



HIV/AIDS IN INDIAN SCENARIO

Aribam Rebecca Sharma*

Dr. R. Lakshmi**

**Ph.D Research Scholar, Annamalai University, Chidambaram.*

*** Professor, Department of Sociology, Annamalai University, Chidambaram.*

Abstract

The HIV epidemic is multifaceted and diverse. It is driven by population groups that practice risky behaviours, such as unsafe sex and sharing of infected syringes and needles among People with Intravenous drug used. Various individual and societal factors influence risk-taking behaviours. In Asia, India alone accounts for 60% of HIV burden. The HIV/AIDS epidemic in India is more than two decades old. Ignorance about the disease, consequent denial for testing and treatment, contribute to spread of the disease. The disease status adds to vulnerability especially in women. Social responses to HIV/AIDS determined the underlining barrier which constitute in the absence of an effective medical intervention. The present study is an effort to explore and understand the various dimensions of HIV/AIDS in global, Asia and India level.

Keywords: *Human Immune Deficiency Virus, Acquired Immune Deficiency Syndrome, Anti-Retroviral Treatment, Intravenous Drug Users Antiretroviral Drugs, Antenatal Care.*

Introduction

Health is considered a fundamental human right and a worldwide social goal. A healthy person is an asset to any society. However, the illness caused by HIV and its possible fatal consequences is considered not only a medical but also a social issue. The human immunodeficiency virus (HIV) is the causative agent of acquired immunodeficiency syndrome. Acquired immunodeficiency syndrome (AIDS) is the final and fatal stage of infection with the human immunodeficiency virus.

HIV/AIDS epidemic is a complex and multidimensional phenomenon that has become an issue among underdeveloped and developing countries. This epidemic emerged in the early 1980s creating unprecedented challenges to human society in various dimensions of human life (Arunkumar & Rajeev, 2009). According to the Global HIV/AIDS epidemic report 2015, there are approximately 36.7 million people currently living with HIV and millions of people have died of AIDS-related causes since the beginning of the epidemic (World Health Organization, 2016). In the absence of cure or vaccine, the enormous number of debilitating illnesses and deaths that will be caused by the rapid spread of HIV in South-east and South Asia, particularly in India, is a major developmental problem with far-reaching impact beyond the health sector.

In present scenario, the total number of People Living with HIV (PLHIV) in India is estimated at 21.17 lakhs in 2015 compared with 22.26 lakhs in 2007. National AIDS Control Organisation (NACO) reported that in India, children (<15 years) and women account for 6.54% and 40.5% of total HIV infections. The report further revealed that the virus is prevalent among 0.26% (0.22% –0.32%) of the country's adults (15–49 years), 0.30% among males and at 0.22% among females.

Definition

World Health Organization (WHO, 2016) has defined HIV as the Human Immuno Deficient Virus (HIV) which infects cells of the immune system, destroying or impairing their function. The infection which the results in progressive deterioration of the immune system, lead to “immune deficiency.” The immune system is considered deficient when it can no longer fulfill its role of fighting infections and diseases. Infections associated with severe immunodeficiency are known as “opportunistic infections”, because they take advantage of a weakened immune system. Acquired immunodeficiency syndrome (AIDS) is a term which applies to the most advanced stages of HIV infection.

The specific objectives of the study are as follows:

- To study the various dimensions of HIV/AIDS in India;
- To analyse the causes of HIV/AIDS infection in India;
- To study various welfare services provided to People living with HIV/AIDS by government.

HIV/AIDS in Global Level

AIDS was first reported among homosexual men in San Francisco, United States, in 1981. The diagnosis was based on signs and symptoms, as no laboratory test was available to confirm the infection. The causative agent, the HIV, was identified in 1983. The first laboratory test to detect antibodies against HIV became available in 1985. During the 1980s and 1990s, the epidemic spread rapidly across the world (Jai, 2012) While new cases have been reported in all regions of the world, approximately two-thirds are in sub-Saharan Africa, with 46% of new cases in Eastern and Southern Africa.



Analysis of data available to UNAIDS suggests that more than 90% of new HIV infections in central Asia, Europe, North America, the Middle East and North Africa in 2014 were among people from key populations and their sexual partners.

In South Africa, surveillance data published in 2015 estimated HIV prevalence among sex workers was 71.8% in Johannesburg, 39.7% in Cape Town and 53.5% in Durban.

The distribution of new HIV infections among key populations varies by region. People who inject drugs accounted for 51% of HIV infections in eastern Europe and central Asia and 13% of new HIV infections in Asia and the Pacific in 2014. Gay men and other men who have sex with men accounted for 30% of new HIV infections in Latin America, 49% of new infections in western and central Europe and North America and 18% of new infections in Asia and the Pacific.

Even though New HIV infections globally have declined by 35% since 2000 in 61 countries, new HIV infections have decreased by more than 20% (UNAIDS, 2006). 1.1 million people died of AIDS in 2015, a 45% decrease since its peak in 2005. Deaths have declined due in part to antiretroviral treatment (ART) scale-up.

Most infections are transmitted heterosexually, although risk factors vary. In some countries, men who have sex with men, injecting drug users, sex workers, transgender people, and prisoners are disproportionately affected by HIV. Although HIV testing capacity has increased over time, enabling more people to learn their HIV status, about 4 in 10 of people with HIV are still unaware they are infected.

Women represent approximately half (51%) of all adults living with HIV worldwide. HIV is the leading cause of death among women of reproductive age. Gender inequalities, differential access to service, and sexual violence increase women's vulnerability to HIV, and women, especially younger women, are biologically more susceptible to HIV (UNAIDS, 2015).

HIV/AIDS in Asian Region

In the Asia and the Pacific region, currently, there are 5.1 million [4.4 million–5.9 million] people living with HIV in the year 2015. There were an estimated 300 000 new HIV infections in the region (Regional Statistics - 2015). New HIV infections declined by 5% between 2010 and 2015. While 180 000 people died of AIDS-related causes in 2015, between 2010 and 2015 the number of AIDS-related deaths in the region decreased by 24%. Treatment coverage was 41% [35–47%] of all people living with HIV. An estimated, 3 million adults did not have access to antiretroviral therapy. There were 19 000 new HIV infections among children in this region which have declined by 26% since 2015 (UNAIDS, 2015).

HIV/AIDS in Indian Region

In 1986, the first known case of HIV was diagnosed by Dr. Suniti Solomon amongst female sex workers in Chennai, Tamil Nadu. Later that year, sex workers began showing signs of this deadly disease. By 1987, about 135 more cases came to light. Prevalence in high-risk groups reached above 5% by 1990. As per UNDP's 2010 report, India had 2.395 million people living with HIV at the end of 2009, up from 2.27 million in 2008.

To control the spread of the virus, the Indian government set up the National AIDS Control Programme (NACP) in 1987. In 1992, the government set up the National AIDS Control Organisation (NACO) to oversee policies and prevention and control programmes relating to HIV/ AIDS and NACP for HIV prevention. The State AIDS Control Societies (SACS) was set up in 25 societies and 7 union territories to improve blood safety.

Currently, the NACP-IV (2012-2017) is midway through implementation. It focuses on consolidating the gains made during NACP-III and aims to accelerate the process of reversal of the HIV epidemic. The key strategies under NACP-IV includes intensifying and consolidating prevention services with a focus on HRG and vulnerable population, increasing access and promoting comprehensive care, support and treatment, expanding IEC services for general population and high risk groups with a focus on behaviour change and demand generation, building capacities at national, state and district levels and strengthening the Strategic Information Management System. Prevention and Care, Support and Treatment (CST) form the two key pillars of all HIV/AIDS control efforts in India.

The package of services provided under NACP-IV includes

a) Prevention Services

- Targeted Interventions (TI) for High Risk Groups and Bridge Population, Female Sex Workers (FSW), Men who have Sex with Men (MSM), Transgenders/Hijras, Injecting Drug Users (IDU), Truckers and Migrants;
- Needle-Syringe Exchange Programme (NSEP) and Opioid Substitution Therapy (OST) for IDUs;

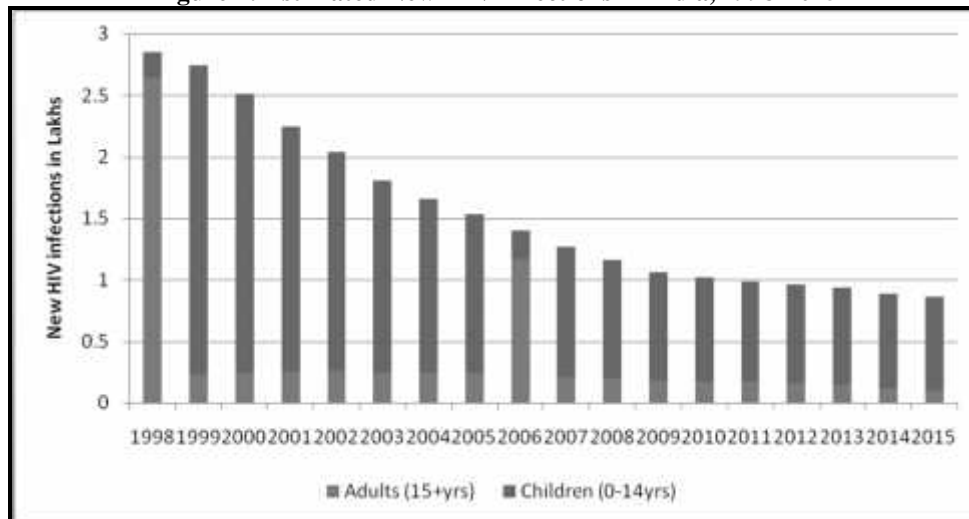


- Prevention Interventions for Migrant population at source, transit and destinations;
- Link Worker Scheme (LWS) for High Risk Groups and vulnerable population in rural areas;
- Prevention and Control of Sexually Transmitted Infections/Reproductive Tract Infections (STI/RTI);
- Blood Transfusion Services;
- HIV Counselling and Testing Services;
- Prevention of Parent to Child Transmission;
- Condom promotion;
- Information, Education and Communication (IEC) and Behaviour Change Communication (BCC)-Mass Media Campaigns through Radio and TV, Mid-media campaigns through Folk Media, display panels, banners, wall writings etc., special campaigns through music and sports, flagship programmes, such as Red Ribbon Express;
- Social Mobilization, Youth Interventions and Adolescence Education Programme;
- Mainstreaming HIV/AIDS response and
- Work Place Interventions.

b) Care, Support and Treatment Services

- Laboratory services for CD4 Testing, Viral Load testing, Early Infant Diagnosis of HIV in infants and children up to 18 months age and confirmatory diagnosis of HIV-2;
- Anti-Retroviral Treatment* (ART) through ART Centres and link ART Centres, Centres of Excellence and ART Centers, Centres of Excellence and ART plus centers;
- Pediatric ART for children;
- Nutritional and psycho-social support through community and support centres;
- HIV-TB coordination (Cross-referral, detection and treatment of co-infections) and Treatment of Opportunistic Infections.

Figure 1: Estimated New HIV Infections in India, 1998-2015



(Source: National AIDS Control Organisation, 2015)

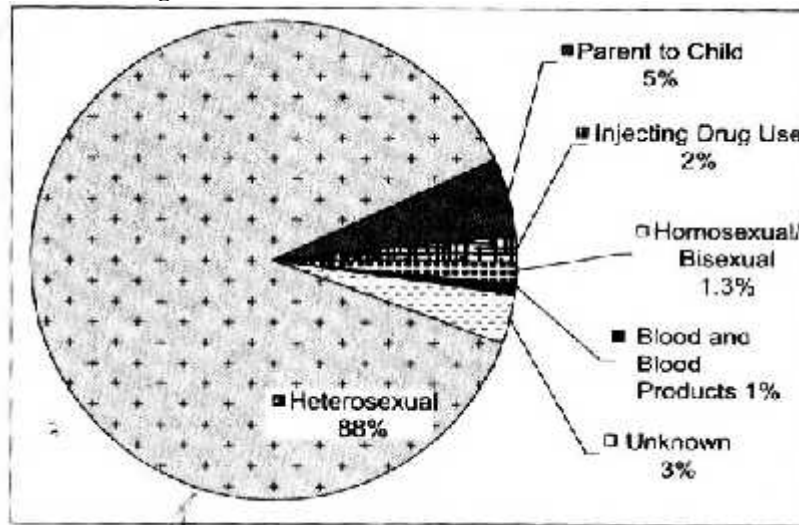
India is estimated to have around 86 (56-129) thousand new HIV infections in 2015, showing 66% decline in new infections from 2000 and 32% decline from 2007, the year set as baseline in the NACP-4. Children (<15 years) accounted for 12% (10.4 thousand) of total new infections while the remaining were among adults (15+ years).

*ART are medications that treat HIV. The drugs do not kill or cure the virus. However, when taken in combination they can prevent the growth of the virus.

Andhra Pradesh and Telangana, Bihar, Gujarat and Uttar Pradesh currently account for 47% of total new infections among adults with each of these States contributing seven thousand five hundred or more new infections in 2015.



Figure 2: HIV Transmission Routes in India



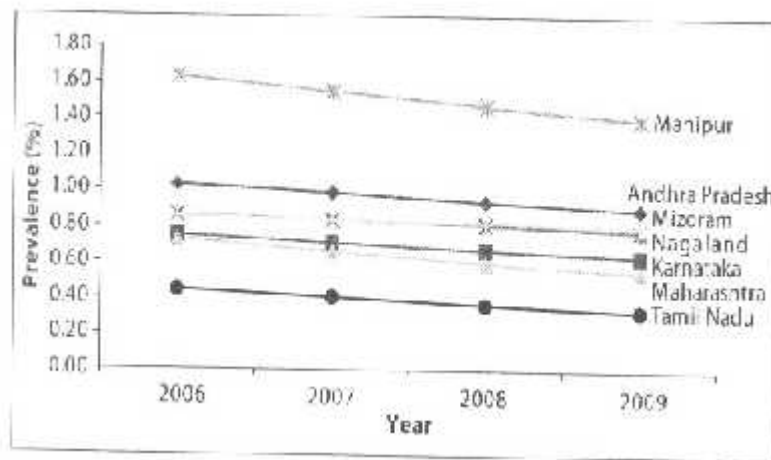
(Source: National AIDS Control Organisation, 2011)

In India, the majority of HIV infections are transmitted heterosexually, followed by parent-to-child transmission. Injecting drug use is the predominant route of transmission in the northern-eastern states, although overall it accounts for a small proportion of transmissions. It also varies by geographical area and specific population groups. Currently, there is no single Indian HIV epidemic; rather, there is a multitude of diverse epidemics in various geographical landscape of India.

Heterogeneity of the Epidemic in India

Almost 55% of the HIV burden in India is concentrated in the four southern states of Andhra Pradesh, Maharashtra, Karnataka and Tamil Nadu. West Bengal, Gujarat, Bihar and Uttar Pradesh account for about 22% of the burden. The low-prevalence states of Punjab, Orissa, Rajasthan and Madhya Pradesh, due to their large population sizes, together account for another 12% of the burden.

Figure 3: Trends of HIV Prevalence in Historically High-prevalence States

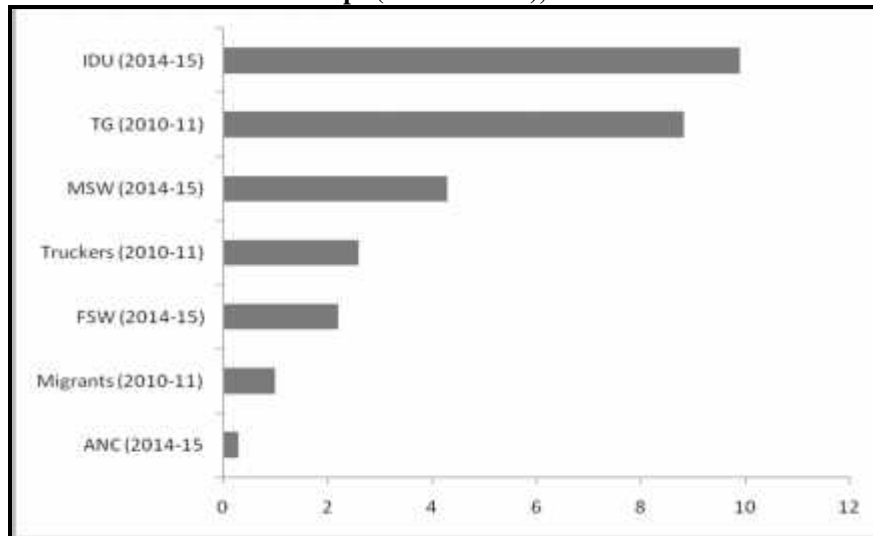


(Source: National AIDS Control Organisation, 2011)

There is heterogeneity in HIV prevalence across various states as well. Manipur has the highest estimated adult HIV prevalence of 1.4%, followed by Andhra Pradesh (0.9%), Mizoram (0.81%), Nagaland (0.78%), Karnataka (0.63%) and Maharashtra (0.55%). Besides these states, Goa, Chandigarh, Gujarat, Punjab and Tamil Nadu have an estimated adult HIV prevalence that is higher than the national average (0.31%). The remaining states and union territories have prevalence levels that are lower than the national average.



Figure 4: HIV Prevalence Among ANC Client (HSS 2014-15), FSW, MSM, IDU (IBBS 2014-2015) And Other Risk Groups (HSS 2010-11), India



(Source: National AIDS Control Organisation, 2010-2015)

India continues to portray a concentrated epidemic. HIV prevalence among different risk groups is given in the figure. National Integrated Behavioural and Biological Surveillance (IBBS) has estimated HIV prevalence among Female Sex Workers (FSWs), nationally, level at 2.2% (95% CI: 1.8 – 2.6). HIV Prevalence among MSM recorded at the national level was 4.3% (95% CI: 3.7 – 5.1) while among IDU, the prevalence of HIV recorded among IDU at the national level was 9.9% (95% CI: 9.0 – 10.9).

The following are the various recommendations to improve the overall HIV scenario at India level.

Recommendations

- The wide gap in the coverage of HIV care and treatment services also needs to be addressed with good planning, provision of integrated services and good management and monitoring.
- Expansion of counselling and testing services to all 24/7 primary health-care facilities.
- The HIV testing, care and support component of the programme needs to be expanded further to ensure universal coverage. Time has come to integrate the Government and non-government organisation with the existing health-care delivery system to sustain an effective response to this epidemic at all levels.
- Improving Access to Antiretroviral drugs (ARVs) by extending across various levels of health care system, linking facilities such as hospitals at the state and district levels with health centres as well as families in their homes through supportive community networks.
- Providing education and increasing access to clean syringes and needles and to drug dependence treatment can reduce the risk of infection among people who inject drugs.
- Administering antiretroviral (ARVs) and advising women on exclusive breastfeeding can substantially reduce Mother-to-child-transmission (MTCT).
- Education programmes must be promoted with improved availability and accessibility of condoms use, and most importantly, the creation of positive social environment without discrimination and stigma to encourage appropriate behaviour change.

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