Health e-Letter

Letter from the Editor

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This month, after a gap of over five years, nimesulide, a popular drug for reducing pain and fever, is back in the news as a petition filed by a former director at Chennai's Institute of Child Health has come up for final hearing in the Madras high court. The first time it hit the headlines was when I broke the story about the reckless use of nimesulide in children despite its potentially serious effects on liver in *The Times of India* in 2002.

Until then the use of this drug for bringing down fever, when safer alternatives were available, had never been questioned outside of medical journals. The story was followed up in the authoritative *British Medical Journal* which questioned the use of this drug, especially in children. Nimesulide is widely and conveniently prescribed by a large number of pediatricians as it brings down a child's fever rapidly. The drug was never approved for use in the US and has been banned in several countries.

However, a weak regulatory system and gullibility of doctors in India has facilitated the easy survival of the drug. The Indian Medical Association went as far as conducting an opinion poll of 50 doctors, even though there are some 400,000 doctors across the country, to buttress its claim that the drug was "safe." Only a few doctors let it be known through the media that they did not agree with such an opinion poll.

The government eventually sought to end the controversy by banning the use of nimesulide in children younger than six months. Ideally, medical scientists themselves should have questioned how this cut off age was decided. For instance, why was a seven-month-old infant not vulnerable to the harmful effects of the drug if the government admitted that it could be harmful for a six-month old? Or why did the government not initiate a full-fledged scientific study into the effects of the drug?

Therefore, it is heartening now to see that some doctors are seriously concerned. Sadly, we are willing to subject innocent lives to avoidable risks as we have still not become serious about public health. Our story on chikungunya, which raises concerns that this viral fever may be much more lethal than we think it is, again brings this out. Our tobacco story, too, shows that the government can compromise public health interests in the face of industry demands. On a positive note, however, we have committed doctors like Dr. Alka Deshpande who strive to get the best for the underprivileged despite the enormous challenges of the public health system.

We are proud to announce that Mr. Shekhar Deshmukh, who was awarded a Kaiser International Health Journalism mini-fellowship to report on HIV/AIDS issues has been awarded the Ramnath Goenka Excellence Award in Reporting on HIV and AIDS for the year 2006. We will be carrying some of his award winning stories over the next few issues.

Kalpana Jain
Editor
Health e-Letter

IN THIS ISSUE

Chikungunya too may have turned into a lethal killer

By Kalpana Jain

Ahmedabad: Dengue, chikungungya and malaria season is back. We know that over the years dengue and malaria have evolved into lethal killers claiming lives year after year. What we do not know is whether a new mosquito-borne viral fever, called chikungunya that resurged across the country last year, is as dangerous. The government announced there have been no chikungunya deaths in the country while data collected by experts in Ahmedabad city could well contradict these claims.

Chikungunya, first reported in 1973, is a viral fever transmitted by the bite of infected household mosquitoes that returned to India last year after a three-decade dormancy. Health systems experts at the prestigious Indian Institute of Management at Ahmedabad counted 3,112 excess deaths from August to November last year, just when the city was hardest hit by the outbreak.

It may be emphasized here that while the experts at the Indian Institute of Management (IIM) at Ahmedabad have enough data to show unexplained deaths at the time of the chikungunya epidemic, the government's claims are not based on any scientific surveillance. In fact, the large number of deaths in Ahmedabad city have not been investigated by the government's disease surveillance programme. What could further make a mockery of the central government's claims is a recent admission by the Ahmedabad municipal corporation that there have been ten chikungunya deaths.

The unexplained deaths and anecdotal evidence should at least alert people to the possibility of chikungunya having mutated into a lethal virus.

Chikungunya, first reported in 1973, is a viral fever transmitted by the bite of infected household mosquitoes that returned to India last year after a three-decade dormancy. Health systems experts at the prestigious Indian Institute of Management at Ahmedabad counted 3,112 excess deaths from August to November last year, just when the city was hardest hit by the outbreak.

Ideally, the excess deaths should have alerted the government's Integrated Disease Surveillance Programme. It should have swung into action at the very first signs of excess mortality to find out the causes and to forewarn people.

The official count for ten states across the country was 1.39 million cases last year. The affected states included Andhra Pradesh, Andaman & Nicobar Islands, Tamil Nadu, Karnataka, Maharashtra, Gujarat, Madhya Pradesh, and Kerala.

Associate professor at the Center for Management of Health Services Public Systems at IIM, Dr. Dileep V Mavalankar, started to look at mortality data as Ahmedabad began to experience an unusually large number of people with chikungunya symptoms. Mavalankar found a "sharp rise in mortality in the city from August to November."

There were 60,777 cases of chikungunya reported by municipal health centres and hospitals in Ahmedabad. Of these, 55,593 occurred between August and September. In September, when cases increased to 27,360, the number of unexplained deaths too showed a sharp increase - around 60 per cent in excess over the previous years.

Dr. Mavalankar counted 3,112 unexplained deaths during this period in Ahmedabad city. The data on deaths were provided by the medical officer of health of the city as part of the city budget debate. The data provided by the health department also include the number of reported cases of

MONTH-WISE CHIKUNGUNYA CASES FOR THE YEAR 2006, AHMEDABAD CITY

Months	Reported cases of Chikungunya, 2006
January	0
February	0
March	0
April	434
May	141
June	31
July	184
August •	28233
September •	27360
October •	3555
November •	539
December	300

• Months in which Chikungunya epidemic was at its peak.

chikungunya per month in Ahmedabad city in 2006.

Mavalankar and his team were alerted to the possibility of a deadlier epidemic as chikungunya cases poured into hospitals. Mavalankar's team then went on to collect data from every possible source. They even waited at crematoriums to get records. "We saw a sharp peak in the number of bodies being burnt at city crematoriums which showed that these were not outsiders but people from within the city," says Mavalankar.

The team then urged the government to form a committee with Central and state representatives. No one, however, wanted to compile the cases, says Mavalankar. Former director at the All India Institute of Medical Sciences, Dr. LM Nath, who is also a well-known epidemiologist, agrees that the government should promptly look into reports of excess deaths.

However, he says, it could also be possible that most deaths were not directly due to chikungunya but due to some related reasons. For instance, he says, "overmedication could have caused some deaths. Doctors in the city were prescribing aspirin to patients which could have led to gastric bleeding and death."

And while the government cannot directly take action to control chikungunya, it can certainly alert people. The vector, he explains has a short flight range. It usually breeds in your own house and bites you.

Chikungunya - a Swahili word for a stooped walk that reflects the physique of a person suffering from the virus - causes high fever and headache. Until the outbreak last year, it was considered to be rarely fatal.

Perhaps, the government, with its inefficient public health systems, was unable to handle the large number of cases. The blood tests were being done only at two laboratories, one at the National Institute of Communicable Diseases in Delhi, and the other in Pune at the National Institute of Virology. These two laboratories were simply overloaded with cases.

MONTH-WISE ACTUAL DEATH REGISTERED, EXPECTED DEATHS AND EXCESS DEATHS IN AHMEDABAD CITY IN 2006 (EPIDEMIC YEAR)

Months	Expected Deaths 2006	Actual Deaths 2006	Excess Deaths
January	2418	2559	141
February	2173	2227	54
March	2251	2337	86
April	2244	2150	-94
May	2406	2510	104
June	2265	2156	-109
July	2149	2270	121
August	2375	2942	567
September	2500	3989	1489
October	2313	3121	808
November	2450	2698	248
December	2556	2537	-19
Total	28100	31496	3396

Expected deaths in 2006 calculated based on average month-specific mortality for 2002-2005

This is not the first time that the government is grappling with such outbreaks. When the plague re-emerged in India in 1994, public health experts called for immediately setting up surveillance systems in the country so the first signs were not missed. A technical advisory committee, headed by the late director general of the Indian Council of Medical Research, Professor V Ramalingaswami, did not mince words when he said "the outbreaks of plague should stir the country to a new awakening of the importance of resurgent and emerging infections for the sake of India's future health security." Thirteen years later the public health system has not reported much recovery.

Chikungunya fever outbreak first started on the Indian Ocean islands of Mayotte, Mauritius, Réunion (territory of France), and the Seychelles in March 2005. The World Health Organisation has advised travelers to all tropical and subtropical areas of the world to take precautions to avoid mosquito bites.

Subsequently, the virus spread to other areas as well. Sri Lanka reported chikungunya fever in patients from several districts; the most affected districts are Batticaloa, Colombo, Jaffna, Kalmunai, Mannar, Puttalam, and Trincomalee. Surveillance activities for chikungunya fever cases are continuing in sentinel hospitals in Sri Lanka.

As of now, no skull and crossbones on cigarette packets

By N P Singh

New Delhi: Despite being a signatory to the international convention on tobacco control under which India is obliged to put graphic pictorial warnings on cigarette packets and other tobacco products, Union health minister, Anbumani Ramadoss, has once again given in to political pressure to put on hold this move which is seen as a key in reducing tobacco-related deaths.

In India, close to a million people die every year of tobacco-related illnesses. India received international praise when it took a leadership role for the World Health Organisation's landmark treaty, Framework Convention on Tobacco Control (FCTC), adopted in May 2003 to check the growing use of tobacco products and the resulting deaths.

An important commitment under the FCTC was that all signatories put health warning labels, including pictorial warnings on all tobacco products. Under Article 11 of the convention this should cover ideally 50 per cent or a minimum 30 per cent of one or more of the "principal display areas of the packet (front and back)." It is also mandatory under the Cigarettes and other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003 as well as the Central government's Cigarettes and other Tobacco Products (Packaging and Labelling) Rules, 2006.

Dr. Monika Arora, Consultant, Public Health Foundation of India and Director, HRIDAY-SHAN (Health Related Information Dissemination Amongst Youth) says, according to this rule, every tobacco product package must display the 'skull and crossbones' warning. "This is to ensure that people understand that tobacco is dangerous for health," she says. "The package must carry a pictorial representation of ill effects of tobacco use on health."

Many will recall that two years ago the Union health minister set off a huge controversy by banning Bollywood from showing cigarette smoking on screen. His view was that it encouraged others to smoke as well. While the move helped raise awareness against tobacco products, it remained more of a populist step. Ensuring that tobacco products carry a pictorial graphic was the measure that would have made a

WHAT TOBACCO CAN DO TO YOU

The side effects of tobacco vary from bleeding gums, and mouth sores to cancer. The cancers can be of the mouth (including the lip, tongue and cheek) and throat. Spit tobacco can lead to leukoplakia (a white leathery like patch that is caused due to holding tobacco in one place). These patches can be different in shape, size and appearance and is considered pre-cancerous. Consumption of tobacco causes a constant flow of nicotine into the blood that increases the heart rate, blood pressure and sometimes irregular heart beats which leads to a greater risk of heart attacks and strokes.

DATELINE TOBACCO

2001	**The Supreme Court imposes a countrywide ban on smoking in public places.**
2003	**Ban on smoking in jails in Kerala is imposed following the High Court Orders.**
2004	**A total ban on tobacco ads including the surrogate ones, smoking in public places and selling cigarettes to children below 18.**
2005	**Government bans images of tobacco use from all Indian movies and television shows because they promote a product that kills.**
2007	**Kerala to lift ban on smoking in jails very soon.**
2007	**In February, India failed to implement Cigarette and other Tobacco Products (Packaging and Labelling) Rules, 2006.**
2007	**In June Chandigarh becomes India's first smoke-free city.**

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The provision was to be implemented by February 1, 2007. It was then delayed to the end of June this year. The group of ministers set up to decide this issue managed to skip that deadline as well. This month the decision was deferred again even as Health Minister Ramadoss stressed that he would wage a relentless war against tobacco. He said the government planned to strictly enforce existing laws banning smoking in public places such as restaurants, bus stops and railway stations, and ensure no one smoked in any workplace including factories.

Alok Mukhopadhyay, chief executive of the Voluntary Health Association of India said in an appeal to the Union health minister that "any delay over the issue will not only take us a few steps back from our current position but will also make us look indecisive." "It will also enable the tobacco industry to expand their market in India and make up for the losses incurred in the developed countries due to stringent implementation of the FCTC," he added.

An argument against this move is that it will hurt the poor bidi workers. The bidi industry claims that 50 percent of the jobs will be lost after the pictorial warnings on the packages are introduced. Referring to the United Nations Economic and Social Council report Dr. Monika Arora says even if smoking prevalence decreases at an annual rate of 1 per cent for the next 20 to 50 years, the total predicted number of smokers would still stand at more than 1.3 billion.

Citing the example of Kerala Dinesh Bidi, Dr. Arora says, they have already started diversifying into businesses that are more labour intensive. This not only safeguards the jobs of the workers but also protects them from occupational health hazards while working in a bidi industry. As citizens of a democratic country we have a right to make our own choices, she says. Bidi packs do not even carry a statutory warning.

On May 31, 2007, World No Tobacco Day, Dr. K. Srinath Reddy, head, Public Health Foundation of India, said, "Over 900,000 Indians lose their lives due to tobacco consumption every year and in monetary terms the country loses at least $7.2 billion as health expenditure." So which economic loss is the tobacco industry talking about?

(with inputs from Shivani Parihast)

WHAT IS THE FRAMEWORK CONVENTION ON TOBACCO CONTROL (FCTC)?

It is a treaty adopted by all the member countries of World Health Organisation in May, 2003. The Framework Convention Alliance is made up of approximately 200 organisations representing 80 countries. Article 11 of the FCTC states that warning messages on tobacco product packages should cover at least 50 percent of the principal display (i.e. both the front and back), but at a minimum must cover at least 30 percent of the principal display area. Having signed the treaty, India is now obligated to implement the pictorial warnings on the tobacco products packages.

Another face of HIV: Meet the doctor who makes a difference

By Shekhar Deshmukh

Mumbai: While the spread of HIV helped many countries improve their public health systems, it also showed how international aid money gets misused fuelling skepticism that more people perhaps live *off* HIV than *with* HIV. In such an environment Dr. Alka Deshpande, senior professor at the government-run JJ Hospital in Mumbai , presents the face of selfless service. Despite the innumerable challenges such as shortages of medicines, stigma within families, dysfunctional equipment and scarce beds, she instills hope, working round- the- clock and building an equally zealous team.

Sitting behind her table in her office at J.J Hospital, the 61- year- old professor is ready to speak out about what she stands for. At times smiling, at times reminiscing about her days at the JJ Hospital and at times allowing her emotions to get better of her as she talks about the child who came to her with HIV infection, she at once appears to be a dictatorial professor, a firm administrator and a sensitive human being.

In that lies her appeal, her zeal and her success with her patients who treat her like she were their God. And in a way she is. She is their lifeline and their support system when their families have thrown them out. Of course, her challenges are huge. She runs the largest anti retroviral centre for Maharashtra. Every Monday, anywhere from one hundred to two hundred new patients register at the OPD. In a year, 15,000 -17,000 new cases come to the centre. At present, around 6,000 people have been enrolled for antiretroviral distribution. About 50 patients are admitted as inpatients to different wards with various infections related to HIV.

Dr. Alka Deshpande

While handling this huge patient load, there are times she is left grappling with problems such as a break down of the machine used for counting CD4 cells (HIV infects these cells which are an important part of the immune system) or shortage of anti retrovirals and tragic happenings such as a positive person committing suicide.

For Deshpande though, all this is part of the job. She has known JJ ever since she was a young 21-year-old student. "JJ is like my second home and its people are like my own close relatives."

Initially, her focus was mostly teaching students, but a visit in 1992 to South Africa changed her life forever. The National AIDS Control Organisation, impressed by her work, sent her to study HIV in South Africa. After that there was no turning back as her life's mission became treating and motivating people to live, work and enjoy life despite HIV.

There are things that she finds frustrating and feels helpless about. Bureaucratic delays with procurements or any other plan for patient welfare is what she finds hard to accept. "The administration fails to provide us even with ward boys. How are we to function? JJ is the largest ART centre in Maharashtra. Thousands of patients come to this centre and the number does not seem to be coming down," she says. Most patients are provided all facilities free of cost.

"People are coming to JJ for treatment. The care they get here makes them positive towards life. They regain their lost confidence. They not only learn to live themselves but educate the others to lead a positive life as well," says Dr. Deshpande, back in her fiery mood. "And when we are trying to do our job to the best of our ability, it hurts if we do not get a similar support from the administration," she adds without mincing words.

If needed, Dr. Deshpande can take a firm stand. And this is perhaps what endears her to her staff more than anything else. It is to her credit that she has built up a strong team that supports her.

Some of the people who come to Deshpande have no support systems as their families have abandoned them. "Stigma and discrimination are so acute in our villages that even if ART centres are started at district levels, patients will continue to seek treatment outside their hometowns." So she is not just a doctor but a caring human being as well.

However, this firmness is replaced by a gentle, caring and sensitive humane face when she is talking to her patients. "I understand HIV. When I talk to a woman or a child with the infection, I understand what they are going through. Earlier, I found that I would get irritated with men for being so reckless and passing the infection on to their family. Later I realised they were all simply human beings. There's no one in this world who would want to buy death."

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She agrees that such stigma is not confined to the homes and neighbourhoods alone, but shows up even in health care settings, where people should be more enlightened. And this is because people who work in hospitals are also coming from the same society where such discrimination is widespread. "My staff goes through intensive

training from time to time. Gradually attitudes have changed within JJ," she clarifies.

There are times when patients who are under tremendous stress get violent with the doctors. Some time back, she recalls, one such patient spat straight in the face of a woman doctor. "She, in turn, got so terrified that she stopped coming to the hospital. She needed to be convinced that she would not get the infection through infected saliva. Eventually, she regained her confidence and came back to work."

It is for this dedication and service that the government awarded her one of the highest honours of the country, the Padamshree in 1997. This otherwise low-profile doctor, clad in a simple cotton saree, perks up while talking about the award and says that she cherishes those moments of recognition.

Working with HIV has made Dr. Deshpande acutely aware of the low status of women in society and its linkages with poverty. Marriage is the biggest risk factor for women in India, she says. A large number of women who come to her are those who were married off when they were just twelve or thirteen. In a number of cases, their parents had married them only because they were unable to give them even two meals a day.

It's the children who really suffer. "There is a 14-year-old boy who has been admitted here. The infection has progressed and he is battling several illnesses. Even after years of treating HIV patients when I go for my rounds in the morning, I am unable to stand next to this boy for long. His innocent eyes and troubled face get me very upset," says this formidable doctor even as tears well up in her eyes.

This is another face of HIV.

The hearing impaired have finally been heard

Government to launch a deafness control programme soon

By Manish Srivastava

Lucknow: Seven- year- old Vivek cannot hear properly. With the help of new medical technologies, doctors could treat Vivek's hearing impairment, but the surgery itself is expensive and Vivek's family cannot afford it. A soon-to-be launched deafness control programme can provide hope for young Vivek and many others suffering from similar conditions.

Much like the Blindness Relief Programme, the Deafness Control Programme would be launched initially as a pilot project in three district hospitals. The government would help organize camps to identify those who could be treated through the programme.

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The Union Ministry for Health and Family Welfare plans to launch this as a national programme. To help kick start the effort, pilots have been started in three districts of Uttar Pradesh: Lucknow, Gorakhpur and Barabanki.

The Balrampur Hospital in Lucknow has been selected for the project. The Ear, Nose and Throat (ENT) Department of the Chatrapati Shahuji Maharaj Medical University has been designated as the nodal centre. Dr. Naresh Bhatia, head of the ENT Department, says increased noise prevalence is contributing to an increasing number of deafness cases. Congenital deafness cases are also on an increase.

The government is planning to train doctors from various districts in different kinds of hearing impairment. King George Medical University in Lucknow has been selected as the centre for the trainings.

The doctors who receive training in this area will help identify patients during the camps and bring them to the hospital for further treatment. An audiologist, trained staff and necessary equipment will be provided to these hospitals.

Dr. SC Srivastava, the person responsible for initiating the programme in Balrampur Hospital, Lucknow, says it is not possible to detect hearing impairment in its initial stages, making it difficult to treat at a later stage.

Spread of HIV raises new concerns for homeless Tibetans

By Sudhir Mishra

Kangra: It's not only the need for a homeland that is worrying Tibetan refugees these days. The spread of HIV amongst Tibetan youth is now becoming a serious concern for them.

In a small community of approximately six thousand Tibetan refugees living in Mcleodganj, about one hundred have tested positive for HIV. The overall prevalence of HIV is also galloping in this scenic hill station, notwithstanding the centre's claim of a sharp drop in infections. The total population of Kangra is a little over 13,00,000.

The prevalence of HIV/AIDS has increased threefold in just two years in Dharamshala (Himachal Pradesh) alone. The place attracts tourists from India and abroad and easy access to drugs and alcohol makes it an ideal setting for HIV to thrive.

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The Tibetan Prime Minister in Exile, Prof. Samdong Rinpoche, promises to conduct a survey to find out the prevalence amongst the Tibetan community. Awareness programmes for HIV/AIDS have already been started amongst the Tibetans in McLeodganj, he says.

At the VCTC (Voluntary Counseling and Testing Centre) of the local medical college hospital in Dharamshala, 455 people tested HIV positive by December last year. Of them, 45 are Tibetan refugees.

However, a health official revealed that by now more than 500 have tested positive and more than 100 among them are Tibetan refugees. District AIDS Project Officer, Dr. Surendra Singh, while refusing to divulge details, accepted that there is a rapid increase in the percentage of Tibetan refugees testing positive.

People from hotel and auto rickshaw associations say that the environment of this once tranquil place has been vitiated. Illegal immigration coming in through Nepal and China has been on an increase. This has also lead to smuggling of drugs. Unsafe sex naturally follows.

VCTC counselor Preeti says the numbers could be a lot more alarming as they apparently seem since the cases that have surfaced up till now are due to either Hepatitis - B or some other ailment.

AWARD WINNING STORY

On the banks of Ganges: Opium, brown sugar, massage parlour and much more!

By Shekhar Deshmukh

Nearly 55 per cent of men living in Varanasi indulge in sex before marriage. Among them 47 per cent are between 21 to 25 years, 42 per cent are addicted to tobacco products, narcotics or alcohol. Close to 97 per cent admit that they have sex without using a condom. Sixteen per cent have never heard about a condom! This data has been collected by Dr. Sanjay Singh, the head of the Department of Social Work at Mahatma Gandhi Kashi University in Varanasi,. He says awareness programmes need to be launched soon to save the city from the devastating health and social impact of these changes in society.

Varanasi: On the face of it Varanasi is just as we see it in films or photographs: the mesmerizing Ganga, about 85 ghats constructed with black rock, thousands of people taking a dip in this holy river, birth and death rituals going alongside, sadhus meditating and people floating oil lamps on the mighty Ganges. Nothing seems to have changed in this holy city over the years.

But start walking a little distance through the narrow lanes that lead into the old houses and gradually another

Varanasi begins to reveal itself. Chandan Mishra, a young student who studies at the department of social work and actively participates in AIDS awareness programmes, has volunteered to show me the different faces of Varanasi.

Walking down the steps of Assi Ghat (80 ghat) near the birth place of Rani Laxmibai Chandan cautions me as 'be careful'. As I start walking down the steps, I realise that the step were uneven and a little less caution while walking would probably send a new visitor like me hurtling down.

As Chandan takes me around the ghat, the real face of the ghat begins to emerge: sadhus, foreigners and devotees throng the place. International female tourists are in Indian attire - some are wearing a sari, some are in a salwar kameez, sporting bindis on their forehead while their male partners are in a sadhu's attire with a rudraksha necklace and chilim (a local hookah) in hand.

Liquor is flowing freely in the hotel near the ghat and foreign tourists can be seen drinking. Bearded Sadhus are smoking chilim in a corner. Dr. Singh says at this time the ghats come alive with all kinds of activities. Small vendors start making rounds supplying brown sugar, opium, and marijuana to foreign tourists.

Smart young guides speaking most International languages such as English, French, Italian and Japanese chase the tourists. The tourists are also an attraction for vendors selling peanuts and poor children begging on the ghats. This still is not the unmasked face of Varanasi that Chandan wants to show me. "This face too will transform as the sun goes down," he says.

To see that inner world of Varanasi I decide to come back in the evening. Accompanying me are the head of the department of social work at the Mahatma Gandhi Kashi University, Dr Sanjay Singh, Chandan and some others. As we reach Assi Ghat, we come across a sadhu who had nothing except Bhasma (holy ash) on his body even as he meditated deeply and chanted 'Bum Bhole' (Hail Lord Shiva).

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Brown sugar, a coarser form of heroin, was never a scarce commodity in Varanasi as it is produced locally on large scale in Gazipur near Varanasi. Sex workers are in demand. Tourists in designer attire, sadhus hunting for gullible visitors, guides, vendors, money lenders, beggars, bootleggers and a don who controls all these activities and calls the shots emerge at this time. This is a new Varanasi.

On our way back, Dr.Singh introduces one young boy, Bunty, sitting idle in one of the nearby shops to me. Bunty's attire reminds me of a don. He seems to be chewing gutkha. Without mincing words, Bunty asks me "What do you want? You will get everything here. You name it and I will provide it."

"Tell me, do you want brown sugar, opium, marijuana or you want to have sex?" There is also a massage parlour around, he says. During our conversation Bunty points towards a house. Around 15 years ago that house was available to rent for Rs. 250. Today it has been renovated as a hotel. The owner is earning in crores. Pointing to a boy in a departmental store Bunty says, "See that boy, he has got a girlfriend in every country. Every night he goes with a foreigner for a party."

Dr. Singh confirmed that marriages with international tourists are quite common here. Women tourists fall in love with their guides and get married to them. Similarly, many local women agree to live with foreign male tourists for months, first as their guides and later on as their mistresses.

This transformation has taken place over the last twenty years or so. With more tourists visiting, the place has become a haven for antisocial elements. Blue films are shown in almost all the cinema houses and the social fabric of the city is changing as a result of this influence. The government, says Dr. Singh, has remained indifferent to these changes in society. If people are not made aware now, the repercussions on society could be devastating for its social norms and peoples' health.

Mr Shekhar Deshmukh received the Ramnath Goenka Excellence Award in Reporting on HIV and AIDS for the year 2006. His reports were published in Daily Loksatta between August 2005 and March 2006. Mr Shekhar Deshmukh was awarded a mini fellowship by the Kaiser International Health Journalism Programme to enable him to travel and research on issues related to HIV/AIDS. This report was published on 19.3.06 in Daily Loksatta. It has been translated from Marathi.

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