Available Online through
www.ijpbs.com (or) www.ijpbsonline.com

IJPBS |Volume 2| Issue 2 |APRIL-JUNE |2012|232-236

Research Article
Biological Sciences

PROFILE OF CLIENTS TESTED HIV POSITIVE IN A VOLUNTARY COUNSELING AND TESTING CENTER IN GOVERNMENT MEDICAL COLLEGE SURAT, GUJARAT, INDIA

Kallol H. Mallick[1*], Bhautik P. Modi[2], Bipin C. Vasava[1], R.K.Bansal[3]
[1, 2, 3] *Department of Community Medicine,*
Surat Municipal Institute of Medical Education & Research (SMIMER), Surat
*Corresponding Author Email: anamikakallol@yahoo.com

ABSTRACT

Introduction: *According World Health Organization, approximately 34.0 (31.6–35.2) million people are living with HIV/AIDS worldwide. The Voluntary Counseling and Testing Centre (VCTC) provides a key entry point for the 'continuum of care in HIV/AIDS' for all segments.* ***Aim:*** *To understand the profile of patients attending VCTC of Medical College.* ***Methodology:*** *The present study was conducted in the VCTC of Government Medical College of Surat in Gujarat state of India. From 1st March 2003 to 31st December 2003 all the patients attending the VCTC of Government Medical College of Surat during the study period were interviewed. A total of 1007 patient was included in this study.* ***Results:*** *The male population constituted 701 (69.6%). The literacy rate among the female subjects was found to be 71.5%, while that in males was 85.7%. Approximately half of the study subjects (40.1%) had visited the VCTC voluntarily. Of the subjects who responded, 396 males (56.4%) had multiple sex partners and 1 was involved in homosexual practices. 23.7% preferred family counseling and 18.6% preferred one to one discussion with doctors. 3.2%of subjects anticipated a disturbance in their marital life, and 2.0% believed that they would be discriminated by their other family members.* ***Conclusion:*** *The medical fraternity should take a stand and fight against the discrimination of sufferers, rather than ostracizing them to have a positive attitude from HIV sufferers. Increased availability and the use of VCTC services will prove to be a huge potential benefit for the society.*

KEYWORDS

VCTC, HIV, Homosexual, Discrimination, Counseling

INTRODUCTION

According World Health Organization (WHO), 31.6 to 35.2 million people are living with Human Immunodeficiency Virus (HIV) infection.[1] Estimated number of HIV positive Indians are 2.7 million.[2,3] Both pre- and post-test counseling have become standard components of prevention-oriented HIV antibody testing programs.[4] The Voluntary Counseling and Testing Centre (VCTC) provides a key entry point for the 'continuum of care in HIV/AIDS' for all segments. According to the National AIDS Control Organization, prevalence rate of HIV in Gujarat is 0.25%.[5] The sentinel surveillance carried out in 2011 revealed that Surat has high prevalence of HIV infection.[6] This study may provide important clues regarding the epidemiological profile of HIV-positive individuals.

MATERIALS AND METHODS

The present study was conducted in the Voluntary Counseling and Testing Centre (VCTC) of Government Medical College of Surat in Gujarat state of India. From 1st March 2003 to 31st December 2003 all the patients attending the VCTC of Government Medical College of Surat during the study period were interviewed. The VCTC was visited daily in the morning hours between 9 am – 1 pm. A total of 1007 patient was included in this study. Permission for the study was obtained from the ethical committee of the institution. All patients were assured of

full confidentiality being maintained on any information provided by them. One Proforma was filled for each patient. Information for all the attendees of the VCTC was available from the records maintained at the VCTC regarding variables such as age, gender, marital status, education and occupational status, residence, behavioral patterns, discrimination anticipated, support expected. In the present study, only the data from patients who tested positive for HIV at the VCTC was included. This information was recorded when the client visited the VCTC for the first time and most of them were unaware of their status of HIV infection. HIV was diagnosed by performing enzyme-linked immunosorbent assay (ELISA) by using three different antigens and a rapid test as recommended by the National AIDS Control Organization (NACO). Data was collected and analyzed using the Epi-Info software.

However, the current study is subjected to certain limitations since it was conducted in a Medical college; therefore, the results are based on the reporting and data collection by the personnel employed in the VCTC. Information regarding certain variables such as socioeconomic status, counseling performed and condom use are not available. All these variables could have unmasked certain behavioral patterns and could have given new dimensions to this study.

RESULTS

The male population constituted 701 (69.6%) of the total 1007 study subjects.

Table 1: Socio demographic characteristics of the study subjects

Variable		Male (%) N=701	Female (%) N= 306
Age in groups	< 15	8 (1.1)	17 (5.6)
	15-49	623 (88.9)	271 (88.6)
	>50	69 (9.8)	17 (5.6)
Education	Illiterate	100 (14.3)	87 (28.5)
	Upto 4th standard	86 (12.3)	41 (13.4)
	Upto 8th standard	287 (41)	118 (38.6)
	Upto 12th standard	196 (27.9)	41 (13.4)
	College and above	30 (4.3)	17 (5.6)
Occupation	Unskilled	200 (28.5)	79 (26)
	Semi skilled	348 (49.6)	59 (19.3)
	Skilled	82 (11.7)	-
	Professional	30 (4.3)	10 (3.3)
	Housewife	-	104 (34)
	Unemployed	34 (4.8)	34 (11.1)
	Student	8 (1.1)	17 (5.6)
Marital status	Married	509 (72.6)	257 (84)
	Unmarried	191 (27.2)	48 (15.7)

Table 1 clearly shows the socio demographic profile of the attendees with positive test result. A majority of the study subjects, i.e., 894 (88.6%) belonged to age group of 15-49 years with 25 (2.5%) subjects being less than 14 years of age. The distribution according to marital status showed that 72.6% of males and 84.0% of females were married of which 11.1% of males and 44.4% of females were divorced, separated or widowed.

The literacy rate among the female subjects was found to be 71.5%, while that in males was 85.7%. The most common source of income for males (49.6%) was semi-skilled occupation, such as bidi rolling and fishing. Among females, 104 (34%) were housewives and 79 (26%) were

working as housemaids or laborers. The unemployment rate among the study subjects was 6.7%. All females and 149 males (93.1%) resided with their family members.

Approximately half of the study subjects (40.1%) had visited the VCTC voluntarily, while almost a similar percentage (59.9%) of the subjects was referred to the VCTC by another doctor. Among the reasons cited for their visit to the VCTC, illness (medical or surgical: 33.3%) was the leading cause, followed by 32.9% who visited for the confirmation of their test result. More than one-tenth (12.9%) of the study subjects had the family members (spouse/parents) who were positive for HIV and 29 (11.6%) were referred from a Directly Observed Treatment Scheme (DOTS) centre for detection and treatment of tuberculosis.

Among the total subjects, 301 males (43%) and 279 females (91.1%) did not respond to the question on the pattern of risk behavior followed. Of the subjects who responded, 396 males (56.4%) had multiple sex partners and 1 was involved in homosexual practices. Among the females, 20 (6.5%) were having multiple sex partners and 7 (2.3%) had a history of blood transfusion.

Table 2: Risk behavior followed by the study subjects

Risk behavior	Male No (%)	Female No (%)	Total No. (%)
Heterosexual multiple partners	395 (56.4)	20 (6.5)	415 (41.1)
Homosexual partners	4 (0.6)	0	4(0.4)
Blood transfusion	0	7 (2.3)	7(0.7)
No response	301 (43)	279 (91.1)	580 (57.4)
Total	701 (100)	306 (100)	1007 (100)

The expectation of the subjects regarding the social support after testing positive shows that 31.7% candidates were in favor of individual counseling by counselors, 23.7% preferred family counseling and 18.6% preferred one to one discussion with doctors. The views of the study subjects regarding problems they would face after disclosing their HIV status revealed that a large percentage of subjects (79.1%) believed they would be discriminated at the time of medical treatment. A small number of subjects, i.e., eight (3.2%) anticipated a disturbance in their marital life, and an almost equal number, i.e., five (2.0%) believed that they would be discriminated by their other family members.

DISCUSSION

The prevalence of HIV seropositivity in VCTC clients in the present study was noted to be 20.5%, which is higher than that reported from a study conducted in a district of West Bengal (17.1%) in 2003.[6]

The present study highlights the fact that males contributed to 69.5% of the case load in VCTC with 30.3% being the females. These figures are slightly lower than the national average of 38.4% for females. Such a high proportion of infection rate in females is a cause for concern since this will lead to a proportionate increase in the children being infected due to transmission from mother to child. It is believed that HIV/AIDS affects the bread winners of the society, which is also evident from the results of this study. According to the study, 88.6% of the subjects belonged to the age group of 15-49 years (the most sexually active age group), which is slightly lower than the national figure (90%) and the figure obtained from another study (92.4%) conducted at a VCTC in Darjeeling.[7]

The present study clearly indicates that 93% of the infected males and 100% of the infected females are living with their families. The information regarding their disclosure of the test result to their family members is not available and hence it is difficult to say whether such a high level of acceptance by the family, especially toward females will be maintained even after the disclosure or not.

The pattern of risk behavior shows that a large percentage of males (56.4%) and females (6.5%)

of those who responded to the study, were had multiple sexual partners. However, none of the women was working as a commercial sex worker. Heterosexual contact was the commonest mode of transmission, which is supported by the findings of another study from eastern India.[8] A large part of the married women (44.4%) who were HIV positive were separated, divorced or widowed. This can be explained by the strong family ties and inhibitions that Indian females have as a part of culture. A large part of the study subjects (42.8% males, 90.8% females) did not disclose their risk status in the questionnaire. The figures for the risk status were 29.9% in males and 53.8% females in a study conducted in West Bengal (2003).[7] This can be attributed to the fear of discrimination or punishment, which still prevails in the society toward HIV-infected individuals.

The major problem anticipated by the subjects was observed to be from the health personnel at the time of medical and surgical treatment. This could be a reason for only 18% subjects responding in favor of doctors as the best option for their support. More than half of the subjects were in favor of counseling since it is gaining importance in the current era as an important step toward normalizing the attitude to HIV and improving the environment for the prevention of its transmission. Another important finding of the study shows that approximately 3% of the subjects actually believed they would be discriminated by their family members, while the remaining thought that they would be easily accepted. This can be attributed to the increasing awareness among the people by the combined efforts of health care personnel and media. This assumption can also be explained by a large percentage of subjects coming to VCTC on their own without being referred by someone else. This was in contrast to the figures reported from a study in Chennai (2004-05) where only 3 of the total 89 HIV-positive patients had visited voluntarily for testing.[9]

The current study highlights the existence of HIV-TB collaboration, which is evident from the study since 29 subjects (11.6%) had been referred from the DOTS centers.

CONCLUSION

The high prevalence of seropositivity in the attendees of VCTC in medical college highlights the importance of this issue for the policy makers as well as health professionals. The medical fraternity should take a stand and fight against the discrimination of sufferers, rather than ostracizing them to have a positive attitude from HIV sufferers. Increased availability and the use of VCTC services will prove to be a huge potential benefit for the society.

REFERENCE

1. Global HIV/AIDS Response. Available at :http://whqlibdoc.who.int/publications/2011/9789241502986_eng.pdf Accessed on : 16/06/2012
2. 2.5 million People living in India with HIV, according to new estimates, NAIDS/NACO/WHO,6July2007.Available from ww.who.int/media centre/news/release/2007.
3. HHS/CDC Global AIDS program (GAP) in India. The GAP India Fact sheet, Available from:www.Cdc.gov/nchstp/od/gap/countries/India.htm.
4. Valdiserri RO, Moore M, Gerber AR, Campbell CH, Dillon BA Jr, West GR. A study of clients returning for counseling after HIV testing: implications for improving rates of return. Public Health Rep 1993; 108:12-8.
5. Modi B, Patel P, Patel S. A Profile of Patients Registered at Anti Retroviral Therapy (ART) Centre at Surat Municipal Institute of Medical Education & Research (SMIMER) in Surat City, Gujarat, India. SAARC Journal of Tuberculosis, Lung Disease And HIV/AIDS 2011;VIII(2):11-16
6. Sengupta D, Rewari BB, Shaukat M, Mishra SN. Study on Clinico-epidemiological profile of HIV Patients in Eastern India. J Posgrad Med 2001; 15:91-8.
7. Jordar GK, Sarkar A, Chatterjee C, Bhattacharya RN, Sarkar S, Banerjee P. Profile of attendees in the VCTC of North Bengal Medical College in Darjeeling district of West Bengal. Indian J Community Med 2006; 31:237-40.

8. Chakravarty J, Mehta H, Parekh A, Attili SV, Agrawal NR, Singh SP, et al. Study on Clinico-epidemiological profile of HIV patients in Eastern India. J Assoc Physicians India 2006; 54:854-7.

9. Studies on HIV/AIDS. Voluntary counseling and testing centre, Chennai: National Institute of Epidemiology; 2004-2005, Available from: www.google.com. Accessed on 12/03/2012

***Corresponding Author:**
Dr. Kallol Mallick
Assistant Professor,
Department of Community Medicine,
Surat Municipal Institute of Medical Education & Research (SMIMER),
Umarwada, Surat-395010
Gujarat

Address:
A3/404 New Model Town Park,
Parvat Patia, Puna Kumbhariya Road,
Magob, Surat – 395010,
Gujarat