Editorial

Scenario of HIV in Indian Rural Population: Editorial

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Abstract

HIV is spreading like epidemic all over world. Scenario is worse in developing countries like India. Rural India is facing more severe problem because of less awareness and accessibility to medical care.

Burden of HIV in rural women of India: Globally the number of people living with HIV / AIDS (PLHA) was estimated to be 34 million claiming 1.7 lives million in 2011[1]. In 2009 the estimated number of PLHA was 2.4 million (1.93-3.04 million) in India of which women comprises 39%[2]. The current trends in India reveal that disease is spreading from urban areas to rural areas beyond groups with typically "highrisk" behaviour such as sex workers, STI clinic attendees and long-distance truck drivers[2-4]. The spread of HIV in rural areas is favoured by widely prevalent sexually transmitted infections (STIs). Rural women are at the highest risk of STIs and likely becoming easy prey for HIV/AIDS too[5]. Apart from the known risk factor of being married to men who transmitted the disease to them via sexual activity; HIV-positive women were significantly more likely to report marital dissatisfaction, a history of forced sex, domestic violence, depressive symptoms and husband's extra marital sex when compared to the HIV-negative women[6]. Women are also at higher risk of psychiatric comorbidities among which most common is depression[7]. In rural Punjab, the data suggests that approximately 66% of women had depression compared to 25% of men[8]. In addition, HIV-positive women were more likely than HIV-positive men to take care of their partners and neglect their own health[9,10].

Challenges in control: HIV/AIDS prevention and care face unique challenges in rural settings of India viz. poor education, limited access to health care and social services, and isolation due to social stigma and a lack of infrastructure and public transportation[11]. The HIV positive rural women also have to face an all pervasive stigma and reluctant discrimination at all levels including health care service facilities[12]. Traditional values and stigma also account for some obstacles that keep rural women from talking about sexuality and learning how to prevent HIV/AIDS. Fear of stigma also stops these women from getting tested, learning their results, and disclosing their HIV status. Women are less likely than men to seek testing, and less able than men to afford treatment[13]. All such factors had limited the success rates of known interventions like group counselling to improve HIV / AIDS awareness among rural women in spite of increasing risk of infection[14]. Therefore though the awareness about HIV/AIDS disease has increased among general population, the people in rural areas and particularly the women are not so much aware about the modes of transmission and prevention of the disease.

Equity recommendations in policy: In 2011, WHO Member States adopted a new Global health sector

strategy on HIV/AIDS for 2011-2015[15]. The common theme for world AIDS days between 2011 to 2015 is "Getting to zero: zero new HIV infections. Zero discrimination. Zero AIDS related deaths". The zero discrimination means that all the population subgroups have equitable access to the care that helps in prevention and treatment of the disease[16]. In India urgent interventions to address gender sensitivity and HIV-related communication and clinical skills particularly in rural areas are recommended[17]. On this background it is essential to conduct more research on the various aspects of HIV epidemic in rural women.

The article presented by Gayathri V[18] et al in this issue reports the HIV disease course among rural women receiving ART. This was a retrospective study with primary aim to explore the course of HIV and response to ART in terms of improvement of CD_4 counts among rural women. The study reports that ART succeeded in improving the CD_4 counts of 80% women and the response was better in younger age groups. The study identified low CD_4 counts and tuberculosis as frequently associated factors among women who died during the course of treatment. The study in has succeeded in documenting the determinants of deaths in these cases. However it does not provide sufficient primary evidence prove that the disease course adverse among rural women as compared to their counterpart's viz. men and urban residents as there was no comparison among the groups.

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