CHAPTER -VI

CONCLUSION

In the proceeding chapters an attempt has been made to examine the Social Dimensions of HIV/AIDS in Churachandpur District of Manipur, North East India. The study has particularly examined the burning problems of HIV/AIDS in Churachandpur district. The rate of its infection particularly in the younger generation is alarming us in every sphere of life. These pointed out that some serious thought should be given for controlling and chalking out a plan of action to kill the disease before it kills you. Hence, an attempt has been made through this (study) to pursue the burning problem and it is hoped that this will effectively help in solving or controlling HIV/AIDS in Churachandpur district.

This study has been divided into six chapters. The first chapter is deals the importance of the study with special reference to Churachandpur district of Manipur and this chapter has a clear understanding of the current issues and problems of HIV/AIDS within the district and outside. Besides, the objectives of the study of the thesis, review of literature and methodology are discussed in this chapter.

The second chapter mainly reflects the area of study and discusses the land and the people in general with special reference to Churachandpur district of Manipur and the trends of HIV/AIDS in Manipur which reflects or shows the district wise distribution of HIV/AIDS as trends started appearing from 1986 up till this very day of 2010.
The third chapter primarily deals with the genesis of HIV/AIDS and its reflects the history of HIV/AIDS development, the disease or virus effects, high risk-and low-risk group behaviours, and the origin of HIV/AIDS are also discussed in this chapter.

The fourth chapter is based on field work and examines the Social Dimensions of HIV/AIDS in Churachandpur district of Manipur and mainly deals with the causes of HIV/AIDS, Socio-economic of HIV/AIDS, and attitudes towards HIV/AIDS patients in Churachandpur district.

The fifth chapter focuses on the preventive measures against HIV/AIDS in Churachandpur district of Manipur and makes available the findings of study. Besides, the intervention of the government, the involvement of Non-religious Organizations (NROs) and Faith-Based Organizations (FBOs) are also discussed in this chapter.

Finally, the sixth chapter highlights the summary of the chapters concerned and the conclusion through observation of the work derived from the study. Thus, this chapter concludes the study by highlighting the major findings and the key issues that have arisen as a result of the study. This chapter is devoted to the explanation of the results and an attempt at interpreting the problems in a suitable and appropriate manner. And at the end, suggestions for further investigation or work have been provided for a more detailed study to improve the quality of the work.

With this knowledge and understanding of the problems of HIV/AIDS, some of the research priority areas, which need to be taken up without delay are suggested below:

1. In-depth study of Intravenous Drug Users (IDUs), Call-girls and Commercial Sex workers (CSWs)
2. Comparison between Low-risk and High-risk blood groups.

3. Thorough study on the issue of HIV/AIDS treatment among the patients so that opportunistic infection can be avoided.

4. Complications of malnutrition and nutritional profiles among HIV infected individuals for better management of the disease.

Further enquiring into these areas may yield useful insights for HIV/AIDS prevention and better understanding of what it means to be in contemporary society. In fact, the first case of HIV infection in Churachandpur district was reported and detected in 1990. By early 1995 to 2000, Churachandpur district had reported 502 cases of HIV. On such set of estimates recently prepared for the district (2003) indicated that there are 574 cases of HIV infection and the number of AIDS deaths rises to 506 between 1995 to 2003. Hence, the people of the district are generally conscious and aware of HIV/AIDS. But the degree of awareness varies depending on the background and literacy of persons. Few among the educated class had been aware of HIV/AIDS as early as 1984 even before the disease surface in India (1986) while few among the illiterate of the district have a superficial knowledge and come to know AIDS as late as 1999 after a series of AIDS related deaths had occurred in Churachandpur district.

So far as the socio-economic of HIV-AIDS is concerned in Churachandpur district, to minimize the negative impact in the community, SHALOM in Churachandpur district has five broad areas of community education, health care and support services, injecting drug users (IDUs) services, women and children programme and T.B. Control and Treatment Programme since 60% at Shalom hospice are suffering from dual HIV-
T.B. infection. The latest addition to SHALOM was AIDS Orphans Education support in 2003 as a part of women and children programme. Under this programme, 98 orphans were given small scholarships in 2000 and in 2001, similar supports were also given to 125 orphans but this programme was discontinued in 2002 due to the lack of funds. So there is an increasing number of AIDS widows and AIDS orphans over the last few years. Since 48% of AIDS patients in Churachandpur district are married couple. In most cases, the husbands were ex-addicts who often infected their wives.

HIV was detected for the first time in Manipur in 1990. The virus quickly spread because of sharing of injecting equipments by intravenous drug users (IDUs) who still form nearly 50% of all HIV positive Persons in the state. Today Manipur is one of the five high HIV prevalence states in India and Churachandpur, one of the eight districts of Manipur in North-East India, is the worst affected district calculated on the basis of the number of HIV infected persons in proportion to its population and also on the report of HIV/AIDS morbidity and mortality. While the largest numbers of HIV/AIDS cases have been reported in Churachandpur district, it is in the urban areas that the situation is most disturbing and worrying. There are many effects of AIDS in the AIDS patient. When a person is told that he has been infected with HIV/AIDS, a series of adjustment problems are set in motion- adjustment that affect every aspect of a patients’ life- such as physical, mental and spiritual. The worst effects are that of debility and dependency for the rest of his life.

Family relationship of HIV/AIDS patient will drastically change. Other people will not yet feel free with the family for fear of being infected. Family members may also
feel stigmatized and isolated because of their relationship to a person with AIDS. For sometime, AIDS is also being considered as something that can only happen to others with loose lifestyles, not something that can affect ordinary people. As a result, if they hear that someone has caught AIDS, they are liable to be disgusted rather than sympathetic. It is sure they keep a distance from the patient. On the part of the family of the victim, there is the additional strain of not feeling able to be frank with their friends about the disease. So they may not get a positive sympathy, help and all support they need to take care of the victims.

Generally, people at large are ignorant about the issue of AIDS in-depth. Because of this, fear of criticism, ostracism and embarrassment may prevent families from sharing their burden with others. So they may be denied of the necessary support that otherwise would be provided if the family illness was other than AIDS related. Family may thus feel angry, feeling that the patient has been irresponsible or sinful and has unnecessarily burdened them. Prejudice may be directed towards a loved one threatening the relationship and generating internal conflicts in the family members who are not understanding or sympathetic. Probably, friends or lover may be an additional source of stress. Family disapproval or rejection in particular may lead a patient to feel that he has to choose between his lover and his family at a time when he needs a loving support and affirmation of all people important to him. The threat of death carried by AIDS means disruption of the earning and the life plans of both patients and families.

Thus, in personal and family level, direct costs of medical care, loss of livelihood from the death of a breadwinner. So trauma of victimization for people with HIV/AIDS
has been associated with the loss of earnings, loss of shelter, loss of community support and fear of being known coupled by social or professional stigma, and violation of individual rights. Thus plans, dreams and hopes will not be fulfilled and they become sources of grief. They mourn the anticipated and actual death. They also grieve the loss of the potential security, which that child represented to their old age. So death vigils may be tense because family members are afraid to hold or kiss their dying loved one. The true diagnosis or has allowed the truth to be told too late for meaningful conversations to take place. Feeling of rejection, neglect and abandonment are not uncommon in these situations. Since then, the healing process of bereavement may be frustrated because of the usual support from friends and family may be foregone or not available.

In a community level, socio-economic impact of HIV/AIDS in the district is also related to economic loss of key productive members, transfer of responsibilities and costs onto community coping mechanism. Hence, community may be compelled to provide help or support in several ways when parents or earning members of the family become ill. But in a wider society level, the impact will concern issues such economic costs as a result of HIV infection among workers in various sectors, production affected as a result of depletion of labour force, burden on health care system and problems at work places in the form of absenteeism. The situation at home may be unknown to family and co-workers. Absence from work may be difficult to explain without disclosing personal information that could place one’s employment in jeopardy. Finally when death occurs, co-workers may be denied the opportunity to be supportive, and the grieving lover may
not be excused from daily activities to mourn. As a further consequence, long-term potential impact of HIV/AIDS in the district might often deals with destitution, social unrest, political instability and so on.

Above all, in the sub-divisions of Churachandpur district, rural poverty has led to migration and rapid expansion of urban towns or area. In these growing towns and semi-towns, social problems such as unemployment, shanty townships, call-girls, prostitutions, like street children etc, have emerged. The traditional stable family structures have come under increasing strains and norms of sexual behaviour are changing. As a result, Shalom has recorded 462 AIDS deaths since 1995 which include 173 deaths reported at its residential 10 bedded community (Hospice) Care Centre (started April 1999) funded by the Government through NACO. Since 58% of AIDS patients admitted at the hospice were married and 30% of those treated so far have already died and that the number of widows and orphans is fast increasing. A recent survey made by Shalom in Churachandpur district has also identified 262 AIDS orphans and the number of widows identified so far is 112. In fact, just a developing district does not have the kind of proper resources, infrastructure of health services, communication network and trained field staffs that industrialized the district. They were unable to draw on mounting public education campaigns, blood screening programmes and treatment of people with HIV/AIDS. For some time, the district may also be called no-industry district.

With chronic financial crunch that has hit hard even government servants who normally draw their salaries once in 2 months, it has become increasingly difficult for average people to provide for families. This is more so in the case of many woman
(widows) who are really struggling to meet both ends especially in the absence of their husbands who have died due to AIDS, alcoholism or armed conflicts in recent years. It has become quite necessary that provision be made for helping these widows in the form of small grants or loans to enable them to earn for their families. These women are mostly from poor family background; financial help to AIDS orphans or widows has become a priority area in this part of the country. Many families or parents are overstretching in their attempts to earn sufficient money to send their children orphaned by AIDS deaths to school. Then Shalom in Churachandpur district of Manipur has provided small assistance to 50 AIDS affected families in the form of grant or loans.

However, the economic impact of HIV/AIDS in Churachandpur district is tremendous. Because the needs of AIDS patients can seem all consuming, especially when resources are limited and the needs for care are extensive and ominous. The case of HIV/AIDS indicated that hospitalization and treatment costs would entirely result in economic loss from future earnings due to the premature illness and deaths. Although such reduction is encouraging, it does not mean the total costs of AIDS population sects are unlikely to increase. Neither the early nor the more recent analysis take into account the intangible costs of pain, suffering, adverse effects on relationship and social stigmatization. But it is clear to us that the impact of HIV on the demand for hospital beds, professional services, and hospice care is already significant and will grow from time to time.

Besides, public education programme and social programmes aimed at risk reduction, which will add to the increasing economic burden. This estimate indicates the
burden of the effects of HIV infection. This economic burden is followed by the picture of pain, suffering and death, which is devastating within and outside the district. The rest of the country now shares these bitter experiences of the district. In short, the greatest tragedy was that AIDS kills people at their most productive age and it further puts strain on their economy. Also child survival rates will be directly affected by infants being born to HIV-infected mothers. This will also result in a major impact on the economy of the district as a whole and decreased productivity. HIV and AIDS pandemic will thus overstretch the already meager health, social and economic resources.

Taking under diagnosis and reporting and delays in reporting into account, AIDS cases to date are thought to have occurred mostly in the urban areas. But rural areas are no exception in HIV trends and were probably unaware of their status going to develop AIDS in near future and become a source of HIV infection to others. Indeed, it is not easy to estimate the actual numbers of people with AIDS and the number of infected with HIV since all cases are not reported. Thus, people living in remote rural areas may die without diagnosis by health workers. Many symptoms of AIDS such as diarrhoea, weight loss, enlarged lymph nodes, etc. are non-specific and were also found with other diseases. As such, many cases of HIV/AIDS may not be recognized. Besides, higher incidence of AIDS among sexually Transmitted Diseases (STDs) risk factors such as syphilis, Cancroids, Gonorrhea, Chlamydea, etc. patients are more likely to be infected with HIV and to transmit the virus to others. In short, already in the entire area of Churachandpur district, death of young adult children and others from AIDS is over shadowing the health centres and the tip off the iceberg. Some AIDS patients are many more AIDS carrier did
not know about the risks and chose to take a chance, while prevention is possible for anyone with a strong will. Thus, some estimates suggest that there could be as much as 1,000 HIV infected persons in Churachandpur district.

World Health Organization (WHO) and Manipur AIDS Control Society (MACS) expertise are also of the view that over thousand cumulative AIDS cases may actually occur in the main town concentration of the district. Even if these infected individuals had unprotected sex with only one regular sexual partner, the number of infected persons could be double. Since HIV positive persons do not show any evidence of infection for some years and look fine and healthy, it is easy to deny their presence. So the attitude towards HIV/AIDS patient in Churachandpur district is quite normal and their approach towards the patient is also humanitarian in accordance with Christian values and principles beside the traditional values. Hence, majority of the people agree and asserted that testing of HIV/AIDS must be done before marriage and legalized to prevent the spread of HIV/AIDS.

Majority of the people of Churachandpur district are also generally friendly, loving and caring towards HIV/AIDS patient and does not discriminate the AIDS patient, though stigmatization unusually prevails. Rather they go against pre-marital sex as sex is considered as a sacred and a special gift of God. The people also feel that if they are infected with HIV/AIDS, they prefer to tell their parents and doctors rather than concealing it. The reason is quite obvious. HIV/AIDS is not the end of everything or that there is no future, no hope and no happiness. They can still rely on God and engage in positive activities till they die and can achieve some great things in life. They can also
regain their values, strength and happiness as a normal being in the society. Thus, even AIDS related deaths are respected and rendered a decent burial.

The main causes responsible for the spread of HIV/AIDS in Churachandpur district has been found to be transmitted between intravenous drug users sharing contaminated needles and syringes or piercing instruments besides heterosexuals, blood transfusions, misuse of sex by illicit drug users and illicit sex through contaminated blood and blood products coupled with the failure of the moral norms of society. Thus, the mode of HIV/AIDS transmission varies from person to person and from place to place.

The social life of the people such as youth programme - social or religious activities at NIGHT is also a contributing factor for the spread of HIV/AIDS in the district, which are occasions for the youth to misuse to satisfy their whimsical desire. Parents were indeed unable to control their children because peer pressure is stronger than that of the parents. Probably, awareness of the high rate of internal and international corridor of drugs trafficking through Moreh (Chandel District) and Behiang in Churachandpur district to Myanmar (Burma) is another living example and its mobility associated with HIV/AIDS.

Some of the other causes for the spread of HIV/AIDS in Churachandpur district may also be noted as follows:

Some of the wrong notion or idea of the victimized was that discharging of AIDS virus through masturbation and passing the virus to others might relieve themselves from HIV/AIDS. Hush-hush encouragement of infected person to infect others by those affected with HIV/AIDS menace or promise incentive (reward) to infected persons by
others has a rampant practice in the district. Besides, others condoms may be the only hope in the HIV war and would change the direction of the epidemic and prevent number of cases of HIV infection in the district.

Particularly in Churachandpur district, drug addicted women or girls are not looking for sexual pleasure or excitement but the drug in exchange for sex with the sex dealers or clients. As such, they ultimately forced themselves almost on every man in the secret place or room and accidentally become infected with HIV/AIDS when sex dealers or clients or someone else totally ignored the use of contraceptive devices or use of condoms.

In short, Churachandpur district is extremely vulnerable to AIDS epidemic since many factors contributed to this vulnerability even when AIDS is confirmed to be transmitted by sexual intercourse in most cases. Intravenous drug users were the primary causative factors, initially responsible for majority of HIV/AIDS infections. More than 50% of the IDUs are estimated to be infected with HIV. But today, experts have now suggested that heterosexual intercourse or sexual transmission is a pre-dominant mode of HIV/AIDS transmissions in the district.

So far the prevention of HIV/AIDS in Churachandpur district, majority of the people feel that the district administrator being the head of the district needs to play a dynamic role by providing factual information, seminars, campaign, training, free HIV testing, social rehabilitation programmes, HIV/AIDS education through the churches, youth's clubs, household campaign, using Out Reach Worker (ORW) or experts providing them remuneration etc for safe behaviours or safe practice. The district
administrator then, declared HIV/AIDS as compulsory subject in religious and educational institutions since adequate knowledge may reach people of all age, sex, religion, etc.

Furthermore, traditional customs and practices like Kut festivals, Thabanchongba, youth club days etc should also be abolished for the time being, since such values have been assimilated and misused by young and old alike and frequently results immoral practices. Since the impact of HIV/AIDS has extended beyond that of the individual loss and coping and brought about significant changes at a community level. So, there is an urgent need to expand these problems to others areas and affective responses will have to draw upon skills and experiences from a wide range of field, working in co-operation for the development of AIDS Prevention that are rooted in local realities.

To be successful, future HIV Prevention must address the importance of socio-cultural issues of stigmatization, family and community, community empowerment, confidentiality and ethnic diversity. One of the ultimate aims of HIV Prevention is of course, to stop the further spread of the virus. Thus, preventive measures may also involve promoting safer sexual practices, better infection control practices in hospitals, sterilization of needles and syringes or piercing instruments, use for giving injections and setting up a rational blood transfusion programmes, improvement of blood transfusion service, check and control sexually transmitted diseases and blood borne infections, e.g. Hepatitis A, B, etc. And the need for planning AIDS Prevention Programmes has to be balanced against the importance of safeguarding human rights of persons found to be infected.
Nevertheless, as the decade progresses in the state, a greater proportion of HIV infection or AIDS will be in the district and that no one will remain untouched in the years to come as the disease spreads into the fabric of society. Hence, HIV will hit the rural poor hardest, just as it has in other urbanizing towns or areas. Consequently, child and adult mortality is expected to increase rapidly.

The WHO experts have estimated that an effective and safely vaccine may not be available cent percent. Even though there are such as AZT, ARU, etc., which stop reverse transcriptase from working and useful in treating AIDS, so far they have not been very successful when given to AIDS patients and the drug itself cause further harms to the patients. It is therefore, important to find out a drug that will destroy the virus without hurting the patient. So the most important vaccine and the way to prevent the spread of HIV/AIDS is to ensure the people that their behaviour (sexual behaviour) or life styles does not put themselves at risk.

Thus, two major changes in sexual behaviour are needed. They are reduction in the number of sexual partners and the move from high risk to low risk activities or no risk sexual activities. But it is crystal clear that complete abstinence for sex may be unrealistic. So promotion of safer sexual practices and counseling services to the individuals for their own choice to meet their needs should be propagated or widely discussed at the right times and at the right places. Indeed, prevention and control of HIV/AIDS transmission requires changes in certain behaviour in all times and in all situations.
Information alone is therefore insufficient to promote meaningful changes in risk behaviour. For instance, sex is a powerful motive and its activities are especially difficult to change through information provision alone. As such, moderate levels of fear will facilitate behaviour change and re-assured the community or society to be able to control the risk and its detrimental consequences. In short, risk perceptions are heavily influenced by social, political and cultural factors, such as social class membership or involvement in social milieu.

Perceptions of risk are closely connected to litigating moral principles. A judgment about risk can be a social comment, reflecting points of tensions and value conflicts in a given society. Researcher on sexual behaviour and risk of HIV infection clearly implies a focus on the specific social interactions that influence individual behaviour, largely absent in traditional society. In the case of HIV/AIDS prevention, community mobilization and a social climate tolerance and solidarity are major elements for maintaining risk awareness and adequate behaviour. Yet in Churachandpur district, unsafe sex might be especially likely to occur if an individual uses alcohol or drugs to cope with his psychological distress. No use of condoms was another related to move emotional conflicts. Changes in behaviour have also occurred just because IDUs in specific areas are more in touch with community responses to HIV/AIDS. Hence, the results from different studies are conflicting and inconclusive.

The man who accepts IDUs is more likely to have had unsafe sex partly as being socially stigmatized becomes with higher levels of risks. Relevant to this point, the more socially disadvantaged a group, the greater the impact of negative life events on its
members from a hostile society. Thus, in the context of HIV/AIDS Prevention, attitudes towards fellow being may operate in a variety of ways and on variety of levels. But the negative societal reactions can stimulate feelings of self-hatred, anger, distrust, or self-denigration and thereby socially affect one’s health status. So it is assumed that the wealth and health of IDUs and AIDS patients were indeed affected by a negative social climate.

The other likely effect of HIV/AIDS is that there has been resurgence and suppression of immunity and mortality, which is a disease of poor socio-economic population. And the greatest tragedy was that AIDS kills people at their most productive age and it further put strain on their economy. This will also increase high morbidity and mortality to the young and old alike to suffer more. In most of the time, HIV/AIDS cases are marginalized socially and were kept as a taboo in the society since the major modes of transmissions are mostly through illicit drugs and illicit sex. So many myths further alienate some of the AIDS patient from the society for mixing with others and suffer from social stigmatization. Hence, some developmental works or activities are hampered and negate in the district.

Practically in Churachandpur district, clinical facilities, counseling centres of detoxification, AIDS prevention education and intervention measures have not kept pace with detection of HIV/AIDS patients. Under such compelling circumstances, HIV positive patients do not know whom to look to relief. Then they ultimately go underground to escape social stigmatization and become offing and awful in the society.
In short, AIDS has also made us realize the economic reasons that push women into shameful professions or flesh trade (e.g. call-girls into prostitutions), manual workers into drug addiction, youth into insurgency or militancy and others to sell their blood for food or for something else. Thus, one has to see, vision and burden the social and economic consequences of HIV/AIDS in the district, in which both professional and layman are no exception to play an active role. Thus, prevention and control programme must be given a top priority now and that mistakes made by others should not be repeated.