CHAPTER - 3

CAUSES AND IMPACT OF HIV/AIDS IN NAGALAND

This chapter 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 as indicated in table 3.1. The chapter begins with an examination of 100 category of respondents who are infected with the virus. They are addressed here as People Living with HIV/AIDS (PLWHA).

This chapter also provides a comprehensive overview of the impact of HIV/AIDS in Naga society. HIV was first detected in the state in the year 1990 and it has been 24 years since 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. This chapter includes the latest 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.

One of the emerging social problem that have been penetrating the present Naga Society is the pandemic of HIV/AIDS and its consequences that comes attached with it. It has affected the individuals as well as the society. It is a complex social and health problem that poses as a threat to humanity.

3.1 CAUSES OF THE SPREAD OF HIV/AIDS IN NAGALAND

HIV/AIDS brings with it a unique social history. It is a complex and multi dimensional phenomenon that has become a major problem in every society. When AIDS first emerged as a disease in the year 1990 in Nagaland, few people could predict how the epidemic would evolve, and fewer still could describe with any certainty the best ways of combating it. It has now been 24 years since the first case was detected and the epidemic is still prevalent. It has created and is still creating unprecedented challenges to human society in various dimensions of human life.
HIV continues to spread across the state irrespective of its geographical expanse causing increase in mortality and morbidity among children and adults along with severe consequences socially and economically at the most. It threatens the basic social institutions at the individual, family and community level which in turn affect the economy, development initiatives and other associated linkages at the national level.

HIV transmission occurs through behaviors that pose a risk for exposure. Transmission is not limited to one particular race/ethnicity, gender, relationship or affiliation, or community membership.

Detailed epidemiological studies throughout the world and accepted medical opinion have shown that HIV can pass on to an individual through four routes namely:

2. Unprotected sexual contact with an infected person.
3. Pre–natal with infected mother to child transmission, through the birth process and breast-feeding.
4. Sharing of contaminated syringes and needles

According to the recent report by the NACO (National AIDS Control Society), Nagaland ranks the Sixth highest HIV prevalent state in the country. According to Sentinel Surveillance Report 2013, Nagaland has the prevalence of HIV/AIDS with an alarming ratio of 0.88% in the country where Dimapur records the highest prevalent rate of HIV. Here in this study a total number of 400 (Four hundred) respondents were interviewed out of which 100 (One Hundred) respondents were PLWHAs (People Living with HIV/AIDS).

<table>
<thead>
<tr>
<th>Routes of transmission</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infected blood transfusion</td>
<td>8</td>
<td>8.00%</td>
</tr>
<tr>
<td>Sexual route</td>
<td>49</td>
<td>49.00%</td>
</tr>
<tr>
<td>IDU</td>
<td>22</td>
<td>22.00%</td>
</tr>
<tr>
<td>Infected Mother to child</td>
<td>9</td>
<td>9.00%</td>
</tr>
<tr>
<td>Cannot say</td>
<td>12</td>
<td>12.00%</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 3.1: Modes of transmission

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Table 3.1 and the figure 3.1 indicate the frequency of the 100 PLWHA respondents on how they got themselves infected with the virus. Although there were about 12% who were not sure through which route the HIV was transmitted to them, the rest 88% were sure of how they got themselves infected. While 49% of the total PLWHA were found to have contracted HIV through the sexual route, 22% of the respondents got infected through injecting drug use. This somehow indicates the high promiscuity and the intensive drug use in the region making it to the top in transmitting the virus. 9% and 8% of the 100 respondents inherited the virus through mother to child and through blood transfusion respectively. These two routes are comparatively very less in comparison to the two earlier routes of transmission.

**Figure 3.1: Proportion of routes of HIV transmission**

![Proportion of routes of HIV transmission](image)

**Table 3.2: Number of HIV test undergone**

<table>
<thead>
<tr>
<th>No. of tests</th>
<th>Frequency</th>
<th>Percentage%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Once</td>
<td>23</td>
<td>23.00%</td>
</tr>
<tr>
<td>Twice</td>
<td>29</td>
<td>29.00%</td>
</tr>
<tr>
<td>Thrice</td>
<td>35</td>
<td>35.00%</td>
</tr>
<tr>
<td>More than thrice</td>
<td>13</td>
<td>13.00%</td>
</tr>
</tbody>
</table>

| Total Respondents     | 100       |
The researcher wanted to know from the PLWHAs, the number of HIV tests undertaken for the confirmation that he/she is infected. Out of the 100 respondents, there were a maximum of 35% who went for tests at least thrice in order to confirm the HIV status.

Table 3.3: District wise classification of HIV infected respondents

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>District</th>
<th>No. of respondents</th>
<th>Gender</th>
<th>Routes of Transmission</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Dimapur</td>
<td>22</td>
<td>M 10</td>
<td>F 12</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>14 (63.63) 1(4.54)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5 (22.74) -</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 (9.09)</td>
</tr>
<tr>
<td>2.</td>
<td>Kohima</td>
<td>20</td>
<td>M 10</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>9 (45) 1 (5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7 (35) 2(10) 1 (5)</td>
</tr>
<tr>
<td>3.</td>
<td>Tuensang</td>
<td>15</td>
<td>M 8</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7(46.69) 1(6.66)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5(33.33) 1(6.66)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1(6.66) 1(6.66)</td>
</tr>
<tr>
<td>4.</td>
<td>Mokokchung</td>
<td>10</td>
<td>M 6</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4 (40) 1(10)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4(40) 1(10)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>5.</td>
<td>Zunheboto</td>
<td>7</td>
<td>M 4</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3(42.9)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- 1(19.2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- 3(42.9)</td>
</tr>
<tr>
<td>6.</td>
<td>Kiphire</td>
<td>5</td>
<td>M 4</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3(60) 1(20)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- - 1(20)</td>
</tr>
<tr>
<td>7.</td>
<td>Wokha</td>
<td>5</td>
<td>M 4</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2(40) 1(20)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- 1(20) 1(20)</td>
</tr>
<tr>
<td>8.</td>
<td>Mon</td>
<td>5</td>
<td>M 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3(60) - - 2(40)</td>
</tr>
<tr>
<td>9.</td>
<td>Phek</td>
<td>5</td>
<td>M 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2(40) 1(20)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- - 2(40)</td>
</tr>
<tr>
<td>10.</td>
<td>Peren</td>
<td>3</td>
<td>M 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1(33.4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- - 1(33.3)</td>
</tr>
<tr>
<td>11.</td>
<td>Longleng</td>
<td>3</td>
<td>M 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1(33.4) 1(33.3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- 1(33.3) -</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>100</td>
<td>M 54</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>49% 8% 22% 9% 12%</td>
</tr>
</tbody>
</table>

Note: The above initials refers to a. Sexual route b. Blood transfusion c. IDU d. Mother to child e. Cannot say
Numbers in brackets refer to percentage of the routes of transmission

Table 3.3 shows the district wise classification of HIV infected respondents with Dimapur taking the lead. Out of the 22 respondents from Dimapur, there were 10 males and 12 females out of which 63.63% of them were infected through risky sexual behaviour followed by 22.74% through intravenous drug use. The remaining districts are also not an exception because a majority of the PLWHAs got infected through the same route followed by intravenous drug use. Except for Zunheboto, Mon and Peren, the remaining districts has responded to have infected through blood transfusion. It is seen that Kohima tops in the category of contracting the infection through intravenous drug use. Kohima and Mon leads the infection caused from
mother to child with 10 and 40% respectively. In this study, it can be seen that 12% of the respondents are not sure and cannot say how they contracted the disease.

Table 3.4: One’s own reaction to HIV when tested positive

<table>
<thead>
<tr>
<th>Feeling</th>
<th>Percentage%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fear of Stigma</td>
<td>88.00%</td>
</tr>
<tr>
<td>Scared of discrimination</td>
<td>80.00%</td>
</tr>
<tr>
<td>Fear of Survival</td>
<td>79.00%</td>
</tr>
<tr>
<td>Inferiority complex</td>
<td>72.00%</td>
</tr>
<tr>
<td>Angry with Oneself</td>
<td>71.00%</td>
</tr>
<tr>
<td>Acceptable</td>
<td>30.00%</td>
</tr>
</tbody>
</table>

Note: Since the respondents have marked more than an option, the percentage is analyzed point wise only.

It is evident from this study that there is a combination of so many feelings when a person is tested HIV positive. The mixed feelings indicate their sign of guiltiness’ and remorse. Fear of stigmatization in society tops it all with a percentage of 88%. It can be seen that the respondents fear the stigmatization by society followed by discrimination which makes them fear for survival. They develop in themselves an inferiority complex and often get angry with oneself. Except for 30% who gently accepts his/her HIV status, 70% lives on with their feeling of regrets.

![Figure 3.2: Duration of HIV infection](image)

- Below one Year: 28%
- 2-3 Years: 25%
- More than Three Years: 47%
Figure 3.2 shows the duration of the HIV infection where out of the 100 PLWHA respondents, 47% opined that they have been infected with virus for at least two to three years. It also shows that 28% got infected since one year and 25% constitutes of having infected for more than three years.

On the basis of the data and information collected from respondents, it can hence be proved that there are four routes of HIV transmission supplemented by some various social factors that invoke them to get involved in high risk behaviour.

1) **Sexual route: Unprotected sexual contact with an infected person**

The chief route of HIV transmission is via sexual activity as table 3.1 projects. Out of the 100 respondents, there were 49% that were infected through unprotected sexual contact with an infected person. Specific sexual behaviours place people at risk of HIV infection. The virus is transmitted from an infected person to his or her partner (man to woman, woman to man and man to man and rarely from woman to woman). Heterosexual intercourse is the most common manner though in Nagaland, in which HIV is transmitted through normal heterosexual relations from men to women and women to men.

As per the response of the respondents, the transmissibility of HIV is far greater in the direction of male-female compared with female-male. Considering mechanistically, this difference in transmissibility is not surprising because study reveals that female are more vulnerable to infection.

<table>
<thead>
<tr>
<th>Table: 3:5 Proportion of sexual route of transmission</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sexual route of transmission</strong></td>
</tr>
<tr>
<td>Casual/non commercial, non regular partner</td>
</tr>
<tr>
<td>Regular partner/spouse</td>
</tr>
<tr>
<td>Commercial partner</td>
</tr>
<tr>
<td>Homosexual/bisexual</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

Note: Out of the total respondents, there were 49 respondents who got infected with HIV through the sexual route. Therefore a proportion of their sexual route is projected above.
The transmission of HIV is still at large and transmission through the sexual route is alarmingly high. The different proportions of sexual routes are depicted in figure 3.2. The cases of sexual route of transmission by indulging in casual/non commercial, non-regular partner is very high with 45%.

Secondly 39% of the respondents who got infected through this route were unwilling at first to disclose their HIV status to their spouses/partners which increased their risk of transmission of the HIV virus resulting in higher number of transmission through having sex with regular partners/spouses. Heterosexual transmission of HIV is also supported by finding HIV positive status both in spouses of married couple and in separate cluster of individuals linked by sexual relations.

Thirdly, this study reveals that even though there are no specified red light areas in the state, the phenomenon of female sex workers or commercial sex workers has increased leading 16% of the respondents in contracting the virus.
After thoroughly analyzing and scrutinizing the response of the respondents, some major reasons can be summed up as the major causes of the outbreak of the pandemic and its spread in Nagaland. Though these factors do not directly lead the person to involve in risk behaviors, it helps to motivate persons who are used to these habits to indulge in perverse sexual acts.

a) Migration

The study reveals that with the onset of globalization and the consequent increase in job opportunities in cities, young Naga men and women are thronging to the already crowded Indian cities. Some respondents were of the opinion that when they reach a place where they do not abide by the strict social norms of their own communities, they often indulge in risky sexual behaviour and consequently found themselves to be HIV positive at a later stage. Casual/non commercial, non-regular partner takes the highest toll in table 3.2 with a percentage of 45 % leaving the life of the Naga youths at stake.

b) Lack of sex education

Rev. Dr. Jose Thenpillil (2006) opines that in the process of socialization, the imparting of sex education to an adolescent is very important. But the concept and the thinking in the Naga society is that speaking about sex and its related topics are considered as a taboo. So parents and elders do not impart sex education to their children. The study reveals that none of the respondents ever received sex education from their parents or teachers. About 70% of the respondents were of the opinion that their source of sex education was only through books, journals, friends, television, newspaper, magazines, posters etc and the remaining 30 % had different opinions like from radio, health workers, IEC (Information, Education and Communication) materials etc

c) Influence of modern media

The advancement of science and technology brings in itself, various advantages and disadvantages. The influence of modern media on the psychosocial development of a person is clearly visible in the present Naga society. Television, internet etc has the potential to generate

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58 Thenpillil, Jose (2006) ‘Socio-Cultural dimensions of the HIV/AIDS affected’
both positive and negative effects. Not all television programmes are bad but data showing the negative effects of exposure to violence, inappropriate sexuality and offensive languages are itself enough to pollute human mind. Along with its advantages, the introduction of internet has paved way to expose things that was not easily available way back. Reading pornographic literature and watching x rated movies are becoming common amongst the youngsters. It instills the urge and desire to experiment in real life. The source of sexual knowledge, reading of pornographic literature, watching x rated films influence people to indulge in risky sexual behaviour.

Out of 400 respondents, 47.25% were of the opinion that influence of modern media is one of the contributing factors to the rise of the epidemic. Social networking sites like the facebook, orkut, watsapp etc exposes a person to the outside world bringing each other nearer. But at the same time people misuse the technology. Time spent on social networking sites also increases the risk of teens smoking, drinking and using drugs according to National attitudes on substance abuse.59

**d) Modern lifestyle**

A respondent from Dimapur was of the opinion that the opening up of lounges and pubs in Dimapur where there is night life, young men and women, booze, weed etc is in a way contributing to the rise of HIV infection. This kind of lifestyle creates a kind of situation where it leads them to have sex with multiple partners making them one of the most vulnerable group responsible for the infection of HIV/AIDS. Peer pressure during adolescence leads young people to seek sexual adventure and exploration.

**e) Increased pre marital and extra marital affairs**

Increased pre marital sex among the youths is also becoming more prevalent. Most often young people do not have access to information on human sexuality. It is learnt that the natural curiosity tendency to experiment, seek sexual adventure and exploration, feeling of invulnerability and the strong peer pressure especially during adolescence results in taking decision to have sex before marriage. This early exploration acts as an agent in the rise of the

59 http://losangeles.cbslocal.com/2012/04/02/usc-study-examines-whether-social-networking-exacerbates-risky-behaviour-among-teens/
epidemic because of their high risk behaviours. One of the main factor observed is, where adult guidance is lacking, youths are left to navigate their way alone into maturation.

Family and workplace play a crucial role in the relationship and behaviour of any individual. When a person lives away from the family, there is a possibility that he/she has to depend on friends or other associates whose influence will have greater impact on the life of that person. Where value ethics are no longer taught or rewarded, extra marital affairs among married peoples starts to sprout out. A married person living away from wife/husband and family for a longer period may develop tendency for extra marital relations. Family proximity to the workplace reduces the chances for risky/promiscuous sexual relationships. The lifestyle of the person is influenced not only by being away from the family but it also depends to a great extend with whom he stays when he/she is away. The place of stay influences the lifestyle of the individual. Sex partners hold a crucial role in the spread of the epidemic. It may be mentioned here that the police and other armed forces usually remains away from their wives and their absence leads some of the womenfolk to the start of extra marital affairs leaving them at high risk behaviour zone. And on the other hand, the husband’s too seek to venture out and seek for partners to satisfy their gratification, thereby leaving them at risk too.

A recent article by ‘International Research Journal of Medical Science’ projects that there are rising numbers of pregnant women in Nagaland, “whose sexual behavior is not believed to be risky,” but are testing to be HIV positive. This may be due to the infidelity of their spouses/sex partners.\textsuperscript{60} Resorting to risky behaviour by having sex with a person other than their own life partner or with people whose sexual activities are not known, poses danger in the spread of the pandemic.

\textbf{f) Alcohol consumption}

Alcohol intake is another factor that leads to perverted sexual relations. Alcoholism has become a popular practice among the Nagas and it is acting as a menace to the society. It affects the social, health, economic, spiritual, psychological and the cultural aspect of society. It poses as a threat in Naga society by spreading its tentacles amongst the vulnerable sections

\textsuperscript{60} International Research Journal of Medical Science (2013) ‘Assessment of HIV/AIDS Sero Positivity in Nagaland’
of the population. Alcohol is a major factor that seeks extra marital affairs. It was revealed that many transport workers have the tendency to drink after the day’s exhaustion and immerse themselves to experience the kick and derive some fun. Alcohol and the urge for sex are strongly co-related. The use of contraceptives in promiscuous sexual relationships is almost absent in case of the respondents that were infected with the epidemic. Though aware of the necessity, they did not bother about it or didn’t use as they were in the influence of alcohol. This added to their risk of getting HIV infection.

**g) Fear of Stigma and Discrimination**

Stigma is a powerful tool of social control. It marginalizes, excludes and exercise power over individuals who show certain characteristic. Stigma and discrimination is caused by lack of understanding of HIV, how it is spread, lack of access to treatment, irresponsible media coverage of the epidemic, the fact that AIDS has no cure, and already existing prejudices related to sexuality, disease, drug use, and death. People living with HIV are often believed (and led to believe) to deserve their status as a result of their doing something inherently wrong. By so alienating and laying blame on others who are somehow different, people can somehow remove themselves from any risk and not confront the issue for the problem that it is.

While the societal rejection of certain group’s e.g. homosexuals, injecting drug user. Commercial sex workers etc may predate HIV/AIDS; the pandemic has in many cases reinforced this stigma. For fear of rejection, stigma and discrimination that follows people who are infected usually do not disclose their identity, making them one of the high risk behavior agents. It does not always only occur to them, but also to others simply associated with them such as family members. Some of the factors observed that was responsible in contributing to HIV/AIDS related stigma in Nagaland are as follows:-

1. HIV/AIDS is a life threatening disease.

2. The disease’s association with behaviours such as sex, injecting drug use etc. are already stigmatized in many societies.
3. People living with HIV/AIDS are often thought as being responsible for being infected and are often looked upon.

4. Religious and moral beliefs lead some people to believe that having HIV/AIDS is the result of moral fault (such as promiscuity or deviant sex) that deserves to be punished.

5. HIV/AIDS is considered as a punishment, horror, crime that reinforces and legitimizes stigmatization.

Denial goes hand in hand with discrimination. If one does not see themselves at risk, or see the potential for the epidemic to affect their community, they are at greater risk. Denial even takes the extreme form of not seeing the pandemic for the serious problem that it is. Either way, denial silences open conversation about the epidemic which hinders preventative measures.

Social stigma attached to sexually transmitted diseases particularly AIDS is enormous in the society. The people isolate the infected person to such an extent that the individual would prefer to run away from the house at least to save the family from social isolation.

This proves that the promiscuity relation is one of the factors, strongly responsible for the transmission of HIV. Table 3.1 shows that 49% of the respondents contracted the infection through the sexual route.

2. Sharing of contaminated syringes and needles

The risk of transmission of HIV infection is higher when previously used syringes and needles are reused without proper sterilization. This more likely happens amongst the intravenous drug users. Table 3:1 projects the Intravenous drug use as the second most powerful route of HIV transmission with a percentage of 22%. Among the drug users, the risk of being infected with HIV is closely linked both to the frequency of drug injection and sharing of needles and injections with previously used needles. The study reveals that many of the respondents started their drug use orally. But in due course of time, they cannot afford to buy drugs, which will be sufficient for oral dose. Injecting takes only a small amount of drugs.
Moreover, the action too is very quick. Sometimes police crackdown on drug smugglers and drug peddlers and heroin is not available in the market. So these respondents started injecting to save drugs and to save money.

Intravenous drug users have become a significant risk group for HIV and now play a major role in the transmission. The first HIV case in Nagaland was detected in the year 1990 by ICMR among the IDUs. Intravenous drug use is risk behaviour because most of the drug users frequently share needles and syringes to inject drugs. Contaminated blood particles are found to remain inside the previously used needles and syringes and thereby providing opportunities for HIV to transmit to the subsequent user of the same needles and syringes. Injecting of drugs is considered to be the principal mode of HIV transmission in North Eastern states of India, especially in neighboring Manipur.

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. Majority of the drug users do inject heroin. While doing so, they share the needles and syringes, thereby sharing a little amount of blood too. So, if one of the drug injecting partners has got the HIV infection, the other members of the group are also likely to get the infection through sharing of needles and syringes.

The increasing cases of HIV/AIDS in Nagaland are particularly based on intravenous drug use and unsafe sex, informs a study published in the International Research Journal of Medical Science. The study titled ‘Assessment of HIV/AIDS Sero Positivity in Nagaland’ states that the prevalence of infection among IDUs has been a cause of major concern.61

According to the 22 respondents who were infected through this route, they exposed why they shared needles and syringes. High levels of syringe sharing have serious implications for the transmission of HIV in the following areas:

a) Sense of urgency that comes with drug craving.

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b) Scarcity of needles and non availability of needles and syringes.
c) Refusal by the pharmacist to sell needles and syringes to young people.
d) Fear of police harassment and arrest with needles and syringes in their possession.

Moreover the study depicts the infection acquired through sharing of contaminated injecting equipments passes on to the non-injecting partners through unprotected sex. Because of the action of drugs, the drug users cannot take rational decision leading them to have unprotected sex and sell sex for money and drugs. In the process, one gets infected. Sexual behaviour and drug use is often inextricably linked. The present study reveals that 22% of the 100 respondents got infected with HIV through the sharing of contaminated needles and syringes. The most dangerous trend is that HIV spreads from this group of injecting drug users to the general public through heterosexual intercourse.

The increase in 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.

Imti Longchar’s article\footnote{Morung Express dated June 17, 2014 ‘IN PERIL: Pangsha grapples with HIV/AIDS’} in the local paper Morung express projects Pangsha, last of Nagaland’s villages under Tuensang district, bordering Myanmar, as silently grappling with HIV/AIDS. In the early 1980’s, this border area, inhabited by the Khiamniungan Nagas, connecting to Lahe and Khamti towns of the Naga areas in Myanmar, was notorious for illicit drug trafficking and gun running. This led to a high rise in the number of Injecting Drug Users (IDU). This was further confounded by unsafe pre-marital sex and an unaware population is now taking its toll. Data received from Nagaland State AIDS Control Society (NSACS) on Pangsha’s HIV/AIDS scenario reveals that at least 104 people from Pangsha village area were
tested HIV positive as recorded from 2006 till date. This figure was reported from the four villages under Pangsha area namely Pangsha Old, Pangsha New, Dan village (International Trade Centre) and Wontsoi, with a total population of hardly 6000. The villages are located a few kilometers apart with the nearest town Noklak located 30 km away. Out of the total tested positive, 58 are female and 46 male. Further, 48 of them are in the age group of 25-34 years of age, 39 between 15-24 years, 11 between 0-14 years and 6 between 35-50 years.

In neighbouring Manipur, high level of heterosexual HIV spread in predominantly injecting settings has been reported. Reports showed that HIV prevalence among spouses of HIV positive injectors increased from 5 to 45 percent over a period of five years. One percent prevalence of HIV among the general population is a high level of infection and indicates large scale heterosexual spread.63

Health care workers are at small but real risk of acquiring HIV infection via accidents with needles and instruments contaminated with blood from infected patients. There has been a report in one of the hospital in state capital Kohima where a nurse contracted HIV through a needle stick injury to the finger while resheathing a needle on a syringe containing fresh blood drawn from an arterial line of a HIV positive woman. Health care personnel therefore have to reconsider the adequacy of the precaution taken both in nursing of HIV positive patient and in handling the laboratory specimen.

2) Pre-natal with infected mother to child transmission, through the birth process and breast-feeding

The most biologically intimate association between two individuals is one between a mother and a fetus developing in her womb. It is clear, therefore, that with such close contact of fetal tissues and maternal tissues over a fairly gestation period of nine months, the risk of transmission of HIV infection from mother to infant is second only to the risk of acquiring infection from a blood transfusion. Mother to fetus or mothers to infant are the ways by which most of the children get HIV infection. Such transmissions can occur during pregnancy, at

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delivery or during postpartum period. The risk of an HIV infected mother passing the virus to her baby is about 30%, the risk being greater if she has symptoms of AIDS.

Table 3.1 shows the transmission of HIV from mother to child with a percentage of 9% out of the 100 respondents. The likelihood of transmission varies with the stage of HIV infection in the mother and consequently the level of virus in her blood estimates of HIV infection rate in babies born to seropositive women range from 25% when the mothers are asymptomatic to 45%, when mothers have had a previous baby with the infection. The overall risk of transmission from an infected mother to an infant is approximately 30% but with other modes of transmission, there are wide variations.

Only HIV infected women give birth to children with HIV infection. The women are infected first before they give birth to HIV infected children. The following categories of women are at increased risk of HIV infection:

1) Injecting drug users through sharing of needles and syringes
2) Women having multi sex partners and unprotected sex
3) Women whose sexual partner or spouse are injecting drug user or HIV positive

French researchers have documented HIV transmission through breast feeding. HIV is present in breast milk. Healthy babies have contracted the infection through imbibing contaminated breast milk. HIV infected infants generally show serious clinical symptoms by six months of age. The symptoms may resemble common problems but often do not respond to usual treatments when the child is infected with HIV. Though there is a risk of passing HIV through the breast milk, the benefits of breast feeding seems to outweigh the risk of HIV infection because breast milk contains many substances which protect an infant from various illnesses.

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64 Thenpillil, Jose (2006) ‘Socio-Cultural dimensions of the HIV/AIDS affected’
67 Goedert, James J (1985) “Mother to infant transmission of HIV-1: Association with prematurity or low Anti-gp120”
68 Sprecher, T. L. (1987) “Isolation of AIDS virus from cell free breast milk of three healthy carriers”
In this study, it is projected in table 1.11 that out of the 100 respondents there were 70 married PLWHA respondents including both male and female. Altogether they have 19 infected children. The positivity rate among the pregnant women in Nagaland as projected in the above figure from the year 2003 to 2013 shows an unequal distribution. The year 2005 displays the highest number of HIV prevalence rate among ANC with a percentage of 18%. This may be a result of highest turn out of HIV positive pregnant women for treatment or it may signify the highest rate of HIV prevalence rate during that year. The latest update in the year 2012-2013 shows a wide decrease with a percentage of 7% only. This maybe an outcome of the various programmes and projects implemented by the NACO in the state of Nagaland yielding lower prevalence rate of HIV among the ANC.69

4. Blood transfusion: Through transfusion of infected blood (unscreened blood)

There is strong epidemiological evidence that HIV can be transmitted by transfusion of blood and blood products.70 Screening of blood and blood products for HIV is now practical

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69 Nagaland State AIDS Control Society M &E BULLETIN 2013
70 Esteban, Juan.L (1985). “Importance of western blot analysis in predicting infectivity of anti-HTLV-III positive blood”
though. One of the respondents was of the opinion that a woman was infected with HIV through transfusion of blood required as an emergency measure in complicated child birth in Nagaland. The present study revealed the transfusion of infected blood as one of the route of HIV transmission in the state. Out of the 100 respondents, 8% were infected through the transfusion of unscreened blood. Transmission of HIV infection through transfusion of blood from HIV infected individual is the most efficient route.

Fortunately this is the most easily preventable route of HIV transmission. National AIDS Control Organisation (NACO) has drawn up a comprehensive plan to combat the epidemic including the mandatory screening of blood at blood banks. NACO has opened up blood testing centres that are open both to the government and private blood banks. This is in fact contributing in curbing the pandemic.

A blood bank is a cache or bank of blood or blood components, gathered as a result of blood donation or collection, stored and preserved for later use in blood transfusion. The term ‘blood bank’ typically refers to a division in the hospital where the storage of blood products occurs and where proper testing is performed (to reduce the risk of transfusion related adverse events).71

At present 8 district hospitals in Nagaland have blood banks to fulfill the mandatory screening of blood and blood products. The rationale behind it is to provide testing facilities to those banks. The government policy of the country requires blood banks to discard HIV positive blood without informing the donors about their HIV status on the grounds of maintain confidentiality and avoid stigmatization of people with HIV/AIDS.72

Out of the 100 respondents, 8 % got infected through the blood transfusion. Having a blood transfusion with HIV infected blood is the most dangerous situation for HIV infection to occur. Virtually every person who has had an HIV infected blood transfusion has become HIV infected. To clarify and make sure, the respondents were interviewed. 6 (Six) respondents were of the view that they underwent emergency blood transfusion at the time of

71 en.m.wikipedia.org/wiki/Blood_Bank
72 Mangla, Bhupesh (1993) “India; HIV positive blood donors”
child delivery, blood loss from accidental injury and 2 (Two) respondents got infected after they were transfused blood following surgical interventions.

The time period from the entry of the virus into the body till it can be detected by the usual test is known as window period.\(^{73}\) The test has a window period of 6-12 weeks and hence, the test may not detect the HIV infection in blood collected from people who have recently acquired infection.

The risk of transmission of infection as a result of blood transfusion varies with the prevalence and incidence in the donor population, the proficiency with which infected potential donors are excluded from donation; the effectiveness of laboratory screening procedures, the ability to detect window period, virus inactivation, the susceptibility of the recipients and the number of blood units transferred.\(^{74}\)

Out of the 100 respondents, 12 % cannot say how they were infected with HIV. It can be analyzed through their case study that they possessed the high risk behaviours like having multiple sex partners, having unprotected sexual activity, injecting drug use etc. Therefore they remain unsure as how they were infected with HIV. Only when they were tested they came to know about their HIV status. HIV cases has been gradually increasing among “vulnerable” population groups, including women, young people, high risk groups and bridge populations. Young people within the age group of 25-34 are contributing the highest number of HIV/AIDS patients in Nagaland state. In this age bracket, the present study displays that the highest mode of transmission is through the sexual route. The incidence of HIV/AIDS infection among STD clinic attendees and ante natal (transmission from mother to child) cases in “rural” Nagaland have also been increasing, thereby posing a major challenge for health managers.\(^{75}\)

Both the epidemiological data and the present study indicate that sexual transmission of HIV is acting as a catalyst for a large scale generalized epidemic. A little decrease in the HIV/AIDS prevalence rate among IDUs making it the second most powerful route of

\(^{73}\) NSACS ‘Why AIDS Prevention Education’ (2010)
\(^{74}\) Lisam ,Khomdon Singh (2004)“HIV/AIDS and YOU”
transmission, it however cannot be denied that this mode of transmission still remains the principle driver of the infection in Nagaland. Although inconsistent, the study informed that prevalence rates, for the most part, amongst attendees of Integrated Counseling and Testing Centres shows a declining trend. This, according to the study, indicates a slowing down of HIV transmissions.

Even after 24 years of the prevalence of the epidemic in the state of Nagaland, though efforts are being done by the State government, Nongovernmental Organisations, Community Based Organization etc. 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%. If the general public is aware of the routes of transmission and the ways to avoid such risk it is easy to reduce the spread of HIV infection. For that a concerted effort synergy and coordination has to be there from the part of the state government, educational institutions, various other agencies like the health and the law departments and all who are concerned with the promotion of health in the Naga society. A maximum effort in educating the general public about the ways of transmission of HIV infection should be put into and the necessary precaution and the necessity to change the risky behavioural patterns should be taken by the members of the society.

### 3.2 IMPACT OF HIV/AIDS ON NAGA SOCIETY

The impact of AIDS is still not fully understandable, particularly when the long term is considered. The epidemic comes in successive waves, with the first wave being HIV infection, followed several years later by a wave of opportunistic diseases, and later still by a wave of AIDS illness and then death. The final wave affects societies and economies at various levels from the family to the community.

The late Jonathan Mann’s insight from the early 1990s that AIDS shines a spotlight on human rights and societal issues has been borne out in many ways, particularly in the epidemic’s interactions with poverty, gender inequality and social exclusion. There is a deep interrelationship of AIDS with problems of human development

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76 Marks SP (2000) ‘Jonathan Mann’s legacy to the 21st century: The human rights imperative for public health’
The above figure 3.5 projects the causes of HIV/AIDS followed by its impact it on Naga society. HIV/AIDS has profound effects on individuals and society. The researcher has measured the social impact of HIV/AIDS at the individual, family and community levels in terms of socio-economic indices, morbidity and mortality.

The study focuses on the impact of HIV and AIDS on the household income and employment of the affected persons and their caregivers; level and pattern of household
consumption, savings and borrowings; education of the children of affected families; and health status and household expenditure on medical care. The social impact is also studied in terms of the stigma and discrimination faced by PLWHA and their families.

The social impact of HIV/AIDS range from expressions of shock and disbelief to social disintegration due to irrational fear, discrimination and stigmatization; changes in community life, cultural norms and practices and demographic changes. Such kind of social consequences often lead to the formation of Community Based Organisations (CBO) and fostering of civil society.

N. Jacob Zhimomi, MLA & Chairman, Development Authority of Nagaland said the prevalence and increase in the ratio of HIV/AIDS in the state is alarming and of great concern for the people of the state. He further added that it was ticking like a time bomb that could devastate the society one day.77

**IMPACT ON WOMEN**

The impact of HIV/AIDS on women is particularly acute. Women are increasingly at risk from HIV. Though outwardly, Naga women seems to have enough freedom and choices in life the present study revealed that women often lack freedom of choices socially, economically and physically (health). Women have very less control over sexual matters and cannot question her husband’s fidelity. Poverty, illiteracy, ignorance, gender inequality, unemployment, male migration, lack of economic opportunities forces women to exchange sex for money, food and favours to meet their basic essential needs. Therefore women bear the brunt of stigma and discrimination to a large extent.

This study reveals that an infected woman is often economically, culturally and socially disadvantaged and lack of equal access of treatment, financial support and education. As per the response from the respondents, women are mistakenly perceived as the main transmitter of sexually transmitted diseases. Together with the traditional beliefs about sex, blood and transmission of other diseases, these beliefs provide a basis for the further stigma of Naga women within the context of HIV/AIDS.

77 Morung Express Dimapur, April 13 2014.
It has been learnt that HIV positive women are treated differently from men in many cases. Men are likely to be ‘excused’ for their behaviour that resulted in their infection whereas women are not. In some cases, the husbands who infected them, abandons the wife living with HIV/AIDS. Rejection by wider family members is also common. Women, whose husband has died from the infection, have been blamed for their deaths.

### Table 3.6 Attitude of the family and relatives

<table>
<thead>
<tr>
<th>Attitude</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not bothered</td>
<td>6.00%</td>
</tr>
<tr>
<td>Acceptable</td>
<td>21.00%</td>
</tr>
<tr>
<td>Caring as before</td>
<td>4.00%</td>
</tr>
<tr>
<td>Shocked</td>
<td>28.00%</td>
</tr>
<tr>
<td>Stigmatize</td>
<td>9.00%</td>
</tr>
<tr>
<td>Angry</td>
<td>32.00%</td>
</tr>
</tbody>
</table>

On being asked, what was the response of the family members and relatives when the HIV infection was made known, there were various answers that popped up. Table 3.6 given below depicts a mixture of attitude showed towards them. 31% of their families and relatives were angry and was unable to accept their status while 28% were shocked. 21% somehow accepted the fact that about their infection. This shows the mixed responses of the people surrounding the PLWHA fraternity. Some even goes upto the extent of stigmatizing and some did not even bother. This study proves that even though high awareness campaigns, advocacy etc. is initiated by various governmental, nongovernmental organizations, churches, schools etc, still there is something lacking in people towards understanding the plight of the infected people.

The responses of the family members towards the persons infected by HIV/AIDS clearly bring out the fact that there is much difference in dealing with them. The family wants to keep it a secret. This is because of the fear that the neighbours and the society at large will despise the infected person and the near and dear ones. The stigma associated to this infection and the fear of ostracisation by the society is the main reasons for this kind of attitude. People do not have a clear knowledge about the route of transmission and how it spreads. Insufficient knowledge and misconception always leads to immature kind of behaviour.
‘Care’ covers a range of services and activities including physical, clinical, psychosocial, emotional, spiritual, financial and practical care. While some provide care for spouses and family members out of love and compassion, this study exposed that the respondents’ relatives and families were shocked, stigmatized and angry as seen in Table 4.1. This show that the Naga society still lacks in accepting and understanding the plight of the HIV women in society. There were responses from women respondents who were harassed by their in laws for spoiling the lives of their husbands though in truth it may be the men who had transmitted the virus to these innocent women.

In order to uncover the impact of HIV/AIDS and to prove our hypothesis, it was necessary to undertake at least three case studies and their experiences. They are reproduced here one after the another below:-

**Case study 1:** Respondent is a Naga woman of 35 years. She is married with three children: one girl and two boys. The time the interviewer met her, she was working as one of the outreach worker in the district organization of people living with HIV/AIDS.

She narrated her story how she came to know about her HIV infection. At the age of 26 years, she married one of the locals and they lived happily. After some years, she got pregnant and delivered a baby girl. Since the baby was born, she was constantly sick. They took her to many hospitals but was not getting better. At the age of four, some doctors suggested that they take her to Vellore for treatment. To their surprise the baby was tested HIV positive in Vellore. They could not believe their eyes and their fate. They wondered how all these happened. After coming back, the husband and wife were also suggested to go for blood test and they were also tested positive.

The respondent further revealed that her husband use to be an Injecting Drug User (IDU) before they were married. So this must be how they all got infected. The whole family kept the secret to themselves. The respondent herself told that the news of their infection was a major shock to her. She was sad but she was not in a position to react or show any hatred towards her husband. She herself knew that he was an IDU before they married but she did not think that it’ll have this kind of implication in later stage of life. They took care of each other and the kid too.
In the later years two baby boys were born to them and she told that they are so far not showing signs of infection and even the test results proved negative. She didn’t breast feed the babies but rather turned to artificial feeding. She then narrated the difficulties and the hardships that she and her family had to undergo nursing themselves as well as the eldest daughter. The husband was just a small business entrepreneur who on his small income could not meet the family’s ends. She told that she herself as well as her husband and their daughter kept falling sick and contracted opportunistic infections from time to time. Soon her husband fall very sick and their infection came known to almost all the people in society.

The amount of stigma she experienced after their HIV status was declared was at time unbearable for the entire family. At some point of time their family was left in isolation and segregation was by some individuals.

Later she was invited by the district people living with HIV/AIDS forum to join them as an outreach worker. She accepted it and was working there at the time the interviewer met the respondent. She narrated how they were looked down by people and how it made them uncomfortable. They had to shift places in order to avoid the discrimination.

After intensive care, the husband succumbed to this disease and at present she is a single mother looking after their three children. The eldest daughter is presently being supported by churches and some NGOs as her income is too less to cover the family’s expenditure.

**Case study 2:** The Respondent is a single grandfather of 71 years. He has three grandchildren aged 12, 9 and 6. He lost his son and daughter in law to HIV in the year 2009 and 2011 simultaneously. His son died at the age of 38 and his daughter in law at the age of 35. According to him both had high risk behaviours like injecting drug use and multiple sex partners before their marriage which makes it difficult to know how the infection was inherited.

Now that he lost them both and the grandchildren are left without parents, he looks after them. He is a retired government servant and his meagre pension money that he gets monthly gets insufficient. All the three children are infected with HIV which makes them get sick often and have to rush to hospital at least thrice a month.
His wife who used to be his support in looking after the grandchildren died of diabetes in 2012 making him really hard to look after them all by himself. Sometimes he feels really down with sorrow and sadness. He narrated the story of his eldest granddaughter who is stigmatized by her peer group at school. Sometimes she comes tear eyed from school saying no one wants to befriend her.

He is so worried about the future of the kids and wonders what will happen if he dies. There are relatives who comfort him but still he is living on the hope that there is some miraculous cure for their illness, so that they can live their lives as a normal human being.

Grandparents often forms the foundation of extended families, according to a UNICEF report in 2003 the percentage of orphans taken care of by grandparents in Namibia increased from 44% in 1992 to 61% in 2000.78

**Case study 3:** The respondent is a truck driver. He is 34 years of age and married with two children. Because of his work, he keeps travelling and remains away from home and family most of the time. Because of the long travels in the roads of Nagaland, during the rest hours he used to drink alcohol with other drivers. In the process, he became acquainted with lots of women and gets involved in having sex with multiple partners by and by. This became his daily routine when he was away from his family.

Beginning with the year 2010, he started falling sick almost frequently. He went to different doctors but still his health kept deteriorating. He even visited quacks that performed different rituals saying he was under the possession of some evil spirit. But this did not help too. Then one day he visited a government hospital in Nagaland who advised him to go for blood test. Before the test was conducted, the counselor based in the hospital took his case history and administered pre test counseling to him. Later he went for blood test and was diagnosed with HIV infection. His whole world collapsed. He was of the opinion that the post test counseling done after the test was little relieving. He was advised by the counselor to bring his wife and families for blood test too. And consequently, all the family members were diagnosed with the infection. The sense of guilt he felt was so much that he wanted to die. He

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78 UNICEF 2003, ‘Community based studies on Gender and HIV/AIDS’
was guilty because it was all because of his extra marital affairs and having multiple sex partners that he got infected and later transmitted it to his family members too.

The respondent kept blaming himself for the entire episode and the mental agony of a person was seen in him. He did not have the courage to share and reveal his HIV status to his relatives and family members. He feared that if he reveals, the entire family will be ostracized by the society. The fear of stigma and discrimination attached to this pandemic is wide, which makes him scared to reveal that he and his family are infected with HIV.

At present the entire family is under the ART (Anti Retroviral Therapy). It is a treatment for HIV infected person. It does not cure the disease but it rather aims to increase the life expectancy, reduce opportunistic infection and may potentially reduce the likelihood that an infected individual transmits the virus to another. The respondent also tries to maintain a good diet as much as possible.

As seen in all the three case studies, HIV infection has profound implications on family relationships. Traditionally, when a person is ill, the family is seen to provide emotional, practical and social support. But the recent study has shown that HIV disease like any other serious illness, affects the family members both in their day-to-day functions and those in the long run. What distinguishes HIV disease from so many other illnesses is the associated social stigma.

Families are the caregivers to sick members. There is clear evidence of the importance of the role that the family plays in providing support and care for PLWHA. However not all family response is positive. Infected member of the families can find themselves stigmatized and discriminated against within the home.

It is clearly seen from the above experience of the respondent in case study 1, that stigma attaches itself strongly to women because of negative assumptions made about sexual risk behaviour—even when a women has not engaged in any - and its association with HIV. This study in Nagaland reveals the fact that the HIV-positive women who were infected by their husbands, faces more stigma and discrimination than men and were often blamed for their husbands’ illnesses by their relatives and families. Women living with their husband’s family frequently faced expulsion when the husband died, and many had trouble finding
anyone to care for them when they themselves became ill. It was also found that domestic violence and physical abuse rises when the woman falls ill.

The gender inequality as well is imbedded in many cultural traditions and Naga society is also not free from it. The domestic burden of AIDS care falls especially heavily on women because of their traditional roles as care givers and homemakers, deeply engrained social attitudes and insufficient social services. Caring for family members affected by AIDS is a compassionate undertaking, but it is learnt that it is also a burden that can limit educational and economic opportunities for women and girls.

From the above case studies, it is found that stigma, discrimination and collective denial makes the life of the individual and that of family members agonizing. Even in their daily lives they are faced with severed relationships, desertion and separation from family members and relatives and even physical isolation at home. Children of PLWHAs regardless of their HIV status often face social and physical isolation for example, separate sleeping arrangements. Due to irrational fears among parents of other children, they are instructed not to befriend the children of PLWHA as seen in case study 2.

The illness and resulting death of fathers, mothers, children and siblings changes the very structure of this primary building block and is further exacerbated by the additional financial constraints placed on the family. The nodes of care within the immediate and extended family are impacted upon as the burden of care starts to exceed the levels of resilience within the family. Nuclear families are the most common in Naga society.

In some cases families are headed by only men or only women in the absence of a gender and families are starting to be constituted of mixed kin and blood. Single parent families are becoming more common as well. Families are headed by grandparents, in the absence of parental figures. The illness and resulting death of fathers, mothers, children and siblings changes the very structure of this primary building block and is further exacerbated by the additional financial constraints placed on the family. Borrowing from friends and relatives in order to sustain and taking loans, selling assets, using savings were also reported by the respondents which deeply affects the family life.

Traditional Naga families that have already developed internal ways of coping with crisis are mostly totally unprepared for the stress created by external pressures such as stigma. Whether the response is rejection or acceptance, families with a member discovered to have HIV infection or diagnosis with AIDS experience high levels of stress and disruption in all areas of family life.

Though the family system in Nagaland has the rich tradition of supporting and caring for the sick and the disabled, with regard to looking after and supporting those infected with HIV and persons with AIDS there are constraints. The main reason is the fear of contracting HIV and the social stigma attached to this infection. The ignorance of the people leads to misconceptions that lead to fear which in turn leads to discrimination. The discrimination by the members of the family increases the stress and this hastens the end of a person living with HIV/AIDS. Some of the respondents openly said that their family takes care of them but are treated as untouchables.

The magnitude of the social impact of HIV is clearly visible in all the three case studies. Case study one portrays the impact it has on women, another on the families and the other on the children. The amount of stigma and discrimination experienced are invariably high. There is actually a huge gap between understanding the problem and the negative response of the society and the individuals.

**IMPACT ON FAMILIES**

Family is one of the primary building blocks of society and forms the net that holds communities together. Families, by nature, are pre-existing networks of care and support and form a very important social resource in Nagaland’s response to the challenges of HIV and AIDS. On the other hand, HIV and AIDS pose one of the greatest challenges to families in history. HIV and AIDS touches at the very heart of families, drawing them closer together or driving them further apart.

According to Carol Levine, “Family members are individuals by birth, adoption, marriage or declared commitment, share deep, personal connections and are mutually entitled

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80 Gronningsaeter (2004), ‘Living conditions and quality of life among people living with HIV in Norway
and obligated to provide support of various kinds to the extent possible, especially in times of need”. The essential characteristics of these relationships are: permanence, commitment to mutuality of various forms of economic, social and emotional support and a level of intimacy. In the traditional marriage vows, there is the pledge to remain faithful even in times of sickness. Illness tests family strength and mutual commitment.  

In order to evaluate the impact of HIV/AIDS on families some case studies were done on families infected and affected with the epidemic. Two of the case studies related to it is elaborated below to understand the ground realities faced by them.

**Figure 3.6: One’s own response**

<table>
<thead>
<tr>
<th>One's Response</th>
<th>Very often</th>
<th>Often</th>
<th>Sometimes</th>
<th>Not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>23.00%</td>
<td>5.00%</td>
<td>43.00%</td>
<td>29.00%</td>
</tr>
</tbody>
</table>

In response to the question to one of the HIV infected respondent how one at times feel and whether they feel ashamed/shy to face the society, 43% of the respondents were of the view that sometimes they did feel ashamed because of their HIV status. While 29% were not at all ashamed. It was found (Refer Table 3.6) that 23% of the respondents very often feel uncomfortable to face the society. 5% opined they do often feel shy in inter mixing with people. Hence it is proved that due to the fear of stigma and discrimination faced in day to day life, they often feel uncomfortable in society.

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81 Levine, Carol (1992) ‘AIDS and the changing concept of family’, Milbank Quarterly
82 Thenpillil, Jose (2006) ‘Socio-Cultural dimensions of the HIV/AIDS affected’
Table 3.7: Stigma and Discrimination faced by the respondents

<table>
<thead>
<tr>
<th>Attitude of the people towards the PLWHAs</th>
<th>Total percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isolation and segregation by some individuals</td>
<td>22%</td>
</tr>
<tr>
<td>Affected ability to stay in a particular area</td>
<td>17%</td>
</tr>
<tr>
<td>Denial of the use of public property</td>
<td>15%</td>
</tr>
<tr>
<td>Unkind remarks and informing everyone about HIV status</td>
<td>10%</td>
</tr>
<tr>
<td>Involuntary participation or refusal of the hospital/clinic staff to medically provide treatment</td>
<td>10%</td>
</tr>
<tr>
<td>The forced relocation/transfer of job activities or fired from job because of HIV status</td>
<td>6%</td>
</tr>
<tr>
<td>Refusal of bank loans, disability or life insurance because of the HIV status</td>
<td>5%</td>
</tr>
<tr>
<td>Undesirable treatment in workplace</td>
<td>5%</td>
</tr>
<tr>
<td>Special identification marks or board displayed in the bed head tickets or on the bed in Hospital</td>
<td>2%</td>
</tr>
</tbody>
</table>

The present study projects how stigma, discrimination and collective denial associated with HIV infection make the life of the individual and that of family members makes the PLWA’s agonizing. Through this study, it was revealed that HIV/AIDS related discrimination is on the rise and they are sometimes denied the right to health services or discriminated against in health settings too. Table 3.7 describes how it even goes upto the extent of isolating and segregating by the individuals and the community.

Societal rejection towards HIV infected people is an important issue that happens in Naga society. Stigma and discrimination by the community is very much visible. A feeling of alienation and frustration develops among the members of the family. A social institution like marriage is also losing its shape, its sanctity and form due to HIV/AIDS that leads to social instability and chaos.
IMPACT ON YOUTH

Young people are the most threatened—globally accounting for half of all new cases of HIV—and the greatest hope for turning the tide against AIDS. The future of the epidemic will be shaped by their actions. Table 1.11 reveals that the maximum number of respondents belong to the age group 25-34, experience and the present study proves this. The few countries that have successfully decreased national HIV prevalence have achieved these gains mostly by encouraging safer behaviour choices among young people. Several factors make youth particularly vulnerable to HIV infection including their age, biological and emotional development, and their financial dependence.

HIV/AIDS has affected the social life of the individuals especially the youths. Domestic violence and abuse tends to affect the life of the youths. Crimes among family members often go unreported. Usually it is informed that victims do not report the issue because it is a “private/personal matter.” Because of the shame brought to the family, the study reveals frequent fights and quarrel in the family between the sibling and the parents. Abandonment by friends and family leads to depression and the victims feel denied and ignored by society.

With the advent of globalisation and western acculturation, premarital sex is rapidly becoming common among the Naga youths as well. The trend of premarital sexual activity is as high in smaller/lesser developed towns and rural areas as it is in larger urban areas, as observed from the proportion of adolescent girls from Tuensang, a district in Nagaland, reporting premarital sex to be as high as 23.3%. Early sexual activity is prevalent in the tribal community as Nagaland at the present juncture. One major observation is the rampant entry of young boys and girls in the various lounges and bars in Nagaland and resorting to anti social activities.

According to a PLWHA who is an injecting drug user of 29 years from Zunheboto, he stated that there is no healthy relationship between him and his parents because of his addiction as well as his HIV status. The study shows that he felt stigmatized and discriminated.

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83 InterAction. (2005), ‘AIDS: Overcoming the global epidemic’
84 UNAIDS, 2004 ‘Report on the Global AIDS Epidemic’
as he is disliked by all his family members because he is often denied of his needs and requirements and also rejected by his family during decision making processes. Often he has to be admitted in hospital and the family members remains negative to his needs and wants. He often feels ignored and unwanted. Most of the time, he stated that he thinks of ending up his life too but with the help of the counselors and other social workers, his spirit is lifted up to some certain extend.

Yet another cause of concern is the problem of unemployment in the state of Nagaland, in which the Naga youths in order to survive throng to the cities and other big towns. Migration in search of new jobs may be the leading cause of contracting the infection. Some respondents were of the opinion that when they reach a place where they do not abide by the strict social norms of their own communities, they often indulge in risky sexual behaviour and consequently found themselves to be HIV positive at a later stage. The observations from this study may be representative of just the tip of an iceberg owing to the small sample size. Since there were youth participating in this study who were working in the cities, it is possible that youths within the state could also be involved in increasing the state’s rise of the pandemic.

This study shows that Naga youths generally have the reliable information about sexual activity and its implications but they are often unlikely or unable to protect themselves appropriately as they demonstrate an inclination to sexual experimentation, often with multiple partners. These sexual behaviours, and sex in conjunction with drug and/or alcohol use, may increase the likelihood of becoming infected with HIV. In addition, young people’s sense of invulnerability (“It can’t happen to me”), combined with lack of experience, may leave them unaware of the consequences of their actions and therefore less likely to take precautions against risk of infection.

Young people have been impacted by the pandemic often indirectly. One of the young respondent of 25 years informed that often he gets mood swings and at times cannot control his temper thinking about all the implications of the infection. Such children often get violent and resort to crime as a way of getting back at society.
Another young female of the same age group who contracted the HIV infection from her parents keeps changing schools. When her peer groups comes to know of her HIV status, she was segregated from the rest of her friends, which makes her change the schools in order to keep herself away from shame. There has been responses from youths where they were rendered unemployed because they cannot or have completed schools or any vocational trainings. In this way young people continue to be at the growing center of the pandemic in society.

It is observed that fearing discrimination, around 28 percent men and 36 percent women have not disclosed their HIV-positive status in the community and as high as 75 percent have not disclosed the same in their workplace. The issue of stigma and discrimination remain at large. There have been reports of refusal to conduct funeral, refusal of treatment in Dimapur and transfer of a government employee from one district to another because of his HIV status. Discrimination even in workplace was noticed.

HIV/AIDS destroys human security both at an individual and at the collective level because it causes suffering and threat. It kills people at an extremely productive and reproductive age and creates demographic problems within the country. The respondents from the NGOs opined that they have lost at least 5-10 young people to this pandemic at their primetime. Society’s time honored security, time tested institution and the well being of its members is jeopardized by the pandemic. People disengage from their societies and AIDS orphans take to criminal activities.

**IMPACT OF HIV AND AIDS ON CHILDREN**

Children are highly valued in every society. They are the assurances of the continuation of the family lineage. Consequently a childless marriage is considered fruitless and incomplete. Unfortunately, according to the respondents 30-40% of their children was born and got infected with the virus. Though there were reported child deaths of about 10%, the remained sustained and goes through numerous sufferings and ailments. Deep emotional and psychological effects are experienced by the family, helplessly watching the children suffer. This trend threatens the survival of the human race in general and a small society like that of the Nagas in particular.
The HIV/AIDS pandemic poses major threats to the socio-economic and psychological welfare of the HIV affected and infected children. The pandemic adversely affect the household stability and sustainability, state of health and nutrition and increases the affected children’s vulnerability to infection.

Children of PLWHAs, regardless of their HIV status, face social exclusion such as not being able to play with other children. There have been cases of children sending away to live with relatives in the case of the death of the parents. HIV orphans are on the rise in the state of Nagaland. Stigmatization by peer groups and classmates is clearly visible through the case studies conducted. On the education front, Children Living with HIV/AIDS (CLHA) has been supported financially and nutritionally by various NGOs, Governmental agencies and the religious organizations. But this does not fulfill all the needs of the HIV infected children. Orphaned HIV infected children often resorts to stealing and robbery. He is not fed well by his relatives and guardians and in order to fulfill his needs he resorts to small thefts and by and by becomes a regular thief.

The loss of parents can have profound emotional, economic, and developmental consequences for any child, especially in poor households. In Mokokchung, AIDS has produced the phenomenon of child-headed households, where the oldest daughter has to care for her siblings in the absence of adults- the grandparents. This situation will be worse in cases where some of the children and are in need of medical care.

Children who lose a parent to AIDS often suffer discrimination, isolation, and impoverishment. When both parents die, extended family or community members, primarily women, often take in these orphaned children. Even when cared for by others, studies reveal that they are still looked down and stigmatized. It was learnt that a girl of 14 years in Dimapur whose parents were both victims of HIV/AIDS committed suicide by hanging herself to death. She was in the ninth standard at the time of her death. Being an orphan, she was raised up by her grandparents but it was learnt that in schools and in other social gathering, friends use to stigmatise her by informing everybody about the parents HIV status. This can be one of the
reasons behind her death. The lone surviving member in this family now is her eldest sister whose HIV status is not known as of now.

So far in Nagaland, child prostitution is not visible though there is the prevalence of child labour. In this study Hypothesis 1 states that poverty leads to prostitution and thus leading to the HIV infection in Nagaland. Through this study it is seen that though in the case of adults, this hypothesis is proved right, it is not relevant here in the arena of the children as child prostitutes are not seen in the entire state of Nagaland. The children are mostly affected through the parents where at the demise of both the parents, the child is automatically placed under the care of their immediate relatives or in other families as helpers in order to earn a living and to sustain in life. Through this study, it was observed that some orphans were eventually placed in orphanages and put up for adoption. The growing need to open up more orphanages for children infected with the pandemic was proposed by a couple of respondents.

The underlying factor of this infection course on the HIV infected family and children is family disintegration, community ineptitude etc. in many parts of Nagaland, traditional structures which provides coping mechanism have disintegrated leaving no one to take care of the children. Fortunate orphans are taken up by their ageing grandparent who struggles to feed their grandchildren (See Case study 2). These old people do not afford nutritious food or an education for these children as they could be seen struggling with age related problems of health and even the depression of losing their own sons and daughters to HIV/AIDS. Grandparents strive hard to keep the family going.

**IMPACT ON SOCIO-ECONOMIC DEVELOPMENT**

Today HIV/AIDS is considered as a major development and health problem in Nagaland. Though the scourge doesn’t have much impact at the macro level, it does have effects on those who are economically productive hence disrupting development in the state at the micro level. The impact of HIV and AIDS on the household income and employment of the affected persons and their caregivers; level and pattern of household consumption, savings
and borrowings; education of the children of affected families; and health status and household expenditure on medical care can be seen.

Because of the very different roles and responsibilities assumed by men and women, an HIV-related illness in the family affects men and women differently, and its impact also varies depending on whether the person who falls ill is female or male. In many instances, when a man falls ill, there is likely to be a drop in disposable household income.

A productive person is defined to be someone aged between 15 to 65 years.\textsuperscript{85} An adult therefore has approximately 50 years of productive work. In the case of death of the supporting parent, it results in lowered economic growth and thus hampers the daily life of the remaining household.

HIV/AIDS strikes people in their most productive years when they should be active in all the developmental sectors like in civil service, private and nongovernmental sectors. It is gender and age blind and brings about immense implication in the society.

\textbf{a) Impact of HIV status on income and employment}

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|c|c|}
\hline
Sl.no & Age group & WFPR & HIV infected household & Non HIV household \\
\hline
1. & 15-24 & 5\% & 7\% \\
2. & 25-34 & 34\% & 11\% \\
3. & 35-44 & 36\% & 20\% \\
4. & 45-54 & 25\% & 32\% \\
5. & 55 and above & X & 30\% \\
6. & Total & 100\% & 100\% \\
\hline
\end{tabular}
\caption{Comparison of Work Force Participation Rate}
\end{table}

The work force participation rate (WFPR) among the 25-34 and 35-44 years age group is higher in HIV households. This is represented by 34 and 36 percent among HIV households, against 11 and 20 percent respectively in non-HIV households. Comparatively,\textsuperscript{85} UNAIDS (2005) in its report on ‘A scaled-up response to AIDS in Asia and Pacific’
through this study it is found that WFPR in above 45 years is higher in non HIV household. It is to be mentioned here that the employed respondents in HIV infected household here are mostly employed in nongovernmental organization. Such high proportions effectively indicate the felt need to earn more in order to meet the increasing financial burden experienced by the HIV households.

b) Impact of HIV and AIDS on household consumption and savings

Respondents disclosed the hardships the family had to undergo nursing themselves as well as the family. They kept falling sick and contracted opportunistic infections from time to time which made them rush to hospital at least thrice a month. This implies that the epidemic is not only increasing the number of poor but also adversely impacting the disparity within the poor across HIV and non-HIV households.

The burden of diseases increases as the stage of infection of PLWHA advances, causing tremendous financial burden on the family. Implications of having ‘AIDS in the family’ have been noticed in the family of the respondents. They range from increased medical costs and expenditures on funerals to withdrawal of family members from work or school to look after those who are ill. When a man becomes debilitated or dies from HIV/AIDS, his wife or partner loses her main source of economic and social support, as are other dependent members of his extended family.

There have been cases in Naga society too where women who are not allowed to own property, at the death of a spouse, lost her home and land. Practices such as levirate (widow inheritance) and women’s limited access to productive resources and work opportunities compels widows to exchange sex for money, food or shelter. These women turned as Commercial sex workers (CSW), in order to earn and feed for herself and the family, which in turn leads to a higher risk of HIV transmission. While interacting with the CSWs mostly in Dimapur, the researcher was informed that they were compelled to resort to these immoral activities in order to sustain their livelihood. A CSW of 38 years informed that because of her husband’s habit of drunkardness, he did not bring any money for the family but use to ask money from her instead to get his drinks. With no other sources of income, they were left with no other option or alternative than to take up this profession. Hence, it is proved
that poverty leads to prostitution and in the process; the practice of unsafe sex leads them to HIV infection

In another case, it was also informed to the researcher that there are reduced savings and investments for the HIV infected families as per the response from one of the infected respondent. Mostly money gets spend in health care and nutritional supplements.

Loss of income, additional care-related expenses, the reduced ability of caregivers to work, and mounting medical fees push affected households deeper into poverty. It is estimated that, on average, HIV-related care can absorb one-third of a household’s monthly income.

Tapping into available savings and taking on more debt with high interest are usually the first options chosen by households struggling to pay for medical treatment or funerals. As debts mount, precious assets such as livestock and even land are sold, and as debt increases, the chance to recover and rebuild diminishes.

HIV epidemic is a complex phenomenon in the world today. It challenges the accepted ways of understanding health and human development in the Naga society and demands new forms of expertise and holistic responses. HIV is not only a product of human action but also a disease of the disadvantaged and uneven development.

Experience of the past decades in Nagaland shows that, along with the change in time, society changes. At the present juncture, Emile Durkheim’s classification of social solidarity into ‘mechanical’ and organic solidarity as part of his theory of the development of societies in ‘the division of labour in society’ (1893) is very much relevant here. Mechanical solidarity normally operates in traditional and small scale societies. In simpler societies, solidarity is usually based on kinship ties of familial networks. Organic solidarity comes from the inter dependence that arises in specialization of work and the complementarities between people- a development which occurs in ‘modern’ and ‘Industrial’ societies. Naga people who used to be hardworking and simple people and confined within the four walls of the state bonded by the social norms of Naga society have witnessed a paradigm shift from mechanical to organic solidarity. Naga society seems to be more into organic solidarity that the mechanical solidarity. The traditional Naga society is transforming into a modern complex
technological culture. People migrate from rural to urban set up and expose themselves to popular culture. It is seen that the members of the urban families abandon their age old cultural values and gets adapted to the new popular culture. Loss of institutional command over the individuals and loss of moral values, ethical values and spiritual values that are seen in mechanical solidarity is vanishing day by day.

Stigma and discrimination are not only obstacles to HIV prevention, care and treatment for people living with HIV, but are among the epidemic’s worst consequences. HIV-related stigma consists of negative attitudes towards those infected or suspected of being infected with HIV and those affected by AIDS by association, such as orphans or the children and families of people living with HIV.

Discrimination against People Living with HIV refers to any form of arbitrary distinction, exclusion or restriction affecting people because of their confirmed or suspected HIV-positive status. Both place a burden on human development by denying hundreds of thousands of people the chance of reaching their full potential. HIV-related stigma and discrimination are found in all parts of the world, but their manifestation varies from place to place. Half the participants in this study believed that punishment was an appropriate response towards those living with HIV, over half (56%) of the respondents were unwilling to be friends with HIV positive people and 73% thought that those living with HIV should be isolated. Stigmatizing attitudes tended to be associated with being male, older, married, less educated and unwilling to be tested for HIV. Such attitudes have serious implications.

Research in other parts of the country shows that to avoid stigma and discrimination some HIV-positive people refuse to get information about HIV and sexually transmitted diseases, staying away from health-care professionals and shunning those suspected of risk behaviour in an effort to blend in with community norms. HIV-related stigma is frequently conflated with negative attitudes towards marginalized groups and may be reinforced by legislation and legal systems that attack basic human rights.

HIV/AIDS has had a powerful impact on other epidemics. For example, AIDS is the primary force behind the global resurgence of tuberculosis. Determined responses in

86 Lieber 2005, ‘HIV/AIDS and Development in South Asia’
prevention, care, support and treatment can do much to reduce the epidemic’s impact, and welcome surprises may be in store as antiretroviral treatment is rolled out around the world. Yet one thing is sure that no matter how the AIDS epidemic takes shape in any given country, its social and economic effects and particularly its erosion of human capital—will continue to grow for many years after prevalence begins to fall.

In order to combat stigma and discrimination, all levels of society needs be involved. The legal process requires its involvement at the international and national levels to ensure that the rights of HIV infected persons are protected. Measures needs to be put in place to ensure that this is enforced at the local level. In the end, education is the key. Stigma and discrimination is largely due to myths about HIV and its transmission. Education programs worldwide about the methods of HIV transmission (in particular the ways it is not transmitted)\(^{87}\), ways in which one can protect oneself from infection and treatment options will go a long way in the battle against stigma and discrimination and thus the battle against the worldwide pandemic as a whole.

Many lives have been infected and destroyed by HIV/AIDS. The stigma and discrimination does not allow the PLWHAs to lead a normal life. It is seeping into the Naga families bringing intense implications. In order to mount a more meaningful response to HIV epidemic, this study suggest that there is an urgent need to actively involve various agencies like the NGOs, governmental agencies, law enforcing agencies, churches, individuals etc. to combat this menace in society. In the absence of increased joint initiatives, it is indicative that this problem will continue to cause untold human suffering and death affecting the whole social system.