Poverty-AIDS Spiral Is Threat to Indian Nation

by Mary Burdman

Extreme poverty, the fast-spreading plague of addictive drugs, and mass migration to huge, unliveable "super-cities," are all coming together to generate a serious threat to the people of India. Visiting India during January, Helga Zepp-LaRouche and I had the opportunity to visit a small clinic for HIV and AIDS patients in East Delhi. Here, as we were told by Mrs. Doe Nair, who invited us to the clinic, a group of women volunteers are working to bring some primary health care to 300,000 people crowded into slum districts of East Delhi. Inside the area is a colony for victims of leprosy, who come from all over the north of India.

The purpose of this small, 10-bed clinic, is to try to *contain* the rapid spread of HIV infection and AIDS in the area. Figures gathered at random by non-governmental organizations (NGOs) running programs in many different areas of India, indicate a much higher rate of HIV/AIDS infection in the country than official government figures admit to—in some areas, even as much as 4% of the population (see *EIR,* Jan. 31, 2003, "AIDS Pandemic Won't Peak for 40 Years").

The clinic has a very active "outreach": Every week, staff members go out to the neighborhoods with leaflets and puppet and "magic" shows, to attract adults and children alike. The staff works very closely with local religious leaders and teachers in each neighborhood. The clinic physician, one of the few in India specializing in AIDS, holds weekly "office hours" in a small, barely furnished shopfront in each neighborhood. The aim is to find AIDS victims, and provide them the help they would otherwise never get.

Urban Migrants in Extreme Poverty

Of the 300,000 people in these communities—who live in an area of just 5-7 square kilometers—some 70% are migrants from the countryside. They come from the most impoverished areas of India—West Bengal, Bihar, Gujarat, Orissa—and from the impoverished countryside of Bangladesh. In the slums, families may earn about 2,000-2,500 rupees per month (less than $40); the very poorest earn as little as $100 *annually.*

The housing consists, at best, of tiny, old houses with no running water or toilets; at worst, huts built of anything to be found, or even just some blankets spread on the sidewalk. Water is available only in pipes on the street, and, in Summer, when temperatures reach 45 degrees Celsius in Delhi, the water supply can fail for days on end. Public toilets are scarce; people have to defecate in the streets or open fields.

While there were excellent fresh vegetables for sale in the local market, the poorer families can only afford to eat vegetables at *one* meal a week. Mostly, they live on bread and dahl (lentils). People keep buffaloes for their milk, who live on the streets with the local dogs, pigs, cats, and goats. Among the children, it is the girls who are the hungriest. Many fami-

AIDS clinic doctor (left center) and Helga Zepp-LaRouche (right center) in East Delhi, where Zepp-LaRouche and EIR*'s Mary Burdman visited the clinic, which fights a difficult battle against the spreading epidemic.*

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The leader of the local Muslim community in the East Delhi neighborhood of the AIDS clinic, surrounded by youth, Hindu and Muslim alike. Most people here are migrants from rural areas of eastern India, whose unemployed farm populations are moving to now-huge cities, without the housing or infrastructure to accommodate them. Poverty in such neighborhoods is extreme.

lies have five to six children: The boys eat first, the girls get what is left.

Why the Virus Spreads

There are many millions of these migrants, although no one seemed to have an accurate overall estimate of their number. Many are seasonal migrants. Land reform had reduced the number of landlords; they need fewer workers. Landless peasants can rent land for a few months to grow vegetables, but have no income for the rest of the year. They look for work in the cities, or in better off agricultural areas, such as the Punjab. Migrant workers who have contracted HIV, carry it with them back to their villages.

In rural areas in India, the virus is spread by infected blood and needles, due to the ignorance of local physicians, health workers, and hospitals. Among migrants, it is most commonly spread by sexual relations.

India has *no* working national health system, Mrs. Nair told us. There is a system of government hospitals, but they are overwhelmed by the number of patients. Barely 0.001% of India's 1.02 billion people have health insurance—which is private. Government hospitals are supposed to give free medical care, testing, and food, but this often fails. Some hospitals are trying to consider the HIV problem, but cases of such basic procedures as surgery are so "backed up," that HIV and other illnesses must take a back place. The leper colonies exist, because although this is an easily curable disease, medicines are not available to the poor.

Drugs are becoming a terrible problem in India, among the better off as well as the poor. Cheap heroin, crack cocaine, and many other drugs are readily available. Poor workers are a target. They arrive from their villages at the Delhi train or bus station, with a little money, but nowhere to go. Drug pushers have a well-organized operation: They "invite" them to hostels at certain temples, for free food and a place to sleep. The migrants are robbed of all they have, dosed with cheap heroin, and then hooked on drugs. Also, coming alone from villages, where there is a close social structure, to the cities, many men go to local prostitutes, where they contract herpes, HIV, and other diseases. They carry these infections to their wives.

Clinic Looks to India's Future

With government funding, the AIDS clinic offers its patients free food, some medicine, a clean place to live, and some education for the patients' children, a few of whom are HIV positive themselves. In India, an HIV-positive child who gets no help, might live a year or so; given nourishing food and shelter, the boy or girl can survive 5-8 years.

The clinic treats "opportunistic" infections, but cannot administer anti-retrovirus drugs; they are simply too expensive. Most dangerous is tuberculosis infection: These patients must be isolated in a separate facility, due to the virulence of the TB virus. There is no central facility for TB patients in New Delhi.

The clinic also offers social support. A young, dedicated staff is being trained to care for AIDS patients; a group of young volunteers, from India and other countries, including Canada, work with the patients. The local police are also very cooperative. And, very importantly, local religious leaders come to help especially those who are very sick.

Religion must take a new and more vital role, for India to cope with this crisis, and to change the indifference which is allowing AIDS to spread, Mrs. Nair told us. India must look to her many great traditions: Hindu, Muslim, Christian, and Buddhist. In the ancient *Vedas,* there was no "caste system," but rather groups of professions—priest, warrior, farmer.

Hindus and Muslims had lived together in India, in villages and cities, for centuries before the country was partitioned along religious lines in 1947—the last act of the British colonialists. This tradition of community is still strong, and must become stronger, for India's better future. In one slum neighborhood, we met the Muslim and Hindu elders, who lead residents in participating in all of each others' festivals; there is no religious strife there. In another neighborhood, we met the local teacher and her husband, who are teaching neighborhood children—boys and girls—Hindi, English, history, and math. Everywhere, were the children, India's future.

When Helga LaRouche asked Mrs. Nair what she would want to tell the people of the United States and Europe, the answer was quick and clear: "We are all human beings! We developed each other; we must take responsibility for each other."