FACTS against MYTHS

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Towards an AIDS Scam or AIDS Care?

Myths behind the AIDS "Epidemic"

COMMENT

The HIV-AIDS pandemic represents a major challenge for India today. Since the first AIDS case in India was detected in 1986 HIV has been reported in all States and Union territories. Today, however, its spread is no longer confined to the usual defined vulnerable groups but has spread to other groups as well.

According to various reports Maharastara is one of the States with high HIV prevalence. It has between 3.5 to 4 lakh HIV-infected people approx. 10 percent of India's 3.5 to 4 m. cases.[1] The other States are Manipur, Nagaland, A.P., Tamil Nadu, and Karnataka. Gujarat and Goa comprise the medium-prevalence States. UP, Bihar and Kerala rank among the low-prevalence State. However, the low prevalence in these latter States is due to lack of proper classified data. The actual extent and magnitude of HIV-AIDS at present is difficult to arrive at conclusively owing to conflicting statistical information being reported by various interests groups.

According to the National Aids Control Organization (NACO), in charge of the monitoring and control programs in India, a high-prevalence State is one where the percertange of pregnant women, testing HIV positive at ante-natal clinics, has crossed 1 per cent and ii) where the prevalence among high risk groups like sex workers has crossed 5 per cent.[1] These estimates are based on annual surveys of only those who visited government-run clinics. In Maharastara and Tamil Nadu, the infections are mostly due to heterosexual contact, while infections are mainly found among injecting drug users and their sexual partners in Manipur in the North East. WHO and UNAIDS reports that India's national adult HIV prevalence rate of less than 1% offers little indication of the serious situation. A large number of people are affected in certain areas leading to localised epidemics with an estimated 3.97 m people living with HIV at the end of 2001.

While normal heterosexual activity is the main route of transmission, certain areas have been affected largely through other routes like the use of injectable drugs and unregulated blood transfusion vis-a-vis blood donation. Mother to child transmission is also the single biggest cause for concern and the major contributor in the massive rise of the ailment.

Mother to Child Transmission[2]

- New infection in children (0-14 years) - 0.8 m
- HIV/deaths in children (0-14 years) - 0.58
- Children living with HIV/AIDS - 3 m
- HIV positive pregnant women - 2.6 m

The estimates of the risk of vertical transmission are:

During pregnancy	- 5-10%
During Labor & Delivery	- 10-20%
During breast Feeding	- 5-20%

Pediatric AIDS another major public health problem. Many children are born HIV-positive but test negative months later. This is because the mother has passed on the antibodies for the virus, not the virus itself, and these antibodies disappear in 18 months[3] Ironically, however, children's' homes all over the city of Mumbai attest that even when children have become HIV negative, these children experience discrimination during adoption in that couples are unwilling to adopt them out of sheer ignorance about HIV and unfounded fears whether or not the child will be socially accepted. However, ignorance of HIV can also be traced among among urbane Indians. For instance two children in Kerala living with HIV showed the extent of ignorance even among India's most literate state, Kerela. In a Government High School in Kaithakuzhi Kollam district the two children were the only ones in attendance. That is because the parents of the other 119 pupils did not send their children to school for fear they would be infected by the two HIV children who had earlier been turned away from four other schools. Moreover, the guardians of these children had also to face threats at home from local residents.

As it is now widely known the HIV infection is no longer confined to just the so-called traditional vulnerable groups. When it was first reported AIDS cases were among gays but later observed among heterosexuals and even among married couples. Today, the ailment includes the youth and college students. According to reports 50 per cent of new infections are to be found among those below the 25 age-group. This is the new vulnerable high risk group[4]. DATA by NACO indicate that of 56,151 AIDS cases in the 0-29 age group in India, 24,663 have been reported from Tamilnadu[4]. For the period ending October 31, 2003, 2,126 children below 14 have AIDS while 19,416 cases have been reported in the age group of 15-29.

The general causes for HIV infection among children[3]
Up to one year old - parent-to-child
1 to 6 years - through parent or thalassemic
6 to 12 years - substance abuse or sexual abuse
12 to 18 years - substance abuse or heterosexual exposure

Apart from youth, the prevalence of HIV is also among women attending ante-natal clinics among whom it was higher than 1% in A.P., Karnataka, M.S., Manipur, Nagaland and TN. It must be noted that women's vulnerability to the ailment are rooted in sexual, social and economic inequality based on gender. This gender bias is even further perpetuated by the recommendation that had been made by the National Commission for Women (Delhi) proposing a moralistic amendment in the marriage laws making HIV/AIDS as grounds for divorce. Gender inequality however is also affected by a combination of factors such as class, caste, sexual orientation, religion and culture.

The increasing levels of HIV-AIDS in women and the consequent rise of pre-natal transmission highlight the relevance of incorporating a strong gender perspective into any strategy to address the ailment. Women's ability to negotiate their sexual relation is rooted in their social and economic status. High dependence on male partners and low education standards limits women's choices which often determine their sexual relations even when faced with high risk and potentially dangerous situation.

The intersection and overlap of different aspects of gender inequality with HIV vulnerability further substantiates the need for a more integrated and holistic approach to HIV prevention and care that would focus both on risk reduction and the removal of social, cultural, economic and legal barriers to effective prevention behavior. This also means addressing the health, social and economic needs of those who are already HIV positive or living with AIDS as well as protecting families with HIV/AIDS from discrimination and stigma. Easing the burden of care through a variety of health, economic and social measures are also highly critical.

Further, mind sets and belief systems also have an influence on the capability of people to not only comprehend the exact nature of the AIDS syndrome but also the capability of people to live a healthy and self-determined life. Another relevant observation is that despite media campaign on safe sex practices a large percentage (around 85 percent) of HIV infections are due to unsafe sex. Many individuals continue to also refuse to be tested for the virus. This, combined with the disinclination to practice safe sex, makes battling the spread of the disease almost impossible. Denial, fear of embarrassment and shame, risk of losing prestige and social status, job, housing are factors to continuing rise of HIV infection. In this sense, AIDS is not merely a public health concern and a

C I R C U S[5]	
A	PROJECTIONS: HIV infected people in India
I	CENTRAL INTELLIGENCE AGENCY (us): 5-8 million existing. 25 million by 2025.
D	WORLD BANK: 10.9 million by 2024
S	NACO: Existing, about 4 million and plateauing

challenge but a litmus test of tolerance and democratic principles.

However, in this whole complex HIV-AIDS question, the central issue in India and in the South is the disturbing emergence of new information that exacerbates our dilemma in effectively dealing with the ailment. These are:

First, conflicting variations in not just the data on HIV-AIDs affected people but on the various studies, approaches, the methodologies, etc, in addressing the issue head on. For instance, Outlook magazine reports of the peculiar prediction by the American CIA that India alone would have 20-256 m. infections by 2010, up from 4 m. today! The earlier issue of this publication reports the following conflicting figures[5].

Second, the questionable nature of those active in dealing with the AIDS syndrome especially the now dubious role of the mega pharmaceutical drug industry for whom AIDS presents a massive lucrative market — products that range from condoms and HIV testing kits to anti-AIDS drugs like ARVs, etc., and microbicides protecting women to HIV Tests itself and Medicare to HIV/AIDS treatment infrastructure. The multi-trillion dollar global market for these products and related facilities is heavily dependent on synthetic drugs that allow an excessively high lucrative investment based on the patentability of the drugs. A large number of these pharmaceutical firms, to get access to this vast market, even exploit the fear and vulnerability of HIV affected persons. Results of drug trials for instance kept secret, released information on it selectively, or even delayed trials in the single-minded drive for maximum profits. Some have not bothered with trials at all before peddling cure or palliatives of a dubious nature. For instance, in the same magazine (above) there is an overservation by the President of the New York-based oraganisation, HEAL (Health Education AIDS Liaison): "The big crime here is that the pharma companies are passing off the HIV tests and the anti-HIV 'treatments' as accurate and effective when both the tests and these anti-retroviral drugs – which are extremely toxic – have already been profoundly discredited in the US".

Third, whether HIV-AIDS is really the #1 "killer disease" both in India and in the South and therefore the country faces an HIV-AIDS "epidemic" even making India the so-called AIDS capital of the World and according to the American CIA that India along with China will see the "next wave" of the global AIDS crisis. This is in contrast to communicable diseases e.g. TB, malaria, Hepatitis B and even asthma which according to reports including the cited magazine (above) kill more people than AIDS. See details on pg.4.

Forth, is the hidden motive of the sudden and incredible deluge of funds flooding into the country for HIV prevention by global financial institutions, private foundations like the Bill and Melinda Gates Foundation, UN, among others.

In all this, however, the greatest consequence is on the AIDS sufferers. Not only must they contend with a ravaging ailment but also the stigmatized social response that makes the coping with AIDS very difficult. Effective public information campaigns need to de-stigmatise the ailment. Laws that protect the privacy and dignity of HIV-positive people need to be championed by public officials and NGOs. Above all, prejudice and the social stigma around HIV-AIDS must be tackled and banished. Zero tolerance is the need of the hour — for those who for instance deny a child an education, or refuse an expectant mother her right to medical attention and treatment, or embarrass anyone with AIDS into shunning such treatment.

Educational campaigns by Government and NGOs too are limited by moral prejudice: they do not inform correctly, and therefore, they do not prevent. Consequently, they are largely useless. The effectiveness of such campaigns depends upon the challenge of an alternative to the existing commercialized medical and health-care system. It is not enough that education itself is the "key to effective AIDS prevention" or that the "best friend is the condom". 'Safe Sex' campaigns with posters, calendars, booklets, videos including the so-called technological

THE AIDS LIE IN INDIA[5]
UNAIDS reported 3.10 lakh AIDS deaths in India in 1999. NACO's toll from 1987 to Dec. 2000 was a measly 1,759.
Figures reveal incidence of HIV in Manipur fell from highest (18 per cent) to among the lowest (0.4 per cent) in 1998.
NACO submits to Parliament in '98 that there are 81 lakh HIV/AIDS cases. Now scaled down to 38 lakh cases.
NACO now describes UNAIDS figures as guesswork. UNAIDS admits better methodology is required.

approach of developing a vaccine are relevant but not at all enough. The colossal expenditure on sophisticated research and vaccine trials is also inappropriate in especially societies like India. There is always the risk of failure as for instance in Thailand where such clinical trials have failed and that to after millions of dollars being spent on such trials. Besides, It is difficult to determine a vaccine's effectiveness without tests lasting several years.

Efforts so far to deal with the issue of HIV and AIDS have thus not only been ineffective but also questionable. The fear of AIDS – rather than AIDS itself – is part of the panic that is widespread and very often artificially generated. AIDS has been responsible for much hysterical discrimination with even instances of human rights violation. This has led to assaults on the rights and dignity of HIV infected persons in areas of work, education, housing and travel. There have been reports of some groups like sex workers and truckers who have often been subjected to compulsory HIV testing without pre-test and post-text counseling. Hospital patients who have been tested without their consent have sometimes committed suicide when confronted with the results of the test. Women in labour have been refused entry into maternity homes and have been forced to deliver their babies on the roadside. Thus, AIDS is not only a very serious problem but first and foremost a social and psychological problem with not only serious consequences at the level of individual suffering but also at the wider societal level of human rights, equality and the power equations between the sexes which women in particular find it almost impossible to negotiate 'safe sex' with men or their clients. However, with the exception of rape, men and women are equally responsible for their safe sex practices.

Still further, the task is to struggle against the iniquitous social structures that lie at the base of the AIDS crisis – that uproot and make the impoverished migrate to urban centres to eke out a living, and in the process separating husbands and wives. In the long run, measures like the cancellation of foreign debt, increased production of nutritious food for local consumption rather than for export, and fairer wages would be comparatively more effective in checking the spread of AIDS. In short, there is the need to also carefully study the best ways to reach communities whose basic ways of seeing things are not written in any textbook. Indeed there is the need to intervene into the control of the infection by other means. For instance, the more holistic health-care systems indigenous to societies of the South which emphasizes that it is the basic balance and health of the body which determines whether a person succumbs to a disease. Traditional health-care systems need also to be dispassionately taken into consideration along with other mainstream and alternate therapies as they hold great promise in the prevention of AIDS. Most disease can be treated by holistic healing modalities. The principles of healing are rather simple; a) the body heals itself b) there is an inner environment and not just the outer environment c) treatment should not be worse than the disease[6].

Strategywise, priority in the control of AIDS must be on prevention. Effective and creative educational programmes, easy availability of cheap and high quality condoms, additional investment in clinical sterilization techniques, women-controlled contraceptive choices, universal blood screening, clinics and health awareness have benefits that will increase the general welfare of the people. Condoms mean lower STD (Sexually Transmitted Diseases) rates in general; improved clinical procedures reduce a variety of iatrogenic illnesses that health-related programmes can build on. Today, however, the immediate need is for strategies like harm reduction (rather than focusing on "war on drugs") on the one hand and on the other to prevent the trafficking of sex workers from the South.

To conclude, it is necessary to also dispel the various myths generated by vested interests like a section of the health care sector, the drug companies and others, both government agencies and NGOS, hand-in-glove with these vested interests.

MYTH: AIDS is a highly contagious disease.

FACT: AIDS is not a single disease but a 'syndrome' or group of specific infections, cancers and other conditions which occur because the body's immune system has been compromised. Examples of possible specific diseases include 'pneumocystis carini pneumonia' and 'cytomegal virus'. Because AIDS is a syndrome it is a diagnosis, not a disease[7]. AIDS cannot, therefore, be 'caught', although people with HIV can transmit the virus to others. That is, the infection does not spread through air or water or simple social contact. It is not contagious in the same sense as measles, chicken pox, influenza, common colds, TB, typhoid, cholera even plague and small pox. On the other hand transmission of HIV require a heavy

KILLER DISEASES IN INDIA	
CAUSE OF DEATH	NUMBERS
Cardiovascular Diseases	28,20,000
Respiratory Infections	9,87,000
Diarrhoeal Diseases	7,11,000
Cancer	6,53,000
Perinatal Conditions	6,12,000
Tuberculosis	4,21,000
Maternal Conditions	1,25,000
Diabetes Mellitus	1,02,000
Astma	21,000
Malaria	20,000
AIDS (from 1986 till 2001)	(NACO) 2,524

Source: Outlook, December 2, 2002

exchange of body fluids from an infected person, which in everyday contact situation does not reach the critical stage.

HIV infection like hepatitis B or syphilis spreads through blood-to-blood contact or through a sexual route. Therefore, it cannot be contacted through the sharing of cutlery, shaking hands, swimming pools, or toilets; or through coughing, sneezing or spiting; sharing of public places or using amenities like transport; or by attending the same school or workplace, etc. Even if people live and work in the same household or worksite with an infected individual, the HIV virus cannot be transmitted. Nor is it spread by social lip-to-lip kissing. This is because when the virus is present in saliva (and that is unusual) it is only in very small amounts, insufficient to infect anyone. Moreover, according to the US National Institute of Dental Research this is also because a protein in saliva protects the white blood cell from infection.

As such a person with HIV does not need to be isolated or quarantined. Even in situations where one is in situations where one is in direct contact with blood from someone infected with HIV e.g. giving first aid at a road accident, that blood would have to enter the bloodstream to be infected. If an infected person is injured and spills some blood this can be cleared up perfectly safely by using diluted household disinfectants like Dettol or bleach which will kill any virus present; even by hot water and washing-up liquid.

MYTH: AIDS today is the single most hazardous disease, killing more people than any other known diseases.

FACT: Over-exposure and minute media coverage is responsible for the mass hysteria and paranoia over AIDS. For instance, the hype on the visit of high profile dignitaries from the world of business and entertainment some of whom like Richard Gere, billionaire Bill Gates of Microsoft have visited India taking up the issue of HIV-AIDS adds to this over-exposure.

However, in terms of human-to-human transmission, HIV is the least dangerous, when compared to other viral diseases like TB, jaundice, small pox which are fast-acting and highly fatal. True, AIDS may be the most serious threat to have confronted the medical community in recent history, but it certainly dwarfs in the presence of an insidious viral diseases that attracts little attention despite claiming, according to WHO, upto 2 million lives every year. Comparatively, Hepatitis – B is clearly a vicious diseases for which, of course, there is a vaccine unlike AIDS. Yet, Hepatitis – B remains one of the most unconquered disease worldwide. It is 10 times more infectious then HIV and accounts for more deaths in a day than AIDS causes in a year.

The battle against these infectious diseases, however, does not preclude the fight against HIV-AIDS

AIDS Cases[1]	
Tamil Nadu	44.7%
Maharashtra	16.7%
Andhra Pradesh	7.9%
Gujarat	6.5%
Mumbai	4.7%
Karnataka	3.2%
Manipur	2.2%
Madhya Pradesh	1.9%
West Bengal	1.7%
Delhi	1.5%
Nagaland	0.6%
Others	8.4%

MYTH: One of most effective means in checking the spread of AIDS is through mandatory testing of HIV-effected people and placing them under quarantine.

FACT: Further to the point made above, mandatory testing is also unethical! Under Article 21 of the Indian Constitution, it is also unconstitutional.

When read with Article 14 (equality and non-arbitrariness), this has been held to mean that firstly there has to be a law, i.e., a statutory enactment, providing for deprivation of liberty: and that law must be fair, just and reasonable, both substantively and procedurally. For instance, taking recourse to the Public Health Amendment Act, the State of Goa had enacted a law providing for mandatory testing and isolation of HIV positive persons.

This was challenged on the grounds of violation of Article 14 and 21 of the Constitution. The Goa bench of the Bombay High Court rejected the challenge except on the limited ground of allowing the persons affected an opportunity to rebut the findings of the HIV test. An AIDS Prevention Bill was introduced in the Rajya Sabha on August 18, 1989 on similar lines but had to be withdrawn after protests by human rights groups as it had focused on sex-workers, gays and drug users as "high-risk" groups.

Apart from this aspect of human rights violations, testing of (say) prisoners for HIV infection will however not arrest the spread of the infection. It could well be counter-productive. If the test is mandatory as opposed to voluntary, the spread of AIDS might actually get aggravated.

In 1992 at a Meeting convened by WHO on the issue, the conclusion was that there was sufficient evidence that such testing was not in the interest of public health in any way that voluntary testing cannot. HIV testing it says can be classified as being done with or without informed consent. "Mandatory testing and other testing without informed consent has no place in an AIDS prevention and control programme". The modes of HIV transmission are limited and known and specific action can be taken for checking its spread. Instead, such patients should be integrated within the community and helped to take up responsibilities in not infecting others. Isolating them would jeopardize the educational

and other efforts to prevent the spread of HIV, causing extra burden and unnecessary human suffering. The Committee of Ministers of Europe also similarly recommended that "there should be no compulsory screening (for HIV infection) of the general population, nor of particular population groups".

There is however no disagreement on testing for HIV for which clear indications exist. However, it appears counter-productive and, at times, disastrous to test each and every person seeking help of counseling agencies, etc., for HIV. An otherwise healthy and carefree person will be reduced to a cowering mass of despair on being told that s/he suffers from an incurable disease. Worse, society at large and even those considered near and dear will be treated with the same revulsion that was once the fate of the leper.

If the logic of testing each and every patient for HIV was to prevail when checking those most likely to convey AIDS to others, the whole medical fraternity must also be tested. Similarly, the staff and all patients should be tested for all STDs, infective hepatitis and a number of other contagious diseases. In short, mass-screening – even screening of particular groups – is not an effective strategy at all. Moreover, such testing diverts scarce resources from effective AIDS control programs. In a large country like India it is thus economically infeasible. It would only end up testing the so-called 'high-risk' group i.e. sex-workers, intravenous drug users and gays. Apart from the fact that this would be irrational (as HIV infection is not related to sexuality but to unsafe sexual practices) and reinforce prejudices against HIV carriers, thereby provoking discrimination, it will defeat the very aim of the programme in as much as it will drive persons of the 'high-risk' groups under-ground. Such as isolationist approach is thus bound to boomerang.

MYTH: Prostitutes are high-risk group in the spread of AIDS.

FACT: Historically, prostitutes have always been accused (and later victimized) for directly being responsible in the spread of STDs and, today, AIDS. It is a long-standing stereotype. The chances of a HIV-infected man transmitting the infection to a woman are higher than a HIV-infected woman doing so to a man. Besides, about three-quarters of the AIDS cases in the country due to HIV infection are through unprotected multi-partner heterosexual relationships with more men than women indulging in multi-partner sexual relationships. If female-to-male transmission of infection is lower than that of male-to-female transmission (as studies show) the prostitutes are at a lower risks of getting infected by them. They enter the trade, disease-free. Only in the course of prostitution that women and increasingly children get afflicted with STDs and HIV from male clients. More than being a "high-risk" group, a prostitute is thus more of a group at risk. When they do receive and transmit HIV and AIDS, it is totally involuntary. Unlike their clients women lack the right to use condoms or the power to negotiate safe-sex. The existing unequal power-equation among the sexes in society is the obstacle.

Sexual transmission being one of the main modes of HIV transmission it was erroneously believed that it was multiple sex partners that led to HIV. Recent studies, however, indicate that general sexual activity and unprotected sex leads to the infection. Thus, prostitutes are not the source of AIDS or so-called high risk group.

Trying to track the spread of HIV from prostitutes flies in the face of both epidemiology and genitourinary data. "Even with the hypothesized greater transmission from women to men if men have genital ulcers, the probability of transmission cannot, and in the epidemiology does not, become equal". If prostitution is one the main explanation for the spread of AIDS, even if each "prostitute" "infected" several men, each one of those men could in turn be expected in infect several other women (his wife, other prostitutes, and others) since the odds of male-to-female (or male-to-male – it is the receptive partner who is at the increased risk) infection are still greater. Combined with the increased infection of women due to blood, there should be more women than men, not the same number.[8]

MYTH: Vaccine trials on AIDS are essential in especially the South. Apart from the direct benefits of a successful AIDS vaccine, these trials will confer substantial and lasting benefits to these countries.

FACT: AIDS vaccine trials in the South are highly dicey proposition! Cindy Patton, in "Inventing Aids" shows how Phases One and Two of these trials are focused on low-risk Western subjects but Phase Three is aimed at determining whether the vaccine actually works on 'high-risk' persons in the South, as a deterrent to HIV infection. In other words, the trials will determine whether the vaccine is harmful to bodies of Western subjects. On the other hand, citizens from the South in the Phase Three trials will discover whether they have received enough vaccine to stay uninfected. The logic of the Phase Three trials is that these are urgent as the people in the South face a great danger of exposure to the HIV virus. And anyway, the proponents maintain, the vaccine's effectiveness cannot be tested until and unless people are subsequently exposed to the agent! What is, however, cleverly masked is the high risk that these Phase Three trials involve which do not effect western subjects! Further, as Patton observes, there are a number of crucial questions apart from the ethnocentrism linking these trials. First, existing epidemiological data certainly does not suggest that HIV is more rampant (for instance) in any locale in the South than in (say) New York, Paris or Amsterdam. Second, if people are dying of AIDS in

huge numbers, as western news reports are wont to exaggerate, who then is left to serve as trial subjects? Third, if preventive steps are certainly possible (and here, ethicists must explain where and why prevention works – if it works in the Sodom of New York, why not the Eden of Zimbabwe), then who benefits from the risks of the vaccine trials? Fourth, if some important number of the HIV cases in the South are attributable to poor blood screening resulting from the low efficiency and high cost of the Western developed tests, are vaccine trials being funded instead of improved screening methods? Is the moderately high (an unavoidable) risk of receiving an HIV-infected blood transfusion to be another route of exposure for potential vaccine trial subjects? Finally, what provisions ensure that citizens in the South and their societies as a whole, will actually be first to receive the vaccine, once developed? Here, the precise arguments about the problems in rural clinical practice — "They cannot properly diagnose AIDS" — come into play as alibis for not distributing the vaccine. Obviously, the AIDS vaccine trials focuses disproportionately on strengthening the scientific and medical infrastructures of the South in preparation for such trials — in these societies. Finally, if every one participating in the trial is successfully educated towards protection and correct condom use, etc., how will scientists be able to tell if a vaccine protests against HIV infection.

The contradictory nature some of these racist perceptions lining these vaccine trials renders them all the more insidious.

MYTH: The Anti-Retroviral (ARV) therapy is also an *effective* treatment to guard against HIV and AIDS.

FACT: The advocacy of such an unwarranted HIV treatment without proper counseling or informing HIV patients about the drawbacks of such a therapy is dangerous. According to knowledgeable health and medical specialists there is strong case for ARV to taken by HIV patients provided that i) HIV patients need to undergo such a treatment ii) their CD4 count (a laboratory test which measures their immune status) falls below 225 iii) patients are informed of the high costs (including hidden costs of regular laboratory tests) iv) the risk of side effects in many people v) irregular treatment could be dangerous and vi) treatment is no guarantee for a cure and needs to be taken life long with a very high level of adherence. This requires excellent rapport with the patient and ensuring that the patient has understood the financial and various other implications and vii) the quality of the drug

It must be noted that the US federal health authorities today realise that ARVs are hoax and that the effects of ARVs are toxic — that is, they include nerve damage, weakened bones, unusual accumulation of fat in the neck and abdomen and drug-induced diabetes. Many people have developed dangerously high levels of cholesterol and other lipids in the blood, raising concern that HIV positive persons might face the threat of another epidemic of heart disease. It could also lead to lipodystrophy, narcotic overdose, insomnia, and high blood pressure. Further, indiscriminate use of ARVs to pregnant mothers is fraught with danger. If a cigarette chain smoking mother can deliver a 'blue baby'; if an alcoholic mother can deliver a 'drunk child', if thalidomide can produce 'monster babies' one is unwittingly playing with the future generation, by demanding that the HIV positive mother be given ARVs compulsorily.

On the last point, in India with poor quality control mechanism there is also the situation where the approval process for drugs like ARVS are not strictly adhered to. This was the case for instance of a patient who had complained to a local clinic of passing Anti-Retroviral drugs intact in the stool.

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HIV is not spread by

Shaking hands

Caring for someone with AIDS

Sharing belongings

Touching and Kissing

Insects

Facts Against Myths is a bi-monthly bulletin of factual information on a number of development myths and fallacies, etc, including information against alien development models, paradigms and false concepts on caste, creed and gender.

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