CHAPTER - 1

INTRODUCTION

1.1: INTRODUCTION

HIV/AIDS is a global phenomenon. It is an epidemic of the modern world that affects the social, health, cultural, social, psychological, economic, religious aspects of a human life. It affects the young, the old and is gender blind. AIDS is a long, often painful and fatal disease that develops in people up to a decade or more after they have been infected by the Human Immuno Deficiency Virus (HIV). AIDS is the last stage of HIV infection. It has got no cure, no effective treatment and no vaccine for its prevention till date. The only vaccine available against AIDS today is education.

HIV stands for Human Immuno Deficiency Virus and it is responsible for causing AIDS- the Acquired Immuno Deficiency Syndrome. The origin of this disease is not known but the first case was identified in America in 1981. It was initially reported among the homosexuals and was therefore labeled the ‘gay plague’. The term AIDS was coined in 1982 and its definition was revised on 1st September, 1987 by the Centre for Disease Control (CDC) “as a disability or life-threatening illness caused by the Human Immuno Deficiency Virus (HIV) characterized by HIV encephalopathy, HIV wasting syndrome or certain disease due to immuno deficiency in a person with laboratory evidences for HIV infection with or without certain other causes of immuno deficiency” (CDC 1987).

AIDS was first recognized as a disease in the 1980’s. Since then it has spread throughout the world. AIDS brings with it a unique social history. It has been identified by the mainstream society as a behaviour-related disease that affects others. Although the disease is no longer restricted to groups that have been traditionally marginalized in this country, the psychological reactions in society stubbornly remain resistant to catching up with reality.

1 Jette Nielson and Bjorn Melgaard on their paper ‘The Economic and Security Dimensions of HIV/AIDS in Asia’
When AIDS first emerged as a disease, few people could predict how the epidemic would evolve and fewer still could describe with any certainty the best ways of combating it. Now in the year 2014, it is known from experience that AIDS can devastate the whole region, knock decades of national development, widen the gulf between the rich and the poor nations and push already-stigmatized groups closer to the margins of society.

According to the World Health Organisation’s 2013 Annual world health report, it is now the leading cause of death in Africa, responsible for one in five deaths. Globally, it is the fourth most common cause of death. However, there is a considerable variation in the pattern of the epidemic spread between countries, within countries and even locally. Consequently, there is also variation in the impact of the resulting illnesses and premature deaths.  

Since the dawn of mankind, no other disease has so menaced civilization as AIDS. The potential for mass destruction has never been as great as in the case of this disease. In no other disease all those affected so potentially capable of transmitting the infection for the duration of their lifetime. Furthermore, most of all those who were infected will probably succumb eventually to the disease of AIDS which will inexorably lead to their death within a few years. Over and above this, the frightful specter of the disease itself is the stigma, discrimination and degradation that are attendant on sufferers from it. It is therefore small wonder that there is no other disease which has been the subject of such misinformation and misunderstanding and which has led to so much of fear, superstition, prejudice and myth as AIDS.

The AIDS epidemic carries with it forces of destruction. It has the power to tear asunder husbands and wives, parents and children, to cause people to turn to one another, to turn away from one another and to perpetuate acts of indignity and inhumanity. It exacerbates poverty and renders the rich poor. The destructiveness of its forces is being felt in affected families and communities as the epidemic unfolds.

Since HIV hits active young adults, it could be described as the killer of the fittest. The population it leaves behind is less able to cope, because it has lost its most productive

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3 World Health Organisations 2013 Annual World Health Report
AIDS is an epidemic of the modern world. From time immemorial, man has been a victim of infectious disorders and diseases. The infecting agents varied from period to period, place to place and society to society. In the past there used to be outbreaks of lethal diseases, assuming great epidemic and pandemic proportions in a limited time and took heavy toll on human life. During the 14th century and afterwards, the plague epidemic took away the lives of millions of people in the world. Scientific achievement and medical advancement checked many of the epidemics and discovered different medicines and vaccines to curtail many of these epidemics. As mankind marched towards a healthier generation, the expectations were met with a serious setback in the form of AIDS.

1.1.1 DEFINITION OF AIDS

In the beginning, AIDS was described as a disease complex in homosexual men. In 1982, the CDC in Atlanta defined a diagnosis of AIDS as “a person with a reliably diagnosed disease that is, at least, moderately indicative of an underlying cellular immune deficiency and one who has no known underlying cause of cellular immune deficiency nor any other cause of reduced resistance reported to be associated with the disease”. John Starke and Rodney Dale defined AIDS as “a disease that results from infection with a virus called Human Immuno-Deficiency Virus (HIV) which spreads from person to person through body fluids”. According to Schoub Barry AIDS is the “end stage disease manifestation of an infection with a virus called the Human Immuno-Deficiency Virus (HIV)”. According to him, the virus infects mainly two systems of the body, the immune system and the central nervous system, and the disease manifestations are principally consequent on damage to these two systems.

The World Health Organisation has produced a clinical case definition for Africa (called the ‘Bangui’ case definition), which is also used in India. According to this, AIDS in an adult is defined by the existence of at least two of the major signs associated with at
least one minor sign in the absence of any known causes of immune-suppression or other recognized etiologies.

1. Major signs
   a) Weight loss of more than 10% of the body weight
   b) Chronic diarrhea persisting for more than one month
   c) Prolonged fever for more than one month

2. Minor signs
   a) Persistent cough for more than one month
   b) Generalized itchy skin lesions (dermatitis)
   c) Recurrent herpes zoster
   d) Oral candidiasis
   e) Chronic herpes simplex
   f) Generalized enlargement of lymph nodes

The recent definition identifies a virus called Human Immuno-Deficiency Virus (HIV) as a cause for AIDS, which weakens and inactivates the T-helper cells in the immune system and directly attacks other essential parts of the body like the central nervous system. In laymen’s language, AIDS is the term used to refer to the physical condition resulting from the infection of HIV.

**Human Immuno-Deficiency Virus (HIV)**

The word virus is derived from the Latin word ‘virus’ meaning poison and also slimy material. It is still defined in most English dictionaries s a malignant or morbid poison. In medical circles the word ‘virus’ often overlaps with the word ‘germ’ in a vague and diffuse way to connote some infectious organisms. The word virus has now taken over by the computer world to denote an infectious corruption of data banks, which is transmissible between computers in epidemic and pandemic fashion.4

**1.1.2: THEORIES ABOUT THE ORIGIN OF HIV/AIDS**

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Given the intense and unique social, political and human implications of AIDS, it is small wonder that questions surrounding the origin of this remarkable virus and its equally remarkable disease have fired the imagination ever since it was recognized is IDS a new or old disease? Did it first arise in Africa or USA? Where did the virus come from? These and other questions have been discussed, debated and argued at great depth in scientific and lay forums alike and still arouse considerable controversy. In reality the answers to these questions will have little relevance to the control or the management of the disease. In fact little is known about the origin of HIV. But the exact origin of AIDS will never be completely elicited. Some of the important views held by different team of scientists are analyzed as under.\(^5\)

a) An international team of scientists, in 1985 had discovered the origin of HIV virus that causes AIDS in human. They suggest that the causative virus, known as HTLV-III may have originated in Africa. Simian retrovirus related to HTLV-III and designated as Simian T Lymphotrophic Virus type III have been isolated from healthy African Green monkeys. Antibodies to STLV-III have also been found in them. It has been postulated that somewhere, sometime this monkey must have bitten or scratched some African in this forest, infecting that person with retrovirus and it is from this virus that HIV, the causative agent of AIDS evolved. The team said that genetic tests show the main human virus, HIV-1, is closely related to a virus that infects chimps but does not make them sick. This would greatly help efforts to prevent and treat the disease in human.

Dr. Beatrice Hahn of the University of Alabama and colleagues made the discovery when analyzing frozen blood and tissue samples from a lab chimp named Marilyn, which died in 1985. Dr. Sarah Nelson-Jones and her team, which published the results in the journal nature, found in Marilyn a ‘grand parent’ virus to the human one. Similar viruses had been seen before in four chimps but the latest research confirmed that only Marilyn’s sub-species, Pan Troglodytes, carried the virus that infects humans.

b) Another group of researchers are of the view that the AIDS virus originated in the laboratories where Polio vaccine were made and tested. The evidence for this theory is

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\(^5\) Thenpillil, Jose (2006) ‘Socio-Cultural dimensions of the HIV/AIDS affected’
given in a research thesis published in ‘rolling stone’. In 1957 there was an outbreak of polio epidemic in “Belgian Kongo” now known as Zaire. Then scientists started research to find out a vaccine. In the Vistar institute of Philadelphia, Dr. Hilari was trying to grow polio virus in the kidney cells of American Green Monkeys. This theory gets more importance after the discovery that American Green Monkeys are carriers of AIDS virus.

If AIDS was originated in the 1950’s why it did not spread soon after that and why the virus which is detrimental to monkeys is fatal to man are some of the the criticism leveled against this theory. Prof. Montagnier gives an explanation for these criticisms. There is evidence that AIDS virus was there in the serum collected from Africa years before. The earliest serum specimen retrieved from archived frozen material, shown to be positive for HIV antibodies, was taken from a patient in 1959 in Kinshasha. Dr. Kawamura and his colleagues gave convincing evidence for this. They reported that over 3000 sera collected from South African countries in 1966-67 were provided by WHO Serum Bank, National institute of Health, Japan. These were screened for HIV-1 and HIV-2. The results suggests that there were at least two cases of HIV-2 infection in the ivory coast in 1966 and two cases each in Nigeria and Gabon in 1967. Positive samples were confirmed by western blot test. No evidence of HIV-1 was found in the sera collected in these countries during this period. This clearly shows that HIV-2 has been present in Western Africa since 1966.

c) Another theory which is yet to be disproved and more likely to be true, is that the virus was confined to and affected only small groups of indigenous populations and with increasing mobility of populations and rapid industrialization, it has spread and became rampant

d) Germ warfare theory: The theory that HIV was produced by the American military as a germ warfare agent is based on a paper published by three German scientist in 1986. This report was taken up by many newspapers and strongly denied by the United States government. This theory has been criticized because the technology for genetic engineering did not exist in the early 1970’s when HIV was thought to have first start spreading. HIV would make a highly unsuitable pathogen for germ warfare, as there would be no means of protecting one’s own people.
A final word however has yet to be said about the origin of HIV. The debate about the origin of AIDS has not been helpful because it created bitterness and diverted attention from the important task of prevention. Kenneth Kaunda, the former President of Zambia, expressed it well when he said “It is not important to know where it came from but rather where it is going”.

1.1.3: EPIDEMIOLOGICAL DETAILS OF THE SPREAD OF HIV/AIDS AROUND THE GLOBE

The epidemiological details about the spread of HIV/AIDS in different countries can be seen below. The severity of the infection in the modern world and how it affects the humanity in general is projected. The extent of the spread of HIV is beyond human imagination especially in the developing countries of the world.

### a. Africa

#### Table1.1: HIV prevalence in selected countries across sub-Saharan Africa in 2012

<table>
<thead>
<tr>
<th>Country</th>
<th>HIV Prevalence (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southern Africa:</td>
<td></td>
</tr>
<tr>
<td>South Africa</td>
<td>17.9</td>
</tr>
<tr>
<td>Botswana</td>
<td>23</td>
</tr>
<tr>
<td>Swaziland</td>
<td>26.5</td>
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<tr>
<td>West Africa:</td>
<td></td>
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<tr>
<td>Senegal</td>
<td>0.5</td>
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<tr>
<td>Cameroon</td>
<td>4.5</td>
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<tr>
<td>Nigeria</td>
<td>3.1</td>
</tr>
<tr>
<td>East Africa:</td>
<td></td>
</tr>
<tr>
<td>Kenya</td>
<td>6.1</td>
</tr>
<tr>
<td>Uganda</td>
<td>7.2</td>
</tr>
<tr>
<td>Tanzania</td>
<td>5.1</td>
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</table>

Source: UNAIDS (2013) 'Global Report 2013'

Sub-Saharan Africa has the most serious HIV and AIDS epidemic in the world. In 2012, roughly 25 million people were living with HIV, accounting for nearly 70 percent of the global total. In the same year, there were an estimated 1.6 million new HIV infections and 1.2 million AIDS-related deaths. As a result, the epidemic has had widespread social and economic
consequences, not only in the health sector but also in education, industry and the wider economy.

b. Southern Africa

Southern Africa is the worst affected region and widely regarded as the 'epicenter' of the global HIV epidemic. In 2012, Swaziland had the highest HIV prevalence rate of any country in the world (26.5 percent). HIV prevalence is also particularly high in Botswana (23 percent). With 6.1 million people living with HIV - a prevalence of 17.9 percent - South Africa has the largest HIV epidemic of any country. The remaining countries in southern Africa have HIV prevalence between 10 and 15 percent.6

Polygynous relationships, as well as multiple partners have been highlighted as key drivers of HIV transmission in these countries. Indeed, the sexual networks of men in particular are quite extensive and are accepted, even encouraged in many communities. Unemployment, labour migration, and displacement as a result of conflict have also contributed to the HIV epidemic in this region.7

c. West Africa

In comparison, West Africa has only been moderately affected by HIV and AIDS. For example, in Senegal, HIV prevalence is as low as 0.5 percent, whereas in Cameroon and Gabon it is an estimated 4.5 and 4 percent respectively. In Nigeria, HIV prevalence is also relatively low (3.1 percent). However, because of its large population (it is the most populous country in sub-Saharan Africa), this equates to around 3.4 million people living with HIV putting it only second behind South Africa in terms of absolute numbers.

In West Africa, the main driver of HIV transmission is sex work, accounting for between 10-32 percent of new infections. In Niger, in 2011, HIV prevalence among sex workers was 36 percent compared to just 0.8 percent for 15-49 year olds in the general

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6 UNAIDS (2013) 'Global Report 2013'
population. Natural disasters have also played a role in the spread of HIV in West Africa as well as other illnesses.\(^8\)

d. East Africa

HIV prevalence in East Africa is generally moderate to high, and second behind southern Africa. However, general prevalence has been in decline for the past two decades. For example, Kenya has seen its HIV prevalence drop from a high of 14 percent to nearly 6 percent. Uganda and Tanzania also have prevalence over 5 percent, with the lowest seen in Madagascar (0.5 percent) and Mauritius (1.2 percent).\(^9\)

Despite this progress, there are new areas of concern with HIV prevalence on the rise among vulnerable groups including people who inject drugs (PWIDs), prisoners and uniformed services (such as the armed forces and the police).\(^10\)

The impact of HIV and AIDS on sub-Saharan Africa

HIV and AIDS have, and are still having, a widespread impact in many parts of sub-Saharan Africa\(^11\).

1. Life expectancy: At the height of the HIV epidemic in sub-Saharan Africa, life expectancy is seen stagnating, even falling in some countries. The rapid scaling up of antiretroviral treatment in recent year, does not do any better and the worst affected countries still have particularly low life expectancies.

2. Households: In the most affected parts of sub-Saharan Africa, the HIV epidemic has had a tremendous impact on households. When the income earners fall too ill to work, they have to be cared for by other household members or extended family. Children can also be removed from school to provide care or to put to work to generate income. In the worst cases, households simply dissolve.

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\(^8\) UNAIDS (2013) 'Global Report 2013'
\(^9\) UNAIDS (2013) 'Global Report 2013'
\(^10\) UNAIDS (2013) 'Global Report 2013'
\(^11\) UNAIDS (2013) 'Global Report 2013'
3. Healthcare: HIV and AIDS is seen putting serious pressure on the health sector, particularly on hospital resources. Moreover, there is a visibility of chronic shortage of healthcare workers, who themselves, are often living with HIV. However, in many parts of sub-Saharan Africa, antiretroviral treatment is relieving this burden.

4. Schools and Education: The epidemic has also impacted heavily on education. School attendance drops as children become sick or return home to look after affected family members. Many lose their parents to HIV and AIDS meaning they can no longer afford to go to school, or are required to work and generate income instead. The epidemic also impacts upon the already limited supply of teachers. However, education is regarded as key to tackling the spread of HIV. Moreover, it is cost-effective.

5. Labour and productivity: HIV and AIDS have had an enormous impact on labour and productivity. The vast majority of people living with HIV in this region are of working age (15-49 years old).

6. Economic development: The combined impact of the epidemic on households, healthcare, education and productivity has stalled, even reversed economic development in parts of sub-Saharan Africa.

**Regional overview of HIV transmission in Asia**

In the early mid-1980s, while other parts of the world were beginning to deal with serious HIV and AIDS epidemics, Asia remained relatively unaffected. By the early 1990s, however, AIDS epidemics had emerged in several Asian countries and by the end of the decade; HIV was spreading rapidly in many areas of the continent.

The diversity of the AIDS epidemic is even greater in Asia than in Africa. The epidemic is also more recent and many Asian countries lack accurate systems for monitoring the spread of HIV. This means that the estimates of HIV infection in Asia are often based on less information than in other regions. The lack of research and information on the nature and linkages between sexual networks in Asian countries also makes it difficult to predict the
future course of the HIV epidemic. Half of the world’s population lives in Asia, so even small
differences in the absolute numbers of people infected can make huge differences in the
infection rates.  

Although it is useful to understand the overall impact that AIDS is having on the
Asian region as a whole, there is no single ‘Asian epidemic’; each country in the region faces a
different situation. Progress has been made in countries such as Cambodia, Myanmar and
Thailand, where there has been a 25 percent decline in HIV prevalence between 2001 and
2011. On the other hand, in Bangladesh, Indonesia, and the Philippines the number of people
living with HIV has increased by more than 25 percent between 2001 and 2011. There are also
huge variations within countries. In China, for example, the six provinces with the highest
HIV prevalence’s account for 75.5 percent of the people living with HIV.  

Asia has had the largest AIDS-related death toll outside of sub-Saharan Africa. Some
have warned that epidemics in Asia could escalate to the extent of rivaling those in some parts
of Africa. Others, however, argue that Asia's epidemics are on a different trajectory to those
found in Africa, as HIV infection in Asia is still largely concentrated among members of 'high-
risk' groups.  

a. South East Asia
i) Cambodia  

Cambodia’s HIV epidemic can be traced back to 1991. After an initial rapid
increase, HIV infection levels declined after the late 1990s and by 2003 HIV prevalence was
estimated at 1.2 percent. As of 2011, HIV prevalence has halved to 0.6 percent. It’s believed
that interventions with sex workers, carried out by the government and non-governmental
organisations (NGOs), played a role in this decline. The adoption of a ‘100 percent condom’
policy that enforced condom use in brothels led to a substantial rise in condom use among sex
workers and their clients and a drop in HIV infection levels among brothel-based sex workers.

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13 UNAIDS (2012) ' Regional Fact Sheet 2012: Asia and the Pacific'
The use of condoms rose from 40 percent in 1997 to 99 percent in 2009; however, HIV prevalence among sex workers is high at 15 percent. UNAIDS estimate that without the prevention efforts, this figure would have been more than 50,000.\textsuperscript{16}

However, ongoing concerns include low levels of condom use among MSM, an increase in sex workers occurring outside of brothels (making it harder to reach sex workers with interventions), and mother-to-child transmission of HIV – around one third of new infections occur through this route. HIV is mostly transmitted through heterosexual sex in Cambodia, and concerns are growing about the number of married women who are infected through their husband. Cambodia also deny HIV testing to people under 18 years of age without parental consent, which has shown to hamper HIV prevention efforts among young people globally.\textsuperscript{17}

### i. Indonesia

Around 380,000 people are living with HIV in Indonesia, which has the fastest growing epidemic in Asia.\textsuperscript{18} This number has risen sharply in recent years and is expected to more than double in 2014 if approaches to HIV prevention are not improved.\textsuperscript{19} This rise is due to several factors including: the country’s extensive sex industry; limited testing and treatment clinics; a highly mobile population; a rapidly growing population of people who inject drugs; the denial of sexual health and reproductive services to unmarried people; and the challenges created by major economic and natural crises (the Asian financial crisis heavily affected the country in 1997, and the 2004 Tsunami devastated parts of Northern Sumatra, the largest island in Indonesia).\textsuperscript{20}

High levels of HIV infection are found amongst high-risk groups, such as injecting drug users, sex workers and their clients and to a lesser extent, men who have sex with men. In 2012, HIV prevalence was reported as high as 36 percent among people who inject drugs. However, local regulations often criminalize high-risk groups and it has been identified that some members of the National AIDS Commission, responsible for tackling HIV/AIDS in

\textsuperscript{16} UNAIDS (2011) ' UNAIDS World AIDS Day Report 2011'  
\textsuperscript{17} UNGASS (2012) ' Cambodia: Global AIDS Response Country Progress Report'  
\textsuperscript{19} Jakarta Globe (2010, 7th October) ' The Thinker: The State of AIDS'  
\textsuperscript{20} UNESCO (2013) ' Young people and the law in Asia and the Pacific'
Indonesia, are failing to address the issue of HIV/AIDS among high-risk groups. Additionally, campaigns to promote condom use among people who engage in high-risk sex have met resistance from some religious groups, who feel that condoms should only be promoted to married couples.

In 2012, the Indonesian government issued compulsory licenses allowing local drug companies to legally bypass drug patents and make their own, cheaper versions for the treatment of HIV and Hepatitis. This development will hopefully increase access to affordable ARV drugs. Currently only 24 percent of people with HIV in Indonesia have access to treatment, with coverage falling even lower among children; the number of children eligible for treatment who are receiving it is estimated to be as low as 11 percent.

**ii. Lao People's Democratic Republic (Laos)**

Despite being surrounded by countries that have relatively high HIV prevalence (Thailand, China, Vietnam, Cambodia and Myanmar), Laos has a comparatively small HIV epidemic, with HIV prevalence of 0.2 percent. There are various reasons for this: the government was quick to acknowledge HIV when it first emerged in the country, and took action to warn people about it; Laos has not seen the same level of large-scale migration that has occurred in other parts of Asia; there are relatively high rates of condom use among sex workers and their clients; and it’s thought that very few people in the country inject drugs. However in recent years there has been an increase of HIV infection among the most vulnerable groups, especially MSM and migrant workers, with the main transmission route being 'unsafe sexual activity'.

**iii. Malaysia**

HIV and AIDS statistics from Malaysia show that an estimated 0.4 percent of the population are living with HIV. Although most people infected with HIV in the country are male, there has been a steep increase in the number of new cases among women. During the late 1990s women made up around 5 percent of new infections, compared to around 21 percent.

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21 Jakarta Globe (2010, 7th October) 'The Thinker: The State of AIDS'
22 PlusNews (2012, 26th July) 'INDONESIA: Condom controversy continues'
23 The Guardian (2012) 'Indonesia in bold move to obtain cheap drugs for HIV'
in 2011. Malaysia, like Indonesia, denies sexual health and reproductive services to unmarried people, perhaps accounting for increasing HIV infections among women.

Malaysia's epidemic is largely driven by injecting drug use, but heterosexual transmission is accounting for an increasing number of new infections. Recent trends have demonstrated a promising decrease in annual HIV infections, from 7,000 in 2002 to 3,479 in 2011. In 2006 the government launched a five-year strategic plan to tackle HIV, which includes drug substitution therapy and needle exchange programmes for drug users, which the government is still committed to in 2013. The Ministry of Health has also developed a training module to teach religious leaders about HIV, which is important in a country where the majority of people are Muslim. In 2011, 5,910 people died from AIDS in Malaysia.26

iv. Myanmar (Burma)

Myanmar is facing a serious epidemic - an estimated 220,000 of the population is infected with HIV. Myanmar’s authoritarian military regime is widely condemned for its human rights abuses, and in 2005 these concerns led the global Fund to fight AIDS, TB & Malaria, to withdraw its proposed $98.4 million grants for the country. Prevention services for injecting drug users are severely lacking with needle exchange programmes operating in just a few locations. Drug users are dealt with heavy-handedly and crackdowns on drug production have led to a scarcity of opium and heroin. This has resulted in drug inhalation being replaced by injecting, as a more cost-effective way of drug consumption, carrying with it a higher risk of HIV transmission. In 2006 methadone substitution therapy was introduced in a small number of government locations. Furthermore, in some cities the HIV prevalence among MSM is extremely high with 23.5 percent of MSM infected with HIV in Yangon and 35 percent infected in Mandalay. However, in 2011 Myanmar implemented a four-year plan to use mass media as a tool for HIV education and reducing discrimination around HIV and AIDS.27

v. The Philippines

An estimated 19,000 people were living with HIV in The Philippines in 2011. The country has traditionally had a very low HIV prevalence, with under 0.1 percent of the population infected. Even in groups such as sex workers and MSM that are typically associated with higher levels of HIV, prevalence rates are only 0.3 and 2 percent respectively. In the case of sex workers, this is possibly due to efforts to screen and treat those selling sex since the early 1990s. However, when looking at The Philippines HIV epidemic as a whole, there has been a 1,490 percent increase in HIV diagnoses between 2005 and 2012. Condom use is not the norm in paid sex, drug users commonly share injecting equipment in some areas leading to HIV prevalence among IDUs being 14 percent, and among Filipino youth there is evidence of complacency about AIDS.

vi. Singapore

Although the number of people living with HIV in Singapore is relatively small, the country’s status as an international travel and business hub, along with the high number of infections found in surrounding countries, make it possible that the country will experience a more serious epidemic in the future. The number of annual new infections has been rising in Singapore. In 2010, a record 441 people were newly diagnosed with HIV, compared to 357 in 2006. The majority of these new infections (54 percent) are diagnosed at a late-stage of HIV infection, by which point HIV treatment should already have started. To combat these rising figures, the government focuses on preventing mother-to-child transmission, but controversially, condom use is only 'emphasized to those at risk'. Another controversial policy in Singapore is the strict law banning sex between men, which undermines efforts to promote safe sex among MSM. This is concerning considering the HIV prevalence among MSM is 3 percent.

vii. Thailand

Thailand is an example of a country where a strong national commitment to tackling the HIV and AIDS epidemic has paid off, with an admirable history of HIV prevention efforts.

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However, some of these past prevention successes are starting to be undermined by a current lack of HIV prevention and rising STD rates. New infections are highest among MSM and women who have become infected by their husbands or sexual partners. Increases in HIV prevalence among MSM is particularly marked in Bangkok, where HIV prevalence among this group has risen from 17.3 percent in 2003 to 31.3 percent in 2009; this is in comparison to the national average of 1.2 percent. An estimated 490,000 people are now living with HIV and AIDS in Thailand.\textsuperscript{30}

\textit{viii. Vietnam}

Around 250,000 people are living with HIV and AIDS in Vietnam. Vietnam's epidemic is still in a concentrated phase; male injecting drug users, female sex workers and men who have sex with men are the groups primarily affected. The number of people living with HIV in Vietnam doubled between 2000 and 2005. This rise included a large increase in the number of people who became infected through injecting drug use.\textsuperscript{31} Despite previous concerns about condom use among sex workers being worryingly low, in 2011 it was reported that 87 percent of sex workers used a condom with their last client. In 2013, a mathematical study was published which predicted an 80 percent decrease in annual HIV infections and great cost-savings, if every person had an annual HIV test, and those who tested positive were offered ARV immediately. The greatest results would be achieved if prevention efforts were targeted at high-risk groups. It is hoped this will encourage HIV prevention services to increase their current scope.

Laws that criminalised sex workers and drug users often cause people that fall under these groups to fear accessing HIV prevention services; in Vietnam, the enforcement of such laws has lead to the incarceration of people in detention centers. Reassuringly, laws that protect the rights of these groups have recently been implemented.\textsuperscript{32}

Adults and children living with HIV in Vietnam still face high levels of stigma and discrimination. One reason for this is that HIV is often strongly associated with immorality. The connection between HIV and ‘social evils’ is exacerbated through the official use of this

\textsuperscript{31} UNAIDS (2008) 'Report on the global AIDS epidemic'
\textsuperscript{32} UNAIDS (2012) 'Alternative action on compulsory detention: Innovative responses in Asia'
type of language, with HIV and AIDS falling under the remit of the Government ‘Department of Social Evils Prevention'. One reported result of this stigma is that people living with HIV remain untreated due to a fear of being seen taking medication, and their status being publicly discovered. In order to dispel myths and misconceptions about HIV life, prevention programmes have been introduced in secondary schools since 2009.\(^3^3\)

b. East Asia

i. China

China’s first AIDS case was reported in Beijing in 1985. Today, an estimated 780,000 people in China are living with HIV and it is feared this number will increase dramatically in future years, as HIV spreads from the groups most at risk to the general population. In 2011 an estimated 28,000 people died from AIDS in China. The six most affected provinces (Yunnan, Guangxi, Henan, Sichuan, Xingiang and Guangdong) represent 75.5 percent of the national reported number of HIV and AIDS cases.\(^3^4\)

ii. Japan

In 2011, around 7,900 adults and children were living with HIV in Japan. Data released by the Japanese government in February 2007 showed that annual numbers of new HIV infections and AIDS cases had risen to an all time high in 2006, to 914 and 390 people respectively. In 2010, this number rose again: there were a total 1,075 new cases of people living with HIV registered that year. MSM are particularly affected as they accounted for 52 percent of annually reported HIV infections in 2010.\(^3^5\)

c. South Asia

i. Afghanistan

Afghanistan is one of the world’s leading producers of opium, and drugs are widely available. The use of opiates, such as heroin and opium, has seen a dramatic increase over the last four years with a 53 percent rise in the number of regular opium users and a 140 percent rise in the number of heroin users in the period 2005 to 2009.\(^3^6\) Further to this, a study of three

\(^3^5\) UNGASS (2012) 'Japan: Global AIDS Response Country Progress Report'
\(^3^6\) UNODC (2009) 'Drug use in Afghanistan: 2009 survey'
major cities in 2009 found HIV prevalence among IDUs had more than doubled since 2006; this is now at 7 percent in 2011. As a result, Afghanistan is now considered to have a concentrated epidemic.

It is estimated that 8 percent of the adult population use drugs, yet only 10 percent of drug users access harm reduction services. Moreover, awareness of the risk of HIV transmission is low among this high risk group, particularly among young IDUs. In 2010, it was reported that 40 percent of IDUs are sharing injecting equipment. Prevalence among the general population is less than 0.1 percent, however, HIV surveillance is minimal. Conditions are in place for a generalised epidemic to develop, including high numbers of displaced people, high levels of illiteracy, low social status of women, and a shortage of health facilities. The epidemic among high risk groups must be curbed to avoid HIV bridging into the wider population.\textsuperscript{37}

\textbf{ii. Bangladesh}

The first HIV/AIDS case in Bangladesh was reported in 1989. Since 1994, HIV infection levels have increased, although the problem is still relatively small scale, with around 7,700 people infected. It is nonetheless predicted that Bangladesh may gradually be heading towards an epidemic, unless a greater response is developed. At the moment HIV is mainly confined to groups such as IDUs, migrant workers and MSM, and it is reported that this focus on risk groups has led to a lack of urgency among policy makers in dealing with the problem. However, in Dhaka, harm reduction programmes have been credited with slowing the spread of HIV among people who inject drugs. HIV prevalence in this population rose from 1.4 percent in 2000 to 7 percent in 2007, but thereafter dropped to 1 percent in 2011, well below the levels observed in areas without prevention programmes.\textsuperscript{38}

\textbf{iii. Nepal}

An estimated 49,000 people are living with HIV and AIDS in Nepal, including 0.3 percent of the adult population.\textsuperscript{39} 4 out of 5 HIV infections are transmitted via unprotected sex, with the

\textsuperscript{38} UNAIDS (2008) 'Report on the global AIDS epidemic'
rest a result of injecting drug use. Seasonal labour migration is an important source of income for many Nepalese, but it is associated with a higher risk of HIV infection and nearly 30 percent of total HIV infections are among male seasonal migrants. Around 4.4 percent of all HIV cases in Nepal are among clients of sex workers and 14.4 percent are MSM. The Nepalese Government have responded to the epidemic despite political instability; in 2009 Prime Minister Madhav Kumar Nepal said the government would increase resources and actions for preventing, treating and controlling the country's epidemic. However, at the end of 2011 the proportion of eligible people receiving antiretroviral therapy was just 24 percent.

iv. Pakistan

Pakistan’s first reported case of HIV occurred in 1987. Until the late 1990s, most subsequent cases occurred in men who had become infected while living or working abroad. The most at risk populations in Pakistan include injecting drug users, sex workers and prisoners. Despite a low adult HIV prevalence (0.1 percent), social and economic conditions in Pakistan – including poverty, low levels of education, and high levels of risk behaviour among IDUs and sex workers – are likely to facilitate the spread of HIV in coming years. HIV prevalence among IDUs has already significantly increased - from 10.8 percent in 2005 to 27.2 percent in 2011. Hijra (transgender) sex workers are also disproportionately affected by HIV/AIDS in Pakistan; HIV prevalence among this group is 5.2 percent.

1.1.4 NATIONAL RESPONSE TO HIV/AIDS

India is painfully realizing the impossibility of achieving the dream of ‘Health for all’ in the foreseeable future. Practically all the governments from the time of independence are guilty of not giving general health, the attention and priority it needs. In the process, public health system has crumbled and is facing prospect of near integration, in certain segments.

The spread of HIV in the country is as diverse as the societal patterns between its different regions, states and metropolitan areas. In fact, India’s epidemics are made up of number of epidemics, and in some places they occur within the same state. The epidemics vary

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from states with mainly heterosexual transmission of HIV, to some states where injecting drug use is the main route of HIV transmission. In the southern states, HIV is primarily spread through heterosexual contact. Infections in the north-east are mainly found amongst injecting drug users (IDUs) and sex workers. Both tracking the epidemic and implementing effective programmes pose a serious challenge to the authorities and communities in India.  

In India, the spread of HIV has been uneven. Although much of India has a low rate of infection, certain places have been more affected than others. HIV epidemics are more severe in the southern half of the country and the far north-east. India has recently seen a broadening of the epidemic across the southern and the western states as well as concentration of HIV among the injecting drug users in the North eastern states. The AIDS epidemic in India consists of a number of local epidemics. Around 70% of India’s population lives in rural areas once thought to be relatively immune to the epidemic. Studies however suggest that HIV has begun to spread in rural areas as well. The epidemic is now moving beyond its initial focus among sex workers and injecting drug users and is shifting towards the general populace; making women and young people the most vulnerable for HIV infection.  

In India, as elsewhere, AIDS is perceived as a disease of ‘others’ – of people living on the margins of society, whose lifestyles are considered ‘perverted’ and ‘sinful’. Discrimination, stigmatization and Denial (DSD) are the expected outcomes of such values, affecting life in families, communities, workplaces, schools and health care settings. Because of HIV/AIDS related DSD, appropriate policies and models of good practice remain underdeveloped. People living with HIV/AIDS continue to be burdened by poor care and inadequate services, whilst those with the power to help do little to make the situation better.  

For India to respond effectively to this infection and limit the social and economic impact of HIV/AIDS, its effort need to be accelerated, intensified and expanded. With HIV prevalence doubling every one to two years in certain groups, there is still a narrow window of opportunity over the next few years to prevent the epidemic from becoming generalized and much harder to control. India’s socio economic status, traditional social ills, cultural myths on sex and sexuality and a huge population of marginalized people make it extremely vulnerable.
to HIV/AIDS epidemic. In fact, the epidemic has become public health problem faced by the country since the independence.

India is experiencing a diverse HIV epidemic that affects states in different ways, and to different extents. India's most affected groups include injecting drug users, sex workers, truck drivers, migrant workers, and men who have sex with men. Some have predicted that India will soon be experiencing a ‘generalised’ epidemic, where the HIV prevalence rate - currently 0.3 percent among adults in India - rises above 1 percent. Others have played down current estimates of the numbers infected, and have argued that, because HIV transmission in India still largely occurs among risk groups, it is unlikely that HIV will spread widely among the general population. Regardless of the future path of India’s epidemic, it is undeniable that AIDS is having a devastating impact, and that there are still many major issues – including stigma and poor availability of AIDS treatment – that urgently need to be addressed.45

When the first case of HIV was discovered in Chennai in 1986, the Indian government responded to the HIV epidemic immediately. Recognizing the seriousness of the situation, the government constituted a high-powered committee under the Ministry of Health and Family Welfare. Subsequently, a National AIDS Control Programme was launched in 1987. The programme activities covered surveillance, screening blood and blood products and health education.46

In 1991, the scope of NACP was expanded to focus on blood safety, prevention among high-risk populations, raising awareness in the general population, and improving surveillance. A semi-autonomous body, the National AIDS Control Organization (NACO), was established under the Ministry of Health and Family Welfare to implement this program. This “first phase” of the National AIDS Control Program lasted from 1992 -1999.47 It focused on initiating a national commitment, increasing awareness and addressing blood safety. It achieved some of its objectives, notably increased awareness. Professional blood donations were banned by law. Screening of donated blood became almost universal by the end of this phase. However, performance across states remained variable. By 1999, the program had also

45 UNAIDS (2010) 'UNAIDS report on the global AIDS epidemic'
46 Thenpillil, Jose (2006) ‘Socio-Cultural dimensions of the HIV/AIDS affected’
established a decentralized mechanism to facilitate effective state-level responses, although substantial variation continued to exist in the level of commitment and capacity among states. Whereas states such as Tamil Nadu, Andhra Pradesh, and Manipur demonstrated a strong response and high level of political commitment, many other states, such as Bihar and Uttar Pradesh, have yet to reach these levels.

The second phase of the NACP began in 1999 and ended in March 2006. Under this phase, India continued to expand the program at the state level. Greater emphasis was placed on targeted interventions for the most at risk populations, preventive interventions among the general population, and involvement of NGOs and other sectors and line departments, such as education, transport and police. Capacity and accountability at the state level continues to be a major issue and has required sustained support. Interventions need to be scaled up to cover a higher percentage of the population, and monitoring and evaluation need further strengthening. In order to induce a sense of urgency, the classification of states has focused on the vulnerability of states, with states being classified as high and moderate prevalence (on the basis of HIV prevalence among high risk and general population groups) and high and moderate vulnerability (on the basis of demographic characteristics of the population).

While the government’s response has been scaled up markedly over the last decade, major challenges remain in raising the overall effectiveness of state-level programs, expanding the participation of other sectors, and increasing safe behavior and reducing stigma associated with HIV-positive people among the population.

The Third Phase of NACP (NACP 3) program has dramatically scaling up targeted interventions in order to achieve a very high coverage of the most at risk groups. Under this phase, surveillance and strategic information management also receive a big boost. Partnerships with civil society organizations was at paramount in the implementation of the programme with special focus on involvement of community in the program planning and implementation.

On completion of NACP III, government of India has realized their strengthens and with the help of development partners and donor agencies, NACO has conducted consultations [they had a series of consultative workshops] with all the stakeholders including the
representatives from civil societies, community representatives, non-health departments and experts from public health and designed the program activities for NACP IV. The focus of this phase will be primarily on scaling up prevention through NGOs and sustaining the efforts and results gained in last 3 phases and integration with the health systems response to the epidemic e.g. through provision of ART, STI services, and treatment of opportunistic infections through the National Rural Health Mission. The focus of the World Bank support to the NACP IV is to further scale up and reach out with targeted prevention interventions to the most at risk population groups to contribute to the reduction in new infections.\(^{48}\)

There are numerous Non-Governmental and Community Based Organizations (NGOs & CBOs) working on HIV/AIDS issues in India at the local, state, and national levels. Projects include targeted interventions with key populations; direct care of people living with HIV; general awareness campaigns; and care for children orphaned by AIDS. Funding for non-government and community-based groups comes from a variety of sources: the federal or state governments of India, international donors, and local contributions. Several CBOs have also piloted innovative approaches to tackling the stigma and discrimination that hinders access to effective HIV prevention, treatment and care services among populations most at risk.

India receives technical assistance and funding from a variety of UN partners and bilateral donors. DFID and the World Bank are pooling partners with NACO in the financing of NACP 3. The Bill and Melinda Gates Foundation’s Avahan program, Clinton Health Access Initiative, DFID, GFATM, UNAIDS, UNFPA, UNICEF, UNDP and WHO.\(^{49}\)

There is still a general lack of awareness about many things that affect people’s lives. The people are as unaware of HIV/AIDS as they are of preventable diseases like malaria, tuberculosis and waterborne diseases. It is therefore, no wonder that HIV/AIDS is now regarded as just another disease. The fact that other diseases are curable and AIDS is not does not seem to matter much as long as one is not directly affected. The moment the HIV positive status is known, there is an inevitable panic reaction. Slowly but steadily the problem of AIDS is coming into the open as the biggest challenge to the ‘Health for all’ concept. The demands emanate from two fronts: the need for effective prevention methods and the urgency to sustain

the health promotion process. The advent of the HIV infection has created priorities for those working in the health promotion, health education and social welfare. And the physical aspects of AIDS and HIV are part of many people’s lives. The broader social dimensions affect the human race.

Inequalities of wealth and power in society, which are largely the result of rapid industrialization that is not people centered, render a substantial number of the population inaccessible to basic resources and incapable of making the right choices to lead a satisfactory life.

High levels of male dominated rural to urban migration and also international migration for better economic remuneration not only disrupts family life but can also create a demand for sexual services in the places where the man lives.

Lack of proper housing, absence of spousal company in the case of married, stress of urban living and freedom from parental or social control motivate many single migrant men to seek paid sex or to share partners. On their annual trips to home these men are likely to put their partners at risk from infection. Mobile populations like those of truck drivers, army personnel and those in touring jobs are also under increased threat of HIV infection as their sexual encounters with strangers are likely to be high.

Demographic changes in recent times towards a younger population are also a critical factor in enhancing the risk of HIV infection in India. This trend coupled with delaying marriages, implies that a larger proportion of the population will engage in sexual activities mostly unsafe and unprotected and therefore at risk from HIV infection.

Several other aspects of the socio-cultural life of India are likely to be significant in understanding the impact of HIV/AIDS, particularly the implication for women. It is now generally acknowledged that women are vulnerable to HIV/AIDS and yet are often powerless to ensure needed behaviour change for protection against this infection. Women’s health needs are generally neglected in India and few women have access to health care services. Therefore, there is a strong likelihood that prevalence of HIV and AIDS among women in India is under-recognized and under-reported.
A single AIDS related illness or death can devastate an entire household through the loss of family income, the strain caused by prohibitive medical costs, or the stigma attached to families affected by HIV. In some cases, surviving family members have been abandoned, abused or attacked, while struggling to cope with their own HIV related illness. As the number of individuals and households affected by HIV multiplies, the social impact of the epidemic both widens and deepens. The social support systems and traditional methods help face unprecedented challenges.

1.1.5 STATEMENT OF THE PROBLEM

Taking the above discussion into account, it can be said that HIV/AIDS epidemic is a complex and multidimensional phenomenon that has become a major health and social problem in the under developed and developing countries. The epidemic emerged in the early 1980’s creating unprecedented challenges to human society in various dimensions of human life. Today, the HIV continues to spread across the globe irrespective of its geographical expanse causing huge increase in mortality and morbidity among children and adults along with severe consequences socially and economically at the most.

All over the world, HIV/AIDS is causing devastation destroying communities and families and taking away hope for the future. The impacts of HIV/AIDS are numerous. In the absence of a cure, and in most cases in the absence of adequate treatment, HIV/AIDS diminishes or destroys quality of life before it takes away life itself. Its psychological, social and economic impact on life quality affects family, friends and community. It affects production as well as household incomes and expenditures; it poses major problem for health system and care practices; it diminishes the capacity of societies’ to provide essential services and plan for the future; and it threatens good governance and human security.

HIV/AIDS is having a dramatic effect on the lives of the individuals, families and communities. The daily threat of stigmatization and discrimination is on rise. HIV/AIDS has become one of the dominant social problems in contemporary society. It has acted as a spotlight exposing many iniquitous conditions in society. It has infected millions of people all over the world and affected not only the individuals dependent upon them but societies and
nations at large. No other epidemic has caused such damage to productive economic and social assets of countries and neutralized the fruits of decades of economic and social advancement.

The HIV/AIDS problem itself has become a vast and complete phenomenon in the world today. The present society is fragmented and has affected the system from its normal functioning. HIV/AIDS is yelling at society where physical, social, ethical, legal, economic, psychological and spiritual life is degrading day by day. It also reveals the tragic consequences of personal actions that endanger others.

There has been an alarming annual rise of new HIV cases in the North Eastern states from 5549 (new cases) in 2001 to 6460 (new cases) in 2011. The total number of HIV infected persons in the whole North East region is 63,049 cases with Manipur leading the list with 25369 cases and Sikkim recording the lowest with just 593 cases. This is just a contrast to the national trend where the overall decline rate in India is 57% recorded from 2001 to 2011.50

Nagaland, like any other North-Eastern State is in turmoil socially with a host of social problems cropping up. The emerging dominant social problem is the prevalence of HIV/AIDS in Nagaland.

According to Sentinel Surveillance Report 2014, Nagaland is the sixth state with highest prevalence of HIV/AIDS in the country with an alarming ratio of 0.88%. Country’s figure stands comparatively lower at 0.37%. 51 HIV/AIDS epidemic is a complex and multidimensional phenomenon that has become a major health and social problem in the under developed and developing countries. The epidemic emerged in the early 1980’s creating unprecedented challenges to human society in various dimensions of human life.52 Today, HIV continues to spread across the globe irrespective of its geographical expanse causing huge increase in mortality and morbidity among children and adults along with severe consequences socially and economically at the most.

The first HIV case in Nagaland was detected in the year 1990 by ICMR among the IDUs. It has now been 24 years since the first case was detected. According to the Strategic

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50 Newmai News Network, June 3 2014 ‘North East AIDS cases show alarming trend’
51 Sentinel Surveillance Report 2014, Nagaland State AIDS Control Society
52 Thenpillil, Jose (2006) ‘Socio-Cultural dimensions of the HIV/AIDS affected’
Information Management System (SIMS), there are 693 children infected with HIV in Nagaland and about 100 children orphaned by HIV/AIDS.

This phenomenon of high HIV prevalence in Nagaland state cannot be explained by mono-casual explanation but it should be seen within the framework of social, political, economic and cultural context of the state. One of the basic reasons is easy access to drug because of drug trafficking across the international border with Myanmar and the economic interest that lies there. The supply and the demand factor of drug i.e heroin when associated with other factors gave rise to high prevalence of Injecting Drug Users (IDUs) in late 1980s and 1990s. The increased unemployment along with the changing lifestyle of the youth also exaggerates the HIV/AIDS epidemic in the state. Out of frustration, family problems, pleasure seeking, IDU as a fashion and the lack of societal control, intravenous drug use emerged as a refuge for the restless youth. Many youngsters in the state start to indulge in drug abuse, gradually changing their lifestyles. Along with this, lack of political will and social unrest lead to increase in the prevalence of IDU. In the present scenario, it is observed that the spread of HIV infection is expanding beyond the IDU to the general population. Even though there are no red light areas in the state, the phenomenon of female sex workers or commercial sex workers has increased.

The problem of the HIV/AIDS pandemic is something that cannot be neglected, as the epidemic poses a challenge for the health of society. As the infection diffuses, the epidemic continues to affect the community, family and individual in different dimensions. The first wave of impact emerged on the infected persons and their families, partners and those who take care of them. It includes the trauma of diagnosis, community reaction (acceptance, stigma and discrimination), economic and emotional impact on their families, reaction of health care workers, illness and death.

HIV is affecting the families, the youth, the children, women and the entire society. People with HIV/AIDS face stigmatization and discrimination, which fuels the epidemic. HIV is a security threat because it threatens the economic, human, societal and even the traditional notions of security. It has become an alarming situation in Naga society. Naga society, which used to be confined and bound by traditional norms and values, has now been attacked by this
pandemic affecting the families, youths, gender-equality and the entire society needing proper attention.

In spite of the high prevalence rate of HIV/AIDS in the state, no intensive and systematic research studies have been carried out to monitor or assess the prevalence/incidence rate in the state. For the reasons stated above, we were convinced to undertake this given topic to study the magnitude of HIV/AIDS and its impact on Naga Society. As per the response of the respondents, the transmissibility of HIV is the greatest through the sexual route followed by the Intravenous drug use as the second most powerful route of HIV as stated in Table 3.1 in Chapter 3.

1.2: METHODOLOGICAL FRAMEWORK

The primary aim of this research is an effort to understand and explore the various aspects of HIV/AIDS in a long term perspective in the state considering characteristic such as household information, individual and family problems, disease history and health services utilization, rehabilitation and welfare measures. This involved an exhaustive study of the demographic characteristics and the details of the pandemic handled by the respondents i.e. both the affected and the general populace. Secondly, the identification of its impact was done by detecting the factors through field survey and comparing them across the various districts and the neighbouring states.

Keeping this in mind, the fundamental objectives of the study are:-

a) To identify and examine the factors and causes leading to the rapid rise of HIV/AIDS in Nagaland.

b) To study the impact of HIV/AIDS on Naga society

c) To examine the level of awareness and understanding about HIV/AIDS among the people in Nagaland and the initiatives taken by the government and NGOs

d) To create awareness education and suggest remedial measures towards controlling HIV/AIDS.
1.2.1: Scope/Significance of the Study

This research study on the magnitude of HIV/AIDS and its impact on Naga society is the first of its kind in Nagaland from sociological point of view. It aims at generating awareness about the pandemic of HIV/AIDS among cross-sections of people. The finding of the present study would serve as a valuable input for the church, government, NGO’s, students and the society as a whole. It is also significant because it is directly related to the present scenario of Naga society where it will serve as a benefit to the PLHA’s (People living with HIV/AIDS), the community, the family and the society. It is also an enrichment of literature in such fields and an indication of avenues for future research by the scholars.

1.2.2: Research Hypothesis

a) Poverty leads to prostitution resulting in HIV/AIDS.

b) Low level education and awareness are related to the spread of HIV/AIDS.

c) The progression of human society will be hindered if the rapid rise in HIV is allowed to continue unchecked.

1.2.3: Research Design

The exploratory and descriptive research design was adopted due to the nature of the study. Exploratory research provides insights into and comprehension of an issue or situation. Exploratory research is a type of research conducted because a problem has not been clearly defined. Exploratory research helps to determine the best research design, data collection method and selection of subjects. While descriptive research, also known as statistical research, describes data and characteristics about the population or phenomenon being studied. Descriptive research answers the questions who, what, where, when and how. Thus, on the basis of the above, the two research designs were appropriate for the present study as it was important to gauge the various causes that give rise to the pandemic and which eventually impacts the society as a whole.

The research study was based on stratified random sampling method. The study aimed at different categories of people from different walks of life. The study covers the entire state of Nagaland consisting of eleven districts viz. Dimapur, Kohima, Mokokchung, Wokha,
Phek, Mon, Longleng, Tuensang, Kiphire, Phek and Zunheboto. For this purpose, 400 respondents were selected randomly from every district as stated in Table 5.1 in Chapter 5. Some of the respondents were very helpful while some were made to understand the sole purpose of the research and assure them that the data so provided will be used for academic research only. Information was also gathered through e-mails and telephonic conversation in order to substantiate the data gathered.

### Table 1.2: Sample frame

<table>
<thead>
<tr>
<th>Samples</th>
<th>No.</th>
<th>Justification (What they represent )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infected (PLHA)</td>
<td>100</td>
<td>They are the core group of this research study. To study the impact of HIV/AIDS</td>
</tr>
<tr>
<td>General population</td>
<td>100</td>
<td>To assess the people’s response, opinion, knowledge, awareness, attitude and community participation</td>
</tr>
<tr>
<td>Jails</td>
<td>11</td>
<td>To analyze the services provided and their approach</td>
</tr>
<tr>
<td>Non -governmental organization</td>
<td>40</td>
<td>To estimate the organizations programme planning, delivery, implementation, monitoring, evaluation, achievements and expectations</td>
</tr>
<tr>
<td>Nagaland State AIDS Control Society</td>
<td>09</td>
<td>To evaluate the departmental initiatives</td>
</tr>
<tr>
<td>Religious organization</td>
<td>50</td>
<td>To review the knowledge, awareness, initiatives and the approach towards the pandemic</td>
</tr>
<tr>
<td>Doctors and medical staff (Hospital)</td>
<td>40</td>
<td>To review their approach as care givers</td>
</tr>
<tr>
<td>Administrators and Law enforcing agencies</td>
<td>50</td>
<td>To assess their initiatives, awareness and approach</td>
</tr>
<tr>
<td>Total Respondents</td>
<td>400</td>
<td></td>
</tr>
</tbody>
</table>

Table 1.2 shows the number of samples followed by justification of why they were incorporated in this research study. The respondents covers the young and the old, infected and
affected individuals and families, households, male and female, pastors, youth directors, police, Hindu Priest, Muslim, doctors, nurses, counselors, administrative officers and employees, NGO functionaries and employees, jailors, commercial sex workers etc. This study has tried to cover all the people from different segments of society in order to get as much as information related to the pandemic and its implications on the individual, the society and the community as a whole. The 400 respondents are the base of this research study and all their views and opinions are taken into consideration.

Due to the sensitivity of the issue of HIV/AIDS, the respondents were divided into two categories out of which 100 are PLWHAs (People Living with HIV/AIDS) and the remaining 300 respondents are the representative from schools and colleges, Religious organizations, Administration; Non Governmental Organization, Jails, Hospitals etc as stated in Table 5.1.

**Strategy of Data Collection**

Stage 1: Construction and finalization of questionnaires

On the basis of the data’s collected from primary and secondary sources, several sets of questionnaires were constructed. Seeing the need of different set of questionnaires for different set of respondents, thorough extensive reviewing and testing of some questionnaires, the final sets of 9 (Nine) questionnaires were constructed as follows for data collection.

Set I : Questionnaire schedules for jails

This questionnaire consists of two parts comprising of 16 questions.

Set II : Questionnaire schedules for hospital/ medical practitioners

This questionnaire consists of two parts comprising of 13 questions.

Set III : Questionnaire schedules for law enforcing agencies/police personnel

This questionnaire consists of one part comprising of 17 questions.
Set IV : Questionnaire schedules for employees of Non Governmental Organizations/Care Centres. This questionnaire consists of two parts comprising of 18 questions.

Set V : Questionnaire schedules for PLHA

This questionnaire consists of two parts comprising of 16 questions.

Set VI : Questionnaire schedules for Religious Organization/churches

This questionnaire consists of two parts comprising of 13 questions.

Set VII : Questionnaire schedules for employees of NSACS (Nagaland State AIDS Control Society). This questionnaire consists of two parts comprising of 18 Questions.

Set VIII : Questionnaire Schedules for Legislators Forum on AIDS/ Directorate of Women Development/ Women Commission for Nagaland State / Family Planning Association of India: This questionnaire consists of two parts comprising of 18 questions.

Set IX : Questionnaire schedules for Non affected and infected population

This questionnaire consists of two parts comprising of 28 questions.

In order to cover up the study, two interview schedules have also been applied such as:-

1. Interview schedules for NGOs Chief Functionaries

2. Interview schedules for NSACS (Nagaland State AIDS Control Society)officials

A total of 400 questionnaires were printed and a sample copy of each set/category is attached in the appendix.

It is to be mentioned here that because of the vastness of the study area and the complexity of the subject itself, the field work could be completed only in two years i.e from 2009-2011. The researcher visited both the urban and rural areas of Nagaland in order to get access to the problem in every nook and corner of the state.
Stage II: Collection of Primary and Secondary data

Primary data was collected through interviews, group discussions as well as questionnaires schedules. Intensive field studies, participant observation and interaction with the cross section of people supplemented to the analysis by providing more primary data. For this purpose, information and data were collected from 400 respondents comprising of the PLWHA (People Living with HIV/AIDS), caretakers from different hospitals and care centers of Nagaland, jails, administrators and law enforcing agencies, NGOs working in the relevant field as well as members from different religious organizations were investigated. Members from various departments and organizations like the NSACS (Nagaland State AIDS Control Society), Directorate of Women Resource Development, FPAI (Family Planning Association of India), Nagaland Commission of Women, Legislature Forum on AIDS etc were interviewed as well.

Through the doctors, nurses, social workers, students, unemployed, drop outs, government officials, journalists, People Living With HIV/AIDS (PLWHA), police, church leaders, youths, lawyers, farmer, housewives etc. information on the prevalence of the HIV/AIDS and its statistics, services, awareness level and other necessary facts first hand information were ascertained. During the process some of the respondents were very helpful while some were made to understand the sole purpose of the research and assure them that the data so provided will be used for academic research only. Information was also gathered through e-mails and telephonic conversation in order to substantiate the data gathered.

Secondary data was drawn from the journals, books, magazines, newspapers, biographies, memoirs, reports, official documents, and relevant publication, websites etc. Three case studies were conducted in this research study which is elaborated in the chapters.

1.2.4: Instrumentation

For effective and flawless data collection, survey method and case study methods were extensively used. Survey method was also extensively used for data collection. Considering the interviews as an appropriate method to use when exploring practitioners perspectives due to the qualitative nature of the information, it has been extensively used. Case study methods are used for an in-depth investigation of a single individual, group, or an event.
It provides a systematic way of looking at events, collecting data, analyzing information, and reporting the results. Three case studies have been included in this study. Thus, these methods have been widely used to extract the most relevant information and help in better analysis of the data. Questionnaire and interview schedules were also implemented extensively in the process.

1.2.5: Data Analysis Procedure

Coding of variables, cross checking, transferring of data marked the procedural aspects of the data Analysis, keeping in mind that coding of variables in quantitative research is very critical for better interpretation of results. Age, total experience, designation, team size, total duration and total value of the research work were all coded and were entered into the computer. The questions and responses were coded and entered in the computer using Microsoft Excel software. Manual tabulation method was applied on the data to get the results analyzed. The data collected from various sources was systematically processed, classified, and computed, results of which are presented in subsequent chapters.
1.3: AREA OF STUDY

Profile of the study area

Nagaland became the 16th state of the Indian Union on 1 December 1963. Nagaland is situated on the easternmost region of India. Nagaland is originally a tribal state covering an area of 16,579 sq.km approximately. It is one of the North Eastern states of India, sharing an international boundary with Myanmar on its extreme South west. The state lies between 25.6°N and 27.4°N latitudes and between 95.20°E and 95.15°E longitudes. Nagaland is bounded by the states of Assam in the west, Myanmar (Burma) in the east, Arunachal Pradesh and parts of Assam in the north and Manipur in the south. The state is mostly mountainous except those
areas bordering Assam valley. Mount Saramati is the highest peak with a height of 3,840 metres and its range forms a natural barrier between Nagaland and Burma.

Geopolitically, Nagaland is a sensitive state as China lies close to it in the north, Bangladesh on the west with Myanmar alongside, Thailand on the east where the valley of Bangladesh, Myanmar and Thailand merge together forming a common valley known as the ‘Golden Triangle’ which is located close on the heels of Nagaland. This valley serves as a central meeting point for these three nations with their respective smuggled goods of all kinds of merchandise.

As per details from Census 2011, Nagaland has a population of 19,80,602, out of which 10,25, 707 are male and 9,54, 895 are female as on March 1, 2011 according to the Provisional Population Totals of Nagaland for Census 2011. Its population is widely diversified and has 16 tribes living in the state.

Figure 1.1: Population of Nagaland

The gender ratio in Nagaland’s population however is the least as compared to other North eastern states. The sex ratio is greater in the rural population as compared to urban. Literacy in Nagaland has undergone an extremely positive improvement in the last decade. The literacy rate in Nagaland stands at 80.11 %which is higher than the National average of 70.04%. There is a marked improvement from 66.59% in 2001 and 61.65% in 1991. In 2011,
the total literate population rose from 1,132,323 in 2001 to 1,357,579 in 2011. The literacy rate of total urban population is 90.21% with urban male and urban female literacy rate of 92.11% and 88.10% respectively.

Table 1.3: District wise population and literacy rate of Nagaland

<table>
<thead>
<tr>
<th>District</th>
<th>Population</th>
<th>Literacy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dimapur</td>
<td>379769</td>
<td>85.44%</td>
</tr>
<tr>
<td>Kiphire</td>
<td>74033</td>
<td>71.1%</td>
</tr>
<tr>
<td>Kohima</td>
<td>270063</td>
<td>85.58%</td>
</tr>
<tr>
<td>Longleng</td>
<td>50593</td>
<td>73.1%</td>
</tr>
<tr>
<td>Mokokchung</td>
<td>193171</td>
<td>92.68%</td>
</tr>
<tr>
<td>Mon</td>
<td>250671</td>
<td>56.6%</td>
</tr>
<tr>
<td>Peren</td>
<td>94954</td>
<td>79.00%</td>
</tr>
<tr>
<td>Phek</td>
<td>163294</td>
<td>79.13%</td>
</tr>
<tr>
<td>Tuensang</td>
<td>196801</td>
<td>73.7%</td>
</tr>
<tr>
<td>Wokha</td>
<td>166239</td>
<td>87.6%</td>
</tr>
<tr>
<td>Zunheboto</td>
<td>141014</td>
<td>86.26%</td>
</tr>
</tbody>
</table>

Source: www.census2011.co.in/census/state/nagaland.html

Mokokchung district has the highest literacy rate of 92.68 followed by Wokha with a percentage of 87.6%. Out of the total population of Nagaland, 28.86% people live in urban regions. The total figure of population living in urban areas is 570,966 of which 299,177 are males and while remaining 271,789 are females. The urban population in the last 10 years has increased by 28.86%. Nagaland has 11 administrative districts. The state has only one airport in its biggest city Dimapur. The state capital of Nagaland is Kohima. It is one of the few states in India to have English as its official language. Due to its variation in its culture, about 20 languages are spoken in the state, Nagamese being the widely used one.

The present study on the magnitude of HIV/AIDS and its impact is concentrated on the entire state of Nagaland which has 11 administrative districts viz, Kohima, Dimapur, 53 Census of India 2011, Provisional Population Totals Paper 2, Volume II of 2011- Rural Urban Distribution, Nagaland Series 14
Mokokchung, Tuensang, Wokha, Zunheboto, Phek, Kiphire, Mon, Longleng and Peren. According to the latest Technical Report, India HIV estimates from NACO, Nagaland is at 0.88% prevalence rate much higher than the national prevalence rate at 0.37%. The highest prevalent state at ANC sites in the country with an estimated HIV prevalence rate of 0.88. Dimapur, the gateway to Nagaland records the highest number of HIV prevalence rate in the state followed by Tuensang and Kohima.

Table 1.4: HIV test undertaken among general clients attending ICTC centres

<table>
<thead>
<tr>
<th>District</th>
<th>Number of clients receiving pre-test counseling/information</th>
<th>Number of clients tested for HIV</th>
<th>Number of clients testing HIV positive (after 3 specified tests)</th>
<th>Number of clients receiving post-test counseling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dimapur</td>
<td>7181</td>
<td>7178</td>
<td>453</td>
<td>7175</td>
</tr>
<tr>
<td>Kiphire</td>
<td>1047</td>
<td>1047</td>
<td>25</td>
<td>1047</td>
</tr>
<tr>
<td>Kohima</td>
<td>5433</td>
<td>5399</td>
<td>137</td>
<td>5399</td>
</tr>
<tr>
<td>Longleng</td>
<td>919</td>
<td>919</td>
<td>6</td>
<td>919</td>
</tr>
<tr>
<td>Mokokchung</td>
<td>7390</td>
<td>7387</td>
<td>40</td>
<td>7380</td>
</tr>
<tr>
<td>Mon</td>
<td>3772</td>
<td>3772</td>
<td>7</td>
<td>3772</td>
</tr>
<tr>
<td>Peren</td>
<td>2174</td>
<td>2174</td>
<td>12</td>
<td>2174</td>
</tr>
<tr>
<td>Phek</td>
<td>1537</td>
<td>1536</td>
<td>10</td>
<td>1536</td>
</tr>
<tr>
<td>Tuensang</td>
<td>4499</td>
<td>4475</td>
<td>97</td>
<td>4480</td>
</tr>
<tr>
<td>Wokha</td>
<td>2642</td>
<td>2642</td>
<td>11</td>
<td>2642</td>
</tr>
<tr>
<td>Zunheboto</td>
<td>2281</td>
<td>2281</td>
<td>10</td>
<td>2281</td>
</tr>
<tr>
<td>Nagaland</td>
<td>38875</td>
<td>38810</td>
<td>808</td>
<td>38805</td>
</tr>
</tbody>
</table>

Source: NSACS 2014

Table 1.4 shows the total number of people (excluding pregnant women) undergoing HIV testing in the state from April 2013 to September 2013 is 38810 out of which 808 were detected with HIV after 3 specified tests. The highest number of ICTC attendees is in Mokokchung, where a total of 7390 clients attended the ICTCs and 7387 clients underwent HIV testing. Comparing the number of testing done in Dimapur and Mokokchung, the number of clients found positive is alarmingly high in Dimapur. The lowest number of testing done is

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recorded in Longleng with just 919 clients attending the 3 ICTCs situated in Longleng district, PHC Tamlu and PHC Yongyah.

Out of the 38810 client who were tested for HIV, 23551 were males and 15259 females. The number of positivity is higher in females with 2.61% as compared to the male positivity rate of 1.74%. The overall data showing the ICTC status and the AIDS cases and related deaths in Nagaland so far are projected below:-

Table 1.5: ICTC Status

<table>
<thead>
<tr>
<th>Particulars</th>
<th>2014-15</th>
<th>Cumulative since 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>G.Clients</td>
<td>ANC</td>
</tr>
<tr>
<td>Blood screened</td>
<td>13336</td>
<td>3197</td>
</tr>
<tr>
<td>HIV positive</td>
<td>294</td>
<td>36</td>
</tr>
</tbody>
</table>

Source: NSACS 2014

Table 1.6: HIV status of Children in Nagaland

<table>
<thead>
<tr>
<th>Particulars</th>
<th>2014-15</th>
<th>Cumulative since 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Blood screened</td>
<td>198</td>
<td>215</td>
</tr>
<tr>
<td>HIV positive</td>
<td>7</td>
<td>9</td>
</tr>
</tbody>
</table>

Source: NSACS 2014

Table 1.7: AIDS Case Surveillance – Since 1994

<table>
<thead>
<tr>
<th>AIDS case reported</th>
<th>2014-15</th>
<th>Cumulative</th>
<th>AIDS related deaths</th>
<th>2014-15</th>
<th>Cumulative</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Adult</td>
<td>Male</td>
<td>Female</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>68</td>
<td>2974</td>
<td>9</td>
<td>406</td>
<td>Female</td>
</tr>
<tr>
<td>Female</td>
<td>69</td>
<td>2545</td>
<td>Children</td>
<td>1</td>
<td>34</td>
</tr>
<tr>
<td>Total</td>
<td>137</td>
<td>5519</td>
<td>Total</td>
<td>19</td>
<td>777</td>
</tr>
</tbody>
</table>

Source: NSACS 2014

Figure 1.2 below shows the prevalence of HIV/AIDS in different districts of Nagaland with Dimapur making the lead followed by Kohima and Tuensang. The rate of positivity is the highest in Dimapur with 453 followed by Kohima, Kiphire and Tuensang at 25, 137 and 97 respectively. The high rate of positivity in Kiphire is because though the number of clients

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undergoing HIV testing is low at 1047 clients, 25 were found to be HIV positive. Comparing to this, the other districts like Phek, Peren, Wokha and Zunheboto where the clients tested are more than Kiphire but positivity is lower than Kiphire. If we look at the HIV positive detected then Dimapur records the highest number with 453, followed by Kohima at 137 and Tuensang at 97.

Figure 1.2: District wise trend of HIV positivity among general clients

In the first half of 2014, the HIV/AIDS scenario in Nagaland still shows new detection every month at an average of 130-140 cases even after numerous awareness and sensitization programs organized and supported by State AIDS Control Society and various other organizations. The issue of stigma and discrimination remain at large.
1.5 PROFILE OF THE RESPONDENTS

These profiles of the respondents are the results based on the data collected for the study. It includes age, gender, marital status, educational qualification, religion and occupational status. The profiles are divided into two categories i.e PLWHA respondents in one set and the general respondents in another. Seeing the sensitivity of the issue of PLWHA and also being the core group to be studied upon, it was important to divide the respondents into two categories; the first set comprises of 100 PLWHA respondents and the second set comprising of 300 respondents.

Table 1.8: Categories of respondents

<table>
<thead>
<tr>
<th>Primary classification of Respondents</th>
<th>Nos</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infected (PLHA)</td>
<td>100</td>
</tr>
<tr>
<td>General population</td>
<td>100</td>
</tr>
<tr>
<td>Jails</td>
<td>11</td>
</tr>
<tr>
<td>Non –governmental organization</td>
<td>40</td>
</tr>
<tr>
<td>Nagaland State AIDS Control Society</td>
<td>09</td>
</tr>
<tr>
<td>Religious organization</td>
<td>50</td>
</tr>
<tr>
<td>Doctors and medical staff (Hospital)</td>
<td>40</td>
</tr>
<tr>
<td>Administrators and Law enforcing agencies</td>
<td>50</td>
</tr>
<tr>
<td>Total</td>
<td>400</td>
</tr>
</tbody>
</table>

Table 1.8 given above, presents the selection of the respondents. The respondents comprises of Students and College goers, Drop Outs, Religious Organizations, Administration; Non –Governmental Organization, Jails, Hospitals, Individuals etc Various law enforcing agencies like the police were also taken into account in this present study. The total sample size
has provided valuable insights in order to grasp the idea of the problem of HIV/AIDS and how it has tremendous impact on society irrespective of tribe, place, age, religion, gender etc.

**Table 1.9: Distribution of the PLWHA respondents by Gender and Age**

<table>
<thead>
<tr>
<th>Gender</th>
<th>Frequency</th>
<th>Age group</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>46</td>
<td>Below 24</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td></td>
<td>25-34</td>
<td>47</td>
</tr>
<tr>
<td>Male</td>
<td>54</td>
<td>35-44</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td></td>
<td>45-54</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>55 and above</td>
<td>X</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>Total</td>
<td>100%</td>
</tr>
</tbody>
</table>

From the table 1.9, it is clear that there are 46 PLWHA female respondents and 54 PLWHA male respondents. Comparatively female PLWHAs are no lesser than the male percentage of the HIV infected males. This depicts that HIV/AIDS does not distinguish between gender and age groups. It is therefore gender blind and infects those who resort to high risk behaviours.

It is evident from the table 1.9 that the maximum number of respondents belongs to the age group 25-34, followed by the age group 35-44. Even though the age group below 24 has only 11 respondents, it signifies the age where people develop themselves in terms of social and economic aspects of the life. It is also the age where people generally face several problems like stress, frustration, intensified conflict and crisis in adjustment, pleasure in taking risk and experimenting new things, a stage of search for one’s self-marked and intimate peer affiliation and clique formation at a later stage. They are easily hooked by the HIV/AIDS epidemic.

**Table 1.10: Distribution of the PLWHA respondents by their marital status**

<table>
<thead>
<tr>
<th>Marital status</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>70</td>
</tr>
<tr>
<td>Unmarried</td>
<td>28</td>
</tr>
<tr>
<td>Divorced</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
</tr>
</tbody>
</table>
With regard to the marital status, table 1.10 shows that 70 were found to be married, 28 were unmarried and 2 respondents were found to be divorced. This study portrays the high level of prevalence rates of HIV/AIDS among married couples. This also indicates a situation where HIV/AIDS hampers the sanctity of marriages and goes up to the extent of mistrust and divorce among the married couples.

Table 1.11: Distribution of the PLWHA respondents by their educational level

<table>
<thead>
<tr>
<th>Educational qualification</th>
<th>No of person</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>X and below</td>
<td></td>
<td></td>
</tr>
<tr>
<td>V</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>VII</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>VIII</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>IX</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>X</td>
<td>27</td>
<td>49</td>
</tr>
<tr>
<td>Higher secondary level</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Graduation level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B.A</td>
<td>16</td>
<td>18</td>
</tr>
<tr>
<td>B.COM</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Post Graduation</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>No response</td>
<td>24</td>
<td>24</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 1.11 given above indicates the educational qualification of the PLWHA respondents. Out of the 100 PLWHA respondents, there is only one respondent who has a master degree and 24 respondents didn’t respond to this query. A large proportion of PLWHA respondents have the educational qualification up to X and below. The PLWHA respondent across the education criteria under graduation level could be still considered as vulnerable to the HIV/AIDS pandemic.

Table 1.12: Distribution of the PLWHA respondents by religion

<table>
<thead>
<tr>
<th>Religion</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christians</td>
<td>82</td>
</tr>
<tr>
<td>Hindu</td>
<td>5</td>
</tr>
<tr>
<td>Muslim</td>
<td>6</td>
</tr>
<tr>
<td>No response</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
</tr>
</tbody>
</table>
From the table 1.12, it is evident that the respondent comprises a majority of Christians. Nagaland being a Christian state, and the data portrayed in this table is not taken by surprise. Out of the 100 respondents there were only 5 Hindus and 6 Muslims and the remaining 7 did not respond.

**Figure 1.3: Distribution of the PLWHA respondents by their occupation**

Occupational status is one of the criteria for determining the socio-economic position of the respondents. When people are less educated and less paid, they cannot meet their family needs and finds it hard to support the everyday existence. They become sick of life and get hooked up in drugs and thereby seek for sexual pleasure. From figure 1.3, it is evident that the respondents are distributed among a wide spectrum of occupational status. However 3 respondents didn’t respond and 25 respondents were found to be unemployed.

Due to the complexity of the study, two different sets of respondents were classified. One set comprised of the 100 PLWHAs exclusively while the other set consists of 300 respondents comprising of all the people from different walks of life.
Table 1.13 below highlights the gender and age of the general respondents. It is clear that 115 respondents out of 300 were males and the rest i.e. 185 comprised of the women folk. It is seen here that the unmarried 175 respondents constituted the bulk followed by 123 married respondents. One respondent each constituted the divorced and the NR category.

**Table 1.13: Distribution of the profile of general respondents**

<table>
<thead>
<tr>
<th>Gender</th>
<th>Marital status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>115</td>
<td>185</td>
</tr>
<tr>
<td>123</td>
<td>175</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

*NR = No Response

**Table 1.14: Religion wise distribution of general respondents**

<table>
<thead>
<tr>
<th>Religion</th>
<th>Christian</th>
<th>Hindu</th>
<th>Muslim</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>292 (97.4%)</td>
<td>3 (1.00%)</td>
<td>3 (1.00%)</td>
<td>2 (0.6%)</td>
</tr>
</tbody>
</table>

Table 1.14 portrays a total of 292 respondents Christians out of the 300 respondents with a percentage of 97.4% and 1% each were Hindus and Muslims. The remaining 0.6% were placed in the others category.

**Table 1.15: Distribution of the general respondents by age**

<table>
<thead>
<tr>
<th>Age group</th>
<th>No. of person</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-24</td>
<td>39</td>
</tr>
<tr>
<td>25-34</td>
<td>148</td>
</tr>
<tr>
<td>35-44</td>
<td>35</td>
</tr>
<tr>
<td>45-54</td>
<td>41</td>
</tr>
<tr>
<td>55 and above</td>
<td>37</td>
</tr>
<tr>
<td>Total</td>
<td>300</td>
</tr>
</tbody>
</table>
Table 1.15 projects the age group of the general respondents. The age group 25-34 had more respondents in comparison to the other age groups.

**Table 1.16: Distribution of the respondents by educational level**

<table>
<thead>
<tr>
<th>Education</th>
<th>No of person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upto X</td>
<td>31</td>
</tr>
<tr>
<td>XII</td>
<td>32</td>
</tr>
<tr>
<td>BA/B.Sc/B.th/BD/B.Com</td>
<td>151</td>
</tr>
<tr>
<td>M.Com/M.Div/M.Sc/M.th/MA/MSW</td>
<td>41</td>
</tr>
<tr>
<td>LLB</td>
<td>2</td>
</tr>
<tr>
<td>MBBS</td>
<td>15</td>
</tr>
<tr>
<td>GNM/B.SC Nursing</td>
<td>20</td>
</tr>
<tr>
<td>MD</td>
<td>1</td>
</tr>
<tr>
<td>Ph.d</td>
<td>5</td>
</tr>
<tr>
<td>No response</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>300</strong></td>
</tr>
</tbody>
</table>

Literacy rate in Nagaland has seen an upward trend. According to the 2011 census, Nagaland has a literacy rate of 80.11%. The literacy rate of total urban population is 90.21% with urban male and urban female literacy rate of 92.11% and 88.10% respectively. In actual numbers, total literates in Nagaland stands at 1,342,434 of which males were 723,957 and females were 618,477. In Table 1.17, it is reflected that the highest respondents are those who have graduated or are undertaking a bachelor’s degree course. Except for 2 respondents who failed to give their educational qualification, remaining respondents comprised of those who were studying or studied up to X and XII, master degrees and varied professional courses.

1.5 CHAPTERISATION

This thesis comprises of 6 (Six) chapters. A brief description of all the chapters are given below:-
Chapter one ‘Introduction’ is an introductory part which depicts the global and the national scenario of HIV/AIDS. It is further followed by an explanation on the definition of HIV/AIDS and theories about its origin. Statement of the problem of the research study and the methodologies implemented throughout the research are incorporated thereafter. The methodological framework covers the objectives, hypothesis, research design, instrumentation and data analysis procedures. Detailed explanation of the study area and the profiles of the respondents mark the end of the chapter.

Chapter two is the ‘Review of Literature’ that gives an overview of the review of literatures related to the selected field of study. This chapter gives a theoretical base for the research and describes, summarizes and clarifies the literatures reviewed. Altogether there are about 200 books reviewed.

Chapter three deals with the ‘Causes and Impact of the Spread of HIV/AIDS in Nagaland’ and seeks to portray the modes of HIV transmission in Nagaland. It depicts the ways in which HIV is transmitted in the state and the factors facilitating transmission are described. The chapter begins with an examination of 100 (One hundred) respondents who are infected with the virus. They are addressed here as People Living with HIV/AIDS (PLWHA). Here the data are presented to support the findings and recommendations of the study. This chapter also provides a comprehensive overview of the impact of HIV/AIDS in Naga society. It has been 24 years since then AIDS emerged as a major health and social emergency in Nagaland, the epidemic has had a serious, and in many places and devastating effect on human development. Nagaland is in the grip of the HIV/AIDS pandemic with an increasing number of infections. Nagaland is one of the six high HIV-prevalence states in the country. The present study has used the existing data that was collected through the primary and the secondary sources. It indicates the scenarios of HIV spread in Naga families and how it impacts on their psycho social and economic life.

The fourth chapter ‘Agencies of HIV/AIDS control measures’ presents the agencies of control measures towards the pandemic in Naga society. In a state like Nagaland, it has been considered necessary to look into the role of the religious organizations, the intervention by governmental as well as nongovernmental organizations, schools and other institutions of learning, the family and the individuals etc. These agencies are the backbone towards the
controlling of the epidemic. A critical evaluation of the HIV control machineries has been evaluated to bring about a qualitative research thesis.

Chapter five deals with the ‘Magnitude of HIV/AIDS: A District wise Comparative Analysis’ brings about a comparative analysis of the magnitude of HIV/AIDS between the eleven districts of Nagaland. It looks into the Socio-economic considerations, seriousness of the issue, educational considerations, people’s response and human rights issues. This chapter stands to make a critical analysis.

Chapter six presents the major finding of the study, observation and suggestion in the form of recommendation marks the end of the chapter.

Various theories on the emergence of HIV/AIDS and the epidemiological details of its spread around the globe not excluding India discussed above, depicts the seriousness of the pandemic and how it evolved over time, hampering the social and economic fabric of the present era. The evolution of HIV/AIDS and the implications brought about around the world, shows how devastating it can be. The various methods applied in this research work brought about satisfactory results which are projected in the subsequent chapters. Basing on the review of literature that forms the base of the research work, this study produces a concerned piece of research work.