the stigma of being identified as HIV infected, e.g., through condom use.

**ABC Prevention Approach**

Uganda has significantly reduced the transmission of HIV by using the ABC (Abstinence, Be faithful, use Condoms) approach. This harm-reduction approach gives each person several strategies for preventing HIV transmission to themselves and others.

Abstinence from intercourse is likely to be most useful with adolescents, who may be encouraged to delay intercourse, and in situations where families or partners are separated by work or travel.

Being faithful (staying with one sexual partner) will prevent HIV transmission if both partners have the same HIV status (both negative or both positive with the same strain of HIV), which can be known only through testing. If only one partner is faithful, the activities of the unfaithful partner may put the faithful one at risk. Where there is a high prevalence of HIV in the population, even one or two additional partners may make infection likely.

Using condoms consistently and properly prevents HIV transmission and significantly reduces transmission of other sexually transmitted infections (STIs) such as syphilis, gonorrhea, and chlamydia. Because having an STI greatly increases the risk of contracting HIV (via infected membranes and sores), both condom use and treatment of any STIs are important.

People must be given all relevant information and allowed to make their own choices as to which prevention method is most appropriate. What works for one person will not always work for another, and what works at one point in life may not work for the same person later. Regardless of their own points of view, health workers are ethically bound not to withhold any information from patients that might prevent transmission of HIV or other STIs. Health professionals must explain the benefits and drawbacks of each approach. We can give our patients the tools in the form of information, and it is up to them to use the most appropriate ones at the most appropriate times.

**Situational Approaches to Prevention**

Sometimes health care providers assume that patients have more individual power to practice prevention than they actually have. For example, someone may have the power to practice prevention in one situation but not in others. One useful approach is to ask patients to list the situations in which they can successfully use any of the ABC approaches and the situations in which they cannot. Issues of power and stigma will often determine prevention, with the weakest person in the situation having the least power. Ask patients to list “risk situations” rather than “risk behaviors.” Then ask how they might avoid getting into such a risk situation if at all possible or how they might reduce the risk if the situation is unavoidable. Explore ways in which patients have some power in the situation to control or modify risk.

**Knowledge, Attitudes, Beliefs, and HIV Prevention**

A common myth among many health professionals is that information about HIV/AIDS is an effective way to prevent HIV transmission. Although adequate information is a necessary condition to prevent transmission, it is often not a sufficient condition. In other words, there needs to be basic information, but by itself information will not always overcome barriers to actually doing preventive activities. The best predictor of whether people will carry out preventive activities is...
their intention to do so. People will have good intentions if they see some value (for themselves, their family, and their community) in preventing the spread of HIV, either to themselves or from themselves.

Even with the best intentions, people may come up against barriers to prevention of HIV transmission. These barriers may be situational (low power in a situation; the influence of alcohol or other drugs; potential violence; no condoms; or a need for food, shelter, or money). They may also be emotional (when people are highly attracted to their partner, when they want children, when they are sexually aroused); often, despite what people know, their emotions override their intentions. It is useful to have people describe the situations in which emotions may override their knowledge and judgment and to identify the point of no return beyond which unsafe sex is likely to occur. A helpful concept to introduce is anticipated regret. Here you can ask patients to describe how they would feel after putting themselves or others at risk and how significant others in their family or community might feel about their actions. How might infected patients feel upon learning that they have infected their partner when that partner gets a positive HIV test result? Can they imagine explaining infection to their partner? Seeing risk situations by envisaging one’s regrets afterward can help to balance the emotional pressures at critical times.

Knowledge and Myths
Increasing knowledge about HIV transmission and prevention (or treatment) cannot occur where the mythology about HIV/AIDS is actively contradictory. Myths will often constitute “folk epidemiology”—a description of beliefs and explanations about HIV. These myths will underlie all aspects of HIV/AIDS: the stigma, HIV transmission beliefs, HIV treatment beliefs, and how people cope with HIV. Cultures will differ on these myths and beliefs, but health workers must be able to list the most prevalent myths. Attempting to deal with HIV/AIDS while ignoring the folk epidemiology will almost always fail. Health care personnel need to be able to credibly refute myths that contradict appropriate psychosocial approaches to HIV/AIDS, or that stigmatize such approaches, while reinforcing those that support optimal psychosocial care and prevention. Myths that have been reported include the following:

- People who look healthy cannot have HIV.
- There are medical and/or folk cures for HIV.
- Religious and cultural rituals can remove HIV/AIDS.
- Being a member of certain religions protects against HIV/AIDS.
- HIV/AIDS is a punishment.
- Intact condoms will allow transmission of HIV.
- HIV cannot be transmitted from females to males.
- Having only one partner will prevent HIV (one partner may put someone at risk, depending on what that one partner has done).
- HIV infection will not harm a person, and only AIDS is dangerous.
- Having sex with a virgin will cure HIV/AIDS.
- HIV does not cause AIDS.

All these myths can hinder HIV prevention or treatment, and health care providers must be prepared to counter them effectively.

Spirituality, Religion, and HIV/AIDS
Existential issues, including spirituality and religious belief, may take on increasing importance to people who get a diagnosis of what is still, despite advances in treatment and health care, a frequently fatal disease. Unfortunately, despite the importance of the spiritual and religious dimensions of life, some officials of some established religions seek to stigmatize, rather than help, people with HIV, even though all the major religions emphasize the importance of caring for the sick and suffering and clearly recognize the obligation to support personally and charitably those suffering from disease.

The health care worker also has a special obligation to help the sick live and die with respect and dignity. Regardless of whether the health care worker personally has a spiritual or religious belief, the patient has an absolute right to be cared for and respected. Stigma, which is a problem in the mind of judgmental others, not inherent in the disease, can be significantly lessened if the patient’s spiritual and religious beliefs are supported. One can do so by recognizing that the spiritual and religious needs of patients may be as important for their mental health and comfort as more widely recognized psychological and social supports. Particularly when medical interventions are of limited effectiveness, the health worker may sometimes, if requested by the patient, support or facilitate (but never impose) ways of meeting the patient’s religious or spiritual needs. Sometimes the consolations of traditional spirituality or religion may make a significant difference to psychosocial
adjustment and mental health. Health professionals should not overlook such existential issues in caring for the total needs of the person with HIV disease.

**Psychosocial Effects of HIV/AIDS on Health Care Professionals**

 Eventually, health care professionals who have lost many patients to HIV/AIDS begin to suffer because they have inadequate time to grieve or deal with their losses. Like their patients, they display many of the symptoms of the stages of grief (denial, anger, guilt, bargaining, depression, and acceptance). However, as they experience loss after loss, the stages become intermingled. They have not worked through one loss before another occurs. Loss of multiple patients can lead to complicated and ongoing grief and can prevent the health care worker from processing the thoughts, feelings, and responses to patients in healthful and helpful ways. Over time, the unacknowledged sadness, anger, and guilt can become compressed and result in cynicism and decreased ability to invest emotionally in patients. It is painful to acknowledge the feelings associated with seeing patients suffer and die, so the professional becomes more hardened and expresses less sensitivity and sympathy for the needs of the next patient.

Symptoms of AIDS-related burnout may be physical (e.g., exhaustion, headaches, back pain, sleeplessness, malaise, and gastrointestinal disturbances) as well as behavioral (e.g., becoming easily irritated and angry, increased alcohol/drug use, marital/relationship problems, inflexibility in problem solving, impulsivity and acting out, and withdrawal from noncolleagues). Cognitive and emotional symptoms may include emotional numbness or hypersensitivity, overidentification with patients, grief and sadness, pessimism and hopelessness, cynicism, indecision and inattention, and depression.

Environmental factors contribute to the stress of health care professionals who care for people with HIV/AIDS. Providers suffer stigma similar to that of their patients and are often unable to talk with family and friends about their work with patients suffering from an often unmentionable disease. Also, HIV counselors must face their own fears about being HIV infected as they encounter patients who may have risk behaviors similar to their own. In a study of HIV counselors in Zambia, 72% worried about their HIV status, but less than one-fourth had been tested for HIV. Half of the counselors said that they did not want to be tested because they did not want to deal with the hopelessness of a positive result or they thought it pointless because there is no cure and only limited treatment. These factors would seem to have a detrimental effect on the ability to counsel effectively or encourage others to seek testing.

Health care providers working with HIV patients see many patients with complicated family situations and seemingly unlimited needs. Often, there are insufficient resources, such as medication and supplies, to meet the needs of such patients. A high caseload combined with inadequate staffing makes it difficult to provide sufficient counseling to the patient. Caregivers are acutely aware of personal limitations and powerlessness to fix the patient’s situation. The provider should remember the power that he or she does have—to provide the medical treatments
that are necessary and available, to try to comfort patients when they are suffering, to provide hope and humor in a potentially devastating situation, and to be a positive influence in the lives of patients and caregivers.

Health care providers can help one another by creating a supportive environment in which they feel free to express their feelings. Doing so reduces the isolation and emotional pain that can affect an individual’s ability to provide sensitive care. Formal support groups for health care providers can not only reduce feelings of isolation but also lead to new ways to cope with the stress of work. In these settings, it is often more important to discuss how the person feels about and responds to difficult situations, and to develop new ways to think about and respond to them, than to discuss in detail the situation itself. Informal discussions are also helpful because they can occur directly after a stressful experience. The goal should be for the person to express feelings, to see things in a new light, and to develop new skills and strategies for coping. Humor is also an effective way of coping with stress.

The health care provider will need to evaluate the effects of stress on his or her life on an ongoing basis. Adequate rest, exercise, and nutrition are important for the promotion of health for the caregiver as well as the patient. Relaxation techniques such as progressive relaxation and breathing exercises can help the stressed professional to detach from stressful situations to address them more effectively. At various times, the health care provider may need to reexamine the stressors and positive factors in his or her life to find balance and positive physical and mental health to continue the important work of caring for patients with HIV/AIDS.

**Discrimination and Human Rights Issues Among Health Workers**

Discrimination against people with HIV may occur at all levels of the community, including to and from health workers. Almost invariably, such discrimination is the result of a lack of education about HIV/AIDS or misperceptions that are also common in the wider community. In a study of an intervention to change health workers’ attitudes and knowledge in Nigeria, Ezedinachi et al. found that health workers (nurses, physicians, laboratory workers) showed less fear of, and more sympathy for and responsibility toward, people with HIV disease. The intervention increased HIV/AIDS knowledge; relevant clinical skills; role modeling; and discussions of appropriate psychosocial, clinical, and human rights issues in treating people with HIV/AIDS. It is apparent that health workers, as members of local communities, may have some of the same community negative attitudes and beliefs until appropriate education and role modeling by senior colleagues and peers occurs. However, after appropriate training, it is apparent that health workers’ views and practices and the health climate regarding HIV/AIDS can change significantly. This change is important from a human rights perspective because ill people have a right to nonjudgmental and professional treatment.

**References**