166 Medico friend circle bulletin

August 1990

OF SHAME AND SORROW: WOMEN IN SILENCE

Manisha Gupte

The fact that women's access to health care is poor needs no proving. The shortcoming of the Indian Health Care System, which sees women only as mother or potential mother is also now more or less accepted by progressive persons in the people's health movement. Even the watered down MCH programme does not effectively reach out to poor, working class, especially rural, women, Last year, in the *mfc* bulletin of May, 1989' I have tried to point out some of the direct reasons as to why rural women do not receive good maternal health services.

To compound the tragedy, the 'woman' is completely neglected by public heath services. Issues that are not directly related to reproduction an9 fertility are conveniently swept under the carpet. Because of the anti-nationalist policy of our Government, infertility either as a physiological or psychological problem does not merit due attention. Violence against women be it through wife battering, harassment by husband's family, rape or incest is either outright rejected or is candled in an atmosphere of mistrust and anti-woman bias.

This article is based on some of the invisible sufferings of women that require sensitive handling by the medical profession. Naturally, all problems are not covered here. The experiences here are limited to one's own personal encounters with the shame that rural women harbour towards themselves and their own bodies, and the resultant pain that they undergo. All the case studies presented here are confined to a rural tehsil in Pune District in Maharashtra State.

The most common ailments that women in our area suffer from are white discharge prolapsed uterus, weakness, anaemia, aches-especially back-aches, menstrual irregularity, genital and urinary infections, infertility and a variety of mental illness such as depression, anxiety, hysteria, nervous break-down a death wish upon oneself and schizophrenias.

Women wait for unbelievable long periods of time before they seek medical aid for their problems. One woman around 40 years of age came to the primary health centre with a history of leucorrhoea that started 15 years ago! Though she may not be the rule, the nurses said that on an average women come to the health centre after 6 months to three years of suffering where white discharge is concerned.

Sometimes women present with a mixed problem-menorrhagia for 10-15 days, followed by white discharge. The cycle repeats almost every month.

Sometimes a copper — T induces white discharge, not to mention heavy menstrual flow. There are instances where women also 'forget' about the copper- T insertion and it is detected inside their bodies when they come for other gynaecological problems. In one unforgettable case Sr. Sable of the PHC narrated how a young primiparous came for her delivery. She was accompanied by her 70 years old grandmother. This grandmother became good friends with the nurse and on the third day confided to her about bleeding and how that was a constant source of embarrassment. When the nurse said that an internal examination was required the old woman further confided that she had a loop inside her! The nurse naturally was greatly surprised. It turned out that 40 years ago when her last son was born a loop was inserted and she had never come back to have it removed. Not surprisingly, the nurse found out that the woman was not only bleeding but that "there was a frohy black, foul smelling discharge, along with pus'. The loop, probably a Dalkon shield was withdrawn amidst great difficulty and pain. The nurse strongly recommended that the doctor should examine her, but the old woman staunchly refused. 'Through all my deliveries, I have never let a male come close to me, and I can't be put to shame in the last few years of my life", She said. She walked away with some vaginal pessaries and vitamin tablets. One can't help suspecting that she may well have been one of the many women who silently suffer from cervical arcinoma.

Women who have delivered at home and who have returned to work immediately after delivery often suffer from prolapses-rectal or uterine, according to the local health workers. They also state repeated pregnancies as a contributing factor. Often untrained delivery attendants (mother's neighbours) get a woman in labour to bear down unnecessarily during the first stage itself. Random tears are not sutured in home deliveries and later on in life, women suddenly realise that they have a prolapses. Our experience has shown that most often women don't seek any remedial treatment for prolapses. Unless they have trouble in a subsequent pregnancy they silently continue to suffer the discomfort and embarrassment. After our Mahila Mandal meetings, sometimes a women will call us aside and then with tremendous shame will venture to tell us a about her white discharge or prolapses. Often she has sought no medical treatment, earlier. Sometimes, she has, but the white discharge continues. The nurses in the health centre have never, to date, seen a doctor treat both, husband and wife for white discharge. Women are often given only oral treatment, due to the patient's aversion of having to introduce vaginal pessaries, oneself. Thus, in course of time, she is re-infected and the cycle continues, until the woman gives up in sheer helplessness. When women come repeatedly with a history of vaginal discharges, health workers speak contempously about their bad hygiene and that intensifies the shame.

Most women refuse internal examination even by a nurse. This makes diagnosis difficult and so often the doctor prescribes without having had a chance to diagnose properly. The nurses said that besides being shy of the doctor, consultant work of home, on the fields or on EGS sites makes it very difficult for women to visit health centres. The only time when women ever come to health 'Centres, they said, was during the summer, when agricultural activity ceased. Some women who have been married for 20-25 years have never stepped out of the village, except to go to their natal families, once a year. Those who live in wadis (clusters) away from the village, come into the village only 3-4 times a year mainly for social or religious functions. Their men folk bring in the grocery and since they have work to do throughout the day, it is never considered necessary for them to leave except to go to EGS sitas, often away from the village. Thus during festivals, women tend to come to the health centre in a "might as well go there" kind of attitude. Obviously, they don't come back to continue a prolonged treatment.

Lack of access to safe abortions is also a great health hazarad for woman. Pre-marital and extra-marital relations are very rampant here as they are everywhere else, and it is distressing sights to see fifteen years old undergo an unsafe abortion.

Interestingly, when we were asking women if a pregnancy detection kit was a felt need here, two women discreetly made enquiries about such a facility being immediately available, and both of them were not cohabiting presently with their husbands: one was widowed and the other deserted.

Recently an unmarried teenaged girl was being forced by her mother to undergo an abortion at the hands of a local abortionist when she found out that the daughter was pregnant. The girl, scared, confided in a nurse, who examined her and told her that she was about four months pregnant. After must counseling, the girl was taken to Pune city and an MTP was conducted at Sassoon hospital. Not everybody is as lucky. Various indigenous abortifacients are used - the dangerous ones being mild poisons administered orally and Neem sticks being used to insert into the uterus. The efficacy of the less dangerous methods' is not yet clear, because abortions are a stigmatised and taboo topic.

Childlessness is another major cause of trauma for women. Whether the couple is infertile, whether the children are dead or whether only daughters are born, the main brunt is borne by the woman in question, Various traditional methods are tried including visiting shrines and fasting to fighting off the 'voodoo' allegedly performed by another childless woman! A young woman who had recently lost her only child was in servere psychological tension. She came with clear 'symptoms' of pregnancy: amenorrhoea nausea and vomiting. When she was examined, the nurse realised that she wasn't pregnant. On closer questioning, the nurse found out that she hadn't even cohabited with her husband for over six months. The young women said that the parents-in-law didn't allow their son to sleep with or even speak to his wife, and having lost her baby, she was felling very lonely. She said "1 m somehow hoping that I have another baby".

If one sees the women who occasionally get possessed by a wide plethora of malevolent Gods and Goddess, one can clearly see that a low majority are childless women, deserted women, and post menopausal women when a local exorcist was asked to why there were such few "normally cohabiting mother" in the crowd, she laughed and said 'where is the time available to those women? When you lack something, you turn to god."

Infertility, either of oneself or of husband (after improvement in the latter case) is thus a cause of great concern, because women fight other women. Constantly suspicious of the motives of other childless women, the woman retaliates with her own voodoo, and thus solidarity between two victims is not possible.

Impotency of one's husband is also borne with shame and in silence. One woman, after twenty years of marriage confided in a health worker and asked if ,here were any tablets available to cure his inpotency, She had, to date, kept silent but since no child was born, the in-law were now coaxing their son to remarry. Another sixteen year old women extremely impoverished has just run away from her husband's house, back to her natal family. The husband is impotent and during the two years of marriage, she was ill treated by her sister-in-law because "she would disclose the fact to someone! She had never been allowed to meet her parents after the wedding for the same reason. When she recently convinced her husband to undergo a checkup; which he did, then law threatened to murder her, Today the doctor is refusing to give her the report, though he has orally said that the husband requires "correctional surgery", and the in-law have now sent her a legal notice. They have also been spreading rumours about her immoral behaviour'!

A forty year old woman, came to the PHC with leucorrhoea. She was pregnant for the first time. Curious, the nurse questioned her about such a late conception. The husband, a perpetual womanizer, has never cohabited with her. Only during the past one year did he ever approach his wife. "I don't care if a kitten or puppy is born to me", the woman said "but let me enjoy the bliss of motherhood".

She begged the nurse not to repeat the story to her husband, for fear that the would neglect her once again.

A rich landlord's daughter-in-law was also being treated for heavy white discharge. She was her husband's first wife. The husband, a truck driver, is a notorious for' womanising. Since they were childless, he renounced, and now both wives are simultaneously pregnant. She raved and ranted about her husband's behaviour, yet she said that she was glad to be pregnant.

The indignity that woman are subjected to by their husband's constant womanising also is a helplessness that they have to go through alone, woman often complain of 'burning sensation' after intercourse. One woman, whose husband is bigamous and an alcoholic asked if 'heat' from him was being transferred to her. The local word for STD especially syphilis is 'garm' or heat.

Another young girl narrated a horrifying experience when a few days after her delivery her husband beat her to unconsciousness, because the refused to sleep with him. He said "I haven't married you so as to worship you" and then he raped her. He regularly visits prostitute women. She was being treated for 'burning sensation'.

A CHG's damphter, barely eighteen years of age was seven months pregnant, their husband is jeep driver and the in-law know about his womanising. Would we have got ourselves a stupid daughter-in-law like you, if he had been straight" they would ask her. Last year, she had a miscarriage and now she is worried that her baby might be infected. She herself had such a heavy discharge that she was "even embarrassed to sit down for fear of staining herself". The mother, being a health worker, was keen not to send the girl to her husband until she was completely cured. Within a week of our conversation, however, the husband came after her, and the daughter immediately returned, saying that "it was the only way to stop him from going to other women".

Not all women want to cohabit sexually with their diseased husbands. Only they have no choice at all. One woman saw some blood on husband's genitals. The husband, also a jeep driver has two mistresses. This woman pleaded us to ask her husband not to touch her". I don't care what he does out of house as long as he leaves me alone". She said that's easier said than done. She is extremely worked up about his behaviour and recently she had a nervous breakdown. She has attempted suicide on three occasions. To make matters worse, her husband is jealous of any male that she speaks to and he viciously beats her, very often.

Another woman, 35 years of age and whose children are now grown up has a similar sorrow, "My husband often brings other women to my own bed to humiliate me". She has severe gynaecological problems: periods stretching over a fortnight each time, while discharge and burning like chilies' after intercourse. A drunkard, her husband is also jealous by nature, and however much she pleads of him to let her alone, he won't listen.

Very few women, with clear symptoms of STD approach the PHC for treatment. Also, when widows or deserted women need contraceptives, including sterilisation, they are, quite understandably, reluctant to approach the Government Health Center. In one case, a childless deserted woman came to are for a laparoscopy, sapping that she had two children and so she now wanted to get sterilised. Often, women from our area will go outside to get a sterilisation performed as two widows recently did. They went to the neighbouring tehsil, stayed at the PHC for seven days and came back sterilised. Sterilisation however does not protect a woman for contracting STD, and a few months ago a health worker found two women, one widowed and the other deserted, both suffering from STD. Inspite of motivation, they refused to come to the PHC for treatment.

The attitude of women, caught in an awkward situation is quite ambivalent as far as the health workers are concerned. "If we detect a tricky pregnancy and help women to have discreet abortions, they pretend not to recognise us afterwards".

(Cont. page no. 8)

Sexually Transmitted diseases: a growing menace

S *V Morankar*

All over the world, sexually transmitted diseases (STDs) are a serious problem; India is no exception. During the past two decades, the number of diseases grouped under STDs has grown from big five (syphilis, gonorrhea, chancroid, lymphogranuloma venereum and Donovanosis) to more than twenty. A number of clinical syndromes are known to be secondary complications of STDs: acute and chronic inflammations of male and female genital tracts, genital cancers, infertility hepatitis and even AIOS. In 1985, over a million cases were reported to have attended STD clinics in India; their break- up is as follows: syphilis (30.5 %), chancroid (25.9 %) gonorrhea (18.8%) and non-gonococcal urethritis (13.3%) Maharashtra has the dubious distinction of having the highest incidence of STD; Tamilnadu and Gujarat are not far behind.

I propose to discuss briefly the origin and transmission of STDs in and around Pune, and various social end cultural factors which have contributed to an increase in the incidence of STDs. These observations are based on an in-depth discussion with four medical practitioners and the functionaries of one primary health centre in Pune district. These health workers have treated STD cases in their clinics in an area covering about 30,000 populations.

Young adults, married as well as unmarried aged between 18 and 25 years, form the biggest group at risk. Each practitioner sees and treats atleast 3-4 fresh cases of STD per week. The majority of cases contact infection from one of the three sources: urban, rural on contacts during traveling.

The practitioners identified Pune as the main urban source for the transmission of STDs since a large number of prostitutes are available there. Prostitution is also prevalent in urban centres nearby. The rural youngsters, naive and gullible as they are, often visit prostitutes when they come to urban centres only to go back with STDs. Strange though it may sound, the popular Ganesh festival in Pune breeds an alarming number of STDs almost year after year. So do *Jatras* and *Tamashas* in villages when the STDs suddenly show a positive swing. People who have visited urban prostitutes and who have developed STD also frequent these women in rural areas only to infect them further. These woman in turn pass on the disease to 'first-timer.

Prostitution is not restricted to Pune city and urban areas but with rural areas in Western Maharashtra getting rapidly industrialised, it has started spreading there too. As an ANM supervisor with a long experience of working in PHCs told us, the prostitutes are steadily migrating from Pune to these virgin areas in search of 'business'. What is even more alarming is the observation of local medical practitioners that the clandestine sexual activities among widows divorced/deserted women unwed girls and economically poor married-women is showing a phenomenal increase. Indeed, the sexual perversions have taken such an ugly turn that sexual promiscuity and extramarital relationships apart incestuous relationships are also surfacing in rural areas.

The roadside *dhabas* and motels, where truck drivers and their assistants usually eat their meals and retire overnight have also developed as new centres for prostitution and large number of STDs owes their origin to these centres.

The local medical practitioner has observed that STDs are no respecter of economic class: rich and poor have been equally found to have affected with STDs. Particularly vulnerable are unmarried adolescents. They develop morbid fears about their potency-borne out of sheer lack of sex education-and in orders to prove their manliness or virility, they visit prostitutes only to come back with STDs. Many a marriage here had to be postponed because of pre-marital sex-induced STDs and the doctors had to prevail upon these youngsters to undergo full treatment before marriage. Since the parents are usually oblivious of these diseases in their grown-up children, the doctors often have tough time explaining them as to why they wish to have marriages postponed.

Since, by and large it is males who get themselves treated for STDs, the number of women infected but untreated-is gradually swelling. The health practitioners usually motivate married men with STDs to have their spouses treated simultaneously but this seldom 'happens and hardly 1-2% couples See their doctor for full treatment. To evade embarrassing probing from the elders in the family, STDs in women-all too often passivity contacted are kept a closely guarded secret. And yet it is invariably the wife who takes the blame.

Further, *Garmi,* as STDs are here colloquially called, is usually attributed by a mother-in-law to her daughter-in-law's indulgence in "too much tea" or "hot and spicy meals". 'The daughter-in-law is not generally forbidden to sleep with her husband nor is she permitted-at times even actively discouraged-to go to a doctor to seek cure. This unfortunately leads to a very piquant situation: extramarital relationships are irreparably broken, new extra-marital affairs develop and STDs simply proliferate!

Repeated, and mixed, infections are common and have been noted in as high as 25% cases.

Even such drastic advices as "next time you might as well loose your penis" or "we will have to chop off the diseased organ next time" fall on deaf ears. Only a quarter of STD cases receive full treatment; majority discontinues treatment midway through. This may cause, and has already contributed to, drug resistance. Access to over the counter drugs and antibiotics is easily possible. The repeat cases seldom see their doctors/health workers. Instead, they would directly go to a chemist, manage to hoodwink him by showing an old prescription and thus would get self-treated. The inadequate and self-treatment is obviously not without dangers but there is little that the health workers can do to stop it.

So what then is the solution? The health practitioners strongly feel that sex education to adolescent boys and girls and students in their pre-college days should help. It might help boys resist the temptation of going for a 'potency test', girls won't easily go astray and the number of unmarried mothers and unwanted pregnancies would fall too, with a substantial reduction in the number of STDs.

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(Contd. page 4)

A nurse said that sometimes' they can almost guess that a women patient has some grave problem back home, but that it is not possible to do anything about it, "Women are suspicious and afraid. They feel that we may misuse the information about their personal problems or even that co-incidentally we may be relatives of their husband's families. They are also scared about the consequences of speaking out their problems." Women, who are victims of stark violence already, are reluctant about speaking out for fear of "what can happen between the four closed walls of *their* homes". *As a cynic aside,* the nurse said "when we are ourselves unable to stop our husbands from beating us, we can hardly help patients."

A vicious circle of silence, shame and sorrow is thus set into motion.

The health system is inadequately equipped to deal with violence against women, or with disorders that can't be cured with quick medication. On the other hand women who suffer can neither speak nor approach the health services. Shame towards one's body is not restricted to *leucorrhoea,* or childlessness it is also manifested through stigma of menstruation and child birth. As principle actions in the struggle towards their own liberation, it is only a progressive organisation of women that can give voice to women's fear and shame, and then proceed to question the inadequacy of the health care delivery system to hear out these demands. It is only through a forceful voicing of our problems outside of our four walls that can reduce our persistent fears about what can happen to us inside them.

* *

Dear Friend

To,
Shri M. S. Gurupadswamy,
Minister for Chemicals and Petro Chemicals,
Shastri Bhavan,
New Delhi-110001

Dear Mr. Gurupadswamy,

It is learnt that the National Front Government is reviewing the drug policy. As a doctor, I strongly feel that good quality essential drugs must be made available t9 all the people at reasonable prices. I believe that this can be achieved by a scientific drug policy and hence I suggest the following:

1) A prioritized essential drug list should be prepared on the basis of the incidence severity, preventability, sequelae of different diseases in our country. The production targets of drugs should be based on the list.
2) Only those medicines which have been recommended by standard medical textbooks or bodies like the WHO should be allowed to be sold. All other drugs and their combinations should be banned. Within a time frame, all hazardous drugs and irrational formulations of the most commonly used top ten categories of drugs should be banned immediately.
3) Resources being wasted on irrational drugs should be utilized to step up the production of those essential drugs (like: Vitamin A, iodized salt, chloroquin, streptomycin, injections, measles and polio-vaccines) which are currently in short-supply; and have to be imported in large quantities.
4) The quality control mechanism must be radically improved and stringent, deterent punishment must be given to defaulters. Production of spurious drugs must be considered as an attempt on the lives of the people.
5) A mechanism independant of the drug companies must be set up to supply up-to-date information on drugs to doctors. A journal be started for this purpose like the Food and Drug Administration (F. D. A.) in the United States, the information supplied by drug-companies should be scrutinized and approved by the drug-authorities before being released.
6) An ethical code for marketing of pharmaceuticals must be drawn up and strictly adhered *to.* Medicines must be sold only under generic name (with the manufacturer's name in the bracket).
7) A list of standard over-the-counter (0. T. C.) drugs and their formula should be prepared. No other formula should be allowed. The advertisement of O. T. C. drugs should be precensored to prevent any misleading of the lay- people.
8) The dire shortage of essential drugs in the Government Sector especially in the Primary Health Centre should end immediately.
9) Abolish all taxes on life-saving drugs and control the prices of all drugs so that drugs are available to the needy at reasonable prices.
10) The drug policy should not be decided by the Industry and Chemical Ministry alone but the Health Ministry should be the nodal agency.
11) For drugs used in non-allopathic systems of medicine, expert bodies should be formed to prepare a standard formulary and drug-policy for such drugs. Cross-prescription of allopathic and non-allopathic drugs by doctors not trained in the other pathy must by banned. Short-training courses be started for doctors desirous of getting trained in other pathies to use simple medicine, from the other pathy.

The above principles have to be adopted to make rational drug treatment a reality. Apart from these medico-social aspects of the drug-policy, there are other aspects like self-reliance which should be decided with the help of experts in the field.

This draft prepared by Lok Vigyan Sanghatana, as a part of National Drug Policy Campaign, was signed by like-minded health activists and lay people and was mailed to the Health Ministry -Editor)

Who'll answer for Pvt. hospitals?

Saroj Iyer

The death of Mr. Eruch Tavaria last August at the B. D. Petit Parsee General Hospital here allegedly, as a result of transfusion from the wrong blood group, has focused attention on the serious anomalies in the functioning and monitoring of private hospitals.

Police investigations have revealed that the doctor who was attending to the patient was not a qualified allopath but a homoeopath, not permitted to give allopathic treatment. The hoshas reportedly employed five more homoeopaths one of them in its intensive care unit.

This revelation is particularly significant in view of the upsurge in complaints against doctors and private hospitals and raises questions about the standard of medical practice in private hospitals, the quality of staff employed and treatment offered, the equipment used, the general administration of these hospitals and above all' their accountability. There are other questions as well: Who monitors the setting up and running of private hospitals? What laws or rules govern their working? From which authority can one seek redressal in case of complaint against a doctor or a hospital?

A writ petition relating to these questions has been filed in the Bombay high court, which not only seeks to expose the lacunae in the implementation of norms by the Bombay Municipal Corporation and the state health department, but also points to the absence of any proper regulating authority. Both the BMC and the government deny their responsibility.

The public interest litigation has been filed by the daughter of the deceased, Ms. Yasmin Tavaria, a sales executive at Bharat Petroleum Ltd., and the Medico Friends Circle, a group working in the area of health, against the state, the BMC, the Parsee General Hospital and the doctor. The petition points to the direct responsibility of the BMC despite its denials.

Quoting the Maharashtra nursing Home Registration Act 1949, the PIL state that under the act BMC is authorised to register private hospitals and nursing homes in Bombay. It further adds that the objective of the Act is to provide for registration and inspection of nursing homes in Bombay and for certain purposes connected therewith.

The Act, while providing for mandatory registration, clearly states that no hospital can function without being registered or without the registration being renewed every year by the local supervising authority, which is the B MC for Bombay.

The Act also lays down conditions under which the local supervising authority can grant or refuse to grant a certificate of registration to any private nursing home or hospital. Thus under section 5 of the Act, the local supervising authority (BMC) can refuse to grant registration if the hospital does not have qualified or adequate staff, sufficient or proper equipment and adequate accommodation.

Under section 7, the BMC is empowered to cancel the registration of a person in respect of any nursing home if the above conditions are not met.

As the BMC has access to sufficient information to decide whether or not a hospital has qualified staff, proper equipment and space, when a hospital founded essentially for discharging allopathic treatment, engages a homoeopath as a houseman, it is the BMC's duty to object to such a practice and ensure compliance by suitable measure. It is also the BMC's duty to ensure that hospitals do not flout the prescribed rules.

The clear directions to the BMC notwithstanding the civics health officer, Dr. Vinobini Desai denies that it has any power with regard to private hospitals. "We are only concerned with municipal hospitals", she asserts.

Queried about their monitoring, she says, “only the Maharashtra Medical Council (MMC) has jurisdiction. How can we control them?” When pointed out that the MMC has jurisdiction only over doctors (MBBS) registered with it, not hospitals, she insists the BMC is not in charge.

According to her, anyone can open a nursing home and "lease it out to MBBS doctors, who are qualified to run them. In case of a complaint of negligence or malpractice, one should go to the MMC, the police or to the court," she says.

Mr. P. P. Mahana, secretary, public health department of the state government, also denies that his department is responsible for monitoring private hospitals.

Interestingly, though the act provides that the state should formulate rules with regard to penalties and related aspects, and that the local supervising authority should frame by-laws, up to now no rules or by laws have been framed either by the state or the BMC. The PIL, therefore, pleads that a writ of mandamus or a writ be issued to both the state government and the BMC to do so immediately and to strictly implement these rules.

The government has framed manual I and II with detailed instructions on the management of government hospitals. Extensive provisions have been made for running government hospitals and providing for minimum necessities. However, these do not apply to private hospitals. The petitioners have urged that private hospitals, too, should be made to follow these rules, especially in view of the fact that they generally change high fees from patients.

The PIL also raises another important issue that of access to medical records. It points out that hospitals do not provide copies of medical records to patients or their relatives, which are valuable for finding out the case history of patients. As the hospitals charge for treating patients, the records must be provided.

The petitioners stress that medical records ought to be treated as the property of the patients/relatives and not furnishing them should amount to withholding of property as this violates the patient's right to information.

It is also demanded that hospitals should refer cases for post-mortem if negligence is suspected in treating the patient. In Mr. Tavaria's case, mismatched blood had allegedly been given leading to renal failure and death. The hospital should, therefore, have referred the case for postmortem.

The PIL thus argues that if medical malpractice is to be controlled, it is most important to tackle the above issues.

(Source: The Times of India 23 *July 90)* *

Claim on AIDS-hit prostitutes challenged

Sapna Bajaj

A recent study conducted by the Indian Council for Medical Research (ICMR), which claimed that 30 percent of Bombay's prostitutes harboured the AIDS virus, has been contradicted and challenged by a specialist in skin and venereal diseases.

According to Dr. J. K. Maniar, associated with the municipal STD (Sexually Transmitted Diseases) clinic at Bellasis road, the ICMR figure was "over-blown". He claimed that the research for ICMR was conducted by a microbiologist at KEM hospital who had covered the same "high risk group" area which his clinic had been surveying since the last three years. The area, comprising Bellasis road, Kamathipura and adjacent localities, had 60,000 prostitutes.

Studies conducted by the STD clinic in the last two years revealed that of the 1,800 male patients screened, 164 (less than 10 percent) were found to contain antibodies to the human immuno-deficiency virus (HIV) and suffered from venereal diseases. About 95 percent of males from this sample were unmarried.

Of the 1,300 prostitutes tested 90 were found to be AIDS positive (6.8 percent).

The director-general of ICMR Mr. A. S. Paintal, stated in a recent press interview that according to a WHO forecast every third pregnant housewife in Bombay is likely to be found carrying the AIDS virus when examined in the antenatal clinic," Dr. Maniar blamed the ICMR for instilling panic and hysteria with such a declaration.

"In a modern society like ours where premarital and extra-marital sex is no longer uncommon, such a figure is frightening and suggests that after 10 years, city's 10 million population will be wiped out," Dr. Maniar said.

Sentinel testing by the ICMR on random samples from the general public revealed positivity as high as two percent. "This is indeed a grave situation," opined Dr, Maniar. He decried the practice of blood banks of discarding blood samples found HIV positive, on the ICMR's directive. "There are no follow-ups, no instructions from the government to blood banks that these HIV carriers should be referred to

MEDICO FRIEND CIRCLE BULLETIN

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STD clinics since most of these donors also suffer from some sexually transmitted disease," Dr. Maniar said.

Two years ago the state government had directed that every hospital should manage AIDS patients with due precautions. However the Union ministry has now provided grants for "separate AIDS wards" to ten centres in India.

One of these centres is at J. J. Hospital. A argument raised by Dr. Maniar is, will this ward be equipped to manage the purportedly large AIDS populace as against different hospitals where such patients are being treated at present? What is the need for a "special ward" or "AIDS specialists"? This will only encourage general physicians to wash their hands of AIDS cases.

"An AIDS clinic should be a part of an STD clinic with general medical staff in attendance, like a public health ward", asserted Dr. Maniar. Denouncing doctors who refused to treat AIDS patients he recommended that their licenses be withdrawn by the medical council and the Indian Medical Association.

A majority of Indian doctors had displayed an irrational fear of AIDS. A pressing need for an intensive education programme for doctors and thereafter the nursing and paramedical staff had thus arisen and the government should concentrate its "awareness programmes" on this issue first, before handling the public at large, Dr. Maniar emphasised.

"Efforts are no doubt being made, but along *wrong* and expensive channels," he noted. A large number of doctors were being sent to Australia from India for "AIDS training". Why Australia queried the specialist. Why not U. S., France, or any other European country which had acquired great expertise on the subject than Australia, which Dr. Maniar claimed, was far behind India, and would present to the doctors a pattern very different from that presented by Indian AIDS patients.

"Africa would be a better guide to us since poor patients are beings managed in hospitals with meagre finances, in conditions akin to India." said Dr. Maniar. The Commonwealth secretariat in London has selected a team of Indian doctors to receive training in African hospitals on AIDS patients.

Dr. Maniar objected to the proposal of constructing of a "home" for AIDS patients in New Bombay, giving them a life-long grant of Rs. 1,500 by the state government. "Is segregation or jailing the only solution? Are we so prosperous a nation that we can provide a monthly allowance to prostitutes, compensating for their lost "income". What guarantee does the government have that they will restrain themselves from promiscuity even after procuring the grant" he asked.

(Source: The Times of India 31st July 90)

· We are running a six-bedded private hospital at Dindori 28 kms from Nasik and also working in community health issues through a trust. We believe that such activities entail a group action. Any doctor willing to join us is requested to write to us. Details can be worked out in mutual discussion.

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