

**From UNAIDS "epidemic update 2002"**

HIV prevalence levels remain comparatively low in most countries of Asia and the Pacific. That, though, offers no cause for comfort. In vast, populous countries such as China, India and Indonesia, low national prevalence rates blur the picture of the epidemic.

Both China and India, for example, are experiencing serious local epidemics that are affecting many millions of people. India's national adult HIV prevalence rate is less than 1%, but an estimated 3.97 million people were living with HIV in India at the end of 2001 — the second-highest national figure in the world after South Africa. HIV prevalence among women attending antenatal clinics was higher than 1% in Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland and Tamil Nadu.

New behavioural studies in India suggest that prevention efforts directed at specific populations (such as female sex-workers and injecting drug users) are paying dividends in some states, in the form of higher HIV/AIDS knowledge levels and condom use. However, HIV prevalence among these key groups continues to increase in some states, underlining the need for well-planned and sustained interventions on a large scale. ■

cover 25–30% of TB cases, even though most AIDS patients in India die because of AIDS-related TB, and TB remains a major killer by itself.

"International donor influence in the Indian health system is disproportionate to the amounts of money they have contributed," says Duggal. "The foreign component in our overall health and welfare budgets is not more than 10%, but the advice and influence affects more like 90% of our spending."

Western and Indian government perceptions can differ widely not only from each other but from grass-roots realities, several studies have shown. A survey of published studies by Ramila Bisht, a senior lecturer in the department of health services at Mumbai's Tata Institute of Social Sciences, found that donor funding between 1985 and 1995 for specific disease programmes did not match evidence of the prevalence of these conditions in the community. For instance, despite being a major killer, TB was not a priority for funders until the 1990s, she says.

Moreover, most international aid is not neutral, Duggal complains: it comes as soft loans with policy conditions attached, such as the introduction of user fees in government hospitals, policies that might attract more private sector participation in health, and emphasis on "vertical" health programmes.

A recent conference of the Asian Social Forum in Hyderabad saw several Indian health NGOs such as Swasthya Panchayat, Lokayan, and the Centre for the Study of Developing Societies, coming together to analyse what they considered to be the negative impact of the Indian AIDS programme, which they said had been shaped by the "monolithic, homogenizing nature of

the response shaped by the perspectives of the 'north'".

According to these NGOs this approach has isolated HIV/AIDS from other public health problems, and promoted technological and managerial solutions while ignoring the social and cultural roots of the problem.

"Unless we strengthen the primary health care base we won't go anywhere," says Sheela Rangan of the Pune-based Centre for Health Research. "There is an urgent need to build management systems, fill vacant posts and train front-line health workers in comprehensive care, so they understand the linkages between diseases."

"The emphasis on AIDS works to the detriment of other communicable diseases, which could stage a resurgence," claims Bisht. "We need to integrate AIDS funds into strengthening the general health services. Improving the primary health system will have an impact on a range of killer diseases, including AIDS." ■

Rupa Chinai, *Mumbai*

## Leprosy elimination in India inches closer

India has recently been oscillating between good and bad news in its bid to defeat leprosy. The Indian government has effectively curbed the disease in many parts of the country, but health experts believe that it may not be able to "eliminate" it from India within the next three years as planned. Elimination has been defined for the purposes of the global campaign to defeat leprosy as bringing the prevalence down to below one case per 10 000 people.

The government announced in December 2002 that it had brought down the leprosy prevalence dramatically from 57.6 per 10 000 people

in 1981 to 4.2 per 10 000 people currently. According to government figures, there were 440 000 leprosy patients in the country in April 2002. "We hope to eliminate leprosy by 2004-05," said Ashok Kumar, the head of the Leprosy Division of the government of India's health services.

Though this figure for the country as a whole may make elimination seem well within reach, the situation in some parts of the country is more daunting. In the eastern state of Orissa, the prevalence per 10 000 people had decreased from 23.9 in 1998 to 8.9 in 2002, which is impressive but still more than twice the national average. In the state of Jharkhand in eastern India, the prevalence was 12.95 per 10 000 people, more than three times the national average. Going down another level, there could be areas within Jharkhand with a prevalence of 20 or more per 10 000 people.

"There are some states where the prevalence is very high," said Serge Manoncourt, the Medical Officer for Leprosy at WHO's Regional Office in New Delhi "and in some parts of those states the figures are higher still." The focus of the government was on the southern region initially, because it was there that the prevalence was highest in the 1980s. The campaign is now being intensified in the east, where three states — Bihar, Jharkhand and Orissa — have a prevalence of more than 8 per 10 000 people.

Leprosy was already recognized as a major public health problem in India in the 1950s, but the real prospect of solving it came only in 1991, after the World Health Assembly had approved a global strategy to eliminate leprosy by the year 2000. It was the advent of an effective treatment in the form of multidrug therapy that had made this possible. With a loan from the World Bank for 1993–94, the government launched an intensive national campaign against leprosy, focusing on early detection and treatment.

The campaign included a comprehensive mass awareness programme. Groups of trained personnel visited schools and village market squares to spread messages about leprosy treatment. Radio and television messages stressed that leprosy was curable. "We had to tell the people that leprosy was not a curse inflicted on them by the gods but a disease that could be treated very easily," said Kumar. Meanwhile "the Indian Government has been ensuring that people have access to free medicines at a health centre near their



WHO/TDR, L. Maurice

A cured leprosy patient from India's leprosy-endemic eastern seaboard with her child.

house," said Kumar. The campaign was effective and the prevalence rate plummeted.

The government is now in the second phase of the campaign funded by the World Bank, which ends in 2004. In this phase, leprosy treatment — which up till now has been the responsibility of a separate department — is being integrated with general health services. Personnel at public health centres have been trained to detect early signs of leprosy. General State, district and village health authorities are now being drawn into the programme. ■

Bishakha De Sarkar, *New Delhi*

## US obesity grows 74% in a decade

A nationwide, randomized telephone survey by the US Centers for Disease Control and Prevention has shown a fat 5.6% growth in obesity in the United States in the single year 2001–02, and a massive 74% since 1991. Type two diabetes is following the same track (*Journal of the American Medical Association*, Vol. 289, 1 January 2003, p. 76-9).

The largest telephone poll on health ever conducted in the US reached nearly 200 000 individuals over 18 years old, outside institutions or the armed forces (where diet is effectively controlled). The "Behavioural Risk Factor Surveillance System" questioned people on their health and behaviour, including height and weight, and calculated their body mass index (BMI), which is weight

in kilograms divided by height in metres squared. Overweight is classed as a BMI of 25 to 29.9; "class two" obesity as 30 to 39.9, and "class three" obesity as 40 or over.

The prevalences represent over 20 million obese men and 30 million obese women. Extreme, class three obesity affects 1.7% of American men and 2.8% of American women, the study showed.

Some 21% — over one in five — American adults are obese, falling either into class two or three; 31% of blacks are obese, according to the study.

The prevalence of diabetes, which correlates with obesity, has risen 61% in the US since 1990, and 8% over 2000–01 alone, to nearly 8% of the population, and 11% among blacks. Among all colours, diabetes was present among 13% — one in eight — of those without high school education.

However "these rates are no doubt substantial underestimates" the authors write. Smaller validation studies where weights and heights were actually measured showed people tend to overestimate their height, and underestimate their weight, the researchers say. The overall proportion of Americans who are obese could be as high as 30%, not 21%, they say.

Previous studies by the same team showed that under 20% of American adults who were trying to lose weight were following recommendations to eat fewer calories and increase physical activity to at least 150 minutes a week. ■

Robert Walgate, *Bulletin*

## Antiretroviral misuse in Mumbai, India

Many patients who have tested HIV-positive in Mumbai are consuming antiretrovirals (ARVs) in fits and starts because of their unstable financial circumstances. The warning comes from the Indian community-based organization Sankalp and the Committed Communities Development Trust. For lack of reliable counselling, patients are unaware that once started, ARV treatment has to be lifelong and without a break.

Patients are also not briefed about the hidden costs of therapy, such as the need for regular, and expensive, laboratory tests, or the possibility of severe side-effects.

AIDS specialist Nagesh Shirgopkar says there is a strong case for use

of ARVs amongst patients whose CD4 cell count, a measure of immune status, falls below 225. Patients with such conditions have experienced a life-saving reversal of symptoms when properly treated with ARVs, but treatment involves care and knowledge as well as medicines.

This advice is being undermined by the expanding interests of pharmaceutical companies and private doctors in Mumbai. According to a senior doctor, patients are being directly approached by medical representatives of drugs firms and persuaded to start ARV courses. Apart from violating the patients' right to confidentiality, this often puts them on therapy when they don't need it, and no monitoring is done, he said.

AIDS drugs companies appear to be racing to expand their Indian markets. Given the current haphazard prescribing and consumption practices with AIDS drugs, many doctors — not just quacks — are experimenting with their own dosage and drug combinations. These factors could lead to HIV developing drug resistance. If that happens, the Indian government will face the enormous problem of how to help those who have already started on the therapy. The majority of AIDS patients in India come from the poorer strata of society, who are the most exposed to haphazard and sporadic therapy.

The rush to market ARVs and the chaotic treatment of AIDS patients was also underlined by government officials at a recent workshop in Mumbai, where they complained of a "mania for HIV testing" by doctors, in both the private and the public sector. Official policy in public hospitals in Mumbai does not encourage HIV testing unless there are clinical symptoms warranting suspicion of AIDS. But private hospitals insist on compulsory HIV testing before patient admission, even if they have no clinical symptoms of AIDS. Nongovernmental organizations have pointed out that an HIV-positive "certificate", in the absence of proper counselling and on the basis of a single ELISA test, is seen as a death sentence by the patient and his family, and this view is endorsed by an ignorant medical profession.

While India's National AIDS Control Organization (NACO) stipulates a minimum of three ELISA tests before a person can be confirmed to be HIV-positive, most patients cannot afford three tests. ■

Rupa Chinai, *Mumbai*