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Introduction to HIV/AIDS

By: Narayna Murthy

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QUESTION PAPER

(June – 2019)

(Solved)

INTRODUCTION TO HIV/AIDS

Time: 3 Hours] ***[Maximum Marks : 100***

Note: *(i) Attempt all the **five** questions.*
(ii) All questions carry equal marks.

Q. 1. Discuss the moral issues involved in HIV testing.

Ans. Ref.: See Chapter-8, Page No. 43, 'Introduction', Page No. 45, 'Moral Issues'.

Also Add : The primary cause will be the use of drugs through defective needle. High-risk factors owes to it. Addicts exchange needle among partners. District level pathologists have apprehended defective needle users and sex coys as some confined group. It has not contacted the epidemic. Nearly five to 10 per cent of infection owes to global users of defective needles. The authorities should dissociate users of defective needles. These should include addicts of psychosomatic and narcotic drugs.

The people are entitled for basic privileges. They ought to be protected from availing basic services. The doctors and healthcare workers are being obliged to extend treatment. The group needs to be screened for other infectious diseases. They should be extended treatment at par with other patients. Medical science focused virtually on healthcare and periodic reforms. Several latitude-based experiments have yielded some breakthrough. Nowadays, every professional pledges to fulfil ethical requirements. We had to ensure the frequency of infection from HIV/AIDS to be around 0.1-0.3 per cent. The percentage of people suffering from Hepatitis B and Hepatitis C stayed at 6-30 and 1.8 per cent respectively. Healthcare from these workers seems to be confined. They're incapable of extending treatment. They had to be trained for caring the PLWHA, as under:

(a) Psychic and interactive requirements.
(b) Comprehensive treatment for HIV/AIDS infection.
(c) Humane and legal clearance for such treatment and
(d) Prevention through adequate strategies of risk-control.

Sero-positive should be availed of basic services. These should not be subjected to discrimination. The privileges enshrined in HCW should be recognized for safety. The agenda needs to be fine-tined from time-to-time. It has been experienced from risk factors galore. The after-effects was among treated lot. Suitable vaccine or single drug should be developed. The practice of daily dosage of multiple medicines should be abandoned.

OR

Trace the history of HIV/AIDS in india.

Ans. Ref.: See Chapter-1, Page No. 5, 'HIV/AIDS : Indian Scenario', Chapter-4, Page No. 24, 'HIV/AIDS : Indian Scenario'.

Q. 2. Define STDs. Describe some of the common STDs their signs and symptoms and treatment options.

Ans. Ref.: See Chapter-9, Page No. 51, 'What are STDs',

Also Add : Sexually Transmitted Diseases (STDs) are diseases that are usually spread during sexual activities. There are some STDs that cause genital ulcers, such as syphilis, chancroid and herpes and these can increase the risk for HIV transmission up to ten folds. Other STDs cause discharge, they are gonorrhea, Chlamydia infection and tricomoniasis. The rate of transmission is up to four fold. As a result, early diagnosis and effective treatment of STD can contribute significantly to a reduction in HIV transmission. Many of the measures for preventing

the sexual transmission of HIV and STD are the same, as are the target audiences for these interventions. STD clinical services are an important access point forpersons at high risk for both HIV and STD, not only for diagnosis and treatment but also for education and counselling on prevention.

Also Add : Page No. 112, Q. No. 7 (Additional Important Question).

OR

Describe the recommendations of International conference for a model Global Aids law.

Ans. The International Conference held, in December 1995 in New Delhi, was organised by the Indian Law Institute under Ministry of Health & Family Welfare with the co-operation of UNDP and WHO. It emphasized the need for a co-ordinated approach to address legal issues of HIV / AIDS to protect the society against spread of the infection and respect the dignity and fundamental human rights of the infected / suspected of being infected and their families.

Guidelines to fight HIV/AIDS: The Conference accepted principles as a guide to develop laws/strategies to help fight spread of HIV/ AIDS as under:

(1) Laws/policies on HIV/AIDS should be based on scientific data and not on presumptions, and prejudices;

(2) In combating HIV/AIDS, it is necessary to adopt a global approach that calls for a model global AIDS law to devise action at local, National and International level;

(3) Approach should respect/protect the human rights of all persons at risk of HIV/AIDS and recognized effective strategies for changing behaviour and ensuring against spread of HIV infection by protecting the rights of the people at risk.

(4) There should be effective /enforceable laws for prevention of HIV and for protection of persons affected by HIV/AIDS.

(5) The law makers should work with the health care workers, government / NGOs, representatives of vulnerable groups, people with HIV/AIDS and common citizens who are well informed about how HIV/AIDS is transmitted and how its infection can be prevented;

(6) There should be emphasis on the importance of moral, spiritual and religious values in response to the HIV/AIDS epidemic.

The Conference mentioned the following objectives of law related to HIV/ AIDS:

- To protect human rights and empower people to help contain spread of HIV infection;
- To promote behaviour to protect the individuals and families;
- To prevent coercive action against an HIV AIDS infected / suspected person;
- To protect society facing an epidemic with a serious threat;
- Law should facilitate access to information about HIV/AIDS prevention, health care services and legal services to uphold the rights of individuals;
- HIV / AIDS laws must be just and consistent with fundamental human rights and to protect individuals and the society;
- Fundamental rights, right to privacy & freedom from discrimination must be ensured;
- To provide adequate resources for prevention & care and support for government / NGOs and the people living with HIV/AIDS.

The Conference also proposed certain terms for priority attention in legislative action in countries and also proposed areas of action of highest priority by the executive, from the legal point of view. The Conference also suggested the Judiciary to familiarize its members with HIV/ AIDS, fair / timely application of common laws and the need for an informed approach to the spread of virus and its impacts.

Q. 3. Answer the following questions:

(a) **Explain various modes of transmission of HIV among women.**

Ans. Explain various modes of transmission of HIV among women.

Ans. In the developing countries, HIV disease among women is acquired heterosexually, from man to woman. This is because the infection gets transmitted during sexual contact from men to women, lack of awareness among women, cultural beliefs about the women in the family / society and the lack of adequate economic power among women. These factors influence the vulnerability of women

Sample Preview of The Chapter

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HIV AND AIDS EDUCATION

BASIC KNOWLEDGE OF HIV AND AIDS

HIV/AIDS: Global and National Scenario

1

INTRODUCTION

HIV is a lenti-virus. It has been responsible for blown-up AIDS. Infected people do not contract AIDS. Once, it is developed in any individual, there is no treatment. Individuals may not have symptoms. However, weight loss, diarrhea, oral fever and candidiasis are common symptoms among the infected. People may suffer from loss of memory. Radiation sickness, autism, Alzheimer's disease or infectious diseases might trouble the victims. The only alternative available is to enhance the immunity potential in our body. Abstinence from sex could empower immunity among the individuals.

In this chapter we will discuss effect of the epidemic across continents, measures taken by local authorities, Indian scenario, and its effect on socio-economic aspects.

CHAPTER AT A GLANCE

HIV/AIDS: GLOBAL PERSPECTIVE

AIDS was earlier noticed among non-human primates in Sub-Saharan Africa. It was later transferred to human beings in the 19th or early 20th century. The first paper recognizing a pattern of AIDS was published in 1981. It has highlighted the virus in two forms–HIV-1 and HIV-2. It was believed to have originated in West-Central Africa. HIV-1 appears to have originated in southern Cameroon through simian immuno-deficiency. It was said to affect wild chimpanzee. HIV-2 belonged to sooty mangabey variety. Monkeys of Guinea-Bissau, Gabon and Cameroon have also exhibited symptoms.

Couple could hug, simply kiss or masturbate. Sexual contacts should be made through condoms. Unprotected, anal or vaginal contact should be avoided. HIV antibiotics should screen any donated blood, organs, semen and ovum. The diagnosis is done through ELISA [Enzyme Linked Immuno Absorbent Assay]. Western Blot test confirms the infection. The virus pattern changes from latitude to latitude. Scientists are rather puzzled to develop suitable vaccine, but were in vain. A gay couple in US was affected in 1981. At home, a sex worker from Chennai reported of being herself on diagnosis.

AIDS became dreadful menace in the universe by 1990. Its impact remains catastrophic. Even the World Wars I and II fought amongst Super Powers and Allies followed by the Cold War couldn't have influenced the world population. AIDS toll has

crossed 25 mn by 2006. It infects about 0.6 per cent of the world population. It claimed some 2.4 to 3.3 mn lives so far, but 5,70,000 amongst them were children. Sub-Saharan Africa suffered heavily from this killer disease. Infection targets some 90 mn leaving 18 mn orphaned. France, Spain, Germany and Italy have found their society utterly shaky. Sweden, Norway and Finland bore the burden. The percentage of the affected across the U.S., Brazil and Mexico, Caribbean Isles, Bermuda, Barbados was equally stunning.

Sub-Saharan plateau has the largest number of HIV infected people. It has surpassed 25.4 mn. It has two-thirds of the infected across the universe. Some 77 per cent of the affected people were women. Some 3.2 mn more people were infected and 2.4 mn were pronounced dead (2005). Aside, the infected were found in Asia and the Eastern Europe. The epidemic crosses its sword across the human race despite efforts being made to protect the communities.

REGIONAL PERSPECTIVE OF HIV/AIDS

The entire human kind has been averse to this epidemic. People are quite puzzled about their lifestyle. A few countries have stopped cooking food by conventional methods–using electricity supply, natural gas, heating, windmill supply. The eating habits, physical fitness exercises, mating and social interaction were subjected to stress. The situation has paralyzed even the healthy people of Sub-Saharan Africa, North Africa and Eastern Europe, Central Asia, Pacific, Latin America, Caribbean and other developed industrialized nations.

Saharan Plateau

Nearly 10 per cent of the world population basks under the Sub-Saharan sun. It has 60 per cent of the global infected people. Infected adults occupy 5 to 30 per cent of the demography. South Africa has 2 per cent of the global population. It has 30 per cent of the infected people. Some 2.5 mn new cases were reported in 2005. Madagascar and Swaziland reported more cases despite efforts to contain the infection. Uganda undertook preventive measures. Prevalent social inequity, poverty and proliferating cases of STD, increased incidents of crime and labour migration were the prominent causes. Women infected occupy 1.2 per cent in contrast with men.

Oceania

Infected has come to about 74,000 among the population. Some 8,200 HIV infected cases were reported with toll of 40,000. Most of the victims found was homosexuals. Papua New Guinea was the worst hit where the infection spread from sexual maniacs resorting to multiple partners.

Eastern Europe and Central Asia

Infection has steadily affected the area. It has increased from 1,60,000 to 1.6 mn (1995-2005). The toll from blown-up AIDS crossed 62,000. Number of women and men affected in the age-bracket stood at 1.6 and 1.3 per cent respectively of the overall population. 12.8 per cent of the affected were less than 30-years of age.

North, East and Central Africa

The cases of blown-up AIDS grew steadily. Some 67,000 new cases were reported (2005–35, 000–20,000).Around 510,000 new cases were reported (220,000-1.4 mn) and 58,000 children and adults have died out of blown-up AIDS.

Latin America

Some 1.8 mn people were affected. The death toll from blown-up AIDS (2005) was around 66,000 (52,000-86,000) with reports of 2000,000 (1,30,000-2,60,000) new cases. The percentage of men and women in the 15-24 year bracket affected from multiple-partner sex stood at 0.4 and 0.6 respectively. The people were appreciable in number through sexual intimacy in contrast with the drug-used through needle. An international survey has justified the increase in infection from 35+ year old female sex workers. The increase in percentage was observed in Nicaragua (1.0), Panama (2.0), El Salvador (3.0) and Guatemala (5.0). Honduras appeared with the highest percentage of infected (10.0). Infection spread at random among homosexuals mating female sex workers.

Caribbean

About 30,000 people were seriously infected. Nearly 30,000 of them were in the age bracket of 15-24 years (2005). The percentage of affected stood at 2.8 mn (2005–2.4-5.8 mn) among women and 1.2

mn (1.0-2.2 mn) among men. Of the seven islands, where the infected ailed seriously, were from Bahamas, Haiti and Trinidad-Tobago. The proportion of the infected was 1.5 per cent in Barbados and less than 1.0 per cent in Cuba. Orgy with multiple partners was the curse of infection. Most of the female sex workers have fleeced customers.

Highest Income Bracket Countries

The number of infected stood at 1.9 mn. It was 3.1 per cent and 0.2 per cent for women and men, respectively (fall of 2005). Inhabitants have good longevity in comparison with other countries. The death toll in the U.S. alone hung at 16,371 (2002) less than 19,005 (1998). Africans were seriously infected among the recently reported cases in the U.S. (50 per cent). It has 12 per cent of African population. However, the situation froze by 11 times when more of the Africans were infected.

Homosexual practice was common among gays in higher income bracket countries. Industrialized nations have increasing incidents of gays mating with multiple partners. Belgium, Norway and England have reported infections sustained from gays in contrast with Sub-Sahara and East European countries. The number of drug-users through needles was disproportional. Western Europe has some 10 per cent of drug-users through needle (2002). Portugal has over 50 per cent. Canada and the U.S. have reported such users around 2.5 per cent.

South and East Africa

The number of infected stood at 8.5 mn (2005). 11 mn among whom were infected earlier. The corresponding toll from blown-up AIDS was around 5,20,000. Some 0.3 per cent women and 0.4 per cent men in the 15-25 year bracket were affected (fall of 2003). Gays have resorted to drug abuse. Bangladesh, Cambodia, Thailand and Myanmar based gays have contracted infection. Vietnam and Indonesia have found infection spreading through other modes. The states were independent of each other. The infection has spread among drug addicts resorting to unsafe sex.

China

The mainland China is expected to surpass some 10 mn (2010) infected, unless the authorities take effective steps to contain the epidemic. The retrovirus has infected almost 31 provinces, prefectures and metro-cities through unique mode. Some 35-80 per cent were found from Xinxiang to have used drug through needle. Guangdong in contrast with 20 per cent of infection contracted farmers selling blood for money in Amoy, Hainan and Shenyang.

Cambodia

Cambodia in East Asia was the most affected slice of island. The percentage national stood at 3.0. Sudden changes overturned the detrimental phase. A sizable reduction of about 50 per cent (1992–02) was reported from flourishing red-light areas and unlicensed quarters. The year 1998 known as Transmission of HIV^+ recorded 43.1 per cent population have been reduced to appreciable level (2003).

Thailand

The number of infections came to minimum (1991-03–1,40,000 to 21,000). Thais have abstained from visiting red-light areas. They could not embrace the mode of safer sex. The infected gays hung on at 15.0 per cent (2005).

Vietnam

The state has been the cesspool of AIDS. The per capita incidents recorded were less than 1.0 per cent. Increasing surveillance tracked the contracted drug users at 20 per cent. Two-thirds among them were drug users, who injected through defective needles. The practice of unsafe sex still haunts most of the Vietnamese.

Indonesia

The infection has saturated the peninsula of 210 mn. Each of the prefectures has been overpowered by the epidemic. People are using defective needles for general treatment and injecting drug intravenously. The rate of contraction oscillates around 125,000-195,000. It was tripled from the use of drugs through needles (16.0 to 48.0 per cent). The number of female workers (2002-03) stood at 20,000 among whom the infection was not uniform.

Bangladesh

The rate of contraction was less than 1.0 per cent among adults. It was more across the border belt. Men spend money to have the orgy. Drug abuse also took an upward swing.

Pakistan

The rate of contraction stood at 1.0 per cent. Some 3.0 mn people were heroin addicts. Many of them have injected the drug through needles.

Influence of the Hiv/Aids

Human resource development was affected by the spread of HIV/AIDS. People affected from the epidemic need to be aligned with the mainstream. The devastating forces have shelved the image of eminent personalities and families on the global level. The world has traversed the internet and SMS-based platform. The opportunities exist in commerce, education, innovation, entertainment, wealth and productivity. The countries with corporate world get more from band of innovators–educators, students, workers and suppliers connected to this platform. Awareness about AIDS and increasing immune strength of the individual adds on to the stream. People may use PC, cellular phones, photo blogs, Google maps; e-mail, the pictures and precise location to the rights of organization or governments. However, they are mute when being affected with HIV^+. A fear of the insecurity, stress and social outrage always surfaces among them. They wonder whether the infection from within affect their social values, economy and productivity of the whole. It is the job of policy planners, educators and peers to change their concepts. Let they switch over to multi-disciplinary modes. Let the concepts connect humankind without barrier and shape the era.

Medicine, education and social development have come to a note. Developed countries have failed to take stock of the situation. The cherished services as such were diverted. People were subjected to misery. Malnutrition, hunger and epidemics have haunted them forever. The local governments have been facing shortage of manpower to tide over the scenario. They were equally hesitant to proceed with the agenda.

Influence on the Demography

The life expectancy of an individual across South Africa is under 59 years (UN Census-1990). It diminished to 45 years (2005-10) whereas, the healthier lot hung on upto 50 years. Sub-Saharan Africa has the least figure. East and South Africa were the worst hit. Incidents of teenage death were up while the overall life expectancy stood around 60 years of age. HIV^+ has made the victims die around 30 years of age. Men outnumber women. Mortality among developed countries is 20 times more. Some 39 countries amongst the least developed and middle income bracket countries have increased life expectancy. The countries don't have uniform stage of infection. Young women were the worst hit with from such contraction.

Influence on Women

Most of the victims contracted were dependent women. They have worked as maids, producing lower income or worked as care-takers, with hung on children. They were asked to guard or babysit the affected victims. Aged women were found to care the orphaned teens. Young widows lost inheritance rights after being widowed, contracting AIDS prematurely.

Influence of HIV/AIDS on and Hunger

Lopsided economy precedes the influence of the dreaded epidemic. Poor have lost their identity. The per capita of Zambia reduced from U.S. $505 to $370 (1980–99). The per capita calorie available also reached 1,934 from 2,273. AIDS epidemic has destabilized the families and communities.

Influence of HIV/AIDS on Healthy Families

The infection has absolutely influenced the income and productivity of the communities. They were subjected to spend appreciable earnings on treatment, funeral and memorial services and support the poverty-rid families through social dexterity. The wards ought to be relocated to places of safety. Most of the affected families had to bear the brunt.

Influence on Education

Long-term prospective on education were curtailed. AIDS had been a diabolic obstacle in materializing the goal of universal primary education (2015). The quality of education and training skills waned. Pupils were denied admission in good number of reputed educational institutions. Africa's appreciable number of teachers and principals were found HIV^+. The rate of infection among women