Dr AJITHKUMAR K

HIV Response in Kerala
Where we are?

We are now in a stage of consolidating our success. Just like other areas in health we have already surpassed the national targets. Our prevalence is at the level of 0.19%, transmission among conventional commercial sex workers is contained to a larger extend. The transmission from infected mother to child is near zero for the last few years.

An epidemic which affects the human kind changes the history. It is Human Immunodeficiency Virus (HIV). Over the last 30 years it influenced all aspects of human life including health, politics and economics. This all-encompassing nature of the disease itself leads to comprehensive global response which has now started paying dividends. According to the recent world and national data, HIV Epidemic has started showing signs of reversal.

Kerala has shown the way in HIV Epidemic management. In spite of being geographically close to three high prevalence states, we continue to have low prevalence in Kerala. This didn't happen by accident but was the result of concerted action on this front. It had resulted from many factors such as high health literacy, female literacy, penetration and visibility of family planning and condom messages, empowerment, capacity building and involvement of high risk groups including commercial sex workers(CSW), males having sex with males (MSM) etc. The establishment of a nodal agency for HIV prevention (AIDS cell which later transformed into Kerala State Aids Control Society), efficient leadership in HIV management, involvement of media, initiatives like Antiretroviral therapy (ART) positive prevention etc. resulted in the lowering of prevalence rate.

We are now in a stage of consolidating our success. Just like other areas in health we have already surpassed the national targets. Our prevalence is at the level of 0.19%, transmission among conventional commercial sex workers is contained to a larger extend. The transmission from infected mother to child is near zero for the last few years. We have registered great majority of detected HIV positive individuals with care and treatment services and almost all eligible patients are getting appropriate treatment. Stigma and discrimination at

Relationship of HIV epidemic and migration is well established. This link is well established in Kerala. Large proportion of HIV detected individuals has a history of migration. This tells us that we should work on the prospective migrants if we want to reduce the infection further. It is time we design a comprehensive package for the prospective young migrants from Kerala which include HIV prevention strategies.

various levels is being managed to a greater extend.

Governments at various levels have come up with welfare schemes like pensions, travel concessions and free treatment. NGOs and other agencies are supporting HIV infected individuals and families. Media is very sensitive about HIV reporting. Integration between various agencies are being monitored and facilitated.

But is it time to rejoice? Is it time to go into complacency mode? Again the history of health care tells us that whenever we relaxed half way, we are bound to loose the race as in the proverbial story of hare and tortoise. We have long way to go. Where should we focus next?

The gap between the projected numbers in HIV infected persons in Kerala is large and we have detected only about 19,000 so far. What does it mean? Does it mean we are unable to identify large proportion of our infected individuals? Are they still spreading the virus? Are they going to sick sooner or later? Or is it a problem in the estimation? What should be our strategy on this number? If they really exist the current strategy has to be revised and we should detect and provide care to them. This is an area which needs urgent and sustained attention.

The commercial sex work has undergone change in the last few years .It is time to study the pattern of this high risk groups, the mode of sex trade etc. It is possible that we are not targeting the new technology assisted commercial sex and still targeting the street based sex work only. Closing eyes to this area will eventually lead to have another invisible core group of infected individuals which can lead to increase in transmission.

Kerala has few high prevalence pockets of HIV infection and these geographical areas are identified and documented. We need to study the factors which make them vulnerable to HIV infection and target those factors comprehensively. This is not an easy task. Many socio-economic and administrative issues are involved in this, but if we can do something fruitful in this area, it will definitely be another model for managing concentric epidemic in the other parts of the world as well.

Relationship of HIV epidemic and migration is well established. This link is well established in Kerala. Large proportion of HIV detected individuals has a history of migration. This tells us that we should work on the prospective migrants if we want to reduce the infection further. It is time we design a comprehensive package for the prospective young migrants from Kerala which include HIV prevention strategies.

Kerala has become a target for job seekers from other states. Majority of these migrant workers are single men away from their family. Even though there are some projects working on these marginalised group we may have to have detailed action plan on the sexual health of these migrants. The task is not easy, especially in the background of diversity of these groups, language and cultural barriers they experience. It is also important to make sure that these populations are not targeted or stigmatised as careers of disease during prevention campaigns.

HIV program currently planned and implemented as a standalone vertical programme. But it has to slowly integrate into the general health care system. At the same time many issues like stigma, involvement of marginalised population like CSWs, MSMs may need strategies and skills which is not available with general health care system. It is the time we should get the general health system tuned to face the challenge.

The rather successful prevention and care program and generally efficient public health scenario in Kerala is in contrast to many other parts of the Country. So the needs of the State also can be different from a national program, which usually addresses situations different from Kerala. This poses great challenges in the planning and implementation of the programme. It is important to involve state government and local self-government in HIV prevention and care activities especially in areas not adequately addressed in the national program and are specific to the local realities.

The greatest challenge in HIV is the feeling of complacency which is slowly creeping into the minds. HIV is a great survivor. It demands very high level of commitment and adherence. This is true regarding the epidemic also. Any complacency at this level can lead to a rebound of the epidemic even with drug resistant strains. So let us commit ourselves to the target of getting to zero in the eve of another World AIDS DAY.■

The writer is Additional professor in Dermatology and Venereology, Govt. Medical College, Thrissur