

Liberalization and HIV in Kerala

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Acronyms

AIDS	acquired immunodeficiency syndrome
ARV	antiretroviral
AZT	azidothymidine
CSW	commercial sex worker
HIV	human immunodeficiency virus
KSACS	Kerala State AIDS Control Society
MSM	men who have sex with men
PDS	public distribution system
NACP	National AIDS Control Programme
NACO	National AIDS Control Organisation
NGO	non-governmental organization
PPTCTP	Prevention of Parent to Child Transmission Programme
SAP	structural adjustment programme
SMA	State Management Agency
STD	sexually transmitted disease

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Summary/Résumé/Resumen

Summary

The HIV/AIDS epidemic is a good illustration of the well-established link between poverty and ill health; job insecurity can indirectly affect people's susceptibility to diseases and infections such as HIV. Working and living conditions can put people at a higher risk for disease and infection: poverty-driven sex work and migration are acknowledged socioeconomic risk factors for HIV. It is also likely that the availability of food and access to health services influence susceptibility to disease as well as the ability to cope with ill health. Without good nutrition and health care, people with HIV succumb to AIDS more quickly.

In this context, this paper by Sandhya Srinivasan and Mini Sukumar explores the following questions: Has structural adjustment in India, implemented since 1991, increased job insecurity and loss of livelihood in the state of Kerala? Did structural adjustment put some groups at higher risk of HIV? Did policy decisions reduce people's access to care, especially through the public health system? If so, what institutional pressures led to these changes, and how were they received?

Kerala was chosen as a case study because its excellent health indicators are acknowledged to be at least partly due to the state's commitment to public services. However, structural adjustment programmes (SAPs) have been linked to worsening living conditions and health status, thus SAPs at the national level will have effects at the state level. Second, Kerala is a state of migrants, and migration has often been identified as a risk factor for HIV infection. The state's reported low HIV prevalence, despite this risk factor, merited further investigation.

The Kerala model, based on public commitment to social services, survived frequent changes of state government and flourished despite the low priority given by the national government to these issues. However, several overlapping trends have combined to create what appears to be a crisis. Some of these pre-date the introduction of structural adjustment, but have accelerated since its implementation in 1991.

Since the 1980s, the state of Kerala started having difficulties paying for its social support schemes through the revenues it generated. This contributed to the decline of the extensive public health care system, forcing people to turn to the growing and unregulated private health sector. Studies indicate that household expenditure on health care has increased drastically with liberalization, sometimes forcing families into debt.

SAPs at the national level are also believed to have affected the livelihoods of various sections of the population, leaving people impoverished and in debt, and forced to work in highly exploitative conditions. Their situation is exacerbated by the Kerala government's apparent reluctance to take action against violations of labour laws. These conditions and the resulting sharp drop in income could be pushing women into the sex trade, thereby increasing their risk of contracting HIV. Some groups may be forced to migrate to other states in search of work, which also puts them at a higher risk. While earlier official figures show that HIV prevalence has remained at a low level in Kerala, recent figures suggest a significant increase.

The Kerala AIDS programme is independent of the health care infrastructure, with separate funding and the involvement of NGOs for implementation. Yet many components of the programme will have to be implemented through the public health system. However, the public services are inadequate, while the private services – to which people with HIV are often forced to turn – are irrational, discriminatory and expensive. There are no policies implemented to protect the rights of people with HIV.

India is facing a growing AIDS crisis but, so far, Kerala does not seem to have been as affected as other states. However, if the latest official estimates suggesting that HIV prevalence may be a growing problem in Kerala are correct, the deteriorating support system, further weakened by the consequences of the national SAP, may be unable to tackle the crisis as it affects Kerala.

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Résumé

L'épidémie du VIH/sida est une bonne illustration du lien désormais établi entre la pauvreté et la maladie; l'insécurité de l'emploi peut affecter indirectement la vulnérabilité des individus aux maladies et aux infections telles que le VIH. Les conditions de vie et de travail peuvent augmenter les risques de maladie et d'infection: la pauvreté pousse à la prostitution et aux migrations, qui sont des facteurs socio-économiques reconnus de risque d'infection au VIH. Il est aussi probable que la disponibilité de nourriture et l'accès aux services de santé influent sur la prédisposition et la résistance à la maladie. Sans alimentation saine ni soins de santé appropriés, les personnes infectées par le VIH succombent plus rapidement au sida.

Ce document de Sandhya Srinivasan et Mini Sukumar, qui s'inscrit sur cette toile de fond, s'intéresse aux questions suivantes: l'ajustement structurel auquel l'Inde a procédé à partir de 1991 a-t-il aggravé l'insécurité de l'emploi et la perte des moyens d'existence dans l'Etat du Kerala? A-t-il élevé le risque d'infection à VIH pour certains groupes? Les décisions politiques ont-elles réduit l'accès des populations aux soins, en particulier ceux du système de santé publique? Si oui, quelles pressions institutionnelles ont entraîné ces changements et comment ont-ils été reçus?

Le Kerala a été choisi comme étude de cas parce qu'il est reconnu que ses excellents indices de santé sont dus au moins en partie à l'attachement de l'Etat aux services publics. Cependant, les programmes d'ajustement structurel (PAS) exécutés au niveau national, ayant été corrélés avec une aggravation des conditions de vie et de l'état de santé, devraient avoir des répercussions au niveau des Etats. Par ailleurs, le Kerala est un Etat de migrants, et les migrations—on l'a souvent constaté à propos de l'infection à VIH—sont un facteur de risque. La faible prévalence du VIH signalée par l'Etat, malgré ce facteur de risque, méritait une enquête plus approfondie.

Le modèle du Kerala, marqué par l'attachement du public aux services sociaux, a résisté à de fréquents changements de gouvernement et dont le succès ne s'est jamais démenti malgré l'importance très secondaire accordée à ces questions par le gouvernement national. Cependant, plusieurs tendances se sont conjuguées pour créer ce qui semble bien être une crise. Certaines sont antérieures à l'introduction de l'ajustement structurel mais se sont accélérées depuis sa mise en œuvre en 1991.

Dans les années 80, l'Etat du Kerala a commencé à avoir de la peine à financer ses régimes d'aide sociale, les ressources encaissées n'y suffisant plus. Cela a contribué au déclin du vaste système de santé publique, qui a contraint les gens à s'adresser au secteur privé de la santé, en pleine expansion et non réglementé. Des études indiquent que les dépenses des ménages consacrées aux soins de santé ont augmenté de manière dramatique avec la libéralisation, parfois au point de forcer les familles à s'endetter.

On estime aussi qu'au niveau national, les PAS ont affecté les moyens d'existence de divers secteurs de la population, laissant les gens appauvris, endettés et forcés de travailler dans des conditions de forte exploitation. La situation du peuple est aggravée par l'apparente réticence du gouvernement du Kerala à lutter contre les infractions au droit du travail. Ces conditions et la forte baisse des revenus qui en a résulté pourraient pousser certaines femmes à se livrer au commerce du sexe, ce qui augmenterait pour elles le risque de contracter le VIH. Certains groupes, contraints d'émigrer vers d'autres Etats à la recherche d'un travail, s'exposeraient ainsi à un plus grand risque. Si, selon des chiffres officiels antérieurs, la prévalence du VIH est restée faible au Kerala, des chiffres récents laissent à penser qu'elle a sensiblement augmenté.

Le programme de lutte du Kerala contre le sida est indépendant de l'infrastructure sanitaire, dispose d'un financement séparé, et des ONG participent à son exécution. Pourtant, de nombreux éléments du programme devront passer par le système de santé publique. Or, les services publics sont insuffisants, et les services privés—auxquels les personnes infectées par le VIH sont souvent contraintes de faire appel—sont chaotiques, discriminatoires et chers. Aucune politique n'est mise en œuvre pour la protection des droits des personnes infectées par le VIH.

La crise du sida s'aggrave en Inde mais, jusqu'à présent, le Kerala semblait plus épargné que d'autres Etats. Cependant, si les dernières estimations officielles sont justes—et elles indiquent une prévalence du VIH en hausse au Kerala—la détérioration du système de soutien, encore affaibli par les retombées des PAS mis en oeuvre à l'échelle nationale, pourrait être dépassé par la crise lorsqu'elle frappera le Kerala.

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Resumen

La epidemia del VIH/SIDA es un buen ejemplo del vínculo bien establecido entre la pobreza y la mala salud; la inseguridad laboral puede afectar indirectamente la susceptibilidad de las personas ante ciertas enfermedades e infecciones como la del VIH. Las condiciones de trabajo y de vida pueden colocar a las personas en una situación de mayor riesgo de contraer una enfermedad o una infección: el trabajo sexual impulsado por la pobreza y la migración son reconocidos como factores socioeconómicos de riesgo de contraer el VIH. Es igualmente probable que la disponibilidad de alimentos y el acceso a los servicios de salud afecten la susceptibilidad ante las enfermedades así como la capacidad para enfrentar los problemas de salud. Sin una buena nutrición y un adecuado cuidado de la salud, las personas infectadas con el VIH sucumben ante el SIDA con mayor rapidez.

En este contexto, Sandhya Srinivasan y Mini Sukumar buscan responder en este documento a las siguientes preguntas: ¿El ajuste estructural en la India, en marcha desde 1991, aumentó la inseguridad laboral y la pérdida de los niveles de subsistencia en el estado de Kerala? ¿El ajuste estructural aumentó el riesgo de algunos grupos de contraer la infección por el VIH? ¿Las decisiones de política redujeron el acceso de la población a la atención sanitaria, en particular a nivel del sistema de salud pública? De ser así, ¿qué presiones institucionales motivaron estos cambios, y qué acogida tuvieron?

Se seleccionó Kerala como estudio de caso porque se reconoce que sus excelentes indicadores de salud obedecen, al menos en parte, al compromiso del Estado con los servicios públicos. Sin embargo, se ha argumentado que el empeoramiento de las condiciones de vida y el nivel de la salud guarda relación con la ejecución de los programas de ajuste estructural (SAP por sus siglas en inglés), por lo que los SAP aplicados a nivel nacional harán sentir sus efectos a nivel estatal. En segundo lugar, Kerala es un estado de migrantes, y se ha señalado con frecuencia que la migración es un factor de riesgo de infección por el VIH. A pesar de este factor de riesgo, los bajos niveles de prevalencia del VIH notificados por el Estado ameritaban una investigación más acuciosa.

El modelo de Kerala, basado en el compromiso público con los servicios sociales, ha logrado sobrevivir a numerosos cambios de gobierno a nivel del Estado y ha florecido, a pesar de que el gobierno nacional considera estos problemas de baja prioridad. Sin embargo, se han combinado varias tendencias yuxtapuestas para crear algo que tiene visos de crisis. Parte de esta situación existía ya antes de la introducción de los ajustes estructurales, pero se han acelerado desde la implementación de estos últimos en 1991.

Desde los años 80, el Estado de Kerala comenzó a tener dificultades para pagar por sus sistemas de previsión social con los ingresos que generaba. Esto contribuyó al declive del amplio sistema

de atención a la salud pública, lo cual obligó a la población a recurrir al creciente sector sanitario privado, el cual no está regulado. Los estudios indican que los gastos de las familias por concepto de atención a la salud han aumentado enormemente con la liberalización y, en algunos casos, llevado a algunas familias al endeudamiento.

Igualmente, se estima que los SAP a nivel nacional han afectado las condiciones de vida de diversos sectores de la población, empobreciendo y endeudando a algunos y obligándolos a trabajar en condiciones de severa explotación. La aparente renuencia del gobierno de Kerala a tomar medidas en contra de las violaciones de las leyes laborales empeora la situación de estas personas. Estas condiciones, y la pronunciada caída en los ingresos que de ello resulta, podría estar obligando a las mujeres a ingresar al comercio sexual, con lo cual aumenta su riesgo de contraer la infección por el VIH. Algunos grupos pudieran verse forzados a migrar hacia otros estados en busca de trabajo, lo que los coloca en una situación de riesgo mayor. Si bien las cifras previas revelan que la prevalencia de la infección por el VIH se ha mantenido en un nivel bajo en Kerala, datos más recientes parecen indicar un aumento considerable.

El programa de Kerala contra el SIDA es independiente de la infraestructura de atención a la salud, con financiamiento aparte y la participación de ONG en su ejecución. No obstante, muchos componentes del programa deberán ejecutarse a través del sistema de salud pública. Pero los servicios públicos son inadecuados, mientras que los servicios privados— a los cuales las personas infectadas con el VIH se ven obligadas a recurrir—son irracionales, discriminatorios y onerosos. No se han puesto en práctica políticas para proteger los derechos de las personas infectadas con el VIH.

La India está enfrentando una creciente crisis de SIDA, pero hasta la fecha, Kerala no parece haber sido tan afectada como otros estados. No obstante, si son correctos los cálculos oficiales más recientes que indican que la prevalencia de la infección por el VIH pudiera ser un problema creciente en Kerala, el sistema de previsión, en situación de deterioro y en vías de agravarse debido a las consecuencias de los SAP nacionales, podría verse incapacitado para enfrentar la crisis que pudiera afectar a Kerala.

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Introduction

The link between poverty and ill health is well established, and the HIV/AIDS epidemic illustrates this connection. Working and living conditions can put people in situations of higher risk for disease and infection. For example, poverty-driven sex work and migration are acknowledged socioeconomic risk factors for HIV (Collins and Rau 2000). Thus, job insecurity can indirectly affect people's susceptibility to disease, including HIV infection. It is also likely that the availability of food and access to health services influence susceptibility to disease as well as people's ability to cope with ill health. Without good nutrition and health care, people with HIV succumb to AIDS faster.

In this context, the following questions are explored: Has structural adjustment in India, implemented since 1991, increase job insecurity and loss of livelihood in the state of Kerala? Did structural adjustment put some groups at a higher risk of HIV? Did policy decisions reduce people's access to care, especially through the public health system? If so, what institutional pressures led to these changes, and how were they received?

Kerala was chosen as a case study because its excellent health indicators are acknowledged to be at least partly due to the state's commitment to public services. However, structural adjustment policies (SAPs) have been linked to worsening living conditions and health status, thus structural adjustment will have affected the state. Second, Kerala is a state of migrants, and migration has often been identified as a risk factor for HIV infection (Collins and Rau 2000). The state's reported low HIV prevalence, despite this risk factor, merited further investigation.

The ideas presented in this paper are based on interviews with public health specialists, health activists and government officials¹ as well as selected published material.

I. Background before 1991

The Kerala model

The south Indian state of Kerala, with a population of 31,838,619 according to the 2001 census, is a unique success story in public health. In 2001, it ranked at the top of the 15 Indian states for which values were calculated for the Human Development Index—a composite of education, health and income—of the United Nations Development Programme. Life expectancy at birth was 73 compared to the national average of 68. The infant mortality rate was 11/1,000 live births compared to the national average of 66/1,000 (Government of Kerala 2004). The sex ratio was 1,058 women per 1,000 men, compared to the national ratio of 933 women per 1,000 men (Registrar General and Census Commissioner 2001). It had a 91 per cent literacy rate compared to the national average of 65 per cent (Registrar General and Census Commissioner 2001). In short, Kerala's health indicators were the highest in the country and similar to those in developed countries.²

Scholars have identified a complex set of factors that are responsible for the overall high health ranking of Keralites, despite low economic development, known as the Kerala Model. For example, various social movements promoted education, opposed caste-based oppression and led to legislation on land reform, wage increases, job security and public support programmes including various pension schemes. Some of these issues were part of the agenda of the Communist Party, which governed the state for various periods, but remained on the state's programme even when the Communists were not in power (Ramachandran 1997). The government's per capita spending on education was among the highest of all Indian states (Panikar 1999). This resulted in a 90.6 per cent literacy rate in 1991, when the national average

¹ See appendix for the list of people interviewed and the interview process.

² There are variations in this overall picture. For example, according to the National Family Health Survey II conducted in 1998–1999, immunization rates—which could be seen as a marker of a certain level of health care coverage—were lower than in many parts of the country.

was 52.1 per cent (Ramachandran 1997). Also in 1991, social movements supporting women's education contributed to the state's high female literacy rate—more than double the national average of 39.4 per cent (Ramachandran 1997).³ The public distribution system (PDS), which provided a supplemental benefit to most people, was the sole source of grain for some and kept food prices low in a food-deficit state (Kannan 2000). And the state government's commitment to providing health care was critical to improving people's health (Ramachandran 1997).

Challenges to the Kerala model

The Kerala Model has been under threat since the 1980s, according to M. Kunhaman of the Department of Economics at Kerala University. The growing fiscal deficit has been seen as a reason for cutbacks in various social services. Starting with the state's formation in 1957, all state governments spent a considerable amount in the social sector, but more recently, Kerala has been unable to raise funds for social services.⁴ It is felt that the allocations of successive Finance Commissions have not been favourable to the state. Achievements such as the extensive social support infrastructure and the below-replacement birth rate counted against it for allocations. Furthermore, Kerala has recently been facing second-generation problems of development. For example, high life expectancy has led to a large population of elderly people in need of special and more expensive health care (George 1993; Government of Kerala 2004).

Political background

India is governed by a federal system in which state governments have significant control over certain areas. Health is one of those areas, though national funding for programmes such as family planning and disease control influences state health budgets.

Kerala has had 18 governments since the installation of the first state government in 1957, many of which were coalitions rather than single-party governments and have been a seesaw between Congress coalitions and left coalitions. The United Democratic Front, a coalition led by Congress that was elected in 2001, currently heads the state.

The national government's adherence to International Monetary Fund (IMF) economic policies is generally considered to have reduced the share of national funds for all states (Das 2004). The Kerala state government may have been particularly affected since it has often been in conflict with the national government, whether because of differences between the parties in power at the national and state level, or because of the state's progressive agenda. Furthermore, as a small state with just 20 members in Parliament in the 545-strong Lok Sabha—comparable to the United Kingdom House of Commons—Kerala, unlike other southern Indian states, is not considered a power block.⁵

Economy

Approximately 24.2 per cent of Kerala's economy⁶ comes from industry.⁷ Agriculture⁸ accounts for 17.6 per cent of the state's economy, primarily in the form of cash crops, an increasing trend since the 1970s (Government of Kerala 2004).

³ The state's female employment rates, however, have declined while they have increased nationally. Moreover, although women have high education levels, their social identity is closely linked to marriage and childcare, thus controlling their sexuality, behaviour and mobility. Studies also point to evidence of increased violence against women.

⁴ Money available to the state government is determined by: (i) state tax collections; (ii) the state's share of national government taxes, determined by the Finance Commission, a national body; (iii) national assistance for state plans, determined by the national Planning Commission; and (iv) discretionary transfers made by the national government.

⁵ In the 2004 parliamentary elections, the Right-wing nationalist coalition led by the Bharatiya Janata Party was replaced by a coalition led by the Congress Party. The Communist Party of India (Marxist), which won all but two of these 20 seats, up from seven earlier, supports the government but is not part of it.

⁶ Defined as the sectoral share of the net state domestic product.

⁷ Comprises manufacturing, electricity, gas, water supply and construction.

⁸ Comprises agriculture, fishing, mining and quarrying.

Despite the low level of industry in the state, per capita state income, which was below the national average in 1980–1981, has since risen steadily to exceed the national average in 2002–2003 (Government of Kerala 2004). This rise is ascribed at least in part to the effects of remittances from migrants to the Gulf countries, which enhanced people's buying capacities, supported local enterprises and boosted the economy. Annual cash remittances are estimated at \$784.5 million⁹—2.55 times more than the state received from the national government, and equivalent to 9.3 per cent of the state domestic product (Zachariah et al. 1999).¹⁰

Migration

In 1998, there were an estimated 3.75 million Kerala migrants, including those living outside the state as well as those who had returned from abroad. Their average age was 27 years and they were better educated than the general population; 40 per cent of households had one or more migrants (Zachariah et al. 1999). Approximately 1.36 million left India (emigrants), of which 95 per cent went to the Middle East and the rest went to other parts of India (out-migrants).

There is considerable internal migration between Kerala and the bordering states of Karnataka and Tamil Nadu, and to some extent with Andhra Pradesh, all high-prevalence states for HIV (Srivastava and Sasikumar 2003). These migrant workers find casual employment with road-building projects, construction sites, saw mills, quarries, fisheries and so on.

Zachariah et al. (1999:27) argue that “the Kerala Model of development—a vibrant social sector co-existing with a stagnant productive sector”—is the driving force behind migration from the state. They identify five contributing factors to this movement: (i) the earlier demographic transition and associated population growth and demographic pressures; (ii) stagnation in the agricultural sector; (iii) an education system that produced educated people without corresponding employment opportunities; (iv) the “failure of the economic organisation in the state to expand employment in the secondary and tertiary sectors” (Zachariah et al. 1999:29); and (v) growing opportunities elsewhere in the country and in the Gulf countries since the oil boom of the early 1970s.

At the mercy of the national government

Kerala faces “acute crises in the spheres of employment and material production” (Ramachandran 1997:212). The state has a severe grain deficit. Its agriculture is based on cash crops—many of which are also export-oriented—that are vulnerable to sharp fluctuations in price. Kerala's unemployment rate of 20.77 per cent is the highest in the country (Government of Kerala 2004). The limited industry is dominated by agro-based small-scale and traditional industries—the coir-processing industry is second to agriculture as a source of employment in Kerala, followed by the handloom/powerloom industry (Government of Kerala 2003). Michael Tharakan, formerly of the Centre for Development Studies, Thiruvananthapuram, described the economy as having a colonial character; raw materials are produced without local manufacture or added value. The support from migrants' remittances is vulnerable to international events such as a war in the Gulf or a ban on Indian migrants. It has been suggested that Kerala's economy does not offer a secure base for the expansion or even maintenance of the social sector, and also leaves the state at the mercy of national government policy.

II. Structural Adjustment in India

In 1991, the Indian government received a loan of \$711 million from the IMF, which was contingent upon implementing structural adjustment to deal with the severe balance-of-payments crisis. Some of the components of SAPs are: (i) relaxing import duties and quotas that protect local products; (ii) privatizing public sector industries to make them more viable;

⁹ An exchange rate of approximately 45 rupees to the US dollar is used throughout the paper.

¹⁰ The government's revenue from remittances comes from all taxable activities that these remittances generate, thus the exact amount of revenue generated from remittances is not available.

(iii) changing labour laws to enable industries to shut down more easily; (iv) encouraging export-based production; and (v) reducing agricultural subsidies and social sector spending, including food support and health care.

SAPs are implemented by the national government, and while state governments are not required to follow the national government's policy, the implementation is likely to affect the states (Narayana 2001).

K.N. Harilal, from the Centre for Development Studies, Thiruvananthapuram, points out that structural adjustment would certainly have had an impact in Kerala. Changes in the national fiscal policy would naturally contribute to the state governments' fiscal crises since the national government requires states to follow fiscal discipline. There would be pressure to make changes in labour legislation and reduce state intervention in public services, including the PDS and health-care services. The national government also reserves certain funds for states in order to implement SAPs, which in turn reduces the allocation of funds to other states (Research Unit for Political Economy 2001). However, the impact of structural adjustment is not immediately visible at the state level in Kerala.

Burdens of liberalization

In the 1990s, Kerala should have done badly by the logic of liberalization, notes Tharakan. There are many reports of industrial closures, and there have been sharp fluctuations in prices of cash crops. However, the state's economic growth was higher than the national average, apparently fuelled by migrant remittances.

Still, demands from the national government since the 1990s have forced the state government to "fall in line" according to Kunhaman, who cites the privatization of public enterprises, the state's increasing withdrawal from services such as health care and education, and its reluctance to defend the rights of workers in closed industries as ways to do this.

The pressure of the "fiscal squeeze" may be compounded by the state government's efforts to raise money through foreign loans and investments that required restructuring public sector units and relaxing labour legislation.¹¹ In December 2002, the Asian Development Bank approved a loan of \$200 million to the state, reportedly part of a larger package of \$500 million (*Business Line* 2002). Opponents of the loan maintain that while it is not a large amount compared to the public debt of \$797.8 million according to the 2004 budget, it requires the government to implement significant changes. Public enterprises would have to assure an annual "net attrition rate of one per cent", extend the voluntary retirement schemes to all categories, and accept "alternative systems of management including privatization and disinvestment" (Ravi Raman 2003:10).

The most obvious changes followed the national government's removal of import duties on primary commodities in 1998–1999 (Sridhar 2000). Also, after signing the India–Sri Lanka Free Trade Treaty in December 1998, the local market was flooded by cheaper imports that affected the state's plantation sector (Government of Kerala 2004).

Vulnerable groups in Kerala

The effects of these changes were most obvious on a small underclass of the marginalized groups in the state—tribals, fishing communities and new migrants. For example, their infant mortality rates were 10 times the state average. Tharakan notes that the extreme conditions worsened after 1991. Tribals and other poor people from the Idduki district were the "donors" in a kidney transplant racket in the state (Krishnakumar 2002a, 2002b). There are reports of starvation deaths among tribals (Ravi Raman 2002) and of tribal labourers being forced into prostitution (National Commission for Women 2001). Many of the new generation of migrants from Tamil Nadu are children, homeless or living in "exceptionally deprived and unhygienic

¹¹ See *Business Line* (2002); Ravi Raman (2003); and Krishnakumar (2003, 2002c).

conditions in new slums in Kerala's towns and villages" (Ramachandran 1997:255). Nearly 1.4 million families were dependent on the plantation sector in Kerala, and many have been devastated by fluctuations in cash crop prices of coffee, tea, pepper and other cash crops (Government of Kerala 2004).

Tea plantations employ an organized labour force of 84,000 in large plantations and many others in newer, small plantations. "The crisis in the tea industry in the 1990s affected the small estates worst", states K. Ravi Raman of the Centre for Development Studies, Thiruvananthapuram. Some small plantation owners reduced their workforces; others just stopped paying wages. Many abandoned their estates. There have been nearly a dozen suicides in closed and abandoned estates, according to Ravi Raman. "Tea plantations are one place you see absolute poverty", says Harilal, "the kind that can force women into sex work".

Kerala has some 476,000 hectares of natural rubber (Government of Kerala 2004), mostly in small land holdings of less than half a hectare with owners employing wage labour to supplement their own work. Coconut provides a livelihood to over 3.5 million families. Both industries were hit by a depression in prices that began in the mid-1990s (National Commission for Women 2001; Baby 2002). The prices have partly recovered, but a disease subsequently struck the coconut industry, reducing the value of much of the crop and obliging owners to cut back on wage labour and forcing people out of work. Furthermore, many families borrowed money to cultivate the land, and faced a crisis when prices plummeted.

Most recently, dozens of farmers from six of the state's 14 districts who cultivated cash crops committed suicide, reportedly because they were unable to repay their debts due to a combination of drought, plant and animal diseases and a fall in cash crop prices (Sarita Verma 2004). "According to some villagers in the worst affected areas, at least one member from each household has left in search of jobs elsewhere, including young women, who are in demand as house maids and home nurses" (Krishnakumar 2004:42).

The report of a public hearing on the impact of globalization on female workers in Kerala, with testimonies from plantations, farms, fish processing centres and an export processing zone (National Commission for Women 2001), highlights people's vulnerability to international price fluctuations, the reduction of social support and weak enforcement of labour regulations that are a result of structural adjustment policies.

Plantation managements have cut workforces, increasing workloads for those remaining, and reduced health and education services. Women, many unmarried migrants, constitute 70 per cent of the workers at the export-processing zone in Cochin. There is no job security, canteen, accommodation or any other facilities, and 40 of the 48 industries produce commodities not covered by the Minimum Wage Act. Women work 10-12 hours per day for less than half the minimum wage in fish-processing areas along coastal Kerala with none of the amenities required by the Factories Act of 1948 – not even toilets.

There is little doubt that marginalized populations are being adversely affected by structural adjustment. There are numerous reports of plantations being abandoned, people losing their land after crop failures and joining a highly exploitative and unorganized labour force, public services such as health care and food becoming less accessible, women being forced into sex work and farmers committing suicide.

Delayed impact?

Despite such anecdotes, there is little evidence, so far, of any dramatic deterioration in the health status at the state level. The infant mortality rate continues to decline at the state level, though it has slowed in recent years. Data from the National Family Health Surveys, conducted in 1992-1993 and 1997-1998, show that child malnutrition and maternal anaemia are also on the decline at the state level. The two drastic SAP-related changes discussed here – cash crop price fluctuations and the dismantling of the PDS – began in the late 1990s; thus, it may be some time before the health impact becomes visible. Still, the conditions described will intensify health

problems in the community, affecting marginalized groups the most. They will also affect people's vulnerability to HIV and their ability to cope with the illness.

III. The PDS

The grain deficit in Kerala, estimated at 50 per cent to 55 per cent in the mid-1970s, was over 75 per cent at the time of writing (Kannan 2000). This makes people vulnerable to high food prices, since grain must be bought from outside the state. The state has depended on the PDS to ensure grain availability and to keep prices down. State governments to buy grain from the national government's Food Corporation of India at a subsidized rate that is fixed by the national government and sell it to the public at a subsidy.

As the first state to introduce rural rationing in response to public protests against food shortages, Kerala's high allocation of PDS grains is the result of negotiation with the national government (Swaminathan 2000). "The political demand for food, reflected in mass protests and struggles, was thus critical in establishing and strengthening PDS" (Swaminathan 2000:59).

Kerala's PDS has often been described as the best in the country. Grains are distributed through a network of "fair price" shops, ensuring availability of 460 grams per day per adult—more than the minimum 370 grams prescribed by the Indian Council of Medical Research. The state government also distributes food staples through a chain of retail outlets and mobile vans (Suryanarayana 1999). The PDS is available to 97 per cent of Kerala's population and utilized by 87 per cent to some degree; the very poor used it for all food purchases. As usage is inversely related to income, the PDS serves as an equalizing measure.

Interestingly, although Kerala's grain intake is below the national average (Suryanarayana 1999), it has a low prevalence of both chronic energy deficiency and severe malnutrition. One explanation for this is that national surveys may not reflect variations in the non-grain sources of nutrition (Kannan 2000). In addition, the interaction between nutrition and health is complex, with the state's extensive health care network and the high maternal literacy likely to have benefited people's health (Panikar 1999).

Changes in the PDS after 1991

Although the per capita amount of grain has declined throughout India since 1991, the drastic changes started in 1998 when the national government modified the PDS, limiting rations that were previously available to families identified as living below the poverty line. The amount of grain available to each state at a subsidized rate depended on the number of people below the poverty line identified in each state; in Kerala it was 25 per cent of the population. Critics of this change argue that the poverty line is an inappropriate measure when the majority of the population works in the informal sector with fluctuating earnings. Furthermore, for those on the margin, an emergency expense—such as for health care—could push them below the poverty line. Consequently, the state decided to supply rations at below the poverty line rates to an additional 17 per cent of the population; and the remaining population would be able to buy rations at close to market price. This decision, however, put a burden on the state government, which increased in subsequent years as the national government raised the price of PDS supplies.

The effects are yet to be systematically analysed, but Swaminathan describes the impact of introducing a targeted PDS in 1977 in Sri Lanka, a country that also had an effective PDS and high social indicators:

Anthropometric data from two surveys of nutritional status, undertaken in 1975-6 and 1980-2, that is, prior to targeting and after targeting, showed an increase in the proportion of children suffering from acute malnutrition (2000:69).

In Kerala, the purchase of PDS rice in 2002 was about one-fourth of what it had been in 1998. Distribution of wheat fell as much. The bulk of the drop was for purchases by people in the above poverty line category (Government of Kerala 2004). Increased prices within the PDS also reduced the amount purchased by those above the poverty line. Today, the PDS is used almost exclusively by the poorest; the rest opt for better quality grain in the open market despite the higher prices.

The destruction of the PDS has been described as a devastating blow to Kerala (Suchitra 2004). Joy Elamon, of the Kerala Health Studies Research Centre, Thiruvananthapuram, points out that the PDS has done away with the role of the government in keeping market prices down. A drop in PDS coverage is likely to have increased market prices (Mohandas 1999). Indeed, the price of rice has risen over the years. This will force people either to spend more on food – and perhaps less on other essentials – or reduce their intake.

IV. Health Care in Kerala

Structural adjustment in health care implies reduced government expenditure on health, introduction of user fees in public hospitals, further growth of the private sector and encouraging the voluntary sector to provide services not provided by the government or the private sector (Seeta Prabhu 1999; Sen Gupta 2002). In Kerala, many of these changes pre-date structural adjustment, although it may have accentuated their impact.

Thankappan (2001) notes that Kerala was the first state government to give priority to health and education. Allocations for health care have been high since the 1950s. For example, in 1955–1956, the state's revenue expenditure on health was 8.48 per cent of total revenue expenditure, compared to the average of all states combined of 4.36 per cent. This has remained the case over the years. In 1994–1995, the state's revenue expenditure on health was 7.44 per cent of total revenue expenditure, compared to the average of all states combined of 2.63 per cent (Duggal et al. 1995a, 1995b).

The importance given to health care was linked to the general notion that the government was responsible for social services. And indeed, "Kerala in the 1960s and '70s could afford to spend on health; it had money from cash crops", notes D. Varatharajan of the Achutya Menon Centre for Health Sciences Research, a government institution in Thiruvanthapuram. And, despite fiscal crises from the 1980s, the state's per capita expenditure on health, including water supply and sanitation – at 1980–1981 prices – continued to increase (Narayana 2001). Raman Kutty and Panikar (1995) note that even as the per capita SDP was below the average of all the states and declining, the state per capita public expenditure on health remained higher than the average and was increasing.

By the end of the eighties, Kerala had a very favourable ratio of personnel and facilities to the population, even though there were pockets in some districts where access to health facilities was really limited (Raman Kutty 1999:432).

Changes starting in the 1980s

Kerala's reduced commitment to public provision of health services can be traced to the fiscal crisis prior to 1991, which reduced the rate of growth in government health expenditure. In particular, it affected "those categories or items of expenditure a cutback on which would evoke least opposition or resistance" (Raman Kutty and Panikar 1995:56). Revenue expenditure increased at the detriment of capital expenditure, as revenue expenditure went to salaries rather than to medical supplies. Thus, no new infrastructure was built, the existing infrastructure was not maintained and public services faced shortages of medical supplies.

This trend is also reflected in figures presented by Narayana (2001) in a study of the impact of macroeconomic adjustment policies on access to health care. Between 1981–1982 and 1997–1998, Kerala's expenditure on medical and public health services, as a proportion of total

expenditure, declined from 9.62 per cent to 6.98 per cent; revenue expenditure on medical and public health services, as a proportion of total revenue expenditure, decreased from 9.74 per cent to 8.7 per cent, and capital expenditure on medical and public health services, as a percentage of total capital expenditure, plunged from 9.61 per cent to 1.57 per cent.

As Kerala's public services declined in quality, people increasingly depended on private health services. Surveys found that patients using the public sector complained of inaccessibility, waiting times, doctors' attitudes and hidden expenses (Homan and Thankappan 1999). This accentuated the impact of other social and economic inequities. Only those who could not afford private services used public hospitals, and even they were forced to pay for user fees, medicines, tests and procedures.¹² In rural areas, 60 per cent of the people avoided the government's primary health centres, citing lack of medicine and long distances (Aravindan and Kunhikannan 2000).

The impact of rising health expenditure

Raman Kutty (1999:433) suggests that the extensive public health care system "contributed to a growing sensitisation to modern modalities of medical care to which people then became habituated". Private services thrived as people turned to them with the deterioration of government services. By the 1980s, private health services "outstrip the government facilities in the density of beds and employment of personnel" (Raman Kutty 1999:433) The private sector is driven by the need for a return on investment and, therefore, is less developed in poorer sections of the state with inadequate government facilities (Sadanandan 2001). Furthermore, the unregulated growth of private services is associated with a growth in irrational and unethical treatment.

Out-of-pocket expenditure on health care can have devastating consequences for poor households. In 1996, a sample of rural households that had been surveyed in 1987 was followed up to look at their health and socioeconomic status. Per capita health care expenditure had shot up during the 10-year interval. Per capita medical expenditure rose from \$2 to \$12, a 600 per cent increase, despite a reduction in morbidity. The impact of "mediflation" was most severe in the lower socioeconomic groups interviewed. The rise in per capita medical expenditure was 326 per cent and 254 per cent for the better-off socioeconomic groups and 768 per cent and 1,010 per cent for the poorest socioeconomic groups. Furthermore, the ratio of medical expenditure to income was also skewed, with the poorest group spending 39.63 per cent of their income on health care, and the richest spending 2.44 per cent. According to Aravindan and Kunhikannan (2000:55), who attribute the changes to the effects of liberalization,

Even granting certain degree of underreporting of incomes, this is a very high figure and undoubtedly is a major contributing factor to debt and further impoverishment among those on the lower rungs of the social ladder.

Narayana (2001) conducted a survey on the effects of macroeconomic policies and health sector reform on access to the health sector, including Kerala. He found that the extensive health care infrastructure in Kerala, where almost 70 per cent of the population used private facilities, ensured that very few were deprived of care. "Obviously adjustment has not affected the income of a large cross-section of people adversely and the access to health care as well" (Narayana 2001:59). However, he also found that 9.08 per cent of the population surveyed in Kerala reported spending more than their annual income on health care, implying that they had had to sell assets for the service (Narayana 2001). Inevitably, some will go into debt, and this extraordinarily high figure deserves further study. The state's campaign for decentralized planning is believed to have enhanced the use of private health care.¹³ However, it has been noted recently that the Modernising Government Programme, funded by the Asian Development Bank, will increase privatization in health care and further reduce access to health services for the poor (Nayar 2004).

¹² User fees pre-date 1991; however, there was an attempt to increase the rates more recently.

¹³ See Isaac and Franke (2000); Government of Kerala (2004); and Ekbal (2000).

The critique of Kerala's health care system should be understood in the context of what it once was; that is, among the best in the country. However, in its weakened form, it will be less able than before to provide care for the new health problems on the horizon, such as HIV.

V. HIV in Kerala

Kerala is categorized as a low prevalence state for HIV, although it is sometimes described as having pockets that may represent localized or concentrated epidemics (Priya 2003). The latest figures, however, suggest a sustained increase of HIV prevalence in samples from antenatal clinics over the last three years, and are seen as a reason for concern.

Antenatal prevalence—representing adult prevalence in the community—has increased from 0.1 per cent in 1998 to 0.33 per cent in 2004. (In comparison, the national adult prevalence is 0.91 per cent.) Prevalence in samples from sexually transmitted disease (STD) clinics has hovered¹⁴ at between 2 per cent and 3 per cent.¹⁵ The government estimates that there are between 70,000 and one million people with HIV in Kerala. Approximately 86 per cent of HIV transmission is reported to be through heterosexual sex (Prasanna Kumar 2004). The peak age of infection is between 20 and 30 years old (Government of Kerala 2001).

Migration and HIV

Kerala was initially categorized as “high risk” and vulnerable to migration-linked infection, notes Rajeev Sadanandan, public health consultant and former state health secretary. In 1994, it had the third highest number of AIDS cases in the country. Migrants are more likely to be in high-risk situations since they are often poor, live away from their families and are more likely to engage in unprotected sex. Indeed, while there is no systematic information on this subject, government surveys indicate that most people who learn of their HIV status can trace their infection to a sexual encounter outside the state.

A survey was conducted of people with HIV from 75 Kerala households in districts with high rates of infection and high rates of migration (Thimothy 2003). Of those interviewed, 66.7 per cent had a migration history and reported visiting commercial sex workers (CSWs) while in transit in Mumbai, where prevalence among CSWs is higher than 50 per cent. Women interviewed said they were forced to have sex by their agents or their employers. Recently, there is evidence of infection in women who report no other sexual partner than their husbands. This is seen as a sign that the epidemic is moving into the general community. In some cases, drug use through injection may fuel the local epidemic.

Questions about the low prevalence

Could estimates based on relatively small samples be accurate? M. Prasanna Kumar, former deputy project director of the Kerala State AIDS Control Society (KSACS), Thiruvananthapuram, states that the surveillance system is meant to monitor trends, not provide accurate estimates. Surveillance data are triangulated with blood bank and other data. Until recently, the general indications were that HIV prevalence was low and had not increased dramatically over the years. Prasanna Kumar emphasizes that the most recent surveillance data—suggesting a sustained increase in antenatal prevalence—call for more information on HIV in the state. He also maintains that the HIV trend can be monitored even without a sample large enough to make an accurate estimate of its prevalence in Kerala. The annual surveillance gives an estimate of HIV prevalence in the state—at a particular point in time—within a confidence interval, or margin of error. If the estimate is outside confidence intervals in previous years, there may have been a change in the trend. If this change persists over several years, it might indicate a true change in trend. Although samples from referral centres for STDs

¹⁴ STD prevalence was 2.6 per cent in 1998, 3.2 per cent in 1999, 5.2 per cent in 2000, 6.42 per cent in 2001, 2.45 per cent in 2002, 2.45 per cent in 2003 and 2.78 per cent in 2004.

¹⁵ See www.nacoonline.org/facts_statewise.htm, accessed on 14 July 2005.

can be useful for surveillance, they will overestimate HIV prevalence among patients with STDs in the community.

Doctors treating AIDS cases report an increase in the number of patients. However, Prasanna Kumar contends that doctors and hospitals known to treat people with HIV are bound to see more patients, especially as antiretrovirals (ARVs) become more available. A better indication of the situation is the prevalence in antenatal clinics and among sex workers, where HIV incidence has remained low.

Should HIV be a bigger problem in Kerala because it borders three high-prevalence states and 40 per cent of families have at least one migrant? Prasanna Kumar and Sadanandan suggest that a combination of factors is responsible for the low HIV prevalence in Kerala. Compared to the rest of the country, CSWs in Kerala are older, their "age at first sex" is higher and they have fewer clients. The National Behaviour Surveillance Survey confirms these statements. CSWs in Kerala are also much better educated, more aware of HIV transmission and use condoms more consistently. They have lower STD prevalence, the highest rate of treatment for STDs and the lowest rate of "no treatment for STDs" (NACO 2001). Furthermore, Prasanna Kumar and Sadanandan suggest that visiting a CSW is not as socially approved in Kerala as it might be in some other states. Also, as there is no taboo of sex during pregnancy, men may not be more likely to visit CSWs when their wives are pregnant. It is also possible that the relatively¹⁶ good access to health care in the state reduces the prevalence of STDs, subsequently reducing risk of HIV infection. In addition, knowledge of HIV and related information is high in Kerala (NACO 2001).

These explanations of Kerala's low HIV prevalence are plausible, but not necessarily convincing. It is not clear, for example, how Kerala has maintained a low prevalence despite being surrounded by the high-prevalence states of Andhra Pradesh, Karnataka and Tamil Nadu, from where there is considerable migration. Indeed, there is a need for further study to obtain a more detailed picture of HIV prevalence among various socioeconomic groups in Kerala and the various influences on HIV prevalence there.¹⁷ The sentinel surveillance system is based on relatively little information: the 2004 prevalence figures in Kerala are based on 400 samples collected from each of four antenatal clinics and 250 samples from each of four STD clinics in the state.

Reason for concern

As mentioned above, the latest official estimates pointing to a sustained increase in antenatal prevalence of HIV suggest that it may be more of a problem in Kerala than was previously believed.

While Sadanandan suggests that pockets of high prevalence such as, for example, in Kozhikode and Trissur warrant concern, Prasanna Kumar points out that these pockets have referral centres for AIDS and that seroprevalence in blood banks in these areas is just 0.2 per cent (17 out of 8,000 samples). However, these towns are close to the borders of high-prevalence states.

Second, the State Management Agency (SMA) reports that recently impoverished women have been moving into sex work for survival, though this is not systematically documented. It is important not to identify marginalized groups and increase their stigma, but the desperation of workers' conditions in many closed industries, plantations and other situations could put them at risk.

Finally, surveillance figures will not pick up those who learn of their HIV status outside the state, although many of them will seek care for HIV-related illnesses. More Keralites know someone with HIV than the national average, placing them just under the high-prevalence

¹⁶ While the Kerala's health care system is under threat, the health care available is still better than in most other parts of the country.

¹⁷ This problem is perhaps even more acute in obtaining national data.

states (NACO 2001). Sadanandan suggests such awareness might indicate that HIV is not so rare in Kerala after all.

“Perhaps the core messages in the anti-HIV campaign have had a greater impact in literate Kerala compared to the other states”, suggests K. Aravindan of the Kerala Shastra Sahitya Parishad, a community organization concerned with education, health, science and development. He added,

Still, the absolute numbers are quite large, and people with HIV will fall ill frequently in the coming years. Most will have to be treated in government hospitals. This will strain a sector already decaying due to lack of investment.

“Each case will add to the social burden and health care burden”, says Sadanandan, “furthermore, there is too much confidence and complacency”.

VI. Responses to HIV/AIDS

The National AIDS Control Programme (NACP), funded by external loans, was initiated in 1992 with the establishment of the National AIDS Control Organisation (NACO). The first stage of the NACP (1992–1998) was to increase awareness of HIV and its modes of transmission. At the state level, it functioned through AIDS cells; in Kerala, this activity began in December 1993.

The second stage, NACP-2 (1999–2004), focused on HIV prevention, but was also meant to develop care and support services. One of the conditions of international support for the NACP-2 was that NACO would run the programme through autonomous AIDS control societies in each state, which in turn would work with management agencies and non-governmental organizations (NGOs) to coordinate implementation of targeted interventions among populations with high-risk behaviour.

KSACS, founded in 1999, implements national programme efforts such as voluntary counselling and testing centres, the Prevention of Parent to Child Transmission Programme (PPTCTP) and services for STDs. KSACS works with the SMA, which supervises 59 targeted interventions. Four of these are specifically for CSWs; the rest are “multi-target” projects covering, for example, men who have sex with men (MSM), migrants, plantation workers and tribals—single-target interventions do not work because the populations at risk are too dispersed. The multi-target project is the only state-specific deviation from the NACO model described by those interviewed.¹⁸ There is also one project that was recently started in Mumbai for migrants.

Did the Kerala programme prevent a crisis?

In 1994, Kerala was categorized as high risk and vulnerable to migration-induced HIV infection. Sadanandan suggests that the state’s low prevalence is a result of the government’s early response, stating:

The anticipation of migration-linked infection in 1994 led DfID to include Kerala in the list of high-risk states in which to develop an AIDS programme that managed to pre-empt conservative opposition regarding working with CSWs, MSM, etc. This was done by first consensus building with women’s groups, judges, senior police officers, members of the state legislative assembly, the media, trade unions, etc., and by assuring them that the programme would be conducted discreetly. We also involved good NGOs to integrate the HIV message into their work and, if they were willing, to work out a partnership.

By 1998, Sadanandan declared that nearly every vulnerable group was covered adding,

¹⁸ It can be argued that multi-target interventions are not much different from single-target interventions as they also focus on groups believed to be at risk, and not on the general population.

I believe that this had a role in keeping the prevalence of Kerala at low levels. Also, NGOs built up social mobilisation and an army of personnel who could respond to the challenges of HIV independently of the government response.

At this time, Kerala was not restricted by NACO regulations for state programmes. As of 1999, NACO required states to set up targeted interventions that followed the pattern of the national programme.

Is Kerala's low prevalence a result of the government's actions? It would, nevertheless, be difficult to demonstrate a link. As Prasanna Kumar points out, worldwide, the few examples of proven effective interventions are linked with a drop in prevalence. Second, in the case of Kerala, it would have had to prevent a rise in prevalence—a matter of speculation. And third, there are the indications that the epidemic in Kerala is migration-based. Some programmes—in schools and industrial training institutes—are directed at potential migrants, but these are too recent to have had an impact.

Other views

Others hold that the Kerala AIDS programme is neither novel nor effective. As elsewhere in the country, the government's first response to HIV was denial, according to Elamon, who added:

It was believed that our culture protected us from HIV. The state AIDS cell was relatively low key. Then, people with AIDS started coming for treatment. The government's response was to publicise messages based on fear and on risk groups, adding to the stigma of HIV.

"At first the medical profession reacted with panic", according to Aravindan. Thus, irrational and unethical practices abounded, such as testing patients without their knowledge and refusing to treat patients with HIV.

According to Elizabeth Vadakarera, who runs a counselling centre and programme for injecting drug users, the major problem of the programme is its failure to provide treatment. The current challenges are the stigma in the community and in health services, the lack of treatment for opportunistic infections, the lack of trained personnel and the lack of laboratory facilities.

This situation is linked to the major critique of the programme in Kerala today—that it is run as an independent programme with separate funding, rather than integrated with the health care system. As a result, it is argued, activities do not necessarily meet people's needs. Senior programme officials acknowledge that the current programme is "directionless". For example, the new emphasis on care and support does not seem to have an organic link to other activities within the AIDS programme or the health system in general.¹⁹

Problems with the NACO model

NACO, as an autonomous society, has become a model for most externally aided programmes following the start of structural adjustment. It is an NGO headed by a senior government official, usually the senior-most civil service employee in that department. It is felt that such programmes create arrangements parallel to the existing government structure, slowly sidelining the government and reducing the role of the state. Such programmes allow for flexibility in administration, but create conflict with the main system (Tilak 2002; Ramachandran 1999).

Sadanandan illustrates the constraints of the NACO model:

¹⁹ Interestingly, in contrast to the NACO model, not one of the board members of KSACS has HIV. This is reportedly because of objections from board members.

The pattern of sex work across India is different. However, NACO requires that each targeted intervention for CSWs must serve a minimum of 1,000 CSWs. To take another example, NACO requires the same fixed salary for coordinators, whether they are in Bombay or Cochin. This is a constraint to states which could otherwise plan their own approach to the problem.

Prasanna Kumar elaborates further on the problems of imposing the NACO model on Kerala. Despite all of its limitations, the state has a functional health care infrastructure, and 97 per cent of women give birth in hospitals. In these locations the PPTCTP could have provided the ARV drug AZT, which is more effective than zidovudine; however it requires hospital-based administration. Similarly, the state has a better water supply, and women are better educated; informed HIV-positive mothers are more likely to use prepared formula instead of breast feeding. However, the NACO model does not allow for such variations.

Prasanna Kumar adds that the NACO model is relatively independent of the health system, which provides services for people with HIV. Health system staff are suspicious of the AIDS programme and believe that funds are siphoned off by government officials and NGOs. The lack of integration and the poor relations between health staff and the AIDS programme are acknowledged at all levels.

“The NACP is a donor-driven programme and hence the priorities are that of the donor”, a senior government official stated.

State government unable to take control

Kerala has modified national government guidelines in the past. For example, the leprosy programme was conducted as part of dermatology services and not isolated as a separate service, in order to tackle the stigma associated with leprosy. In fact, notes Elamon:

In Kerala, vertical programmes have been implemented effectively through the network of the health care system. The AIDS programme could have been incorporated into this network.

However, there has been little effort to adapt the NACO model to Kerala’s needs and strengths. According to Elamon, over the last 20 years Keralites’ priorities have changed:

Health is no longer on the agenda. No one reacted when a number of people died from dengue. Earlier this would have caused a fracas. The primary health centres have become less used, the public distribution system has declined. The middle class is not affected; those who are affected are scattered, they cannot (or do not) unite and complain.

However, it has been suggested that the state government is unwilling or unable to take control of the AIDS programme and integrate it into the health system. The state’s weak financial position may have put pressure on it to accept funds with conditions attached. As a result, the current approach has no clear priorities such as ensuring access to rational care and preventing stigma and discrimination.

Social, political and legal responses of the system

Given the state’s history of progressive movements, including the advancement in women’s education, it might be surprising that Kerala is referred to as a “conservative society”. However, women’s activists have argued that the majority of educated women have access only to “respectable” occupations such as teaching, clerical work and other service positions. Women’s groups and some social scientists have expressed concern about the status of women in Kerala (Eapen and Kodoth 2002; Ramachandran 1997).

In this conservative society, stigma and discrimination against people with HIV has been extensively documented in the health services, the workplace, education and elsewhere (Maya 2004; *The Hindu* 2004a, 2004b). According to Sadanandan, Kerala has the highest levels of stigma

of any state. Indeed, there are increasing reports of stigma against people with HIV. Some committed suicide because of ostracism. Orphaned children whose parents died of HIV have been refused entry into school. As in many other states, various groups in Kerala have called for mandatory pre-marital testing. The religious leadership has not always acted rationally (*New Indian Express* 2004). The community response to HIV has been uneven. While a few NGOs have participated in education and advocacy, many individuals working in public health have kept their distance from HIV/AIDS-related work.

A study on HIV-related stigma and discrimination notes that though some positive changes have been observed over the years, NACO guidelines are generally disregarded.²⁰ There does not seem to be any coherent political response to HIV. Politicians have taken action on reports of HIV-related stigma and discrimination, but the impression is that they did so for self-promotion and their responses were inadequate. When two AIDS orphans were refused entry to school, the chief minister responded only when the grandparents launched a public protest along with civil society organizations, by offering home schooling at the state's expense (Varma 2003; Raghaviah 2003). Groups conducting HIV advocacy work have met with the chief minister and civil service employees on these and related issues such as the harassment of marginalized groups, but say that it is difficult to judge the effect of these meetings.

In Kerala, once known for strong legislation to protect workers, there is no concerted effort to protect the rights of workers with HIV. However, in 1999, the management of the Tata Tea estate in Munnar developed a workplace policy and programme that banned pre-employment screening, ensured confidentiality, protected the right to work, provided HIV education and medical care for STDs and opportunistic infections. Unfortunately, the programme has since been discontinued. The SMA claims that it funded the programme entirely without any financial support from the company.

Private health services for people with HIV

In unregulated private health services, ignorant and discriminatory practices abound. The study on HIV stigma found that private hospitals routinely test patients without their knowledge, people with HIV are denied treatment or charged extra and, because of the stigma, people with HIV seeking treatment do not disclose their status. Health care institutions do not have written protocols on the treatment or management of people with HIV. Pre- and post-test counselling is still not done in many situations.

"In the initial phase there were a few scandalous instances of denial of care", noted Aravindan, "though this has changed and there is widespread acceptance of AIDS as just another disease". He added that even now

many are forced to forgo treatment or take inadequate treatment due to the financial burden. Others seek alternative medical systems or even quacks, when they cannot afford hospitalisation.

According to Ajith Kumar, a government physician:

I don't know any private hospital in Kerala happy to take patients with HIV, except one private medical college hospital and a private hospital where the doctor is interested in HIV. There are shelters run by NGOs or missionaries but they don't provide treatment. Some gynaecologists do Caesarean sections. A few doctors treat people with HIV for other problems.

Most members of a recently established network of doctors interested in HIV are from the public sector.

²⁰ The Kerala Health Studies and Research Centre along with Deakin University, the Indian Network of Positive People and the Council of People Living with HIV/AIDS in Kerala undertook the HIV/AIDS-related Stigma and Discrimination Study as part of a seven-country study. At the time of writing, the study was being finalized, but the general findings were presented at a meeting in New Delhi in April 2003.

Following a sharp drop in the cost of ARV drugs in India in 2001, pharmaceutical companies aggressively marketed the drugs to specialists and general practitioners. There are many reports of patients being prescribed short courses of ARV drugs, reportedly to deter patients with HIV. At times, the prescriptions are further self-modified by the patients according to their ability to pay for the drugs. "ARV needs labs, protocol, training, continuity which means financial commitment", notes Vadakarera, because "people have taken the drug for a few months, sold land, then eventually stopped treatment".

A survey of 75 people with HIV in Kerala found that 32 per cent had spent between \$1,111 and \$2,222 on treatment for HIV-related illnesses (Thimothy 2003). A little over 5 per cent had spent between \$2,222 and \$4,444. These expenditures did not include associated costs such as travel. Another 24 per cent had used ARV drugs at one time but had stopped, presumably because they could no longer afford them. A further 13.3 per cent were currently on some ARV treatment. Several experimented with "miracle cures". While 65 per cent of respondents paid their direct treatment costs by selling assets, 22.7 per cent depended on savings. Just 9.3 per cent depended on their current income, while 22 per cent lost their homes and 46 per cent their land.

Public health services for people with HIV

Public hospitals are often the only possible source of treatment for HIV-related illnesses. However, patients, researchers, activists and health administrators alike agree that in the current environment of severe shortages, they do not even have drugs for opportunistic infections, which should be provided as part of general health care. Basic equipment is often poorly maintained. Ajith Kumar declares that he must juggle supplies so that his outpatients get the needed drugs, adding, "I manage to get the system to work". As a result, people who need care are often forced into the private sector or to unqualified medical personnel.

Public provision of ARV drugs is essential to improve and extend the lives of people with AIDS, reduce the consequences of irrational private practice and decrease stigma and discrimination. However, this distribution depends on a functioning public health system with effective curative care (Priya 2003).

Since the prices of ARV drugs fell sharply in 2001, there has been a national campaign to supply them through the public health system. In late 2003, the central government's minister of health announced that children with HIV would be entitled to free treatment with ARV drugs (Rashid 2003). Shortly afterwards, the government announced free ARV drugs to people in high-prevalence states (Press Trust of India 2003). In December 2003, the Kerala government announced that it would provide free ARV treatment for anyone in the state who needed it—the first such state government-financed scheme. ARV drugs would initially be supplied through the state medical colleges. KSACS officials expect that between 1,000 and 1,500 people would need the drugs at a cost of approximately \$33 per month per patient.²¹ As of October 2004, the state government's ARV programme had not yet started.²²

The announcement of the national ARV campaign is seen as a populist decision, not part of an overall response to people's health needs. According to an anonymous public health researcher:

HIV gets international exposure. The government should have developed a protocol after identifying the real problems in the public health system. Instead, it has just carved out funds for ARVs from the health department's budget. This was a bureaucrat's decision, which the government accepted because it does not have a policy on health. It wasn't even mentioned as an achievement during the elections.

²¹ However, other estimates conclude that about 10 per cent of people with HIV need ARVs. This would mean that 7,000–10,000 people in Kerala would need the drugs. Assuming that they can be obtained at a discounted price of about \$22 a month, the programme would need to budget between \$155,560 and \$222,220 per month for the drugs alone. The entire budget for the ARV programme is about \$370,000, though the time period for this amount is not clear.

²² Not more than 20,000 people in the country are on the triple-drug regimen of ARVs for AIDS, according to industry estimates at the end of 2004.

Ajith Kumar supports the provision of ARV drugs for everyone who needs them, but through a proper strategy, a treatment protocol and the training of doctors, and with assurance of a regular supply of medication, stating:

How are we going to assure regular supply of medications for lifelong treatment when we are often unable to provide a regular supply of free paracetamol, oral rehydration therapy and many other life-saving drugs in the government health care system? How are we going to monitor prescriptions? How will we monitor the acute and chronic side effects of ARVs? Do we have plans for a cheap second-line therapy for those intolerant and resistant to the first line of drugs?

Elamon asserts that while treating HIV is a priority, it is not the first item on the agenda. Equally important, the public health system will need preparation and modification to provide care. This is not being done.

Ineffective government response

The state AIDS programme is part of an externally funded, vertical intervention at the national level. The character of the state's intervention has been influenced by the decline of public health services, its weak bargaining position with the national government and its growing inability to devise its own response. By following the national model with little modification, the state government's AIDS programme does not seem to have taken advantage of the strengths of the state's extensive health care system. If public services are inadequate, private services are irrational, discriminatory and expensive. Finally, there are no policies implemented that protect the rights of people with HIV.

Conclusion

The Kerala Model, based on public commitment to social services, survived frequent changes of state government and flourished despite the low priority given by the national government to these issues. However, several overlapping trends have combined to create what appears to be a crisis. Some of these pre-date the introduction of structural adjustment, but have accelerated after its implementation in 1991.

Since the 1980s, the state started having difficulties paying for its social support schemes through the revenues it generated. This contributed to the decline of the extensive public health care system, forcing people to turn to the growing and unregulated private health sector. Studies indicate that household expenditure on health care has increased drastically with liberalization, sometimes forcing families into debt. Furthermore, the impact on people has been exacerbated by the destruction of the PDS.

It has been long thought that the PDS and the public health care system are at least partly responsible for the Keralites' good health. Thus, the withdrawal of food subsidies and the deterioration of affordable health care are cause for concern.

Structural adjustment is believed to have affected the livelihoods of various sections of the population, leaving people impoverished and in debt and forced to work in highly exploitative conditions. Their situation is exacerbated by the state government's apparent reluctance to take action against violations of labour laws. Drought has forced many farmers to commit suicide. Such conditions can push women into the sex trade and put them at higher risk of HIV infection. Sharp drops in income for some groups may force them to migrate to other states in search of work, putting them at higher risk of contracting HIV. As significant SAP-related changes have been implemented only since 1998, the impact may take some years to become evident. While official figures show that HIV prevalence has remained at a low level in the state, recent figures suggest a significant increase.

The AIDS programme is independent of the health care infrastructure, with separate funding and the involvement of NGOs for implementation. Yet, many components of the programme will have to be implemented through the public health system. The absence of a proper government response has allowed the private sector to discriminate against people with HIV and to promote irrational and expensive treatments.

India is facing a growing AIDS crisis but, so far, Kerala does not seem to have been as affected as other states. However, if the latest official estimates suggesting that HIV prevalence may be a growing problem in Kerala are correct, the deteriorating support system, further weakened by the consequences of the national SAPs, may be unable to tackle the crisis as it affects the state.

Appendix: The Interview Process and List of Interviewees

The ideas expressed in this paper emerged from a number of interviews with public health specialists, health activists and government officials in Thiruvananthapuram. Most of the interviews were conducted jointly by Sandhya Srinivasan and Mini Sukumar. Some interviews and other inquiries were conducted by Srinivasan or Sukumar independently, either by telephone or email. Most of the interviewees were identified in discussions with B. Ekbal and Joy Elamon of the Kerala Health Studies Research Centre, Thiruvananthapuram. The interviews took place between January and March 2004, and were supplemented by researching selected published material, much of which was suggested by the interviewees to substantiate their points.

The following were interviewed:

- K.N. Harilal, K. Ravi Raman, S. Irudaya Rajan and D. Narayana from the Centre for Development Studies, Thiruvananthapuram
- Michael Tharakan, formerly of the Centre for Development Studies, Thiruvananthapuram
- M. Kunhaman, Department of Economics, Kerala University, Thiruvananthapuram
- V. Raman Kutty and C.R. Soman, Health Action by People, Thiruvananthapuram, a health-oriented non-governmental organization
- K. Thankappan and D. Varatharajan, Achutya Menon Centre for Health Sciences Research, Thiruvananthapuram, a government institution
- A.K. Jayasree and Maithreya, Foundation for Integrated Research in Mental Health, Thiruvananthapuram, an AIDS-oriented non-governmental organization
- M. Prasanna Kumar, former deputy project director, Kerala State AIDS Control Society, Thiruvananthapuram
- K. Ramamurthy, health secretary, Kerala
- E.K. Bharat Bhushan, state health secretary whose portfolio includes the AIDS programme;
- Joy Elamon, Kerala Health Studies Research Centre, Thiruvananthapuram
- Abraham Mathew, project director, State Management Agency
- Ashok Nair, Council of People Living with HIV/AIDS, Kerala
- Elizabeth Vadakarera, THRANI Centre for Crisis Control, Kerala
- K. Aravindan, Kerala Shastra Sahitya Parishad
- Ajith Kumar, government physician
- Rajeev Sadanandan, public health consultant and former health secretary

Note: the affiliations mentioned here are relevant at the time of writing.

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