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The impact of HIV and AIDS based on Gender in Delhi

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Abstract: The study attempts to analysis the impact of HIV and AIDS regarding gender in Delhi. Both, the primary and secondary data were collected. The self-setructured interview schedule was used for data collection from the HIV and AIDS respondents who were admitted in Manipal Hospital and Aashlok Hospital. The total 1,550 respondents were selected by using purposive sampling technique. The result shows that in the case of hospitalization fever, tuberculosis and loose motion/diarrhoea emerge as common health problems for which both men and women. It is also seen that the percentage of illnesses reported is similar for men and women in respect of most of the illnesses. The average number of days admitted in a hospital at a time is more or less the same for men and women in most diseases barring malaria, headache, and STD. However, there is no gender difference in the average number of days admitted considering all the diseases. So, it could be concluded that the respondents were impacted negatively by HIV and AIDS, both either men or women in the study area.

Keywords: **HIV and AIDS, Gender**

I. INTRODUCTION

According to the estimates of NACO for the year 2005, in India, women account for around two million of the approximately 5.2 million estimated cases of people living with HIV and AIDS, constituting 39 percent of all HIV infections. The surveillance data indicates that, in high prevalence states, the epidemic is spreading gradually from urban to rural areas and from high-risk groups to the general population. A significant proportion of new infections is occurring in women who are in monogamous relationship and have been infected by husbands or partners who have multiple sex partners. According to NACO, of the 1,11,608 AIDS cases reported in the country till 31 July 2005, females accounted for nearly 30 percent. Biological, socio-cultural and economic–factors make women and young girls more vulnerable to HIV and AIDS. The HIV virus is more easily transmitted from men to women than from women to men; male-to-female transmission during sex is about twice as likely as female to-male transmission. In India, the low status of women, poverty, early marriage, trafficking, sex-work, migration, lack of education and gender discrimination are some of the factors responsible for increasing the vulnerability of women and girls to HIV infection. The impact of HIV and AIDS reaches far beyond the health sector with severe economic and social consequences and it has been found that it is much more severe on women than men. Women and girls seem to bear disproportionate brunt of the epidemic psychologically, socially and economically. This study attempts to assess the impact of HIV and AIDS on women and female children in India in terms of:

- Burden of care, domestic work and economic responsibilities on women in the HIV households and the role of women as caregivers;
- Health-seeking behaviour and out of-pocket expenditure incurred by the HIV households on the treatment of opportunistic infections (OIs) suffered by the PLWHA;
- Ever and current enrolment of girls in school, gender differences in the reasons for discontinuation of schooling and the type of school attended by the children from HIV and non-HIV households;
- Stigma and discrimination experienced by the PLWHA in various contexts such as family, community, workplace and healthcare facilities;
- Knowledge, awareness and misconception about HIV and AIDS, and attitude towards PLWHA among the general population; and
- Status of HIV-positive widows whose heads had poor educational background.

II. BACKGROUND

Globally, HIV and AIDS has become a major public health issue and is posing a serious challenge to the developed as well as the developing world. It has become a leading cause of death in sub-Saharan

Africa and in the worst hit countries, HIV and AIDS is reversing the gains of human development including life expectancy. In some of these countries, the epidemic is worsening the progress in human development by affecting the economic growth, human capital formation, health, education, and by increasing poverty and income inequalities (Mahbub-ul-Haq Human Development Centre, 2005). As more and more women get infected & affected by HIV, the target of the Millennium Development Goals (MDG) of arresting and reversing the spread of HIV and AIDS by 2015 may not be met. The MDGs adopted by 189 countries, including India, aim to promote gender equity and achieve universal primary education. It is feared that HIV and AIDS could be an impediment to achieving some of these goals as more and more women and girls get infected and affected by HIV and AIDS (UNDP, 2003). At the outset of the epidemic in the 1980s, women were considered marginally at risk from a virus that seemed to be mostly confined to the so-called high risk groups-intravenous drug users (IDUs), men who have sex with men (MSM) and sex workers. Now, HIV has infected tens of millions, many of them women, who are practicing monogamy within marriage or in a long-term relationship (Dixit, A.P. 2005). By the end of 2005, an estimated 40.3 million (36.7-45.3 million) people were living with HIV, worldwide. Close to 5 million people were newly infected with the virus in 2005 (UNAIDS/WHO 2005). Of these 40 million PLWHA, as many as 17.5 million i.e. more than 40 percent were women. As compared to 2003, one million more women were living with HIV in 2005. The "feminisation" of the epidemic is most apparent in sub-Saharan Africa where an estimated thirteen and a half million (12.5 to 15.1 million) women live with HIV and women account for 57 percent of the infection among adults in this region.

In the South and South–east Asia region, almost two million women now have HIV and women form more than one-fourth of the adults who are infected by the virus. Globally, there has been a dramatic increase in the number of young women being infected by HIV. Young women account for over 60 percent of 15 to 24 year old PLWHA and they are 1.6 times more likely to be living with HIV and AIDS than young men (UNAIDS/ UNFPA/UNIFEM 2004). According to NACO, in India, an estimated 5.21 million PLWHA in 2005, accounting for 13 percent of the PLWHA globally (NACO, 2005). Though the current prevalence rate is less than one percent of the country's population, given the large population base, any rise in this ratio of the HIV-prevalence rates can push up the number of PLWHA to several millions. The rates of HIV infection amongst women in India are steadily rising. Women account for around 2 million of the approximately 5.2 million estimated cases of PLWHA, constituting 39 percent of all HIV infections. Of these, only 0.5 percent of the women are sex workers. Of the 1,11,608 cases of AIDS reported in the country till 31 July, 2005, females accounted for nearly 30 percent. The biggest HIV and AIDS risk for many women and girls is through heterosexual sex; almost 85 percent of infections in women result from sex with their husbands or primary partners. In India, women are increasingly getting susceptible to HIV and a large proportion of new infections are occurring in women who are married and are infected by husbands who (either currently or in the past) frequent sex workers. The surveillance data indicates that in high-prevalence states, the epidemic is spreading gradually from urban to rural areas and from high-risk groups to the general population. The epidemic continues to shift towards women and young people and is slowly moving beyond its initial focus among sex workers. HIV transmission through sex between men is also a major cause for concern in many areas of India as the research shows that many MSM also have sex with women. In 2002, behavioural surveillance in five cities among MSM found that 27 percent reported being married, or living with a female sexual partner. than older women; in sub-Saharan Africa, young women aged 15-24 were 2.5 times more likely to be infected as compared to young men. The linkages between gender inequality and vulnerability to HIV and AIDS is now fairly well known. In fact, gender inequality and poverty are responsible for the spread as well as disproportionate impact of HIV and AIDS on women. "Faced with economic hardship, women and girls become more vulnerable to prostitution, trafficking and transactional sex in which they have little power to negotiate safe sex." (UNICEF, 2005) In India, women in general enjoy a very low economic and social status; the sex ratio of 933 women to 1000 men is one of the lowest in the world. This is the result of a strong son preference and the widespread sex selective abortion that is prevalent in the country. There is a large gender gap in literacy and employment as well.

While the number of people diagnosed with AIDS in the country has decreased in the last three years, the cases in Delhi have marginally increased in 2017-2018. As many as 6,563 new patients have been diagnosed with AIDS in Delhi in the year 2017-2018. The number was 6,340 in the previous year.

Increasing HIV prevalence in STD clinic attendees in Delhi, India: 6 year (1995–2000) Hospital based study

The association between the occurrence of HIV infection and the presence of other STDs has been strongly established. STDs act as important co-factors that promote HIV transmission. The trend of HIV infection in STD clinic attendees, one of the high risk groups, may reflect the trends of HIV epidemic in the community. To estimate the frequency of HIV infection among various STD patients over a period of 6 years from January 1995 to December 2000 and to observe the interrelation between HIV infection and different other STDs, we analyzed the HIV status of 1504 STD clinic attendees (M:F ratio 1:0.1, average age of 25.2 years) in Dr RML Hospital, a centrally located major tertiary care centre in Delhi. The breakdown in the number of STD attendees tested for HIV voluntarily out of total STD attendees was as follows: 180 out of 407 (44%) in 1995, 261 out of 513 (51%) in 1996, 245 out of 414 (59%), in 1997, 280 out of 363 (77%) in 1998, 235 out of 368 (63%) in 1999, and 296 out of 442 (67%) in 2000. This variation of percentage from year to year is due to the voluntary nature of testing. HIV testing was done with one of the ELISA/rapid/simple tests. Any reactive serum sample was retested using a different assay. A sample that was positive in both the tests was considered HIV positive. The other STDs were diagnosed clinically and using appropriate laboratory tests. Out of 1504 STD patients screened for HIV infection, 42 (2.8%) were found to be seropositive (40 males out of 1354 and two females out of 150). Annual breakdown revealed a slow but gradual increase in HIV prevalence (1.7% in 1995, 2.2% in 1996, 2.1% in 1997, 2.5% in 1998, 2.7% in 1999, and 3.4% in 2000). The cumulative prevalence of HIV seropositivity in different STDs is shown in table 1. HIV positivity was observed in 4.5% patients with GUDs, in contrast with only 1.7% HIV positivity among non-ulcerative STD patients, which is statistically significant (p >0.002). All but one male HIV positive patients gave a history of sexual contact with at least one commercial sexual worker. Out of two HIV positive women, one possibly was infected by her husband and the other from her regular sexual partner; both were not pregnant at the time of HIV testing. Five (19%) HIV seropositive patients had more than one STD.

HIV sentinel surveillance in India shows the HIV epidemic at different stages of evolution in different states of India. Six out of 32 states have HIV prevalence of more than 1% in antenatal clinics (ANC) and are classified as high prevalence states including Maharashtra and Tamil Nadu. In seven other states the ANC rates are less than 1% but prevalence among STD clinic attendees is more than 5% classified as moderate prevalence. The remaining 19 states including Delhi are low prevalence states because HIV prevalence among STD attendees is less than 5%.1 2 The HIV sentinel surveillance data of Delhi show 1.6% and 3.2% HIV infection in 1998 and 2000, respectively, among STD attendees from four other major STD clinics in Delhi, where anonymous HIV testing was done from VDRL blood samples.3 These data as well as ours are comparable and support the belief that Delhi is still in a low level epidemic category. From the experience of the Mwanza trial in Tanzania and the Rakai trial in Uganda, it is speculated that the eVect of STD control on HIV transmission may decrease with the maturation of the HIV epidemic.4 Therefore, it is high time to extend vigorous intervention programmes in all high risk groups as well as the general population of this city which is still in the early epidemic phase to ensure this cost eVective opportunity is not missed.

III. OBJECTIVE

- To analysis the nature of illness suffered by HIV-positive of the respondents based on gender

Sources of Data

Primary data: the primary data was collected from HIV-AIDS positive patents.

Secondary Data: the secondary data was collected from published articles, books, newspapers, internet websites etc.

IV. SAMPLING

The sample was from two hospitals in Delhi. From “Manipal Hospital”, 601 male and 282 female respondents were selected by using purposely sampling technique. Besides, 470 males and 226 females were selected from “Aashlok Hospital” respectively. So, the total 1550 respondents were selected for this study. The data was collected during the 2020. The respondents were interviewed in detail whose belong to the age of 20 to 55 years.

Distribution of Hospitalization cases by nature of Illness suffered by HIV-positive Men and Women and number of days Hospitalized

Nature of illness	Percentage of cases			Average no. of days Hospitalized		
	Male	Female	Total	Male	Female	Total
Respiratory infection	4.2	4.8	4.4	12.3	9.9	11.5
Malaria	1.2	0.2	0.9	9.8	20.0	10.5
Fever	20.1	13.9	18.2	8.8	10.8	9.2
Headache	2.9	2.5	2.8	8.3	15.8	10.4
Weakness	7.2	7.6	7.3	9.5	8.9	9.4
Loose motion/diarrhoea	27.0	24.6	26.2	9.1	6.9	8.5
Typhoid	1.7	1.5	1.6	7.8	9.9	8.4
Jaundice	2.1	1.5	1.9	7.5	8.4	7.7
Tuberculosis (TB)	18.8	15.0	17.6	12.5	13.11	12.7
Skin diseases	2.5	3.8	2.9	8.2	11.6	9.6
STD/gynaecological/ reproductive problems	0.8	7.0	2.7	13.9	6.0	11.0
Meningitis and viral encephalitis	1.6	1.1	1.4	11.5	15.4	12.4
Others	10.1	17.4	12.3	7.9	9.1	9.8
Total	100	100	100	9.85	9.79	9.83
No. of hospitalization cases	1,071	479	1,550	---	---	---

In all 1,550 hospitalization cases, 1,071 by men and 479 by women were reported. As reported in the case of hospitalization fever, tuberculosis and loose motion/diarrhoea emerge as common health problems for which both men and women. It is also seen that the percentage of illnesses reported is similar for men and women in respect of most of the illnesses. The average number of days admitted in a hospital at a time is more or less the same for men and women in most diseases barring malaria, headache, and STD. However, there is no gender difference in the average number of days admitted considering all the diseases.

V. OBSERVATIONS

- The gender difference becomes more noticeable from the fact that not only the percentage of women's illnesses, which go untreated, is higher than that of men, but in the case of most of the women financial constraints turn out to be the reason for taking no treatment.
- The source of treatment indicates that a lesser percentage of women take treatment from private hospitals than men, the costs in private being more than that of government health facilities, whether for no-hospitalized or hospitalized illnesses. For both hospitalized and non-hospitalized illnesses, in spite of the fact that nearly the same percentage of men and women suffer from the same diseases, and with even the number of days of hospitalization being nearly the same, the cost per treatment in case of women is less than that of men, be it in a government health facility or a private one.

The study shows that as compared to men, women have poorer access to healthcare. It has also been pointed out that in the states where sample female PLWHA who were generally better educated, were having better access to health facilities. The financial constraint is a big impediment for getting proper healthcare and it is more so for women. It is imperative to see that women, who are affected more by HIV and AIDS, get equal opportunities to access treatment. One of the ways is to provide more education to women. Creating earning opportunities for more women will reduce their dependency and expand their financial freedom. As women get empowered with education and employment, they can demand better healthcare.

VI. CONCLUSION

The HIV infection in India is no longer confined to high-risk population such as the intravenous drug users, men who have sex with men, truck drivers and commercial sex workers. The infection is gradually spreading from urban to rural areas and from high-risk groups to women who are mostly in monogamous marriages. Though the "feminisation" of the pandemic is most apparent in sub-Saharan Africa, in India too women are increasingly susceptible to HIV infection, as they account for around 2 million of the approximately 5.2 million estimated cases. Of these, only 0.5 percent of the women are sex workers. The fact that, in India, most of the women who are newly infected with HIV are practicing monogamy within marriage shatters the myth that marriage provides natural protection from AIDS. During the FGDs conducted with the HIV-positive women in the sample states, it was found that though in most of the cases the husbands of these women did not know their HIV status at the time of marriage, in a few cases the men were already aware of their status. But, in spite of knowing their status, these men entered into wedlock without disclosing their status. In a country like India, where women have a low status in society and low bargaining power in the marriage market, it is not possible for them to insist on a HIV test at the time of marriage.

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