CHAPTER V

KERALA SCENARIO

5.1 Introduction

As a result of improvements in the field of education, literacy rate, hygienic practices etc. as part of changing life style, social medicine led to improvement of life expectancy, control of communicable diseases and restructuring and reorientation of health care delivery systems. The best example for the above situation is the state of Kerala where we have shown how social changes can result in better health. We have shown reduction in birth rates, growth rates, infant mortality rates, crude and age related mortality rates, pregnancy and delivery related mortality rates and elevations in female to male population ratio, child survival and life expectancy. In almost all of these indices Kerala is at par with or better than many developed countries of Europe & America. But quite paradoxically over the last decade, many studies have revealed an increase in the morbidity rates – rate of occurrence of illnesses -, occurrence of epidemics, and increase in the amount of money – as proportion of income – spent for treatment of illnesses. While some of these can be viewed as part of the increase in health seeking behaviour of the people, many are
worth detailed analysis. We are also witnessing the resurgence of the importance of social values in the health care system.

The first HIV positive person was identified in Kerala in 1987. Since then there has been a gradually growing epidemic in the State. The HIV epidemic in Kerala is distinctly related to migration and presents unique features which differ from other neighbouring states. Kerala has high literacy and poor industrial development, as a result of which, there is considerable migration to other states and to the Arabian Gulf countries for work. 40% of the households have at least one migrant. Many out migrants are unmarried and the lack of urban housing forces most married men to leave their families behind. Most of the men have been infected in cities outside the state through sex with female sex workers. The emigrants have generally been infected in India while visiting sex workers either before leaving or on transit. The infected men in turn infect their wives. For every two infected men, there is an infected woman. In India, the HIV epidemic generally is more prevalent in the cities and is much less in the rural areas. Unlike other Indian states, there is no higher HIV prevalence in urban areas in Kerala. This might also be due to the fact there is no great difference between the urban and rural areas in Kerala.
Generally skilled workers are most commonly infected. Surveillance data show that more than 79% of HIV infections in the state was acquired heterosexually and that only about 2% were acquired through blood transfusion and about 5% through injecting drug use. There has been a change in the pattern of infection recently. Now more and more infections are acquired within the state. Most of the women who are positive have been infected by their own husbands and now infants are also being identified who have been infected through their mothers. Till now, the total number of AIDS cases reported from different parts of Kerala is 1863 and more than 500 AIDS deaths have been reported. This indicates gross under-reporting since, we have an estimated 70,000 to 100,000 people infected with HIV in Kerala. Infection has moved out into the society from the high-risk group into the general population and this arouses grave concern.

The HIV prevalence among antenatal women is less than 0.3%, that among STD clinic attendees 4.2% and that among blood donors 0.18%. But this gives a false impression regarding the state of the epidemic, since, much of the currently infected population live outside the state. They often come back for care and to be with the
family, when they learn, that they are infected or become symptomatic. Awareness of migrants regarding AIDS is low because of unfamiliarity with the local language. Interventions were tried outside the state but have not been very successful. They were also found to stigmatize the people addressed. The HIV burden of Kerala is much more than what is apparent. Interventions among those who migrate for work should be done before they leave. Cooperation with other states and even work with organizations abroad is required.

Every year, the trend in the HIV prevalence in the state is assessed by conducting serum surveys among two groups, pregnant women and sexually transmitted clinic attendees. There are 4 sentinel survey sites for pregnant women (ANC) four sites for STD clinic attendees. Each year, at each ANC site, 400 samples are taken using the unlinked anonymous method and 250 samples are taken from each STD site. The sentinel surveillance has been conducted regularly from 1998. The data obtained show that the HIV prevalence among STD clinic attendees have been gradually increasing while there is no statistically significant increase in the HIV prevalence among pregnant women.
The recent rapid mapping of high risk behavior groups has revealed that there are large numbers of infected drug users in Trivandrum, Kochi especially Mattancherry and in Kozhikode. This survey has also revealed that there are a very large number of men having sex with men in Kerala. The Behavior Surveillance Survey done by the National AIDS Control Organization showed that 11% of men in Kerala have had sex with a non regular partner in the last 12 months. All this suggests that the HIV epidemic in Kerala is likely to escalate further.

Studies done and analysis of personal observations suggest that this epidemic has cut across the borders of social, economic and educational strata of Kerala society. We have a large number of young adults and children, rich and poor, migrant and immigrant rural and urban persons affected with HIV. The number of AIDS patients being observed in almost all parts of the state do tell us that Kerala was not very different from other parts of the globe.

Even though there is supposed to be a fair degree of awareness among the public, the desired results are not seen as the epidemic continues to rage across.
The effect HIV has on the medical field in Kerala is unimaginable. The health sector now a major drain on the resources is going to move from worse to worst. It is estimated that at the present rate, even the state of Kerala will have to keep all its beds in all hospitals in another ten years. The treatment being very expensive, no country or state will be able to afford proper treatment for all. This is in addition to the various infectious diseases like Tuberculosis and other emerging infectious diseases which will become more severe and again demand lot of man and money from the health sector. And then there is the possibility of large number of people getting shunted away from the profession for fear of being HIV infected. The positive thing that has happened is the fact that the profession is gradually trying to realise its inefficiencies, mistakes and is trying to correct many mistakes, albeit very slowly.

Kerala society has been number one in tolerance to disagreements and adaptability to realities for generations. However, of late this quality is slowly disappearing and as a consequence, this state is gradually trailing behind in many spheres of human life. Health field is no exception. As in many socio-economic fronts, this state’s achievements in health are being questioned now.
5.2 Indian Situation

HIV/AIDS pandemic is posing serious challenges the world over. South and South East Asia contributed 6.0 million and share of India alone in this continent is 4.8 million, which is next only to Sub Saharan Africa. Therefore, the threat of HIV/AIDS looms large over India; necessitating adequate and effective response to meet this unabated scourge.

The activities of screening of blood for HIV commenced in India way back in 1985 at National AIDS Research Institute, Pune and Christian Medical College, Vellore. During this phase of restricted surveillance the purpose was to validate the presence of HIV infection in India First HIV positive was detected in 1986 from commercial sex workers in Madras. Soon, thereafter, HIV reporting system was set up under the aegis of ICMR with sero surveillance and reference centres spread over throughout the country with a view to identify the geographical spread of HIV infection and determining the major modes of HIV transmission. Most of these testing centres were located in Medical Colleges and activities of screening were confined to high risk and institutional population.
This activity indicated that HIV was widespread in the country and every state reported the presence of HIV infection by the end of year 1997\textsuperscript{2-3}. The distribution and spread was not uniform and was highly uneven. The Maharashtra, Tamil Nadu, Andhra Pradesh, Karnataka and Manipur experienced heavy burden of HIV. The 1998 estimates of HIV seroprevalence in the adult population of India was about 0.7\%. The cumulative rate for HIV tests performed in the country, including both high risk and low risk groups, has shown a slow pattern of increase from 1\% in 1992 to 2.3\% of tests in 1998. The cumulative sero-positivity rate acquired alarming epidemic proportion of 2.46\% by the year 1999 and it provided a clue of rising trend of HIV in India\textsuperscript{23}, not obeying to the command of all appropriate measures undertaken through Phase 1 of National AIDS Control Programme. The predominant mode of transmission in India happened to be unprotected hetero-sexual intercourse (83.88\%). Hitherto for the sero-surveillance activity was limited to bigger cities and metropolitan areas and it was not population based surveillance and could not be considered as an epidemiological surveillance by any stretch of imagination, but nevertheless it provided some useful information for action during phase I of National Programme of HIV
and AIDS. By and large the activities during this phase were highly
centralised in terms of planning and implementation of the
programme. The sentinel surveillance commenced at 55sentinel sites
in 1994\textsuperscript{4}. During the year 1998, a bold step was undertaken by NACO
to initiate nationwide HIV sentinel surveillance activities and the task
was entrusted to nodal agency (National Institute of Health and
Family Welfare, New Delhi). A test run sentinel surveillance from
Feb. to March 1998 was undertaken by 154 sites, mostly urban in
character\textsuperscript{5}.The objectives of sentinel surveillance during this phase
were to monitor trends of HIV infection in the country as also to
determine burden of HIV infection and geographical variations.
During August to Oct. 1998 over 180 sentinel sites representing all
states and union territories in the country were covered for sentinel
surveillance.

For monitoring trends of HIV epidemic in India strategy of
unlinked, anonymous surveillance was adopted covering high risk
population (attendees of STD clinics, injecting drug users, men
having sex with men and commercial sex workers) who manifest high
risk of contracting and spreading HIV infection and low risk
population (pregnant women) representing general adult population
Accordingly, STD clinics attendees and pregnant women seeking antenatal care through clinics were targeted for surveillance activity. Essentially it happened to be cross-sectional annual surveys to determine HIV prevalence, spread over three months (August to October every year) \(^5,6\). For antenatal clinic sites a sample size of 400 consecutive women attending the antenatal clinic for the first time during the sampling period and similarly for STD clinic site 250 consecutive individuals presenting to STD clinic for the first time were chosen to complete the pre-determined sample size, if the quota was met before twelve weeks the sampling was stopped and if the sample size was not met during the predetermined twelve weeks period, that was no problem the sampling stopped. Inclusion criteria stipulated that all new patients visiting STD clinics and suffering from one or other type of STD’s where blood is drawn for VDRL testing and all pregnant women attending antenatal clinic to be tested only once during the round. Designated regional co-ordinators of various Medical Colleges and regional research centres (Epidemiologists and Microbiologists) were made responsible to oversee the implementation (Operational aspects) of HIV sentinel surveillance to ensure quality aspects Generally two supervisory visits were ensured.
by regional coordinating experts to each site in their respective region. 25% of the sites were checked by NHFW teams to enhance the quality of surveillance. External quality assurance programme was introduced in the year 2001. All the samples tested positive in the laboratory were sent to designated reference laboratory for retesting and conformation and similarly 5% of negative samples were also sent for retesting. Epidemiological sentinel surveillance, operation covered 180, 180, 232, and 320 sites in the years 1998, 99,2000 and 2001 respectively in various parts of the country. On the basis of data of sentinel surveillance using certain assumptions and consistence methodology estimates of HIV infections in adult population (15-49 year age group) in the country have been worked out during 1998, 99, 2000 and 2001. The point estimates for these years were arrived at 3.50, 3.70, 3.86 and 3.97 million respectively indicating rising trends. It is claimed that burden of new HIV infection is on the decline from 0.16 million (year 2000) to 0.11 (year 2001); however, it is to be interpreted with cautions. The HIV sentinel surveillance provides useful estimates of burden of HIV infection in the country as also its trends in various risk groups of population. There are wide regional variations of HIV prevalence.
2001 census population of India was 1027 million and over half a billion in the age group of 15-49 years. The overall prevalence of HIV in adult population was less than 1%(approximately 0.8%) offers little indication of serious situation facing the country. An estimated 3.97 million people were living with HIV at the end of 2001, is the second highest figure in the world after Sub Saharan Africa. Based on the consistent high prevalence rates of three rounds of surveillance, 49 districts have been identified as high prevalence districts. Prevalence among women attending antenatal clinics was higher than 1% in Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland and Tamil Nadu indicating that epidemic has shifted from high risk population to low risk or general population over a period of time. HIV Infection has crossed 2% in Mumbai, it is more than 1% in Hyderabad, Bangalore and Chennai and is below 1% in Calcutta, Ahmedabad and Delhi metropolitan area; further, the HIV infection is being propagating from high risk groups to low risk groups population. HIV infection among women, who are not sex workers was “disturbingly high” in India. Young girls were especially vulnerable to HIV. Around 50% of all HIV infections most of whom contract HIV before they are 20 years
Prevalence of HIV infection in age group 15-19 years in STD attendees and pregnant women in the states of Andhra Pradesh, Maharashtra, Tamil Nadu, Karnataka, Nagaland, Chhattisgarh, Punjab and MP indicates recency of infection affecting adolescent age group necessitating focused response and intervention for adolescent health, accepting responsible sexual behaviour.

Based on the analysis of existing sentinel surveillance data, the states and union territories can be broadly classified into three groups. Group I - High HIV prevalence states which include Maharashtra, Tamil Nadu, Karnataka, Andhra Pradesh and Manipur where HIV prevalence rates were 1% or more in antenatal women. Group II - Moderate prevalence states include Gujarat, Goa, Kerala, West Bengal and Nagaland where HIV prevalence rates were 5% or more among high HIV risk behaviour groups but below 1% in antenatal women. Group III - Low prevalence states include the remaining states where HIV prevalence rates in any of the high risk behaviour groups were still less than 5% and as also HIV prevalence less than 1% in antenatal women. Since the distribution of HIV in India is not uniform, the epidemic is focussed sharply in few states, with most of
India having low rates of infection, therefore, differential strategies and responses are required for different regions.

To achieve zero level of growth of HIV/AIDS by 2007 appears to be a herculean task in view of rising trend and unabated spread of HIV to general population. Fight against HIV/AIDS needs to be integrated with control of STDs, adolescent health, control of reproductive infections and tuberculosis through primary health care and augmenting facilities for treatment of RTIs and STIs in rural areas on sustained basis. Most attendees of STD clinics were men. To obviate the problem of adequate coverage and to complete the desired sample size the modus operandi of sentinel surveillance was changed in the year 2001. To enrol the female clients it was resolved that from year 2001 onwards the STD sites would collect consecutive samples from two sources i.e. 150 samples from Skin and V.D. clinics (STD clinic) and 100 samples from Obstetric and Gynaecology clinic of the same hospital from OPD. With these modifications though the sample size was achieved but it had adverse effects on prevalence rates as many non-STD women were recruited to complete the sample size only. Therefore, the prevalence rates of year 2001 and 2002 in high risk groups should be interpreted cautiously in view of inclusion
of 100 females from the OPD of Obst. and Gynae. The participating sites were not clear of the specified objectives of surveillance and were not imparted adequate training. State run STD clinics had poor infrastructure and best practices of waste disposal, personal protection, safe disposal of needles and syringes were seldom followed. Most antenatal clinics could achieve the desired sample size but practice of consecutive sampling was not followed by them. In many of the antenatal clinics the routine VDRL testing was absent and they resorted to VDRL testing only during the period of surveillance.

One of the basic tenet of surveillance was data collection for action; however, HIV surveillance was driven by collection of data only as there was no action on that data. It was expected that the participating sites would build up the counselling and awareness generation activities to focus on behaviour changes as also establish best practices in the clinic and hospital and sustain these on endurable basis, but these were conspicuous by their absence. Similarly, condom promotion programme in STD clinics was seldom undertaken. There was hardly any feed back to participating sites by the State or Nodal agency or even by NACO. Wisdom prevailed only once, when the
State level Assistant Project Directors could interact with the State Co-ordinators at Delhi; to understand the problems and arrive at some solution.

Summary sheet on prevalence of HIV infections, site or centre-wise as brought out by NACO and NIHFW gives erroneous impressions on prevalence as the sample size for many of the sentinel sites appears to be too inadequate to draw valid conclusion\textsuperscript{7-11}. Zone-wise/ region-wise results on prevalence seems to be more appropriate for planning and implementation strategies. Almost all the participating sites were located in urban areas only and the clients or attendees most probably were urban in most settings. Thus, the data of HIV sentinel surveillance does not unfold the true picture of prevalence of HIV in rural areas. Antenatal clinics and post partum centres tend to function under different administrative control and there is not much cohesion or co-ordination among these centres to accomplish the task of surveillance. Moreover, the sentinel surveillance programme is run as crash programme without much thought of pre-planning and sustained quality services for antenatals and STD clients. All good/best practices initiated/carried out during sentinel surveillance period come to halt or vanish once the period of
surveillance is over. Most STD clinics are established on an adhoc arrangement to tide over the period of surveillance. STD clinics and antenatal clinics are located in urban settings and in Government setup, their utilization is sub-optimal, barring some metropolitan cities which are heavily used and sometime the situation runs out of control. Refusal rate in sentinel surveillance site is not recorded. Since blood bank screening for HIV has become mandatory and is making substantial progress, anonymous and unlinked screening of voluntary blood donors can provide useful information on prevalence of HIV in population of young adults.

Since there is no cure for HIV/AIDS efforts have largely been focussed on prevention, raising awareness for behaviour change targeting high risk groups and general population (focus on adolescents).

Behaviour surveillance activities have become essential. Behavioural surveillance surveys initiated in 1995(Preventive indicators surveys)\textsuperscript{13-14} and repeated in year2001-2002 highlight important facets of the country’s bid to curtail the epidemic\textsuperscript{15}. General population survey in India during 1996 revealed that percentage of adult population(15-49 years) who could cite at least two acceptable
means of prevention against HIV infection in urban areas of Delhi, West Bengal, Maharashtra and Tamil Nadu was of the level of 57.2, 54.4, 55.1 and 77.3 respectively while for rural domain in these respective states the levels were low and discouraging at 43.6, 13.4, 27.5, 63.8 respectively. Men had better knowledge while female lagged much behind because of poor access to media and least exposure to outside world. Similarly, the condom use rate in most recent sexual act with non-regular sexual partner/partners in urban settings of Maharashtra, Tamil Nadu, Delhi and West Bengal was 62.2, 77.8, 28.6 and 19.4 respectively while rural domain within these states manifested low level of condom use rate at 9.1, 8.6, 25 and 10% respectively. National Family Health Survey I and II data revealed very low use rate of condom, 2.4 and 3.1% respectively as contraceptive. NFHS II data indicates that only 4 out of 10 ever married women in India have heard of AIDS and there was low level of knowledge among rural women, illiterate women and women belonging to scheduled caste and tribes. Television was the most important source of information followed by radio and peer groups and friends.
Behavioural surveillance survey undertaken in year 2001 in India in general population, commercial sex workers and men having sex with men unfolds mixed picture of success and failures. Countrywide, awareness of HIV/AIDS is high as 76% of adult Indians (aged 15-49) and almost same proportion of adult population were aware that consistent and correct use of condom helps in prevention of transmission of HIV/AIDS. More than half of the respondents in the country (57%) were aware that having one faithful and uninfected sex partner could prevent transmission of HIV/AIDS. But in general, awareness and knowledge of HIV/AIDS remain weak in rural areas and among women. More than 80% of urban men recognized the protective value of consistent condom use, compared to just 43% of rural women. As against 55.5% of men, 38.3% of women could cite two cardinal methods of prevention of HIV namely uninfected faithful sex partner and consistent condom use. Sex with non-regular partner in the last 12 months was prevalent to the extent of 7% in urban and 6.3% in rural areas and condom use rate with such kind of risky sexual relationship was 62.4% in urban areas and 42.9% in rural areas. This is the “bridge population” which connect high risk and low risk populations. The larger the size of “bridge population” the
greater the risk of transmission into general population\textsuperscript{15-16}. High level of awareness and knowledge about HIV/AIDS and evidence of high condom use among vulnerable population in state that have mounted consistent prevention efforts, was obvious in the state of Maharashtra which is home to a long-standing, generalized epidemic. Behaviour change in high group such as female sex workers, their clients and injecting drug users was obvious as 66\%, 77\% and 52\% of them respectively consistently used condoms which is quite encouraging figure. Thus the targeted interventions have paid dividends. Similarly, in Gujarat focussed programmes have helped ensure that some three quarters of female sex workers used condoms, the last time they had sex with commercial or casual partner. But the state also reminds that HIV/AIDS responses have to reach the wider rural population if the epidemic is to be kept under check. Kerala where intervention for general and marginalized populations have taken place together, they have helped keeping HIV prevalence low. The survey goes to show that significant proportion of men who have sex with men in India also have sex with women (almost 31\% had sex with female partners in a six month recall period) and many (36\% during a month’s recall) have sex with commercial male partners, hitherto hidden facet of
epidemic. Condom use rates were distressingly low in men having sex with men (39%), this points for further urgent action. Thus a major challenge for India is to rapidly expand the coverage of groups at high risk (vulnerable population) and provide intervention such as peer counselling, condom promotion, treatment of STIs and enabling environments. Besides this, the bigger challenge is that the response reaches young, illiterate population and rural community especially women.

The AIDS cases surveillance is done with a view to ensure reporting of AIDS cases as per standard AIDS case definition by specified institutions and trained physicians (PRAM) to capture the disease burden and opportunistic infection and subsequently, strategy of management of such cases. The number of AIDS cases reported in India represent only a small fraction of the actual AIDS cases. The reported AIDS cases do not tell anything about the magnitude of the problem because of underreporting by states and lack of diagnostic skills. Epidemiological analysis of reported AIDS cases reveal that disease is affecting mainly the people in sexually active and economically productive age group of 15-49. Common in men than women, the ratio being 3:1. The majority of patients (89%) are in the
age group 15-44. The predominant mode of transmission of infection in AIDS patients was through heterosexual contact (80.86%), followed by blood transfusion (5.52%), IDU (5.30%), perinatal transmission (0.72%) and others (7.60%). The major opportunistic infection in the AIDS patients was tuberculosis indicating a possibility of a dual epidemic of TB and HIV in the country. Nearly 60% of the AIDS cases are reported to be opportunistic TB infection cases. Treatment of TB among the HIV infected persons is a new challenge to the National TB Control Programme. AIDS case surveillance data can supplement the HIV surveillance data in monitoring the epidemic and could contribute to the planning of Hospital and home/community based care for AIDS patients under the programme.

The picture that appears in Fig.2 (page 209) depicts the change that has happened from 1986 to 2002. This change is from one lonely case in Chennai in 1986 to millions in 2002.
Transition Map of HIV prevalence
Evolution of HIV from 1986 to 2002

1986
First case of HIV detected in Chennai

1990
HIV Prevalence reaches over 5% amongst high risk group in Maharashtra and Manipur

1994
1.74 m infected

5.1 Million Indians Living with HIV/AIDS

1998
3.5 m infected

2001
4.01 m infected

2002
4.58 m infected

□ □ □
> 1% antenatal women > 5% high risk groups < 6% high risk groups

Fig.2 Transition Map of Indian scenario
During the year 2002, efforts have been made to launch community based studies on prevalence of sexually transmitted diseases (STD) in urban and rural areas of India. The study is under progress. The overall objectives envisaged for such a study were to determine the prevalence, knowledge, risk and health seeking behaviour of the community in the context of sexually transmitted diseases in the country. Focus of this study is adult population between 15-49 years of age. Nationwide about 17000 adults would be selected in different parts/regions of the country from identified primary sampling units (PSU). From each PSU, 100 individuals (50 male and 50 female) will be selected and subjected to interviews, clinical examination and collection of samples for laboratory testing, right at the village level, which is a challenging situation indeed. The laboratory tests would be conducted for T.Pallidum, Trichomoniasis, Candidasis, HIV, HSV2 and HPV, dysplasia, chlamydia plus Neisseria gonorrhoea and bacterial vaginosis. The results of this community based study are keenly awaited. However, it is felt that success rate of such survey is limited, because of limited coverage of desired sample size and difficult to ensure the random sample, apart from many operational problems of organizing camps for such surveys in rural
and urban slum population. Such like studies are fraught with severe limitations; because of ill-designed and ambitious model for community based STD survey, hence it needs to be rethought. It is imperative to intensify and improve the quality of surveillance for effective HIV/AIDS response. Surveillance data as well as behavioural research provides vital information to design a sound and comprehensive HIV/AIDS programme and effective response

5.3 Stigma and discrimination in Kerala

It may be noted that we had many instances where very bad and inhumane treatment has been meted out to HIV infected people. The story of the family from Kilimanoor, the crisis that arose from the difficulty in burying a dead body in the Nattakom panchayat of Kottayam, the denial of a place in Cemetery for the dead body of a Christian in Kochi, the tonsuring of a woman alleged to be a commercial sex worker in Malapuram, the burning of a house in Wayanad, the increasing number of HIV related suicides all point to the intolerance of the society at large. The oft reported story of burning of all clothes and furniture belonging to the patient, turning away of the widow from the late husband’s family and denial of heirship to the widow and children are all being reported from this
state. We also had instances where the uninfected family members have lost their jobs, the vehicles have been refused to drivers and situations where even the church, clergy and temple authorities have refused people a chance to pray with others. The instances of Benson and Bency from Kollam, Reeja from Palakkad, Syam and Archana from Kayamkulam, Akshara and Ananthu from Kottiyoor have a common factor amongst the diversities; that of denied schooling in a state that boasts of universal access to education upto the higher secondary level. They were all victims of intelligent traps organized by their own teachers, parents of classmates and the society at large. Even when the health & education departments offered the maximum care that was possible in a country like India, even when the highest dignitaries of the country and abroad came forward to help them, this state could not wake upto the realities happening everywhere in the world.

The Catholic church in Kerala is said to be considering HIV test must before marriage mandatory. The steady increase in cases of AIDS across India has spurred a regional Catholic priests' conference in Kerala to urge the Church to insist on HIV blood tests before solemnising marriages. The Nazrani Catholic Priests’ Conference, a
powerful body of the Kerala-based oriental Syro-Malabar Church, said the apex Kerala Catholic Bishops Council must incorporate a law to empower parishes to ask for HIV-negative certificates from couples before solemnising marriages. "We have submitted a proposal to the Church. It must frame a law to make AIDS tests mandatory for marriages in India," the NCPC general secretary, told.

5.4 Studies on Kerala Behaviour

The most exhaustively conducted 'Kerala HIV Risk Behavioural Surveillance Survey' (BSS) was in late 1999 for the Kerala State AIDS Control Society (KSACS). The findings of this survey contributed to the baseline measurements of behaviour and knowledge indicators against which trends could be tracked over time. The results of this wave of the BSS also provided useful and actionable information regarding HIV related risk behaviours and knowledge prevalent at that point of time in Kerala.

- In order to calculate the sample sizes required for the survey, the proportion of each sub-population group that would report sexual intercourse with a non-regular partner (which included female commercial partners, male partners and non-regular non-commercial partners) in the past year was estimated. The
results of the baseline wave of the BSS had shown that there is a difference between the estimate and the actual measurement of the indicator. For example, in the case of auto rickshaw drivers, while the estimated measurement was 25%, the actual measurement was 13.8%. Similarly, for plantation workers although the estimated measurement was 20%, its actual measurement was 4.8%. In the case of University students living in hostels, the estimate of 10% was closer to the actual measurement of 9.3%.

- The study indicated that the proportions of male university students reporting sex with a female sex worker and a male partner was not very different (3% and 2%). Students reporting sexual intercourse with only female non-regular partners was 8.3%, and with inclusion of male partners, the proportion becomes 9.3%. However, consistent condom use with the female sex worker partner (43%) was higher than with the male partner (15%).

- The reported condom use during last sex was relatively high for all subpopulation groups with female sex worker and female non-regular partners (Range 26% to 91%). However,
the reported consistent condom use was relatively lower (range from 13% to 52%).

- Female sex workers reported lower last time as well as consistent condom use with regular clients (a difference of 23%) than with one time clients (a difference of 37%).

- More clients of sex workers had reported non-regular partners (both non-commercial female and male) than any other male sub-population group.

- While print media was the most frequently cited source of HIV/AIDS information, there was a wide disparity between different groups. For example, 44% of the sex workers had reported hearing about HIV/AIDS through newspapers and magazines as compared to 85% to 95% among other groups for the same source of information.

Acting as the State Management Agency (SMA) – set up in 1996 by the Government of Kerala with funding from Britain’s Department for International Development (DFID) – Dalal Mott MacDonald has been managing and facilitating a focused initiative for prevention and control of HIV/AIDS as part of DFID’s Partnership for Sexual Health project in Kerala.
The SMA addresses sexual health by managing and facilitating focused interventions which are implemented by partner organisations formed of NGOs, community based organisations and the local government. The broad objectives of the SMA are to identify high-risk groups in both states and, working together with partner NGOs, encourage behavioural change. Empowering marginalised communities by providing information and developing their skills is one way in which we work to do this. Allowing members of the community to participate throughout the project life cycle and be a part of the decision-making process is another.

Addressing people's needs in a practical way, the SMA partner organisations work toward providing counselling, shelter and access to healthcare services – all of which foster behavioural change and help improve quality of life. Facilitating self-help groups encourages people to interact with one another and seek advice while building self-esteem. Research is another important aspect of the projects, providing for proper intervention planning that addresses a community's sexual health needs on the ground. Currently the SMA manages around 37 intervention projects in Kerala focusing on
prisoners, migrant workers, street children, female sex workers and tribal populations.\textsuperscript{21}

In one study by Achutha Menon Centre for Health Science Studies, Trivandrum, India, most students had heard about AIDS and were aware of the modes of transmission of HIV\textsuperscript{22}. However, knowledge about STD and prevention of AIDS/STD was low (34\% and 63\% respectively). These findings are surprising given the high literacy in Kerala. Attitudes towards AIDS were entangled with moral values; 41\% of the students associated AIDS with immoral behavior. Multivariable regression identified male sex, urban residence and Christian religion as important correlates of higher knowledge scores and favorable attitudes towards AIDS.

5.5 Kerala's Migrant Populations and related issues

Migrant populations are at a higher risk than the overall population for poor health in general and HIV infection in particular. There are several reasons for these phenomena, some of which are related directly to the effects of sociocultural patterns of the migrant situation. Others are related to economic transitions and changes in the availability and accessibility of health institutions and the difficulty to cope with the traditions and practices. In terms of these factors,
HIV/AIDS is not different than other problems, but it is further complicated by the stigma and sense of otherness attached to those infected with the virus.\textsuperscript{23}

Epidemiological data show that migrants could be at great risk. AIDS case data for different countries of the world, different states of India and different districts of Kerala indicate variations. In many states however the outsiders are not included in health care or even in estimates. This is more true about Indian states as there is very little structural systematic data on the migrant labourers who are mostly mobile.

The definition of immigrants or migrant populations can be complicated and will depend on whether we use the area of origin or the separation from family as the criterion. Many questions are usually raised whenever we discuss their problems. These include

a) whether the person left by his choice or was forced out of necessity?

b) The degree of similarity between the places, culture and people

c) Whether the stay is temporary with intention to return, or to keep the family with and stay for ever. Significant differences
exist between short term migrants (seasonal), medium term migration and permanent immigration.

d) It may also be necessary to identify whether they have a willingness to approach and whether there exist really accessible health and welfare services.

It is also important to distinguish migrants from travelers and tourists and also from those who travel and stay away from family as part of the job. 24

Certain type of travelers are at higher risk for HIV infection while traveling, particularly those who seek sexual experimentation. Their vulnerability is also related to the type of people they associate during travel. The distinction between these groups or ethnic minorities is difficult. It has to be borne in mind that migrant conditions usually add to difficulties induced by minority status too.

Immigration can precipitate many issues that stem from cross cultural encounters.

• The breaking down of traditional norms and institutions like family, church etc.. with resulting confused, unstable, and insecure behaviour
• Difficulties in interpreting the new environment on the basis of pre-migration cultural patterns

• Difficulties in accepting the new environments, which could cause behavioral discrepancies

• Widening of inter-generational gaps, and

• Feelings of estrangement and stigma.

These issues could change at a fast pace among immigrants and could interact with other factors that could affect relationships. The issues of HIV/AIDS are unique because they involve intimacy and sexual relations. In these areas, strong familial and social pressures exist for continuity and conformity on both original and host sides, a situation that may create strong tensions. Such tensions are likely to be more among the marginalized and stigmatized groups. These issues are further aggravated by the fact that in many cultures (in most Indian cultures) the issues of intimate relations and sexual behaviour are shrouded in secrecy and taboo. Such cultures (usually traditional) have a tendency to avoid discussing sex in the public too. This public stance is a form of denial of the possibility of either premarital or youthful sexual behaviour. When young people migrate from one area to another, they may misinterpret or misunderstand
situations based on their previous mindset. Thus persons migrating from traditional cultures (like the Malayali) may misinterpret intimacy and acts of persuasion as signs of invitation and increased sexual activity. They may be tempted to believe that promiscuity is the norm in such cultures. Many studies have shown that such miscalculations lead to adoption of the erroneously perceived promiscuous norms as normative behaviour to be acted upon once he is out of his original culture.

An examination of the epidemiologic and behavioural data suggests that part of the greater apparent risk for HIV infection among migrant populations may stem from other living condition variables. For example the increase in the number of sexually transmitted infections among migrants is seen to be a major factor only in single migrants. The single status may be related to specific groups who want to improve their income or those who get low paid jobs. They tend to have multiple partners and commercial sex because of their single status, geographic mobility, and lower chances of creating stable relationships. The pressure for frequent change of working place is one reason often quoted by the fabrication workers of Kerala for not keeping the families with them. The original culture
they belong to prevents them from maintaining a nomadic family tradition too. There are difficulties in establishing a proper interaction with these groups too. Migrants may simply be more known to health officials because they are represented in many public services. They do not have the knowledge or economic resources to use the other, more confidential services. Many institutions are usually established for screening the migrant populations, even though they do not intervene in a similar manner with the general public. As the situation of immigration is by definition, one of constant and rapid change both at individual and community levels, education programs have also to be highly flexible.

Another peculiarity based on observations is that migrant groups tend to have sexual partners and form liaisons mostly within their own groups. Thus there is a greater risk of transmission which is internal. The external transmission sources can also be shared by smaller cultural and ethnic groups. This can also lead to smaller communities spreading the infection among themselves. When the prevalence of HIV/ AIDS among immigrants is higher than that in the general population, and this becomes a public issue, their marginality to the general population further increases their risk. The
perception of them as a “risk group” (e.g. the returnees from Mumbai) the may cause a grave public health problem. This will also wrongly give a false sense of security to the “general population”. When the host population erroneously perceives that risk stems mainly from migrants or immigrants, members of the general population may reach a high risk level. This happens when they do not feel the need to comply with protective measures with non immigrants.

General population reactions that need to be dealt with are alarmism combined with scapegoating and stigmatization. Irrational fears in the face of a threatening deadly disease are natural and should be recognized as such. But an alarmist reaction is an inadequate social behavioural response, aggravating the distress of immigrants and the HIV infected among them in particular. It may start with a sensationalist media report and may widespread damage. Such instances are likely to be triggered by inappropriate handling of epidemiological, medical or behavioural data that, even when correct, can be easily misinterpreted when not presented correctly. These could be followed by shunning, discrimination, breaches of ethics, and even violent reactions\textsuperscript{25,26}.\textsuperscript{25,26}
Stigmatisations and shunning can increase the tendency of the persons or groups to deny the issue and can sometimes alienate people with HIV/AIDS, make them angry, and drive them into hiding. Thus the risk can be intensified by external pressure.

5.6 Response from Business Community

Kerala does have a large number of industrial and plantation units. Many of them do have trade unions too. But just like their parent organizations, many of them have not come forward to show their presence in this area. Standing among them is a unique picture of Tata Tea Limited, Munnar which has formulated a definite plan and was one of the signatories to a declaration signed by corporate houses, showing company’s commitment to HIV/AIDS, at the 5th International Congress on AIDS in the Asia and the Pacific (5th ICAAP) on the 23rd October 1999 in Kuala Lumpur. Key elements of Tata Tea, South India Plantation Division’s HIV/AIDS Policy include the following:

- No pre-employment screening for HIV.
- Non discrimination of employees living with HIV/AIDS.
• Commitment to protect workforce from HIV through awareness and sensitization efforts.

• Commitment to maintain confidentiality regarding HIV status.

• Commitment to all standard social security benefits to HIV positive employees.

• Commitment to introduce reasonable changes in working arrangements, whenever needed.

• No termination due to HIV status. Fitness to work the only criteria as in case of other illnesses.

• Special care of health providers to protect from infection in case of occupational exposure.

• Free treatment of opportunistic infections associated with HIV.

• No obligation for the employee to inform the employer regarding his/her HIV/AIDS status.

The project also demonstrates a model through which corporate houses can join hands with local groups like IMA/NGOs etc. for a partnership. Integration of HIV/AIDS into the ongoing welfare programmes is necessary for long-term sustainability and cost effectiveness. Wherever possible, this integration should be done at the inception of the programme itself and at all levels. Bringing
HIV/AIDS in the fold of overall health education has distinct advantages which need to be harnessed to accelerate the pace of empowerment. Need to sensitize and educate key people in the workplace setting such as trade unions, estate managers and welfare officers. Importance of conducting needs assessment before starting an intervention. It is extremely important to assess the vulnerability of target population to STI/HIV in order to design appropriate interventions. Periodic assessment of the impact of such programmes on behavioural changes and vulnerability may be valuable in framing future strategies for intervention.

Rehabilitation Plantations Ltd. (RPL), a joint venture of Govt. of India and Govt. Kerala has rehabilitated about 700 repatriate families, in two estates viz. Kulathupuzha Estate and Ayiranallur Estate. The company has provided labour lines to the settled repatriates in both the estates in 14 colonies and as such around 50-60 families are residing in each colony. Considering the potential threat of HIV / AIDS, especially among the migrant population, the industry, with motivation of KSACS, State Management Agency and with the professional support of World Vision Unit at Punalur, has initiated programmes imparting awareness to the workers/ repatriates.
regarding HIV/AIDS. Following are the some of the programmes carried out towards the cause of prevention and control of HIV/AIDS in the in RPL workplace setting. An assessment of the potential vulnerability in the sector has been done prior to the implementation of these components.

• General Awareness programme

• Promotion of Community Volunteers

• Free Supply of Condoms – Kulathupuzha & Airanalloor Estate

• Condoms are collected from primary health centres – stakeholders collecting it from the outlets.

• STD Identification and management - Referral cases are done with the estate workers in RPL.

Currently the project is in a saturated stage and moving to the next level – rehabilitation / care and support.
References


