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Socio-Economic Conditions of the HIV Infected Male Patients: A Case Study in Rims Y.S.R. Kadapa

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Abstract:
The Indian epidemic is concentrated among vulnerable populations at high risk for HIV. The concentrated epidemics are driven by unprotected sex between sex workers and their clients and by injecting drug use with contaminated injecting equipment. In India, sexual transmission is responsible for 87.4 per cent of the reported HIV cases and HIV prevalence is high among sex workers (both male and female) and their clients. A large proportion of women with HIV appear to have acquired the virus from their regular partner who was infected during paid sex. Overall HIV prevention efforts targeted at sex workers are increasing in India. However, the context of sex work is complex and enforcement of outdated laws often acts as a barrier against effective HIV prevention and treatment efforts. In 1991, the Government of India and the World Bank expanded their collaboration on infectious disease control programmes and by 1992 the first National AIDS Control Project was launched with a World Bank credit of US$84 million. At the end of 2011, an estimated 34 million people were living with HIV worldwide, with two-thirds of them living in sub-Saharan Africa. This reflects the continued large number of new HIV infections and a significant expansion of access to antiretroviral therapy, which has helped reduce AIDS-related deaths, especially in more recent years. The number of people dying of AIDS-related causes fell to 1.7 million in 2011, down from a peak of 2.2 million in the mid-2000s; in 2012 alone 700,000 AIDS related deaths were averted.

1. Introduction

The Government of India estimates that about 2.40 million Indians are living with HIV (1.93 -3. 04 million) with an adult prevalence of 0.31 per cent (2009). Children (<15 years) account for 3.5 per cent of all the infections, while 83 per cent are the in the age group 15-49 years. Of all HIV infections, 39 per cent (930,000) are women. India's highly heterogeneous epidemic is largely concentrated in only a few states in the industrialized south and west and in the north-east. The four high prevalence states of South India (Andhra Pradesh-500, 000, Maharashtra-420, 000, Karnataka-250, 000, and Tamil Nadu- 150,000) account for 55 per cent of all HIV infections in the country. West Bengal, Gujarat, Bihar and Uttar Pradesh are estimated to have more than 100,000 PLHA each and together accounting for another 22 per cent of HIV infections in India.

The Indian epidemic is concentrated among vulnerable populations at high risk for HIV. The concentrated epidemics are driven by unprotected sex between sex workers and their clients and by injecting drug use with contaminated injecting equipment. Several of the most at risk groups have high and still rising HIV prevalence rates. According to India's National AIDS Control Organization, the bulk of HIV infections in India occur during unprotected heterosexual intercourse. Consequently, and as the epidemic has matured, women account for a growing proportion of people living with HIV, especially in rural areas. The low rate of multiple partner concurrent sexual relationships among the wider community seems to have, so far, protected the larger body of people.

2. Risky Sex and Low Condom Use

In India, sexual transmission is responsible for 87.4 percent of the reported HIV cases and HIV prevalence is high among sex workers (both male and female) and their clients. A large proportion of women with HIV appear to have acquired the virus from their regular partner who was infected during paid sex. Overall HIV prevention efforts targeted at sex workers are increasing in India. However, the context of sex work is complex and enforcement of outdated laws often acts as a barrier against effective HIV prevention and treatment efforts. Although recent data suggest an increase in condom use, in many places, condom use is still limited, especially where commercial encounters take place in 'risky' locations with low police tolerance for this activity. In addition, interventions tend to primarily target brothel-based sex workers, who represent a minority of sex workers. HIV information and awareness among sex workers appears to be low, especially among those working in the streets. Some prevention programs run by sex workers'.

3. Men Sex with Men (MSM)
Relatively little is known about the role of sex between men in India's HIV epidemic, but the few studies that have examined this subject have found that a significant proportion of men in India do have sex with other men. As per the recent data of HSS 2010-11, Chhattisgarh (15 per cent), Nagaland (13.58 per cent) and Maharashtra (13 per cent) have the highest HIV prevalence among MSM. Poor knowledge of HIV has been found in groups of MSM. The extent and effectiveness of India's efforts to increase safe sex practices between MSM (and their other sex partners) will play a significant role in determining the scale and development of India's HIV epidemic.

4. Injecting Drug Use (IDU)
Injecting drugs with tainted injecting tackle is the main risk factor for HIV infection in the north-east (especially in the states of Manipur, Mizoram and Nagaland), and features increasingly in the epidemics of major cities elsewhere, including in Chennai, Mumbai and New Delhi (MAP, 2005; NACO, 2005) and in the state of Punjab. Products injected include legal pharmaceuticals (e.g. buprenorphine, pentazocine and diazepam), in addition to heroin. Current interventions targeting IDU tend to be inconsistent and too small and few and far between to yield demonstrable results. Comprehensive harm reduction programmes, including clean needle and syringe exchange and upload substitution therapy (OST) needs to be extended and expanded as a matter of urgency in those parts of India with serious drug injecting-related HIV epidemics.

5. Relocation and Mobility
Migration for work takes people away from the social environment of their families and community. This can lead to an increased likelihood to engage in risky behaviour. Concerted efforts are needed to address the vulnerabilities of the large migrant population. Furthermore, high quantities of female sex workers in India are mobile. The mobility of sex workers is likely a major factor contributing to HIV transmission by connecting high-risk sexual networks.

6. Widespread Stigma
Stigma towards people living with HIV is widespread. The misconception that AIDS only affects men who have sex with men, sex workers and injecting drug users strengthens and perpetuates existing taste. The most affected groups, often marginalized, have little or no access to legal protection of their basic human rights. Addressing the issue of human rights violations and creating an enabling environment that increases knowledge and encourages behaviour change are thus tremendously important to the fight against AIDS.

7. Stigma and Inequity
Stigma and discrimination against people living with HIV and AIDS and those considered to be at high risk remain entrenched. Stigma and denial undermine efforts to increase the coverage of effective interventions among key populations such as men having sex with men, sex workers and their partners and injecting drug users. Harassment by police and ostracism by family and community drives the epidemic underground and decreases the reach and effectiveness of prevention efforts. Though there is significant increase in awareness due to efforts by the government, there is much room for improvement, including scaling up to stigma reduction innovations, piloted by communities at risk.

8. Targeted Interventions for Most at Risk Populations
Although India is increasing the coverage of targeted interventions for the most at risk populations, it will be critical to sustain these efforts and expand more rapidly in those areas and among those population groups, which are lagging behind and hard to reach. Most importantly, comprehensive harm reduction programs among injecting drug users, and safe sex among men having sex with men.

9. World Bank Response
In 1991, the Government of India and the World Bank expanded their collaboration on infectious disease control programmes and by 1992 the first National AIDS Control Project was launched with a World Bank credit of US$84 million. The project helped the government to broaden prevention efforts and to establish institutions and procedures necessary to curb the spread of HIV. Building upon lessons learned from the first project, India requested World Bank financing for a follow-on project. With a World Bank credit of US$191 million, the Second National HIV/AIDS Control Project was started. The use of State AIDS Control Societies to speed the distribution of funds at the state level helped increase the pace of implementation. In 2006-07, the Bank worked closely with the Government of India and other donors on the preparation of the third National HIV/AIDS Control Project (US$ 250 million) which was launched in July, 2007. The mid-term review of NACP 3 in December 2009, showed encouraging progress towards the national goals of curbing the epidemic and preventing new infections. NACP 3 coordinates all donor and NGO activities within the scope of the country's national program on AIDS control -in consonance with the Three Ones. It aims for higher coverage of key populations at risk of HIV infection (NACP 2 covered 10-60 per cent of key populations, NACP 3 envisages to cover 80 per cent). The NACP 3 also clearly differentiates activities that must be delivered through general health services and places responsibility on those relevant government health programs. It will also further support CBOs to deliver about half of all interventions targeting the most at risk groups.
Moving forward with the preparation for the fourth phase of the national response, (2012–2017), the Government of India is mobilizing domestic financial support (more than 80 percent of program cost) and seeking sustained support from development partners, as well as the Bank. The Bank has been asked by the Department of Economic Affairs to support the fourth phase of the

programme as it aims to accelerate reversal of trends and integrate the programme with other health programmes and increase convergence with other health services over the next programme phase. The national program will continue to innovate and generate lessons from its innovative performance administration system. World Bank will continue to support the programme in NACP IV (US$250 million) with a focus on targeted interventions and institutional strengthening.

At the end of 2011, an estimated 34 million people were living with HIV worldwide, with two-thirds of them living in sub-Saharan Africa. This reflects the continued large number of new HIV infections and a significant expansion of access to antiretroviral therapy, which has helped reduce AIDS-related deaths, especially in more recent years. The number of people dying of AIDS-related causes fell to 1.7 million in 2011, down from a peak of 2.2 million in the mid-2000s; in 2012 alone 700,000 AIDS related deaths were averted.

10. HIV Treatment

It is estimated that at least 8 million people in low- and middle-income countries are currently receiving HIV treatment, reflecting an increase of 63 percent from 2009 to 2011. Ten low- and middle-income countries (including Cambodia, Rwanda, Swaziland, Zambia and Namibia) have achieved universal access, defined as extending coverage to at least 80 percent of those in need of treatment. Worldwide, there were more than 500,000 fewer deaths in 2011 than there were in 2005, and the number of AIDS-related deaths declined by nearly one-third during that time. International efforts as channelled through the Global Fund have been critical; by end 2012 Global Fund-supported programs had provided 1.7million HIV-positive pregnant women with treatment to prevent transmission to their children, 250 million HIV testing and counseling sessions, the purchase and distribution of 4.2 billion condoms, and more than 19 million basic care and support services have been provided.

11. Challenges to Reversing the Spread of HIV

Thirty years after AIDS was first reported, HIV continues to spread. Existing prevention efforts, although civilizing, are often insufficiently wide-ranging or inadequately tailored to local epidemics. Epidemiological surveillance systems at the country level also need to be strengthened, particularly where there are key populations at higher risk of HIV infection. For example, studies in Eastern Europe and Central Asia show that many people who inject drugs actively avoid seeking health services due to the risk of ostracism or fears that their health providers will report them to law enforcement authorities. Such obstacles limit individuals' access to basic health services as well as treatment for HIV. Greater political commitment to implementing evidence-informed programs is also needed if progress is to be made in achieving the Millennium Development Goals.

12. HIV and Human Rights

The Global Fund is committed for fighting for the rights of people directly or indirectly affected by HIV and AIDS through the programs it supports. It works to ensure that these programs address the needs of the poorest, at-risk and marginalized groups.

13. Objectives

- To study the socio-economic condition of HIV infected male persons.
- To study the feelings of the HIV infected male persons.

14. Sample Design

In drawing representative sample for the study main problem of the non-availability of a proper sample form in the absence of any other source. It was decided to collect information through schedule non-availability of exact extent of number of HIV patients, because there was floating nature of HIV patent in RIMS in Kadapa. About 75 HIV male infected persons were selected in this study by a simple random sampling method.

15. Results and Discusion

15.1. Caste wise AIDS Respondents

Sl.No.	Caste	Respondents	Percentage to Total
1	OC	12	16.00
2	BC	22	29.33
3	SC	25	33.34
4	ST	16	21.33
Total		**75**	**100.00**

Table 1:Cast-wise Analysis of the HIV Infected Persons
Source: Primary data RIMS, Y.S.R Kadapa.

The above table shows that 25 respondents (33.34 per cent) have SCs, 22 respondents (29.33 per cent) have BCs, 16 respondents (21.33 per cent) have STs and 12 respondents (16 per cent) have OCs. It is fulfilled that 33 per cent respondents are in SCs.

15.2. Age wise HIV Positive Patients

This is a positive co-relation between HIV disease and age. The younger age cluster persons are very major to HIV disease because of their habits like drinking, drug addictions, and urge for sexual pleasures. The age wise sharing of the HIV infected persons is presented in the table-2.

Sl.No.	Age	Respondents	Percentages to Total
1	Below 20	03	4.00
2	21-25	20	26.66
3	26-30	16	21.34
4	31-35	14	18.66
5	36-40	12	16.00
6	41-45	06	8.00
7	46 and Above	04	5.34
Total		**75**	**100.00**

Table 2: Age-wise Distribution of the HIV Infected Persons
Source: Primary data in RIMS, Y.S.R Kadapa.

The above table-2 shows that 20 respondents (26.66 per cent) are in the age group of 21- 25 years, 16 respondents each (21.34 per cent) are in the age group 26-30 years, 14 respondents each (18.66 per cent) are in the age group 31-35 years, 12 respondents (16.00 per cent) are in the age group 36-40 years. Six respondents (8.0 per cent) are in the age group 41-45 years, four respondents (5.34 per cent) are in the age group 46-50 years, and three respondents (4 per cent) are in the age group below 20 years. It is concluded that 26.66 per cent of the HIV respondent are in the age group of 21-25 years.

15.3. Educational Qualifications of the HIV Infected Persons

Sl.No.	Educational Qualifications	Respondents	Percentage to Total
1	Up to 7^{th}	17	22.67
2	SSC	16	21.33
3	Inter	09	12.00
4	Degree	07	9.34
5	PG	02	2.66
6	Illiterate	24	32.00
Total		**75**	**100.00**

Table 3: Educational Qualifications of the HIV Infected Person
Source: Primary data RIMS, Y.S.R Kadapa.

The table presents that the 24 respondents (32 per cent) are illiterates, 17 respondents (22.67 per cent) have upper primary, 16 respondents (21.33 per cent) have SSC education, 9 respondents (12 per cent) have inter qualification and 07 respondents (9.34 per cent)are graduates, and 02 respondents(2.66 per cent) are post-graduation. It is concluded that 32 per cent respondents are illiterates.

15.4. Marriage wise Analysis of the HIV Infected Persons

Both married, un-married and widow persons are pain from HIV infection. According to researcher study the number of HIV infection is more in the middle of the married person than un-married, widow persons.

Sl.No.	Marital Status	Respondents	Percentage to Total
1	Married	45	60.00
2	Un-married	20	26.67
3	Widow	10	13.33
Total		**75**	**100.00**

Table 4:HIV Infected Among Married, Un-marred Widow Persons
Source: Primary data RIMS, Y.S.R Kadapa.

The above table-4 clearly shows HIV virus is more among the married persons 45 it means married couples have extra marital sex or not truthful to their partners.

15.5. Manage with Life

Manage with life with HIV positive is a very composite process. Majority of their HIV positive patients totally lost their hope with life and they tell very negative feeling regarding their potential life. The feelings of HIV positive patients are elicited and presented in the table-5.

Sl.No.	Feelings of HIV Patients	Respondents	Percentage to Total
1	A Ray of Hope	8	10.67
2	Completely Lost Hope	62	82.67
3	Not Specified	5	06.66
Total		**75**	**100.00**

Table 5: Feelings of HIV Positive Patients
Source: Primary data RIMS, Y.S.R Kadapa.

The table shows that 62 respondents (82.67 per cent) completely lost their hope, 08 Respondents (10.67 Per cent) have just a ray of hope and mere 5 respondents (60.66 Per cent) have no specific feelings of HIV. It is concluded that 82.67 per cent of the respondents have completely lost their hope.

15.6. The HIV Positive Patients towards Public Blaming

The investigator understands the feelings of HIV patients regarding blaming of HIV patients by the society. The views of the respondents towards public blaming are presented in the table-6.

Depicted that the table-6 35 respondents (46.67 Per cent) worried very much about public blaming, 16 respondents (21.33 per cent) extremely worried and 10 respondents (13.34 per cent) worried a little. On the contrary 14 respondents (18.66 per cent) not at all worried about public blaming for their possessing HIV. It is concluded that 46.67 per cent of the respondents have very much worried about public blaming.

Sl.No.	Public Blaming	Respondents	Percentage to Total
1	Not at all	14	18.66
2	A little	10	13.34
3	Very much	35	46.67
4	Extremely	16	21.33
Total		**75**	**100.00**

Table 6: Patient's Attitude towards Their Public Blaming
Source: Primary data RIMS, Y.S.R Kadapa.

15.7. The HIV Patients towards Their Negative Feelings

It has come to know that by the researcher during investigation that majority of Male HIV positive patients seem to be depressed and lost pleasure in life because of negative feelings towards their life and society.

Sl.No.	Negative Feelings	Respondents	Percentage to Total
1	Not at all	12	16.00
2	Often	18	24.00
3	Rare	08	10.67
4	Many times	22	29.33
5	Every time	15	20.00
Total		**75**	**100.00**

Table 7:Male HIV Positive Patient's Attitude towards Negative Feelings
Source: Primary data RIMS, Y.S.R Kadapa.

The table shows that 22 respondents (29.33 per cent)have negative feelings many times, 15 respondents (20 per cent) have unhelpful feelings every time, 18 respondents(24 per cent)have negative feelings frequently and then12 respondents (16 per cent) have negative feelings not at all.

15.8. Patients Feelings Regarding Death

In general people are very fearful only for death. It is true with researcher investigation during field study that bulk of HIV patients is very afraid towards death.

Sl.No.	Feelings of Death	Respondents	Percentage to Total
1	Not at all	5	6.66
2	A little	9	12.00
3	Very much	25	33.34
4	Extremely	36	48.00
Total		**75**	**100.00**

Table 8: HIV Patients Feelings Regarding Their Death
Source: Primary data RIMS, Y.S.R Kadapa.

The table-8 shows that 36 respondents (48 per cent) afraid extremely about death, 25 respondents (33.34 per cent) very much afraid about death and 09 respondents (12 per cent) worried a little about death. On the different plain 05 respondents (6.66 per cent) have no fear about their death.

15.9. Patient's Perception Regarding Fear of Their Future Life

Sl.No.	Future Life	Respondents	Percentage to Total
1	Not at all	05	6.66
2	A little	13	17.34
3	Very much	40	53.34
4	Extremely	17	22.66
Total		**75**	**100.00**

Table 9: Regarding Fear of Their Future Life of HIV Patients
Source: Primary data RIMS, Y.S.R Kadapa.

The table shows that 05 respondents (6.66 per cent) have no fear at all about their future life, 13 respondents(17.34 per cent) have a little fear 40 respondents(53.34 per cent) have very much fear of their future life and finally 17 respondents (22.66 per cent) have an extremely suffer about their future life. It is concluded that the table the highest 53.34 per cent of the respondents feared very much about their future life.

15.10. HIV Patients Income
The income is tannic and tablet for sustenance of life higher the income higher will be the health and living environment. The income levels of the patients have been presented in the table-10.

Sl.No.	Income	Respondents	Percentage to Total
1	Below 10000	05	6.66
2	10001-20000	10	13.34
3	20001-30000	30	40.00
4	30001-40000	12	16.00
5	40001-50000	08	10.66
6	50001 and above	10	13.34
Total		**75**	**100.00**

Table 10:Income wise Distribution of the HIV Male Patients
Source: Primary data RIMS, Y.S.R Kadapa.

The table-10 shows that the majority of the respondents 30 (40 per cent) have the increase range between Rs. 20001-30000, 12 respondents (16 per cent) have the income range between of Rs. 30001-40000, 10 respondents (13.34 per cent) have the income range between that Rs. 10001-20000 and Rs. 50001 and above, and 08 respondents (10.66 per cent) have the income range between of Rs. 40001-50000 and that the 05 respondents (6.66 per cent) have the income range below Rs. 10000.

16. Conclusion
The Government of India estimates that about 2.40 million Indians are living with HIV (1.93 -3.04 million) with an adult prevalence of 0.31 per cent (2009). Children (<15 yrs) account for 3.5 per cent of all the infections, while 83 per cent are the in the age group 15-49 years. Of all HIV infections, 39 per cent (930,000) are women. India's highly heterogeneous epidemic is largely concentrated in only a few states in the industrialized south and west, and in the north-east. The four high prevalence states of South India (Andhra Pradesh-500000, Maharashtra-420000, Karnataka-250000, TamilNadu–150000) accounts for 55 per cent of all HIV infections in the country. West Bengal, Gujarat, Bihar and Uttar Pradesh are estimated to have more than 100,000 PLHA each and together account for another 22 per cent of HIV infections in India. In 1991, the Government of India and the World Bank expanded their collaboration on infectious disease control programs and by 1992 the first National AIDS Control Project was launched with a World Bank credit of US$84 million. It is concluded that 32 per cent respondents are illiterates. More than 26 per cent sample respondent of HIV persons in the age group of 21-25 years and82.67 per cent of the Respondents have completely lost their hope. Moreover more than46.67 per cent of the respondents have very much worried about public blaming in the study.

About 53 per cent of the respondents feared very much about their future life. That the majority of the respondents 30 (40 per cent) have the increase income range between Rs. 20001-30000.

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