HIV/AIDS INDUSTRY

AGENDA BEHIND THE EPIDEMIC

SCIENTIFIC GENOCIDE
ECONOMIC DISASTER
CIVIL UNREST

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In the '70s JACK was working on small training programs in rural areas with funds from International charitable donors. We soon realized that these kinds of resources were grossly inadequate for any meaningful development. This led us to explore possibilities of bilateral and multi-lateral funding. In this process we found that donor agencies had their own policy agendas and pre-packaged programs which they were routing through a handful of consultants operating out of plush offices in big cities. The lure of money as well as the illusion of consultations led NGOs to believe that donors were actually supporting people's programs which would eventually translate into development. We also realized that the high visibility of the NGOs did command respect in society, but they had no real following among people. We saw this kind of donor agency and NGO cooperation as a dead-end in developmental activism and pulled out of it.

Around this time HIV/AIDS became the focus internationally. We were also working on this crisis and were initially swept away by concepts of "foreign disease", "testing" and "high-risk groups". However, within three years we realized these actions were not contributing to HIV prevention and we were on the wrong track. But we were unable to raise our voice on this issue since people were unwilling to even talk about AIDS, leave alone discuss any criticism of AIDS interventions. It was only in '95-96 that we were able to confront donor agencies with our questions. And then a strange thing happened. We were threatened and systematically discredited in the NGO sector. Internationally recognized experts working on donor programs who supported JACK's stand were branded traitors, maligned, mistreated and dismissed from their jobs on flimsy grounds. This panic reaction convinced us that there was a larger conspiracy behind the HIV prevention program.

In the effort to get to the bottom of this conspiracy, we found many startling things. For instance, unofficial drug trials on pregnant women had been going on In India since the late '80s. What disturbed us most was the criminal silence being maintained by India's scientific community.

At that point we decided to close our routine activities and concentrate on understanding the full gamut of issues relating to HIV at policy level. This, it turned out, was like opening up a Pandora's box and has taken us several years.

Many people have shared JACK's concerns. A few have directly supported our effort to find out the truth about AIDS, often at great personal and professional cost. We salute these people.

This booklet is a first attempt to draw attention to some of the most serious issues surrounding HIV/AIDS in India. Due to the necessity of limiting the size of the Initial booklet and, at the same time providing an overview, we have had to present the issues in a compressed manner, although each one of them could have merited a book

Purushothaman Mulloli, August 15, 1999

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World Overview

AIDS was first diagnosed in the US in the early '80s. But many still look to Africa for its origin, blaming African monkeys and African sexual practices. The West – through international donors – labeled Africa the epicenter of the AIDS epidemic. For the West, Africans and Asians are the "high risk group" (as tribals, truck drivers, sex workers, etc are "high-risk groups" within these countries).

In the West HIV estimates have *declined*. In the US official statistics show that the number of HIV positive persons had not increased from 1 million since testing began and experts say the figure has now come down to between 6 - 800,000. In UK also the official estimate of 23,000 HIV positive cases nationwide is about a half or a third of earlier estimates. In Russia 30,000 were earlier estimated to be HIV positives, but later *only 66* were found to be so!

But in Africa the "estimated" HIV positive total has *risen* to 20 million – seemingly in direct proportion with the increasing international donor activity in the HIV/AIDS sector with the entire action shifting from the West to Africa. Even as the ***reported AIDS cases in Africa number only 129,000 (half the US figure)***, many damaging claims about AIDS continue to be made by a multitude of western research projects and by government and non-government organizations. Amongst the most publicized of these were stories relating to whole villages identified as "dying from AIDS" in Kagera district of northern Tanzania and to hordes of "AIDS orphans". Less publicized were the facts that two years later in 'most affected' villages only 5 to 13% of the people tested HIV positive or that the "orphans" were children left with grandparents in polygamous cultures and had nothing to do with AIDS!! But the damage has already been done – and is only now being understood. The 'New African' magazine, which circulates across the continent, says ***"alarmist and exaggerated" forecasts made by western experts, supported by the WHO, have done immeasurable harm to African confidence and the way Africans are seen abroad*** and has called for an international inquiry to establish the truth about AIDS.

Since in most African countries, HIV tests are too expensive for general use, AIDS is diagnosed through guidelines laid down by the World Health Organization and known as the 'Bangui clinical case definition'. To qualify for AIDS someone must have a combination of symptoms like weight loss, persistent diarrhoea and fever for a month and a dry cough. The trouble with such **symptomatic HIV diagnosis** is that many of these symptoms are indistinguishable from symptoms of old, established diseases like TB and malaria. Nor is the kind of testing being carried out in Africa free from the danger of exaggerated results. According to Dr. Harvey Baily, "Some of these **tests are so non-specific that 80 to 90% of the positives are false positives**. ... The inevitable outcome is that the ***figures for numbers of HIV infections in Africa will become wildly exaggerated and feed into a very deadly self-fulfilling prophecy***."

Today Africans with symptoms of almost 20 old and established diseases that have come to be identified with HIV are ***refusing to seek medical help for old disease due to the fear of being labeled as an AIDS case!*** At the same time, as noted by the minister of health and child welfare in Zimbabwe, WHO and the 'AIDS industry' had fostered a damaging epidemic of ***'HIV-itis'*** in Africa, which is ***distracting money, attention and personnel from known problems like malaria, TB, STDs and safe motherhood***. Likewise in Uganda, in 1992 the total budget for malaria treatment and control was less than $ 57,000, yet foreign funding for AIDS was over $ 6 million. Under the circumstances, Africa is witnessing resurgence of old and curable diseases like and malaria and TB, which are beginning to assume the proportions of a public health hazard – a clear signal of the **disruption of health care systems by HIV interventions**. Furthermore, as people die on the streets – not from HIV/AIDS, but from curable diseases – governments are unable to respond, as they are completely dependent on and controlled by donors who came in with funds for controlling opportunistic diseases but drew the health system into the HIV prevention program.

Africa has everybody – from the World Bank, the churches, the Red Cross, the UNDP, African Medical Research Foundation... About 17 organizations in Kagera alone are **doing something for AIDS**. The numerous AIDS agencies that have flourished in much of Central Africa have also brought **"development"**, turning small neglected towns into towns full of Land Rovers and Toyotas. The day the epidemic goes away, a lot of "development" is going to go away! Many who have seen ground realities say it is ***easy to 'do good' in Africa*** as it is so disorganized that the one who is doing good is also the one reporting the good he is doing! So Africa is a good market and experimental ground for many organizations, ***a perfect field for fake charity which benefits the benefactors***.

Meanwhile, the immense international ***funds available*** for HIV and AIDS work remain an ***incentive for exaggerated statistics***. Indeed, many of the horror stories in Africa came into existence due to the funds they brought. Political factors have also played a part in the **scramble for funds**. For instance, when Kenya lost $300 m desperately needed foreign currency in 1991, due to an attempt by industrialized world to force political and economic reforms, the Health Minister made a crisis announcement showing AIDS figures spiraling out of control and horror stories of AIDS deaths. This was internationally recognized as an attempt to win back donor sympathy and funds. Many African countries are now facing **mounting debts**. There are cases where merely the annual interest payment on borrowings for HIV prevention add up to more than twice the total annual health budget of the country!

Thus in Africa the HIV prevention program driven by the AIDS industry through international donors has made for a medical crisis and social disarray of tragic proportions in just about a decade.

AIDS industry achieves
ANARCHY in AFRICA
in less than a decade!

Indian scene

After labeling Africa "the epicenter of AIDS", international donors have labeled India **"the world's AIDS Capital"**. And they have lent their support for AIDS prevention and control in India through the application of their "African model" – the same one that has placed Africa in the midst of a medical crisis and social disarray of tragic proportions. Unlike other activities in India that are planned, driven and controlled by certain donor countries, the HIV/AIDS program cuts across everything. It is a health issue that is also a social issue, an overarching concern that concerns everyone, a potential entry point into any issue or community. This makes it the best possible case study for an insight into the machinations of certain donor countries.

To say that HIV/AIDS prevention is both a manifestation of and a mechanism for control by foreign donor sounds far-fetched. This is only if we view colonization in terms of cannons and Robert Clive. Today we are far away from agrarian and industrial societies and well into market economies. Soon there will be no nations, only markets. Now colonization is about exploitation and control in a market context, not about cannons and Robert Clive in an industrial state. Its instruments are as insidious as the process itself. One instrument is taming the system via the bureaucracy. Another is institutionalizing activism (in the form of "NGOs") so it too can be tamed. A third is the instrument of the "draft policy" drawn up through the bureaucracy after consultations with NGOs. Such policies need not see the inside of Parliament and can therefore circumvent the democratic process. And they carry no accountability leaving open possibilities for "adjusting" interventions to serve various agendas with the complicity and cooperation of the bureaucracy and the NGO sector.

The donor controlled HIV/AIDS program in India is a clear manifestation of these processes of insidious colonization.

- A number of measures for prevention and control of HIV/AIDS are in place as a result of the combined efforts of multi-lateral and bilateral-donors and the governmental and non-governmental systems through which they operate. These include targeted interventions for high-risk groups, banning of professional blood donors, testing, PEP treatment, STD control, sexual health projects, reproductive and child health (RCH) projects, TB, leprosy, vertical transmission programs, etc. But by now it has become abundantly clear that **these measures are contributing virtually nothing to the prevention or control of HIV/AIDS**.
- This is not about poor implementation, insufficient coverage, inadequate resources or any of the usual reasons for ineffective interventions. This is about the completely misguided nature of interventions. HIV/AIDS has no cure. We only have some idea how it spreads. It can affect any one. The purpose of any prevention and control measure must be – indeed, can be – merely to build awareness and empower people to take informed decisions on their own behavior to protect themselves. Nothing else in the name of HIV/AIDS prevention has any scientific basis or moral sanctity. In this context, a closer look (in the following pages) at current measures makes it obvious that **these measures *cannot* contribute significantly to prevention and control of HIV/AIDS**.

It would be naïve to assume that in funding for so long an obviously ineffective and futile HIV/AIDS program certain donor countries are acting out of innocent ignorance. It is far more plausible that what seems a misguided strategy from the perspective of HIV/AIDS prevention is actually a successful effort in using HIV/AIDS as a mechanism for colonization of the most populated (lucrative?) country. by the AIDS industry.

- HIV/AIDS prevention measures may have failed to achieve their stated objectives. But they have succeeded in fostering an irrational fear psychosis, unethical medical practices (such as abandoning patients testing positive), irresponsible institutional behavior, violation of individual rights by forced testing, marginalisation of "high-risk groups", manipulation of public health concerns by market and vested interests, etc. It is very clear that **these measures have had far-reaching disruptive impacts on our healthcare system as well as our social and democratic fabric and the resultant chaos has left us vulnerable to all sorts of machinations.**
- Donors control not only HIV/AIDS prevention measures but also research and statistics on HIV/AIDS. It is therefore child's play for them to tailor research conclusions and manipulate statistics to exploit this chaotic situation to the fullest. There have been several instances of dubious identification of high-risk groups and HIV/AIDS affected regions to serve other ends. There has even been an instance of the NACO lying to the parliament to protect donor interests! It is becoming clear that **HIV/AIDS "studies" and "statistics" are being effectively used to manipulate opportunities for donor activity using HIV/AIDS as an entry point.**

On the whole, in the name of HIV/AIDS prevention, some utterly ineffective and highly disruptive measures are being taken – not only at great public expense but also at the cost of urgently needed effective measures for HIV/AIDS. It is becoming increasingly evident that HIV/AIDS prevention and control is less about HIV/AIDS prevention and more about control of societies The gainers from this strategy are readily identifiable in the form of large pharmaceutical interests, researchers and other market forces that control certain foreign donors.

Whatever is happening in the name of HIV/AIDS ***threatens the sovereignty – even identity – of nations like ours***, a threat that needs to recognized and addressed now, urgently. It is imperative that processes that have for long circumvented democracy be made accountable and find their rightful place on the nation's political agenda. In this context, the following sections first look at the **misguided measures** currently in place for HIV/AIDS prevention and control and questions their validity and then put forth some thoughts about the **real objectives of this errant strategy**.

AFRICA is under control...

INDIA looks good!
Lets go GET THEM!!

Misguided Measures

"High Risk Groups": Creating new untouchables?

The notion of "High Risk Groups" (HRGs) for HIV/AIDS is a central construct of the public health strategy being promoted by donor agencies through "targeted Interventions", "highway clinics", "coastal area projects", "reproductive and child health projects", "sexual health projects", etc. Over the years various "classes" of people – commercial sex workers, truck drivers, street children, etc. – have come to be labeled HRGs for HIV/AIDS. And most of what is being done in the matter of prevention and control of HIV/AIDS is in the form of targeted interventions for these HRGs.

Some targeted interventions are taking shape and others are said to have "effectively" worked, such as the well-known Sonagachi initiative launched in 1992 in one of the oldest and largest red light areas of Calcutta. By 1996 the Sonagachi initiative had earned the status of an "effective approach" meriting nation-wide replication. Even as donors are standing up and cheering Sonagachi there are several questions that cast doubt on the efficacy of the HRG approach that is claimed to have succeeded there:

- Are manipulated statistics on increased use of condoms, decline in STDs and no increase in HIV infection over a 4-year period in a localized red light area sufficient for identifying an "effective approach" for HIV/AIDS in India?
- Does the fact that, notwithstanding the Sonagachi success, Calcutta did record the highest increase in HIV/AIDS cases not suggest that the targeted intervention was not really an effective approach for HIV/AIDS?
- What is the basis for the assumption of rampant Indian male promiscuity or prostitute-like behavior amongst the Indian populace that is implicit in the suggestion that this "model" be replicated in other parts of the country?

There is also the matter of how HRGs are actually being addressed. Staying with the example of commercial sex workers, it is well known that very large percentages of these in major cities are mobile and do not operate out of identifiable "red light areas". In Delhi only 4000 of the city's estimated one lakh prostitutes are found in GB Road. Even complete "condomization" of this 4% of the HRG is likely to achieve little beyond glamorizing selected NGOs, as evident from official claims of 50% of the CSWs in GB Road being HIV positive !

The fact is that the HRG construct cannot possibly do much for prevention of HIV/AIDS inasmuch as it is **a flawed approach that focuses on identifying "high risk groups" rather than building awareness on "high risk behavior".**

Further, a closer look at the basis of identifying HRGs clearly shows that it is highly suspect and tantamount to a **scientific fraud** on the people (Box-1).

In other words, most of the population is being excluded from the purview of substantive HIV/AIDS prevention and control measures which are only being targeted at a dubiously identified priority group. Clearly there is no way such a strategy can achieve any significant success in preventing HIV/AIDS.

Box-1: Identifying HRGs – A "scientific" fraud: Kerala Experience

The British Government's ODA (Overseas Development Administration, now DfID) launched in April 1996 a project on targeted interventions in Kerala. It listed tribals, street children and sex workers among HRGs and said this was based on NACO's studies in 65 cities, including 3 in Kerala. When asked for the study, ODA said it was confidential. Nor was the study available with Kerala Government.

- Surely a GoI report meant to help in prevention of AIDS and generated at huge public expense could not be confidential.
- Surely a foreign donor can not keep material relating to people's health confidential from the very people concerned.

But still it was only after approaching Kerala High Court and after 14 months of effort that 3 portions of a patchy report could be obtained. It turned out that the 65-city HRG study was only a 36-city study, in which only 21 city-reports had been completed. The study does not mention tribals at all and nowhere does it mention prevalence of HIV in the other groups listed as High-Risk Groups. In fact, Kerala has no identified street children and sex workers are also not a visible group.

- Surely un-identified and invisible groups can't be labeled high-risk.
- Surely, if they are, there must be a hidden agenda

Meanwhile, the HRG construct has had three significant damaging effects:

- First, it has misled public in respect of perceptions of risk. People are lulled into the belief that if they do not belong to or associate with HRGs they are not at risk.
- Second, the medical profession – in an appalling display of ignorance and "quack" like behavior – has come to consider the HRG label a "symptom" of HIV/AIDS. This was obvious from the remarks in a recent television program of no less than Head of Microbiology of Rohtak Medical College that a truck driver admitted with a number of problems was "clinically diagnosed" as having AIDS.
- Thirdly, since HIV is an infection with extreme social stigma attached to it, labeling groups of people as HRGs leads to their marginalisation – even ostracism and can be viewed as being undemocratic, subversive, discriminatory and a violation of individuals' rights.

All this raises a number of questions.

- **Why are certain donor countries interested in interventions in, say, tribals in Kerala in the name of HIV/AIDS?** Could such communities really be seriously at risk? Or is there a hidden agenda?
- **Why are NGOs content to be implementing unscientifically identified and formulated HRG projects?** After all aren't they the ones usually most concerned about resource crunches and flaws in approaches? Then why are they running (for foreign donors) HIV projects like highway clinics, coastal area projects, red light area projects and, of course, projects in tribal areas? Are donors and NGOs acting out of ignorance? Or are they collaborating on some hidden agenda?

A bureaucrat and a truck-driver (both frequently travelling men)

went to a Doctor for oral thrush.

The bureaucrat got an antibiotic.

...The truck driver was sent for HIV TEST

Misguided Measures

Blood banks

Did a PIL mislead Supreme Court for private interest?

In January 1996 the Supreme Court passed a landmark judgement on blood banks in the wake of a public interest litigation. This judgement speaks of, among other things, total elimination of professional donors on account of the risk of spreading HIV and establishing a National Blood Transfusion Council (NBTC) for modernizing blood banks and ensuring availability of adequate and safe blood. The NBTC was created. But it was the National AIDS Control Organization (flush with World Bank loans) that, in the name of implementing the Supreme Court's directives, went on a spending spree. It installed imported equipment worth Rs.250 crores in 40 blood banks across the country in a bid to improve their capacity. In Delhi, for instance, the blood storage and processing capacity was upgraded to 2.4 million (24 lakh) units even though the annual requirement in Delhi is of the order of o.4 million (4 lakh) units.

Also, to date the blood bank reforms have not led to any improvement in collection. In fact collection has reduced. This raises a number of fundamental questions about the blood bank reform process:

- Why is it that the NBTC has remained quite inactive, spending till 1998 a meager 1.5 crores – and that too mainly on administration and seminars? Who then is going to ensure that all blood collected is screened for HIV?
- What made for the recent "problem of plenty" when blood banks turned away voluntary donors during the Kargil incident on account of "inadequate storage" even after NACO had equipped 40 blood banks with very expensive facilities for upgrading capacity and quality? Was this equipment inappropriate? Or is it just lying unused out of administrative inefficiency? Who is ensuring that public investments made in the name of HIV/AIDS prevention through enough safe blood supply are not being wasted?
- Why have blood bank reforms been taken over by NACO, which has no expertise in the sector? Why are blood bank reforms being implemented in the name of HIV/AIDS control? Is blood safety not required for other diseases like Hepatitis B? How does banning professional donors help that?

It is obvious that the current process of blood bank reforms is doing little for prevention and control of HIV/AIDS. It must be appreciated that blood-banking reforms can contribute to this only to the extent of ensuring blood safety. And this can only be done by ensuring that all blood collected is screened for HIV/AIDS through processes recommended for transfusion safety. Banning a group of donors does nothing to ensure transfusion safety.

What it is achieving is some far-reaching detrimental impacts on blood banking:

- Firstly, since professional donors contribute anything between a third to half of blood reserves (which are half of the blood required), banning them has far reaching implications for blood availability – and blood imports. An idea can be had from the fact that the value of imports of blood products has increased from 25 lakhs in 1993 to an estimated 2000 crores for the current year, with international experts placing the figure closer to 3000 crores!

Secondly, banning of professional donors has created a mindset in which "Indian" blood banks are beginning to be perceived by general public as being unsafe. Indeed, no less than the report of the Parliamentary Standing Committee on Dreaded Diseases (1998) actually says, "Blood Banks are places from which infected blood is donated and transfused" (para-3.4). Such a mindset is likely to further increase costly imports of blood products.

In effect, therefore, the Public Interest Litigation on blood bank reforms appears to have served foreign private market interests rather than achieve anything whatsoever by way of improvements in blood banking.

In the context of the above, and since blood banking reforms were initiated by a Supreme Court judgement, one needs to examine a bit further how these reforms, especially the ban on professional donors, came to be suggested.

- The Supreme Court judgement was based on a study on blood banks. The study – known as the Ferguson Study – which is claimed to have been commissioned by the Health Ministry to a firm of Chartered Accountants – was aggressively projected as the Blood Banking Bible, something that experts swear by without even seeing.
- The Ferguson study *strongly recommends* banning of professional donors. But it does so on the basis of flimsy and scientifically absurd data. The study *fails to scientifically prove* that professional donors are in any way a risk to the blood banking process on account of HIV.
- Data collected by the government over the two years period (within which the Supreme Court judgement had directed that professional donors be banned) clearly shows that, of professional donors, replacement donors and voluntary donors, professional donors, in fact, are the lowest risk group for HIV and voluntary donors the highest!

Since the study on which the Supreme Court judgement is said to be based contains nothing to suggest banning professional blood donors, one wonders how this recommendation crept into the judgement. **Is it that the Supreme Court took note of the recommendations of the study without a detailed perusal of the study report? Or was the Supreme Court deliberately misled?**

It is noteworthy that the Parliamentary Standing Committee states with respect to professional donors (para 2.12) that they "have a very objectionable kind of lifestyle" and that they "keep on donating blood once in fifteen days and once they get money they immediately go to a red light area"! **Why is the Parliament making such absurd statements? In fact, why is it making any statements about professional donors since there is already a three-year-old Supreme Court judgement in the matter? Could it be that this completely absurd and unfounded perception is being reinforced at the highest levels to serve some hidden agenda?**

We've banned professional donors due to HIV risk...
If we can discourage all the other donors by insisting
on announcing their HIV test results... then...
... **we can import ALL our blood requirement!**

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Testing:
Policy for securing World Bank loan alone?

Based on international policies NACO's national policy also has clear guidelines against mandatory testing and states that testing for HIV/AIDS should only happen by consent, in confidentiality and with adequate counseling.

But this policy is being blatantly violated at the instance of NACO! These violations have been happening for some time now in both private and public hospitals (Box-2). In Delhi they are to happen even in observation homes (Box-3). And the Health Minister's recent announcement regarding blood donors has not only endorsed these violations, but has also paved the way for similar violations at a national scale.

Box-2: "Enforced" testing in private and public healthcare sector

HIV tests of surgery patients and pregnant women have been going on for some time all over the country at private hospitals, nursing homes and ante-natal clinics as well as public hospitals including AIIMS. These are prescribed as routine tests, with total disregard for confidentiality, consent, and counseling. Inquiries at major testing labs in Delhi, Bombay, Calcutta, Bangalore, Madras and other cities have revealed this is already an accepted norm in, especially, the private health sector. While not strictly "mandatory" such testing is not far from this given the nature of the doctor-patient relationship is such that a patient has no choice in the matter of prescribed tests.

Box-3: Mandatory testing by Delhi Government

In January 1999 Delhi's Social Welfare Minister announced the decision to test destitute women and children housed in government observation homes for HIV. When it was pointed out that there is no such treatment available, hence there is no justification for the decision, the minister made another statement saying she will be "*curing them through yoga*"! She also said that mandatory testing is only "*being done for HIV not AIDS*"! In a reply to our letter she further said that the proposed HIV testing was not compulsory but "*a sort of voluntary adaptation*"! The situation has been further compounded by the Delhi health minister who, while pleading ignorance of his colleague's decision, has publicly come out in support of mandatory testing, saying that the center should allow the implementation of mandatory tests. This is a situation where ignorant, irrational and illegal decisions are being taken. What makes it more serious is that these decisions have the added danger of becoming established practice having been taken by the government institutions themselves.

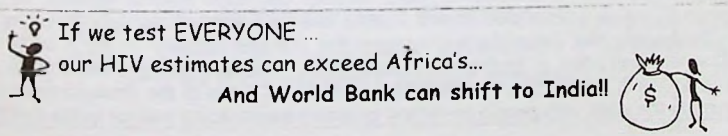
NACO's stand on violations of its policy is as appalling as the violations themselves. Regarding private clinics, NACO is of the view that the HIV testing in them is not mandatory and, in any case, these are not under its control. Regarding Delhi government's decision to conduct mandatory tests in its observation homes for destitute women and children, NACO (while admitting that these were a violation of the national policy) expressed no authority other than 'being hopeful' that the Delhi Government would not pursue such a course. Regarding the health minister's statement, NACO is satisfied he has also announced that he will be consulting the WHO in this regard.

Testing can do nothing for HIV/AIDS prevention. Those testing positive cannot be cured, rendered non-infectious or quarantined. For those testing negative there is no guarantee they will not acquire the infection in future. For these obvious reasons the national policy does not include mandatory testing in the HIV/AIDS program. For other reasons, including high expenses (at the cost of other urgently needed healthcare interventions) and social implications (including infringement of individual rights), it is explicitly excluded.

But not only is testing is going on, it is fast becoming the most visible HIV/AIDS intervention, raising several questions:

- **Why are doctors in both private and public healthcare systems prescribing HIV tests?** Are they using HIV tests as a measure for protecting themselves by turning away patients testing positive? If this is so should they not be considered guilty of unethical behavior? And more importantly what happened to millions of dollars worth of awareness building on universal protection amongst healthcare workers?
- **Why are politicians recommending HIV testing at the risk of making them established practice?** Are they, like the state minister in Delhi, acting out of ignorant beliefs such as that HIV can be cured through yoga? In which case, should they be allowed to take decisions on any crucial matter relating to public health? And, of course, whatever became of all the awareness training? Or are they, including the union health minister, unaware of the national policy? Or are they no longer representing people but some hidden agenda?
- **Is NACO really *unable* to ensure implementation of the National Policy?** Is there really no mechanism for it to seek compliance from either private sector or state or union government? Why should the union minister be consulting WHO and not NACO? In short, what is the role of NACO besides collaborating with donors on all manners of dubious research?
- **Or is it that NACO is *unwilling* to ensure implementation of the national policy?** Is it driven by some hidden agenda to lend its support to HIV testing (and to human rights and national policy violations that this entails)?
- **What are the NGOs – who should be crying foul at these human rights violations – doing?** Why are they not objecting? In fact, why are they through their STD clinics in coastal area projects, highway projects, red light area projects and even tribal area (!) projects participating in blood testing? Do the strings attached to the foreign funds for their projects tie their hands or does the color of foreign money blind their perception of their role?

These questions need to be answered, as HIV testing is becoming an industry that professionals are being used to feed. Promotion of HIV testing is creating a captive market for introducing (questionable and dangerous) drug trials. And by allowing the situation to get out of its hands, NACO is paving the way for a society subjugated in the name of HIV/AIDS by market forces and other vested interests.



Prevention in health workers:
"Prevent HIV through PEP treatment", says NACO!

Nowhere in the world has AZT or any other drug been projected as either curative or preventive HIV drug. But NACO is projecting AZT as 'preventive therapy'. It is recommending, practically along with a prescription, AZT drugs, in the guise of Post Exposure Prophylaxis (PEP) treatment for Health Workers exposed to needle stick injuries. This treatment, they say, is already being provided in government hospitals.

NACO cites as the basis for this guideline a US government study that claims that starting this treatment within hours of accidental needle stick exposure to HIV can decrease the chances of becoming infected by 79%. What they do not mention is that this carries the assumption that 100 out of 100 exposures to the virus through needle stick injuries would result in HIV infection. But the fact is that possibility of contracting the virus this way is miniscule, and in all likelihood the 79% in whom HIV infection is said to have been prevented, would not have contracted the virus in any case ('PEP' or not). Also, there is no way any study can conform that a potential infection has been averted by AZT treatment started within 'a few hours' of exposure since there is a 'window period' of a few months after infection, when the virus cannot be detected.

Box-4: AZT – No ordinary drug

Arthur Ashe died because he was taking huge doses of AZT, while Magic Johnson, who discontinued AZT treatment, has resumed his basketball career. AZT is no ordinary drug; it is a cocktail of anti HIV drugs, recommended for HIV positive people. Initially hailed as a miraculous breakthrough in AIDS medication, the therapy temporarily seemed to work. AIDS patients who were administered these drugs showed improvement for a few months till the virus, which is able to mutate at a very high rate, developed a resistant strain. Since then various combinations of these drugs have been tried, and in all cases the virus is able to come up with a multi-resistant strain of itself. At best AZT has been shown to delay the onset of AIDS and even that is directly linked to drug compliance. Once you start AZT therapy, you have to take the drugs every few hours, every day, every week, every month, for years, without missing a single dose. What makes this difficult is that it involves taking 15 to 20 pills every day, and night, no matter where you are or what you are doing. One you must have with a quart of water, another after a full meal, for some you wait till your stomach is empty. You have to be prepared to plan you whole day according to the pill schedules. If you miss a few doses or take the wrong drug at the wrong time (which is highly probable given the confusing drug schedules) the virus becomes resistant to the therapy and the viral load is not only back to pre-therapy levels, it is now resistant to all other drugs. It is feared that this resistant strain might spread and cause an outbreak of untreatable AIDS. Besides debatable medical benefits, AZT is known to cause severe side effects - some even life threatening. AZT is a form of chemotherapy and chemotherapy ravages the immune system. To top it all is the extremely high costs of treatment. Costing about 18000$ a year and more for every drug added to the therapy. All these factors make AZT one of the most controversial drugs in the west, with people preferring to defer treatment and wait for better options

So all one is achieving through PEP treatment is

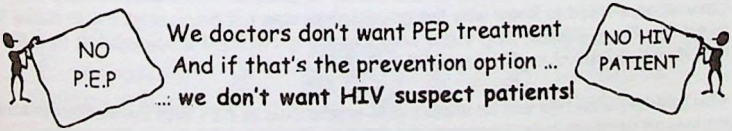
(a) making healthy people start expensive and unsafe AZT treatment (see Box-4) even before confirming they have been infected, and

(b) diverting attention from universal precautions.

Health workers don't need PEP. They simply need to follow the basic Universal Precautions to avoid getting infected. The fact that NACO is recommending PEP treatment as a guideline for standard precautions in health care settings even as AZT drugs are being shunned throughout the west raises a number of questions:

- **Are healthcare workers really expected to take PEP treatment for all needle-stick injuries?**
  Do they not know that PEP treatment would mean subjecting themselves to all kinds of dangerous side effects, enormous expense and future implications of multi-drug resistance?
- **Are healthcare workers not likely to want to first confirm if they need PEP treatment?**
  Since for this they would need to know the HIV status of the patient, is not the NACO, by recommending PEP treatment, implicitly supporting HIV testing of patients in the interest of health care workers and against its own policy and all public health rationale?
- **Is NACO not implying that universal precautions are inadequate for HIV/AIDS?**
  Is this not adding to the AIDS scare within the medical community? And is this not, therefore, resulting in irrational and unethical practices like testing or abandoning suspected HIV patients?
- **Given that AZT is not an accepted preventive drug why is NACO recommending PEP treatment?** Does not NACO realize that this can only cause confusion and unreasonable fear in the medical community? By projecting AZT as a preventive drug, isn't NACO misleading the people in matters relating to their health?
- **Why are NGOs putting alarming findings of unscientific studies on precautions in public hospitals in the media?**
  Will not the recent report in the HT about alleged high levels of HIV infection amongst doctors in public hospitals in Bombay based on this dubious study create a baseless fear? Will this not divert attention from Universal precautions to untested PEP treatment and similar knee-jerk reactions?

These questions need to be answered urgently as NACO has put us on our way to becoming the biggest guinea pig farm for HIV drug trials, to benefit treatments that are ultimately in the control of western pharmaceutical companies.



Misguided Measures

Vertical transmission:
UNICEF, women NGOs "rescue" newborns from HIV?

1998 end and early 1999 saw three developments with a bearing on transmission of HIV from mother to child (vertical transmission) in India:

- NACO announced that AZT drugs would be administered to pregnant women. This is to be done through UNICEF's mother and child health programs and has officially commenced in six centers.
- The Parliamentary Standing Committee Report on Dreaded Diseases was tabled. The last paragraph reads:

  "The Committee decides that our country should contribute its own might, for it may so happen that the research conducted in India may ultimately lead to success."
- US government announced the decision to "stop recruiting pregnant women" for administration of AZT drugs.

To understand the full importance of these developments one needs to understand that administering AZT drugs to pregnant women is not something starting now – as suggested by NACO or the Parliamentary Committee report. It is **something that has been going on from the beginning of the '90s as part of unofficial drug trials!** Thousands of pregnant women in India have already been administered deadly AZT cocktail drugs. Several hundreds of them have already suffered devastating side effects of AZT (refer Box-4) and several hundreds of children have already been born with birth defects as a result of AZT (Box-5).

Unofficial drug trials on pregnant women in India have been going on at the instance of foreign research institutes in collaboration with some of the most respected private and public sector health institutions in the country, with NRI researchers and experts serving as the conduit. From the early '90s onwards a number of "experts" on HIV have been created and projected through the media to a medically gullible public that believes anything that the "Doctor says"! Faith in the doctor, combined with the fear surrounding HIV, led people to believe that "expert doctors" recommending AZT were not just saviors as far as HIV was concerned but noble men making a noble effort to bring fruits of western scientific achievements to India even as the inertia-ridden government was doing nothing. Through early and mid '90s the media continued to report experts on AZT. Especially in 1997 there was a veritable media blitz of statements by international and Indian experts at various seminars and workshops highlighting the success of AZT treatment in various parts of the world and expressing concern over non-availability of AZT drugs in India. Thus it was that by 1998 AZT drugs had gained acceptability in the minds of people. The Parliamentary standing Committee wanted to know why the government was not doing anything to make AZT drugs readily available. And there was already a Rs.3000 crore market in India for AZT drugs manufactured in the west!

Now that UNICEF has lent its impeccable credentials to AZT and the Parliament has expressed concern over government's lethargy in using AZT drugs, this market seems poised to grow.

Box-5: What AZT can do for pregnant women and children

Particularly alarming side effects of AZT treatment of pregnant women are **spontaneous and induced abortions**. A study carried out in Asia reports these effects in 16% of the pregnant women administered AZT. Equally alarming is the high incidence of **birth defects among surviving children**. The Asian study revealed horrifying birth defects in babies born to women who took AZT while pregnant, including babies born with holes in their chests, malformed hearts, abnormally small brain, progressive blindness, misplaced ears, extra digits, etc. AZT has been pronounced to be downright harmful when taken by children. In fact, HIV positive **children who take AZT die faster** than children who don't. There is a 30% chance of an HIV positive mother passing on the virus to her child. It is claimed AZT can bring down the risk of transmission to 7%. In view of the hazards that AZT poses to the health, even survival, of the child, the risk of administering AZT should be weighed against the likelihood of the child developing AIDS. Put simply, from the fetal viewpoint **the risk of intervention needs to be less than the risk of transmission. And there is no scientific basis to suggest that this is the case!**

The convergence between UNICEF's intentions and the pharmaceutical companies' interests is no coincidence. It is well known that the UN is facing a severe resource crunch following the failure of member countries to contribute funds and has solicited contributions from the private sector. UNICEF and UNAIDS are both heavily funded by pharmaceutical companies. The survival and sustainability of UN organizations has thus become inextricably linked with the interests of their "holding companies"! By taking on the task of administering AZT drugs to pregnant women, knowing fully well their damaging effects on both mother and child, UNICEF has made it clear that it is no longer dedicated to the service of the needy, but rather to the service of those that can fund its own survival.

All this raises some other serious questions:

- **Who decides that pregnant women in India may be administered dubious drugs?**
  Who permitted this? On what basis? Who is accountable for disastrous side effects on the mothers? And for deformities in children? Is the Indian government responsible for the survival of UNICEF or of Indian mothers and children?
- **And what is the role of all the "gender-sensitive" womens' organizations who will be implementators (and beneficiaries) of this UNICEF endeavor?**
  Why are they not protesting against – instead of participating in – such a program? Is it because no foreign funding is available for such a protest? Is it because they see their role of serving people as a poor second to their own need for staying in business?

Misguided Measures

STD control:
Cross-connection with HIV?

NACO recently launched a 'pilot project', named innocently enough "Family Health Awareness Week". The purpose of this program is to control the spread of HIV by controlling Reproductive Tract and Sexually Transmitted Infections (RTI/STI). The methodology consists of identifying all cases of RTI/STI in the rural population of these districts and treating them, so that HIV can be prevented. Since it is not possible to ask people to get themselves tested for STD, they are to be coaxed to do so by projecting testing as a general health check up.

Several selected NGOs are also operating STD clinics under various projects in coastal areas, on highways, in red light areas and even in tribal areas throughout the country where blood tests are being done at will.

Justifications being offered for conducting an STD control campaign in the name of HIV/AIDS prevention merit closer scrutiny and seem rather dubious (Box-6).

Box-6: NACO's pilot project for STD control: Dubious justifications

In India 90% of HIV transmission is said to be through heterosexual activity
What of NACO's own figures that say that at worst 74.15% and at best 46% of HIV transmission is through heterosexual activity? Does this not epitomize the dramatic and misleading way in which statistics can be used to scare the public?

STD infections increase the chances of transmission of the HIV virus
What is the basis of this? Can the higher prevalence of HIV among STD patients correctly be interpreted to mean STD causes HIV rather than merely that a certain type of behavior is leading to both STD and HIV infections?

Studies show that Tanzania has been able to control HIV by controlling STD.
What of latest studies from *Uganda*, which have proved that treatment of STDs has no effect on the risk of transmission of the AIDS virus? Or are lessons from international research to be selectively applied to serve other interests?

This targets "low risk" rural populations which have not been covered so far
But then why is the same methodology that is used for prostitutes being applied to villagers who are, generally speaking, neither aware of STDs or HIV nor a promiscuous lot? Will not projecting HIV as an STD, to a rural population who have not been exposed to any other awareness campaign, serve to enhance the stigma and fear associated with HIV? Will it not, instead of encouraging villagers to come out and seek counseling, drive potential HIV cases underground?

Moreover, it is not easy to diagnose particular STDs and STD clinics tend to circumvent this problem by symptomatically prescribing broad-spectrum anti- biotic drugs for treatment. These drugs, besides their harmful .effects on mis-diagnosed patients, have no effect on HIV infections, which cannot be cured by drugs.

The proposed modalities of NACO's pilot project also raise a number of questions:

- Is it right to test people without their consent and without their knowledge?
- Is it right to go ahead and test people without working out mechanisms for guaranteeing confidentiality?
- Is it right to go ahead and test people without first installing mechanisms for awareness and counseling?

Obviously, NACO's pilot project violates its own policy against testing in spirit, if not in letter. It does seem that the Government has found a novel way of bypassing the prohibition of mandatory testing for HIV – that of testing people by fooling them into getting themselves tested for STDs!

NACO's STD project and the STD clinics being operated by various NGOs also appear to disregard all past experience with the handling of stigmatized diseases like leprosy and TB. Despite widespread awareness regarding this – a benefit that highly stigmatized STDs do not enjoy – experience has shown us that no one likes to be seen coming to such facilities.

Given the highly dubious justifications, the pathetically inadequate modalities and the ridiculously low possible impact – not to speak of past experience that tells us that clinics for stigmatized diseases are bound to be poorly used – what is really expected of these STD control measures?

- **Why is NACO carrying out an STD control project in *villages* in the name of HIV control?** Why is it deliberately misleading people with manipulated statistics and selectively projected international research findings to justify its project? Why is it interested in promoting the use of broad-spectrum antibiotics for STD treatment even though these have no effect on HIV?
- **Why are NGOs operating STD clinics in all kinds of places including *tribal areas*?** Do they real believe these are needed or will work? Or are these a means to some other hidden end that just happens to need a lot of blood tests?

These questions need to be answered because all manners of testing are being carried out in the name of HIV/AIDS prevention and control which, without the "official" knowledge of our country, seem to be serving research and experimental work elsewhere.

India has **another World Bank loan for HIV.**
What can we make them buy now? ... ...After condoms, testing kits, blood equipment, AZT...
broad-spectrum antibiotics for STDs.

Real objectives?

It is clear that measures currently in place are not doing much for HIV/AIDS prevention and control. Nor *can* they do much on account of their flawed rationale and inadequate scientific basis. Instead, they are making for far-reaching disruptive impacts in healthcare as well as society. That foreign donors (with their vast "international experience"), key NGOs (with their "alternative" perspectives) and so many bureaucrats (trained by IAS academies and groomed by mid-career training in foreign lands) have all missed the fact that these measures are most misguided is not possible. Or so one hopes, since the alternative implies that the country's – in fact the world's – developmentis in the hands of an extremely asinine assemblage of partners who are unable to individually or collectively see the obvious! Rejecting that alarming alternative, ***one tends to assume that foreign donors, NGOs and bureaucrats do see that current HIV/AIDS prevention measures are misguided.*** The question that follows is why are they abetting, endorsing and promoting such wasteful, ineffective and disruptive measures. The answer lies in what these measures are really achieving (since they are not achieving stated objectives). Some of these "achievements" are outlined here. All these clearly cater to the multi-billion dollar thriving AIDS industry.

Creating an "HIV/AIDS scare"

The most obvious "achievement" of HIV/AIDS prevention and control measures has been to create an "AIDS scare", as borne out by media reports such as the following:

- In a village in Kerala when a whole family committed suicide out of fear of ostracism when the head of the family found he was infected with HIV.
- In a village in Bengal the village priest's family was thrown out of the village when it was found out that their son, a casual laborer in Bombay, was HIV positive.
- In Tamil Nadu, within a week of UNAIDS declaring it as a "successful state" a suspected case of HIV was burnt alive in the street.
- In Haryana, an entire village was ostracized when medical community, without benefit of recommended tests, declared a villager to be suffering from AIDS.
- In AIIMS – India's premier medical institute –recently an "HIV suspect" was denied treatment. He died. And his HIV tests turned out to be negative.

Current measures are contributing **directly** to an AIDS scare in many ways. The high-risk group construct has fuelled the AIDS scare through a vicious cycle of fear-rejection-fear among groups labeled HRGs, driving potential cases underground. The banning of professional donors has created an AIDS scare in the blood-banking system and public at large is wary of both using and donating to blood banks. Testing for HIV has frightened not only those targeted for testing but also everyone else as it implicitly exaggerates the scale of AIDS. Promotion of Post Exposure Prophylaxis (PEP) treatment has scared healthcare workers (who are beginning to avoid "HIV suspect" patients) as well as general public (who is becoming scared to visit a hospital for fear of becoming infected). Current measures have **indirectly** contributed to an AIDS scare by diverting attention from counseling and awareness building that could have promoted more rational perspectives. ***The fear psychosis that has been created has made for a situation in which anything can be done in the name of HIV/AIDS prevention without being questioned by the public at large.***

Creating chaos in the health care system

A related "achievement" of current measures for HIV/AIDS prevention is the weakening of the healthcare system. This has been effected in two broad ways. ***Firstly***, economics of healthcare systems have been completely distorted. High costs have been built in either directly (such as through large scale expensive testing) or indirectly (such as by banning professional blood donors, which increases import requirements). These are bound to increase dependency on aid, besides being at the cost of implementation of, say, measures for hospital infection control procedure that could have prevented more infectious diseases like hepatitis 'B'. ***Secondly***, through creating an AIDS scare, inadequately handling awareness building and coming up with knee-jerk over-reactions in the form of recommending PEP treatment, the HIV/AIDS program has fostered irrational and unethical behavior in the medical community. There are growing numbers of instances of insistence on HIV testing, denial of treatment to patients suspected of having HIV and even all manners of "clinical diagnosis" of HIV. The medical community seems to want to distance itself from the disease. ***A resource starved healthcare system manned by a medical community that would rather stay clear of HIV/AIDS can hardly be expected to constructively intervene (interfere?) in HIV/AIDS prevention and control, leaving the field clear for certain donor countries to manipulate.***

Medicalisation and research

Creating an AIDS scare and chaos in the healthcare system of the country, of course, are not ends in themselves. They merely create the setting in which more tangible objectives can be realized. So far the most obvious evidence of such a tangible real objective is medicalisation. In the name of preventing and controlling a disease that cannot be prevented or cured by drugs, a large market for broad-spectrum STD drugs, controversial AZT drugs for PEP treatment for healthcare workers and for pregnant women and expensive testing kits has already been created. Boldly disregarding the national policy on AIDS control ***certain donor countries – in connivance with NACO, NGOs and highly respected medical institutions - are using the HIV/AIDS prevention program to reduce us to hapless subjects on which to dump (at lowered prices) all sorts of unnecessary drugs.*** A second "real objective" is to facilitate research and drug trials. Again violating with impunity the national policy on testing, donors controlling the HIV/AIDS program have succeeded in opening up the floodgates for rampant "testing" in the name of HIV/AIDS prevention and control. Private clinics, public hospitals, government agencies and politicians are all endorsing and promoting testing and NACO seems unable or unwilling to stop them. Even respectable organizations like the UNICEF (through its mother and child programs) have been roped into this exercise. All this is happening even though there is no basis whatsoever to view testing as a prevention measure or, say, to consider tribals a high-risk group for HIV/AIDS. ***For about a decade now we have been evolving into one of the largest research laboratories and a guinea pig farm for experimenting with dubious drugs. Obviously, this is not happening without the knowledge – even connivance – of concerned authorities.***

HIV industry -- driving disease control programs that are DEADLIER THAN THE DISEASE !

Draft Policy: New mechanism for colonization!

Mechanisms of colonization via the bureaucracy and NGOs

It is evident from the foregoing that the HIV/AIDS prevention and control program is being used not for preventing or controlling HIV/AIDS but for exploiting and controlling the nation to serve the interests of foreign donors in the emergent market economy context. It was stated at the beginning of this note that this is what colonization in a contemporary context is about. It was also stated that the instruments of this insidious process of colonization are a tamed bureaucracy, a tamed NGO sector (dominated by women led NGOs) and the artifice of the draft policy.

The modus operandi of foreign donors has evolved into a fairly standard procedure.

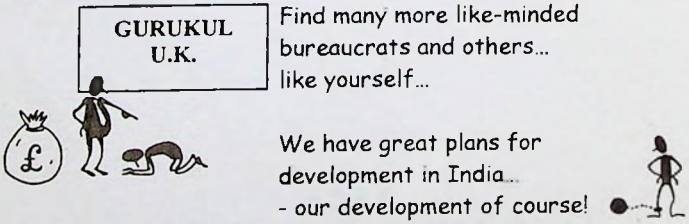
- It begins with identifying (or creating) and supporting (with funds and, more significantly, consultant inputs) a "suitable" NGO to "work on" a certain issue. Often these "NGOs" are not voluntary agencies, but arms of large corporate houses or management consultancy firms or just friends and relatives of bureaucrats!. The specific objectives of the task vary but the agenda is to draw attention to the "need for policy".
- Once this "need" is brought into public consciousness, a "suitable" bureaucrat is fixed. This is typically a "shishya" of one of the "gurukuls" abroad where bureaucrats routinely attend all manners of "training" who is now in a position of strength in the administration. So effective are these "gurukuls" that it is seldom necessary for the "gurus" to participate in the process beyond briefing stages.
- The "shishya" then rounds up something in the nature of a chapter of an "alumni association" by way of a handful of state secretaries who have been to the same "gurukul" in younger days and a draft policy is written up.
- A bunch of "suitable" NGOs/firms is then rounded up for a series of "regional consultations" at which the draft policy is "widely endorsed". *The Planning Commission in due course of time reprints it under its aegis.*
- Often a political figure – if necessary, even the Prime Minister – is invited to inaugurate one or more of these consultations or give a speech in a specially arranged forum. In certain matters of great concern the endorsement of the draft policy by a larger political cross-section may be arranged. This is done not through the democratic mechanism of a parliamentary vote, but our British legacy of a "parliamentary committee" advised, of course, by the same "experts" from the tamed bureaucracy and NGO sectors.

The draft policy for HIV, like all other draft policies on which our country is running, went through the above process. But unlike other draft policies, the HIV draft policy has the distinction of having been released during election time by the Prime Minister and having been permitted to be declared as government policy by the Election Commission. ***This procedure of announcing a policy is unprecedented in the history of independent India.*** And the policy itself, allowing as it does the kind of things discussed so far in this note, ***is tantamount to gifting away the sovereignty of the nation to foreign donors working for market forces.*** It is, therefore, obvious that we have already been colonized.

Thus it has come about that foreign donors are replicating the African model of HIV prevention and control in India and have, thereby, firmly pushed us on the same path to a scientifically created genocide and civil unrest. Unfortunately, all our own democratic institutions are party to this. The Parliament of India is appreciated worldwide as a symbol of the maturity of the electorate of the world's largest democracy. Sadly, parliamentarians have repeatedly betrayed the trust placed in them by the people. The Parliamentary Standing Committee's 73rd Report on Dreaded Diseases shows once again how parliamentarians can let down the nation through their blissful ignorance. The Supreme Court which has a history of delivering social justice and commands immense respect and credibility amongst the Indian masses and the international community has also come under a cloud on account of the consequences of its judgement on blood bank reforms. **But, in the ultimate analysis, and above all, it is the National AIDS Control Organization (NACO) that is squarely to blame for the betrayal of the nation in the name of HIV.**

The responsibility for HIV prevention and control in India – along with millions of dollars of World Bank loans – were vested in NACO. But NACO it has become reduced to a being an arm of foreign donors serving market forces. This was recognized by no less than the Parliamentary Standing Committee, which states: "The Committee has learned that the various international agencies are implementing various programs in different parts of the country for tracking the problem of HIV/AIDS. In this connection the Committee is constrained to note that NACO is not involved in the implementation of all projects in all parts of the country." **NACO seems to be guilty of nothing short of treason. Nothing short of a criminal trial against NACO will redress this betrayal of the nation.**

Things have come to this because the powers that be believe we do not deserve better and we believe that things cannot change. But it is our right and our duty that things change. We must shake off the indifference and inertia that has become our tradition and act to protect our interest and make those who are charged by the constitution to protect our interest do their job. **It is imperative that HIV/AIDS no longer be viewed merely as a medical issue, health issue, socio-economic issue or even developmental issue. It must be seen for what it is – an urgent political issue. If it is not handled as such now we are doomed to economic disaster and national disintegration.**



HIV/AIDS is one of the greatest crises being faced by mankind today. History tells us that whenever there has been a crisis there have also been those who have exploited the crisis. HIV/AIDS is no exception to this historic truism. The self-serving **HIV/AIDS Industry** is very industriously exploiting the global HIV/AIDS crisis.

It **thrives on chaos** – where fear becomes the central creed, irrational behavior becomes the norm, knee-jerk reactions pass off as policy and strategy – and ***anything goes, no questions asked.***

It systematically **undermines systems** – systems of public healthcare, systems of governance, systems of society, systems vital for functioning, even, survival of a people – ***so that anarchy can make way for total exploitation.***

It is the most unconventional and deadliest **form of warfare** – where not a missile is fired, not a soldier is killed, not a border is changed, not a building is destroyed – but ***enduring subjugation is achieved.***

While AIDS can kill individuals, the HIV/AIDS industry destroys society and nationhood – not by any obvious manner of biological death but by insidious and persistent cultural, social, economic and political annihilation. Thus the HIV/AIDS industry has emerged as the most effective ever instrument of colonization, compromising the survival of nations to the sustenance of vested, market interests.

Africa is already showing the consequences of allowing the HIV/AIDS industry to prevail. And we are hurtling with inevitability on the same path to economic disaster, civil unrest and national disintegration.

While much is being said about the deadly AIDS, little is being said of the equally – if not more – deadly HIV/AIDS Industry.

This booklet is intended to draw attention to this little known, scarcely acknowledged and barely understood deadly dimension of the HIV/AIDS scenario, so that HIV/AIDS is no longer seen as just as health or medical issue, but as a socio-political issue.

It is intended to provoke Indians into shedding off their inertia and heeding the warning signs so that whatever is needed can be done to get the nation off this doomed course of colonization in the name of HIV/AIDS prevention and control.

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