CHAPTER - I

INTRODUCTION

Acquired Immune Deficiency Syndrome (AIDS) is a disease of the human immune system caused by the human immunodeficiency virus (HIV). The condition progressively reduces the effectiveness of the immune system and leaves the individual susceptible to opportunistic infection and tumour. HIV is transmitted through direct contact of a mucous membrane or the bloodstream with a bodily fluid containing the HIV, such as blood, semen, vaginal fluid, pre-seminal fluid and breast milk (Sepkowitz 2001). This transmission can involve anal, vaginal, or oral sex, blood transmission, contaminated hypodermic needles, exchange between mother and baby otherwise called vertical transmission during pregnancy, childbirth, breastfeeding or other exposure to one of the above bodily fluids. However, sexual intercourse accounts for most of the transmission of HIV/AIDS. The HIV found mainly in West Africa is the HIV-2 strain, and the HIV-1 strain is prevalent in Europe, Asia, America and the rest of Africa (Peeters et al. 2003). The first recorded instance of a man who died of AIDS appeared in 1979 in the US and the discovery of the HIV-virus as the cause of AIDS was made in 1983 (Ibid). When it was established that the causative organism of mysterical disease was a virus, the name AIDS was first described in the United States of America in 1981.

Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) epidemic came to the attention to the world during the early 1980s and debates as to its origin continues to this day. According to Treichler (1999), some trace the origin of the virus to the African continent, whereas many Africans believe that AIDS may have originated somewhere else. This retroviral
disease has cost the lives of millions across the globe both in Western and in developing countries. The first case of AIDS is believed to date as far back as the 1930s, but only in the 1980s did it reach global proportions. The NACO (2013) estimates about 36.7 – 45.3 million people around the world are living with HIV/AIDS, and more than 25 million people have died of AIDS since 1981. Over 5 million people are newly infected each year, and more than 6 thousand lives are lost every day; 2.3 million children had been infected with HIV since the start of epidemic.

In India, the first case of HIV/AIDS was reported in the year 1986 in Madras. Since then, HIV and AIDS have become unquestionably the major public health problem in India and its prevalence have been on the rise for more than a decade and have reached alarming proportions in recent years. AIDS has become one of the major public health threats globally. So far, all the estimates have made us to recognise that HIV/AIDS is an alarming growing epidemic in India. According to UNAIDS (2013), India has the third highest number of people living with HIV/AIDS in the world as much as 2.1 million infected people. Whereas, the NACO (2013) estimated number of people living with HIV/AIDS in India is 2.8 million. In Manipur, about 40,855 persons have been infected with HIV/AIDS (MACS 2013).

It is currently the most devastating and contagious disease, as neither vaccine against HIV/AIDS exists nor does any medicine that can cure an infected person discover. Access to antiretroviral is essential for any possible survival for an infected person. However, because of the lack of vaccine or medical cure against AIDS, HIV-prevention is an important way to implement the right to good health. Preventive work does not only focus the medical aspect of HIV/AIDS but also on knowledge, behavior and the social response of HIV/AIDS. The virus is a great deal
more than a medical disease; it is also a social, psychological and economic problem that it affects society as a whole.

Stigmatisation and discrimination of people infected by HIV/AIDS is a common phenomenon all over the world. This tendency is often a result of lack of knowledge that leads to fear based on prejudices. In 1987, in the early epidemic’s history, Mann (1987), the former Director of the WHO Global programme on AIDS, identified three phases of the HIV/AIDS epidemic: the epidemic of HIV, the epidemic of AIDS, and the epidemic of stigma, discrimination, and denial. According to him, the third phase is “as central to the global aids challenge as the disease itself” (Ibid.). Parker (2000) also mentioned that AIDS has moved from being seen simply as a “disease to being reclassified as a social problem and one which carries devastating implications”.

Worldwide, stigma and discrimination are tremendous barriers to addressing the HIV/AIDS epidemic (UNAIDS 2001; Reidpath and Chan 2005). Despite international efforts to tackle HIV/AIDS since then, stigma and discrimination remain among the most poorly understood aspects of the epidemic. Piot (2000), Executive Director of UNAIDS, identified stigma as a “continuing challenge” that prevents concerted action at community, national, and global levels. Stigma and discrimination rarely act as single factor. In most cases, it is a result of different factors such as gender, poverty, ethnicity, and marginalised groups.

STIGMA AND DISCRIMINATION

The terms stigma and discrimination lack common, clear differentiation, and are often interchangeably used in the literature. This leads to a degree of academic uncertainty and even confusion (Geiselhart 2009). In the work Stigma: Notes on the
Management of Spoiled Identities (1963), Goffman provides the most profound modern theoretical discussion of stigma, as well as Geiselhart (2009) critically examined the two terms in use.

The term ‘stigma’ goes back to the days of Greek civilisation, when it referred to a mark branded on an individual’s skin for a wrongdoing (Crawford 1996). Since then, the term has undergone changes in meaning, no longer referring solely to a bodily mark, but also implying the ascription to or the bearing of an attribute that differentiates and distinguishes a person from others.

Stigma has often been associated with disfiguring or incurable diseases, in particular, diseases that societies perceive to be caused by the violation of social norms, including those that sanction sexual behavior (Crandall and Moriarty 1995). HIV/AIDS is a good example of this type of disease (Ibid.). A definition of stigma that has frequently been used in association with HIV/AIDS comes from a 1960s’ study on stigma in relation to mental illness, physical deformities, and “socially deviant” behaviours. This definition describes stigma as societal labeling of an individual or group as different or deviant because of a “discrediting attribute” (Goffman 1963). Parker and Aggleton (2002) describe stigma as a social process that involves identifying and using “differences” between groups of people to “create and legitimise social hierarchies and inequalities”.

When Goffman (1963) uses the term stigma, he refers to an attribute deviating from the norm, with the capacity to differentiate a person. According to him, a normative set of expectation is shared by every society, under which people are judged and categorised. Generally, the attribute carries negative connotations, possibly lowering the self-perception of the affected person. However, Goffman faced criticism from several authors for his narrow definition of stigma as he “fails
to consider that normative sets are not static and universal” but stigma is rather “…defined as a process constituted by social life” (Geiselhart 2009). In short, these dynamic processes are of changeable character. Charmaz (2000) writes, “…stigma arises in interaction and within relations”.

Stigma given may lead to possible negative consequences in the form of discrimination, exclusion of the affected person from the society. Whether consequences are negative or positive, it depends on the character of the attribute according to the valid set of standard normality. If an attribute threatens the security of the majority, as would a contagious disease, a negative reaction is more obvious.

According to Geiselhart (2009), “stigmatization appears as a matter of morality and thus is often regarded as being beyond the scope of an individual’s influence”; consequently, it adheres to logic that a moral evaluation accompanies stigma. Stigmatisation is rather a matter of cognition, being located in the imagination and attitudes of individuals not of action (Ibid). This might explain why people judged based on any one or many attributes tend to speak of stigmatisation rather than use the term discrimination while referring to themselves, denominated by Geiselhart as an “avoidance strategy of words”. However, Charmaz (2000) insists, “both enacted and felt stigma contribute to difficulties in preserving prior identity”, potentially leading to withdrawal from social relations and isolating the person in general.

In his book The Geography of Stigma and Discrimination (2009), Geiselhart is critical of Goffman (1963), advocating that the acceptance of the stigma in general is not a consequence of necessity. Furthermore, stigma and stigmatisation are not exclusively negative, but dependent on the view of the conferrer and carrier.
Cases where the person internalises the experienced discrimination or stigma they have been assigned are defined as cases of self-stigmatisation. Not only the person bearing the stigma is affected, but also the surrounding society might fear a “spread to family and social networks in reciprocal ways as well” (Kleinman 2011). This fear causes society to react adversely to the stigmatised, avoiding the person and his or her family or friends (Weiss and Ramakrishna 2001). Disclosure can however serve to gather support for the individual from similarly afflicted peers, for example via support groups (Ibid.).

The verb to discriminate derives from the Latin word *discriminare*, meaning to distinguish (Patridge 1977). Hence, this already implies a process of action, whereby it has become a term often used in political debates, consequently leading to negative connotations (Geiselhart 2009). Discrimination signifies an unequal treatment of a person or group. There is positive, neutral or negative discrimination although the term is often associated with negative treatment of someone. “Institutional discrimination is when rules, practices and regulations in a social system leads to that people or groups are being treated different; some are being discriminated” (Bergman 2005).

Discrimination can be seen as a possible consequence of deviating from the norm and being embodied in oneself or a group. Following Geiselhart (2009), to discriminate means “acting against” (most often minorities), whereas in contrast, stigmatisation refers to “attitudes”. These actions infer certain negotiable and changeable social and cultural conditions. Discrimination functions like a separative power; it makes difference amongst the undifferentiated. Discrimination separates the society and small social groups such as the family and neighbourhood into different units. It separates men from women and healthy from unhealthy into a
society that is split up into different parts (Hastrup and Ulrich 2002). It is also true that people experiencing discrimination often tend to deceive themselves, an attempt of self-protection.

**STATEMENT OF THE PROBLEM**

Tangkhul is one of the major Naga tribes predominantly living in Ukhrul and Senapati districts, Manipur in India and in the North-Western part of Myanmar. The epidemic of HIV/AIDS disease is not new in the Tangkhul society. Since 1993, the year when the first HIV/AIDS case was reported in Ukhrul, the number of infection continues to increase at an alarming rate. Since then, the initiation and attempt to control the HIV/AIDS epidemic by the people immediately began. However, to this day, the rate of HIV/AIDS infected people is on the rise. Further, many have died because of this epidemic. The first group of HIV positive cases was reported among drug users. Later, it spreads from IDU to sexual transmission, and then further into the general population. The impact remains devastating and the efforts to control HIV/AIDS are found inadequate, which in fact resulted to spread HIV and AIDS further. Based on the data collected by the District AIDS Prevention Control Unit, Ukhrul in 2014, there are at least 1324 people living with HIV/AIDS in Ukhrul district. According to MACS (2013), the number of HIV positive in estimated as much as 1670 in Ukhrul district.

It is learnt that the preventive measures have been undertaken over the last decade to mitigate the growth of this epidemic within the risk groups. Attempt has also being made by many groups for the well-being of the infected people through the execution and implementation of programmes under various HIV/AIDS related projects. Despite the public, institutions and the NGOs’ efforts in various ways in
the fight against HIV/AIDS, the infection diffuses; the epidemic continues to affect the infected people and their families, partners, and the caretakers of the infected people. Reports of HIV infected people who are being abandoned by the family members are widely known in the district. Some infected people have been evicted from their home and the community have denied their right to property and right to ownership. While many other infected people received verbal abuse and rejection from the uninfected people of the community. The community reactions towards the HIV/AIDS infected people have many negative implications on the life of PLWHA. These include traumatisation, economic insecurity and emotional disorder of the infected people. In the absence of in-depth studies on the above-mentioned issues, to study on the issues become a necessity. No individuals, institutions or organisations have done commendable study on the HIV/AIDS in Tangkhul society with an exception of some scanty reports on HIV/AIDS by the NGOs. The present work attempts to study the HIV/AIDS related issues in the identified district, primarily focusing on the HIV/AIDS related stigma and discrimination.

An anthropological study from a holistic perspective can help and throws a light on such phenomena and propose a number of solutions to overcome these issues through examining more closely on the fields in which stigmatisation occurs, the forms that HIV/AIDS related discrimination takes, individual, social and institutional determinants, and the responses to which stigmatisation gives rise. Only by understanding more about such processes will it be possible to develop the kinds of programmes and interventions that will be successful in preventing HIV/AIDS related stigma and the negative consequences to which it gives rise. Perhaps, this research may also have a positive implication and contribution for the district, state and even for future studies as well.
REVIEW OF LITERATURE

Stigma and HIV/AIDS:

From the beginning of the HIV/AIDS epidemic, stigma has been a crucial issue (Treichler 1999). AIDS related stigma refers to all unfavorable attitudes, beliefs, behaviors, and policies directed at persons perceived to be infected with HIV, whether or not they actually are infected and regardless of whether or not they manifest symptoms of AIDS. Stigmatisation is identified as members of social groups about which others hold negative attitudes, stereotypes, and beliefs, or which, on average, receive disproportionately poor interpersonal and economic outcomes relative to members of the society at large due to discrimination against members of the social category (Crocker and Major 1989).

The societal rejection of certain social groups may predate HIV/AIDS; the disease has in many cases reinforced this stigmatisation. By attributing blame to specific individuals and groups, society can absolve itself from the responsibility of caring for and looking after such populations (McGrath 1992). Gilmore and Somerville (1994) have described what they see as the four main features of any stigmatising response: the problem that initiates the reaction; the identification of the group or individual to be targeted; the assignment of stigma to this individual or group; and the development of the stigmatising response. Felt stigma is more prevalent - feelings that individuals harbour about their condition and the likely reactions of others (Scrambler and Hopkins 1986). Enacted stigma refers to actual experiences of stigmatisation and discrimination (Jacoby 1994).

Sources of HIV/AIDS related Stigmatisation and Discrimination:

The real or supposed contagiousness of disease has resulted in the isolation and exclusion of infected people (Volinn 1989). Sexually transmitted diseases (STD) in
particular are “notorious for triggering” socially divisive responses and reactions (Goldin 1994). Sources of stigma include fear of illness, fear of contagion, and fear of death. Fear of illness and fear of contagion are common reactions among health workers, co-workers, and caregivers, as well as the general population. Stigma is one means of coping with the fear that contact with a member of and affected group will result in contracting the disease (Meisenhelder and La Charite 1989).

From early in the AIDS epidemics, a series of powerful metaphors were mobilised which serve to reinforce and legitimate stigmatisation. Together with the widespread belief that HIV/AIDS is shameful, metaphors constitute a series of “ready-made” but highly inaccurate explanations that provide a “powerful basis for both stigmatising and discriminatory responses” (Omangi 1997).

People living with HIV/AIDS are seen as ignominious in many societies. In individualistic societies, HIV/AIDS may be seen as the result of personal irresponsibility (Kegeles et al. 1989). In yet other circumstances, HIV/AIDS may be seen as bringing shame upon the family and community (Panos 1990). While negative responses to HIV/AIDS are by no means inevitable, they not infrequently feed upon and reinforce dominant ideologies of good and bad with respect to sex and illness, and proper and improper behaviours (Warwick 1998).

Anxiety, anger, and depression, which commonly are experienced by people with HIV disease (Kelly and Lawrence 1988), are likely to be exacerbated by AIDS related stigma. Anxiety results not only from fears about the physical effects of HIV disease, but also from fears about others’ response; infected and sick individuals approximately anticipate rejection, discrimination, hostility, and even physical violence from others who learn of their condition (Herek and Glunt 1988).
Depression can be intensified by self-blame and internalisation of societal stigma concerning AIDS, homosexuality, drug use, and race among others. Depression also may result from feelings of “universal helplessness”, which are likely when people with AIDS perceive themselves as being treated “unfairly and attribute the cause to forces that are external, stable, and global, i.e., widespread and enduring prejudice” (Abramson et al. 1978; Crocker and Major 1989).

Bruyn (1993) has recently identified five factors as contributing to HIV/AIDS related stigma. According to him, HIV/AIDS is a life threatening disease; people are afraid of contracting HIV; disease’s association with behaviours such as sex between men and injecting drug use are already stigmatised in many societies; people living with HIV/AIDS are often thought of as being responsible for having contracted the disease; and religious or moral beliefs that lead some people to conclude that having HIV/AIDS is the result of a moral fault such as promiscuity or “deviant sex that deserves punishment”.

**Forms of HIV/AIDS related Stigmatisation and Discrimination:**

HIV/AIDS related stigma and discrimination take different forms and are manifested at different levels - societal, community and individual and in different contexts (UNAIDS 2000). Societal, laws, rules, policies and procedures may result in the stigmatisation of people living with HIV/AIDS. A significant number of countries have enacted legislation with a view to controlling the actions of HIV/AIDS affected individuals and groups (Tomasevski et al. 1992).

Stigma and discrimination, both real and perceived, may also arise from a variety of community-level responses to HIV/AIDS. It is often stimulated by the need to blame and punish and can, in extreme circumstances, extend to acts of violence and murder (Nardi and Bolton 1991). HIV/AIDS related stigma affects
issues related to HIV testing including delays in testing, the effect of delay on further transmission of HIV, and individuals’ responses to testing positive (Chesney and Smith 1999). Early detection of HIV infection is important. Knowledge of one’s HIV sero-positivity can lead to earlier treatment and improved outcomes (Herek 1990).

Studies provide evidence that stigma is associated with delays in HIV testing among individuals who are at high risk of being infected with HIV (Myers et al. 1993; Stall et al. 1996). People at risk for HIV infection were more likely to seek testing that was offered anonymously than testing that was offered confidentially (Fehrs et al. 1988; Johnson et al. 1988). HIV/AIDS related stigma aggravates the psychological burden of receiving a positive HIV test (Chesney and Smith 1999). There were reports of severe psychological responses to notification, including denial, anxiety, depression, and suicidal ideation (Coates et al. 1987; Ostrow et al. 1989). In extreme situations, any disclosure of one’s health status would mean immediate expulsion; Goffman (1963) refers to this as “forbidden places”.

Isolation can extend to exclusion from social and sexual relationships and, in extreme circumstance, this has led to “premature death through suicide or euthanasia” (Hasan et al. 1994). More often, stigmatisation causes a kind of “social death” in which individuals no longer feel part of civil society, and are no longer able to access the services and support they need (Daniel and Parker 1990).

HIV and AIDS have been blamed for reinforcing existing forms of social inequalities including gender inequalities (Barnett 2004; Kakuru 2007). Gender inequality has been described as a form of denial of equal treatment and opportunity (Unterhalter 2003; Aikman and Unterhalter 2005; Subramanian 2005). Gender inequality is an important aspect of vulnerability differentiation. Inequalities in
rights and obligations based on “sex and age largely determine differences in the capacity to respond to shocks” (Moser 1996). Women are more vulnerable to the stigma associated with HIV/AIDS as a sexually transmitted disease (Cullinane 2007; Lawless, Kippax and Crawford 1996).

Women living with HIV/AIDS are frequently referred to as ‘vectors’, ‘disease’ and ‘prostitutes’, but these terms are seldom used with infected men (Ndinda et al. 2007). Clearly, discrimination toward PLWHA is not simply about HIV/AIDS as a disease. Rather, it intersects with other social prejudices, including homophobia, racism and sexism (Parker and Aggleton 2003). Hence, when women living with HIV/AIDS feel stigma, it is not only their internalisation of the AIDS stigma, but also an effect of their interactions with others or actual experiences with public attitudes through which AIDS related social standards are manifested (Zhou 2007).

Gender inequality and discrimination intensify women vulnerability to HIV by limiting their power and confidence in sexual decision-making. Vulnerability to HIV refers to the “circumstances of people’s lives that influence their risk of exposure to HIV” (Buchanan-Aruwafu 2007). Gender inequalities go beyond sexual relations in making them vulnerable to HIV infection. Economic dependence on men is seen as one of the greatest threats to women’s physical and mental health (UNAIDS, UNFPA and UNIFEM 2004). Economic need also drives some women into sex work where the risk of HIV and other sexually transmitted disease is great (Baylies and Bujra 2000). There is clear evidence from recent UNAIDS supported studies of household and community responses to HIV/AIDS in developing countries (Aggleton and Warwick 1999) that sero-positive women are likely to be
treated very differently from men. Rejection by wider family members has also been reported as common (Bharat and Aggleton 1999).

HIV/AIDS related stigmatisation and discrimination might appear in a variety of contexts. Central among those are the family and local community, employment and the workplace, and the health care system. AIDS related stigma is manifested in a variety of ways (Bloom and Carliner 1988; Hay, Osmond and Jacobson 1988; Scitovsky, Cline and Lee 1986; Scitovsky and Rice 1987). People with AIDS are at risk for several kinds of victimisation, ranging from interpersonal rejection and ridicule to job and housing discrimination to violence (Dalton and Burris 1987; Dundes 1987; Herek 1989).

Several researchers have argued that the lack of support from friends, family and community decreases disclosure and generates rejection and discrimination which increases emotional distress experienced by those who are HIV positive (Bond, Chase and Aggleton 2002). In a review of interventions to reduce HIV/AIDS stigma, Brown, MacIntrye and Trujillo (2003) noted that stigma affects “prevention behaviours, test-seeking, care-seeking, quality of care provided to positive clients, and perceptions and treatment of people living with HIV and AIDS” by communities and families.

As the family is often the only source of care giving for HIV positive individuals, it is very important to reduce stigmatisation in this sphere. Malcolm and others (1998) further argued that by “inhibiting open communication in the family stigma makes disclosure in the family difficult and without disclosure prevention and care become impossible”. Social exclusion of PLWHA that begins in the family and extends into the community has been linked with poor self-esteem of PLWHA (Fieldblum and Fortney 1988).
Rosenthal (2003) reported that until recently, the legal system has not sufficiently protected people living with HIV and AIDS. Chen and others (2005) found that community factors such as the level of HIV/AIDS related risk behavior and level of development in the community affected people’s perceptions of an acquaintance with HIV/AIDS. Fear of rejection and stigmatisation within the home and local community may prevent people living with HIV/AIDS revealing their sero-status to family members (McGrath et al. 1993). Families may reject sero-positive members not only because of the stigma with HIV/AIDS, but also because of the connotations of homosexuality, drug use and promiscuity that HIV/AIDS carries (Misra 1999; Mujeeb 1999). There is also evidence that where people living with HIV/AIDS are open about their serostatus at work they are likely to experience stigmatisation and ostracism by others (Gostin 1992).

Health care professionals, particularly those who frequently encounter HIV-positive people, can be insensitive to their patients’ concerns about stigma. In addition, “health care professionals are not always knowledgeable about appropriate procedures for maintaining patient confidentiality” (Herek et al. 1998). The literature on care giving reveals that stigmatisation is evident among health care providers. “Fear of contagion and fear of death” have clear negative effects on health care providers’ attitudes toward and treatment of HIV-positive patients (Gerbert et al. 1991; Weinberger et al. 1992).

**Anthropology and HIV/AIDS:**

Like many other disciplines, anthropology may have failed to distinguish itself in its initial responses to the HIV/AIDS epidemics. Anthropologists for the most part contributed only irregularly to such early research mobilisation, largely based on their own individual research initiatives and publications rather than as part
of a formal or organised research response (Bolognone 1986; Conant 1988; Feldman 1985; Feldman and Johnson 1986; Gorman 1986; Lang 1986; Stall 1986). Herdt (1987) wrote, “thus far, anthropology has had minimal involvement in AIDS prevention and understanding”. However, it will be wrong to say that no important anthropological contributions are made to the study of HIV/AIDS. Anthropologists have and there are useful surveys on their contribution (Akeroyd 1997; Parker 2001; Schoepf 2001).

From slow beginnings in the mid-1980s, AIDS research by anthropologists has grown rich and diverse. Anthropological research on infectious diseases, particularly HIV/AIDS has contributed significantly to moving global public health away from a narrow focus on risk groups (Baer et al. 2003; Trostle 2005). The rapidly expanding anthropological literature includes numerous edited collections and rich database mostly from Africa. There are many works on AIDS research authored by the anthropologists. These richly contextualised studies of anthropologists allow the voices of sufferers and people at risk to be heard by incorporating narratives, texts of interviews, observations and public speech. Most adopt a historically grounded “political, economy and culture” strategy (Schoepf 1998; Singer 1998). The anthropological methodology used is qualitative, as well as quantitative. This allows description of illness, disease, health and treatment in a certain cultural context (Trestle and Sommerfield 1996). The combined strength of theory and practice in the field of international research on AIDS is a significant contribution to anthropology in the 21st century.
OBJECTIVES OF THE STUDY

The main objectives of the study are:

- To identify HIV/AIDS-related stigma and discrimination in the society;
- To understand people’s perception and attitude towards HIV/AIDS;
- To examine whether sero-positive men and women are equally treated; and
- To study the relationships of people living with and without HIV/AIDS within and outside family.

METHODOLOGY

Erickson (2004) rightly pointed out that the central activity in anthropological research method is fieldwork. The present study is based on intensive and extensive fieldwork focusing on the Tangkhuls living in Ukhrul Central block and Kamjong block of Ukhrul district, Manipur.

Due to the sensitivity of the topic, the study was carried out with qualitative approach. Data were collected form primary and secondary sources. Conventional tools of social research like interview schedules, telephonic interviews, questionnaires and observations were used. In-depth case studies of HIV/AIDS infected people were also done during the study. Stratified Sampling Method was used for the selection of respondents. Primary data were collected through personal interviews conducted with the HIV/AIDS infected people, affected families, health workers, non-infected people and NGOs staffs of various organisations working on the HIV/AIDS-related activities.

The NGOs interviewed during the fieldwork include UNP+, CARE, ISWAR, Elshadai Resource Centre, RRF, PASDO, and Women for Health Clinic among others. Appointments for interviewing the infected respondents were arranged with
the help of the above-mentioned NGOs. It may be mentioned that it was almost impossible to cover all the sero-positive persons, therefore, a total of 110 samples were taken (Male-40, Female-70). With the consent and knowledge of the respondents, audio recording and photography were also taken during the study. The study maintained the confidentiality of the HIV/AIDS infected respondents. Secondary data were obtained widely from various available sources like books, academic journals, internet, research reports, news reports and publications that involved similar studies.

AREA OF THE STUDY

Ukhrul district has seven sub-divisions - Ukhrul Central, Chingai, Jessami, Kamjong, Phungyar, Lungchang Maiphei and Kasom Khullen. For this study, two sub-divisions viz. Ukhrul Central and Kamjong Block were selected for intensive study. The district headquarters Ukhrul is linked to Imphal through the NH 150, a distance of 82 km. Kamjong lies in the eastern part of the district bordering Myanmar. Imphal to Kamjong is 127 km. It is 40 km away from the district headquarters of Ukhrul.

The Ukhrul Sub-Division with Ukhrul as the headquarters of both the District and the Sub-Division occupies the central part of the district. Ukhrul Sub-Division was established in 1919, which was upgraded to a District in 1969. One Additional Deputy Commissioner and some Sub-Deputy Collectors (SDC) assist the Deputy Commissioner, who is the head of the district administration. One SDC and three Extension Officers assist the Sub-Divisional Officer (SDO) cum Block Development Officer (BDO).
All the district officers including the office of the Deputy Commissioner, District Magistrate, District Council, Superintendent of Police, and the 10 Sector “B” Range Brigade Headquarters are located in Ukhrul. Besides the headquarters of the 6^{th} Battalion Manipur Rifles, the 20^{th} Battalion Assam Rifles and the 25^{th} Battalion Assam Rifles are located in Yikun, Somsai and Shangshak respectively under Ukhrul Sub-Division (Muivah 1996). Ukhrul town comprises of twenty-five localities viz. Somsai, Naphang, Meizailung, Khararphung, Luiyainao, Kasomtang, Awungtang, Awontang, Alungtang, Tangrei, Rayotang, Khaiyishat, Greenland, Wino, Kahumtang, Viewland, Khamphasom, Seipet, Phungreitang, Khaivaren, Mayotang, Finance, Soyatang, Hamleikhong and Dungrei. According to the Government of India 2011 census, the town has 3241 households with 27187 populations approximately.

Kamjong is one of the sub-divisions of Ukhrul district, Manipur bordering Myanmar. It was established in 1971. The Sub-Division of Kamjong covers 44 villages with 2977 households having an approximate population of 16717. The town consists of six localities - namely Awung tang, Alung tang, Leiya tang, Tangrei tang, Awon tang and Sapu tang. The town has 400 households with a total population of 3350. The Sub-Divisional Officer (SDO) is the head of the block administration assisted by Block Development Officer. It has one police station under the in-charge of Sub-Division Police Officer (SDPO). Besides, the 44^{th} Battalion Assam Rifle is located in Chassad.

Fieldwork was conducted in Ukhrul Central block and Kamjong block that falls under Ukhrul district, Manipur. The terrain of the district is hilly. Both the places lie in high altitude areas. The difference between the two study areas is that Ukhrul is the district headquarters and it is more urban in nature, and Kamjong is in
rural area and it is one of the towns in the district. Many active NGOs like Elshadai, UNP+, ISWAR, PASDO, WHC, ORCHID and others are found stationed in Ukhrul headquarters, primarily working for HIV/AIDS. Whereas, in Kamjong only two NGOs namely CARE and SCCRC exist working for HIV/AIDS infected people and other high risk group in collaboration with Community Health Centre, Kamjong.

The reason for the selection of Ukhrul and Kamjong for intensive study is because of the fact that most frontal NGOs dealing with HIV/AIDS are based in these two areas, therefore, making it possible for data collection and research study. Another important reason is that the impact of HIV/AIDS on society is particularly severe and the number of HIV infections is rising in the two selected areas. This alarming situation could be attributed to many reasons. These two blocks have an easy access with heroin and other substitute drugs that are found in abundance in Imphal market and in India-Myanmar border areas.

The fieldwork for the present study was conducted in four phases – first phase (August 2010 to October 2010), second phase (September 2011 to December 2011), third phase (February 2012 to April 2012), and fourth phase (August 2012 to November 2012). Further, telephonic interviews were also taken and recorded simultaneously especially in the later stage of the course of study (2013 to 2014) for further queries and clarifications.