HIV-1 prevalence in young adults in south India

The article by Rajesh Kumar and colleagues (April 8, p 1164)

begins with misrepresentations. Although the title speaks of trends in HIV-1 in young adults of south India, the southern state of Kerala was omitted from the analysis. Paradoxically, Maharashtra, always represented as a western Indian state, was included. We do not understand the logic behind redefining the regional geography of India.

The omission of Kerala is significant because Kerala stands out as a low-prevalence state. Its inclusion would have slightly reduced the initial prevalence and attenuated the slope of the decline. The deliberate inclusion of Maharashtra serves the purpose of increasing the credibility of the conclusion in the paper. We also note that the three states in north India—Mizoram, Nagaland, and Manipur—excluded by the authors are high-prevalence states that do not fit into the pattern in north India. The title would have done more justice to the article if “south India” had been replaced by “selected states of India”.

An examination of the crude prevalence of HIV-1 in antenatal clinics indicates no consistent trend in the south Indian states (figure). It is quite clear that the steady decline in the prevalence of HIV-1 among young pregnant women is mainly driven by prevalence in Tamil Nadu, followed by Maharashtra (see Kumar and colleagues’ reference 1 and webfigure 1). The significant decline of HIV-1 prevalence in Tamil Nadu seems to counteract the apparent lack of trend in other south Indian states. If Kerala was included and Maharashtra excluded (figure), one would conclude that the decline in HIV-1 prevalence in south India is a Tamil Nadu phenomenon.

The aggregate analysis suggesting that the rate of infection in south India is declining among young women is likely to generate an air of optimism leading to complacency. The need of the hour is to establish more antenatal clinics in every Indian state and generate reliable state-level estimates of HIV-1 prevalence. Until that time, broad generalisations based on deliberate selection of states seem premature.

We declare that we have no conflict of interest.

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Although the report by Rajesh Kumar and colleagues on the reduction in HIV-1 prevalence in south Indian states is good news, several questions remain.

A month before publication, the Tamil Nadu State AIDS Control Society’s 2005 Annual Report on Sentinel Surveillance was released. The crude data on prevalence in pregnant women (the same dataset for Tamil Nadu used by Kumar and colleagues) showed a peak (1·13%) in 2001 and thereafter a steady decline each year (2002-05: 0·87%, 0·75%, 0·65%, and 0·50%, respectively). In 2005, the prevalence by age-groups was: 25–29 years 0·74%, 20–24 years 0·50%, and 15–19 years 0·48%. Among men in clinics for sexually transmitted diseases, the prevalence was more than 16% in 2000, 14·7% in 2002, but about 9% in 2003, 2004, and 2005. In summary, Tamil Nadu has had a clear decline in prevalence since 2000/01.

The paper does not mention the degree of interstate variability, or whether decline was consistent in all “southern” states. I suspect that the overall decline of “more than a third” is predominantly, if not solely, due to the decline (of about 56%) in Tamil Nadu. If so, the prevalence in Karnataka, Andhra Pradesh, and Maharashtra might not have convincingly declined and the message of decline in all southern states might be misleading. If National AIDS Control Organisation (NACO) interventions alone were the major reason for the success in Tamil Nadu, then such a decline would have been seen in other states as well. Therefore it is important to distinguish between the achievements of Tamil Nadu and those of the other states.

Of all the vertical public-health programmes in India, in my opinion, HIV control is the most efficient. For successful control (India’s National Health Policy 2002 calls for stabilisation of prevalence by 2007),