AIDS becomes a serious health problem in India

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AIDS is rapidly becoming a major health crisis in India, which the government is only beginning to address in a limited fashion. The real extent of the disease and its impact are not known but various estimates put the number of deaths a year in the six-digit realm. The World Health Organisation (WHO) publication *Epidemiological Fact Sheet on HIV/AIDS and sexually transmitted infections* (2000 update) estimated that a staggering 310,000 adults and children died of AIDS during 1999.

According to the latest figures released by Indian Department of Health on March 20, the number of adults believed to be HIV-positive was 3.86 million in 2000. UNAIDS estimated that 5 million people were HIV-positive in India at end of 1998 and WHO put the number at 4 million. If one expresses the WHO figure as a percentage, then 0.4 percent of the population or 0.7 percent of the adult population are HIV-positive. Although the rate is less than 1 percent, the sheer volume of HIV-infected people makes India second only to South Africa in terms of overall numbers. India is now home to 12 percent of the HIV-positive people in the world.

The number of identified cases of HIV-infection is relatively low as a result of serious underreporting due to general ignorance of the disease, cultural taboos and other factors. According to the government's National AIDS Control Organisation (NACO), the number of reported cases from 1986 to February 2001 was just 19,115. NACO stopped publishing the data explaining that there was "gross under-reporting of HIV infections" and the data was therefore of limited value.

The surveillance studies done by the NACO reveal a dangerous spread of the disease. Over five years, HIV infection has grown from 1 percent to 51 percent among commercial sex workers in Bombay in Western India and from 1 percent to 55.8 percent among drug users in North-East State of Manipur. Among truck drivers in Tiruchi in the south Indian state of Tamil Nadu, the rate jumped 2.7 percent to 5 percent in just two years.

Dr Rajan Gupta, a nuclear physicist at Los Alamos National Lab in the US, who is concerned at the spread of AIDS in India warned of a disaster: "Given the current conservative numbers of HIV-positive individuals (UNAIDS estimates 5 million HIV positive people in India at end of 1998) and doubling every 2-3 years means that there will be 50 million by 2007 and 100 million by 2010. This is one in 10 people, i.e. on average one in every family. Also, it is important to realise that all socio-economic levels are already affected. Thus life as we know of will cease to exist by year 2010, if not sooner."

A World Bank report published in September 1999 entitled "India's National AIDS Control Program" warned: "By early in the next century, India will have the highest number of AIDS cases in the world. Even if HIV infection reaches the 'low' level of five percent seen in many other countries, more than 37 million Indians would be HIV-infected."

Poverty and inadequate health services are contributing to the spread of the disease. The same World Bank report pointed out: "HIV infection in India is concentrated among poor, marginalised groups, including commercial sex workers, truck drivers, migrant laborers, men having sex with men, and injecting drug users."

Originally confined in the 1980s to prostitutes and their clients—mostly long-distance truck drivers and migrant workers—HIV-infection spread to the general population in the early 1990s. By the mid-1990s, the first cases of children born HIV-positive began to appear. Narcotic drug users are at high risk through the use of unsterilised needles.

The HIV virus is also transmitted in hospitals and health centres through blood transfusions, the use of unsterilised needles for intravenous drips and unsterilised surgical instruments in operations. According to the *Bulletin of the WHO*, Volume 77, No.10, 1999, the level of unsafe injections in India is estimated as 50 percent.

While the World Bank claims that the Indian government has taken extensive measures to prevent HIV-infection through blood transfusion, Dr Gupta comments: "An Indian government study based on data from HIV sentinel survey centres concludes that about 10 percent of HIV infections are due to blood, blood products, surgical instruments and needles... To me the more telling statement of the severity of the risk is that, today, no educated and well-to-do person is willing to go to a hospital, especially a government hospital, and accept a blood transfusion unless they personally know a doctor there who will pull the ropes and do the checks."

Although government regulations require the screening of

blood and the use of sterilised needles and surgical instruments, the rules are not strictly adhered to as result of the lack of funding. According to a World Bank report published in January 2000: “In health, India's public spending is very low: an estimated 1.2 percent of its GDP. This figure places India among the lowest quintile of countries, and on a per capita basis, is far less than the amount recommended to provide basic services by the World Development Report 1993.” The report also pointed out that of the total spending on health the government contributes only 20 percent while the private sector, oriented to wealthier social layers, makes up the rest.

Even though the first HIV case was identified among prostitutes in Madras in 1986, the government's initial surveillance, screening and education programs were very limited. It was not until 1992 that it established the NACO under the Ministry of Health and Family Welfare. According to a WHO report, NACO only began to seriously establish consistent HIV surveillance in each state in 1998.

The total funding for first five-year plan for NACO was just $US100.5 million, of which only $15 million came from the government. The remainder was made up of $84 million of interest free credit from the World Bank-affiliated International Development Association and $1.5 million from the WHO. In the second phase of the program for the period up to 2005, financing has increased to $328 million, which is a pittance compared the latest defence budget of around $13 billion or the tax concessions of $1.2 billion provided for big business

Dr Gupta commented: “The money we see for HIV/AIDS prevention in India has mostly come from international sources. The Phase II of NACO is 86 percent funded by loans, primarily from the World Bank and USAID. The 14 percent Indian contribution is of the same size as the foreign exchange incentives given to Indian business for hard currency trade. So, in spite of the rhetoric, as far as the indigenous government funding is concerned, India is treating HIV/AIDS no different than any other disease. Also, there is no sustained awareness campaign through TV or the newspapers, or any other media.”

As in South Africa, access to anti-retroviral drugs to retard the onset of AIDS is developing as a major issue. In the West, a triple-drug cocktail costs $US10,000-15,000 a year per patient. Indian drug companies such as Cipla Ltd. have charged markedly less—until recently $1,800 per year per patient. Now Cipla is offering the drug combination at $800 per patient per year to the Indian government, $600 for underdeveloped countries and $350 to Doctors Without Borders.

Major drug corporations such as Britain's Glaxo Smith Kline and the US-based Bristol-Myers Squibb are seeking to use their patents to prevent Indian firms from manufacturing generic drugs. They claim the high prices are necessary to cover the cost of research. But as Cipla's chairman Dr Yusuf Hamied commented: “The name of the game is monopoly... If these companies spend ‘x' on research, they spent ‘9x' on protecting their monopoly. I have broken no laws, and I am not a threat to anyone. There is room for a hundred Ciplas. I am not against patents and I am willing to pay royalties, but a country like India, with a billion people, simply cannot afford a monopoly on these drugs.”

Under existing Indian laws, it is only drug-making processes that are protected by patents and so local companies can copy foreign medicines. As a result, Cipla and other Indian companies are able to produce anti-AIDS cocktails at relatively low costs and, of course, can make substantial profits. The prices of local generic drugs are still far beyond the reach of the vast majority of people, who have to rely upon government and non-governmental agencies.

The limited character of the government programs was highlighted in an article in the *New York Times* on March 27, which noted: “India is also failing to prevent women from passing the disease to their newborns. The appropriate drug, nevirapine, is simple to administer and costs about $1 per child. Yet India is only now beginning pilot projects to cut mother-to-child transmission. Generic manufacturers in India are negotiating to sell a cocktail of AIDS medicines to African governments for $600 a year. But, shamefully, India's government does not buy these drugs. It claims that even $600 a year is too much and would drain health budgets.”

The situation for HIV patients is likely to dramatically worsen in 2005 when India will be subjected to the World Trade Organisation rules related to patents. Not only drug-making processes but also the end products—the drugs themselves—will be protected, effectively putting an end to the cheaper generic drugs that are currently available.

Taken together, these trends—the rapid spread of the disease, the indifference of the Indian government, the lack of adequate health programs and the high cost of drugs—have all the makings of a major health catastrophe on the Indian subcontinent.