Health e-Letter

Letter from the Editor

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Is external funding defining the perceptions of serious and enlightened people on the AIDS epidemic? Many of us who have been tracking the HIV epidemic from the time it came into India have often felt that perception of funds around HIV have led to questions being raised even on good journalistic intent.

First some basic facts: Health is a state subject in India, and most of the financial outlay (up to 85 per cent of the government spending) is made by the state governments. Yes, HIV does constitute a substantial part of the Central government's budget (in 2005-06 HIV accounted for 37 per cent of all public health expenditure of the Central government) but state governments do not contribute any money towards HIV prevention or treatment. As states do not get to decide how much priority they give to HIV, some of them return substantial unspent amounts to the Centre. Again, much of this money comes through external funding.

The big question is whether this money is being used efficiently? We need to look for those answers; not just on HIV but on several other health programmes that have shown dismal results. For instance, we need to question the pulse polio programme, the immunisation programme, anaemia control, and efforts on maternal mortality - to name a few.

The fact is that public health has never been on the top of the agenda. And it is for this reason that all of us pay out of pocket whether for life-saving expensive drugs or hospital services. HIV exposed the threadbare public health system. Whether it was infection control, blood safety, or access to health services, the issues stared us in our face.

Unfortunately, the very same people who became critical of the funds that were coming in for HIV prevention had not raised a cry for public health issues. It is small wonder then that the large number of preventable annual deaths in the country due to tuberculosis, diarrhea, pneumonia, measles or maternal mortality have never become serious national issues.

Sadly, most of the first converts that HIV did find here were the rich and famous, with little or no sense of issues at the grassroots level. As the British Medical Journal aptly points out, HIV became the "crusade of the famous, fashionable and influential." Expectedly, the message never went down to the people. HIV awareness events were reduced to being glam-shows.

To this date the message has not trickled down. If our reporter from Mumbai almost felt hounded as he went about feeling the pain of people, traveling to remote areas, writing about issues that not many were taking up, then there is something seriously amiss. As a first and last step, those who question any of us for writing on these issues, should raise their hands and spell out the real face of HIV - in a middle-class home, in rural India, among impoverished women and orphaned children. Only then will they have earned a right to comment.

Kalpana Jain
Editor
Health e-Letter

IN THIS ISSUE

MONEY MISUSE

Funding distorts face of HIV

By Shekhar Deshmukh

Mumbai : This reporter recently shared a platform with celebrities such as filmmakers Govind Nihalani, Sai Paranjape, film actress Kiron Kher, pop singer Sunita Rao and celebrity columnist Shobha De. The discussion, meant to focus on gender issues, veered towards HIV/AIDS. An agitated Govind Nihalani cynically questioned that crores were being spent for the cause of HIV/AIDS but the results were not visible. "Where is all the money going?"

Around a year and a half ago, I received a fellowship that helped me travel and write about real-life HIV/AIDS issues. I had to deal with loads of cynicism even as I tried to do my honest best. People, including those from the media, equated the fellowship with money. At times, even well-known doctors with a deep understanding of public health issues displayed little understanding when they carried the common man's skepticism into their words: "There are so many diseases in India. Why is AIDS being given so much attention? It is all hogwash."

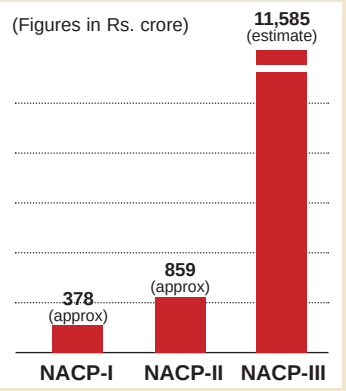
NATIONAL AIDS CONTROL PROGRAMME

In 1992, the Government launched the first National AIDS Control Programme (NACP-I) with an IDA Credit of USD 84 million (Rs 378 crores) and demonstrated its commitment to combat the disease.

NACP-I was implemented during 1992-1999 with an objective to slow down the spread of HIV infections so as to reduce morbidity, mortality and impact of AIDS in the country.

In November 1999, the second National AIDS Control Project (NACP-II) was launched with World Bank credit support of USD 191 million.(Rs 859 crores)

Financial requirement for National AIDS Control Project (NACP-III) which has been launched from April 1 is Rs 11,585 crores.



Source: NACPIII Plan Document

Last year a function was organised in Mumbai two days before World AIDS Day (December 1). An HIV positive woman from Alandi (Pune) was applauded for her courage to come out publicly with her status. I too had an opportunity to share my thoughts with other participants. We discussed how HIV and AIDS differ from each other and often media persons are not aware of this. A doctor, who heard this, expressed her gratitude for the information and said: "I am glad you touched upon this topic. Even I did not know the difference."

For many, AIDS is simply another name for money that can be misused. The sense that funds meant for people are being wasted is perhaps the most dominant feeling when one hears about AIDS. As a result, no one really takes note of the good work that may also have been done

For many, AIDS is simply another name for money that can be misused. The sense that funds meant for people are being wasted is perhaps the most dominant feeling when one hears about AIDS. As a result, no one really takes note of the good work that may also have been done. For instance, it is a fact that funds have been used constructively to build a new and positive image of the infection. Today, people are able to deal with it and lead better lives.

What gives rise to the cynicism: For the past fifteen years, AIDS awareness programmes have been going on in India. Whopping amounts of external funding is received. What people get to see are the workshops, seminars and debates organised in five star hotels; film stars such as Richard Gere, Shilpa Shetty and Bipasha Basu campaigning; musical programmes being organised in big and small towns in the name of awareness. Do these make a difference? Why is more money being spent on HIV/AIDS as compared to any other disease in India? Why should such an amount be invested? Why are the common people not helping in the fight against HIV/AIDS even after such efforts? In fifteen years if the common man has not been convinced, what does it point towards? Are we moving in the right direction? If yes, then

MAJOR DONORS/OTHER EXTERNAL SUPPORT

• Currently more than 30 donor government agencies work with NACO, including: the Australian Agency for International Development; Canadian International Development Agency; Danish International Development Agency; Swedish International Development Cooperation Agency; UK Department for International Development; and U.S. Government.

• The U.S. Government provides bilateral assistance to India for HIV/AIDS, and support through its contributions to the Global Fund. USAID has supported activities in India since 1995 and Centres for Disease Control since 2001. India is not one of the 15 focus countries of the US President's Emergency Plan for AIDS Relief (PEPFAR) but has been identified as a country of "concern outside of the focus coun-tries." U.S. bilateral aid for India was over $26 million in 2005, the largest outside of the 15 focus countries.

• The World Bank has been a main financier of NACO, providing $84 million for Phase I of the National AIDS Control Project and $191 million for Phase II.

• The Global Fund to Fight AIDS, Tuberculosis, and Malaria has approved two HIV/AIDS grants in India totaling $118,533,024 and one HIV/TB grant for $2,667,346.

• UNAIDS, UNDP, UNICEF, WHO, and the other UNAIDS co-spon-sors provide technical assistance and other support, through in-country offices and partnerships.

• The Gates Foundation has committed $200 million in India through its Avahan Initiative.

Source: Kaiser Family Foundation

why do sensitive filmmakers such as Govind Nihalani still have doubts in their mind when it comes to AIDS?

It's time policy makers, political leaders and national and foreign NGOs working in India look for answers to these questions. If these questions are not answered then it will only add to the difficulties. The common person will keep distancing himself from the issues. The fact that no mission can succeed without taking the common man along has not changed yet.

XDR TB

Is a new TB strain cause for concern?

By Shivani Parihast

New Delhi : A lethal new resistant strain of tuberculosis, which has claimed several lives in a South African province, is forcing public health experts to forewarn that a deadly new tuberculosis pandemic may be round the corner. This new strain of extensively drug-resistant tuberculosis (XDR TB) was detected in Tugela Ferry, a rural town in South African province of KwaZulu-Natal (KZN) in September last year.

Indian experts, however, do not agree with such doomsday predictions. Deputy Director of the Tuberculosis Research Centre, Chennai, Dr. Soumya Swaminathan, says that India does not need to panic. "It is unlikely that there will be an outbreak of XDR-TB in India," she says. ``TB patients here are part of the general population and not concentrated in a pocket."

Former head of medicine at the All India Institute of Medical Sciences and a well-known expert on TB, Dr J.N. Pande says: "Multi-drug resistant TB(MDR TB) has been known in India for a long time."

TUBERCULOSIS IN INDIA

20 lakh	**people get infected every year**
10 lakh	**highly infectious sputum positive cases every year**
20,000	**people get infected everyday**
5,000	**people develop the disease everyday**
1,000	**people die from TB everyday**

Source: Directorate General of Health Services

In multidrug resistant TB, the bacillus becomes resistant to the two known potent drugs - isoniazid and rifampicin. The difference between the new virulent strain and the multi-drug resistant strain is that it is resistant to the second line of drugs as well - injectables known as fluoroquinolones. These experts add that they have seen several cases that are resistant to this last line of defense. But that has not led to any large-scale spread of the resistant strain, they say.

A lethal new TB strain is cause for concern. India already has a huge TB burden - about a third of the global cases. The directorate general of health services estimates in its report that more than 20,000 people get infected with the tubercle bacillus each day. Of these, more than 5,000 develop the disease and more than 1,000 die from TB each day. In India, tuberculosis kills 14 times more people than all tropical diseases combined, 21 times more than malaria, and 400 times more than leprosy. Every year, another 20 lakh people develop tuberculosis in India, nearly one million of them highly infectious sputum positive cases - two such cases developing every minute.

TUBERCULOSIS KILLS...

14 times more people than all tropical diseases combined

21 times more people than malaria

400 times more people than leprosy

Source: Directorate General of Health Services

"The only way to check the lethal strain from coming in is to improve adherence of multi-drug resistant TB patients," says Dr Swaminathan. Drug resistance usually happens when patients stop taking the medicine before they have been cured. For this reason, the government introduced DOTS (Directly Observed Treatment Short Course Strategy). While this has improved compliance, it does not ensure adherence for all. Patients drop out from the line of treatment as they are unable to go to the DOTS centre regularly. Also, the side effects (nausea, vomiting and in certain cases even deafness) are too much for many to handle.

"The only way to check the lethal strain from coming in is to improve adherence of multi-drug resistant TB patients."

Ensuring compliance for multi-drug resistant patients is even more difficult. A third of these, too, drop out in the middle of the treatment. The medicines priced approximately at a lakh and a half rupees need to be administered over a period of one and a half to two years in combination with other necessary parenteral drugs, rendering the medicines out of reach for the less privileged Indian. Moreover, it is not available for free under the government programme. "These second line of drugs are more toxic having such contra indication as nausea, vomiting and gastritis," says Dr. Swaminathan.

The good news is that XDR-TB is not more communicable than ordinary TB or MDR-TB, says Dr. Swaminathan. Also, the doctors treating these patients do not stand a higher risk of contracting the infection, unless their immune system is weak.

An outbreak of XDR-TB, especially among the HIV positive people, as it happened in South Africa among the gold miners, is unlikely to occur in India, says Dr Pande. Hence XDR TB does not pose a greater risk to the HIV positive people as compared to any HIV negative person. However, the treatment for XDR-TB among the HIV positive people can be a lot more challenging.

COUNTDOWN POLIO

UP polio travels to J&K

By Toufiq Rashid

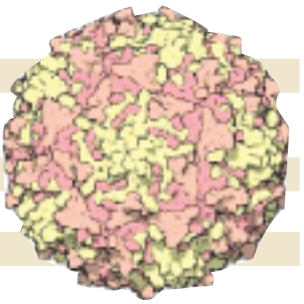
Jammu: After remaining free from polio for more than three years, the U.P polio strain has reached as far as Jammu and Kashmir. In what the state called a "worrying development", Jammu and Kashmir reported its first case of polio at the end of December 2006.

In December last year, 14 polio cases were detected from the rest of India, taking the total number of cases of children affected by the disease to 624 in 2006. The total number of polio cases in the preceding year had only been 66 from all of India.

According to officials, it was the first case of polio from Jammu and Kashmir, an area considered as a low risk area for the disease. The polio virus was detected in a five-year-

"The recent surge in the cases in north India is a cause of worry. The first case from Jammu is a clear indication that the polio strain is constantly covering new grounds."

POLIO VIRUS



- **The polio virus lives in the throat and intestinal tract of infected persons.**
- **The virus enters the body through mouth, usually from hands contaminated with the stool of an infected person.**
- **Objects, such as eating utensils, can also spread the virus.**
- **Food and water are not thought to play a major role in the spread of polio.**
- **The polio virus attacks the nerve cells that control muscle movements.**
- **Many people infected with the virus have few or no symptoms. Others have short-term symptoms, such as headache, tiredness, fever, stiff neck and back, and muscle pain.**
- **More serious problems happen when the virus invades nerves in the brain and causes paralysis of the muscles used in swallowing and breathing.**
- **Invasion of the nerves in the spinal cord can cause paralysis of the arms, legs, or trunk.**
- **Symptoms usually start 7 to 14 days after exposure to the virus.**
- **Infected persons are most contagious from a few days before to a few days after the start of symptoms. However, persons with polio can spread the infection for as long as the virus is in their throat or stool.**
- **The virus can be found in the throat for about 1 week after infection and in the stool for 6 weeks or longer.**

old girl in Jammu.

According to an official who requested that he not be named, the girl was from a very low economic background and had visited Uttar Pradesh in the recent past.

Another reason for worry is that Jammu and Kashmir is a border state that shares its boundaries with Pakistan. Pakistan, along with India, Afghanistan and Nigeria are major sources of polio in the world and the border state might see more infection.

"The recent surge in the cases in north India is a cause of worry. The first case from Jammu is a clear indication that the polio strain is constantly covering new ground," an official said. The immunization drive however has been very satisfactory in the state. According to official figures there has been more than 95 per cent coverage in the state.

"Unlike Uttar Pradesh, the Muslim majority in Kashmir is not against immunization. Even routine immunization here is very good," the official added. The immunisation drive seems to have yielded results already. As India has already recorded 21cases across the country - with 8 in Uttar Pradesh, 9 in Bihar, 2 in Andhra Pradesh, one each in Maharastra and Haryana, Jammu Kashmir has remained safe this year.

The last case date remains December 17, 2006.

VITAMIN A CONTROVERSY

Who killed Akash and Manasi?

By Sudhir Mishra

Lucknow: Kalavati is catatonic with grief. Her grandson Akash was among the two children who lost their lives soon after being administered Vitamin A drops in their school. The cause of their death is still not known.

But this is not an issue important enough to occupy the mind space of key politicians busy drumming up support for themselves for the forthcoming Assembly elections in the state. UP chief minister Mulayam Singh Yadav has not been able to give directions on the file of this case. In this file is an appeal to reopen the cases of these two children, Manasi and Akash, from the Chitvapur area who died after consuming Vitamin-A drops on December 1 last year.

Opposition parties have been quick to cash in on peoples' sentiments following the deaths. The deaths seem to have blown up into a major campaign issue. In the absence of hard facts, allegations are flying thick and fast

Some believe that the health department officials, in their defense, did not send the right sample of Vitamin-A. The magistrate in charge of this investigation, ADM (City) J. P. Singh, finds this allegation baseless. However, more facts than mere statements are needed from both sides.

On September 27 last year, Lucknow's chief medical officer Dr. K. K. Singh issued instructions that children suffering from Vitamin-A deficiency must be given the drops under a school health programme. Following this, a team from the health department went to the Primary School located in Chitvapur and administered Vitamin-A drops to the children at 11:30 a.m. The team was headed by Dr Dayavati Chaturvedi.

Around noon, after the drops were administered, children were given porridge under the mid-day meal programme. It was about 12:15 p.m. when children, including Manasi and Akash, started vomiting. The children were sent back to their homes. Around 1:30 p.m. health workers visited these children to administer some drugs but their condition did not improve. These children were then rushed to Shyama Prasad Mukherjee Hospital. By 6 p.m. the same day, Manasi succumbed. This resulted in a massive public outrage. Other children were then rushed to the more specialised Pediatrics department of King George Medical University. But by the next day, Akash too died.

With the media following up the issue, ADM (city) J.P. Singh was given the responsibility to probe into the matter. Two samples of Vitamin-A were sent to Central Drug Laboratory (CDL), Kolkata, for investigation. Samples were also sent to Central Drug Research Institute (CDRI) and Industrial Toxicological Research Centre (ITRC), located in Lucknow.

The post-mortem reports of the children were made available on December 6. The cause of their death was not made clear in these reports. In the meantime on December 8, the Food and Drug Inspector conducted a raid on the pharmaceutical company that provides Vitamin-A. Samples were collected from its unit in Maharashtra. On December 11 government gave a clean chit to the mid-day meal.

It hinted towards the Vitamin-A samples being flawed. But on December 30, the company manufacturing Vitamin-A received a clean chit by the food and drug administration of Maharashtra. If the report of the Central Drug Laboratory, Kolkata, is to be believed, the vitamin-A samples were not adulterated.

In retrospect, now that all the reports are finally out, and everything is as it should be, the million dollars question is 'how did the children die?' Protests were carried out under the leadership of local MLA Suresh Tiwari. Manasi's father, Ravi, says that if the cause of the death is not discovered, then he would set himself on fire in front of the Assembly House. Following the public outcry, the chief secretary, health, A.K Mishra summoned the file of this case. Around ten days ago the file was sent to the chief minister asking for re-investigation. But of course the chief minister is busy with the upcoming elections.

Did the children need vit A?

Dr. Umesh Kapil, additional professor, department of human nutrition, All India Institute of Medical Sciences, New Delhi, says school children in Lucknow should not have been given Vitamin A as it was not part of the government's vitamin supplementation programme. Health workers are mostly untrained and in a hurry to achieve their target administer the dose in haste. This could result in an overdose.

An overdose of vitamin A can result in what is known as hypervitaminosis A or vitamin A toxicity. Toxicity may result acutely from high-dose exposure over a short period of time and is often fatal.

In 2001, more than 20 children died during a vitamin A distribution campaign in Assam when instead of using a 2 ml. spoon a 5 ml. cup was used resulting in an overdose. Close to 700 children of the 3.2 million who were given the vitamin A dose, became ill.

For several years Indian scientists have said vitamin A campaign does not need to continue in many parts of the country as children now are getting vitamin A from its natural sources such as green leafy vegetables. However, Dr Kapil says, commercial reasons are keeping the campign going. Pharmaceutical companies want to make profits out of malnutrition in developing countries.

-By a Health e-Letter reporter

BIOMEDICAL WASTE

At last biomedical waste is raising a stink

By Shekhar Deshmukh

Mumbai : Justice J.N. Patel, a senior high court judge may well have voiced common sentiments when he said: "It is better to die than seek treatment at government hospitals."

He made this observation recently as he heard a public interest litigation which gave out grisly details of the environment pollution being caused by biomedical waste. The PIL, filed by the Consumer Welfare Association, a well-

known NGO in Mumbai, said of the 366 government hospitals in Maharashtra, 162 do not follow the guidelines on bio waste management as listed under the Bio-Medical waste (Managing and Handling)Rules, 1998. Hospitals do not have basic facilities such as an autoclave or a shredder to help them dispose the waste.

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However, the admission did not compel authorities to set things in order. Four days ago, several leading dailies in Mumbai published a photograph of the well-know Sion hospital with bio-medical waste littered for days. Rag-pickers and stray animals were rummaging through the contents of this waste.

This can have serious public health consequences- for the rag pickers and others in the neighbourhood. Rats found to be scampering in the waste will be quick to spread infection if they enter the hospital.

Experts say that 80 to 85 percent of waste is non-infectious. But a good 10 to 15 per cent is infectious and hazardous. If only hospitals train the sweepers, ward boys and nurses to segregate waste then the infectious waste can be disposed more safely. It would also reduce the load on incinerators.

Holding the government accountable for failing to implement rules, acting Chief Justice J.N. Patel and Justice S.C. Dharmadhikari had asked the Public Health and Welfare Department to file an affidavit within eight days. Principal Secretary (PHWD) Chandra Iyengar requesting the court for more time, said: "I respectfully say and submit that a maximum period of six months will be required to rectify the lapses and to fully implement and adopt the Bio Medical Waste rules, 1998." Crores have already been spent without any apparent results. Fresh budgetary allocations too have been made. The director general of health services has allowed Rs. 2 lakh for district hospitals and Rs. one lakh if other hospitals needed to rectify the lapses pointed out by the Maharashtra Pollution Control Board.

It is time we become conscious that negligence in medical waste disposal is creating a potential public health hazard. These hospitals cater to a larger section of our society who cannot afford expensive private care. It is time these hospitals maintained at least minimum hygiene levels. The government needs to ensure that hospital workers are provided gloves and other protective gear for handling pathological waste.

When millions of human lives are at stake is it too much to ask for?

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