HIV Disease: “Facts and Controversies in India”

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Abstract Human Immunodeficiency Virus (HIV) disease pose a significant health hazard in developing countries like India which is carrying pressure of world second most population burden. Both visible and covert factors dominate in the failure of control of this disease. But despite that intensified efforts are needed to surmount this hurdle of misery and debility.

Keywords Human Immunodeficiency Virus, Epidemiology, Stigma of AIDS, India

According to UNAIDS, in 2009, 2.5 million (2.3-2.8 million) were new infection and 2 million (1.6-2.1 million) people died due to AIDS related death worldwide.[5] This exponential growth rate of HIV/AIDS in recent year led to increased number of HIV/AIDS cases. Hence, more awareness about this disease is required to start early preventive and treatment measures. HIV infection leading to acquired immunodeficiency syndrome (AIDS) is probably the most compelling issue to address, for its economic, cultural and social impact in population worldwide.[6]

1. Overgrowing Problem: the Interminable Culprit

Since the detection of first case of Human Immunodeficiency Virus (HIV) disease in USA in 1981, HIV has spread all over the world. Recent data [1] from UNAIDS states that around 33.3 million (31.4-35.3 million) people are infected with HIV worldwide. Of this number, it is estimated that around 2.4 million people are currently living with HIV infection in India[2]. Infection rates soared throughout the 1990s, and today the epidemic affects all sectors of Indian society, not just the high risk groups – such as sex workers and truck drivers – with which it was originally associated [3]. Acquired immunodeficiency syndrome (AIDS) / HIV disease is a pandemic with an increased global prevalence. Human immunodeficiency virus (HIV) has reached an important threshold in India. India has the world's fourth largest population suffering from AIDS. The provisionally estimated number of people living with HIV in India is 2,390,000, with an estimated adult HIV prevalence of 0.31% in 2009 [4]. HIV/AIDS is concentrated among high-risk group populations and is heterogeneous in its spread. The primary drivers of HIV epidemic in India are unprotected paid sex, unprotected sex between men and injecting drug use. Heterosexual route of transmission accounts for 87% of the HIV cases detected.[4] In the north-eastern part of the country, however, injecting drug use is the major cause for the epidemic spread; sexual transmission comes next. Over the years, the HIV/AIDS epidemic has moved from urban to rural India and from high-risk to general population, largely affecting youth.

2. Rigid Conceptions and Covert Rationale of Spilling Problem

Stigma due to AIDS exists around the world in a variety of ways, including ostracism, rejection, discrimination and avoidance of HIV infected people. Often, AIDS stigma is expressed in conjunction with one or more other stigmas, particularly those associated with homosexuality, bisexuality, promiscuity, and intravenous drug use. There is an association between AIDS and homosexuality or bisexuality, and this association is correlated with higher levels of sexual prejudice such as anti-homosexual attitudes. There is also a perceived association between AIDS and all male-male sexual behavior including sex between uninfected men.[7]

The topic of religion and AIDS has become highly controversial in the past twenty years, primarily because many prominent religious leaders have publicly declared their repulsion to the use of condoms, which scientists feel is currently the only means of stopping the epidemic. However, there is a growing openness to faith-based methods due to the failure rates associated with condoms. Other issues involved religious participation in global health care services and collaboration with secular organizations such as UNAIDS and the World Health Organization. The religious approach to prevent the spread of AIDS according to a report by American health expert Matthew Hanley titled 'The Catholic Church and the Global Aids Crisis' argues that the cultural changes are needed including a re-emphasis on fidelity within marriage and sexual abstinence outside of it.[8] Fear, ignorance and discrimination regarding HIV continue to exact profound human costs, including in the worst forms – abusive treatment and violence. Negative attitudes and

beliefs within communities can also increase internalized self-stigma, including guilt, shame and alienation felt by people living with HIV. The persistence of stigma and discrimination also undermines efforts to deliver essential HIV prevention and treatment services. Little progress has been made in reforming laws that discriminate against people living with HIV and other key populations at higher risk. HIV-related restrictions on entry, stay and residence impose severe burdens on people living with HIV and their households. As well as adding to the suffering of people living with HIV, this discrimination is hindering efforts to prevent new infections. While such strong reactions to HIV and AIDS exist, it is difficult to educate people about how they can avoid infection. AIDS outreach workers and peer-educators have reported harassment, and in schools, teachers sometimes face negative reactions from the parents of children when they teach about AIDS and sex education.

HIV continues to profoundly affect women and girls across all regions. Women are most severely affected by HIV and bear the greatest burden of care. The lower socioeconomic and political status women are assigned, including unequal access to education and employment, and fear or experience of violence compound women's greater physiological vulnerability to HIV. Because of social and economic power imbalances between men and women and the associated limitations in access to services, many women and girls have little capacity to negotiate sex, insist on condom use or otherwise take steps to protect themselves from HIV. Gender norms also increase men's vulnerability to HIV, encouraging high-risk behavior and deterring them from seeking sexual health services or acknowledging their lack of knowledge about HIV. In addition, stigma and discrimination against transgender people render them highly vulnerable to HIV and impede their access to HIV service and secure livelihoods.

HIV and AIDS affect economic growth by reducing the availability of human capital. Without proper nutrition, health care and medicine that is unavailable in developing countries, large numbers of people suffer and die from AIDS-related complications. They will not only be unable to work, but will also require significant medical care. The forecast is that this will probably cause a collapse of economies and societies in countries with a significant AIDS population.[7]

In India, as elsewhere, AIDS is often seen as "someone else's problem" – as something that affects people living on the margins of society, whose lifestyles are considered immoral. Even as it moves into the general population, the HIV epidemic is still misunderstood among the Indian public. People living with HIV have faced violent attacks, been rejected by families, spouses and communities, been refused medical treatment, and even, in some reported cases, denied the last rites before they died.

3. Objective Consensus is Mandatory

Behavior change programmes seek to promote safer

individual behaviour as well as changes in social norms that generate healthier patterns of sexual behavior. Behavior change is complex; it involves knowledge, motivations and choices which are influenced by socio-cultural norms, as well as risk assessment in relation to immediate benefits and future consequences. It involves both rational decision making and impulsive and automatic behavior [9]. HIV behavior change programmes have largely been measured against the outcomes of reduction in the number of young people initiating sexual intercourse early and the number of sexual partners and increase in the correct and consistent use of condoms among people who are sexually active. Education plays important role in stopping HIV epidemic and discrimination. Shaking hands or having dinner et al. with HIV-infected people is fine and such messages should be given to every nick of community.

Intensified efforts are needed to improve treatment coverage among children, especially those who are youngest and most vulnerable, and to reach more men earlier with HIV testing and treatment services in high-prevalence settings. Health systems need to be more responsive to the needs of vulnerable populations. Health reporting systems need to be strengthened to monitor treatment retention by age and sex. Finally, greater efforts are needed to speed the next phase of HIV treatment by accelerating implementation research and heeding the lessons learned in different parts of the world.

HIV was first identified in India in 1986, in Chennai, shortly after the Indian Council of Medical Research (ICMR) initiated surveillance for HIV. Surveillance was later taken over by the National AIDS Control Organisation (NACO), set up under the Ministry of Health and Family Welfare. The National AIDS Research Institute (NARI) was established in the early 1990s. Currently, research on HIV/AIDS is conducted in various ICMR institutions, other research institutes, medical colleges, hospitals, voluntary organisations and also in public sector agencies. Various pilot projects have been undertaken in the indigenous systems of medicine and homoeopathy in different places in India. Ayurveda and Siddha products have shown encouraging results and extensive studies are needed to further validate these findings. In India, the first vaccine trial was initiated at NARI Pune, in 2005 and was completed in January 2007. This was a Phase I study of the Adeno Associated Virus (AAV) based HIV-1 subtype C vaccine. In this study, the safety and the ability of the vaccine to evoke an immune response (immunogenicity) were studied in healthy volunteers.

Funding for research in India comes from national sources like the ICMR, NACO, the Department of Biotechnology, and the Department of Science and Technology; from international agencies such as WHO, USAID, UNAIDS, the National Institutes of Health in the USA, the UK Medical Research Council, the UK Department for International Development, Indo-French collaborations, and from international foundations such as the International AIDS Vaccine Initiative, Gates Foundation and the Clinton Foundation.

Low- and middle-income countries like India, however, have had limited progress in slowing the spread of HIV among people who inject drugs. Nevertheless, transmission can be reduced substantially. Such countries as Australia and the United Kingdom that have implemented evidence-informed HIV prevention strategies have sharply reduced the number of people who inject drugs who acquire HIV infection, with some approaching the elimination of drug-related transmission.

As the reach of AIDS programmes has expanded, so too have opportunities to integrate HIV into broader health efforts, and the resulting systems are proving greater than the sum of their parts. Opportunities to multiply beneficial outcomes through joint approaches with AIDS initiatives exist across the range of social and economic development programmes. . Indicators for integrated approaches – and the integration of existing monitoring systems in different sectoral platforms – need to be developed, allowing regular reporting to track progress in integration.

There are less number of studies available worldwide and particularly in India to know the epidemiological and social factors responsible for late approach to HIV diagnosis and treatment services and factors responsible for admissions with HIV related and unrelated co-morbidities.

The final deduction about this perpetual crisis of HIV disease from the above discussion is that despite the glaring deficits in AIDS awareness a need for call of action is required. Though the magnitude and seriousness of the HIV disease is enormous still we have to stand tall to fight not only with this insurmountable virus but also with our own selves.

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