CHAPTER - II

REVIEW OF LITERATURE

The present study aims at studying how the widows of HIV infected men live and cope up with the family and social needs. The study aimed to analyse the access and use of the available welfare measures. There are numerous studies, being conducted in the field of HIV/AIDS, as it is a serious human concern. Most of the studies are related to either medical provisions or communication to influence behaviour of the people for HIV/AIDS prevention. There are numerous studies about the knowledge, attitudes, beliefs and practices (KABP), etc. However, the review process showed that there are very few studies which can provide understanding about the lives and people affected by HIV/AIDS. In this context, lives of widows of HIV/AIDS affected men deserve a special concern. Hence, the relevant literature reviewed has been presented under the following heads:

2.1 Studies about awareness level and risky behaviour HIV affected people

2.2 Studies on stigma and discrimination faced due to HIV/AIDS.

2.3 Effect on socio-economic condition due to HIV positive status.

2.4 Coping mechanism of families affected by HIV infection.

2.5 Support system of HIV positive at the Global, National and State level.

2.1 Studies about awareness level and behaviour of HIV affected people

It is evident from multiple researches that awareness level among women especially in rural areas about HIV/AIDS is low. Many of them have a poor understanding and false belief on AIDS, which in turn increased the risky behaviour. Centre for Disease Control and Prevention (2007) conducted a study on HIV/AIDS among women of Asian and Pacific Island women found that some women may be unaware of their male partner’s
risk factors for HIV infection such as unprotected sex with multiple partners, men who have sex with men (MSM), or injecting drug users. This lack of HIV knowledge, lower perception of risk, drug or alcohol use, and different interpretation of safer sex may contribute to risky behaviour. Most women are infected with HIV through high-risk heterosexual contact.

UNDP (2011) in Asia found that increasing individual’s knowledge and awareness of HIV is critical in both reducing transmission and eliminating stigma and discrimination against those it affects. However, Non-affected household respondents in China and Indonesia reported very low knowledge levels of HIV (only 70% of those in China had heard of HIV and 72% in Indonesia). In addition, of those who had heard of HIV, knowledge of where they could go for a test was limited (62% in Cambodia, 40% in China and 44% in India). With regard to HIV prevention methods, there was fairly widespread knowledge of condoms as a form of prevention (above 80% in Cambodia and Indonesia, though only 58% in India). However, females in all countries were less likely than males to cite condom usage as a form of protection against HIV. Similarly, Bishwa, R. (2008) in Nepal found that majority of the people had heard about HIV/AIDS but they lack comprehensive knowledge on the mode of transmission. Many of them have the misconceptions like mosquito “bite can transmit HIV virus” and “sharing food HIV infected people will transmit the virus”. Such misconceptions build fear and negative attitude towards PLWHAS/AIDS.

Anand and Dawar (2008) in Delhi found in their study that young women were at high risk, and the population which were considered to be at low risk, had become high risk since they received little formal education and were victims of patriarchal society. Ghosh, (1997) studied two slums of South Delhi and found that the knowledge about HIV/AIDS/STDs was poor among the slum dwellers. The prevalence of high-risk behaviour amongst them raises concern about the spread of STDs and AIDS. As reported by UNAIDS (2004) in Uttar Pradesh that knowledge about sex in general is also surprisingly low in many places. It further revealed that 71 percent of the women know
nothing about how sex occurs when they began cohabiting with their husband and 83 percent did not know how a woman could become pregnant. This lack of knowledge magnifies the risk of infection. In most countries, most young women do not know how to protect themselves against HIV infection.

Edwin, (1995) in Tamil Nadu indicated that knowledge is the only factor that may be related to behavioural change. Many students had misconceptions about AIDS transmission like its spread through mosquitoes, from swimming pool, hugging an infected person and from toilet. Educational programmes alone can remove these misconceptions. Karuppaiah (2000) studied the socio cultural and economic correlates of HIV/AIDS in Madras found that the economically poor and illiterate and educated up to primary level people were more vulnerable to infected with HIV/AIDS due to high risk behaviour, lack of knowledge on HIV/AIDS, prevention and control measures. Pallikadavath, S.et al, (2004) carried out a study in Pune among the high risk groups such as sex workers, STI clinic attendees and long-distance truck drivers. The study was largely undertaken in urban areas. They found that participants in all of the four focus groups in this study had heard about HIV and AIDS and knew that it was a disease. However, the differences between HIV and AIDS and the technicalities of the disease were often unclear. For some, AIDS was a disease and HIV was a virus; for others both were the same, and a few others believed that HIV and AIDS were different but could not say how. Although health workers from the Rural Health Programme work in these villages, television was reported to be the major source of information about HIV.

Medhi, G.K. (2012) carried out a study to assess the factors associated with HIV sero-positivity among female sex workers (FSWs) in Dimapur, Nagaland, and a high HIV prevalence state of India. A total of 426 FSWs were recruited into the study using respondent driven sampling (RDS). Consistent condoms use with regular and occasional sexual clients was found 9% and 16.4%, respectively. About 25% of the participants’ ever used and 5.7% ever injected illicit drugs. RDS adjusted HIV prevalence was 11.6%. Injecting drug use was found to be most potent independent risk factor for HIV. Because
of lower consistent condom use among them, FSWs may act as bridge for HIV transmission to general population from injecting drug users (IDU) through their sexual clients. Marrow (2007) in Nagaland and Manipur revealed that some people with disability are potentially vulnerable to HIV infection due to lack of awareness and knowledge of HIV transmission. Social exclusion and poverty, gender norms are the obstacles to accessing HIV programmes, Neither HIV nor disability organisation currently address the risk, needs and preference of people with disability. In Manipur, Sehgal and Singh (1993) found that 89.7 percent people were aware about AIDS and 79.8 percent expressed that they would frankly discuss it with their spouse if they acquired HIV infection. 69.2 percent believed that test for AIDS is necessary for all persons coming/returning from abroad. They further indicate that almost all the persons were aware and had good attitude and belief towards HIV/AIDS but the epidemic is increasing day by day.

Gojendra et al, (2005) in Manipur found that only 16.2 percent (3/37) had complete knowledge of routes of HIV transmission and preventive measures. Majority of them also used plain water and saliva for cleaning needles and syringes. Out of 31 injectors, 30 (96.8 percent) had reported sharing of needles & syringes during the last episode of injecting drugs. This lack of knowledge increases the risky behaviour.

2.2 STUDIES ON STIGMA AND DISCRIMINATION FACED DUE TO HIV/AIDS

HIV and AIDS-related stigma and discrimination can appear in a variety of forms, at various levels and in different contexts. This stigma gets compounded by fear arising from lack of knowledge about the modes of transmission of the infection. Because of the stigma attached to it, PLWHAs have experienced violent attacks, have been deserted by spouses and families, rejected by communities and workplace, refused medical treatment and been denied even the last rites. Stigma is not unique to HIV/AIDS. It has been documented with other infectious diseases like tuberculosis, syphilis, and leprosy (Goldin 1994). Stigma is most frequently associated with diseases that have severe, disfiguring, incurable, and progressive outcomes, especially when modes of transmission are
perceived to be under the control of individual behaviour. It is also common in diseases that are perceived to result from the transgression of social norms, such as socially unsanctioned sexual activity (Crandall and Moriarty 1995). These criteria fit HIV/AIDS. Bruyn, De (2002) writes that stigma and discrimination comes with afflicted individual to be seen as wrong doers, which is compounded by a fear of contamination by them. The HIV/AIDS people face social exclusion, loneliness and lack of support and comfort of friends, family and other networks. A study of AIDS-related discrimination in Asia by Paxton, S and Welbourn (2004) found that over ten percent of women had lost financial support from family members since being diagnosed as HIV positive, compared with 4.6 percent of men, while 12 percent of HIV positive women had been forced to change their place of residence, compared with only 6 percent of men.

Thus, the trends indicate that the impact of HIV/AIDS is more profound. Along with this UNDP (2011) studies in Asia reported high levels of internal stigma (shame, low self-esteem, and suicidal thoughts) by PLWHAs. Non affected households in India and China reported very high levels of bias against PLWHAs and their families. In conjunction, PLWHAs reported very high levels of stigma and discrimination. Over 50% of PLWHAs in China and India reported social isolation and neglect - an average of 20% of PLWHAs in all the countries reported being verbally abused because of their status. Perhaps most concerning is the high level of discrimination in health facilities in Indonesia (30%), Viet Nam (17%) and China (13%). This reduces the likelihood of PLWHAs disclosing their status and receiving the care they need, as evidenced by the high percentage (over 40%) of pregnant HIV positive women in Indonesia who had not disclosed their status to their health care provider. Goldin (1994) reveals that the stigma is not new to public health, nor is it unique to HIV and AIDS. For instance, leprosy was viewed as a punishment for moral misconduct in the past and it has taken years to change people’s negative attitude. Any sexually transmitted infection has always been imbued with stigma due to its association with behaviour considered deviant or immoral. Discrimination is the operational sting of stigma through ostracizing, shunning or rejecting.
According to UNDP-NACO-NCAER study, more that 80% of widows were forced to leave their married homes after the death of their husbands due to AIDS related illness. Daughter-in-laws did not have a place in the family for them if the son died (Bharat, 1999). Stigma and discrimination in communities was commonly visible in the form of blaming, isolating, difficulty in procuring a place of stay, teasing and name calling. Household assets are sometimes liquidated to pay for treatment of the husband’s illness, leaving his wife with fewer resources after his death. For example, a wife will sell her gold or other jewellery for quick cash to cover health expenses. In other cases, the marital family may deny her claim to the matrimonial property after her husband’s death because they equate their contributions for treatment to the husband’s share of the family inheritance. A New Delhi based study (Mahendra et al, 2006) revealed that Stigma and discrimination was manifested in health care settings in the form of unwarranted referrals to other facilities, condescending, judgmental, and moralistic attitudes among staff, segregation and labelling of patients, excessive use of barrier precautions by staff, HIV testing without consent or disclosure of test results to family and non-treating staff without consent.

In a study sponsored by UNIFEM and jointly conducted by Centre for Advocacy & Research (CFAR) and the Positive Women’s Network (PWN+), in Chennai, Kerala, Karnataka and Tamil Nadu, in the year 2002 reported that women faced harassment and violence within and outside the family. Humiliation in both marital and natal homes and lack of programmatic response from the state drove women to destitution. ICRW (2004) revealed that discrimination and stigma surrounding HIV/AIDS also severely affects the ability of HIV positive women to find and keep work. Women whose HIV positive status is known or suspected within the community may find that people no longer buy their goods. Other women may be sacked by their employers after receiving an HIV positive diagnosis, sometimes after compulsory testing, even women who remain employed may suffer intense discrimination in the workplace. A National AIDS Research Institute of Yale University (U.S.A., 2003) conducted a study in a high prevalence city in Maharashtra, India and used qualitative and quantitative methods to document stigma in
health setting. The study revealed (i) a wide range of feelings exhibited by clinicians about HIV-positives who often made morale and non-clinical attribution about individuals, past ‘misbehaviour’ and ‘misconduct’; (ii) few providers reported fear of touching HIV/AIDS patients; (iii) hospital practices, such as a separate AIDS ward, HIV diagnoses on open charts, and the conspicuous use of biohazard labels serve to discriminate HIV/AIDS patients, and (iv) hospital practices often have discriminatory consequences.

Voluntary Health Association of India (VHAI, 2003) in New Delhi recommended that stigma against HIV/AIDS infected people killed them faster than the infection itself and should be an important area of intervention. A study by Bharat, (1999) in Mumbai and Bangalore found that discrimination and denial due to HIV/AIDS is manifested in all areas of life but the major context was the health care and services or poor quality of treatment. Besides health care, the household and the community were found to be unsupportive and even oppressive, especially for women members of marginalized groups. Another important finding in relation to the workplace is the widespread denial on part of corporate heads to the threat of the epidemic to industry. Other discrimination that was caused to people with HIV/AIDS is life insurance and education of children. Monogamous married women who were infected by their husbands are often scorned and even evicted from their homes by their in-laws when their HIV status becomes known (Bharat, 2001). As in the other parts of the world, PLWHAs in India suffer from stigma and discrimination in several contexts: household, workplace, health settings, and communities (UNAIDS, 2001). The UNDP (2006) reported refusal of medical treatment; workplace discrimination; physical attacks; rejection by families, partners, and communities; and in some cases denial of last rites before death to PLHA. Vulnerable subgroups of PLWHAs like CSWs, transvestites, and homosexuals face further discrimination. Families experience stigma from their communities because they are blamed for the behaviour (e.g., drug use or sex work) that led to infection (ICRW, 2004) or because members of the community fear that the rest of the family is also infected.
UNAIDS (2010) studies on prevalence of HIV-related stigma and discrimination and their impact on the HIV epidemic and response, show that HIV-related stigma and discrimination are pervasive and have a harsh negative impact on the quality of life of people living with and affected by HIV. Stigma and discrimination have been found to act as impediments to uptake of HIV testing, and to adherence to treatment. HIV-related stigma and discrimination also affect men and women differently. Women and girls in many countries face discrimination that makes them more vulnerable to HIV. Due to harmful gender norms regarding social expectations, stereotypes roles, status and power, many women and girls in worldwide lack the social power to control key aspects of their lives, including sexual and reproductive decision-making. Women and girls are often discriminated against in public and in private spheres, such as in the context of employment, education, property ownership, marriage and community. As a result of this structural discrimination, women in many countries are at a disadvantage when it comes to negotiating sexual encounters and accessing HIV prevention information and commodities.

SPARSHA an organization of Kolkata visited Manipur on 7 September 2001, found out that HIV persons were not allowed to stay with the family, a separate hut was built near the residence for them. Food from family kitchen was not provided; they had to cook their own food in some cases. Widows had to return to their parents’ home due to discrimination at in-laws house; they are blamed for their husband’s death and not given proper and full share of the family’s property or income. Widows do not go for HIV test for the fear of ostracism. Neken, S. (2011) reported that discrimination of HIV infected people in Manipur society is not a new story. The stigma and discrimination attached to HIV infected people are due to ignorance about the disease by the general people. When the ignorance and misconception surrounding the HIV and AIDS menace is removed, when we all realize that HIV virus is not transmitted via social gatherings, we will not discriminate infected people.
One day seminar on “HIV/AIDS, human rights and social psychology in the conflict situation of Manipur” (2012), was held at the Regional Institute of Medical Sciences (RIMS) in Imphal in relation with the peace march of the Manipur Diaspora. The seminar, called for an end to discrimination against those affected with the disease. During the seminar, the State minister of health asserted that HIV/AIDS was more dangerous than the historical event of the ‘Seven years of devastation’, of Manipur of the 19th century and called for an end to any discrimination of the disease. In Manipur too, PLWHAs are stigmatised or ostracised throughout the world and called for an end to such discriminations. It was also reported that people close to those affected by the disease also had to face discriminations and stigma.

2.3 EFFECT ON SOCIO-ECONOMIC CONDITION DUE TO HIV POSITIVE STATUS

It is widely known that HIV severely impacts the economic and social spheres of all societies. Over the past several years, governments and non governments have made important advances in the introduction of new policies and programmes aimed at mitigating the socio-economic effect of HIV on individuals living with HIV and their households. In order to live well, widows need economic and social services and emotional support. HIV infection has had economic, psychological and social effects in many countries. AIDS is the greatest social, economic and health problem in Uganda (Ntozi N, 1999). Similarly, HIV/AIDS is having severe and growing economic and social consequence on women in India, “Women and girls seem to bear the brunt of the pandemic in many ways and the disease disproportionately affects them psychologically, socially and economically” (NCAER, NACO and UNDP 2006). Therefore, the reviewed literature was again sub-divided under the following heads.

2.3.1 Economic problems

2.3.2 Psychological problems

2.3.3 Social problems
2.3.1 Economic Problems

HIV/AIDS and poverty are closely linked. However, AIDS cannot accurately be termed as “disease of poverty”. Although it is true that poor individuals and households are likely to be hit harder by the downstream impacts of AIDS, their chances of being exposed to HIV in the first place are not necessarily greater than wealthier individual households. (Gillespic, Kadiyal and Greenet, 2007). In addition, Gaigbe-togbe and Weinberget (2003) in Sub-Saharan Africa show that HIV/AIDS has been taking a devastating toll on many lives. Households are feeling the impact of AIDS in terms of loss of earning members and increased expenditure on medical care. As a result of HIV/AIDS, food consumption is decreasing in many AIDS affected households, leading to malnutrition, especially among young children.

Shisana and Letlape (2004) in Sub-Saharan Africa found that HIV/AIDS has an impact on the economy, is also affecting the rate of new infections, ability to provide care and treatment, and hence, increase the mortality. The economic impact of HIV/AIDS on the individual and household is delayed because of the time lag between infection and development of disease is eventually felt. At an individual level, the effect is direct involving poor health status, stigmatization, loss or reduction of income and increased cost for health care. At the household level, the effects are both direct and indirect. Direct effects include loss of income from earning of the official person, increased caring responsibility for the person who is ill, increased cost for medical care and funeral expenditure. Indirect costs occur because of reduced or lack of income a family saves for medical expenses by cutting off the expenditure on food and other needs and children dropping out of school when the income earner eventually dies, the children become orphan. This has a long-term intergenerational economic impact in those countries that are heavily affected. They further reveal that the micro-economic impacts accumulate to have a macro-economic impact due to the prevalence of HIV/AIDS. The impact has increased over time and the individuals, households, labour, formal and informal sectors are affected. Reduced human capital has a major impact on domestic saving, domestic
investment and eventually on economic growth as measured by slow growth or shrinkage of the Gross Domestic Product (GDP). They conclude HIV/AIDS has a significant impact on the African economy. In addition, Oyekale (2005) in Rainforest Belt of Nigeria found that economic and social problems that household undergo due to HIV/AIDS infection has increased drastically. He revealed that the income generated by the household reduced by an average of 27.09 percent due to the reduction of income, the food intake of the household members may also decline.

A study by Douahue, Kabbucho and Orinde (2001) in Kenya and Uganda described a clear sequence of asset liquidation in order to cope with the impact of HIV/AIDS. They liquidate saving and protection assets first and sell productive assets only when they run out or other options. Pritchett and Summer, (1996) explored the close relationship between the health of the people and wealth of the nation. It concludes healthier people make up that wealthier nation because good health enhances the productivity of labour. FAO (1999) carried out a study in two districts of Kenya, revealed that, the commercial agricultural sector of Kenya is highly susceptible to the HIV epidemic and facing severe economic crises due to its impact. The morbidity and mortality due to the disease have raised the direct costs, which include medical and funeral expenses, as well as the indirect cost through the loss of valuable skill and experience. Similarly, food consumption dropped in a household after the male adult died. Ntozi and Mukiza-Gapere, (1995) conducted extensive focus group discussions in the six districts of Uganda reported that with the AIDS epidemic, widows financial situation has deteriorated. Even if a widow is HIV negative, the husband’s male relatives fear to inherit her because of HIV/AIDS and the husbands generally would have spent of his money on AIDS treatment and little financial capital would be left over for the widow and children. Widowhood often causes financial stress because a major income source is lost with the death of a husband.

Sherr (1995) in London explored that economic ramification are severe at many levels as those who are sick lose the ability to earn a living and provide for their families. Their need to do work may be greater given that their partner may be ill or have died.
Simultaneously, they must deal with medications, hospitalizations and the variety of financial costs associated with AIDS. Such financial costs have ramification for many years to come, as they affect inheritance, parenting, skill training and extended family burden where economic demands are multiple, effects are also compounded. Niang and Ufford (2002) in Senegal found that HIV/AIDS affected families’ health care expenses constitute a heavy burden, notably expenses related to the treatment of opportunistic infection and related to the consulting of marabouts (traditional nurse) and traditional medicine. HIV/AIDS appeared to have a strong impact on self-perception, emotional stability and the construction of individual and family identities, among adults as well as among children. In the study by Loomba, R. (2010) in United Kingdom revealed that the plight of widows is an important hidden issue in many countries and has grown significantly due to poverty, disease and social justice. Often they are the poorest of the poor, invisible, forgotten and unheard. The combination of breadwinner of the family and the associated social stigma has devastating effects on dependent children.

Mahal and Rao, (2005) and Barnett and Whiteside, (2002) reported that HIV largely affects individuals in their most productive years. This causes a loss of earnings and incomes of households on various accounts, premature death of an AIDS affected earning member of the household, reduced earnings due to reduced physical ability to work because of the infection, loss of work time of the non-infected members due to the caretaking responsibilities of the infected members, and reduced employability due to the stigma associated with the infection.

Godwin (2000) in Philippines, India and Thailand identified that both short and long term economic impacts of HIV at the household level. The enormous increase in expenditure (exceeding income) associated with the recurrent illness and slowly deteriorating health of the HIV infected person was a short term impact. But the long term impact is the problem to recover, even many years after death.

UNDP (2011) studied the Socio-Economic Impact of HIV at the Household Level in Asia found that overall members of HIV household lived in lower living conditions, were
more likely to be unemployed, and had lower household incomes than members of Non-affected households. At the most basic level, respondents from Non-affected household in Cambodia, China, India and Viet Nam were more likely to live in stable structures than those in HIV-households. With regard to employment, male members of HIV households in Cambodia, China and Indonesia had lower employment levels than those in Non-affected households, and PLWHAs in Cambodia and Indonesia were almost twice as likely to be unemployed as Non-affected household members. Specifically for PLWHAs, their employment levels in Cambodia, China, India and Viet Nam dropped substantially after their diagnosis.

Pandav, Anand, Shamanna, Chowdhury and Nath (1999) based on their work in New Delhi reported that HIV/AIDS imposes a major burden on the economic front. The World Bank has estimated the Disability Adjusted Life-Years (DALY) lost due to HIV/AIDS in India to be 4 billion. In 2002, International Labour Organisation (ILO), indicated that in India the average monthly income of a PLWHA was about Rs.1, 117 (US $ = Rs. 46), whereas average monthly expenditure was Rs. 3,185. In many cases, this gap was met by loan or sale of assets leading to an increase in indebtedness’ to the tune of Rs.4, 818 per family. While medical costs varied in accordance with the stage of illness, the fact that HIV-infected persons had to go for regular check-up underscored the economic impact of the infection. The World Bank further claims that HIV/AIDS care related expenses, medical fees and funeral expenses push AIDS affected household deeper into poverty.

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Phradhan et al, (2006) in Manipur found that the impact of HIV/AIDS on the households and the economy is severe because it mainly affects the people in working age group, thereby forcing the elderly family members to bear the additional burden of looking after the family. It is also observed that prior to detection of HIV, 11.99 percent of the people living with HIV/AIDS (PLWHA) were unemployed. The burden of disease increases as the stage of infection advances, causing tremendous financial burden on the family. Further, they revealed that due to financial constraints HIV widows would be left with little money after meeting the medical expenses of their husband’s treatment so they are left untreated. The HIV affected families are resorting to borrowing and liquidation of assets to meet the medical expenses.

2.3.2 Psychological Problems

HIV/AIDS represents an acute psychological crisis and the infected person and his or her close family relations may face a life-threatening event and multitudes of emotional trauma. With no treatment is view, HIV/AIDS is also associated with psychological implication. It is because of the various misconceptions still prevents with HIV/AIDS and the resultant social prejudices. As it has been found mostly transmitted through sexual contact, the infected persons are viewed as sexually promiscuous. People are scared to communicate with the infected. The psychosocial trauma caused is for not only the people infected, but also their family members who are closely associated with them. (Kaur H. and Kar H.K.1997) reported that infected persons are normally in fear because they have to adjust to a new lifestyle. It is not easy to accept that one is infected and thus shock and disbelief, leading to denial, is a frequent initial response. In the mental health literature, women are recorded as suffering from greater levels of mental health problems than men. The differences may be real and may reflect the fact that female life-styles are more susceptible to emotional burden while demands of child rearing and home making. Mental health considerations extend from early in the disease process at the time of HIV testing through disease progression, illness and death.
Sherr (1993) observed that psychological crisis was high in HIV/AIDS women as a result of heavy emotional burden and high levels of suicide attempts and rape. She found in her study carried out in London that women who lose their employment due to HIV infection or associated illness may suddenly face traumas of livelihood, of providing for their dependent children, of maintaining housing and a standard of living and the spiralling costs of health care, which typified psychological crisis. Persons with HIV/AIDS may be caused to see themselves as undesirable by others who view them as “contagious”. It is an emotional situation that can cause infected people to withdraw, not disclose their feelings, and become socially isolated. Inevitably this may lead to an emotional breakdown because these feelings continue to be suppressed. The most destructive stressor is that of feeling isolated. This isolation can have many causes, including the loss of support by lovers, family, and friends.

A presentation by Sleap, B. in Panos AIDS programme (2001) in London explored the attitude of the society. He reported that AIDS is often seen as the result of women’s immoral sexual behaviours. All member of the society, including other women, often blame women. This may compound the psychological impact of widowhood for young widows whose husbands have died of AIDS. Further, he revealed that the trauma of being widowed is great enough in the best of circumstances but for a widow affected by HIV/AIDS, the additional psychological burden is particularly great. A significant number of researchers also suggest social stigma, discrimination, and social isolation of HIV-infected individual cause greater psychological and emotional turmoil, which may ultimately lead to mental health problems and affect the quality of hospital care (Mahendra et al, 2006).

National AIDS Trust (2010) in a project in UK in Psychological support for the people living with HIV/AIDS revealed that there is higher prevalence of psychological need amongst people living with HIV compared with the general population. People with a mental health problem are at greater risk of HIV infection, and people who have been diagnosed with HIV are more likely to develop mental health difficulties. It is also clear
that these psychological needs are not being met consistently or being addressed strategically. Gielen, A.C. et al (2005), conducted a study in Baltimore (Maryland) in USA found that the highest rates of mental health problems are observed among women who were both HIV positive and abused, for whom the risks of depression, anxiety and suicide were significantly elevated, compared to HIV negative women without history of abuse.

A study by Bhuyan (2000) in Assam revealed that AIDS epidemic is not only a medical problem. It also challenges the behavioural, psychological, social and development aspects of a society. He further revealed that psychological factors which may precipitate to suicide in AIDS patient include the social stigma related to the illness, the withdrawal of family support, diminished or lost occupational functioning, long term dependency, loss of friends or lovers and the spectrum of an inexorable terminal illness that lead to pain and emaciation. Similarly, Devi (2000) in Imphal found that females are more prone to develop depression and anxiety than their male counterparts are. Depression and anxiety was significantly higher in sero-positive than in sero-negative dementia. Public attitudes towards AIDS patients are still not very rational and are associated with unfounded fear, which in turn increases psychological problems. Additionally, people living with HIV/AIDS may suffer psychological distress as a result of the many physical, social, and economic effects of the disease on their lives. Among the various stressors are chronic physical pain, physical disfigurement, the possibility of infecting other people, and discrimination, abuse, and loss of fundamental human rights. Other challenges include changes in lifestyle to accommodate the illness itself and the financial burdens that treatment brings for oneself and one's family. People with HIV often also face loss of independence; physical, social, and emotional isolation; uncertainty concerning the timing and nature of treatment and disease progression; and uncertainty in their personal and social lives. As a result of these many stressors, people diagnosed with HIV infection often suffer from a number of psychological symptoms, including anger, frustration, anxiety, depression, and chronic somatic preoccupation (that is, a fixation on physical symptoms) (Kelly et al, 1993).
2.3.3 Social Problems

HIV/AIDS is a social issue that highlights the consequences of social injustice. People are socially located and socially constructed into a number of relationships that empower or disempower them within the family, community, church, work place, government and international class. Dube, (2002) and Oyekale (2005) in Nigeria found that the social life of HIV/AIDS patients and entire household is negatively affected as their participation in community development programmes also reduced. HIV is an infection that preys on social and community vulnerabilities. From the very outset, this infection was been accompanied by social responses of widespread stigma and discrimination. Stigma refers to unfavorable attitudes and beliefs directed toward someone or something. HIV/AIDS related stigma refers to all unfavorable attitudes and beliefs directed toward people living with HIV/AIDS (PLWHA) or those perceived are infected and towards their significant others and loved ones, close associates, social groups and communities. HIV/AIDS related stigma is complex, dynamic and deeply ingrained.

Discrimination is often defined in terms of human rights and entitlements in health care, employment, the legal system, social welfare and reproductive and family life. Stigma and discrimination are interlinked. Stigmatizing can lead to discrimination and human right violation. The forms of stigma and discrimination faced by the PLWHA are varied and complex. Individuals are stigmatized and discriminated because of not only their HIV positive status but also because of what that status implies. UNAIDS sponsored research in India and Uganda showed that women with HIV/AIDS may doubly or triply stigmatized as women, as PLWHA, as the spouse of a person who is HIV infected or the widow of a person who died of AIDS. She may be treated poorly or denied medical and psychological support services.

The social impact of HIV infection will result from the illness and death of individuals and the consequent effect on the family, community and broader society. The death of an adult male, who is an income earner, will affect the family’s access to resources. The death of an adult female may result in children receiving less care and females being
taken out of school (ILO, 1995). UN Secretary-General Kofi Annan (1999) said "By overwhelming the continent's health and social services, by creating millions of orphans, and by decimating health workers and teachers, AIDS is causing social and economic crises which, in turn, threaten political stability." As the cost of AIDS in Africa are terrible and causing social problems.

Ngozi, C., Mbonu, B. B., and Nanne K., Vries, D. (2009) conducted a study in Sub-Saharan Africa to elucidate what is known about HIV/AIDS and stigma. It was found that the cultural construction of HIV/AIDS, based on beliefs about contamination, sexuality, and religion, plays a crucial role and contributes to the strength of distancing reactions and discrimination in society. Stigma prevents the delivery of effective social and medical care (including taking antiretroviral therapy) and also enhances the number of HIV infections. In a study of HIV stigma in Vietnam, family and community members were aware that HIV could not be transmitted through casual contact but remained hesitant to share drinking glasses or sit near someone who was HIV positive for fear of being infected “accidentally” (International Centre for Research on Women [ICRW], 2004).

Hingar, A., Sharma, P.L. and Paliwal, V. (2013), stated that the Human immunodeficiency virus has a large social impact on infected individuals and their families. Stigmatization worsens the prevention and treatment of HIV and hampers social support and HIV disclosure. A study in Thailand reported that families often take dramatic steps and exhaust financial resources to ensure a “normal” burial for their loved one so as not to reveal that the cause of death was AIDS (Songwathana & Manderson, 2001). In the Paxton study (2005) in India, Thailand, Indonesia and the Philippines also, they found that both men and women had experienced some form of discrimination in the workplace. Approximately 7 percent of individuals from these countries had lost their jobs because of their HIV status and nearly 10 percent had experienced changes in their job responsibilities after their HIV status became known. In another New Delhi based study (Mahendra, 2006) revealed that stigma and discrimination was manifested in health
care settings in the form of unwarranted referrals to other facilities, condescending, judgmental, and moralistic attitudes among staff, segregation and labelling of patients, excessive use of barrier precautions by staff, HIV testing without consent or disclosure of test results to family and non-treating staff without consent.

Pardhan et al (2006) in Manipur revealed the main difference between Manipur and the rest of the states in India are that the mode of transmission is intravenous drug use and that being IDUs (Injecting Drugs Users) attracts social stigma for the whole family. The group felt that the IDUs are not only stigmatized but also treated as criminals. The IDUs are held guilty for any theft or similar illegal activity in the locality. They further revealed that the stigma/discrimination is encountered in the uniform services. They also reported the case of a woman who was selected for a job of a cook, but did not get the final offer letter once her HIV status was disclosed.

2.4 COPING MECHANISM OF FAMILIES AFFECTED BY HIV INFECTION

Coping mechanism refers to the specific efforts both behavioural, psychological that people employ to master, tolerates, reduce or minimize stress. Behaviour helps people to function better in a given situation. A study conducted by Munnthali, (2002) in Malawi, revealed that suppose, the husband dies, a woman may choose to remain with her children or will be taken care of by the relations of her late husband. Though the assistance provided might be inadequate as the late husband’s relatives might also be providing for their families, this is a coping method for not only these families affected by HIV/AIDS but for other families as well. He narrates one of many stories of the impacts of HIV/AIDS illness and deaths and of the coping mechanism of households and families to adapt to the changes caused by the pandemic. In this story, Ngozi a widow of HIV infected man gets some support from the wives of her husband’s brothers as well as from her own family, which even, pays some of her hospital bills during the period of her illness. He further revealed that remarrying especially for women is also a form of coping method and the extended family system is still the first choice of coping though it is under great strain due to HIV/AIDS. Early marriages, dropping out of school in order to
head a family, casual labour and piecework, small scale are some of the strategies being used in Malawi to cope with the impact of HIV/AIDS.

Lewis, C.L., Brown, S.C. (2002) in Louisiana, USA assessed coping strategies of female adolescents infected with HIV/AIDS. It revealed that the most often utilized coping strategies identified by the adolescents were: listening to music, thinking about good things, making their own decisions, being close to someone they care about, sleeping, trying their own to deal with problems, eating, watching television, day dreaming and praying. The adolescents also reported low utilization of certain maladaptive coping strategies such as alcohol and illicit drug usage.

In case of married people, Ntozi and Nakayiwa (1999) found that remarriage and migration is a coping mechanism for the HIV widows in Uganda. Jatum and Schoech (1992) in USA found that AIDS patients moved from one area to another to obtain better or closer services, find knowledgeable physicians, participate in chemical drug trials and escape discrimination, rather than die at home. A study conducted by Ukpong (2003) in Nigeria found that many persons living with HIV use different strategies for coping with the experience and impact of stigma. Some cope by disclosing their status in order to get support of family friends and health care workers and a few cope by joining support groups while others play active roles in HIV/AIDS education and advocacy efforts. Others move away from the area of residence and go to a new place where he/she is not well known. That way, life starts a new with individuals making efforts to prevent stigma. Sun, Zhang, and Fu (2007) found that most frequently used coping style by PLWHAs in central China was confrontation. Both acceptance – resignation and avoidance were the coping style used by them.

Singh, R. (2007) in Mumbai observed that majority of HIV infected people avoid those situation as far as possible, which they feel, can cause stress for them. These being verbally abused by their neighbours, in-laws and natal family reported that in order to avoid hearing abuse and unnecessary comments, they preferred staying indoors. They have isolated themselves from the neighbourhood and severed their relationship with
their in-laws. About half of the respondents have isolated themselves from any kind of social gathering. Singh (cited in Nybade, 2003) found that PLWHAs and their families develop various strategies to cope with the stigma. Some cope by participating in network of people with HIV and actively working in the field of HIV or by confronting stigma in their communities. Others look for alternative explanation for HIV besides sexual transmission and seek comfort, often turning to religion to do so. In an evaluative study, Kalluba et al, (1997) found out that counseling had a positive effect on people’s ability to cope with AIDS.

UNDP (2011) conducted a study in the states of Gujarat, Orissa, Rajasthan and Tamil Nadu in India and it revealed that the HIV households liquidate their assets in order to cope with the burden of the medical expenses. The asset most likely to be liquidated is a house or a land in the rural areas. Households also tend to borrow money from local money lenders at high interest rates. For example, nearly 46 percent of HIV households had borrowed as compared to around 27 percent of non-HIV households, in the last one year, as depicted in Pradhan et al (2006). Similarly, almost 43 percent of HIV households had either borrowed or liquidated assets after one of the family members tested positive. Studies indicate that children of HIV households drop out of school either to reduce expenses or to take care of siblings or contribute to the household income by engaging in work. Those who continue with education often find it difficult to balance school and household work and eventually quit school (Nankarni and Soletti, 2006). In other cases, orphaned children have to depend on grandparents, extended family members or NGOs for care and support. A study on child-headed households in Tamil Nadu and Andhra Pradesh revealed that support from family and relatives are often superficial and without financial help. Grandparents are able to extend psychological support, but have little to offer when it comes to financial help (Nadkarni, et al, 2006). Lack of education reduces the future capacities of these children to engage in skilful employment thereby contributing to the poverty situation of such households.
Studies done by Mahal and Rao (2005) show that coping mechanisms of households to deal with risks/shocks associated with HIV and AIDS were households cope by reducing expenses on essential items, including food. Women (if not already working) feel forced to join the workforce. Women without skills often settle for non-skilled jobs with smaller incomes. School dropout is seen as a way of reducing expenses or to have helping hands for the domestic work at home. Households with assets resort to selling them. Households without assets tend to borrow money from informal credit sources like relatives or local moneylenders at higher interest rates. Households with more than one ill person and without any assets could be pushed towards destitution that could result in dissolution of the household or complete dependence on charity.

In Manipur Paradhan, Sundar and Mandal (2006) conducted a study, and found that various types of coping mechanisms are adopted by PLWHAs. Out of those, 51 percent reported that the counseling received from the counselors helped them to come to terms with their situation, about 23 percent had not disclosed their HIV status in the community, some of them reported that they had received family support and similar support from friends and relatives.

2.5 Support system available to positive people at the global, national and state level

The global AIDS strategies are to provide adequate and equitable health care for the growing number of HIV infected people with HIV/AIDS. Treatment of STDs, which increases people biological vulnerability to HIV infected, reduction of women’s social vulnerability to HIV infections by improving their health, education, legal status and economic prospects, more supportive socio-economic environments for AIDS prevention, immediate Planning in anticipation of the pandemic’s socio-economic impact, a greater focus on conveying effectively the compelling public health rational for overcoming stigmatization and discrimination.
The AIDS epidemic is taking and will continue to take a devastating toll on human lives. This AIDS pandemic has led many nations to write and jointly fight to combat the HIV. To stop the spread of this pandemic disease many organization were set up to give support to the HIV positive people.

2.5.1 Global support

UNAIDS

The Joint United Nations Programme on HIV/AIDS (UNAIDS) is the leading advocate for global action on HIV/AIDS. It brings together eight United agencies in a common effort to fight the epidemic: The United Nations Children Fund (UNICEF), the United Nations Population Fund (UNFPA), the United Nations International Drug Control Programme (UNDCP), the International Labour Organisation (ILO), the United Nations Educational, Scientific and Cultural Organisation (UNESCO), the world Health Organisation (WHO) and the World Bank. UNAIDS both mobilizes the responses to the epidemic of its eight cosponsoring organization and supplements these efforts with special initiatives. It purpose is to lead, assist, and expansion of the international response to HIV/AIDS on all fronts: medicinal, public health, social, economic, cultural, political and human rights. UNAIDS work with a broad range of partners- governmental and NGO, business, scientific and lay- to share knowledge, skill and best practice across boundaries. Development for International Development (DFID) halting the spread of disease in developing countries and providing life-saving care to the millions in those countries living with HIV and AIDS in one of DFID’s fundamental goals. DFID works on other fronts to tackle the epidemic. DFID in supporting education programmes in countries such as Nigeria, Bangladesh and Afghanistan to ensure that girls are less likely to contract the diseases. DFID is working to defeat the stigma and discrimination surround the disease changing attitudes is a key component of DFID’s strategy on HIV/AIDS. DFID is the second largest donor on the world on HIV and AIDS.
International HIV/AIDS Alliance

The International HIV/AIDS Alliance is an International development non-governmental organization, which was set up in 1993 by Consortium of international donors. The Alliance was established to respond to the need for a specialist, professional intermediary organization that would work in effective partnership with non-governmental and community based organization in developing countries, as well as with national, governments, private and public donors and the UN system. The alliance is committed to making access to care, treatment, and prevention a reality for all, including HIV testing and counseling, treatment, palliative care, support and prevention.

WHO

World Health Organisation (WHO) takes the lead within UN system in the global health sector response to HIV/AIDS. The HIV/AIDS department helps them scale up treatment, care and prevention services as well as drugs and diagnostic supply to ensure a comprehensive and sustainable response to HIV/AIDS. It provides support in the health aspects of HIV/AIDS not only to government organizations but also to NGO’s and private sectors. The support includes disseminating information, providing training and guidelines to health-care workers, supply HIV testing kits, ensuring safe blood transfusion and monitoring trends of the pandemic.

UNICEF

HIV, AIDS, and its impact on children continue to remain at the core of UNICEF’s work. For too long, children have been the missing face in the HIV and AIDS response and their needs are often being overlooked. Yet, they are the ones who offer the greatest hope for defeating the epidemic. UNICEF provides support in procuring supplies for children Anti-retroviral medicines for children, preventing mother to child treatment HIV and providing pediatric treatment, etc.
**Keep a child alive**

Keep a child alive provides life-saving AIDS treatment, care, nutrition, support services and love to children and families affected by HIV/AIDS in Africa and India by directly engaging the global public in the fight against AIDS.

**World Bank**

The World Bank helps developing countries reach the Millennium Development Goals that call for the elimination of poverty and sustained development. As a Cosponsor of UNAIDS and under the UNAIDS division of labour, World Bank is the lead agency for support to strategic, prioritized and cost national plans; financial management; human resources; capacity and infrastructure development; impact alleviation and sectoral work. The World Bank- Supports more strategic, results-oriented national HIV/AIDS planning, and better integration of HIV in national development planning. Provides sustained, predictable funding for HIV programmes and strengthening health systems. Supports faster, more efficient, effective and transparent HIV programme implementation. Helps strengthen country Monitoring and Evaluation systems and capacity to collect, analyze and use data. Supports evaluation and analysis to generate and share knowledge to improve programmes.

**World Vision**

World Vision is a Christian relief and development organization dedicated to helping children, families, and communities worldwide reach their full potential by tackling the causes of poverty and injustice. They help transform the lives of the world’s poorest children and families in nearly 100 countries, including the United States, through interventions such as nutrition and safe drinking water programs, poverty relief and community development programs, disaster assistance, and more. Our non-profit work extends assistance to all people, regardless of their religious beliefs, gender, race, or ethnic background. World Vision has helped bring Americans together to care for the millions of orphans, widows, and other vulnerable children affected by HIV and AIDS.
Through the Hope Initiative, World Vision is helping to turn the tide against HIV and AIDS around the world. Orphans and vulnerable children often do not have enough food to eat, have no access to proper medical care, cannot attend school, and face abuse and neglect. In many cases, they must care for sick and dying parents as well as younger siblings. It is involved in more than 162 projects in 25 states. It projects its community development programmes as “holistic development”. This is implemented through Area Development Programmes (ADP). Each ADP works in an area that is contiguous geographically, economically or ethnically. These programmes provide access to clean drinking water, healthcare, education and setting up of income generating projects.

**Rooftops Canada**

Rooftops Canada is one of the pioneers in identifying and responding to the critical link between housing and HIV and AIDS. Rooftops Canada-supported programs in South Africa, Zimbabwe, Tanzania, Kenya, Cameroon, Uganda and India as well as its African regional and international networking efforts all put HIV and AIDS on the housing and human settlements agenda. Since 2003, Rooftops Canada has been working to integrate HIV and AIDS issues into para-legal training on women’s rights to tenure and inheritance. Rooftops Canada partners are encouraging the use of wills to ensure that widows and children receive their entitled housing inheritances. Other responses include insurance to cover housing loan repayments and youth leadership training. Urban agriculture is also being promoted for better nutrition, food security and income generation among affected households. Rooftops Canada supports a growing global network focused on housing as a crucial element in the response to HIV and AIDS.

**2.5.2 National Support**

AIDS entails an enormous loss of human and economic resources and posses a substantial threat to the economic and social growth of many nations in the developing world. Indian Government has set-up many programme to prevent the HIV/AIDS epidemic. The National AIDS Control Programme (NACP), launched in 1992, is being
implemented as a comprehensive programme for prevention and control of HIV/AIDS in India. Over time, the focus has shifted from raising awareness to behaviour change, from a national response to a more decentralised response and to increasing involvement of NGOs and networks of people living with HIV/AIDS (PLHA). NACP’s Phase-III has the overall goal of halting and reversing the epidemic in India over the five-year period (2007-2012). NACP-III has placed the highest priority on preventive efforts. At the same time, it seeks to integrate prevention with care, support and treatment through a four pronged strategy:

1. Preventing new infections in high risk groups and general population through saturation of coverage of high risk groups with targeted interventions and scaled up interventions in the general population;

2. Providing greater care, support and treatment to larger number of PLHA;

3. Strengthening the infrastructure, systems and human resources in prevention, care, support and treatment programmes at the district, state and national levels; and

4. Strengthening the nationwide Strategic Information Management System.

Care and support for people living with HIV/AIDS is a cornerstone of the AIDS prevention effort in India. NACO is committed to bringing a large number of PLWHAs under the umbrella of treatment, care and support. In addition, to optimize prevention efforts that will help to reduce the impact of the epidemic on individuals and societies. Expanding access to care is an enabling environment increases demand for integrated counseling and Testing Services, bolsters prevention messages, de-stigmatizes AIDS and motivates those living with HIV to adopt and sustain safe behaviour.

Government of India assists care and support of PLWHAs by- Ensuring availability of essential drugs for managing opportunities Infections (OIs). Providing drugs for post exposure the prophylaxis to all government hospitals for admitting PLWHAs. Linking
HIV care services to Revised National TB control Programme with the objectives of facilitating free treatment of TB amongst PLWHAs. Initiating intensive advocacy and sensitization programmes among medical practitioners to pre-empt and counter stigmatization of PLWHA and denial of health care. Holding training workshops for doctors on clinical management of HIV/AIDS, making rational use of anti-retroviral drugs and reducing discriminations against the infected. Facilitating establishment of Infection Control Committees in all major hospitals. Expanding sub-districts level Integrated Counseling and Testing Centres (ICTCO) in a phased manner. Scaling up the Prevention of Parent to child Transmission (PPTC) of HIV throughout the country in a phased manner. Increasing access to paediatric ART treatment and nutritional supplement for children and adults on ART.

Anti-retroviral drugs are made available free to HIV/AIDS patients in Tamil Nadu, Andhra Pradesh, Karnataka, Maharashtra, Manipur and Nagaland since April 1, 2003. The supply would be provided through Government hospitals & antenatal clinics. A $ 25 million initiative to stem the spread of HIV/AIDS in Andra Pradesh was launched. The Bill and Malinda Gates Foundation India AIDS Initiative Avahan provided the money for the project. India with the objective of helping people with AIDS has forged a partnership with United Nations World Food Programme (WEP) under which nutritional supplements would be provided to the affected to help them fight the disease. The Government is taking an integrated approach to check the spread of the disease. The WEP will provide technical support in the form of research and survey.

2.5.3 State Support

The government of Manipur is an agency for the welfare of the people in general. The government of Manipur has adopted a policy on AIDS, which is termed as "Manipur State AIDS Policy", in the year 1996. The policy is for the benefit of the HIV affected victims for an overall health care system under the authority of the department of Health, through many NGOS, and in order to make the victims live positively and happily in a normal life and to avoid further proliferation of the HIV/AIDS.
The general objectives of the Policy are to prevent the epidemic from spreading further and to reduce the impact not only upon the infected persons but upon the health and socio-economic status of the general population at all level. It envisages achieving zero-level of new infection in the general population. The specific objectives are:-

1. To reiterate strongly the Government’s firm commitment to prevent the spread of HIV infection and reduce personal and social impact. (Draft Revised State AIDS Policy) 2010
2. To prevent further spread of HIV infection in the general population.
3. To ensure effective and efficient implementation of the HIV/AIDS prevention and control programme at various levels with the active participation of the stake holders like community at large, NGOs, CBOs, civil society, government departments, private and voluntary organizations, faith- based organizations etc.
4. To ensure that people living with HIV/AIDS have easy access to all kinds of necessary medical investigations and treatment facilities and other social support services.
5. To intensify and expand the information, education and communication campaigns so as to reach all sections of the Society.
6. To ensure highest level of political commitment through the Legislators Forum, Zilla Parishad Forum, District Council Forum in the implementation of the HIV/AIDS control programme and through inclusion of HIV/AIDS in the common minimum programme of the Ministry.
7. To ensure mainstreaming of the HIV/AIDS control programmes so that each and every government department can take up HIV/AIDS control programme and has earmark in their own budget.
8. To overcome stigmatization and discrimination of the people living with HIV/AIDS in all spheres of life through legislation and any other measures.
9. To generate a sense of ownership among all the participants both at the Government and Non Government Organizations to make it a truly community effort.
10. To ensure that services are monitored and evaluated from time to time.
11. To create a helpful supportive and enabling social environment in the community so as to enable the people at risk to come forward for seeking information, counseling, HIV testing and other social support services.

12. To create an enabling socio-economic environment for prevention of HIV/AIDS, to provide care and support to people living with HIV/AIDS, to ensure protection of their rights including right to access Health care (Draft Revised State AIDS Policy) 2010 System, Right to Education, Employment and Privacy, and to mobilize support of large number of NGOs/Community Based Organization for an enlarged community initiative for prevention and alleviation of the HIV/AIDS problem.

13. To decentralize the HIV/AIDS Prevention and Control programme to the grassroots level.

14. To provide adequate and equitable provision of health care to the HIV infected people and draw attention to the compelling public health rationale for overcoming stigmatization, discrimination and seclusion in the society.

15. To ensure availability of adequate and safe blood for the public through promotion of voluntary blood donation in the state.

16. To ensure availability of adequate and safe blood for the public through promotion of voluntary blood donation in the state.

17. To promote better understanding of HIV infection among the people especially students, youths and other sexually active sections to adopt safe behavior practices for prevention.

18. To provide support to the affected and infected people with HIV.

19. To prevent women, children and other socially weak groups from becoming vulnerable to HIV infection by improving health education, legal status and economic prospects.

The State Government considers the AIDS problem as Socio-Economic problem rather than a mere public health challenge, a matter of great urgency and a top priority requiring immediate action. The State Government is fully committed to effective and efficient implementation of the HIV/AIDS Control Programme as a part of the overall health care
system in the state. The State Government shall provide necessary support for proper implementation of the programme at the State, district and community levels. (Draft Revised State AIDS Policy) 2010

The Government therefore adopts the Manipur State AIDS Policy based on:

- provision of accurate information and education to make the people aware of and to protect themselves from HIV infection,
- participation of people with HIV/AIDS and high risk behavior,
- safeguard of confidentiality,
- respect of privacy, human dignity and individual human rights,
- avoidance of discrimination and stigmatization,
- provision of quality medical and health care,
- provision of social benefits and social support system for people infected and affected by HIV/AIDS,
- creating a helpful, supportive and enabling social environment in the community so that people who suspect themselves to be infected with HIV can come forward for voluntary counseling, testing and for seeking help and support so that they can live peacefully with other members of the society,
- avoidance or removal of fear psychosis from the minds of the people,
- To advocate and enhance gender sensitive environment
- Provision for prevention of mother to child HIV transmission and Early Infant Diagnosis (EID).
- To constantly interact with international and bilateral agencies for support and cooperation.

In Manipur, a number of NGOs have responded very positively to the HIV/AIDS epidemic. Many NGOs help in preventing in HIV infections through awareness, knowledge, practice and education. NGOs play a vital and pivotal role in the empowerment process of the widows. NGOs have remained reliable in terms of their
economic, psychosocial and legal empowerment agendas to the widows. NGOs also play a mediatory role in the families and help widows’ access legal assistance which may be beyond their reach given their economic hardships.

**The Manipur Legislators Forum on HIV/AIDS**

The Manipur Legislators Forum on HIV/AIDS, constituted on 30th June, 2007 under. The main focus of the Manipur Legislators Forum on HIV/AIDS will be to ensure active involvement of the Members of the Legislative Assembly (MLAs) in the day to day HIV/AIDS prevention and control programme. In order to enable them to implement the HIV/AIDS related activities, the Manipur State Government will allow utilization of the Local Area Development Fund of MLAs for this purpose.

Some of the NGOs, which are, recognised for their support to HIV/AIDS victims:

(i) Social Awareness Services Organisation (SASO)

(ii) Manipur Network Positive People (MNP+)

(iii) Integrated women and children Development Centre

(iv) Kripa Foundation (Manipur)

(v) Kripa Society

(vi) Nirvana Foundation

(vii) Social Development Association, Manipur, etc.

With this background of multiple research findings at the Global, National and the State level along with policy framework, it is essential to arrive at the strategies so as to meet the needs of HIV/AIDS affected people. This study is therefore an attempt to arrive at the state specific realities of Manipur and how the services can be planned to reach and to HIV/AIDS affected families and especially women.