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National debate provoked on how to meet the threat

by Susan Maitra from New Delhi

A great fuss has broken out during the month of June in India that may determine whether or not the country can prevent the deadly AIDS virus from getting a foothold here.

Dr. A.S. Paintal, the distinguished physiologist and head of the Indian Council of Medical Research (ICMR), is an unlikely person to provoke such a fuss. But at a recent ICMR function, Dr. Paintal mentioned, apparently in passing, that the Health Ministry had approved a proposal from ICMR for legislation banning sex with foreigners and visiting non-resident Indians (NRIs) in an effort to "save the nation from self-destruction."

In a very private society that likes to think of itself as sexually conservative and immune to the decadence of the West, the reaction was immediate. News blasts, commentaries, and editorials poured out. An impassioned buzz began. Impossible to enforce! An infringement of rights! Invasion of privacy! The man is crazy! How dare he question our moral standards!

National debate

Dr. Paintal's proposal itself may well be outrageous and unworkable, but as this writer learned in a discussion with the ICMR chief, making it was part of a deliberate strategy to force a wide public debate on how to meet the AIDS threat. Indeed, that such a distinguished scholar should raise this kind of public controversy defies every norm of business-as-usual in Indian bureaucratic public life—and that, more than anything else, offers the chance for a useful result.

Dr. Paintal would like to see workshops of young people and their parents and teachers across the country. The demand for discussion of the AIDS threat will be concretized with a full-scale formal debate organized through the universities when the fall term opens. The precise terms of the debate are now being finalized, Paintal told *EIR*, but contestants will be challenged to defend Paintal's proposal, and explain how to implement it, or propose a workable alternative.

"We will make sure that more marks are given for substance than for style," Paintal said, adding that ICMR is now preparing extensive educational materials to feed into the debate on the campuses. The winner will be announced on Jan. 1, 1989, and, hopefully, the concluding rounds of debate will be televised nationally.

So far, there have been 14 reported cases of AIDS in India—of these, 10 were Indians and 4 were foreigners. Of the 10 Indian cases, evidence suggests that the infection was acquired abroad in eight cases; the ninth case is the wife of one of the patients. The tenth case appears to be the first "genuine Indian case," the result of a blood transfusion from a local Indian donor who had never been abroad.

"Now we have waked up," Paintal told *EIR*. "And we must see to it we don't make the same mistakes as the West," he added, referring to the AIDS education campaigns which, in his view, have been a failure.

Paintal's worry

Of immediate concern to Dr. Paintal are the urban upper-class Indians, of which the NRIs are a prominent part—9 of the 10 Indian AIDS cases have emerged from this group, and it can no doubt be considered the major pool for "fast track" spread of the AIDS virus here. This is the section of the population where traditional values have given way to a heady cosmopolitanism, where sexual and even drug experimentation is rife, where extended stays abroad in America, Europe, and Africa are common, and where wealth buys exemption from such things as the nationwide AIDS surveillance system.

It is this section of the population, more than foreigners per se, that must be provoked or coerced into responsible behavior—such as getting tests—according to Paintal, and a notice in the mail simply won't do it. Unlike Thailand, the Philippines, and some other nations, Paintal explains, India has never been on the "sex tour" map. Tourists come, usually in groups, to see the Taj Mahal and the Himalayas in Kashmir. Their routes are defined and their contact with the population minimal.

The streams of what used to be called hippies that have made a point of pilgrimages to Goa and a few other spots are identifiable, and potentially screenable. According to recent press reports, the Indian government will initiate spot checks

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at airport arrival terminals, where suspected AIDS carriers among incoming passengers can be tested on the spot and delayed for several hours pending preliminary results before being cleared through immigration.

In January, at an AIDS conference in London, Indian Minister of Human Resources Narasimha Rao advocated that an AIDS-free certificate be routinely issued abroad as part of the travel documents carried by foreign travelers, but there has been no discussion here of such a proposal, and so far there is no indication that the Indian government has seriously considered making such a certificate mandatory for visitors. Besides ritual invocation of the World Health Organization's view that such a measure is impractical, Dr. Paintal again pointed to what he views as India's peculiar dilemma—what about the NRIs? Most of them are Indian citizens, he points out, and all have families and relations here—can you tell them they cannot enter India?

Broader mobilization

Since 1985, when the ICMR first set up a task force to investigate how HIV might affect India, the issue has become a central concern of the health establishment. "I am being pushed to the wall," Paintal told another interviewer. "The ICMR is responsible for the health of the nation. I shudder when I think of the scenario in Britain: only one case in 1981, and a projection of 10,000 in 1991."

Besides the national debate initiative, several other measures are in the pipeline. First is a policy for screening *all* blood donors in the country, a measure which, just a year ago, had been dismissed as "too expensive." Over 1 million bottles of blood are transfused in India annually, and testing for hepatitis B, a serious problem in India, is not even 100% yet. According to Dr. Paintal, following the detection of five seropositive blood donors in the course of spot checking in late 1987, surveillance of blood donors was intensified and a pilot project undertaken in Tamil Nadu for 100% screening to determine its cost and feasibility.

"We must give more attention to the person with AIDS," Paintal added, referring to the intolerable incident in Calcutta several years ago, when a prostitute found to have HIV infection—the first case in Calcutta—was thrown in jail. She escaped from the jail and was never found again. A decision has been taken, he said, to treat AIDS patients as ordinary patients, and another meeting on hospital policy on AIDS was convening at the institute as this writer left.

Meanwhile, the country's surveillance system is being strengthened as much as possible. In just over two years, when the first tests were done at the Christian Medical College in Vellore, Tamil Nadu—and 10 prostitutes from a vigilance home in Madras were found to be seropositive for HIV—a nationwide system of 39 surveillance centers and four reference centers has been built up. All centers are equipped with ELISA kits, laboratory facilities, and trained staff for conducting the tests. Positive results are referred to one of the reference centers for confirmation using the Western Blot test.

Screening and followup

For the most part, survillance is limited to so-called high-risk groups—prostitutes, heterosexually promiscuous men and women attending sexually transmitted disease (STD) clinics run by the government, and to a lesser extent, homosexuals and drug users, blood donors and repeated recipients, and suspected cases of ARC/AIDS. The surveillance network is operated as a collaboration among ICMR, the Health Ministry in Delhi, and the state health authorities, who are expected to organize sample collection and designate medical colleges to serve as centers. As a result, the centers' operation has been uneven; in many states where the local authorities have not been able to function effectively, very few individuals have been screened.

By February 1988, some 87,000 individuals had been screened, and 263 were found to be seropositive for HIV. By April this number had jumped to 305, all seropositive and asymptomatic. Included in this number are 30 foreign students. India acted quickly in early 1987 to institute testing of all foreign students in the country, more than 80% of whom come from Africa. In spite of initial political resistance from some student groups and a few days of noisy demonstrations charging the policy was "racist," more than 6,000 students have been tested. The policy is still in force, and may be strengthened as some universities have apparently failed to implement it fully.

From the outset, emphasis has been placed on rigorous followup of the asymptomatic, seropositive individuals. The ICMR's December 1987 bulletin notes that this followup will provide the data base from which to evaluate the validity of the WHO's criteria for clinical diagnosis of AIDS in developing countries where undernutrition is common and diarrheal diseases, tuberculosis, and parasitic and skin infections are prevalent.

The reference center at the All India Institute of Medical Sciences (AIIMS) in New Delhi has also initiated studies on the immune status of the HIV seropositive persons. Interestingly, the studies have shown that although some of these individuals had moderate immune depression and hypergamma globulinemia, none have so far shown any clinical evidence of increased susceptibility to infections. Two women have become seronegative during followup and remain asymptomatic. The significance of these findings is not yet clear, states ICMR.

Both AIIMS and another reference center, the National Institute of Virology in Pune, have reported successful isolation of HIV from seropositive individuals in India. This is an important step toward definitive characterization of the Indian virus—HIV 1, HIV 2, or something else—and possible identification of more specific courses of action to combat the disease.