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PERSPECTIVE**In Shortly about HIV and AIDS**

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ABSTRACT

HIV is a human immunodeficiency virus, a retrovirus that causes AIDS in the event of untreated infection. The virus causes the weakness and inability of the organism's defense system. HIV disease is a chronic progressive process that begins with the onset of HIV virus into the body, and over time (in adults over 10 years), a gradual destruction of the immune system occurs. The host during the infection becomes vulnerable and is suffering from complications of opportunistic infections and malignancies. A person infected with HIV feels good until developing AIDS, does not notice any changes in health, and has no specific external signs of infection. The only way to detect infection at this stage is HIV testing. HIV is transmitted: unprotected sexual intercourse with the infected person, exchange of needles, syringes or accessories with infected persons when taking drugs, with infected mother on her baby before, during or after delivery (breastfeeding).

KEYWORDS: HIV, AIDS, Screening.

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INTRODUCTION

The human immunodeficiency virus (HIV) which causes acquired immunodeficiency syndrome (AIDS) is transmitted through body fluids, in particular blood, semen, vaginal secretions and breastmilk [1].

Acronym for Acquired Immune Deficiency Syndrome, where the body's immunological defences are impaired by the action of HIV (human immune deficiency virus) [2].

TESTING

Testing for HIV infection provokes ethical questions about rights to privacy, potential discrimination, and the rights of others not to be put at risk for HIV infection [3]. Early in the AIDS epidemic, those at risk for infection were often urged to be cautious about seeking testing because of a possible loss of rights if they should be found to be infected. In recent years, however, the availability of new and effective treatments for HIV infection, clinical trials, and legislated protections for those infected with the virus have encouraged those at risk to seek testing. Such testing is voluntary and can even be anonymous, protecting rights to self-determination and privacy.

Informed consent has always been a requirement for HIV testing because those at risk for infection are considered to be competent persons with rights to self-determination. As self-determining individuals, they also need to consider the risks and benefits of knowing their HIV antibody status carefully. An adequate informed consent for testing must

include receipt of information, comprehension of the information, and voluntariness on the part of the person to be tested. Information that might be conveyed includes the availability and cost of treatment for HIV infection, the lack of a cure for AIDS, the possible stigma and discrimination that might threaten the well-being of a person found to be infected with HIV, and the availability of counseling for the HIV infected. Only when the person voluntarily agrees to testing can the test be done. If the test is found to be positive, the individual can exercise his or her rights to begin therapy or to enter an available clinical trial for treatment.

The European Court of Justice decreed that HIV testing had to be with the patient's specific consent in order to uphold the patient's rights to privacy under European Community Law [4]. Again, the underpinning belief was that the possibility of deception would result in people who were infected or at risk of becoming infected from seeking appropriate medical management. Likewise compulsory testing, detention and isolation would be an infringement of the liberty of the affected persons.

At the time that these policies and laws were decreed there was no vaccine and no cure for AIDS. With the development of Highly Active AntiRetroviral Therapy (HAART), which involves taking a variable combination of drugs, there has been a dramatic reduction in the viral load rendering the person less infectious to others. This treatment delays the onset of AIDS and therefore overall

mortality. The use of anti-retroviral therapy in pregnant women has also reduced perinatal transmission. These advances have led to a reduction in the financial burden to the various health systems and HIV/AIDS has been downgraded from a 'fatal disease' to a 'chronic condition'. As a result AIDS no longer constitutes a state of emergency in Europe. This has helped to reduce the stigmatisation of the infection and consequently the need for specific consent for HIV testing has had to be re-addressed. It could be argued that testing without consent is justifiable (both legally and ethically) in the context of the patient's best interests (e.g. where a person lacks capacity, whether through mental illness/disability or in the unconscious patient). Whether this applies to testing for the benefit of others not yet infected remains undecided.

CONFIDENTIALITY

The protection of confidentiality has been considered important to HIV testing in that it encourages people at risk for HIV to come forward for testing, counseling, and treatment [3]. Preserving confidentiality, however, can test the duties of health professionals to protect others, especially sexual partners of those with HIV or AIDS, from harm. Professionals have both a moral and legal duty to warn others who might be harmed significantly by a patient's actions. Applying this standard for the duty to warn in regards to HIV infection and AIDS treatment, however, has not been easy. The actual risk of HIV transmission between sexual partners (thus, the "foreseeability of harm") is hard to quantify in each case. In the final analysis, the health professional is expected to weigh the likelihood of harm to other parties against his or her duty to keep confidentiality and to act accordingly.

VIRUS

HIV destroys the human immune system, leaves millions of adults vulnerable to a wide range of lethal illnesses in the prime of their life and kills millions of children whose lives have barely begun [5].

PANDEMIC

HIV morbidity and mortality has had a huge impact on economies of LMIC (low- and middle-income countries) [6].

RESEARCH

As the major lethal infection of the late 20th and early 21st centuries, AIDS has generated a massive research enterprise [3]. It is the very nature of medical research that it produces ethical controversies. By definition, research is activity undertaken with the intention of producing generalizable knowledge. It, therefore, is not conducted primarily for the benefit of the patient. In much medical research involving sick patients, especially critically ill patients such as those with HIV, research may be comparing a standard treatment with one that offers promise to be a better treatment but that may also be more harmful. Randomized clinical trials are ethical only if there is no reason to believe in advance that one of the treatments

is better than the other. Hence, the randomization is never used for the benefit of the patient.

The nurse often participates in medical and behavioral research involving human subjects—sometimes as a principal investigator and other times as a research team member or advocate for the research subject [3]. Systematic research designed to test hypotheses and generate statistically significant generalizable results is a quite modern phenomenon. Traditionally, the primary objective of trying new interventions was to benefit the particular patient, especially when the usual remedies were not producing satisfactory results. Since about the middle of the 19th century, however, we have seen a change. Healthcare professionals now attempt to conduct systematically designed studies for the purpose of gaining knowledge to benefit society or specific groups within society, as well as the individual subjects of the investigation.

When this new purpose is added to the agenda, a new group of moral problems arises. The most conspicuous problem is the potential conflict between the healthcare professional's traditional duty to serve the individual patient—to benefit the patient or, as holders of newer, more rights-oriented biomedical ethical positions would say, to protect the rights of the patient—and the newer interest in benefiting others.

Since the post-World War II Nuremberg trials, researchers, potential subjects, and society at large have been concerned about the possibility that research agendas might conflict with traditional patient-centered obligations. At Nuremberg, after all, it became conspicuously clear that any investigator who approaches a human being as a subject for the purpose of gaining generalizable knowledge was abandoning, at least partially, the traditional focus on the welfare and rights of the patient. There were two major options: return to the ethic that required the healthcare professional to work only out of concern for the patient, or develop an ethic of research that would permit a limited shift of attention and, at the same time, protect the rights and interests of the potential subject.

FUTURE

The future of HIV/AIDS presents a mixed picture [5]. While HIV/AIDS incidence has begun to level off in some high-prevalence countries, new infections have increased in many developed countries. While several science-based prevention strategies need to be scaled up significantly, the increase in mother-to-child prevention has dramatically reduced infections among newborns and male circumcision is a promising new prevention strategy. While millions still lack access to treatment, there has been a large increase in funding, drug prices have dropped dramatically, several key drug patents will expire in the near future and efforts to develop new treatments continue. While stigma and discrimination remain obstacles to effective prevention and treatment, human rights laws have proved to be an effective vehicle for addressing discrimination and increasing access to treatment around the world. Thus, while HIV/AIDS continues to pose a

significant threat to public health, there are many signs that progress in fighting this pandemic can and will continue, as knowledge gradually replaces ignorance.

CONCLUSION

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