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HIV-Related Knowledge in PLHIV: Issues to Consider in the Indian Context—A Reply to Banagi Yathiraj et al

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The article by Banagi Yathiraj et al reports poor knowledge of HIV transmission among People Living with HIV/AIDS (PLHIV) in India which signifies the need for the provision of regular, effective counseling services.[1] As per the guidelines of the National Aids Control Program IV in India, care and support centers (CSCs) are established and linked to Anti Retroviral Therapy (ART) centers for provision of counseling services to PLHIV.[2] ART centers in India provide refills usually lasting for at least 1-month duration which enable PLHIV to participate in regular counseling session that is expected to improve their knowledge of HIV transmission. However, the Banagi Yathiraj's et al study did not find duration of ART to be associated with HIV-related knowledge in their subjects. This suggests that either counseling sessions were not being conducted or attended regularly or they were ineffective in increasing knowledge of HIV transmission in a majority of the subjects. An accompanying situational analysis of the operational status and referral linkages of ART centers with CSCs along with assessment of the quality of counseling services and the information, education, and communication (IEC) material used should also be considered in future research.

Illiteracy was reported as an independent predictor of poor HIV-related knowledge by the Banagi Yathiraj's et al study. Indeed, the lack of literacy correlates with lower health literacy which undermines patient comprehension of health information imparted during counseling.[3] Thus, the covariate for low educational status when considering disease-related knowledge in patients is more appropriately due to lack of functional literacy as opposed to only illiteracy since the former includes the subset of the patient population who experience challenges in basic reading and comprehension skills which hinder their utilization of the health information (IEC materials) received either from media or during counseling. Furthermore, it has been observed especially in context of low and lower middle-income countries including India that increase in school enrollment does not necessarily translate into favorable learning outcomes, with less progress likely among children in economically and socially disadvantaged families.[4] Nevertheless, the presence of a certain number of years of schooling usually at least until primary school may be considered as an acceptable proxy for functional literacy.[5]

The Banagi Yathiraj's et al study also should have reported the methodology and definition used for assessment of nonadherence to ART. Multiple methods based on self-report, pill counts, and pharmacy records may be used for assessing ART adherence.[6] Furthermore, the definitional cutoff for nonadherence to ART can be set at an adherence rate <80%, <95%, and also <100%.[7] Since the proportion of ART nonadherent PLHIV subjects in the Banagi Yathiraj's et al study is likely to vary depending upon the method and definition used for assessing ART adherence, it may also influence the outcome of the relationship between ART adherence and HIV-related knowledge.

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