CHAPTER – I
INTRODUCTION

HIV/AIDS has been a major threat and a great challenge to the quality of life and humanity. It came to be one of the main concerns of the day. It awfully affects people mostly in the prime of their lives, causing tremendous suffering and great sorrow to millions of people in the world. Today, the HIV epidemic continues to grow alarmingly and invisibly, and the number of people diagnosed with AIDS is increasing rapidly. More people have become infected in 2003 than ever before and more people have died of AIDS than ever before. Joint United Nations Programme on HIV/AIDS (UNAIDS) has estimated that while 12.9 million people were living with HIV/AIDS in 1992, today we are having 42 million people living with HIV/AIDS in 2002 and by the end of 2010, numbers of 114 millions people will be living with HIV/AIDS in the world. This statistic masks the fact that 27.9 millions people have already died of AIDS by December 2003 since the beginning of the epidemic, of which 11.1 were men, 11.3 were women and 5.5 were children below 15 years of age. The Second World War killed only 43 million people; The Hiroshima Atom Bomb has killed only 70,000 people. That means the impact of AIDS will be much more dangerous and severe than the impact of Second World War.¹

By 2010, over 50 countries will register dramatic decreases in life expectancies. Funding is one of the topmost constraints in the battle against AIDS. UNAIDS estimates that about $10 billion a year will be needed for a global response- about five times more
than what is spent now. With various Projects vying for a share of the $53 billion that is at present available each year, AIDS hardly gets the funding it needs. According to WHO AIDS director and epidemiologist, Bernard Schwartlander, 45 million more people will be infected by 2010 if efforts against AIDS continue at the present pace. The quality of future lives solely depends on the quality of life today. A sense of anger is engulfing all sections of the AIDS community. UNAIDS country adviser, David Miller said: "People are impatient with meetings and we have already lost many an opportunity to save lives." Thus one Indian is infected every minute and we have to use that understanding urgently. In India, HIV is spreading at a furious pace. For instance, Bombay prostitutes have registered a twentyfold increase during the past seven years. This is perhaps the most rapid rate of increase and spread of HIV seen anywhere in the world and it is all the more a grim and alarming.

The History of HIV/AIDS in India

India is one of the largest and most populated countries in the world, with over one billion inhabitants and around half of whom are adults in the sexually active age group. At the beginning of 1986, India had no reported cases of HIV or AIDS. But there was recognition that this would not be the case for long and concerns were raised about how India would cope once HIV and AIDS cases started to emerge. HIV emerged later in India than it did in many other countries.

HIV is thought to have entered India in the early 1980s, but it was only in March 1986 that the first cases of HIV infection were detected and the first case of AIDS was
reported in Bombay in May 1987. Since then HIV infection has been reported in all states and union territories. The spread of HIV in India has been uneven. Although much of India has a low rate of HIV infection, certain places have been more affected than others. HIV epidemics are more severe in the southern half of the country and the far north-east.

The highest HIV prevalence rates are found in Andhra Pradesh, Maharashtra, Tamil Nadu and Karnataka in the south; and Manipur and Nagaland in the north-east. In the southern states, HIV is primarily spread through heterosexual contact. Infections in the north-east are mainly found amongst injecting drug users (IDUs) and sex workers. Infection rates soared throughout the 1990s, and today the epidemic affects all sectors of Indian society, not just the high risk groups such as sex workers and truck drivers etc with which it was commonly associated. In a country where poverty, illiteracy and poor health are rife, the spread of HIV presents a daunting challenge.

Later in the year, India’s first cases of HIV were diagnosed among sex workers in Chennai, Tamil Nadu. It was noted that contact with foreign visitors had played a role in initial infections among sex workers and HIV screening centres were set up across the country and there were calls for visitors to be screened for HIV. Gradually, these calls subsided as more attention was paid to ensuring that HIV screening was carried out in blood banks. In 1987 a National AIDS Control Programme was launched to coordinate national responses. Its activities covered surveillance, blood screening and health education. By the end of 1987, out of 52,907 who had been tested, around 135 people
were found to be HIV positive and 14 had AIDS. Most of these initial cases had occurred through heterosexual sex. But at the end of the 1980s, a rapid spread of HIV was observed among injecting drug users (IDUs) in Manipur, Mizoram and Nagaland - three north-eastern states of India bordering Myanmar (Burma).

At the beginning of the 1990s, as infection rates continued to rise, responses were strengthened. In 1992 the government set up NACO to oversee the formulation of policies, prevention work and control programmes relating to HIV and AIDS. In the same year, the government launched a Strategic Plan for HIV prevention. This plan established the administrative and technical basis for programme management and also set up State AIDS bodies in 25 states and 7 union territories. It was able to make a number of important improvements in HIV prevention such as improving blood safety.

By this stage, cases of HIV infection had been reported in every state of the country. Throughout the 1990s, it was clear that although individual states and cities had separate epidemics, HIV had spread to the general population. Increasingly, cases of infection were observed among people that had previously been seen as 'low-risk', such as housewives and richer members of society. In 2001, the government adopted the National AIDS Prevention and Control Policy. During that year, Prime Minister Atal Bihari Vajpayee addressed parliament and referred to HIV/AIDS as one of the most serious health challenges facing the country. The Prime Minister also met the chief ministers of the six high-prevalence states to plan the implementation of strategies for HIV/AIDS prevention. But HIV had now spread extensively throughout the country.
In 1990 there had been tens of thousands of people living with HIV in India; by 2000 this had risen to millions. The national HIV prevalence rose dramatically in the early years of the epidemic, but a study released at the beginning of 2006 suggests that the HIV infection rate has recently fallen in southern India, the region that has been hit hardest by AIDS. In addition, NACO released figures in 2008 suggesting that the number of people living with HIV has declined. Some AIDS activists are doubtful that the situation is improving: “It is the reverse. All the NGOs I know have recorded increases in the number of people accepting help because of HIV. I am really worried that we are just burying our head in the sand over this.” Anjali Gopalan, the Naz Foundation, Delhi.

In India, the highest numbers of AIDS cases are found in Mumbai, which is supposed to be known as AIDS Capital of India. It has 30 to 35 percent of the country’s recorded AIDS cases and HIV carriers, although half of the patients are from other states. The AIDS Research Centre of Pune was also of the opinion that the prostitutes of red-light area of Mumbai alone produce three to four HIV infected cases every one hour. This means that out of 400 new HIV infected cases every 15 minutes in the world, one is produced in Mumbai. Indian Health Organization (IHO) of Pune has estimated that about 10,000 people will die everyday in India on account of this man-made calamity, leaving 20,000 children orphans and 5,000 women widowed daily. Furthermore in a study in Pune, it was found that 80 percent HIV cases related to sexual promiscuity, 5 percent to blood transfusion and 4 percent to injecting drugs with infected syringes. But in India, the rate and pattern of HIV infection is not uniform in various states. The states that have
not reported any HIV positive cases does not necessarily means they are HIV free may be because of poor surveillance or lack of HIV testing facilities. Indeed, HIV infection is not AIDS but its infection however leads eventually to AIDS. It is also estimated that at least half of HIV infected worldwide are between 15 to 24 years of age and that 16,000 were newly infected each day. As such all School, College and even University Students were vulnerable and the vulnerability to AIDS becomes more pronounced each day.

**Stigma and discrimination in India**

In India as elsewhere, AIDS is often seen as "*someone else's problem*" – as something that affects people living on the margins of society, whose lifestyles are considered immoral. Even as it moves into the general population, the HIV epidemic is still misunderstood among the Indian public. People living with HIV have faced violent attacks, been rejected by families, spouses and communities, been refused medical treatment, and even, in some reported cases, denied the last rites before they die. As well as adding to the suffering of people living with HIV, this discrimination is hindering efforts to prevent new infections. While such strong reactions to HIV and AIDS exist, it is difficult to educate people about how they can avoid infection. AIDS outreach workers and peer-educators have reported harassment. Thus in schools, teachers sometimes face negative reactions from the parents of children that they teach about AIDS: "When I discussed with my mother about having an AIDS education program, she said, 'you learn
and come home and talk about it in the neighbourhood, they will kick you'. She feels that we should not talk about it—"Female student, Chennai."28

Discrimination is also alarmingly common in the health care sector. Negative attitudes from health care staff have generated anxiety and fear among many people living with HIV and AIDS. As a result, many keep their status secret. It is not surprising that for many HIV positive people, AIDS-related fear and anxiety. At times, denial of their HIV status can be traced to traumatic experiences in health care settings. "There is an almost hysterical kind of fear ... at all levels, starting from the humblest, the sweeper or the ward boy, up to the heads of departments, which make them pathologically scared of having to deal with an HIV positive patient. Wherever they have an HIV patient, the responses are shameful."29

A 2006 study found that 25% of people living with HIV in India had been refused medical treatment on the basis of their HIV-positive status. It also found strong evidence of stigma in the workplace, with 74% of employees not disclosing their status to their employees for fear of discrimination. Of the 26% who did disclose their status, 10% reported having faced prejudice as a result.30 People in marginalized groups - female sex workers, hijras (transgender) and gay men - are often stigmatised not only because of their HIV status, but also because they belong to socially excluded groups.31 To learn more about the way that prejudice is hindering the global fight against AIDS.
The Spread of HIV/AIDS in North Eastern States

The northeastern region of India consists of seven states: Arunachal Pradesh, Assam, Manipur, Meghalaya, Mizoram, Nagaland and Tripura, whose combined population (32 million) makes up approximately 3.7% of the country. The HIV/AIDS epidemic in north-eastern states is becoming heterosexual in nature. It is an ominous sign for India's AIDS control programme. In the early 1980s drug use became popular in northeast India and it was not long before HIV was reported among injecting drug users in the region.32

"In the north-east, the dual HIV epidemic driven by unsafe sex and injecting drug use is highly concerning. Moreover, there are many areas in the northern states where HIV is increasing, particularly among injecting drug users." Sujatha Rao, Director General of NACO.33 Experts from NACO have evidences of intravenous drug-users in the north-eastern states infecting their partners with HIV by having unprotected sex. Nagaland has already reported such a trend. India is home to nearly two lakhs IDUs and of these over 50,800 people are from Nagaland, Manipur, Mizoram and Meghalaya. Over 20 %( percent) of them are HIV positive solely due to sharing of contaminated needles. The situation is really threatening as now IDUs are indulging in high risk behaviour. Manipur may soon follow.

NACO experts said another worry was the large number of IDUs living in non-classical states like Orissa, West-Bengal and Punjab. The MSM population in India had started to swell. At present that population is estimated to be 2.5 million. They
indulge in very high-risk behaviour. Under India's $2.5 billion NACP-III NACO will try to work with this community. NACO will increase the number of interventions meant for the MSM community from 30 at present to 232 in the next five years. Studies have found HIV infection rates as high as 16% in MSMs in India. Data in Asia show that without interventions MSM will become one of the main sources of new HIV infections in the region.

IUDS will officially be given bupemorphin and syringes from the government. While clean syringes will help reduce the risk of addicts getting infected with HIV through sharing needles, bupemorphin will help them get over hard substances like heroin and cocaine. First addicts will be asked to exchange their syringes with safe needles. They will then be put under the 6-9 month long OST programme. This strategy has worked very well for China, US, Holland, Germany and Australia (Azad India Foundation (aif.orgn@yahoo.co.in).

The first case of HIV is supposed to have entered the Seven Sister States of the North East in the early 1986. So far there are more than 15,000 HIV positive cases in North Eastern states of India. Majority of them are in the age group of 30-44 years, followed by 15-29 years. HIV is no longer confined to IDUs, but has spread further to the general population. “The challenges India faces to overcome this epidemic are enormous. Yet India possesses in ample quantities all the resources needed to achieve universal access to HIV prevention and treatment... defeating AIDS will require a significant intensification of our efforts in India, just as in the rest of the world” (Peter Piot, Director of UNAIDS).
Spread of HIV/AIDS in Manipur

Manipur, a landlocked state, borders Nagaland on the North, Assam on the West, Mizoram on the South, and Myanmar (Burma) on the East. Manipur, a small state with a population of only 2.4 million in the northeast region of India has the highest concentration of HIV infection in the country. Currently, Manipur, despite being home to only 0.2% of the national population, accounts for nearly 17% of India’s total known HIV cases. The state has approximately six times the HIV prevalence of the next most affected state, Maharashtra, and 20 times the HIV rate of the country’s third most affected state, Tamil Nadu (Beyrer, et al.). Injection drug use has been the largest mode of transmission of the infection, though there is now evidence that HIV/AIDS has spread to the wives and children of injection drug users (IDUs), and thus into the general population.

Manipur in north-east Indian has a high prevalence of HIV in injecting drug users but the rate in CSWs is not known. Perhaps, data on STDs and sexual practices in commercial sex workers (CSWs) is in general limited in India. The connection between HIV/AIDS in Manipur and the sex work industry do not contain in-depth research or fieldwork regarding sex work in Manipur, nor do they provide a thorough picture of the industry. They do not describe what types of sex work exist, whether the industry is largely brothel-based, secret, or otherwise, etc. The Agarwal et al. article briefly suggests that sex work is largely not based in brothels, and that the number of commercial sex workers (CSWs) is highest in Churachandpur and Moreh, the drug trafficking
Although NACO report a state-wise HIV prevalence of 7.9% (percent) among IDUs, studies from different areas of the state find prevalence to be as high as 32% (percent). HIV is no longer confined to IDUs, but has spread further to the remotest areas. Hence, HIV prevalence at antenatal clinics in Manipur exceeded 1% in recent years, but then declined to 0.75% in 2007; estimated adult HIV prevalence is the highest out of all states, at 1.57%. Manipur is one of the poorest, least developed areas of India.

Thus in 1996, the per capita income was estimated at around 3,500 Rupees per year, about one-third of the Indian national average. This is exacerbated by conflict and ethnic tension, which have wracked the region for years. The political situation is complex, characterized by inter-ethnic conflict, armed separatist movements demanding political autonomy, and a constant influx of migrants and refugees into Manipur from Myanmar. There is a long-standing and violent conflict between the Kukis and the Nagas, the two dominant tribal groups of the region, which has almost reached the level of "ethnic cleansing" (Thomas, et al.). Border Security Forces, special divisions of the Indian Armed Forces, continuously patrol the area and paramilitary Central Reserve Police Forces are in place to control the insurgencies as well as the constant influx of migrants and refugees that flow into Manipur from Myanmar.
In fact, drug trafficking Manipur shares a 358-kilometer border with Myanmar, which is the site of extensive drug trafficking. This drug trade brings high quality heroin into Manipur, which is the drug of choice for the majority of the state’s IDUs. Manipur’s successful drug trade is primarily due to its geographical surrounding area to Myanmar and the ‘Golden Triangle,’ the area where Myanmar, Thailand and Laos meet, and where heroin is refined in mass amounts and sent out to neighboring areas. Manipur’s location on the route of National Highway 39 (NH 39) also makes it highly vulnerable to drug trafficking. Studies show that the geographic presence of IDUs correlates clearly with the path of the national highway (Sarkar, et al.).

The ‘Golden Triangle’ has been a major center of opium poppy cultivation since at least the 19th century, but in the last 15 to 20 years the center of production has shifted as Thailand’s production has drastically reduced and that of Myanmar has increased (bringing the center of production closer to Manipur). Cross-border trade is poorly monitored, and one of the main trade routes goes across the India-Myanmar border from Moreh (India) to Tamu (Myanmar). Users travel by truck inland to Mandalay to purchase heroin and test the drug which often results in needle sharing with traders. Article in *Bulletin on Narcotics* (1993) reported that knowledge of safe needle use is extremely low among Manipur’s IDUs, and needles are rarely cleaned and commonly shared (Sarkar, et al.). Most studies report that education and awareness regarding safe injection techniques is severely lacking.

Manipur borders Myanmar (Burma), one of the world’s largest producers of illicit opium. Thus Heroin from Myanmar began to appear in Manipur in 1982-84 after which...
avaiability rose sharply. Heroin trafficking reached a peak after 1990, mirrored by a surprising increase in HIV prevalence in the state. IDUs form the majority of victims to HIV/AIDS in Manipur and the northeast in general. Indeed, according to a 1999 article in AIDS Care, some 70 % percent) of Manipur’s IDUs were HIV positive (Beyrer). Kohima, the capital city of Nagaland and termination of NH 39, shows a similar prevalence of HIV infection among its smaller, but still substantial, IDU population. Between 1990 and 1991, as drug availability increased, HIV prevalence in Manipur rose from under 1% (percent) among IDUs to over 50 percent.

By 1997, prevalence among IDUs had reached 80% (percent). A more recent estimate in 2004 by UNAIDS reports a combined prevalence of HIV among injection drug users in Manipur and Nagaland as 56% (percent). According to a 2002 UNAIDS report, approximately 75% (percent) of Manipur’s HIV cases are among IDUs. Data discussed in a 1999 AIDS Care article indicate that the highest concentration of cases are found in the capital, Imphal 69% (percent) and the district of Churachandpur, which includes Moreh 8.6 percent (Beyrer, et al.).

The linked issues of injection drug use and HIV/AIDS in Manipur are particularly problematic due to the social stigma involved. A 1997 article in the Journal of Reproductive Medicine suggests that the sense of immorality often connected with drug use and HIV/AIDS often hinders awareness-raising regarding the public health implications of the disease. In particular, religious leaders who often have significant influence even beyond the religious community, view drug use as ‘antisocial’ and ‘immoral’. The same article also describes the discrimination faced by IDUs within the
health system and known seropositive IDUs were frequently discharged from the hospital. The confidentiality and vagueness of HIV testing among IDUs was often not maintained (Hangzo et al.).

In the state of Manipur, the first case of AIDS was officially reported and detected only in October 1989. Illegal drug trafficking is prevalent in Manipur since 1970. While in 1981, 73% drug abusers used either morphine or pethidine, or both through intravenous route. Even in 1982, only 1% of the addict in Manipur used to smoke Heroin known as No.4. Heroin is sold in packets of different sizes costing between Rs. 20 and 50 or more per dose. Hence in 1983, heroin became the drug of choice for abuse. In the beginning most of the heroin drug abuses was observed along the National Highway No.39, which originates from Moreh town to Indo-Myanmar border and runs towards Dimapur in Nagaland. But now, this characteristic has been lost and there is hardly any village, which is not affected. In Manipur, many use illicit drugs daily. The addicts start using the drug orally either by smoking or inhaling (Chasing the Dragon). Then they switch on to injection (fixing) often sharing with friends, peers or lovers. While injecting they share the injecting equipment like needles and syringes or improvised syringes like plastic ink-dropper fitted with needle among a group of 2 or 3 normally but sometimes as many as seven at one go.

According to a study conducted by Voluntary Health Association of India (Manipur Branch) during 1992, there were about 40,000 heroin addicts in Manipur. An estimated 72% of drug addicts in the state are HIV positive and 95% of them are between 15 to 35 years of age with needle sharing habits. Manipur is geographically close to the
Golden Triangle where 20% of world's heroin is produced. This border state is an optional route for illegal international drug trafficking, resulting in easy availability of heroin of good quality at cheap rate. With rapid rate of drug abuse, HIV infection has reached an alarming epidemic proportion. As on May 2000, a total of 68,448 persons were screened resulting in the detection of 10,064 HIV seropositive (9,068 males and 997 females) giving seropositivity rate of 14.7 per 100 in Manipur against all India figure of 2.6. It should be noted that Manipur with only 0.2% of India's population contributes nearly 8% of India's total HIV positive cases.

Reported AIDS cases in the state are 650 and reported AIDS related deaths amounts to 137. In Manipur the most important mode of transmission of HIV has been the sharing of injecting equipment during injecting drug use, which in turn has been made possible due to the case of supply and availability of heroin in the region. Thus as on May 2000, a total of 8,705 Injecting Drug Users (IDUs) were screened and it result to 5,062 HIV positive cases. The rate of sero-positivity was 58.15% against the number of other high risk groups. This demonstrates continued drug trafficking in the region since 1987 and the significant amount of heroin, ganja and opium seized every year. The agencies responsible for drug enforcement are the Border Security Force, Central Excise and the Custom Departments, Narcotic Control Bureau, police department and the Department of Border Affairs and Narcotics. In attempting to curb drug trafficking, the enforcement agencies alone were not sufficient to stop the flow of drugs into the region. The active help and participation of the local community in addressing this problem is essential.
M.C. Rita, Project Co-coordinator of the Inter-medicine for Women at Risk (IWR) told the North East Daily that IWR conducted a state-wide survey recently, free of cost during March 31, 2000 and March 31, 2001 and found that a number of women have stepped into the world's oldest profession (flesh trade) owing to extreme poverty (not because they like it) though there is no legal Red Light Area in the state of Manipur till date. Of the 800 women with Sexually Transmitted Disease (STDs), 17.6% were found HTV positive. Most of the victims include women who have been separated from their husbands. Like other provinces in any developing country; most HIV infections and AIDS cases particularly in Manipur remain unrecognized and unreported.

This is mainly due to lack of HIV testing facilities and inadequate system for diagnosis and reporting. Thus, it is only after 2000 AD that HIV infection has been officially reported and most cases attributed to the recent facilities in the state capital at Imphal Incorporation with Manipur AIDS Control Society. Yet even though facilities become available, problems of access remain due to ignorance, confusion and no affordability. There is lack of courage, lack of social and medical knowledge to face current issues and challenges related to HIV/AIDS. Looking into the near future, it is tempting to imagine the worse case scenario for HIV epidemic. Misconception and social prejudices about people living with HIV/AIDS still abounds; but the prejudices reflect more about human nature than the nature of the disease.

The Spread of HIV/AIDS in Churachandpur District

In the state of Manipur, HIV/AIDS is a grave concern and a greater threat to human lives. It is devastating to know that Manipur with a population of about 2 million
has 7,886 HIV infected people with 726 AIDS cases and 144 AIDS death. This figure accounts for only reported cases, but the figure is far larger if we include those that are unidentified and unreported. Similarly, Churachandpur District of Manipur is no exception with a population of about 1,76,184 of whom about 549 HIV are infected. Again, this figure accounts for only reported cases. Richard Sill from Churachandpur District was declared the first AIDS Death in February 1990 as an injecting drug user (Laisuih, AMPGSU, Shillong 1998:172). A study in Churachandpur among IDUs revealed that heroin was used by all IDUs a majority of whom were males between the ages of 15-35 years. The education levels of these youths were quite high, 78.5% having studied up to high school or pre-university levels. Unemployment accounted for 53% of the IDUs, out of which 34% were students. Earlier estimates stated that female injecting drug users constituted 5-8%. Recent report indicates an increase to 10% (Sharma, 1999). The overall dropout rates from schools are very high. In the past few decades, HIV/AIDS does not affect the general population in Churachandpur district. It was limited to certain sections of the society called high-risk groups such as drug-users, commercial sex workers, prostitutes, call girls, immigrants etc.

Today low-risk group such as housewives, maidens or reputed persons in the society are no exception. Fear of social prejudices still makes many high-risk group infections invisible to health workers. Such groups were often mistakenly viewed as reservoirs of HIV infection. They were many a time when they were wrongly accused, discriminate and distrust by the wider society. Most of them were reject by their families, friends, neighbours and traditional support groups. Furthermore, they were accused of
being the only source of the dreaded virus. In an atmosphere of distrust and despair, many are pessimistic about their future and have very little interest in trying to improve their lives. Above all, the rehabilitation centres in Churachandpur District were found to be skeptical to begin work. In the beginning, there were few visible cases of HIV/AIDS in the district. There are also quite a number of unqualified medical professionals, social and public leaders, educationist, church ministers, social activists, social scientists, administrators and policy makers who were not competent in their profession. These leaders resorted to the denial mode and turned a blind eye to the new threat.

**Symptoms and Transmission Routes of HIV/AIDS**

In the early days in many countries, those with AIDS often spent a long time in hospital as doctors battled to get grips with the complex spectrum of illness. Now people with AIDS are usually able to spend more time at home, with many treatments given in clinics or in the home. However, many have multiple problems and need practical help, backed by nursing care and symptom control, to stay at home in comfort and in control of their own lives. Yet infected persons are not free from signs and symptoms.\(^{30}\) Signs and symptoms of HIV/AIDS were all sorts of opportunistic infections which attack the AIDS patients. It is ordinarily mild and seldom have life threatening and these infections become uncontrollable and serious enough to kill. Symptoms in patients can differ from person to person, group to group, race to race and so on. For example, *Pneumocystis Carinii* is the commonest form of infection in American white population causing 25-50 % of mortality. But in the African Aids cases, Candidiasis is common in women, nervous disorders in children and also Kaposi Sarcoma is common in homosexuals.\(^{51}\)
The common signs and symptoms of HIV/AIDS may be associated with signs and symptoms as in the following:25,32,34,55

Major signs of HIV/AIDS (1) Unexpected weight loss 10 % body weight (2) Chronic diarrhea one month (3) Prolong Fever one month (Constant) (4) Persistent Cough one month. Such as were the major signs which eventually developed inside the human body when one is infected by HIV/AIDS in most cases. Minor Signs of HIV/AIDS were associated with (1) Generalized Pruritic dermatitis (2) Recurrent Herpes Zoster (3) Enlarge Glands or Swollen Lump Glands (4) Chronic Progressive Herpes Simplex Infection (5) Night Sweat, Fevers and Chills (6) Dry Cough, General weakness and loss of appetite (7) In some cases, a severe temporary illness.56,57

The above clinical signs and symptoms common in HIV/AIDS is proposed by WHO case definition. This has been used as the basis for HIV/AIDS statistics in many countries, but is inaccurate. Such being the case, 90 % of those infected in the world are unaware that they carry virus. The current global estimates of HIV and AIDS was that Sub-Saharan Africa was hit hardest and highest yet by HIV/AIDS with 29.4 million infections whereas South and South East Asia second with 7.4 million people living with the virus. According to UNAIDS, Sub-Saharan Africa had approximately 3.5 million new infections and lost 2.4 million people to AIDS in 2002. The Sub-Saharan Africa is now home to 70% of the people living with HIV/AIDS.58 One fact is that the HIV epidemic in the Sub-Saharan Africa is quite old. The epidemic had spread before the disease was recognized-long before the virus was discovered or the name AIDS was coined or the
diagnostic test was available. In the beginning, there was denial from the Government and from the agencies that there was no disease called AIDS.

There is enough evidence to show that AIDS might have spread in Sub-Saharan Africa as early as 1959. Moreover, there are many favourable conditions for rapid spread of HIV in Sub-Saharan Africa. Denial, ignorance, superstition, illiteracy, poverty, civil war, famine, political instability, low status of women in the society, sexual permissiveness, and other cultural and social factors have led to the rapid spread of HIV in Africa. There have been an explosive increase rates throughout the Asian countries and it is also spreading like a wild fire to every countries of the world. Further, WHO also showed that the efficiency of HIV transmission by various routes in the countries of the South-East Asia Region are as in the following:

Various Routes of HIV/AIDS transmission in South-East Asia with the frequency Percentage (1) Sexual Intercourse 0.1-1.0 %, 80-90 % (2) Blood Transfusion 90 %, 3-5 % (3) Injecting Drug Use 0.5-1.0 %, 5-10 % (4) Equipment/Needles 0.5 %, 0.1 % (5) Perinatal 15-45 %, 0.1 %. In one of these cases the health worker accidentally injected himself with blood from a patient. The modes of HIV/AIDS spread in India may be briefly shown with the responsible percentage as in the following:

(1) Heterosexuals 72.00% (2) Blood Transfusions 12.00% (3) Intravenous Drug Users 4.00% (4) Spouses of AIDS patients 4.00% (5) Blood or Blood products 3.00% (6) Homosexuals 1.00% (7) Others 6.00 %. To sum up, any activities which include the transfer of saliva, sputum-infected blood, semen or vaginal fluids from an infected person into the bloodstream of another person can also be a source of HIV infection.
(A) Importance of the Study

HIV/AIDS epidemic is fast spreading in an exponential manner. It has already reached even the remotest rural population mostly through the sexual route from infected to uninfected persons. Such persons do not fully realize that they could pass on the virus to scores of people or receive the virus during unprotected sexual intercourse. They apparently failed to appreciate how HIV/AIDS posed serious and horrible consequence for personal lives, families and the society. A life of illness is bound to put an intolerable mental strain, frustration, helplessness, despair and depression. No other victims of disease bear the same degree of social stigma as People Living with HIV/AIDS (PLWHA). So to be living with AIDS or to have a family member with HIV/AIDS is a very heavy burden indeed as one needs to bear the painful tragedy that society inflicts. When some persons or doctors showed no sympathy for HIV/AIDS patients, such victims understandably will turn their face to the wall to wait for death. However, Dr Pushpa Khurana pointed out that in case of other epidemics and illness, it is a matter of chance or co-incidence but in a matter of AIDS, it is a voluntary act done in full knowledge of the possible consequences. HIV/AIDS is not confined to anyone class, community, religion, age groups, sex, or professions; but it spread across all regions and all groups. India Health Organization (INO) believed that women and children are more prone to AIDS and currently it is also spreading to the healthy community.

If we do not control or arrest the spread of HIV/AIDS in the coming years, we are going to see and witness unprecedented number of AIDS victims such as AIDS widows,
AIDS orphans, and AIDS beggars. In fact, the disastrous consequences of AIDS will affect our social fabric, destroy our human resources, ruin our economy, shatter our religious and educational institutions and dampen the human spirits. AIDS will eventually become epidemic among the people at large and the anguish of illness might often be an issue of death – the life and death of our family, our friends, our neighbours and ourselves. The vaccine of HIV/AIDS may be identified but we are far from conquering it. No other disease has been so urgency ridden as the research on HIV/AIDS treatment. Everyone pitched in for funding – Governments, private funding, pharmaceuticals, individuals, philanthropic institutions, biologists, pathologists, epidemiologists, bio-chemists, physicians, psychiatrists, geneticists. All got together to stem the flood before it turns into a deluge. The reasons for the urgency to deal with the new challenges generated by AIDS are not far to seek. The urge for that activity is so compulsive as to be uncontrollable and the disease is colour blind, sex blind, and age blind and knows no geographical barriers.

But fortunately, effective and increasingly affordable techniques for treating HIV/AIDS such as Anti-retroviral Therapy (ART) are becoming more accessible. Treatment not only alleviates human suffering, it also minimizes the socio-economic costs of the epidemic. It allows people living with AIDS to lead productive lives as workers, parents, and community members. Yet only a handful of regions have responded well to the challenges of treatment, and today HIV trends suggest that large increases in the numbers of people living with AIDS can be expected in the near future. But it is never too early to start thinking about treating HIV. As in any infection, earlier
you start treatment; the better is the outcome. At present the drug AZT which one of the three combination drugs in use is manufactured in India. STAVUDINE is recently manufactured in India. The pricing of AZT is at rupees 2700 plus for 100 capsules.

The other two drugs are not manufactured in India but they are available on prescription from chemist and druggist in Mumbai. The cost of 1 month's therapy comes nearly to Rs.18,000 to 20,000 (eighteen thousand to twenty thousand). These anti-viral drugs are not yet proven as a cure for HIV/AIDS but they represent a significant improvement over what had been available before. These drugs may not work as expected. Or for some, the side effects would be too severe to continue the medicine. So, for many people with HIV, opting for these treatment decisions are not easy. To stop HIV from the human body, all anti-viral drugs are prescribed these days in combination. This means usually three drugs at a time. Because these drugs attack HIV at different stages of its development, it makes it harder for HIV to develop resistance to them.

You can help prevent HIV from becoming resistant by not missing any of your dosages. If you miss dosages regularly or stop taking the drugs for a few days then the virus will start multiplying again. Those that multiply are more likely to be a little resistant. The drugs may not be as effective as before. So don't take less than have been told. If you miss a dose don't double up on your next dose. If you have only 2 drugs when you are supposed to take 3, don't take any at all. But, at the next dose, all three must be taken. The experiences of many people with HIV taking these new combinations are that they require major commitment on their part to take them regularly. It is worth talking to your doctor thoroughly before deciding to start on combination
HIV-therapy. The new information about how HIV works in the body, the new viral load test and new anti-viral treatments provide compelling reasons for people with HIV to think seriously about HIV treatment. The more active the virus is, the higher the viral-load and the more damage HIV is likely to be doing to the immune system. In other words, the more active the virus is, the more likely HIV is damaging the immune system.

In the same manner, HIV infects cells of immune system itself and the immune system began fighting itself. HIV like any other virus also infects a particular cell type of the body. After HIV enters the body at the viral level, there is no latency period even though the person may remain apparently healthy. The infected person remains seemingly healthy because of the balancing act of the immune system of the body and HIV. But during this time the virus is still busy, slowly doing damage to the T cells. Eventually the virus may overwhelm the immune system and then can replicate much faster. In theory the drugs will work best while the immune system is working against the virus too. In practice, no vaccine has been invented till today as a cure for AIDS, though some scientists claimed in October 1995 that it was likely to be invented in the foreseeable future. Cooperation in the search for an AIDS vaccine is intensifying with the creation of a new initiative by the WHO and UNAIDS. The new initiative provides an independent forum where everyone working on HIV vaccine, from North or South, from industry or from research agencies, and from affected communities, can identify common ground for collaboration and coordination.

The HIV vaccine initiative will focus on strengthening capacity in developing countries to ensure that vaccine trials are conducted with the highest ethical and scientific
standards. But unfortunately, the development of a vaccine not only faces scientific difficulties but also ethical and logical dilemmas. With this in mind, UNAIDS established an “Ethical Committee On Vaccine,” which acts as a forum of discussion (including Peggy MC Evoy, Team Leader, UNAIDS Caribbean Team, Broadcast Line Via Satellite from St. Thomas, US Virgin Island to Nassau, Bahamas, Caribbean Conference On HIV/AIDS on February 24-25, 2000). Even if a vaccine existed today that was 100% safe and reasonably effective, it would probably take years to come widely available at reasonable low cost. When it does come, it will almost certainly be useless at treating those millions already infected. We are indeed in an incredibly pivotal time in the epidemic (AIDS) where we are looking at how to help people live rather than how to help them die. It is a huge shift logically as well as psychologically. A responsible person cannot remain a silent spectator to the ominous danger and the urgent needs of the society.

(B) Objectives of the Study

The problem of HIV/AIDS is not only a medical problem but it is increasingly recognised as a social problem. Hence, it is important to examine the many influences in the society that have a bearing on HIV/AIDS. Indeed, development of an appropriate respond to HIV/AIDS requires an understanding of the specific society, its history, its culture and its dynamic. Social issues surrounding the risk of HIV/AIDS and its infection are important ones that illuminate a number of social problems and value conflicts within the society. The issue of HIV/AIDS is part of a larger fabric of a person's outlook or attitude in which moral values, psychological characteristics; social and cultural
surroundings play a determining role. Keeping in mind the above factors, the present study focuses mostly on social dimension of HIV/AIDS. There is a sad lack of longitudinal body of data related to comparative socio-demographic aspects, natural history study of HIV infection, in-depth related risk factors, constitutional changes of the body in response to HIV related diseases, nutritional status and estimated energy needs of HIV affected persons in different stages of infection.

A counselor or researchers of public health (related to HIV/AIDS and drug abuse) need to interpret the intricacy of the medical and social problem to remove myths and misconceptions from the affected individual, family, community. Thus, society as a whole needs to acquire enough factual information which is contextually sensitive to local socio-cultural background of people living with HIV/AIDS. This study may at least give a partial if not a complete body of knowledge to health workers, community care providers and policy makers and also have a positive and a far reaching contribution within or outside the district, state or region. Therefore, the present study had been undertaken with the motivation to prevent the rampant spread of HIV/AIDS infection. The main objectives of the study are given as below:

(i) The causes of the spreading of HIV/AIDS in Churachandpur district.
(ii) Socio-economic impact of HIV/AIDS in Churachandpur district.
(iii) Attitudes towards HIV/AIDS patients in Churachandpur district.
(iv) Preventive measures of HIV/AIDS in Churachandpur district.
REVIEW OF LITERATURE

There are not many systematic studies on HIV/AIDS in India. It is particularly so in the case of tribal communities inhabiting the SEVEN-SISTER STATES of the North-East. However, some very comprehensive studies are mainly the products of Governmental or Non-Governmental consultant, counseling, guidance and renown experts of HIV/AIDS involving with health and social services, community workers and researchers (Thomas, Gracious 1994, Gracious Thomas 1995, M Shreedhar, Jaya & Colaco, Anthony 1996, Ram, Ahuja 1997, Khurana, Dr. Pushpa 1998, Goel, Dr, Satish 2005, Misra, Dr. R.S 1996, Lisam, Singh, Dr. Khondom 2004, Chowhury, Shankar 1995, Singh, Y.N., Dr; AIDS 1991, Dixon, Dr, Patrick 1990, Misra, Dr. R.S 1996, Singh, Yaima, Ningthoujam 1998, etc) has been of immense values as other valuable source of information and education on HIV/AIDS. These facts will help oneself to protect from the infection of the virus or disease. But some of the limited studies available in the North-East may be noteworthy to find out some of the causes and spreading of HIV/AIDS. These sources may now be available in the forms of books, booklets, journals, magazines and throughout the newspapers. These works however do not deal with Social Dimensions of HIV/AIDS in Churachandpur district of Manipur. Therefore, the study was mainly based on primary sources of data and this work happens to be one of a huge work on this significant field.
(C) Methodology

The present study uses both primary and secondary sources of information. Originally, the intention was to collect and analyze materials and data generated by the Government agencies and NGOs. Official records of state agencies or Non-Governmental Organizations or district-level records and files consulted where available. But the sources available in relation to HIV/AIDS in Churachandpur District are inadequate for the problems under investigation. Consequently, we had to rely both on secondary and primary sources of data. The primary sources of data and materials were collected from respondents through questionnaires. The above source materials are supplemented by in-depth interview with several public health officers, project managers and knowledgeable health workers related to HIV/AIDS. This method is useful in the present case because we hope that this method is the best way to get certain thoughts, ideas and valid information or reliable sources for this research work.

In the field study, persons of different background and personalities were interviewed and most of them were educated. At least 25 persons were interviewed; and most of them were educated. Questionnaires and interviews were carried out to ascertain valid information concerning any related matters on HIV/AIDS and its grim issues. The number of respondents for the purpose of this work was 100 persons and most of them were male which include social workers, opinion leaders of NGOs, scholars, religious leaders and well-informed persons of different localities or communities.

The chosen sample population falls between ages of 15 and 60. In the study area, Injecting Drug Users (IDUs) have shown much great awareness about transmission
routes of HIV/AIDS. Though there were about 506 HIV cases in the study area, different community leaders felt that HIV/AIDS may not be really a serious problem. But IDUs are aware of the exact mode of HIV transmission and its infection risk, and they assume the existence of widespread infection among the masses partly through an injection culture that still prevails in the study area.

Secondary sources of data are mainly drawn from the publication of Indian and Foreign scholars related to drugs, sex, etc in general and the HIV/AIDS in particular and the secondary sources of data also include published and unpublished research papers, booklets, magazines, journal articles, newspaper reports, records of Governmental and Non-Governmental organizations or institutions; Statistics provided by the Directorate of Economics and statistics, Government of Manipur are also widely used.

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