9. **Ritu Priya, AIDS, Public Health and the Panic Reaction [Part I], The National Medical Journal of India, Vol. 7, No. 5, 235-240, 1994**

As reporting and surveillance of HIV infection and AIDS cases is grossly incomplete, estimates have to be made.

The WHO estimates and projections of HIV-infected persons and AIDS cases are considered too high by many even though the WHO claims them to be 'conservative'

Many immunologists predict a much lower incidence and mortality in the future as the human population and the virus 'adapt' to each other.

There are other serious and genuine problems in making estimates. Some of them are :

HIV infection is not distributed uniformly among national populations.

HIV infection disproportionately affects individuals whose behaviour places them at a higher-than-average risk. But data are not available on the number of persons engaging in such behaviour.

The tools for detection of infected persons and AIDS cases have a very low predictive value in areas where the prevalence of HIV infection is low.

International AIDS experts, being aware of the fallibility of their figures and methods, add caveats to their estimates. The caveats precede the presentation of estimates in scientific workshops and articles but not in plenary sessions or in statements made before non- technical audiences. The lay public is thus confronted with huge and frightening figures given by the experts 'infallible' certitude, a degree of certainty which is false.

Fear as a Tool

Why are such statements made to the public as scientific facts? (Because) the best way to control this virus is to create so much fear in the minds of the masses that they stick to their own husbands and wives.

Another purpose of these numbers is to generate an awakening in the minds of policy makers about the seriousness of the threat of AIDS and to impress upon them the need to take urgent action to control it. The third purpose is to help plan AIDS control activity rationally.

But is this really an effective weapon? Does it induce long-term behavioural changes or build the attitudes conducive to such changes? Public health experts on AIDS, even those vocal about the necessity for an anti-discriminatory attitude towards persons living with HIV, have not spoken much about the effects of fear generation. However, others involved in AIDS education work have spoken of its negative impact.

High Risk Groups and Social Stigmatization

Another important part is that it largely afflicts members of certain high risk groups and that the spread to others is primarily through and because of their members.

It was public health experts who developed these high risk groups. While there is some truth in the concept, how far it holds in the Indian context needs to be demarcated, especially because of the negative impact that it creates.

The basis on which these groups have been singled out is debatable. These groups had been identified elsewhere and it was assumed that the same held true for India.

Homosexuals

In India, homosexuals are not a group, except in very small pockets in metropolitan cities.

The advantage of identifying high risk groups is that they can be focused upon for AIDS education, testing and medical care. If they do not exist as distinct groups this rationale does not hold. What the label has done is to prompt greater harassment of homosexuals by the police in the name of 'cleansing' operations.

Professional blood donors

Professional Blood Donors (PBDs) and those frequently receiving blood transfusions, blood products or dialysis are seen as a high risk group. Voluntary donors constitute a group for 'sentinel surveillance'.

Of all these, the PBD is singled out for blame for spreading HIV infection while the other two categories are seen as victims. Why? To qualify as a high risk group, the PBDs must themselves have a higher seropositivity rate than the general population (or, alternatively, than voluntary donors). Whatever data is available points to an equivocal situation; some data showing a higher seropositivity among PBDs and the other showing little difference.

Even if we accept the marginal difference, does this make PBDs a high risk group? Is the perception of why they run the added risk based on facts or bias? The commonly held view even among AIDS experts is that PBDs are a promiscuous, criminal lot who contract the disease because they are intravenous drug users (IDUs) and have contact with sex workers. There is almost no data on such behaviour among the PBDs or among other occupational groups in the general population.

Another unsubstantiated but equally plausible mode of PBDs contracting the disease is through health care workers. Yet no AIDS expert ever mentions that the doctors' needle could be the source of the slightly higher prevalence in this group!

Truck drivers

Truck drivers have been identified to be a group whose conditions of work, prolonged absence from home and long periods on the road make them prone to visit commercial sex workers (CSWs). They pick up the infection in this manner and carry it with them along the highways and into their homes. Can one not think of innumerable other occupations where similar conditions prevail. For example, salesmen, railway employees and aircraft crew? What about the elite -- professionals, diplomats and multinational company executives who travel the world?

While the concept of high risk has resulted in targeting certain socially marginalized groups and the concept of high risk behaviour has been used as a corrective, it has also put the responsibility entirely on the individual leaving society, which influences behaviour, untouched.

The concept of conditions is also important for control because it makes behavioural change possible. For instance, it was appreciated that poverty tends to make the risk of AIDS an unimportant matter to the poor.