



Review Article

Health Related Quality of Life in HIV Positive Individuals

Sana Noreen¹, Abdul Rehman² and Rabia Kanwal¹¹University Institute of Diet and Nutritional Sciences, Faculty of Allied Health Sciences, The University of Lahore, Lahore, Pakistan²Department of Medicine, Services Institute of Medical Sciences, Lahore, Pakistan**Keywords:** Human Immunodeficiency Virus, Health Related Quality of life, AIDS, HIV**How to Cite:**Noreen, S., Rehman, A. ., & Kanwal, R. (2021). Health Related Quality of Life in HIV Positive Individuals . *Pakistan Journal of Health Sciences*, 2(02).<https://doi.org/10.54393/pjhs.v2i02.30>**Article History**Received: 10th July 2021Accepted: 8th August 2021Published: 31st December 2021**Corresponding author:**

Sana Noreen

University Institute of Diet and Nutritional Sciences, Faculty of Allied Health Sciences, University of Lahore Pakistan, Lahore, Pakistan

sananoreen.rizwan@gmail.com**ABSTRACT**

Human Immunodeficiency Virus (HIV) patients require social assistance which has a substantial influence on Health Related Quality of Life (HRQOL). Physical, emotional and awareness aid are the three key building blocks of societal support system. It is critical to distinguish between these types of societal support because they are so interrelated yet their roles are so diverse and substitutable. For individuals suffering from AIDS/HIV it's difficult to do day to day chores, engage in simple to severe physical activity. They also usually lack the potency to indulge in any social life actively. In these individuals, lack of energy or fatigue has resulted in psychological and physical morbidity, along with poor QOL.

INTRODUCTION

Human Immunodeficiency Virus (HIV) is a member of the lentivirus subgroup of retroviruses, which have a lengthy incubation time. Clinically HIV infection is divided into three major stages: an early acute stage that begins 2-4 weeks after infection with symptoms similar to mononucleosis, lethargy, fever, sore throat, and a generalized lymph-adenopathy; a late acute stage that begins 2-4 weeks after infection with symptoms similar to mononucleosis, lethargy, fever, sore throat, and a generalized lymph-adenopathy [1-4]. HIV patients may have a wide range of symptoms. However, people suffering exclusively with HIV had an overall better standard of living. Those Patients with additional illnesses to HIV/AIDS may have a varied living standard. The second stage is the latent phase, which is characterized by the absence of symptoms. Third stage of immunodeficiency is when the person is vulnerable to opportunistic infections [5]. The phrase "health-related quality of life" points towards an individual's functional abilities as well as feelings of welfare regarding mental, social and physical aspects of his life [6].

For estimating the return on healthcare investment, recording the number of chronic diseases reported, recording the health differences over time, evaluating results for the treatment and calculating the cost of chronic disease it is important to analyze the health associated standard of living. The American psychologist John Flanagan's quality of life scale, created in 1970s is adapted for use in chronic illness groups [7]. Because of the illness's lengthy and severe nature, as well as the unknown influence of current treatments on morbidity, wellbeing living standards in individuals infected with HIV disease may be especially important: In spite of the fact that the duration related to therapeutic impact is unclear, and there are severe side effects commonly reported, the newly introduced antiretroviral treatments has shown promising results [8]. Since 1983, when scientists first discovered the AIDS virus, it has infected 78 million individuals and killed around 39 million. These estimates obscure the dynamic character of this developing pandemic in terms of time, geographic spread, size, viral variety, and mechanism of transmission. There is now no region of the planet that has not been affected by this outbreak. The United Nations and World Health Organization (WHO) have launched a program on AIDS (UNAID) that provide annual revised HIV/AIDS surveillance figures on a global scale. In the developing world, AIDS and HIV



surveillance systems are less comprehensive and HIV trends are generally tracked through repeated cross-sectional HIV sero-prevalence system surveys among women attending antenatal clinics as proxies for the population of sexually active adults of childbearing age [9]. According to UNAIDS/WHO, at the end of 2006, 39.5 million were infected with HIV with majority (63 percent) living in Sub-Saharan Africa. In 2005 alone, 41 million HIV-1 newly infected patients and 28 million deaths were reported caused by AIDS. In 2006, an average total 4.3 million individuals were infected with HIV, and an approximately 2.9 million died as a result of AIDS [10]. Southern Africa has the highest HIV seroprevalence rates among pregnant women in the world (20-50 percent). China declared its first AIDS-related case on June 6, 1983[11].

In 1986, the first case of HIV in India was discovered in Chennai, Tamil Nadu's southernmost state. NACO (National AIDS Control Organization) has reported that in adult HIV currency in India was 0.88 percent in 2005, equating to about 52 million persons infected with HIV, or one in every eight HIV infections globally [12]. Whenever under-diagnosis, under-recording, and postponements in treatment occur, it will result in increase of cases, currently there are 40 000 HIV-infected people. The WHO, on the other hand, projected that at the end of the year 1994, there were actually reporting HIV [13]. According to the Pakistan National AIDS Control Program, HIV was first identified in Pakistan in 1987, and the number of cases has grown since then (NACP). Pakistan is a South Asian developing country and like other developing countries it lacks in basic health related services causing lack of monitoring system needed to fight this disease [14].

The majority of the data obtained is from point-occurrence studies of blood donors and a limited number of people those are at risk due to these activities [15]. Given the increased lifetime made available by modern HIV prevention and treatment approaches, quality of life (QOL) is recognized an important medical result indicator, and improving it is a critical goal. QOL or living standards can be expressed a feeling that involves traits like being happy and general contentment in life. WHO defines standards of living as a relationship between that person's insight on one's standing position in life and his goals, standards, expectations and concerns built on the basis of his cultural and religious values [16].

To buffer stress in non-HIV settings it is important for the society to accept in order for an individual to feel a sense of belonging and a space for growth and exceedance is extensively established. Researchers found that emotionally sustaining assistance was more sought and frequently used than other types of care. HIV-infected are leading normal, longer and healthier lives. Many HIV-positive individuals are now expected to live as much as non-HIV individuals around them [18]. Furthermore, tiredness and a lower than five hundred CD4 T-cell count are related to physical in capabilities and impairment [19]. In HIV positive people, illness development is characterized by declining productivity, greater difficulty with daily chores, and pain. With the introduction of combination ART, AIDS/HIV has now become potentially treatable condition. ART has the potential to increase survival, decrease the frequency of HIV-related opportunistic illnesses, as well as improve individual's standard of living [20, 21].

REFERENCES

1. Patel P, Rose CE, Collins PY, Nuche-Berenguer B, Sahasrabudhe VV, Peprah, E., Levitt, NS. Noncommunicable diseases among HIV-infected persons in low-income and middle-income countries: a systematic review and meta-analysis. *AIDS* (London, England), 2018, **32**(Suppl 1), S5. doi.org/10.1097/QAD.0000000000001888
2. Smith C, Sabin CA, Lundgren JD, Thiebaut R, Weber R, Law M et al. Factors associated with specific causes of death amongst HIV-positive individuals in the D: A: D Study. *Aids*, 2010, **24**(10), 1537-1548. doi.org/10.1097/QAD.0b013e32833a0918
3. Palios J, Kadoglou NP & Lampropoulos S. The pathophysiology of HIV-/HAART-related metabolic syndrome leading to cardiovascular disorders: the emerging role of adipokines. *Experimental Diabetes Res.*, 2012, 2012. doi.org/10.1155/2012/103063
4. Neufeldt,CJ, Cortese M, Acosta EG & Bartenschlager R. Rewiring cellular networks by members of the Flaviviridae family. *Nature Rev. Microbi.*, 2018, **16**(3), 125-142. doi.org/10.1038/nrmicro.2017.170
5. Emerson B, Plough K, Pangloli A, Haq S, Serinaldi D & Bannister E. Detection of acute HIV-1 infections utilizing NAAT technology in Dallas, Texas. *Journal of Clinical Virology*, 2013, **58**, e48-e53. doi.org/10.1016/j.jcv.2013.08.005

6. Andersson GZ, Reinius M., Eriksson LE, Svedhem V, Esfahani FM, Deuba K, Ekström AM. Stigma reduction interventions in people living with HIV to improve health-related quality of life. *Lancet HIV*, 2020, **7**(2), e129-e140. [doi.org/10.1016/S2352-3018\(19\)30343-1](https://doi.org/10.1016/S2352-3018(19)30343-1)
7. Dutra BS, Lédo AP, Lins-Kusterer L, Luz E, Prieto IR & Brites C. Changes health-related quality of life in HIV-infected patients following initiation of antiretroviral therapy: a longitudinal study. *Brazilian J. Infec. Disea.*, 2019, **23**, 211-217. doi.org/10.1016/j.bjid.2019.06.005
8. Moro ALD. Fatores de risco para falha virológica primária em pacientes com HIV e genotipagem pré-TARV: um estudo de corte retrospectivo, 2018, <http://hdl.handle.net/10183/188749>
9. Strathdee SA, Martin NK, Pitpitan EV, Stockman JK & Smith DM . What the HIV pandemic experience can teach the United States about the COVID-19 response. *J. acquired immune deficiency syndromes* (1999), 2021, **86**(1), 1. doi.org/10.1097/QAI.0000000000002520
10. Oster AM, Switzer WM, Hernandez AL, Saduvala N, Wertheim JO, Nwangwu-Ike, N, Hall HI. Increasing HIV-1 subtype diversity in seven states, United States, 2006-2013, 2017, *Annals of Epidemiology*, **27**(4), 244-251. e241. doi.org/10.1016/j.annepidem.2017.02.002
11. Becasen JS, Denard CL, Mullins MM, Higa DH & Sipe TA. Estimating the prevalence of HIV and sexual behaviors among the US transgender population: a systematic review and meta-analysis, 2006-2017. *Am. J. Pub. Hlth.* 2019, **109**(1), e1-e8. doi.org/10.2105/AJPH.2018.304727
12. Ramachandran S, Thai H, Forbi JC, Galang RR, Dimitrova Z, Xia G-l, Gentry J. A large HCV transmission network enabled a fast-growing HIV outbreak in rural Indiana, 2015, 2018, *E Bio Medicine*, **37**, 374-381. doi.org/10.1016/j.ebiom.2018.10.007
13. Bala R & Yadav C. Targeted Intervention with Female Sex Workers: Role of Punjab State AIDS Control Society and National AIDS Control Organization. *Int. J. Res. Soc, 2019, Sci.*, **9**(1), 2.
14. Ali A, Ali NS, Nasir U, Aadil M, Waqas N, Zil-E-Ali A, Anjum I. Comparison of knowledge and attitudes of medical and dental students towards HIV/AIDS in Pakistan. *Cureus*, 2018, **10**(4). doi.org/10.7759/cureus.2426
15. Khan R & Bilal A. Knowledge about HIV and Discriminatory Attitudes toward People Living with HIV in Pakistan. *Pakistan J. Pub. Hlth.*, 2019, **9**(1), 37-41. doi.org/10.32413/pjph.v9i1.237
16. Hipolito RL, Oliveira DCd, Costa TLd, Marques SC, Pereira ER & Gomes AMT. Quality of life of people living with HIV/AIDS: temporal, socio-demographic and perceived health relationship1. *Revista latino-americana de enfermagem*, 2017, **25**. doi.org/10.1590/1518-8345.1258.2874
17. Ghiasvand H, Wayne KM, Noroozi M, Harouni GG, Armoon B & Bayani A. Clinical determinants associated with quality of life for people who live with HIV/AIDS: A Meta-analysis. *BMC Health Services Research*, 2019; **19**(1), doi.org/10.1186/s12913-019-4659-z
18. Cotto B, Natarajanseenivasan K & Langford D. HIV-1 infection alters energy metabolism in the brain: contributions to HIV-associated neurocognitive disorders. *Progress in Neurobiology*, 2019, **181**, 101616. doi.org/10.1016/j.pneurobio.2019.101616
19. Cho H, Iribarren S & Schnall R. Technology-mediated interventions and quality of life for persons living with HIV/AIDS. *Applied Clinical Informatics*, 2017, **8**(02), 348-368. doi.org/10.4338/ACI-2016-10-R-0175
20. Kreuzer K.-A, & Rockstroh J. Pathogenesis and pathophysiology of anemia in HIV infection. *Annals of Hematology*, 1997, **75**(5), 179-187. doi.org/10.1007/s002770050340
21. Pelchen-Matthews A, Ryom L, Borges ÁH, Edwards S, Duvivier C, Stephan C, Weber J. Aging and the Evolution of comorbidities among HIV-positive individuals in a European cohort. *Aids*, 2018; **32**(16), 2405-2416. doi.org/10.1097/QAD.0000000000001967