HIV/AIDS are the worst plague the world is fighting today. No one is immune to HIV. But this is not said that the peril is equal, for some people are greater risk of getting infected by the AIDS virus than others. According to NACO, every minute one Indian gets infected by the killer HIV and every 30 minutes one person died from AIDS disease. In India the infection is gradually spreading from urban to rural areas and from high risk groups to women. HIV associated tuberculosis (TB) remains a major global public health challenge, in worldwide.

HIV is the human immunodeficiency virus. It is the virus that can lead to acquired immune deficiency syndrome, or AIDS. CDC estimates that about 56,000 people in the United States contracted HIV in 2006. There are two types of HIV, HIV-1 and HIV-2. In the United States, unless otherwise noted, the term “HIV” primarily refers to HIV-1. Both types of HIV damage a person’s body by destroying specific blood cells, called CD4+ T cells, which are crucial to helping the body fight diseases. Within a few weeks of being infected with HIV, some people develop flu-like symptoms that last for a week or two, but others have no symptoms at all. People living with HIV may appear and feel healthy for several years. However, even if they feel healthy, HIV is still affecting their bodies. All people with HIV should be seen on a regular basis by a health care provider experienced with treating HIV infection. Many people with HIV, including those who feel
healthy, can benefit greatly from current medications used to treat HIV infection. These medications can limit or slow down the destruction of the immune system, improve the health of people living with HIV, and may reduce their ability to transmit HIV. Untreated early HIV infection is also associated with many diseases including cardiovascular disease, kidney disease, liver disease, and cancer. Support services are also available to many people with HIV. These services can help people cope with their diagnosis, reduce risk behavior, and find needed services.

AIDS is the late stage of HIV infection, when a person’s immune system is severely damaged and has difficulty fighting diseases and certain cancers. Before the development of certain medications, people with HIV could progress to AIDS in just a few years. Currently, people can live much longer - even decades - with HIV before they develop AIDS. This is because of “highly active” combinations of medications that were introduced in the mid 1990s.

No one should become complacent about HIV and AIDS. While current medications can dramatically improve the health of people living with HIV and slow progression from HIV infection to AIDS, existing treatments need to be taken daily for the rest of a person’s life, need to be carefully monitored, and come with costs and potential side effects. At this time, there is no cure for HIV infection. Despite major advances in diagnosing and treating HIV infection, in 2007, 35,962 cases of AIDS were
diagnosed and 14,110 deaths among people living with HIV were reported in the United States.

In India where 90 percent of female infections occur within marriage, women who stand up to their husbands risk violence-and those who get infected by their husbands are often shunned by their families. Lacking other skills, they may survive by selling sex – which of course, spreads the disease further. According to the 2010 report of the Joint United Nations Programme on HIV/AIDS (UNAIDS, 2010) sexual intercourse is the primary mode of HIV transmission in India, accounting for about 90 percent on new HIV infections. More than 90 percent of infected women acquired the virus from their husbands or intimate partners. In most cases, women are at an increased risk not due to their own sexual behavior, but because their partners are IDU’s (Injecting drug users) or also having FSW’S or MSM as other sex partners.

In India the infection is gradually spreading from urban to rural areas and from high risk groups to women who are mostly in monogamous marriages. Newman and Sarin (2006) have shown that having sex exclusively with one’s husband was the only HIV risk factor for the majority of women. The presence of other sexually transmitted infections (STI’s) and inflammation of genital mucosa increase vulnerability to HIV infection in women through heterosexual vaginal intercourse (Fleming et al., 1999). Women are frequently forced to tolerate abuse, violence and infidelity from
their husbands (Soloman et al., 2003). When they engage in sex, their lack of knowledge about their own sexual health ignorance about their regular partner’s and continued culture of silence make them unable to negotiate safer sex practices. The NFHS – 3 (2005-06) found that only 61 percent of women ages 15 to 49 had heard of AIDS, compared with 84 percent with 84 percent of men. Only smaller percentages (20 percent of women and 36 percent of men) had comprehensive and correct knowledge of HIV/AIDS. The prevalence of HIV among ever married women is higher than the national average (NACO, 2010).

Human Immunodeficiency Virus (HIV) infection poses one of the greatest challenges to tuberculosis (TB) control, with tuberculosis killing more people with HIV infection than any other condition.

Tuberculosis is a disease caused by an organism called *mycobacterium tuberculosis*. The mycobacterium tuberculosis bacteria can attack any part of the body, but most commonly attack the lungs. A person can have active or inactive (sometimes called latent) tuberculosis. Active tuberculosis or TB disease means the bacteria are active in the body and immune system is unable to stop them from causing illness. People with active tuberculosis in their lungs can pass the bacteria on to anyone they come into close contact with. When a person with active tuberculosis cough, sneezes or spits, people nearby may breathe in the tuberculosis bacteria and become infected.
Tuberculosis and HIV infection are two major public health problems in many parts of the world, particularly in many developing countries. TB is the most common opportunistic disease and cause of the death for those infected with HIV. Similarly, HIV infection is one of the most important risk factors associated with an increased risk of latent TB co-infection progressing to active TB disease. It is estimated that one third of the 40 million people living with HIV/AIDS worldwide are co-infected with TB. The people who worldwide died of tuberculosis in 2009, it is estimated that 400,000 were infected with HIV. Tuberculosis is the leading cause of death among HIV infected people. The challenge of the TB and HIV co-epidemic has been recognized by World Health Organization, and collaborative TB/HIV actives were launched in 2004 to manage the TB and HIV co-infection.

TB can spread through the air, the increase in active tuberculosis among people infected with both tuberculosis and HIV. More transmission of the tuberculosis bacteria, more people with latent tuberculosis, and more TB disease in the whole population.

People with latent tuberculosis are increasingly becoming infected with HIV, and many more are developing active TB because HIV is weakening their immune system. People who are co-infected with both HIV and latent TB have an up to 50 times greater risk of developing active tuberculosis disease and becoming infectious compared to people not infected with HIV.
People with advanced HIV infection are vulnerable to a wide range of infections and malignancies that are called ‘opportunistic infections’ because they take advantage of the opportunity offered by a weakened immune system. Tuberculosis is an HIV related opportunistic infection. A person that has both HIV and active tuberculosis has an AIDS defining illness.

The HIV/AIDS epidemic is reviving an old problem in well resourced countries and greatly worsening the existing problem of tuberculosis in resource poor countries. There are several important associations between the epidemics of HIV and tuberculosis: Tuberculosis is harder to diagnose in HIV positive people, Tuberculosis progresses faster in HIV infected people, Tuberculosis in HIV positive people is more likely to be fatal if undiagnosed or left untreated and Tuberculosis occurs earlier in the course of HIV infection than other opportunistic infections.

Social Support is one of the most important factors in predicting the physical health and well-being of everyone, ranging from childhood through older. The absence of social support shows some disadvantage among the impacted individuals. In most cases, it can predict the deterioration of physical and mental health among the victims. The initial social support given is also a determining factor in successfully overcoming life stress. The presence of social support significantly predicts the individual’s ability to cope with stress. Knowing that they are valued by others is an important psychological factor in helping them to forger the negative aspects of their lives, and thinking more positively about their environment. Social support
not only helps to improve a person’s well-being, it affects the immune system as well.

Social support is concept that is generally understood in an intuitive sense, as the help from other people in a difficult life situation. One of the first definitions was put forward by (Cobb, 1976). He defined social support as ‘the individual belief that one cared for and loved, esteemed and valued, and belongs to a network of communication and mutual obligations’.

The Oxford dictionary defines support, in part, as to keep from falling or giving way, give courage, confidence, or power of endurance to apply with necessities. What presumably social support from the border concept is that it necessarily involves the presence and products of stable human relationships. The concept of social support has been variously addressed in term of social bonds (Henderson, 1978, 1977; Henderson et al., 1978), social networks (Muller, 1980), meaningful social contacts, availability of confidants (Brown et al., 1975; Levinthal and Haven, 1986; Miller, 1976; human companionship (Lynch, 1877), as well as social support (Cobb, 1976; Dean and Lin, 1977; Murawaski et al., 1978). Although these concepts are hardly identical, they share a focus upon the relevance and significance of human relationship.

Stephen explained that social support is “resources from the environment that can be beneficial to psychological and physical health”. According to Encyclopedia of Psychology (Alan E. Kazclins Chiefed)
“The terms social support refers to the process through which help is provided to others”. This process is influenced by characteristics of the social environment and individual participants, transactions that occur between participations, the resources that are provided, and participant’s perceptions of these transactions and their implications.

Social relationship has a great impact on health education and health behavior. There is no theory adequately explaining the link between social relationship and health. Closely related to health components of social relationship are social integration, social network and social support (Berkman et al., 2000).

Social support refers to the experience being valued, respected, cared about, and loved by others who are present in one’s life (Gurung, 2006). It may come from different sources such as family, friends, teachers, community, or any social groups to which one is affiliated. Social support can come in the form of tangible assistance provided by others when needed which includes appraisal of different situations, effective coping strategies and emotional support.

Anxiety is a physiological response to a real or imagined threat. It is a complex emotional state characterized by a general fear or foreboding usually accompanied by tension. It is related to apprehension and fear and is frequently associated with failure, either real or anticipated. It often has to do with interpersonal relations and social situations. Feelings of rejection
and insecurity are usually a part of anxiety. According to Frost (1971), anxiety is “an uneasiness and feeling of foreboding often found when a person is about to embark on a hazardous venture; it is often accompanied by a strong desire to excel”. Hence, anxiety state arises from faulty adaptations to the stress and strains of life and is caused by over actions in an attempt to meet these difficulties.

Speilberger (1966) has defined anxiety in two terms: trait anxiety and state anxiety. Trait anxiety is a tendency to respond emotionally to a wide range of non-threatening stimuli. It refers to a predisposition to respond with heightened arousal to certain class of stimuli. State anxiety, on the other hand, is the actual feeling of tension and nervousness.

Death anxiety refers to the fear and apprehension of one’s own death. It is the neurotic fear of loss of the self which in intense state parallels feelings of helplessness and depression. Man’s awareness of his own death produces anxiety than can only be dealt which by recognizing one’s individuality. According to Fromm and the existential analysts, man’s awareness of death gives him the responsibility for finding meaning in life. Death is a biological, personal, socio-cultural and existential phenomenon. The biological death is useful to distinguish between the process of aging and the ending called death. Yet when the actual time comes, and the individual faces death alone, the psychological reactions appear to be remarkably similar. Kubler (1969) had found that in the majority of persons,
almost regardless of age, the personal reactions to imminent death pass through five phases – Denial, Anger, Bargaining, Depression and Acceptance (although not every individual achieves the final phase). Dying and death, like other major aspects of human life, are also every important cultural and social phenomenon.

Even less than a century ago, death was a common and familiar event in everyday life. There was no widespread technology to control infection and medicine could not do much for most diseases. Among the poorer classes the young died at an appalling rate, and the old died in their time, and they all died at home. The average person had been in the immediate presence of dead bodies at least half a dozen times before reaching adulthood. Against this background, death was in former years much more a part of life than it is today. It was not a matter to be shunned or a taboo to be mentioned by means of euphemisms such as ‘passed on’ but was dealt with directly and was even elaborated at the wake. It was not unusual in small European towns of a few centuries ago, for someone who was dying to pass their death bed hours in the public square, greeting friends, saying goodbye, and glorying, for at least brief time in a position of respect. Under such circumstances, death was an occasion for sadness but not for shame. No one would have dreamed of hiding away the dying as we do, in the wards of hospitals or in old age homes.

The death can be fully understood only if it is viewed as one of the central meanings of human existence. An idea of the centrality of one’s own
death can be gathered if individuals could be made to contemplate seriously the possibility of their own death (McCarthy, 1980). As death is the final stage of life cycle, it can be approached naturally by dying individuals and their families. Death and dying can be seen as part of the life process, or they can be viewed as a dramatic, painful, tortured experience both for the patients and the families. Increasingly, more research reports are being presented on the nature of death and dying. Research on exactly when death occurs, how the dying should be treated, and how their families might better cope will continue for many years (Lefton, 1982).

In old age, people must confront the possibility of their own death as well as the death of loved ones. Death may also be considered in statistical terms, which supply us with significant figures and facts. Even though death most commonly occurs in later years, it may happen at any stage in life. Accidents and suicides are the major causes of death among younger persons, and continue to be so in later years, although their relative significance declines. Often death is associated with some special psychological stress; it may be acute mourning, or an anniversary, or some particular loss of status or self esteem. Death is sometimes defined as the absence of certain clinically detectable vital signs. A person is dead “if his heart stops beating and he quits breathing for an extended period of time, his blood pressure drops as low as to be unreadable, his pupils dilate, his body temperature begins to go down, and so forth. This clinical definition has been used over the centuries, both by physicians and laymen.
More recently death has sometimes been defined as the lack of brain wave activity. Still others say that death can only be defined as a bodily state which represents an irreversible loss of vital functions and from which the individual cannot possibly be revived. According to the concept of terminal drop, death can be predicted from certain dramatic changes in cognitive function in the period preceding demise. That is, significant changes both in personal adjustment and performance may serve as indicators of impending death (Reigal and Reigel, 1972).

Certain attitudes toward death are typical. Even when approaching death people ask, “why me?” and wish to find a meaning for their suffering. This question cannot be answered in generalized terms because the meaning of life and death vary from one individual to another (Kubler, 1975). The act of dying itself may involve a certain amount of “anticipatory self grief”, grief over the loss of one’s own life— that, fears what it may be to lose one’s self. In addition, fear of dying is often associated with unfounded beliefs that dying itself is quite painful, that one may be abandoned by everyone when dying, that death involves an ultimate aloneness, and “that there may be final medical procedures that will further dehumanize oneself by being turned into a sort of plumbing shop” (Holocomb, 1975). The fear of pain can be relieved by the knowledge of modern pain relieving processes. It can help to know that tough dying is rarely pleasant. It is neither as painful nor as unpleasant as is often feared. Fear of dying involves not only physiological but psychological factors, too. Pain is more easily dealt with than loneliness.
It helps if the patient’s family visits frequently, communicate openly, and gives constant assurance that the dying person will not be abandoned. About two-third of the dying are anxious about separation from their loved ones, they are concerned about how their loved ones will get along after they die. Many also feel that life no longer has any real meaning.

In recent years, psychological well-being has been the focus of intense research attention. Psychological well-being resides with the experience of the individual. It may be defined as the state of feeling health, happy, having satisfaction, relaxation, pleasure and peace of mind. It deals with people’s feeling about everyday experiences in life activities. Such feelings may range from negative mental states or psychological strains, such as anxiety, depression, distress, frustration, emotional exhaustion, unhappiness and dissatisfaction, to a state which has been identified as positive mental health (Shobhna Joshi et al., 2008).

Psychological well-being is a general term denoting feelings of high self-esteem, life satisfaction and lack of negative symptoms. Well-being or positive health can be defined as consisting of those physical, mental and social attributes that the permit the individual to cope successfully with challenges to heal and functioning (Stephens and Antonovsky, 1993). There measures that closely related to the conception of well-being on the psychological dimension are sense coherence, self-esteem and mastery.
Psychological well-being attempts to understand people’s evaluation of their lives. These evaluations may be primarily cognitive (e.g., life satisfaction or marital satisfaction) or may consist of the frequency with which people experience pleasant emotions (e.g., depression). Researchers in this field strive to understand not just undesirable clinical states, but also differences between people in positive levels of long terms of well-being. In social psychology, dimensions of psychological well-being, especially constructs including self-esteem and self-evaluation, are generally defined as function of one’s actual characteristics relative to the characteristics or achievements one would ideally have (Carr, 1999).

Psychological well-being or well-being (these two are used interchangeably) consists of factors like self-esteem, positive effect, satisfaction, wellness, efficiency, social support, somatic symptoms, personal control and the like. The well-being is a constituent of quality of life which a conceptualized as a composite of physical, psychological social well-being of individuals, as perceived by the person and the group. An important aspect is happiness, satisfaction and gratification subjectively experienced which is often called subjective well-being or psychological well-being. Thus, well-being is based on subjective experience instead of objective life condition, it has both positive and negative affects and it is global experience (Okum and Stock, 1987).

Quality of life is multidimensional concept, which includes specific core domains including physical, psychological, social and occupational
well-being, physical pain, mobility, sleep appetite and nausea; sexual functions; personal social and sexual relationship; engagement in social and leisure activates; occupation ability and desire to carry out paid employment, ability to cope with house whole duties, etc., all constitutes the contributory factors.

Psychological well-being represents a proactive stance toward emotional health. Well-being refers to a person’s ability to cope with events in daily life function, responsibility in society and experience personal satisfaction. Mental health has several dimensions, each of which contributes to people overall health and well-being (Kisku Kiran K., 2001).

According to Hettler (1980) wellness encompasses of six dimensions namely social, occupational, spiritual, physical, intellectual and emotional. A health individual needs a good physical and psychological well-being. Psychological well-being is directly or indirectly affected by many psychological factors among which self-esteem and emotional maturity are vital importance of the several problems facing the entire life span, the problems of the transition phase starting from late adolescent to early adulthood is a crucial one for the development of the individual. When coped up, it leads to successful achievement of the developmental tasks in the present and future.

Ryff (1989) explored the construct of well-being extensively in the light of various measures, i.e., autonomy environmental mastery, personal
growth, positive relations with others, purpose in life, self-acceptance, family bonding etc.

Bhogale and Jayaprakash (1993) found satisfaction variables to be closely related to well-being while distress and meaningless represented a negative aspect or ill-being. Thus, PWS is a component both positive and negative. The factors like satisfaction, positive effect, social support and several others clearly reveal the multidimensionality of psychological well-being.