CHAPTER I

UNDERSTANDING HEALTH, DISEASE AND SOCIALISATION: AN INTRODUCTION
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AN INTRODUCTION

Culture provides individuals a framework for understanding their everyday life experiences, including those of health and disease. Specifically, each culture has its own perspectives of disease and health care practices which have a bearing on how individuals identify, select and respond to health, disease and the medical care. Through socialisation, such perspectives and beliefs are transmitted from one generation to another. Besides, every society has its own references and definitions of what is good health, what are sound health practices and prescribes dos and don'ts since childhood through socialisation process. This, in a way, makes the child aware of the acceptable and expected health behaviour in that society. Thus, socialisation of an individual right through the childhood holds the key to his/her health behaviour in his/her adolescence, youth or adulthood which in turn has a bearing on the general well-being of the society.

More importantly, education, both formal and informal, performs the crucial role of transmitter of the process of socialisation of the child or adolescent or adult. The informal socialisation that takes place at home, in the peer groups and in the community, transmit both facts and myths about sound health practices that may shape the health behaviour and beliefs of an individual. While the facts have positive effects on the individual and group behaviour, myths tend to perpetuate ignorance, fear, taboos, etc. On the other hand, the formal socialisation in the school or in the college may further accentuate or reinforce both the facts and myths in the minds of an individual. Schools/colleges transmit values of health through curriculum, through the teacher, through specific campaigns of ‘good’ health, etc. It is in this
context, the study aimed to examine the perceptions of college-going youth to HIV infection or AIDS disease in the case of Manipur. The study chose HIV/AIDS as a case because, it is still not explored in so far as research studies in social sciences are concerned and not many studies have focussed on the socio-cultural context of HIV/AIDS awareness among the undergraduate youth in the country. In recent times, rates of HIV infection continue to rise among the young people. More than half of all new HIV infections occur among young people (aged 15-24 years) and almost 11.8 million youth are living with HIV/AIDS in the world. The growing menace of the HIV infection and AIDS among the young people is seen as a threat to the progress and development of a society. Since vaccine and cure for AIDS remain elusive, the steep increase in the number of young people living with AIDS is an issue of universal concern and a great challenge. Thus, awareness continues to be one of the most important strategies in the fight against AIDS. That is why, the present study explores the linkages between socialisation, culture and awareness about AIDS. Manipur is selected as it is one of the high HIV/AIDS prevalence states in India and it has been an interesting case on the HIV/AIDS map of the country. Primarily, HIV/AIDS in Manipur is spread mainly through Intravenous Drug Users (IDUs), but now spreading rapidly through sexual transmission even among the general population. The study examines the issue from the perspectives of sociology of education, health, and public health. It makes an attempt to understand how under-graduate students view, interpret and respond to health and disease in Manipur. The study focuses on the under-graduate college students as they form the most vulnerable group for the incidence of the infection and disease. The study aimed to understand how cultural elements are
incorporated into the education of the students in terms of health practices, mainly in terms of the educational elements that are taken into account at the level of the family, community and the formal structures like schools and colleges. The study also examines the perceptions of students towards the HIV/AIDS infected individuals and groups and presents cases of a few HIV/AIDS infected people and how they perceived their own predicaments.

This Chapter presents a discussion of the conceptual and theoretical perspectives to understand and examine the issues of health, disease and illness. It provides a discussion of the cultural context to understand the linkages between socialisation and health practices. The Chapter also discusses 'AIDS' as a disease and also draws the socio-cultural implications of HIV/AIDS which may provide the basic theoretical and thematic background for the present study.

**Health, Disease and Illness: Conceptual Understanding**

The concept of health may be regarded a situated concept (Mehta, 1992). This implies that one may be in good health as now and then and the next moment, the same person may become unhealthy, sick and ill, which is the obverse of health. Thus, health is to be viewed in a time frame and in the context of a socio-cultural or physical environment. This does not, however, mean that one cannot conceive health with a consistent pattern of its presence or absence. To a layperson, health would mean a sound physical body. It is, more so, a condition of a body that helps a person to perform his/her day to day activities to the expectations of others.

It is difficult to conceive health without its contrasting concepts, that is, disease and illness. Health may be considered as
absence of disease which reflects some discontinuity with the everyday state of being of an individual. Thus, the concept of health may mean absence of disease or illness and illness would logically, mean absence of health. According to Mechanic (1978), disease usually refers to a deviation in the normal functioning of the body which produces discomfort or adversely affects the individual's future health status.

Moreover, every society has certain norms, values and ideals in regard to health and disease, a deviation from which is treated as an aberration or a disease. Disease can also be explained in terms of an invasion of an organism by germs, bacteria or other pathogenic agents which disturb the homeostatic balance and result in some form of malfunctioning (Najman, 1980). Thus, the concept of health and illness can perhaps be distinguished from one another for a qualitative understanding (Mehta, 1992). However, in common usage, one may be visualising them with similar reference. Health is defined by the Constitution of World Health Organisation (WHO) in its Preamble as “a complete state of physical, mental, and social well being, not merely free from sickness or infirmity” (1946: 100). This is a definition of positive health. It goes beyond the mere absence of a disease, the focus being on maintaining good health, rather than on treatment of different diseases. This definition views health as a multi-dimensional concept and components of health being physical, mental, and social health. Perry (1999) also describes health as a dynamic state of well being, with physical, social, psychological and spiritual dimensions. He maintains that a broad view of health which includes all these dimensions is very important while considering the health behaviours of adolescents. Because the outcomes of health risk behaviours may occur in more than one dimension of a young person's life.
In medical sociology, a disease, on the other hand, is considered an adverse physical state consisting of a physiological dysfunction within an individual (Cockerham, 1995). Illness refers principally to a person’s subjective experience of lack of health and is indicated by feeling of pain, discomfort and the like. To say that a person is ill implies that the consequences of such a state transcend not merely the biological or physical consequences of organic malfunction, but it also affects the person’s social life in important ways (Field, 1976).

The concept of health and illness becomes institutionalised within the social and cultural milieu of each society. According to Banerjee (1982), every society has a health culture of its own - its own cultural meaning of its health problems, its health practices and its corps of practitioners. Health culture has been considered as a sub-cultural complex of the entire way of life of the people. This changes with the dynamic change of the culture of a community. As a component of its overall culture, the health culture of a community is shaped by the interplay of a number of social, political, cultural and economic factors (Basu, 1992). Thus, there is a change in health culture in different social milieu.

Every community views health or illness from its own cultural perspective (Mehta, 1992: 114). The beliefs, practices, customs and traditions of a community significantly determine the perception of the disease, interpretation of symptoms and the techniques of the treatment. Primitive human beings relied more on their instincts to stay healthy and since they could not largely comprehend the functioning of the human body, magic became an integral part of the beliefs about the causes and cures of health disorders (Dubos, 1969). Further, what is illness and what is not is determined largely by cultural orientations of the people. In other words, what is considered illness in one society may not be viewed the same in
another. Thus, perceptions of a disease, illness or sickness are relative in reality.

No society or individual is free from illness although the frequency and degree may vary from man to man and society to society. Every society has developed a system to cope with diseases according to its beliefs and values (Pokarna, 1994: 83). The perception of a disease and its cure assumes different dimensions in different societies. Regardless of a society's level of medical knowledge and technology, the structure of medical science still functions within the context of values, attitudes and beliefs of the people comprising that society (Cockerham, 1995).

In traditional societies like India, the common beliefs, customs and practices connected with health and disease have been found to be intimately related to the causes of a disease. For example, religion is very important in guiding individual health behaviour. Disease has been attributed to extra-biological reasons such as man's disobedience of natural and religious laws. It has been attributed to the sins and crimes committed by a person in the present life or in the previous lives (Srivastava and Saksena, 1991: 74). Some diseases have been attributed to the wrath of gods and goddesses. Sickness to people in rural India is as much a moral as a physical crisis, that is, in their conception; the roots of illness extend to the realm of human conduct and cosmic purpose (Carstairs, 1955). Further, Hasan (1967) points out that in a village, people attach no importance to health; their beliefs, values, customs and practices are directly related to the phenomenon of health and disease. In his village study, he argues that there are some factors which directly affect the health of the community. These are related to certain beliefs, values and religious taboos. Further, the lack of knowledge in rural areas affects and influences the health behaviour of the people (Hasan, 1967).
Sociological Perspectives on Health, Disease and Illness

The determinants of health and disease are observed to be influenced by the social, economical, cultural and political factors. It has been observed that physical, cultural and social environments affect the state of health of an individual, family, group and society. The sociological study of health and disease opens an important window on more general social processes rather than the biological processes. One of the few attempts to outline the conceptual foundations of medical sociology can be found in Gerhardt’s (1989) book, *Ideas about Illness*, which provides a critical account of the sociological importance of health and illness. According to Gerhardt, the first sociological perspective which developed a distinctive analysis of health and illness is that of functionalism. This is concerned with the importance of health to the functioning of the social system as a whole.

Parsons (1951) was one of the first to view illness as deviance and to postulate his concept of sick role through the functional perspective. Parsonian functionalism looks at the role a sick person plays in society and focuses on how ‘being ill’ is given a special form in human societies. It is concerned with the importance of health to the functioning of the social system as a whole. In the writings of Parsons (1951), health is conceived as one of the preconditions of social action. An optimum level of health in the population as a whole is seen as a prerequisite for the smooth functioning of modern society, based on achievement and effective social organisation. Further, illness, both biological and socio-cultural in origin, is conceptualised by Parsons (1951) as the inability of individuals to carry out their everyday tasks and social roles. This might be because of either the incapacity of the person to remain well in the face of disease or trauma, or a (partially
motivated) tendency to fall ill in response to stress; in the latter instance, illness is conceived as a deviance (Bury, 1997: 4).

The basis on which illness has been defined as a deviant behaviour lies in the sociological definition of deviance, for instance, any behaviour violating the social norms within a given social system. Parsons (1951) views sickness as a disturbance in the “normal” condition of human being, biologically and socially and ‘being sick’ is not just experiencing the physical condition of a sick state. Rather it constitutes a social role since it involves behaviour based on institutional expectations and is reinforced by the norms of the society corresponding to these expectations (Mehta, 1992). A major expectation relates to inability of the sick to take care of himself/herself and the consequent need to seek medical help and to co-operate with the medical practitioner to get well.

Conflict perspective of health, disease and illness developed in reaction to Parsons and functionalist theory in medical sociology. With its roots in the work of Karl Marx, conflict perspective is concerned mainly with the relationship between health and illness and capitalist social organisation. The main focus of this perspective is on how the definition and treatment of health and illness are influenced by the nature of economic activity in a capitalist society (Bilton et al., 2002: 359). According to Bury (1997: 6), Marxists emphasised that, despite the contention that (capitalist) society had a stake in recognising and promoting positive health, a great deal of ill health went unrecognised. Much illness went officially unrecognised and therefore untreated. Marxists also claim that health problems are closely tied to unhealthy and stressful work environments. Rather than seeing health problems as a result of individual frailty or weakness, they are seen in terms of unequal social structure and class
disadvantages that are reproduced in capitalist societies (Bilton et al., 2002). Patterns of mortality and ill-health (morbidity) are closely related to occupation, especially in the case of the industrial working class. Thus, social divisions and conflict are seen to be behind observed patterns of illness; and that health and illness are not just biological events or the result of ill-specified forms of social strain (as they had been in Parsons' formulation) but socially created through deprivation and social environmental breakdown (Gerhardt, 1989: 267).

Conflict is also seen to be at the root of the doctor–patient relationship. For Freidson (1970), the rational medical model is a means of exerting medical dominance over the patient and excluding the lay construction of illness from the clinical encounter. In this account, patients are occupied by their subjective experience of illness while doctors are preoccupied with disease. It is the doctors' definition of the situation that prevails. This approach to medical power formed part of a general sociological critique and a more negative view of professional power in modern societies (Bury, 1997: 6).

An alternative approach, based on the interactionist perspective, developed alongside conflict theory. Symbolic interactionism is concerned with examining the interaction between the different role players in the health and illness drama (Bilton et al., 2002: 359). The focus here is on how illness and the subjective experiences of being sick are constructed through the doctor–patient exchange. The argument put forward is that illness is a social accomplishment among actors rather than just a matter of physiological malfunction. Interactionist theorists emphasised negotiation in both the occurrence and social responses to illness. In illness occurrence, a negotiated element is seen as central to the detection and naming of symptoms. As Gerhardt (1989: 159)
suggests, in chronic disorders in particular, a series of exchanges are seen to take place between the individual and others as the 'negotiated reality' of the disorder unfolded. Chronic illness, entailing a long term threat to self and identity, had to be negotiated with others in an attempt to maintain a sense of normality. Interactionist theory emphasise the significance and meaning of behaviour rather than its causation (Burns, 1992).

According to the symbolic interactionism, identity is created through interaction with others. Learning to become a social being means learning to achieve control over this process by managing the impressions others have of us. This creative capacity is evident when we play the role of a patient in our encounters with health-care practitioners. Practitioners also attempt to create impressions of themselves for us (Bilton et al., 2002: 360). Thus, responses to illness, including those in doctor-patient relationships, could be characterised as a process of interaction, involving negotiation. The changing nature of illness over time also emerged as important in the negotiation perspective because the long term effects of treatment are seen as equally important to the experience of symptoms. Agreements about the nature of illness and its treatment, reached through negotiation, whether in professional or lay circles, are seen to be influenced by the social context as the trajectory of the illness unfolded (Gerhardt, 1960: 160).

Thus, sociological perspectives are based on distinct theoretical assumptions about how best to understand health and illness in a society. On the one hand, Parsons (1951) suggests that illness and disease create structural and behavioural problems that society needs to resolve through normative, rule-governed role performances and, on the other hand, Marxists emphasise the political economy of health, in that there is considerable inequality in the ways in which health and illness are defined and managed,
and this reflects the wider social structures of capitalism. Further, Interactionists stress on how definitions of illness and appropriate behaviours surrounding it are elastic and precarious because they are constructed through interaction (Bilton et al., 2002). In sum, each of the three perspectives have laid stress on different processes to understand the notions of health, illness and disease.

**Cultural Context of Socialisation and Health Practices**

The process by which individuals learn the culture of their society is known as socialisation. The socialisation of the young means that they learn to appreciate the shared meanings and values of the culture at large or take them as guide to direct behaviour patterns in their own life. In any particular culture, it is through the process of socialisation that the child acquires the attitudes and values of that culture and develops into an individual with culturally appropriate behaviour patterns. The life style that an individual adopts and his/her personality are largely a matter of the socialisation practices prevalent in his/her culture. As such, socialisation is a mechanism of cultural transmission. According to Duncan Mitchell (1968), socialisation is the life long process of inculcation whereby an individual learns the principal values and symbols of the social system in which he/she participates and the expression of those values in the norms composing of the roles he/she and others enact. It subsumes all the processes of enculturation¹, communication and learning through which the individual human organism develops a social nature and is able to participate in social life (Mitchell, 1968).

¹ Enculturation is the process whereby an established culture teaches an individual by repetition its accepted norms and values, so that the individual can become an accepted member of the society and find his or her suitable role. Most importantly, it establishes a context of boundaries and correctness that dictates what is and is not permissible within that society's framework.
In an article written in 1911, entitled 'Education, its Nature and Role', Durkheim asserts, on the basis of 'historical observation', that 'every society, considered at a given moment in its development, has a system of education which is imposed on individuals' (Cited in Filloux, 1993). Every society sets itself a certain 'human ideal', an ideal of what a person should be from the intellectual, physical and moral points of view; this ideal is the crux of education. Durkheim (1956) defined education and socialisation as the processes by which individuals learn the ways of a given group or society. Education and socialisation are the moral tools needed to function in society. According to Durkheim, education is "...the means by which society prepares in its children, the essential conditions of its own existence". He goes on to add, "society can survive only if there exists among its members a sufficient degree of homogeneity, education perpetuates and reinforces this homogeneity" (p.203). In other words, through education, the 'individual being' is turned into a 'social being'.

The process of socialisation is operative not only in childhood but throughout life. It is a process which begins at birth within the context of the family and continues unceasingly until the death of the individual. According to Parsons (1955), two basic functions of the family are: (a) the primary socialisation of children and (b) the stabilisation of adult personalities of the population of society. Primary socialisation takes place during the early years of childhood when children are taught norms and social roles within the family; secondary socialisation occurs subsequently when the child is influenced by other agencies such as school and peer groups. Primary socialisation involves (a) the internalisation of society's culture and (b) the structuring of the personality. According to Parsons, only the family can effectively carry out these two functions (Parsons and Bales, 1955: 16-17)
The Family and Socialisation in terms of Health Practices

As mentioned earlier, the family is by far the most important primary group in any society. The primary socialisation of the new generation through the family is probably the most important aspect of the socialisation process. By responding to the approval and disapproval of parents, the child learns the basic behaviour patterns, required norms, beliefs, values, etc. of the society. The family represents the primary setting within which individuals acquire information concerning health, learn specific health-related behaviours, and function as caregivers to others (UNAIDS, not dated). It has a significant influence on the variety of health related behaviours. From their family, most children learn basic health and hygiene, eating habits, beliefs and a prescribed set of values.

Further, norms at home, encouragement from family members, emotional support and positive or negative reinforcements are extremely strong influences on a child's health-related behaviour (Potvin, 1995). For example, how food is viewed and used in a family has a powerful influence on a child's eating behaviour and his or her future dietary choices. Parents' attitudes make a difference as to whether or not children will adopt certain desirable or undesirable behaviours. Their health related behaviour also strongly influences whether a child or adolescent will adopt a healthy behaviour and family support is an important determinant of an individual's ability to change an unhealthy life style (Campbell and Larivara, 2004). American researchers, Nolte et al., (1983) found that a child whose parents disapprove of smoking is five times less likely to start smoking than one whose parents show no objection.

A family environment that enables children to develop autonomy and a sense of responsibility generally leads to their adoption of healthier lifestyles. According to Potvin (1995), children
from families offering a lot of verbal exchange and emotional support have been found to have healthier diets. On the other hand, low family cohesion, high family conflict, too rigid or too permeable family boundaries, lack of clear communication and poor spousal support have all been consistently linked with poor health. Traditionally, elders of the family guide and regulate the individual choices of lifestyle and behaviour. As individuals experience greater freedom, they are exposed to new situations, opportunities and problems having to take decisions on their own (Hans, 1994: 26).

Moreover, the secondary informal socialisation reinforces the primary socialisation by the family. As contact with others grow, other alternatives become available to the child. He/she is introduced to the new social institutions or agencies. The influence of parents/family is reduced because the new reference groups such as peer groups become more important. Main agents of secondary socialisation include community, peer groups, the schools/colleges etc.

**Secondary Informal Socialisation and Health Practices**

Firstly, community\(^2\) plays an important role in the socialisation of an individual. It plays an important role in health and disease by adopting practices designed to prevent illness and promote health. Public health measures such as sanitation, safe drinking water supply, immunisation of children against diseases, maternal and child health care, nutritious food, health education of community members, etc. help in the socialisation of the child

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\(^1\) According to MacIver (1996: 8), wherever the members of any group, small or large, live together in such a way that they share, not this or that particular interest, but the basic conditions of a common life, we call that group a community. The mark of a community is that one's life may be lived wholly within it. Further, agencies like UNAIDS defines a community as "a group of people who have shared concerns and will act together in their common interest".
Moreover, traditional healers and community health workers could also provide health and counseling services, which enable the socialisation culturally rooted (Aggleton and Warwick, 1999a). Traditional healers are consulted by a great majority of people at some time or the other, and are often the first resort in times of sickness. The traditional healers provide client-centred, personalised health care that is culturally appropriate, holistic, and tailored to the needs and expectations of patients. The fact that they are trusted and respected within their communities is especially important with sensitive issues like sexually transmitted infections.

Secondly, a child’s peer group allows them to escape the direct supervision of adults. Children are free to act like children rather than like adults. Children talk more freely about topics that they may not feel comfortable discussing with adults (sex, drugs, girls/boys) (Rogers, 1999). Peer groups become more prominent during adolescence. As adolescents begin spending more time with their friends and less time under their parents’ supervision, their greatest source of influence may change from that of family to that of their peer group (Selvan and Kurpad, 2004). Adolescence is a very crucial period in the life of an individual. It is a twilight zone in which society neither accords them full adult responsibility and roles nor considers them children. During this period, children move from a period of sheltered, cared and dependent life towards independent and responsible life of adulthood. The adolescents tend to assert their identity, start taking their own decisions, distancing from their parents, depending more on their peer groups and demonstrating strong preference for privacy. In direct

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3 Peers are people of roughly the same age (same stage of development and maturity), similar social identity, and close social proximity. They are friends, buddies, pals, troops, etc. Usually these are neighbours, family members, or day care mates. With peers, the child begins to broaden his or her circle of influence to people outside of the immediate family.
alliance with the media, teenage peers form their own sub-culture. They learn how to navigate the complexities and nuances of group interaction largely without adult guidance or supervision.

Peer groups aid in the socialisation process because children in certain groups conform to the ideals/accepted ways of that group while disliking other groups. Joint activities, sharing, trust, and mutual understanding become key concerns while interacting with peers (Tiwari and Kumar, 2002). Sometimes children learn the norms and behaviour patterns of members of their groups and these may be in contradiction to those of their family. An adolescent’s health behaviours or practices are also largely influenced by his peer groups. According to Keenan et al., (1995), adolescent’s peer group culture is believed to play a significant role in the onset of life style risk behaviours, and empirical observations have reported that having friends who practice health risk behaviours is a strong predictor of teenagers also adopting such behaviours.

The young people are hesitant to talk about matters like their own physical and physiological growth and related issues (safe sex, condom use, sexually transmitted diseases, contraceptives) with others. As a consequence, they seek most of their information from their peers. The information they receive from their peers is not always adequate or accurate. Due to the lack of correct information and knowledge they practice behaviours that put them at risk.

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4 A subculture is a group of people with a culture (whether distinct or hidden) which differentiates them from the larger culture to which they belong. If a particular subculture is characterised by a systematic opposition to the dominant culture, it may be described as a counterculture.

5 A risk group may be defined as all those individuals belonging to a set with the characteristic that is associated with increased relative risk.
The School and the Formal Health Socialisation

Education is aimed at preparing students for adult roles and responsibilities through socialisation and transmission of knowledge and skills. The "School" here, is used to refer to a whole range of formal educational institutions. It is an example of formally organised agency for the purpose of inducing the child into his/her society. Schools enlarge children's social world to include people of more diverse socio-cultural backgrounds. In other words, the school is the official agency where a society transmits its accumulated knowledge and skills from one generation to the other.

Schools provide two contexts for students. The first is the formal context of the classroom wherein the content of socialisation is determined by the curriculum, text books and the cognitive aims of the process of teaching. Whatever the students learn through curricula and co-curricular activities of the school is a part of the cultural heritage of the society (Shah and Shah, 1998). The second context is informal and can be perceived in the interpersonal relations of students with teachers and also among students (peer group). Regardless of the relative strength of these influences, schools are designed to promote learning in this moral, social sense as well as in academic work (Shipman, 1976: 173).

For children a teacher becomes a model with authority and knowledge. In schools, teachers may provide students information and experiences about the change in the modes of living, in the fields of health and health practices, leisure, vocation, etc. Sometimes, they may formalise the information about health and disease by including it as a part of the curriculum or sometimes they may simply launch informal educational camps/campaigns to make students aware of the problems of health and disease. In schools, the content of socialisation as well as knowledge to be
transmitted becomes the focus of the curriculum and syllabi and a set of carefully prescribed practices. What parents did or do by instinct and with love, professionals do it with clear, regular and justifications. The socialisation process within the school may or may not supplement or reinforce the process within the family. Thus, in the process of socialisation, health and health related behaviours are transmitted from one generation to another through informal and formal socialisation of a student. It is in this context that the present study aims to understand the linkages between culture, socialisation and health practices with reference to HIV/AIDS.

**AIDS as a disease**

AIDS stands for 'Acquired Immuno-Deficiency Syndrome' and describes the collection of symptoms and infections associated with acquired deficiency of the immune system. Infection with 'Human Immuno-deficiency Virus' (HIV) has been established as the underlying cause of AIDS. HIV is a retro-virus that infects cells of the human immune system and destroys or impairs their function. Infection with this virus results in the progressive depletion of the immune system, leading to 'immune deficiency' (UNAIDS, not dated). The immune system is considered deficient when it can no longer fulfill its role of fighting off infection and diseases. Immuno-deficient people are much more vulnerable to a wide range of infections, most of which are very rare among people without immune deficiency. According to UNAIDS (not dated), infections associated with severe immuno-deficiency are known as 'opportunistic infections'⁶, because they take advantage of a

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⁶ People with advanced HIV infection are vulnerable to infections and malignancies that are called 'opportunistic infections' because they take advantage of the opportunity offered by a weakened immune system.
weakened immune system. The level of HIV in the body and the appearance of certain infections are used as indicators that HIV infection has progressed to AIDS.

There are multiple ways in which HIV is transmitted. It is transmitted to the individual through sexual contact with an infected partner; transfusion of HIV infected blood and blood products; HIV contaminated syringes, needles and other body piercing instruments, in case they are not properly sterilised and shared by others and pre-natal transmission of HIV from an infected mother to foetus (NACO, not dated 2). Most people infected with HIV do not know that they have become infected, because no symptoms develop immediately after the initial infection. Some people have a glandular fever-like illness (with fever, rash, joint pains and enlarged lymph nodes), which can occur at the time of sero-conversion\(^7\). HIV infection causes a gradual depletion and weakening of the immune system. This results in an increased susceptibility of the body to infections and can lead to the development of AIDS. Despite the fact that HIV infection does not cause any initial symptoms, an HIV-infected person is highly infectious and can transmit the virus to another person. The only way to determine whether HIV is present in a person's body is by taking an HIV test. Persons infected with HIV may take ten years before they develop AIDS.

AIDS was first recognised in the United States in 1981, but probably existed at a low endemic level in Central Africa before the HIV epidemic spread to several areas of the world during 1980s (WHO, 2003). AIDS epidemic continues its expansion across the globe. In 2003, almost five million people became newly infected with HIV, the greatest number in any one year since the beginning

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\(^7\) Sero-conversion refers to the development of antibodies to HIV and usually takes place between 6 weeks and 3 months after an infection has occurred (UNAIDS, not dated).
of the epidemic. According to Joint UNAIDS and WHO reports on AIDS epidemic update on the global AIDS in 2007, the AIDS epidemic appears to be slowing down globally, but new infections are continuing to increase in certain regions and countries. The estimated number of persons living with HIV worldwide in 2007 was 33.2 million, a reduction of 16 percent, compared to 39.5 million in 2006. According to the same UNAIDS/WHO (2007) report, the single biggest reason for this reduction was the intensive exercise to assess India's HIV epidemic, which resulted in a major revision of India's estimates. An estimated 2.5 million became newly infected with HIV and an estimated 2.1 million lost their lives due to AIDS in 2007 (UNAIDS, 2007). Overall, the HIV incidence rate is believed to have peaked in the latter 1990's and to have stabilised subsequently, notwithstanding increasing incidence in several countries. Favourable trends in incidence in several countries are related to changes in behaviour and prevention programmes.

Till today, there is neither any vaccine to protect the individual and the community from this dreadful virus, nor any drug to cure if infection occurs. Progression of the disease can be slowed down but cannot be stopped completely (UNAIDS, not dated). The right combination of antiretroviral drugs can slow down the damage that HIV causes to the immune system and delay the onset of AIDS. AIDS thus, stands as an example of how certain types of behaviours (especially homosexuality or drug use) provided a particular virus with the opportunity to cause a deadly disease. The sociological implications of the AIDS epidemic are enormous and involve not only the widespread modification of sexual behaviour, but the deeply discrediting stigma attached to AIDS.

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8 In November 2007, UNAIDS has released fresh data on HIV/AIDS worldwide prevalence and it cites the total prevalence at 25 million across the globe.

9 HIV incidence rate is the proportion of people who have become infected with HIV.
victims, the social rejection of AIDS patients, the subjective distress associated with becoming an AIDS patient, and the moral and religious debate centering on AIDS as a punishment for a deviant lifestyle (Bennett, 1987).

**Social and Cultural Implications of HIV/AIDS**

From the moment scientists identified HIV and AIDS, the social responses of fear, denial, stigma and discrimination have accompanied the epidemic (UNAIDS, 2003). Discrimination has spread rapidly, fuelling anxiety and prejudice against groups most affected as well as those living with HIV/AIDS. Thus, this stigma and discrimination associated with HIV/AIDS may to be examined within the broader social, cultural, political and economic framework rather than individually (UNAIDS, 2003). Due to the association of HIV/AIDS with commercial sex, drugs and men having sex with men (MSM), the disease has acquired a stigma that is difficult to overcome in any society. Those infected and affected by HIV and AIDS have faced discrimination and alienation. Thus, it goes without saying that HIV/AIDS are as much about social phenomena as they are about biological and medical concerns.

Stigma, according to the UNAIDS definition, is a powerful tool of social control that can be used to marginalise, exclude and exercise power over individuals who show certain characteristics. While the societal rejection of certain social groups (e.g. homosexuals, prostitutes, etc) may predate HIV/AIDS, the disease has, in many cases, reinforced this stigma (WHO, not dated). Thus, much of the HIV/AIDS-related stigma builds on and reinforces earlier negative perceptions. People with HIV/AIDS are often believed to have deserved what has happened by doing something wrong. Often these wrongdoings are linked to sex or to illegal and socially frowned upon activities (Aggleton and Parker, 2002: 8). In many countries, for example, people with HIV and AIDS are often
viewed as having engaged in illicit sex with prostitutes (if they are men) or as having been "promiscuous" (if they are women). In some parts of the developing world, HIV may be seen as a "woman's disease," similar to many other forms of sexually transmitted infection (Malcolm et al., 1998).

An HIV/AIDS victim is exposed to discrimination right from the moment his/her illness is disclosed. According to Maluwa et al., (2002), the stigma associated with HIV/AIDS and the resultant discrimination frequently violates the rights of people living with HIV/AIDS, as well as the rights of their families. These stigma and discrimination can originate from governments, private organisations, and institutions, as well as from communities, families, and individuals. For example, in a study by Verma et al., (2000) on the impact HIV/AIDS with special reference to children in India, it is found that HIV/AIDS affected children are likely to be withdrawn from schools, are being forced to leave schools or prevented from playing with other children. According to UNICEF (2003), at the level of family and community, it causes people to feel ashamed, to conceal their links with the epidemic, and to withdraw from participation in more positive social responses. At the same time, family and community also often perpetuate stigma and discrimination, partly through fear, partly through ignorance, and partly because it is convenient to blame those who have been affected first.

Further, some jurisdictions require mandatory HIV tests before granting marriage licenses, thus denying those who test positive the right to marry (Maluwa et al., 2002). For instance, the Supreme Court of India in 1998 had held that the right of an HIV-positive person to marry is suspended as long as the person is HIV-
positive. A Bill was proposed in Andhra Pradesh, which requires mandatory HIV testing before granting marriage licenses. There have also been cases where companies have refused employment or dismissed employees from their companies because of a person’s HIV positive status. For instance, in Mumbai, the High Court had to step in and reinstate the dismissed workers who were dismissed because of their HIV positive status (UNAIDS, 2002b).

The stigma and discrimination associated with HIV/AIDS have also other effects. The shame that people living with HIV/AIDS experience when they internalise the negative responses and reactions of others is evident. Self-stigmatisation can lead to premature death through suicide. For instance, a patient who had tested HIV positive jumped off the fifth floor of a government-run South Mumbai hospital. This was not the only suicide in that hospital. The day after the incident, yet another HIV positive patient, who was admitted in the same ward with a respiratory infection, jumped off the fifth floor injuring himself and died soon after (The Hindu, May 5, 2005).

The impact of HIV/AIDS-related stigma and discrimination does not end here. AIDS stigma does not spare them even in death. There is no place for the AIDS-afflicted even in death. People are sceptical about the HIV spreading from buried corpses. For example, a woman in Kerala, which has the highest literacy rate in India, waited three days to bury the decomposed body of her beloved husband who had died from AIDS. The couple’s relatives, neighbours, and villagers stayed away and resisted his burial in the Panchayat burial ground. Hence the weeping women poured

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10 Judgement given by the Supreme Court in Mr X vs. Hospital Y Authority [reported in (1998) 8 SCC 296]. Considering that, at present, there is no cure for AIDS, in effect the decision in Mr X implies that the Petitioner's fundamental right to marry was completely infringed, and he could never marry. This judgement has now been set aside by the Supreme.
kerosene on her husband's body and burnt it while her little son and the scared villagers watched (*The Hindu*, October 17, 2002). Further, the stigma attached to HIV/AIDS may extend into the next generation, placing an emotional burden on those left behind. Thus, stigma and discrimination constitute one of the greatest barriers to dealing effectively with the epidemic and breaking the chain of transmission of HIV in the community (UNAIDS, not dated).

It is in this context, the present thesis explores, describes and examines how undergraduate students view, interpret and respond to AIDS within their own social background. The thesis is organised into seven chapters. Chapter II discusses the spread and issues relating to AIDS in India and Manipur. Chapter III presents a review of studies on HIV/AIDS in India and Manipur and provides the objectives and methodological details of the study. It also situates the study in its socio-cultural context, namely, of the state of Manipur. Chapters IV, V and VI present a discussion of the data gathered from students, parents and teachers. In Chapter IV, social determinants of HIV/AIDS awareness are discussed. The role of the family, school/college in generating HIV/AIDS awareness is discussed in Chapter V. The perceptions and attitudes of students towards aspects of stigma, discrimination and social exclusion of HIV/AIDS patients are examined in Chapter VI. The last and final Chapter VII summarises the findings of the study and draws the conclusions.