SOCIAL DIMENSIONS OF HIV/AIDS IN CHURACHANDPUR DISTRICT OF MANIPUR

BY

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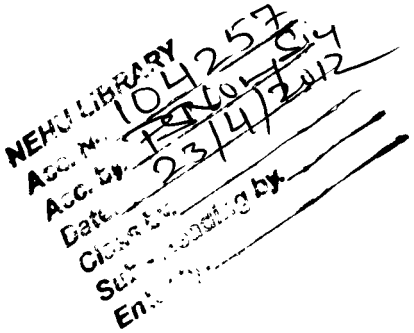

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Declaration

I, Shri Johny Lalbiaklian, hereby declare that the subject matter of this thesis is the record of work done by me, that the contents of this thesis did not form basis of the award of any previous degree to me or to the best of my knowledge to anybody else, and that the thesis has not been submitted by me for any research degree in other university or institute.

The suggestions made at the time of Pre-Submission Seminar have been incorporated.

This is being submitted to the North Eastern Hill University for the degree of Doctor of Philosophy in the Department of Sociology.

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Abbreviations

AIDS:	Acquired Immuno Deficiency Syndrome.
ARC:	AIDS Related Condition, AIDS Related Complex.
ART	Anti-Retroviral Therapy
AusAIDS	Australian Agency for International Development
AMPGSU	All Mizo Post Graduate Students' Union
CBDAP	Community Based Drugs and AIDS Programme
CCP	Community Caring Programme
CM	Community Mobilizers
CSWs	Commercial Sex Workers
CDC	Centre for Disease Control
DDRC	Drug De-addiction &Rehabilitation Centre
DMD	Department of Mission and Development
DAO	District AIDS Office.
DAO	District AIDS Officer
DAC	District AIDS Committee.
DSSS	Diocesan Social Service Society
EHA	Emmanuel Hospital Association
EBC	Evangelical Baptist Convention
FBOs	Faith Based Organizations
GBC	Grace Bible College
GRID	Gay-Related Immune-Deficiency
ICMR	Indian Council of Medical Research
IGS	Income Generating Skills
HIV	Human Immuno Deficiency Virus.
HYA	Hmar Youth Association
IHO	Indian Health Organization
IWR	Inter-medicine for Women at Risk
IDUs	Intravenous Drug Users
IEC	Information, Education and Communication
LRRC	Lamka Rehabilitation and Research Centre

LWF	Lutheran World Federation
MACS	Manipur State AIDS Control Society
MELC	Manipur Evangelical Lutheran Church
MNP+CCPUR	Manipur Network of Positive People, Churachandpur
MSF	Medicines Sans Frontiers (Doctors without Borders)
NACO	National AIDS Control Organization
NACP	National AIDS Control Programme
NSEP	Needle Syringe Exchange Programme
NGOs	Non-Governmental Organizations
NROs	Non-Religious Organizations
ORCHID	Organized Response for Comprehensive HIV/AIDS Policy in the Districts of Churachandpur and Nagaland
PLWHA	People Living with HIA/AIDS
SHG	Self Help Groups
SYO	Simte Youth Organization
STDs	Sexually Transmitted diseases
SA	Salvation Army
SHALOM	Society for HIV/AIDS and Lifetime Operation in Manipur
TNP	Tribal Network of Positive
VHAI	Voluntary Health Association of India
UNAIDS:	Joint United Nations Programme on HIV/AIDS
VCCTC	Voluntary Confidential Counselling and Testing Centre
WHO	World Health Organization
YMA	Young Mizo Association
YPA	Young Paite Association
ZYO	Zou Youth Organization
ZMA	Zomi Mothers' Association

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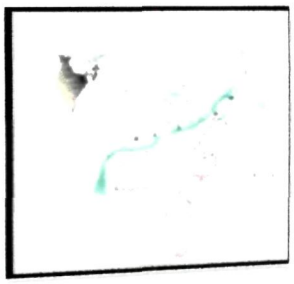
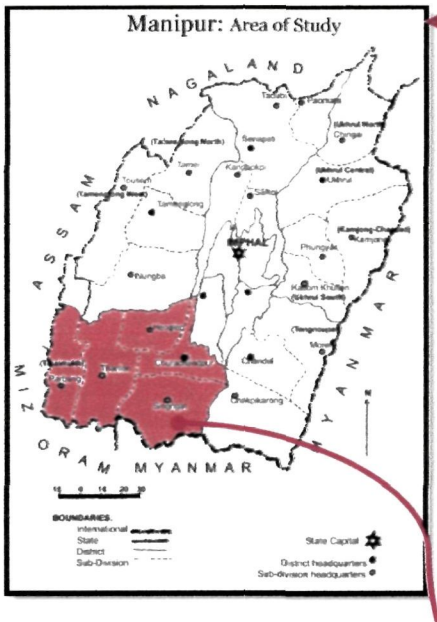
LOCATION OF STUDY AREA





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 while12.9 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.[2] 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.[3] 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.[4] Thus one Indian is infected every minute and we have to use that understanding urgently."[5] 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.[6]

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.[7] At the beginning of 1986, India had no reported cases of HIV or AIDS.[8] 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.[9] 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.[10] 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.[11,12] In 1987 a National AIDS Control Programme was launched to co-ordinate national responses. Its activities covered surveillance, blood screening and health education.[13] 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.[14] 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).[15]

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.[16] 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.[17] 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.[18] 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.[19] 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.[20] 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.[21] In addition, NACO released figures in 2008 suggesting that the number of people living with HIV has declined.[22] 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.*[23]

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.[24] 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.[25] 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.[26] 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.[27] 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 bupernorphin and syringes from the government. While clean syringes will help reduce the risk of addicts getting infected with HIV through sharing needles, bupernorphin 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.[34] 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).*[35]

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.[36] 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

center(Agarwal, A. K., G. B. Singh, et al. (1999). "The prevalence of HIV in female sex workers in Manipur, India" (The Journal of Communicable Diseases, Vol. 31, No. 1, pp. 23-8).

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).[37] 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;[38] estimated adult HIV prevalence is the highest out of all states, at 1.57%.[39] 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

availability 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.[40] 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.[41] 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.[42] 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.[43] 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.[44]

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 HIV positive. Most of the victims include women who have been separated from their husbands.[45] 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.[46] 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.[47] 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 [48] 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%.[49] Recent report indicates an increase to 10% (Sharma, 1999). The over all 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.[50] 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 Carnie* 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:-[52, 53, 54, 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.[59] 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:-[60]

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) Perintal 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:-[61]

(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.[62]

(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.[63] 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.[64] 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 [65]

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 out come. At present the drug AZT which one of the three combination drugs in use is manufacture 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 months therapy come nearly to Rs.18, 000 to 20,000 (eighteen thousand to twenty thousand).[66] 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.[67]

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.[68] 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.[69] 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 Nassan, 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.[70] 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 interprete 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 LITERAURE

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, Gracious1994, Gracious Thomas 1995, M Shreedhar, Jaya & Colaco, Anthony 1996, *Ram, Ahuja* 1997, Khurana, Dr. Pushpa1998, 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, Ningthoujam1998, etc) has been of immense values as other valuable source of information and education on HV/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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CHAPTER – II

AREA OF THE PRESENT STUDY

A. THE LAND

(a) Geographical Profile of Churachandpur District of Manipur

Churachandpur district lies in the South West of Manipur between 24.0^0 North and 24.3^0 North of latitude and 93.15^0 East and 24.0^0 East longitude as well as 914.4 meters of altitude. Given below are her neighbours:-

North – Tamenglong and Senapati Districts.

South – Mizoram and Chin States.

East – Bishenpur and Chandel Districts.

West – Assam and Mizoram States.

Churachandpur district being considered as the second largest district of Manipur has unique areas and physical features as pictured below:-

Total area of lands: 4581 sq. km (1971) and occupied area by sub-divisions in 1991:-

Churachandpur Sub-division – 668 sq. km

Henglep Sub-division – 717 sq. km

Singngat Sub-division – 1101 sq. km

Thanlon Sub-division – 1291 sq. km

Parbung Sub-division – 804 sq. km

The physical features of Churachandpur district may also be seen as under the following:-

The Western lowland – Parbung/Tipaimukh

The Central High Land – Thanlon, Henglep & Singngat

The Eastern Transitional Hills – Churachandpur.[1]

We can also briefly note some facts about land utilization in Churachandpur district. Land utilization in (1986-87) of the district may be as in the followings[2]: - (a). Geographical area – 4,57,000 hectares.

(b). Area under forests – 20,376 hectares.

(c). Total cropped area – 1, 96,700 hectares.

(d). Barren and uncultivable land – 8,800 hectares.

The following are also the Sub-Divisional Headquarters and the distribution of villages as in 1991 census:-[3]

Table 1: Distribution of villages and population 1991

T.D.Blocks	No. of Villages	No. of Houses	Total Population
Churachandpur	207	9678	80,149
Henglep	107	3472	20,455
Singngat	65	3013	18,643
Thanlon	45	3014	19,209
Parbung	42	3412	23,995
Samulamlan	36	3132	13,733
Total	504	25,721	1,765,184

(b) Climatic Condition

Churachandpur district has a moderate sub-tropical to temperate monsoon climate varying from place to place depending on the density of rainfall and elevations.The hottest recorded lies along the foothills of Vangai Range, followed probably by Leijangphai area near Thanlon. They are well known for forests and cereal crops *viz* chillies, oranges and gingers.[4]

Records of temperature at selected centres in Churachandpur district may be mentioned follow:-[5] Rainfall: Maximum 4013 mm Tinsong, 1983; Minimum 7770 mm Geljang, 1986.Temperature (1969-91): Maximum 41^0 Celcius, Thanlon; Minimum 0^0 Celcius, (Lamka) Churachandpur.Humidity (1969-91): Maximum 89% Thanlon,1987;Minimum 20% Lamka, 1983.

(c) Transport and Communication

The precipitous rolling mountains running from north to south with deep channels of streams in between make transport and communication from east to west extremely difficult and costly. Roads are the only means of movement and the district headquarter – Churachandpur town had been maintaining its inter-town and inter-town relations by surfaced roads as well as *kucha* roads.[6] Several roads were constructed and were also connected to different area of the district. Of all the roads, Tedim road appeared to be one of the most important roads in the whole district.

Tedim Road: It was constructed by British as bridle path during 1893-94. The Tedim Road (Imphal-Lamka-Singngat-Behiang-Falam in the Chin Hills of Myanmar (Burma)) passes through Churachandpur town. It was widened and constructed as motorable road from Hiangtam Lamka to Tedim in Chin Hills in 1943 and has come to be known as Tedim Road. Moirang Lamkhai to Singngat including Behiang was declared as State Highways in 1992. The existing roads in Churachandpur town generally meet the Tedim Road diagonally and rectangularly. The general pattern is trellis. Tedim Road serves as a vertebrate road. It is seen that the volume of traffic along the Tedim Road is

the highest as the frequency of buses is one bus for every 5 minutes on Tedim road. More than 69 buses are originating from Churachandpur to Imphal and this road bears maximum number of traffic and vehicles of all kinds. Cycles and peddlers are the main traffic on all roads. Rickshaws do not ply in Churachandpur except locally called"*Sihsakolkangtarai*" due to the undulating topography of the town.

Tipaimukh Road: This road was constructed as bridle path in 1922. It was widened and the first time passenger was introduced in 1977. This road was diverted to the South-West from the centre of the town.

Guite Road: This road was constructed as bridle path from 1926 connecting Singhat and Pherzawl. It was widened and constructed as jeepable road in 1960. This road appears to be "The Paradise of Politicians".

Sugnu Road: This road was constructed as bridle path at about 1890. It was widened and constructed as motorable road and later upgraded as District Road. This road is supposed to be one of the most expensive and controversial one in the whole district of Churachandpur.

Kawl-Lamlan (Old Cachar Road): This road was constructed as footpath from time immemorial. This road connecting from Nungba to Thanlon was constructed as jeepable road and a jeep was brought at Thanlon in 1965.[7]

(c) Location of the town

Churachandpur, the regional growth centre and the district headquarter as well as the largest urban settlement of the state after Imphal is the solitary township and the second biggest town in Manipur. The general elevation of the town is 920m above sea level.[8] Churachandpur town is located in the north eastern corner of India in the middle of Khuga Valley rolling down from the western foothills of *Tuitha* River gently spreading over the river bank between the following hills. The surrounding areas of green corn fields, rows of pineapples redden ginger areas on the hill slopes over-looking the valley mingle into the vast expanse of paddy fields. With the hills touching the skyline, the whole landscape looks like "*a kitchen garden.*"[9]

Indeed, as a whole, Churachandpur district also presents fascinating and beautiful landscape, precipitous mountains on the skyline, thunderous waterfalls and dangerous gorges, enraptured luxuriant greenery, murmuring streams and muttering streamlets, twittering brooks and creaky brooklets, enchanting fauna and fragrant flora, amazing orchids and flavoring orchards, natural orchestra vibrating the nature, salubrious climate nurturing mankind and above all personalities of high caliber.

Churachandpur town has seen a remarkable growth during the past few decades from a small twin village of few hutments in 1930 to a beautiful township in 1961. The importance of town lies in its situational location at the foothills at 62 km away from the Indo-Myanmar boundary in the southern end of Manipur. In 1973, Churachandpur was divided into 12 wards and the town has been upgraded to the level of municipality in March 27, 1980.[10] Yet surprisingly, the Manipur Municipality Act, 1994, statutorily

debars application of Municipal Council in Churachandpur town as in the cases of the other seven municipalities in the valley of Manipur. The functions of Municipalities were given to the District Council with no proper provisions for maintenance of town administration.

Extending the Provisions of Manipur Municipalities Act, 1994 in the District Council areas will prove to be tending to cause harm to the tribal people because it is just being added for their safeguard without proper provisions. Insufficient statutory protection of the tribal would not only change the demographic situation of the town but the town would come into the hands and controls of non-tribals. Alienation of tribal land and other forms of exploitations of the tribal will be more evident in the near future.[11] Churachandpur town has only 28% of its people classed as main workers and 70% non-workers. About two-fifths of its workforce is employed in agriculture and the remaining three-fifths in secondary and tertiary activities.[12]

Nevertheless, Churachandpur is an important religious and educational centre for North Eastern India. There are 7 Bible Colleges and it also has 2 Government Colleges, 4 Private Colleges, 2 Higher Secondary Schools both with Arts and Science stream, and over 20 High Schools and 2 Training Centres viz., District Institute of Education and Training (DIET) and School of Nursing (ANM/FHW). As many as 35 denominational groups have their base in Churachandpur town and its great denominational diversity could rightly earn it the nickname "Miniature America". One can see church buildings at

street corners and in prominent places throughout the town, a testimony to Churachandpur religious profile.[13]

Formerly, Churachandpur town is regarded as the only "Peaceful Town" unaffected from the spectre of terrorism and extremism for the last 3 - 4 decades. Even though there are so many different tribes and so many organizations to zealously preserve ethnic identity that Churachandpur has even been called "the town or the land of presidents and secretaries", there always exists a keen sense of healthy competition in the fields of education and employment and there are also no communication problems as people understood each of the dialects spoken, so that Churachandpur may be called "The Pentecostal Town". It is often compared to Jerusalem in A.D 33 – when the Holy Spirit came upon the apostles and the language they spoke in was understood by the people speaking as many as fifteen (15) different dialects.[14] Churachandpur town founded in the year 1930 by Pu Zenhang Valte and Pu Phungkhothang Guite, has grown from being small twin villages to a very beautiful town today. It is one of the fastest growing towns in the recent history of Manipur. It may not be a misstatement to say that the growth of the town is not so much because of Government patronage as the case in Sihzang of Myanmar as it has been because of the efforts of its own inhabitants. It is a combination of various factors that makes Churachandpur as the fastest growing town. It has been an important religious centre, a business centre, a seed of learning centre or seat of institutions and civil administration.[15]

At present there are one Government hospital (District Hospital) and one Private hospital (Sielmat Christian Hospital) and also over 13 rehabilitation centres for Drug Addicts and HIV/AIDS patients as mentioned below:-

1. Shalom with many branches in Churachandpur district.

2. Chief Medical Officer's Continuum and Care Project.

3. The Salvation Army Community Caring Programme.

4. Joshua Inn (Joshua Home).

5. Gamnuam Christian Home (G.C.H).

6. Social Care Ministry.

7. Happiness Centre.

8. Sahara.

9. Siloam Rescue Centre (S.R.C).

10. North Eastern AIDS Foundation.

11.Indian Council of Medical Research (I.C.M.R).

12. Lamka Rehabilitation and Research Centre (L.R.R.C).

13. Grace Bible College Home- Based Care.

14. District AIDS Office(DAO).

15. Love in Action.

16. Community Based Drugs and AIDS Programme by DSSS.

17. Medicines Sans Frontiers (MSF)-Doctor without border.

18. Infected and Affected Network (IAN).

19. Tribal Network of Positive (TNP).

20. Manipur Network of people, Churachandpur.

21. Beth-Saida, Vengnuam, Saikham Road; Lamka.

22. Giledbam, Towna Road, New Lamka.

23. Mahanaim Home, Rehabilitation Centre, New Lamka.

24. Society for HIV/AIDS and Lifeline Operation in Manipur.

25. Voluntary Confidential Counselling and Testing Centre.

26. Manipur Evangelical Lutheran Church Care Project.[16]

B. THE PEOPLE

(a) Demography and Literacy: Churachandpur district is predominantly inhabited by the so called Chin/Kuki/Mizo/Zomi/Zo tribes of the North East India. Linguistically, they belonged to the Tibeto–Burman family of the Mongoloid origin. According to the mouthpiece of elders or legends, it is learned that these people hailed from the first three

brothers-Songthu alias Chongthu (Chhawngthu), Songja and Zahong, who first dwelt in a cave or in a rock having cavity popularly known by the people as Khul/Sinlung/Chhinlung` somewhere in china but the exact locations is not yet traceable by any scholar or Anthropologists.[17]

Churachandpur district assumes an isolated entity not only in its geographical settings but also in peopling by virtue of the land. The main ethnic groups such as the Zou, the Simte, the Paite, the Sukte, the Thadou, the Gangte, the Vaiphei, the Hmar, the Kom, etc were in the surrounding hills. The Non-aboriginal groups of Indian origin locally called 'Kol-leh-Vai/Mayang people' and illegal immigrants from Nepal, Bangladesh (East Pakistan) and Myanmar (Burma) who had been migrated to Manipur have been contributing in part and partial in the making of the present day of people in Churachandpur district.[18] Churachandpur district being one of the second largest districts in the state of Manipur has a unique distribution of area, population and administrative set up as in the following[19]:-

Table 2: Churachandpur District: Area, Population & administrative set up-2002

Area	4570 Sq.km	Percentage
Population	2, 23,866	
Male	1, 10,087	47.17
Female	1, 13,779	50.82
Literates	1, 44,115	64.37
Male	79,937	55.47
Female	64,178	44.53
Revenue Sub-Division	5	
Community/Tribal Development Block	6	
Town (Census town)	1	
Vidhan Sabha Seat	6	
Police out Post	1	

The following are the Sub-divisional headquarters and the distributions of villages as per the census in 1991 (provisional) are as given in the table 3 below[20] -

Table 3 Distribution of Villages and their Population 1991

Sub-divisional Headquarters	No of villages	No of houses	Total population
Churachandpur	246	9678	80,149
Parbung	56	3412	23,995
Henglep	107	3472	20,455
Thanlon	67	3014	19,209
Singhat	85	3013	18,643
Samulamlan	36	3132	13,733
Total	597	25,721	1,76 184

It is pertinent to note the sex-ratio of the district (Table No 3)

However, it is interesting to note that 546 villages were inhabited in Churachandpur district as per 2001 census (provisional) and the literacy rate increased to 74 67 per 1000 excluding age group 0-6 The total population soars up to 2, 28,707 and its density per Sq km to 50 per 1000 males 993 females [21]

The sub-divisional wise populations of Churachandpur district since 1971 to 2001 are noted as follows -[22 23]

Table 4 Decadal Growth of Population (1971 – 2001)

Sub –division	1971	1981	1991	2001
Churachandpur	46,418	63,993	93,882	1,34,147
Henglep	12,114	16,732	20,455	26,401
Parbung	15.214	21.176	23.995	25.374
Thanlon	12, 889	17,939	19,209	22,947
Singngat	11,480	14,936	18,643	19,838
Total	98,114	1,34,77	1,76,18	2,28,707

The district-wise decadal growth of population in Churachandpur district between 1951 - 2001 is portrayed in the following table -[24 25]

Table 5 Decadal Growth of Population (1951 - 2001)

Year	Total population	Growth (%)	Rural	Urban
1951	42,696	-	42,695	-
1961	62,418	46 20	62,418	-
1971	98,114	57 19	90,408	80,706
1981	1,34,776	37 37	1,09,617	25,159
1991	1,76,184	30 72	1,48,518	33,666
2001	2,28,707	29 85	2,28,707	

The decadal percentage Growth rate of population in the district of Churachandpur between 1951-2001 and can also be noted from table 5 as 1951-1961 with 46 20%, 1961-1971 with 57 19%, 1971-1981with 37 37%, 1981-1991 with 30 72% and 1991-2001 with 29 85% as the whole percentage growth rate of population in the district

Besides, 2003 census also makes a clear picture of Churachandpur sub-division as in the following -[26]

Table 6 Village-wise numbers of houses and population 2003

Sub-divisions	No of Villages	No of houses	Population
Churachandpur	261	19,115	1,07,686
Thanlon	62	3,018	18,855
Parbung	51	3,915	23,605
Henglep	126	4,749	27,417
Singngat	82	3,755	21,068
Samulamlan	93	3,155	17,169
Total	675	37,707	2,15,800

The above table 6 showed us that more numbers of villages and more numbers of houses with highest numbers of population are in Churachandpur Sub-Division followed by Henglep and Samulamlan sub-divisions. It is also worth noting that Parbung sub-division have lessen numbers of villages but maintain one of the highest numbers of population compared with Thanlon and Samulamlan sub-divisions.

Furthermore, the trends of literacy percentage between 1961 –2001 in the district (provisional) are presented as given Table 7 below:-[27]

Table 7: Literacy in Churachandpur district 1961-2001

Year	Total population	% of literate
1961	62,418	35.4
1971	98,114	34.7
1981	1,34,776	44.30
1991	1,76,184	58.17
2001	2,28,707	74.67

The above table 7 showed us the literates population of Churachandpur district since 1961 - 2001 censuses and it may also be briefly mentioned as: Number of literates were 62,418 with 35.4 percent in 1961, and 98,114 with 34.7 percent in 1971 and 1, 34,776 with 44.30 percent in 1981and the rest 85,355 in 1991 and male consists 50,597 (66.38%) whereas female consists 34,758 (49.30%). But in the year 2001, numbers of literates was increased to 1, 48,829 and male consists 84,537 (84.98%) whereas female consists 64,292 (64.40%) percentage growth rate of literacy population in the district.

The district being inhabited by various tribal communities, it is therefore worthwhile to have a brief overview of their population, education and published research materials available. Also in Churachandpur district, some scheduled tribe

education by number of graduates, gazetted officers and printed books published in each dialects may also be noted (Table 8) [28]

Table 8 Select Tribal Communities in Churachandpur district 1980-81

Name of the tribes	Population (1981)	No of Graduates (1980-81)	No of gazetted officers (1980-81)	No of books published (Manipur)
Aimol	1862	8	-	-
Anal	9349	26	3	6
Lusei (Mizo)	6129	120	28	4
Chiru	13744	8	-	2
Chothe	1687	3	-	1
Gangte	7891	68	19	42
Hmar	29216	245	65	133
Koireng	748	4	-	-
Kom	9830	35	2	5
Paite	30959	306	83	140
Ralte	109	N A	N A	-
Simte	5034	35	7	4
Sukte	282	-	-	-
Thadou	56467	333	58	132
Vaipei	14463	57	17	11
Zou	12576	24	5	11

The population structure of Manipur according to religion - wise in 1881 census have been reported to constitute 59 21 percent Hindus, followed by Hill tribes which accounted to 38 57 This is elaborated in the following table 9 as given below -[29]

Table 9 Population of Manipur by religion in 1881

Religious groups	Total population	Percentage
Hindu	1,30,892	59 21
Mohammedans	4,881	02 21
Christian	07	00 03
Buddhist	02	00 01
Hill Tribes	85,288	38 57
Total	221,070	100 00

The census –wise distribution of population by religion and its decadal growth between the years 1961-1991 may also be shown as Table 10 below -[30 31]

Table 10 Population by religion and its decadal growth 1961-1991

Religion	1961	1971	1981	1991
Christianity	48,544	87,433	1,18,887	1,64,453
Hinduism	2,825	5,574	10,560	9,425
Muslims/Islam	36	186	1,036	1,248
Jains/Jainism	23	6	25	14
Sikhs/Sikhism	51	83	140	192
Budhism	4	88	42	4
Others	10,925	4,794	3,086	347
Total	62,925	98,114	1,34,776	1,75,683

Besides, the distribution of population by religion in the state of Manipur and its decadal growth since 1931 and 1951-1991 censuses may also be given in the table 11 as in the following -[32]

Table 11 Growth of population by religions in Manipur 1931-1991

Religion	1931	1951	1961	1971	1981	1991
Christianity	10,401	68,394	1,25,043	2,79,243	4,21,702	6,26,669
Hinduism	2,57,255	3,47,325	4,81,112	6,32,597	8,53,180	10,59,470
Muslims/Islam	22,864	37,197	48,588	70,969	99,327	1,33,535
Jainism	0	150	778	1,408	975	1,337
Sikhism	0	50	523	1,028	992	1,301
Budhism	0	33	325	495	473	711
Others persuations	1,55,086	1,24,486	96,668	83,167	35,490	14,066
Religion unstated	0	0	0	3,846	8,814	60

The people of Churachandpur district may also be classified according to tribes – wise population since 1971-2001 Censuses as follows -[33,34]

A remarkable feature among them in Churachandpur district is that majority of the members of the different tribes can converse with one another by using their own respective dialects or languages

Table 12: Growths of population in Churachandpur district 1971-2001

Name of the Tribes	1971	1981	1991	2001
Paite	24,753	30,959	41,108	44,861
Hmar	23,312	29,216	36,092	42,690
Zou	10,060	16,666	18,000	19,112
Mizo	7,483	6,129	1061	10,520
Thadou	51,955	56,467	1,03,667	1,15,045
Koireng	458	948	798	1,056
Vaiphei	12,347	15,427	25,136	27,791
Simte	4,177	5,034	6,146	7,150
Gangte	6,307	7,891	13,580	15,100
Sukte	03	282	017	311
Ralte	154	109	529	110
Kom	6,550	9,831	13,481	15,467
Anal	6,670	9,349	12,034	13,853
Aimol	816	1,862	1,760	2,643
Chiru	2,785	3,744	4,564	5,487
Total	15,7830	19,3914	27,7973	32,1196

They also have a good deal of homogeneity. Within Churachandpur town, the largest single community is the Paite numbering 35159 speakers which is over 61.42 % of the tribal population, followed by Hmar - 7,566(13.21%) and then thirdly the Zou - 2687 (4.69%).[35] Other Indian languages and communities are found in their hundreds mainly as businessmen. These populations indicate that some communities are not indigenous to the district but settled in the urban area due to their socio-economic engagements. These sections included the Marwali businessmen and so on.[36]

According to Census conducted by the worthwhile Municipality of Churachandpur Town as on 31-3-1980, the many different communities residing in the town of Churachandpur district may also be mentioned as given below(Table 13):-[37]

Table13: Communities and population in Lamka town-1980

Name of the communities	No. of persons	Name of the communities	No. of persons
Paite	5,036	Punjabi	94
Hmar	3,148	Kabui	23
Meitei	2,883	Nepali	50
Thadou (Kuki)	2,150	Malayalam	23
Lushei (Mizo)	2,030	Kacha Naga	18
Gangte	1,010	Tamil	15
Vaiphei	1,006	Assamese	14
Zou	831	Guzarati	14
Simte	748	Tangkhul	11
Bengali	359	Rongmei	10
Marwari	223	Kom	4
Bihari	195	Biate	4
Pangngal	117	Dhar	3
Sukte(Tedim-Chin)	113	Anglo-Indian	2

The table 13 clearly indicates that the communities of Paite, Hmar and the Meities are mostly found in the town than any other communities as per the year of 1980.

The ward-wise population of Churachandpur town, 1991 census is one of a remarkable for the people of Lamka and it may also be noted as in the following (Table 14):-[38]

Table 14: Ward-wise population in Churachandpur town-1991

Location code	Name of ward	Person	Male	Female
1.	Tuibuang	3543	1748	1795
2.	Bijang	1733	901	832
3.	Sielmat	1977	997	980
4.	Lower Lamka	2190	1116	1074
5.	Rengkai	2523	1232	1291
6.	Peace land	1406	749	657
7.	Appolo veng	1944	986	958
8.	New Lamka	5217	2644	2573
9.	Upper Lamka	1269	661	608
10.	Hill Town	1371	689	682
11.	Mualveng	1890	939	951
12.	Salemveng	1356	663	693
13.	Headquaterveng	1401	693	708
14.	Chiengkonpang	1911	977	934
15.	Phailien	2396	1202	1194
16.	Bungmual	1539	784	755
Total:		33,666	16,981	16,685

Nevertheless, Churachandpur town is an ethnically pluralistic area. It is predominantly a tribal town and the tribal population were accounting to 91.35 percent as in 1995 tribe-wise census of the town. The following are the tribe-wise population of Churachandpur town as on 1995 to 1996 censuses:-[39]

Table 15: Tribe-wise population in Churachandpur town 1995-1996.

Name of the tribes	No of persons	% of population
Paite	35159	61.42
Hmar	7566	13.21
Zou	2687	4.69
Mizo	2525	4.41
Thadou	2332	4.07
Vaiphei	2130	3.72
Simte	2037	3.55
Gangte	1768	3.08
Sukte	920	1.60
Kom	113	0.19
Others	5416	8.64

Other ethnic communities found in the town according to the community-Wise Census as on 1995-1996 were also shown as given below -[40]

Table16 Other ethnic communities in the town (1995-1996)

Name of communities	No of persons	% of population
Meitei	3756	69 35
Muslim	379	6 99
Mayangs	814	15 02
Bengali	414	7 64
Nepali	53	0 97

Table 17 Tribe-wise Population in Churachandpur town-1995

Sl No	Name of tribes	No of persons	Percentage of Population
1	Paite	35159	61 42 %
2	Hmar	6566	13 21 %
3	Zou	2687	4 69 %
4	Mizo	2525	4 41 %
5	Thadou	2332	4 07 %
6	Vaiphei	2130	3 72 %
7	Simte	2037	3 55 %
8	Gangte	1768	3 08 %
9	Sukte)	920	1 60 %
10	Kom	113	0 19 %
11	Others	5416	8 64 %

Source Tribe-wise Census of Churachandpur Sub-Division conducted by SDO based on hill houses counting register of 1995

Furthermore, it is also worth to note that the ethnic composition of the town clearly reflects numbers of different tribes as studied on 1995 which represents the tribal population as shown below -

The population and literacy of most developing countries have been growing rapidly in recent decades Once in every ten year, it is possible for us to study the growing pattern of population and literacy Thus some light on the nature of population

growth and emerging trends of literacy in Manipur may also be noted below table 18 as follows:-[41, 42, 43]

Table 18: Population Trend in Manipur 1911-2001

Census years	Population	% Rate of increasing	N.E. % average	All India average
1911	3,46,000	18.42	21.71	5.75
1921	3,84,000	18.71	10.92	0.31
1931	4,46,000	19.44	16.04	11.00
1941	5,12,000	20.15	14.92	14.22
1951	5,75,000	19.06	12.88	13.31
1961	7,80,000	41.33	35.04	21.51
1971	10,73,000	35.04	37.53	24.80
1981	14,21,000	33.24	32.46	25.00
1991	1,826,714	21.87	28.56	23.50
2001	2,388,634	30.02	30.02	21.34

From the above it is clear that population in Manipur is increasing at a much higher rate than that of the whole country, particularly from 1951. Manipur occupies 20th rank among the Indian states in respect of population but only 0.20 percent of the total population in the country lives in Manipur.[44] Also, literacy is an essential aspect of human dignity and a window to the world (Athreya: 1991). It not only helps in occupational mobility but also opens the door of modernization. Thus education has an important role to play in the overall development of the society. Indeed, education is recognized to be the best indicator of individual mobility and modernization.

(C) HUMAN RESOURCES AND SOCIO – ECONOMY

Churachandpur district of Manipur has been mainly occupied by the so called Chin/Kuki/Mizo/Zo ethnic groups of the Tibeto-Burman branch of Indo-Mongoloid race. They came to the present area through different waves of migration and occupied the area

where they could find suitable land for agriculture, besides consideration of their security. They occupied the land, which was either virgin, or capture the land by deriving out earlier settles. But their migratory nature did not change and as such, they went on changing the places of habitation. There was no permanent settlement, they make till the advent of British administration at the end of the last century. After the permanent settlement, they make their abode either on the hilltop or slopes maintaining defensive position. They developed local culture traits, which were distinguishable from one another.[45] However it is worth to note that there are also some communities who are not indigenous to the district or the towns settle mainly in the urban area due to their socio-economic engagements. These sections include the Marwari businessmen, Bengali, Bihari, Nepali; Muslim etc.[46] These different communities have followed their own patterns of socio- economy, though their numerical strength is negligible.

Hence, different communities in Churachandpur district have not maintained watertight compartment relation in their socio-economic life. Their mutual social relationship reflects social unity and harmonious ethnic relationship. This exhibits a close-knit society. Indeed, their social and religious custom are common with a little variations, but the Bengali, Bihari, the Meitei, the Muslim, the Nepali etc. maintain a very distinct social customs due to their difference in religious practice.[47] The advent of Christianity in Churachandpur district in the early part of the 19th Century had excellent impact on the socio-economic and cultural life of the people. Their mode of life was changed and their social structure was completely transformed. Besides, Christianity made them adaptable to western culture. Its impact on socio-economic activity is also

significant. Their mental horizon widened by its teaching and the superstitions and faith in spirit vanished.

The Christianity spread education and gave them lesson of love, sympathy and a sense of value that were completely missing during their traditional life. As they lived for many ages in a well-knit society and their life being inspired by Christianity, there is no caste or class or the egalitarian perception has made them classless and casteless. The community life is comprehensive and free from any rank or statues consciousness. They participated in all Social or Religious function as a member or as a representative without any consideration of social hierarchy.

The festivals such as Christmas, New Year, kut festival etc. have promoted community feelings and have helped in influencing the attitude of the people. Thus, the community feasts and festival have widened the boundary of community life. But after the advent of Christianity, most of the festivals like Pawlkut, Mimkut, Tangkut or Khawdo Pawi etc. disappeared. However in their social life, animal sacrifice, arranging feasts, offering drinks and inviting large number of guests are still the common cultural phenomena of the people.

The community life of Churachandpur district is deeply an agricultural activity and their economy is dominated by agriculture, which invites the whole community to share both pleasure and pain. This main occupation is an ideal one and the people helped the poor, hungry and the needy persons. This gives birth to a socio-cultural and economic unity. At present, there are more than 80% of the total populations engaged in agriculture

and related activities.[48] The age-old traditional system of agriculture is jhuming (Slash and burn). The agricultural land used pattern in the district is the result of interaction of the physical and historico-socio-economic factors. The development of agriculture depends upon physical and socio-cultural processes in which relief, fertility of soil, gradient of slope; drainage system and climatic condition play a pivotal role. Since the pattern of agriculture defers in mountains, plateaus, plain, valley flanks, flat plains and so on.

The human factors like the durations of occupation of the area cropped, density of population, socio-economic milieu and technological development and its applications in land utilizations are equally important in the study of land use pattern. Out of total geographical area of 4, 57,000 hectares in Churachandpur district, the area reported for land utilization may be noted as: Total crops area is 1,96,700 hectares while area under forest is 20,376 hectares. Out of this, barren and uncultivable land includes 8,800 hectares.[49] All the areas of the district, excluding reserve forest, streams, riverbeds, roads, town and villages including very steep slopes are used for shifting cultivation. This is a primitive system of land use on the hill slopes of the mountains region, in which the hill slopes are cleared of grasses, vines and small bushes during the dry season. The field plants are left to dry for a month or so and burnt thereafter. This system is also known as "Slash and Burn" system of farming. Any area of the land for other purposes, however, rests with the government. In the jhuming, no permanent tenancy system is possible as the jhum land changes from time to time or year-to-year. While selecting the site,

preferences are given to the land that is sunnier, and where less weed with grow, land facing east and level land that does erode.

The method of cultivation used in Churachandpur district is almost primitive. In most cases, the modern scientific methods are almost impossibility under the prevailing geographical constraints. Agriculture tools and implements like dao, axe, hoe, chisel etc are age old. Thus, agriculture is still in an infant stage and it is not a viable area agriculturally. The cereals produced here can hardly meet the requirement for a few months, and for the rest of the months of the year the district has depended on imports from other districts or states. As a result mixed cropping is a very common practiced with jhuming in the district. A variety of mixed crops like paddy, maize, taro, cotton, yam, ginger, chilies, cucumber, watermelon, lentil and other vegetables are widely grown.

Agriculture production in Churachandpur district is mainly oriented towards the attainment self-sufficiency and there is absolutely no tendency to preserve surplus stock for sale or for exchange for better amenities. Thus, the surplus food grain is utilized not for material gain but for humanitarian purposes and in performing various types of ritual feasts. Though agriculture continues to be the main economy of the district, yet till today double cropping system is practicable only in the valley or in some of the plain area where a settled form of agriculture is prevalent. Shifting cultivation is commonly practiced in the district. The success or failure of the crops depends almost entirely on the capricious rainfall.[50] Nevertheless, it is said earlier that they practiced terrace and wit cultivation on hill slopes by making artificial channels and shifting (jhum) cultivation on

the hills as well as wit cultivations with wooden plough and bullock or buffalo in some of the hill and plains. The jhum cultivation is wasteful as it destroys the forest erodes the soil, diminishes fertility and yields less productions.[51] Hence, men folk also engage themselves off- seasons in subsidiary occupations of blacksmith, bamboo and cane work and also other handicrafts for their own requirements. But female workers are much interested for their domestic weaving and embroidery work than agriculture work in the fields. Thus, a wide range colours and designs produced on looms and the textile weaving seems to have become a sacred duty of compulsion among the ladies.[52]

In the real sense of the term, the total population of Churachandpur is the human resources with the youth groups as the potential future manpower resources. The district is rich in its manpower resource with 2, 28,707 in 2001 as per the census of India.[53]

Then the working population is estimated to be only 28 percent of its people classed as main workers and 70 percent non-workers. About two-fifths of its workforce is employed in agriculture and the remaining three-fifths in secondary and tertiary activities (Dr. Tualchin Neihsial 1996:29). The whole district economy is predominantly depended on this working group of population. The percentage of workers in Churachandpur district between 1971 to 1991 may also be briefly noted in table 19 as follows: - [54]

Table 19: Percentage of workers in Churachandpur district 1971-1991.

Cultivators		Agricultural Labourers		Workers in Household Industries		Other Service workers	
1971	1981	1971	1981	1971	1981	1971	1981
85.29	78.31	1.92	1.80	1.04	1.27	11.75	18.62

Thus, it is seen that from 1971 till today agriculture continues to be a single largest sector of the district economy and more than 80% of the people were engaged in agriculture sectors.

Besides, the numbers of workers in Churachandpur district according to 1991 census may also be mentioned in table 20 as given below:-

Table 20: Numbers of workers in Churachandpur district 1991.

Non-workers	Marginal workers.	Other Service.	Cultivators.	Agricultural Labourers.
98,533	2,752	11,030	57,986	1,988

From the above it is obvious that agriculture has been playing a predominant role for contributing the economic growth of the district due to non-availability of infrastructure facilities like power, skilled labour, transport and communication, financial institutions etc and also there is practically no big industries worth naming in the district or state.[55] The total number of employment was estimated to 75.8% in the public sectors and 6.2 % in the private sectors of the district showing an extremely narrowed employment avenue in private sector. But it should also be noted that percentage changes over the previous year and hence public sector in the state was (-) 0.39 while 3.33 in private sector.

At present the Government of Manipur and its departments are inundated with more than 4, 07,014 lakhs of educated job seekers.[56] With this, the height of corruption has caused an unhealthy environment in the appointment sectors. As a result, hundreds of

youths are frustrated and claimed to remain useless without contributing anything in the society.[57]

The literacy rate in the district is high as 74.67 percent as against the 65.38 percent of all Indian average.[58] This is a great concern and crucial stage reminding the concept of proper management of manpower. Failure to adopt and implement a strategic policy in this regard, the people of Churachandpur district is considered to face a tough time in near future. The initial sign of failure is now manifest as hundreds of youth are indulging in drug menace and still others remain in the crossroads of uncertain future.[59] Thus, a severe damage of manpower resources is observed in Churachandpur district.

The rampant use of unfair means in the examination and false employment in various sector (Singh and Shyamanada, 1988) is also found to be associated with the wide spread drug abuse among the teenagers and the youths especially in the age group between 15-35 years. This is also a great threat to the potential energy pool of human population (NICED, 1990). Drug abuse was found more common to the urban youths than the rural population.[60] About 40,000 drug addicts were found in the state of Manipur, of which 70 % is more or less HIV /AIDS positive (The Times Of India, June 27th, 2004: p.4).[61]

What is worrying most is irrepable lost due to HIV infection among the youthful manpower resources of the district. According to a report of NGOs and Government, the estimated number of Intravenous Drug Users (IDUs) is 1,438 and number of HIV infection among adult population in the district is estimated to be 574 in 20001.Ever

since, there is an increasing number of AIDS widows and AIDS orphants since 48% of AIDS patients in Churachandpur district are married people. In most cases, the husbands were ex-addicts who often infected their wives.[62]

Churachandpur District AIDS Committee (2001) has reported that 85% of HIV positive youths and adolescent are belonging to the age groups between 15 to 35 years. These are the living examples for manpower resources damaged resulting a severe impact in the district economy and caused mental restless among the people. With their uncertain future culminated with all sort of activities, many of the youths has fallen into a victim of drug menace and HIV epidemic. The actual costs of HIV/AIDS treatment, prevention and together with manpower labour are also additional burden to hundreds of affected family and the society.[63] Furthermore, lack of irrigation facilities, industrial backwardness, poor transport facilities etc and lack of skills in the manpower planning are all the determining factors for poor economy in the district.[64] Over the last decades, the mobilization of economy and generating of a soundman power-planning programme in the district has been far less to the desire goal.

(D) Trends of HIV/AIDS in Manipur

In the state of Manipur, the first case of AIDS was officially reported and detected only in October 1989 but now HIV/AIDS infection has reached an alarming epidemic proportion. According to a study conducted and recorded by Manipur AIDS Control Society between the period of September 1986-March 2009, a total of 310527 persons of blood samples were screened and it result to HIV positive cases of 31972, AIDS cases to

4363 and number of AIDS death to 625. In particular, number of HIV/AIDS cases to 8053 females giving one of the highest rates because most of the victims include women who have been separated from their husbands. Thus the Sero-positivity rate per 100 samples is 10.8 through Sero-Surveillance whereas through Sentinel-Surveillance the Sero-positivity rate per 100 samples is 8.7 and a total of 10.3 as a whole in the state.[65]

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. 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. 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. So it is interesting to note some trends of HIV/AIDS in Manipur which reflects the behavior of the people as follows: -[66]

Table 21 Manipur Trends of HIV/AIDS Surveillance (1986 -1994)

Year	Blood Samples	HIV positives	AIDS Cases	Deaths
1986	371	00	00	00
1987	970	00	00	00
1988	525	00	00	00
1989	828	00	00	00
1990	3147	961	04	00
1991	2223	422	00	00
1992	3409	351	00	00
1993	4204	254	08	O4
1994	16958	1187	56	11
Total	49593	3175	68	15

The above table 1 showed us that no cases of HIV/AIDS were reported even though 2694 samples were screened between 1986 to 1989 The cases of HIV/AIDS were grim only from 1990 years onwards As a result, more numbers of blood samples were screened in 1991 and 422 become infected but no cases of AIDS were reported It was only in 1993 that AIDS cases and death due to AIDS were reported So it is interesting to note some trends of HIV/AIDS in Manipur which reflects the behavior of the people in generally and the year between 1995 to 2003 are also clearly shown as given below - [67]

Table 22 Manipur Trends of HIV/AIDS Surveillance (1995 -2003)

Year	Blood Samples	HIV positives	AIDS Cases	Deaths
1995	2926	429	36	11
1996	2021	557	114	35
1997	2117	757	83	29
1998	2779	984	61	06
1999	3436	1037	196	29
2000	4859	1242	203	18
2001	4329	1192	286	51
2002	6195	1389	632	73
2003	5423	1419	1187	133
Total	34085	9006	2798	385

The above table 2 indicates that the cases of HIV/AIDS were amply reported and 385 deaths due to AIDS were reported between 1995 to 2003.The district-wise distribution of HIV/AIDS positive cases (Sero-Surveillance) in the districts of Manipur since January to December 2004 to 2009 may also be noted as shown below:-[68]

Table 23: Manipur Trends of HIV/AIDS Surveillance (2004-2009)

Years	Blood Samples	HIV/AIDS positive	AIDS Cases	Death
2004	6854	2019	461	65
2005	13481	2394	297	48
2006	31811	2749	324	50
2007	47844	3235	264	45
2008- May	21114	1116	151	13
2009				
Total				221

The above table 3 clearly showed to us that the numbers of HIV/AIDS were increasing year after year and 2004 appears to be more exposing year of AIDS cases and deaths due to AIDS whereas numbers of HIV/AIDS cases are also fast growth in 2007. Since then, the district wise distribution of HIV/AIDS positive cases in Manipur between 2000 to 2001 may also be noted as given below:-[69]

Table 24 Manipur Inter-District Variation in HIV/AIDS (2000 &2001)

Districts	2000		2001	
	Blood Samples	HIV/AIDS positive	Blood Samples	HIV/AIDS positive
Imphal	3,251	833	3,053	837
Thoubal	255	125	518	124
Bishnupur	592	60	280	60
Churachandpur	186	56	87	42
Senapati	305	59	197	54
Ukhrul	135	52	97	46
Chandel	104	52	60	23
Tamenglong	31	5	36	5
Unknown	-	-	1	1
Total	4, 859	1, 242	4, 329	1, 192

From the above table24 we can see that the highest number of HIV infection and AIDS cases were found in Imphal district followed by the district of Thoubal whereas the lowest infection of HIV and AIDS cases were found in Tamenglong district We can also see the district wise distribution of HIV/AIDS Positive Cases in Manipur between the years 2000 to 2002 were as follows -[70]

Table 25 Manipur Inter-District Variation of HIV/AIDS (Sero-Surveillance), 2000-2002

	Districts	2000		2001		2002	
		Screen	Positive	Screen	Positive	Screen	Positive
Hill Areas	Senapati	305	59	197	54	277	64
	Tamenglong	31	5	36	5	25	5
	Churachandpur	186	56	87	42	296	50
	Chandel	104	52	60	23	149	73
	Ukhrul	135	52	97	46	126	50
	Total	761	224	477	170	873	242
Valley Areas	Imphal	3251	833	3053	837	4087	897
	Bishnupur	592	60	280	60	407	85
	Thoubal	255	125	518	124	828	165
	Total	4098	1018	3852	1022	5322	1147
	Manipur	4859	1242	4329	1192	6195	1389

The above table 5 clearly indicates that more numbers of HIV/AIDS infection or cases are in the valley of Manipur as more numbers of population were tested in the district of the plain valley as sources of factual information between 2000 and 2002 whereas conservative hill people remain less aware of HIV test for their good

The epidemiological analysis of HIV/AIDS positive cases (Sero-surveillance) in the districts of Manipur since 2003 to 2005 may also be briefly mentioned as under -[71]

Table 26 Manipur Inter-District Variation of HIV/AIDS (Sero-Surveillance), 2003-2005

	Districts	2003		2004		2005	
		Screen	Positive	Screen	Positive	Screen	Positive
Hill Areas	Senapati	275	73	402	89	94	34
	Tamenglong	22	6	54	11	9	1
	Churachandpur	198	70	664	271	150	52
	Chandel	159	65	146	79	58	23
	Ukhrul	178	87	315	160	98	56
	Total	832	301	1581	610	409	166
Valley Areas	Imphal	3500	891	4106	1123	1022	285
	Bishnupur	418	105	431	126	118	29
	Thoubal	673	122	736	160	196	35
	Total	4591	1118	5273	1409	1336	349
	Manipur	5423	1419	6854	2019	1745	515

From the above table 6 we can see that the highest number of infection, cases and highest percentage of the districts were found in Imphal district, followed by Thoubal district whereas the lowest of all were found in the district of Tamenglong Then a total number of 1077 people were found HIV/AIDS positive in the hill areas whereas in the valley 2876 were found HIV/AIDS positive in the years between 2003-2005

It is also more interesting to note the age group who have been infected to HIV/AIDS between 200-2002 as a behavioural problem which reflects the young and old alike in the cases of HIV/AIDS in the state of Manipur as mentioned below:-[72]

Table27. Manipur Age-Sex Proportion of HIV Positive Sero-Surveillance 2000-2002

Age-Group	2000			2001			2002		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-10	38	32	70	65	27	92	53	35	88
11-20	22	34	56	8	23	31	7	22	29
21-30	381	205	586	320	193	513	356	256	612
31-40	318	104	422	344	99	443	392	153	545
41 & Above	82	26	108	83	30	113	85	30	115
Total	841	401	1242	820	372	1192	893	496	1389

The above table27 indicates that ages group of 21 to 30 were exposed to more danger followed by age group of 31 to 40 and 41 and above ages were no exception. It is also a well known fact that between 2003-2005 the young and old alike in the state of Manipur are still badly infected by HIV/AIDS as shown below: -[73]

Table 28: Manipur Age-Sex Proportion of HIV Positive (Sero-Surveillance) 2003-2005

Age-Group	2003			2004			2005		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-10	54	49	103	84	78	162	23	20	43
11-20	16	23	39	18	34	52	6	2	8
21-30	279	287	566	334	316	650	82	80	162
31-40	392	196	588	677	256	933	182	67	249
41 & Above	83	40	123	149	73	222	39	14	53
Total	824	595	1419	1262	757	2019	332	183	515

The above table28 also indicates that the highest numbers of HIV/AIDS positive cases were found among the male age group between 31 to 40 years and were exposed to more

danger followed by female age group of 21 to 30. Nevertheless, the age groups of 41 and above were less exposed to danger between years of 2003-2005.

It is also more interesting to note that people of all ages have been infected by HIV/AIDS in the state of Manipur between 2000-2001 as mentioned below:-[74]

Table 29: Manipur HIV/AIDS Positive Cases (2000-2001)

High Risk Group	2000		2001	
	Screened	Positive	Screened	Positive
Heterosexually promiscuous	1229	238	1680	415
Homosexuals	00	00	00	00
Injecting Drug users(IDUS)	780	509	626	451
Blood Donors	00	00	00	00
Blood Recipients	66	20	42	12
Antenatal Mother	97	40	00	00
Patients on Dialysis	00	00	00	00
Suspected ARC/AIDS patients	299	110	250	85
Relatives of AIDS patients	259	100	254	122
Perinatals Transmission	00	00	00	00
Others	2,129	225	1,477	107
Total	4859	1242	4329	1192

The above table 29 clearly indicates that the highest numbers of HIV/AIDS positive cases were found among the suspected ARC/AIDS patients and is followed by relatives of AIDS patients whereas the Injecting Drug Users (IDUs) were also seen very much responsible for the infection of numbers of HIV/AIDS in the state.

It is also more interesting to note the people who have been infected with HIV/AIDS between 2002-2003 and the route of transmission within the year may be as mentioned below:-[75]

Table 30: Manipur HIV/AIDS Positive Cases (2002-2003)

High risk group	2002		2003	
	Screened	Positive	Screened	Positive
Heterosexually promiscuous	1619	457	2056	670
Homosexuals	4	1	14	3
Injecting Drug users(IDUS)	635	427	767	457
Blood Donors	00	00	00	00
Blood Recipients	55	10	75	27
Antenatal Mother	00	00	00	00
Patients on Dialysis	00	00	18	01
Suspected ARC/AIDS patients	30	06	11	05
Relatives of AIDS patients	16	08	01	00
Perinatals Transmission	200	69	280	101
Others	3636	411	2201	155
Total	6195	1389	5423	1419

The above table 30 indicates that the highest numbers of HIV/AIDS positive cases were found among the Injecting Drug Users (IDUs) and were also seen very much responsible for the infection of HIV/AIDS in the state and were followed by heterosexually promiscuous and perinatals transmission were no less responsible in the state.

It is also keener to note the people who have been infected with HIV/AIDS between the years 2004-2005 through various route of transmission as follow: -[76]

The above table 30 showed us that all the blood samples from the above for blood transfusion are screened for HIV at the Blood Bank since 1996.Before that, there was no compulsory HIV testing for transfusion. Hence; there have been cases of HIV positive among blood recipients who have received blood before 1996 as given above. Besides, it is good to note that `00` means nil with reference to above Table No 30.

Table 31: Manipur HIV/AIDS Positive Cases (2004-2005)

High risk group	2004		2005	
	Screened	Positive	Screened	Positive
Heterosexually promiscuous	2479	873	604	221
Homosexuals	33	09	12	05
Injecting Drug users(IDUS)	1143	763	271	177
Blood Donors	00	00	00	00
Blood Recipients	85	27	19	08
Antenatal Mother	1387	40	248	06
Patients on Dialysis	86	02	21	00
Suspected ARC/AIDS patients	82	11	18	00
Relatives of AIDS patients	03	02	00	00
Perinatals Transmission	620	179	183	46
Others	936	113	369	52
Total	6854	2019	1745	515

Furthermore, the NACO report on Sentinel Surveillance for HIV infection in Churachandpur between 2005 to 2006 may also be briefly highlight for easy references as given in Table 32 below.

It is also more interesting to note the people who have been infected with HIV/AIDS in 2007 through the numbers of screened as mentioned in Table 33 below:-[77]

From the table 33 we can see that the highest number of infection, cases and highest percentage of the districts were found in Imphal district, followed by Thoubal and Churachandpur districts whereas the lowest in all cases were found in the district of Tamenglong.

Table 32: Churachandpur Sentinel Surveillance of HIV infection (2005 – 2006)

Selected Centers	Sentinel Group	Number Tested	HIV/AIDS Positive	Percentage
Churachandpur	ANC	400	06	01.05
Churachandpur	STD	250	39	15.08
Shalom, Churachandpur	IDUs	250	50	20.00
LRRC,Churachandpur	IDUs	250	84	33.06
Churachandpur	ANC	400	09	02.25
Churachandpur	STD	250	17	06.08
Shalom, Churachandpur	IDUs	250	60	24.00
LRRC,Churachandpur	IDUs	250	41	17.00

Source: National AIDS Control Organization Programme State Summary Report on Sentinel Surveillance for HIV infection from Ist August to 31th October 2005 and I st September to 30th November 2006.

Table 33: Manipur Inter-District Variation of HIV positive-2007

Districts	Samples Screened	HIV positives	Sero-positivity rate (%)	Percentage
Imphal	83045	12722	15. 32	57.09
Thoubal	21894	2181	9.96	9.79
Churachandpur	9724	1841	18.93	8.26
Bishnupur	13650	1304	9.55	5.85
Senapati	7783	1099	14.12	4.94
Chandel	4476	1080	24.13	4.85
Ukhrul	7222	1594	22.07	7.15
Tamenglong	2987	102	3.41	0.46
Total	150781	21923	14.54	98.38

It is also a well known fact that in the years 2007 the young and old alike in the state of Manipur are badly infected by HIV/AIDS as shown below: -[78]

Table34: Manipur HIV Positive Cases (Sero-Surveillance)-2007

Age-Group	Males	Females	Total	% of total positives
0-10	745	669	1414	06.35
11-20	899	378	1277	05.73
21-30	6481	3332	9813	44.04
31-40	5621	2287	7908	35.49
41 & Above	1316	555	1871	08.40
Total	15062	7221	22283	100.00

It is also more interesting to note the people who have been infected with HIV/AIDS in 2008 and the route of transmission may also be note worthy [79]

Table 35 clearly indicates that the highest numbers of HIV/AIDS positive cases were found among the Injecting Drug Users (IDUs) and were seen highly responsible for the infection of HIV/AIDS in the state followed by heterosexually promiscuous and thirdly followed by perinatal transmission

It is also more interesting to note the people who have been infected with HIV/AIDS between 2007 and the route of transmission within the year may be as mentioned below -[80]

Table 35 Manipur Different High-Risk Groups Screened - 2007

High-Risk Groups	Screened	Positive	Sero-positivity rate (%)	Percentage
Heterosexually promiscuous	27933	6500	23 27	29 17
Homosexuals	222	58	26 13	0 26
Injecting Drug users(IDUS)	17098	9636	56 36	43 24
Blood Donors	10587	219	2 07	0 98
Blood Recipients	1609	277	17 22	1 24
Antenatal Mother	60617	897	1 48	4 03
Patients on Dialysis	265	12	4 53	0 05
Suspected ARC/AIDS patients	2215	394	17 79	1 77
Relatives of AIDS patients	739	299	40 46	1 34
Perinatal Transmission	5788	1218	21 04	5 47
Others	33635	2773	8 24	12 44
Total	160708	22283	13 87	100

Table36: Manipur Inter- District Variation of HIV positive Cases -2008

Districts	Samples Screened	HIV positives	Sero-positivity rate (%)	Percentage
Imphal	92929	13279	14. 29	56.04
Thoubal	26437	2405	9.10	10.15
Churachandpur	12440	2078	16.70	8.77
Ukhrul	8772	1713	19.53	7.23
Bishnupur	17157	1371	7.99	5.79
Senapati	10001	1178	11.78	4.97
Chandel	5873	1204	20.50	5.08
Tamenglong	4291	106	2.47	0.46
Total	177900	23334	13.12	98.48

From the above table 36 we can see that the highest number of infection, cases and highest percentage of the districts were found in Imphal district, followed by Thoubal, Churachandpur and Ukhrul districts whereas the lowest in all cases were still found in the Tamenglong district. It is also more interesting to note the people who have been infected with HIV/AIDS between 2008 and the route of transmission within the year may be as mentioned below:-

Table 37: Manipur Age-Sex Proportion of HIV Positive (Sero-Surveillance)-2008[81]

Age-Group	Male	Female	Total	Percentage
0-10	866	782	1648	06.96
11-20	921	409	1330	05.61
21-30	6680	3533	10213	43.10
31-40	5963	2499	8462	35.71
41 & Above	1443	598	2041	08.61
Total	15873	7821	23694	100.00

The above table 37 screened result showed us that 21-30 ages group in the society are a very dangerous year for the infection of HIV/AIDS and were followed by 31-40 age groups whereas 11-20 age groups are more unlikely than any other age groups.

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CHAPTER – III

GENESIS OF HIV/AIDS

A. History of HIV/AIDS Development

Almost unknown ever before 1981, an elusive enigma, a disabling or life-threatening illness, a sensitive issue and a worldwide panic -Acquired Immuno-Deficiency Syndrome (AIDS) caused by Human Immuno-Deficiency Virus touches on so many different aspects of conscience and morality such as sexuality, sexual behaviour, freedom of the individual, protection of society, care for others, euthanasia, treatment or testing by force, use and abuse of drugs, suicide and so on.[1] Hence, AIDS has been identified as a major crisis, tension, debate and a research priority all over the world.

With its deleterious effects on mankind, it was described as one of the most serious health problems. But indeed, AIDS is much more than a health issue. The health care crisis in many developing countries was already acute before the impact of AIDS. Poverty, malnutrition, poor health care, lack of respect for human rights, illiteracy, inadequate housing, discrimination against women and children, and unresponsive [2] political system makes worse its impact on any given society.[3] AIDS has an inordinate impact on the poorest countries, affecting their social, political and economic conditions. But AIDS as a serious issue had been quite sometime clearly ignored by politicians and by development technocrats. As such, we still lack concrete and detailed information about the real impact of the pandemic.[4]

The world came to know for the first time about this new mysterious disease (AIDS) when the American scientists had published articles in the prestigious medicinal journal - The New England Journal of Medicine on 10th December, 1981. The disease was reported in Los Angeles and subsequently in New York and California in previously healthy male homosexuals who suffered from Pneumocystis Carinii Pneumonia (PNP) and Kaposi's Sarcoma (KS) with clinical and laboratory evidence of immune dysfunction (Centre for Disease Control, 1981a, 1981b, Gottie b, et al, 1981; Ansary, et al, 1989). And opportunistic infections caused by micro-organisms that rarely give rise to diseases in persons with normal immune defence mechanism were also reported (National Academy of Science, 1986a).

By early 1982, still AIDS was known by a variety of names or acronyms. Some called it Gay Plaque. Others called it Grid (Gay-Related Immuno-Deficiency). The syndrome was first recognized among homosexuals not only in USA but also subsequently in European countries and Australia. However, when the disease was detected in groups other than gays such as intravenous drug- users, infected blood products and parental transmission, the staff members at Centre for Disease Control (CDC 1982) refused to call it GRID because they were aware that the disease was not restricted to homosexuals only.

To solve the problem of nomenclature, the experts met under the aegis of CDC in 1982 and came out with a resolution to name the disease AIDS, an acronym for Acquired Immuno-Deficiency Syndrome (Shilts, 1987). Among the heterosexual individuals, the first AIDS cases were recognized from central Africa and Haiti in 1983 (ASTPHLD, 1994).[5] In African situation, AIDS is often called "Slim Disease" [6] while in the bygone days people coined a new term called "Love Plaque" because it

killed people in large numbers as plaque and was thought to be caused by the sexual act.[7] Abstaining completely from sex is the safest way of avoiding infection but this may be unrealistic for most people and even in reducing the number of sex partners, there is little guarantee that all the partners will always stick to each other. Strictly speaking, the term safe is incorrect as a few of the low risk activities described earlier are not completely 'safe' although they certainly reduce some of the risk. Some young people may not get married for several years or more, men and women away from home and sex workers for whom sex is vital source of earning.[8]Before the discerning of HIV, AIDS by then was shrouded in mystery because the actual agent was not yet identified till 1983 and those who were infected were inevitably dying, because there was yet no known cure for it. This led to unprecedented panic among the populace. The disease has been spread first among the risk groups in an epidemic form and then to the general population in a pandemic nature.

The stories of ostracism, discrimination and people fleeing from AIDS victims are legion. Thus people started worrying about getting its infection from toilet seats and in buses and subways. Even doctors and nurses were affected by this mass hysteria. Many of them refused to treat anyone with the faintest suspicion of AIDS and hospitals Wards were deserted by other patients (Malaviya, 1990).[9] The worst fathomless fears were that a person could get AIDS through the air, like catching a cold or flu.[10]

Therefore, physicians, scientists and researchers have taken up a challenge to discover the mysterious of AIDS in the human society. These stories of AIDS and alarming responses of the world has led the European and American physicians and scientists to think of what could really be the main causes of the disease and

vigorously searched for its cause. Some of the virological laboratories around the world then started the arduous work of discovering the causative agent in right earnest. To mention a few, Paul Fiarimo at CDC, J. Levy in San Francisco, A. Karpas in Cambridge, Luc Montaigner at the Institute of Pasteur in Paris, Robert Gallo at the National Institute of Health in Bethesda, USA and Max Essex at Harvard, Boston were some of the scientists who took the challenge. Subsequently, as luck would have it, the special efforts made by Montaigner's and later Robert Gallo's group made it possible to grow the virus in the laboratories in bulk amount. Then it was believed to many working in this area that AIDS was probably caused by a certain micro-organism.[11]

Then just two years after the first cases of AIDS were described, the virus that causes AIDS was discovered in 1983, [12] almost simultaneously by three laboratories and given three different names such as Lymphadenopathy Associated Virus (LAV), Human T-Cell Lymphotropic Virus type-III (HTLV-III) and AIDS-Associated Retrovirus (ARV). It turned out that all the three viruses were very similar and were actually variations of the same virus, which in 1986 was given the single name called Human Immuno-Deficiency Virus type-I (HIV).[13] However, Montaigner's and Robert Gallo's group isolates have subsequently been found to be identical, and are now recognized to be the cause of AIDS. But still, there was a dispute between the two research Institutes as to who was the first discoverer of AIDS virus. In 1987, both scientists were given credit for the discovery and in 1991; Gallo dropped his claim to have discovered the virus. In the meantime, an international agent renamed the virus as Human Immunodeficiency virus (HIV) for AIDS was finally discovered to be HIV.[14] Today, the molecular structure of HIV and its response to treatment was

unlike that of two decades ago. Much had been advanced in the molecular and genetic variability of HIV. It has been classified into HIV-1 and HIV-2.[15] According to a study made over a period of 6 years, persons infected with HIV-2 are 10-12 times less likely to develop AIDS than person infected with HIV-1.

More recently, it has been shown that HIV-2 is not only pathogenic than HIV-1, it is also spreads much slower than HIV-1.[16] Despite early efforts to standardize the nomenclature of HIV, it remains inconsistent, and there are no widely accepted definitions for the HIV types. Some called it as strain and still others used it as sub-type or variants. But study on this aspect is out of the scope of the present study.[17] Almost immediately after the first case of AIDS was reported in the United States of America in June 1981; researchers at the CDC began tracking the disease backward in time to discover its origin. They ultimately determined that the first cases of AIDS in the United States of America probably occurred in 1977 (Biggar, et al; 1988). Several reports of cases resembling AIDS both clinically and immunologically have appeared in the literature (Katner and Pankey, 1987; Huminer, et al. 1987).

Another convincing first case of AIDS in United States may be dated back to the 1960s. This was known when a 15 years old boy who had anal sex was found to have been infected with HIV (Garry, et al. 1988). So, it is believed that HIV or genetically related virus may have entered several communities before the current epidemic.[18] The earlier civilization had witnessed devastating global epidemic/pandemic with 'bubonic plaque' in the 18th century and the 'Spanish Flu' in the 19th century which had globally killed millions of people within a short period.[19] Hence, the debate about the origin of HIV/AIDS has been mixed with questions of who, which country, which race, is yet to be blamed for starting the epidemic. Yet, suggestions and ideas on

where the HIV/AIDS virus could have originated first started led to a raging controversy including allegations of racism. Indeed, whenever misfortunes occur, we are liable to blame other people for which no evidence is required.[20]

As such, the debate about the origins of AIDS has not been helpful because it has created bitterness and diverted attention from the important task of prevention. So, what is more important than knowing where the disease came from is where it is going? [21] In fact, the origin of the HIV viruses and AIDS is still shrouded in a mystery and the actual origin is still remaining undecided. Blaming others for a problem as a substitute for tackling the problem itself, is a human characteristic. Further, the process of attributing blame does not always require evidence, and tends to focus on people who are not considered normal by the majority, especially minorities or foreigners. Epidemics of dangerous infections such as plaque, smallpox, syphilis or even influenza have historically prompted social responses based on blaming others for spreading the disease by their "deviant" behavior.[22] Blaming others may itself be a contagious psychological process leading on to stigmatization, scapegoating and persecution. The debate about the origin of AIDS is largely irrelevant to immediate action against the disease. Thus Professor Luc Montaigner, Co-discover of AIDS virus, regarded the theory as "not serious enough even to raise the hypothesis". The Soviet daily - IZVestia also criticized the Soviet press for spreading the false US laboratory origin theory.[23]

The first argument against it is that genetic engineering was not sufficiently advanced to develop such a man-made virus or home-made evil at the time HIV first appear. If one accepts the evidence for AIDS cases as early as 1957 or several years before 1980, it must have been in existence since the mid-1950s. Virologists are

emphatic that even if such a virus could be developed today, the science of genetic engineering in the late 1970s for this to be possible. Thus, virologists take seriously the theory that HIV is not the result of a scientific conspiracy.

So far, there is no substantive evidence whatever that this is where AIDS came from, where there are number of convincing arguments that this origin is unlikely in the extreme. The United States debate over the possible African origin of AIDS has appeared repeatedly in the third world newspapers. However, it is an evidence of racism and a determination to blame Africans. However psychologically comforting it may be, blaming other clearly offers no safety from the AIDS virus.[24] The existing practice of blaming one another has been already seriously hampering the efforts to control AIDS. It is hoped that further research into the "origin", if continued will provide some clues to developing a vaccine against HIV, without which AIDS cannot be eradicated. Such research will also help to resolve the mystery of where this new and unusual virus came from.

The desire to know the origin of HIV/AIDS and its development cannot be suppressed as it may help the scientists and medicinal experts to develop some vaccine to combat the disease. At the same time, accusation and blame which are likely to retard further research and investigation for developing a vaccine need to be given up. We should be more concerned about the prevention and control strategies than become preoccupied with the question "where did AIDS originate".[25] There have been many theories to find out when and where the first case of AIDS occurred though none so far had been proven in practice. However, in theory, it should be possible for us to find out its first origin since the most likely evidence or first and second hand in formations on HIV/AIDS has been made available from many sources

today. Chronologically speaking, there are four main theories or hypothesis for the origin and development of HIV/AIDS.[26] These schools of thoughts have given different opinions and vividly throw varied light on it. Such theories or hypothesis were popularly known as the following: -[27]

1. Isolated community theory;
2. Germ welfare theory;
3. Mutation theory and
4. Green Monkey / Simian theory.

ISOLATED COMMUNITY THEORY: In this theory, AIDS is believed to have been existing for decades and has been developed from an old human disease in a remote region of Africa and limited to small and isolated ethnic groups or population.[28] There are few completely isolated peoples left in the world, mainly in the rain forests of New Guinea, Amazonia, and perhaps central Africa where the possibility and much speculation of the early locations of AIDS was focused with some evidence. They had acquired immunity to it. When it spread outside this group and reached people who had no such immunity, it became a killer disease.[29]

Social mores of those relatively isolated population may not have been conducive to the rapid spread of the disease. The few cases that did develop could likely have escaped detection against the backdrop of multiple life threatening infections that at common in Africa. As to supplement, after the world War - II, the urbanization of Africa was accompanied by social changes and family disruptions, combined with the anonymity of urban life, all of which increased the livelihood of behaviours that contributed to the spread of sexually transmitted diseases.

In time, the prevalence of HIV increased sufficiently to make AIDS visible as a new clinical entity in Africa and elsewhere.[30] Hence, the medical condition which was to be called AIDS began to be noticed in the late 1970s and early 1980s in several widely separated locations, including Belgium, France, Haiti, the United States, Zaire, Zambia, India, Thailand, Philippines etc.[31] During the early stages of the AIDS epidemic the flimsiest evidence was used to blame AIDS on Haitians and African. There has been a strong reaction from African nations to the racism shown in many of these early pronouncements.[32]

GERM WELFARE THEORY: This theory is based on a paper published by three East German Scientists in 1986. This report was taken up by many newspapers that HIV was produced by the American military as a germ welfare agent. But it was strongly denied by the United States government. This theory has been criticized because the technology for genetic engineering did not exist in the early 1970s when HIV was thought to have first started spreading.[33]

MUTATION THEORY: It is impossible to tell in which country that mutation first took place. Viruses are continually changing and 'mutating' into new strains. It seems a highly likely hypothesis that a mutation took place in a virus to produce a new virus with the deadly properties of HIV. Searching through case records it has been suggested that the first recorded cases of HIV infection found have been in a New Orleans teenager who died with strange symptoms in 1969 and in a woman in 1959 from Zaire. However, there were probably additional cases of AIDS in other countries of which we have no knowledge.[34]

SIMIAN/GREEN MONKEY THEORY: This theory holds as being responsible but the scientific arguments against the Simian hypothesis have not

become widely known.[35] A variation of this theory is that the virus was presented in an animal where it did not cause disease and in some way was transferred to humans where it caused disease. There are several diseases that have animal reservoirs such as Lassa fever and Plaque. The animal that has received most attention as a possible source has been the African Green Monkey.

The evidence that appeared to support this is that the virus HIV-2 is genetically similar to a virus called 'Siamian Immuno-Deficiency Virus (SIV)' which was found in some monkeys kept for experiments in a laboratory in California. These were Asian monkeys but the virus could not be found in wild monkeys in their natural habitat in Asia. It was then speculated that they may have caught it from African Green Monkeys who were also kept at that laboratory.[36] Hence, an alternative theory suggests that the African Green Monkey has been singled out as a prime suspect for the original source of the AIDS virus with the hypothesis that somehow the virus mutated and entered the human population when monkeys bite hunters in the attempt to capture them for food (National Academy of Science, 1986b).[37]

Interestingly, there is evidence that SIV could get into humans.[38] For instance; the Green Monkeys from Africa had shared cages with the Macaques in California since AIDS had already appeared in Africa but not in Asia, Kanki and Essex selected wild-caught African Green Monkeys for their research. In 1985, they announced that they had isolated a new virus, which they called STL-3 agm (agm for African Green Monkey), from wild African Green Monkeys which all appeared healthy and unaffected. Later, Kanki and Essex in collaboration with French and Senegal scientists, decided to look for evidence of such infection in Senegal, West Africa. In 1986, this international team announced that all the blood samples they had taken

from apparently healthy Senegalese people contain antibodies which reacted strongly with STLV-3 agm, the virus carried by African Green Monkeys. The virus isolated from these people was named HTLV-4. Thus, an intriguing and plausible theory came into existence.[39]

At least three other groups of scientists in the United States, Germany and Japan say they also have isolated HIV like viruses from African Green Monkeys, although by early 1988 their work had not been publish. Their results have therefore, not been subjected to the scientific scrutiny which eventually discredited the work of Kanki and Essex.[40] In October 1987, before Kanki and Essex's retraction had been published, a leading French virologist Luc Montaigner suggested to be Le Mode: "All these viruses have a common centre, or origin, which remains to be discovered". Thus, the Green Monkey virus STLV-3 agm, which did not seem to cause disease, might be the original source of AIDS. Somehow, it had infected West Africa people changing slightly into HTLV-4, but still not causing any noticeable disease. HTLV-4 then evolved into HIV-2, which causes AIDS, and then HIV-2 evolved into HIV-1, the killer virus linked with AIDS around the world.[41]

However, this is not the case as the original AIDS epidemic is based on HIV-1 and the relatively smaller HIV-2 epidemic only appears later. The reason for doubting the Green Monkey is that SIV is closer to HIV-2 and the theory would predict that HIV-2 would have appeared first. But in contrast, the Simian theory or the African Green Monkey would leave the origin of the original HIV-1 unexplain.[42] HIV-1 is the virus most frequently encountered and causes epidemic all over the world while HIV-2 is found mainly in West Africa and to a much less extend in some other countries. Incidentally, in India serological evidence for HIV-2 has been provided in the

Western and in Southern regions although the virus has not yet been isolated. Anyway, among the various Immuno-Deficiency Viruses there seems to be a closer relationship between the SIV and the HIV.[43]

On the other hand, there is evidence of isolation from a Liberian agricultural worker of an HIV-2 virus that is much more closely related to SIV, than to other HIV-2 strains. Simians' viruses have been obtained from captive monkeys used for laboratory experiments and also from feral monkeys. It was thought that the virus might have been transmitted from Sooty Mangabeys or wild Mandrills, living in the coastal forest belt of West Africa, the areas where HIV-2 is prevalent.[44] Hence, it could have occurred during some fighting among monkeys as they might often scratched and drawn their blood or some accidental leading to bleeding might have occurred.[45] Similarly, eating, hunting, trapping and other sorts of illicit exposure to monkeys may facilitate transfer of virus. Indeed, human being engaging in sexual relationship with animals is not a new phenomenon. Even people from several parts of India have spoken about this practice in rural India. Although this practice is not normally reported, many young people are believed to engage animals such as sheep, goats, buffaloes, cows and dogs for sexual activities. Yet, no incidence of any diseases crossing over from these animals has so far been reported.[46]

In some African countries, for sexual stimulation, the male blood for males and the female monkey blood for females inoculated directly in the public area, in the thighs and back were supposed to have transmitted the monkey virus. Some of these viruses belong to retrovirus and were the so-called slow virus because they take a long time before they manifest themselves as a clinical entity. An important characteristic of Lentiviruses has been their species specificity; this means that the cat virus is likely

to cause disease only in cats and the sheep and horse viruses only in sheep and horses respectively.[47] Thus, we can also get rabies virus from dogs, cats and even from monkeys. Similarly some herpes viruses from monkeys can also infect us. There are a few examples, unusual in the part of Lentiviruses and uncommon which cross the species barrier as is thought at present.[48] Studies on genetic relatedness or scrutiny of phylogenetic trees using computer analysis confirm the possibility of such transmission. In fact, it might have occurred at one point of time. That is to say that the Chimp virus evolving into HIV-1 and the SIV from Sooty Mangabeys or mandrills into HIV-2, could have been a single-time affair.[49]

Among all the monkey business, Sooty Mangabey's appeared to be a potential ancestral candidate, at least for HIV-2. Sooty Mangabey, quite a handsome looking animal may partly be the reason why some people keep these as pets.[50] From the Phylogenetic tree, some workers have considered the Simians viruses as a possible ancestor of SIV and HIV. But African Green Monkeys captured in Kenya and Ethiopia had also yielded a retrovirus termed SIV_{AGM}. These monkeys and wild mandrills from Gabon showed no illness themselves but did carry the virus in the wild.[51]

Incidentally, HIV-2 is not only much less pathogenic; it is shown to be spreading much slower. This is the kind of relationship viruses must like the best as they can survive as long as the infected animals live. The longer they live, the better for the virus. In contrast, the Asian Monkeys (Macaques) seem to suffer from an illness similar to AIDS in human. Consequently, they provide a very useful experimental model for HIV/AIDS (Advances in Immunology 52: 425-474, 1992).[52] With the recognition that the African Green Monkeys are (potential) virus carriers, there

emerged a hypothesis connecting the origin of AIDS with the use of polio vaccine. This vaccine for polio viruses had been derived from the primary kidney cultures of African Green Monkey's.

However, the argument against this hypothesis-polio virus vaccine being contaminated with some SIV retroviruses-is that hundreds of millions of people (mostly children) vaccinated throughout the world have remained free from AIDS.[53] As it so happens, some scientists forwarded a suggestion that the virus and thus AIDS might have entered the human population via direct inoculation of blood containing a malaria parasite from infected Chimpanzees including some Sooty Mangabeys into human prisoner volunteers supposing one of these animals harboured a retrovirus similar to HIV-1 (Chimp SIV_{cp2}) or HIV-2 (Sooty Mangabey SIV), causing AIDS in human.[54]

In an interesting presentation, Charles Gilks proposed this hypothesis. He traced the experiments carried out in 1939 and also in 1954-55. But such hypothesis could linger only as an interesting possibility. The time lapse of 40 to 50 years also seems right but it would be difficult to obtain any evidence in one way or the other.[55] Thus, the scientists in 1988, who thought they had isolated a similar virus to HIV, from wild African Green Monkeys announced they had made a mistake.[56]

So far, almost all studies seem to have been made on HIV strains (both HIV-1 and HIV-2). But a hypothesis is to be based on a solid foundation of scientific facts. It should also explain all that has happened earlier and/or presented scientifically and should not be contrary to any established features and facts. Steve Sternberg report stated that Myers found HIV isolates from Gabon and thus suggested that Gabon could be considered as the epicentre or the source of AIDS in the world. However,

these hypothesis are unlikely to get tested and therefore, anything goes as long as we have some fun [57] Almost any hypothesis, however convincing it may appear, will probably remain untested and therefore, unconfirmed After all, research on how a virus could have originated and how the seemingly new disease syndrome emerged on the global scene might help in understanding other such emerging public health problem [58]

Indeed, AIDS constitutes a variety of clinical signs with objective evidence that can be observed by a physician and a symptom with various physical and mental complaints-reported by the patient It also has a wide range of the so-called AIDS indicator diseases and opportunistic infections and cancers, which start causing diseases only when our natural defense mechanism and immune system function abnormally Hence, nothing definite could be said in one way or the other [59] In these circumstances, retrospective investigations have been carried out on stored Sera and other material which were collected from different countries for an entirely different purpose Some of the other information are available in good quantity and quality yields very useful information For example, in Sera from Africa collected to study viral haemorrhagic fevers at CDC - a sample taken in 1959 from Zaire contained HIV-1 antibodies AIDS was suspected in seaman and his family from Norway in 1960s who died in 1976

Therefore, the earliest case was still considered to be from Africa, until 1990, when the information about a seaman from Manchester, England was published This patient had died in 1959 with an unexplained immuno-deficiency and with some typical opportunistic infections Based on this scanty information, one may assume that AIDS could have started in the 1940s [60] Of course, we cannot categorically say

there were no cases of AIDS earlier because they might have occurred in a scattered way here and there - what we call sporadic cases and therefore, might have gone unrecognized.[61] It seems, the virus has always been presented pre-existent in humans but remained unnoticed and confined to an isolated group of people. But, it might have had an extremely low prevalence or low virulence or both.[62] It is sad but also true that internationally, Haiti became the first developing country to be singled out by international publicity as the possible place of origin of AIDS while some doctors began to suspect that AIDS might have existed for many years, unnoticed in tropical Africa.

Today, however, medical opinion has totally abandoned the idea that AIDS originated in Haiti while it seems very likely that some homosexual tourists from the United States picked up the virus by having sex in Haiti, it seems equally probable, that others also took AIDS in Haiti and left it there. Now, there is also a strong opinion among scientists and others that the AIDS epidemic is as new to the African continent as it is to the rest of the world. A series of serological studies, using sensitive and specific blood tests subject to experienced interpretation have failed to find high prevalence of the AIDS virus in Africa before the mid 1970s, exactly the same situation in United States and Europe. On the evidence available to the date, the theory about AIDS as a disease was more widespread in Africa than it was in the United States and Europe before the 1980s appears to be a premature conclusion reached on the basis of faulty blood tests.[63]

Indeed, AIDS is a disease of civilization resulting from certain changes in human behavioural patterns or changes in the life styles of the people. It does not necessarily have to be sexually transmitted diseases. In the ultimate analysis, human

behaviour factors might have ignited a slow smouldering into a raging life. Rapid urbanization, breakdown of old family systems and values, sexual promiscuity, emancipation of gays (no more fear of the law at least in the Western world), rapid air and other modes of travels, massive use of blood transfusions (especially in African countries), unscrupulous trade in blood or blood products, and selling of organs, indulgence in self-injectable psychedelic drug-all must have participated in fanning the fire. At the same time, the virus must have been good and ready to spread into human.[64]

Of all the myths associated with HIV/AIDS, its origin provokes the most fantastic and contentious theories. Among the more colourful speculation is that HIV came from outer space on a meteoric.[65] In fact, in a broader sense, the natural history does not just begin with its infection and end with the death of the ailed person. To an extent, the problem behaviours of HIV disease and the emotional and economic trauma left after the expiry of the patient may also be considered as the end stage of it.[66] In order to have a better understanding or various reasons on HIV/AIDS development and its origin, classification and staging of the disease have been needed for persons dealing with AIDS patients.

Several terms and classification systems for HIV infection have been described (CDC, 1982). Among other reasons for staging HIV infection, the most important of which is management of patients with timely medical therapy and public health projections all over the world.[67] As the epidemic evolves, more of the previously asymptomatic people become ill, and also more non-infected people will become infected. This drastic change prompts us what people is going to face in near future if

attempts are not made to slow down the speed of the virus by changing the life style and risky behaviours of the people.[68]

B. How the disease / Virus Effects

The surface of HIV/AIDS is specially shaped but the clinical signs vary according to the germ responsible and the organ it affects. As such, the longer we study HIV/AIDS, the more we understand the progress of the diseases/virus and its effects. Thus, it is important to note that not every HIV infected person goes through each stage and the timing of his or her appearance differs from person to person, and also the opportunistic infection differs from patient to patient. Indeed, the rate of profession in Asia is unclear because AIDS was found here only a few years ago and the survival period greatly depends on the quality of public sanitation, housing, health care support and nutrition. So in India and in other parts of Asia, survival is likely to be short.[69] It is likely that the infected cells in semen or vaginal fluids are the main source of HIV transmission during sex. Since then, each cell infected by HIV/AIDS becomes a biological time-bomb travelling in the blood stream. At this point of time, the effect of the virus is finally revealed into hundreds of thousands or millions waiting to explode.

Since then, infected white blood cells become factories for more viruses, instead of factories to help the body make antibodies. Yet the trouble is that despite our modern science and technology, it is almost impossible to detect an infected cell. They look identical from the outside until they are dying. They were something that does not breath, does not need food, does not live but never dies; yet rapidly multiplying into hundreds of thousands and thousands of millions. These infections are nightmare for doctors and patients. The germs may be hiding deep in a lung or

hiding in the fluid covering the brain and the spinal cord or hiding in the brain cell Thus, HIV/AIDS can hide anywhere and generally get infection to the chest, lungs, nucleus or brain cells and most commonly to the skin Such a strange germ is silent victim, unnoticed, unrecorded and incredibly rare except in AIDS [70]

As the disease/virus progresses, the person develops other conditions and problems related to HIV/AIDS such as simple boil, warts, mouth sores, or red skin, herpes, cough, fever, headache, giddiness and may feel overwhelmingly tired all the time, have high temperature, night sweats, weight loss, strange infection of diarrhea and sometimes damage of heart organs Yet no other cause is found and blood test will usually be positive called ARC (AIDS Related Complex) The damage happens gradually and they develop difficulties in thinking, difficulties in co-ordination balance and moving, and changes in behaviour As a consequence, they will be violently sick and becomes confused, forgetful and cannot even remember a telephone number for two seconds but aware of his shortcomings They will get up in the night, feel ill and tired and asked for breakfast Good friends, team of nurses and volunteers manages and has to put back to the bed [71]

The reason is quite obvious A very small number of HIV/AIDS can damage many parts of the body, but the brain in particular and its victims causing dementia Brain cell are destroyed resulting in progressive loss of memory, impaired thought processes, personality change and sometimes incontinence or in a state of inconsistency Such serenity requires constant care while the victim lives [72] Some patients from home care gradually become more unwell and were fighting breadth and also have become frightened They were readmitted to Hospital, despite their therapies and dies within or after a stipulated time Contradictorily HIV/AIDS can

develop differently in children Some children seems able to live with HIV infection for years, and children who later test negative may still carry HIV If first infected in the womb, the child may regard HIV as part itself and not react to it [73]

Similarly, a five years old Los Angeles boy who at birth was infected with the HIV virus has now been declare virus-free, according to a study by the University of California at Los Angeles (UCLA) According to Yvonne J Bryson, the principal researcher of the study and a pediatrician and member of UCLA AIDS Institute, tests showed that the boy was HIV positive for at least a month during his first two months of life But later test found no sign of the virus Bryson believes it is the first well-documented case of an HIV-infected infant somehow eliminating the virus from his body by his first birthday without any medical intervention Surprised doctors could offer no examination but they are studying the unidentified bodies immune system for clues that could help others afflicted with the deadly virus [74]

C. High-risk and Low-Risk Group Behaviour

Undoubtedly, we have heard a lot about the infection of HIV/AIDS and its consequences No wonder we might be confused or frightened about the chance of getting this dreaded disease The truth is that there is not only any mystery about it Today we know exactly how this infection is spread from person to person and how it is not spread We also know exactly which people are most likely to get it and which people are not [75] In many advanced countries, people living with HIV are that potentially society's most effective AIDS campaigners, educators, counselors and care givers Even without publicly declaring their HIV positive status, they can contribute their unique valuable insights to AIDS prevention programmes and self-help care and

support groups. If they feel able to declare their HIV positive status openly, the impact of their work can be even greater.[76] However; most people in India who know themselves to be HIV positive are reluctant to join a support organization because they are afraid this will result in their HIV positive status becoming known.

Thus, they remain cut-off from the information, care, counselling and support they need, and may be more likely to be continued practising high-risk behaviour. In other words, infected people with HIV and undergoing treatment continued to be engaged in high-risk behaviour such as sex without condoms, sharing of needles/syringes/infected piercing instruments.[77] Generally, the pattern of sexual behaviour, injecting drugs use, rural-urban migration etc has had a particular impact on HIV/AIDS. The epidemic will exact a terrible tool of pain, suffering and grief on individuals, families and communities not only in India, but throughout the whole of the human family worldwide.[78]

In the western world, many citizens of the so-called 'mainstream general (heterosexual) population,' lay people and politicians alike consider the disease self-inflicted. And no significant causes of heterosexual transmission were documented, many people including decision-makers, did not feel concerned. They did not care. Thus, the largest numbers of AIDS cases in the western are till homosexual and bisexual males and intravenous drugs users. By and large society rejects these forms of behaviour and consumption. This rejection takes on different forms, including negative feeling in face to face contact.[79]

In India, AIDS is still a virtually invisible epidemic. Some have overcome this problem by focusing on the widespread and readily acknowledged problems of STDs. Any forms of safer sexual behaviour such as abstinence, mutual fidelity, condom use,

non-penetrative sex were also an effective form of HIV/AIDS prevention. However, the many Indian NGOs vary enormously in their purposes, objectives, size, strategies, geographical scope and area of activity. Thus in most cases, some staffs of the NGOs were initially unconvinced of the importance of HIV/AIDS as a health and development issue in India, others were reluctant to discuss sensitive issues such as sexual behaviour, or nervous about distributing condoms and demonstrating their use in public. Some were uneasy to combat discrimination and also working with stigmatized groups such as women in prostitution, homosexual men and injecting drug users. At community level, staffs faced the problem of how to convince people of the need for behavioural change for their lives and protecting their health.[80] Thus AIDS problem had been a twin problem among the group behaviour.

In general, there are high-risks and low-risks group behaviour which may be briefly discussed with the following example as under:-

High-Risk Group Behaviour

The activity of having sex under the influence of intoxicants were a high risk because one cannot be sure whether condoms are used in the first place or used properly in the event of the person remembering to use one. However, it would be of no risk if it is between two uninfected partners. The activity of buying blood from a commercial blood donor is a high risk since the behavioural patterns of the commercial blood donors are not always known and it is possible that the screening of blood might not indicate the presence of HIV. The activity of having many sexual partners is definitely a high risk as more number of partners increases the possibility of acquiring HIV. Over 80-90% of the HIV transmission in the country takes place through sexual contact. The activity of liberated girls on oral pills is a high risk as oral

pills are no protection against HIV/AIDS/STDs. Also the liberated girls do not insist on condoms. The activity of HIV infected person wanting to have a child is a high-risk behaviour as the person may transmit HIV to his or her child as well as the spouse, since usage of condom is ruled out in this case. Moreover, the chances of the child becoming an orphan are high. The activity of having sex with a neighbour without a condom is a high risk as no one can be guaranteed to be HIV free, even if it is your neighbour.

The activity of having sex with a truck driver and with an expensive call girl (commercial sex worker) is a high-risk behaviour. HIV does not differentiate according to the economic status. It is the behaviour that exposes you to risk. The activity of anal sex is a high-risk behaviour. This type of intercourse involves the rectum, thin, easily and richly supplied with blood vessels, which is not naturally designed for sex. During such an act the possibility of wear and tear is great which provides for an opportunity for the virus to enter the body easily. The activity of using vaseline/hair oil for lubricating a condom is a high-risk behaviour. Condoms are made up of latex rubber. Any oil-based lubricant chemically reacts on this rubber and may make microscopic holes, which are enough for HIV to pass through; only water-based lubricants should be used. Lubricated condoms contains enough qualities of lubricants however, one could use saliva if more lubrication is required. The activity of using condom only with wife and not other is a high-risk behaviour. It will only reduce the possibility of your wife not getting the infection or passing it on to you.

You may still acquire the HIV virus from others. The activity of sharing needles/syringes/infected piercing instruments with a group of injecting drug users is a high risk behaviour. The practices of such will increase the chances of HIV

transmission as they can contain minute amounts of blood which may have the HIV virus. The activity of breast-feeding is a high-risk behaviour since mothers can pass HIV to their babies through breast milk. HIV is transmitted through the exchange of blood and blood products or through body fluids.

Low-Risk Group Behaviour

The activity of having an injection is a low risk if the needles/syringes are sterilized. The chances of infection through tattoo needles/syringes are very low but one must not eliminate the chances of infections, especially in a group situation. The activity of caring for someone who has HIV/AIDS is a low risk behaviour. HIV/AIDS can not be transmitted by casual contact or by caring the helpless or the infected patient. The activity of hugging or kissing or deep kissing is not a high risk behaviour as long as both of them are not bleeding in the mouth or have deep cuts or wounds. However, it should be remembered that there is very little HIV in saliva.[81] The activity of oral sex is a low risk behaviour. The chance of HIV transmission is low.

Even in such a situation the use of a condom is advocated. However, taking infected vaginal fluid or semen into the mouth of a man or woman is the riskiest kind of oral sex. The risk for HIV infection during oral sex is due to HIV being absorbed by the mucous membranes of the mouth or through a sore or other opening.[82] The activity of using public latrine/bathroom/urinal/telephone etc is a low risk behaviour since these casual contact cannot transmit or pass HIV/AIDS to others.

Being bitten by mosquito that has bitten someone with HIV is a low risk or no risk. There has been no documented proof of HIV transmission by mosquitoes. Mosquitoes only suck blood and do not inject blood. HIV is a human virus and cannot

live in the body of a mosquito.The activity of blood donation is a low risk behaviour since donating blood does not cause transmission of HIV. The blood collecting bags are disposable and sterilized and most of them were kept in the blood bank. The youth should come forward and donate blood as it decreases the dependence on professional blood donors. With increase in voluntary blood donation, more amount of HIV tested blood would be available at the blood banks which can be used in emergency situation.[83] Nevertheless, in many countries drug users are badly infected, others prostitutes and sex industry workers; and in other countries, homosexuals.

Yet the number of people not in a "high risk group" who acquired HIV from heterosexual intercourse is growing very fast. So rather than talk about high-risk group it is far better to talk about high-risk practices, sexual or otherwise.[84] It is well recognized that disadvantaged and marginalised group such as low-income woman, migrant workers, refugees, injecting drug users, sex workers etc are most vulnerable to HIV. Many millions of Indian women are at high risk of becoming infected with HIV through their husbands, who are likely to have other sexual partners while working away from home. Even after marriage, it is not unusual for men to have sexual partners other than their wives.[85]

In contrary, growing numbers of Indian women who have had sex only with their husbands are now being infected with HIV. In Pune, a study in 1994 found that 14% of married women with STDs- none of whom reported sexual contacts outside their marriages- were HIV positive. A considerable number of family women also sold sex without the knowledge of their families. They do so out of dire poverty or to supplement the family's meager income.[86] Thus, until people feel the desire to protect themselves and empowering themselves to change their behaviour, simply providing

informations and services will only make a little difference to the spread of HIV/AIDS Increasing numbers of pregnant women are testing positive for HIV For example, at the HIV Sentinel Surveillance centre in Salem district, Tamil Nadu, HIV prevalence among pregnant women rose from 0 1% in September 1994 to 0 9% in October 1995 [87]

Similarly in a recent report of Churachandpur district in Manipur, the weekly Frontier Weekend said that about 460 people have since died in Churachandpur due to AIDS and its related diseases and the figure is rising There are about 241 children who have been orphaned and 102women were also said widowed because of the disease The report also said that there may be about 90-100 sex workers within the town besides the call-girls Thus, AIDS related deaths occur almost on a daily basis Director of SHALOM, Chuarachandpur, Rev (Dr) V L Muana said that the problem is inseparably tied with poverty and unemployment and urged against attacking stigma (socio-economic) issue on the infected persons [88]

More importantly, it is interesting to note that women are at a greater risk for getting HIV/AIDS than the man The reason is quite obvious HIV exists in vaginal fluids and the mucous membrances that line the vagina, rich with blood vessels and cells can be easily infected with HIV When having sex during menstrual period, semen can also carry the highest amount of HIV being found in infected blood and the mucous lining of the vaginal provides a large surface for HIV infection during vaginal intercourse This can be twice or even 10 times as likely when compared with risk from women to men However, it does not mean that men are at low risk [89]

It is worth remembering that safe sex is a health issue and a right-not a moral judgement on any one's behaviour. Thus, certain factors need to be weight up against possible risks. Such were related to the following:-

(a) You can say, "Sorry, no condom, no sex."

(b) I would be happier if you use a condom.

(c) I have made the decision to practice safer sex.

(d) You can say, "Sorry, no sex during menstruation."

(e) You can say, "No risk behaviour to avoid AIDS."

Though women are at a greater risk, women can take their own time to know their partner and to collect accurate information about sexual intercourse, contraception, HIV and STDs. Only then women can be at risk or no risk behaviour.

Women at risk behaviour

1. Having multiple sex partners.
2. Having sex with a person who has multiple sex partners.
3. Sharing unsterilised needles and syringes.
4. Getting untested blood transfusion.
5. Having sex with a person who is an injecting drug user.

Women at no risk behaviour

1. Abstinence from sexual contact before marriage.
2. Sex with one uninfected and faithful partner.
3. Use of condom in sexual relationship.
4. Not sharing of used needles and syringes.
5. HIV free blood transfusion. [90]

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CHAPTER- IV

SOCIAL DIMENSION OF HIV/AIDS IN CHURACHANDPUR DISTRICT OF MANIPUR

General background of the respondents

For the study of the present problems of social dimension of HIV/AIDS in Churachandpur district of Manipur, a total sample of 100 respondents was selected following the random sampling techniques from various backgrounds and the studies also include the government or non-governmental organizations or agencies run by different people in Churachandpur district; where drug injectors along with the non-injecting drugs users are kept as inmates irrespective of their caste, tribes and locations. To guide the present study, great care is also taken in the protection of the personal identity of the respondents. The purpose of the present study and potential risk were explained explicitly to the respondents besides confidentiality of their characteristics and their private life history was ensured.

Moreover, assurance was given not to cause harm to the respondents due to the present research work. To achieve these goals, a verbal informed consent was taken from each of the respondents. Sensitive data are agreed upon to protect with great confidentiality. For the qualitative data, face to face (or vis-avis) interview and silent observation techniques were employed to understand the networking activities of IDUs, CSWs, call-girls, etc. Furthermore, recall method was also employed to collect

retrospective data on the past history of risk bahaviour in an attempt to establish the nearest truth on AIDS issues.

But for the quantitative data, socio-economic and demographic variables are employed to understand the general background of the respondents such as age, sex, occupations, educational qualifications and also information regarding personal and family income and sociological factors like marital status and demographic information such as residential or place of birth (rural/urban), religion and social involvement and ethnic language spoken etc were also investigated or included in the study.

Table No.1: Age, Sex and Occupations of the Respondents

Age	Sex			Occupations			
	Male	Femal e	Total	Cultivator	Govt. Servant	Others	Total
15 – 20	06	01	7	01	01	05	7
21 – 25	10	02	12	00	03	09	12
26 – 30	10	04	14	00	04	10	14
31 – 35	10	06	16	01	03	12	16
36 – 40	10	03	13	02	04	07	13
41 – 45	10	02	12	01	05	06	12
46 – 50	10	01	11	00	04	07	11
51 – 55	10	00	10	00	02	08	10
56 - 60	05	00	05	00	02	03	05
Total	81	19	**100**	05	28	67	**100**

Source: Field Work by the Author, April -June 2007, June-August 2008.

As shown above in table 1, altogether we have 100 respondents with age ranging from 15 to 60 years of age. They are grouped into nine categories according to their age groups. It is seen that 7% of the respondents belongs to 15 – 20 age group whereas 12% of the respondents belongs to 21–25 age group, 14% belongs to 26-30 age group, 16% belongs to 31-35 age group,13% belongs to 36-40 age group,12% belongs to 41-45 age group,11% belongs to 46-50 age group, 10% belongs to 51-55 age group and

the rest 5% belongs to 56 – 60 years of age group. Therefore, the above data indicates that majority of the respondents are below 50 – 60 years of age. Besides, it is seen that male respondents out numbered the female respondents. Our data also showed us that 5% of our respondents are cultivator, 28% of them are Government servants or employee and the rest 67 % of our respondents are involved in different types of professions and occupations. Most of them were well educated and were also persons of different background, personalities and professions such as doctors, social workers, pastors, intellectuals, counselours, NGOs staffs, their clients and so on.

Table2. Respondents' educational qualification, monthly income & marital status

Age	Educational qualification				Monthly income			Marital status		
	Literate Class1to10+2	Graduate BA,BSC, etc	Post-Graduate& above	Total	Self below Rs5000	Family above Rs5000	Total	Married	Single	Total
15 –20	04	03	00	07	02	05	07	01	06	07
21 –25	03	08	01	12	05	07	12	03	09	12
26 –30	04	07	03	14	04	10	14	05	09	14
31 –35	04	05	07	16	06	10	16	09	07	16
36 –40	04	05	04	13	03	10	13	08	05	13
41 –45	02	07	03	12	02	10	12	09	03	12
46 –50	03	06	02	11	02	09	11	10	01	11
51 –55	01	04	05	10	01	09	10	10	00	10
56 -60	00	03	02	05	01	04	05	05	00	05
Total	25	48	27	**100**	30	70	**100**	60	40	**100**

Source: Field Work by the Author, April -June 2007, June-August 2008.

The above data table 2 showed us that 25% of our respondents are literate ranging from class I to10+2, 48% of them are Graduate and the rest 27 % of them are Post-Graduate and above. Our data also indicates that 30% of our respondents have monthly income of self below Rs 5000 whereas 70% of our respondents are having a family

income of Rs5000 above and so on Furthermore, our data shows us that 60 % of our respondents are married persons and the rest 40 % of the respondents are still remaining unmarried or single

Table 3 Religion and social involvement of the respondents

Age	Religion of the respondents					Social involvement of the respondents			
	Christian	Hindu	Islam	Others	Total	Social worker	Games & sports	Others	Total
15 – 20	07	00	00	00	07	00	05	02	07
21 – 25	12	00	00	00	12	00	08	04	12
26 – 30	13	01	00	00	14	02	05	07	14
31 – 35	14	00	01	01	16	03	04	09	16
36 – 40	12	01	00	01	14	04	01	09	14
41 – 45	10	01	00	01	12	05	00	07	12
46 – 50	10	00	01	00	11	07	00	04	11
51 – 55	10	00	00	00	10	03	00	07	10
56 - 60	05	00	00	00	05	01	00	04	05
Total	92	03	02	03	100	25	23	52	100

Source Field Work by the Author April -June 2007 June-August 2008

The above table 3 of the data shows us that the respondents are involved in religious activities and were from different religious background and community and embracing different religion such as Christianity, Hinduism and Islam and so on Thus, our data makes it clear that 92 % of the respondents are Christian, 3 % of them are Hindu and 2% of them are Islam and the rest 3% of them are belonging to other groups of religions The data of table 3 also figured out that 25 % of our respondents are social workers, 23% of them are involved in Games and sports and the rest 52% of them are involved in other activities

Table 4: Respondents place of birth and language spoken

Age	Place of birth			Language spoken			
	Rural	Urban	Total	Local dialects Zo/Chikim	Hindi	Manipuri	Total
15 – 20	02	05	07	07	00	00	07
21 – 25	04	08	12	12	00	00	12
26 – 30	05	09	14	13	01	00	14
31 – 35	07	09	16	15	00	01	16
36 – 40	06	07	13	11	01	01	13
41 – 45	10	02	12	10	01	01	12
46 – 50	08	03	11	11	00	00	11
51 – 55	07	03	10	09	00	01	10
56 - 60	03	02	05	05	00	00	05
Total	52	48	**100**	93	03	04	100

Source: Field Work by the Author, April -June 2007, June-August 2008.

The above table 4 of the data shows us that we categorize our respondents in terms of place of birth as rural and urban. Thus we see that 52% of our respondents birthplaces are from the rural areas whereas 48% of them are belonging to urban areas. It is not surprising that some of our respondents migrated from rural to urban areas due to easy means of communications, health, education, medical and other facilities in and around town and cities.

The data table 4 shows us that 93% are local language or dialect speakers whereas Hindi speaker are only 3% and the rest 4% of our respondents are Meitei speaker. The local dialect has been noted as Chin/Kuki/Mizo/Zomi languages or dialects or more commonly as Zo/Chikim languages or dialects. The data indicates that the highest percentages of our respondents are from rural areas and they could easily pick up the local languages or dialects. It is quite a surprising thing from our respondents that they

have no problem in communicating to each other as more than 90% of them could pick up most of the local language or dialects spoken in the district.

Causes of HIV/AIDS

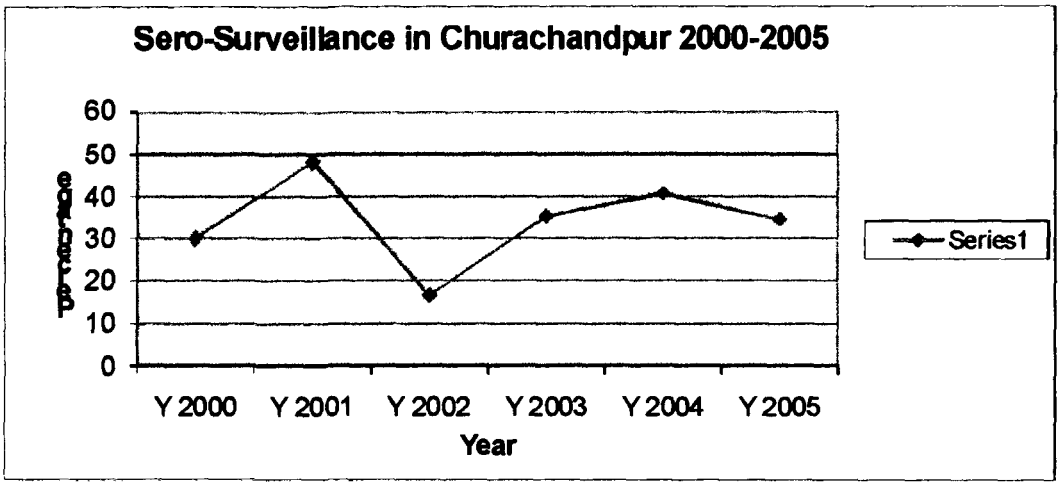
HIV/AIDS is a massive killer disease of young people. Unfortunately this commonplace observation has a special significance in Churachandpur district of Manipur. The virus spread to Churachandpur district in the early 1990s; and it has already taken its toll of over 480 lives[1]. As of November 2007, the minimalist official figure of deaths due to AIDS for Manipur is still as high as 608. The first case of HIV infection in Manipur was detected by MACS in 1990 from the blood samples of a group of six injecting drug users[2]. Though undetected till then, HIV must have already spread to Manipur by the 1980s. It is difficult to arrive at the exact figure of People Living with HIV/AIDS (PLWHA) in Churachandpur district. As of January 2008, the official statistics released by Manipur AIDS Control Society put the accumulative figure of persons living with HIV/AIDS at 1,899 for Churachandpur district. But Dr. Vum Chin Pau[3], the District AIDS Officer, reveals that the number of clients on Anti-retroviral Therapy (ART) at the state-funded District Hospital is 1,069 and another 1355 at MSF, Churachandpur, till June 2008. This adds up to 2,424 infected persons.

Manipur State AIDS Control Society has been monitoring the growth rate of HIV infection in Churachandpur district for many years. In 2000, of the 186 blood samples, 56 tested positive (30.1%); in 2001, 42 tested positive out of 87 samples (48.2%); in 2002, 50 tested positive out of 296 (16.8%); in 2003, 70 tested positive out of 198 samples

(35.3%); in 2004, 271 tested positive out of 664 (40.8%); and in 2005, 52 tested positive out of 150 blood samples (34.6%)[4].

A graphic representation of the rate of HIV/AIDS infection in Churachandpur district is provided below:-

Figure 1: Sero-Surveillance in Churachandpur district



Meanwhile, the HIV infection route is reported to have shifted from IDUs to the sexual route. In 1997, infection through the IDU route accounts for 76% and this has came down to 19.8% by the year 2006 (Dr.Pau 2008: 5).

The seriousness of sexual route transmission is measured by a limitation in sentinel surveillance conducted every year with pregnant women in antenatal clinics in Government hospitals. This shifting trend in the transmission route has been confirmed by the results of my field work. In a questionnaire about the riskiest group for HIV infection in Churachandpur district, 30% of the respondents identified drug users

(including IDU) as the riskiest group. Nevertheless, the riskiest group for 70% of the respondents remains people associated with the sex trade – Commercial Sex Workers (CSWs),drivers, migrants, etc. (see Table 1 below). While 30% of the respondents grouped drug users as the riskiest group, 25% of them considered sex worker as the riskiest, and yet another 20% identified promiscuity as the riskiest factor. These figures are collected only for Churachandpur district; but they are broadly similar with the official statistics of MACS[5] for the entire state of Manipur from September 1986 – November 2007. According to MACS, IDUs constitute 43.24% out of the total HIV positives in the state, and the heterosexually promiscuous persons consist of 29.17% of the total HIV positive population.

Table 1: Causes of HIV/AIDS in Churachandpur district of Manipur

SL No.	The riskiest group for HIV/AIDS infection	Frequency
1	Drug users	10
2	Intravenous Drug Users (IDUs)	20
3	Call girls	04
4	Commercial Sex Workers (CSWs)	25
5	Truck drivers	01
6	Auto drivers	01
7	Homosexuals	01
8	Lesbians	00
9	Bisexuals	08
10	Immigrants	10
11	Promiscuity	20
12	Others	00

Source: Field Work by the Author, April-June 2007, June-August 2008.

A sociological enquiry into the issue will be able to throw some light on how HIV infection recently follows the sexual route in the 'hill society' of Churachandpur district. This approach considers the social behaviour and practices of the people living in an age of global media. Previous research by Kapur and Mukhopadhya (1995) rightly observed

that "AIDS in Manipur is not a medical problem alone but a psycho-socio-developmental problem also" (p. 63). Based on focus group discussion with youth and drug users, Kapur and Mukhopadhya suggested linkages between the problems of youth unemployment, insurgency, peer pressure, weak family support and drug abuse. In other words, the spread of HIV/AIDS relates to the issue of overall socio-economic development in Manipur.

The sexual transmission route of HIV lies at the intersection of obscene media, permissive society, drug trade, sex trade and gun trade. The tribal Christian communities of the district have a fairly long tradition of night life associated with the local church and voluntary organizations. Song practice, choral practice and condolence meeting routinely take place till late night – sometimes throughout the night.

Moreover, the annual harvest *Kut* festival in Manipur has been reduced to a night-time celebration involving the widest kind of public partying. Under the cover of night and the influence of alcohol, such an event increases the risk of unprotected sex through which HIV may be transmitted. These community activities used to serve useful *social functions*; and one may argue, they still *do* today. However, many respondents suspect that these traditional practices have been abused. Whereas 60% of the respondents disapproved of social and religious activities at night, only 40% show great concern on funeral get-together at night (See Table 2). Given the unpopularity of condom use, the night life involved in traditional practices might have facilitated the spread of HIV through the sexual route in Churachandpur district.

Unregulated electronic media is not conducive to cultivation of self-restraint and abstinence. In Churachandpur, video parlours somehow came to be associated with promiscuity among the youngsters. Morally supported by pseudo-nationalist speech and evangelical morality, militants of Manipur imposed a *bandh* on mainstream Hindi cinema, which was considered too obscene and lewd. This move ironically resulted in a boom for video parlours. Since it was difficult to regulate the small screen video, the new parlours took to screening of pornographic films. These cheap shows implicitly sell very unconventional views on sex and sexuality. Then 55% of the respondents indicated the local video parlours in Churachandpur may have contributed to the spread of HIV through the sexual route (see Table 2).

Mobility of goods and people is a welcome change. Yet it has disorienting and de-stabilizing effects on the fabric of a tribal society. Due to its geographical location, Churachandpur lies on a porous Indo-Myanmar border. Illegal arms trade, drug traffic, immigrants and insurgents run the show. They all enjoyed mobility of movement comparable to automobile drivers and personnel of Indian defence establishment – the army, *sepoys* and paramilitary forces. In Churachandpur, most sex workers are found to be drug users originally generated by the drug trade across the border. Then defence personnel, who arrived here in pursuit of ever-moving militants, become the greatest patrons of the local sex trade. It is, therefore, multiplied by the activities of client-patron relationships.

Table 2: Causes of HIV/AIDS in Churachandpur district of Manipur

	Yes	No
Youth programmes, social and religious activities at night	60	40
Cable TV, video parlour, movies, lotteries and gambling	55	45
Regular participation at village/town/church activities: song practice, condolence meeting at night	54	46
Negligence & ill-treatment of HIV/AIDS patients	65	35
Law and order problem due to insurgency and militancy	45	55
Personnel of state police/ national security: sepoys, infantry and army	52	48
Poor quality of HIV/AIDS counselling, education and awareness programmes by the Government and the NGOs	54	46
Lack of HIV/AIDS screening centre; sanitary hygiene in hospitals, clinics, vaccination, blood bank, child birth, etc.	53	47
Possible reasons for the failure of parents to protect their children from the danger of HIV/AIDS suggested by the respondents.		

Source: Field Work by the Author, April -June 2007, June-August 2008.

In fact, majority of the respondents (60%) strongly believed that youth programmes, social and religious activities at night are a contributing factor for the spread of HIV/AIDS in the district which are generally occasion for the youth to misuse to satisfy their whimsical desire whereas less than half of the respondents (40%) disagree and are of the view that these groups in no way spread HIV/AIDS if they are disciplined and these factors are not related to spreading of HIV/AIDS.

More than half of the respondents (55 %) agree that Cable, Television, Video Parlours, movies or Lotteries and gambling contribute for the spread of HIV/AIDS in the district since all these demoralize the life of the people and advertise sexual activities or immoral practices and misbehaviour among the youth in particular since they are outside parental control- feel free and seek their own pleasure thereby leading to the

spread of HIV/AIDS and are more exposed to multiple sex partners. Parents are unable to control their children because peer pressure is stronger at the fire of the youth than that of the parents. Besides, the whole Churachandpur district lives is a typical free society of tribalism indirectly influenced by other culture and it is promoting spread of HIV/AIDS whereas(45%) of the respondents feels that these are not related to spreading of HIV/AIDS.

More than half of the respondents (54 %) asserted that regular participation at village or town or church activities such as song practice, condolence meeting etc at night are also a contributing factor for the spread of HIV/AIDS in the district whereas less than half of the respondents (46%) say that these groups in no way spread HIV/AIDS and these activities are only for service to God and men and not related to spreading of HIV/AIDS in the district.

Overwhelming majority of the respondents (65%) feel that negligence and ill-treatment of HIV/AIDS patients is unknown in the district today as the head of the district (Deputy Commissioner), NGOs etc concerns their problems and tries their best for their relief but less than half of the respondents (35%) advocated that negligence and ill-treatment of HIV/AIDS patients are well known facts that many a time their needs are not met and the service of health and medical services of Government and NGOs are for profit or monitory gain.

Overwhelming majority of the respondents (55%) advocated that insurgency and militancy have their own goal and rather prevent drinking, drug trafficking, prostitutions etc in order to control the wide spread of HIV/AIDS in the district, whereas (45%) of the

respondents feel that insurgency and militancy also contribute to the spread of HIV/AIDS as they were indirectly promoting social imbalance and lawlessness in the district to increase their side income.

Overwhelming majority of the respondents (52%) disagree and are of the view that personnel of state police or national security such as sepoys, infantry and army are well disciplined and are believed to be better aware and better informed, though they are suspected to be one of the contributing factors for the spread of HIV/AIDS in the district whereas (48%) of the respondents feels that they are also contributing factors to the spread of HIV/AIDS in the district.

Majority of the respondents (54%) disagree and are of the view that poor quality of HIV/AIDS counseling, education and awareness programmes by the Government and the NGOs are just for duty sake and their value system and their approach on the issues of HIV/AIDS are totally guided by fiscal thing and quite unsatisfactory though some awareness campaign benefit some people and reach some of the rural poor in the district whereas (46%) of the respondents agree and feel that their rapid intervention and care project minimized the harm and the worse growth rate of HIV/AIDS in the district.

Overwhelming majority of the respondents (53%) disagree and feel that lack of HIV/AIDS screening centre; sanitary hygiene in hospitals, clinics, vaccination, blood bank, child birth etc does not contribute to the spread of HIV/AIDS in the district whereas (47%) of the respondents agree and feel that they contribute to the spread of HIV/AIDS and conceal in the district.

In fact, the possible reasons for the failure of parents to protect their own children from the danger of HIV/AIDS in Churachandpur district as suggested by the respondents may further be mentioned as follows:-

1. Negligence of children at an early age largely resulted in the production of family and society that lacks dynamic Christian principles.

2. Peer pressure among teenagers has been found stronger than parental influences upon them, resulting in the general disobedience of children to parental control.

3. Curiosity and the easy availability of illegal drugs, drinks and sex partners in the market place, made worse by the easy accessibility of pornographic movies to minors makes unguarded children susceptible to drug abuse.

4. Parents' neglect of their children forfeit them the chance to strictly discipline their children when they go astray.

5. The ever-increasing basic needs and demands of modern life upon children are not met by some irresponsible parents.

6. Excessive liberal social behaviour among most tribal societies can lead to the breakdown of social control, leading to anomic conditions in the society. In such a norm less state, the youth remains directionless and hence fell victim to drugs and other bad habits.

7. Lack of knowledge about HIV/AIDS and its consequences are rampant in the district, side by side with the unchecked HIV/AIDS infected persons roaming the streets freely.

8. Lack of parental teaching about traditional and modern values among children. Generation gap between 'outdated' parents and modernized children can cause

communication breakdown unless parents keep themselves abridge of the contemporary values and practices.

9. Social workers and religious leaders are lacking up-to-date knowledge to help meet parental needs in guiding their respective children to become good citizens or morally upright persons.

10. Lack of free and frank education on sex or HIV/AIDS. Many parents find it difficult to break the ice when it comes to talking about sex-related issues to their children.

11. Under-supervised social responsibilities and obligations in the society and the church become the breeding ground for social misfits.

Some of the other main causes of the spreading of HIV/AIDS in Churachandpur district as suggested by the expertise may also be mentioned below:-

1. Some of the wrong notion or view of the AIDS victimized was that discharging of AIDS virus through masturbation and or passing the virus to others might relief themselves from HIV/AIDS. Hence, the wrong notions by the infected that infecting others may always reduce or cleanse HIV in them.

2. Encouragement of infected person to infect others by those affected with AIDS menace or promise of incentive (reward) to infected person by others has rampant practice in the district.

3. Some of the HIV/AIDS infected persons have the desire to infect other and neglect condom use. Hence, HIV/AIDS infection is still prevalent at large in the district.

4. Drug addiction is one of the most burning problem not only in Churachandpur district but also a problem of each one and everyone in the world today. The rate of

addictions in every society, particularly in younger generation is alarming us. Hence, some serious and sincere thoughts should be given for controlling and checking out a plan of action for immediate relief or de-addiction. 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, women become virtual slaves to both the drug itself and the sex dealers. Perhaps, these were the major source to support her habit when nothing more could be stolen in the family. Besides, some addicted persons also drugged minor boys and girls in order to stimulate them to do what they desired. Then several minor girls are exploited through drugs and continue on illicit drugs and were also lured into call-girls or prostitutions. Hence, drug addiction, call girls and prostitutions are closely linked.

Indeed, prostitution is a hard work both in physical and emotional terms, still it is not surprising that quite a number of call-girls use one kind of drugs or another because drug dependent call-girls can take more clients than other prostitutes for earning a large amount of money to support a habit. Then they forced themselves almost on everymen in the secret place or room and accidentally become infected with HIV/AIDS when sex dealers or regular clients or someone else totally ignored the use of contraceptive devices or condoms. Unlike other call girls, most of the call girls in Churachandpur district are not from a well to do family or an elite group but hailed from a middle class or a classless family background. These call girls operate in secret and men with wealth go in more and more due to the secrecy involves. Nevertheless, some of these call girls are educated, sophisticated and aristocratic type who are smartly dressed and mix freely in society.

These call girls rarely entertain customers in their own living place. They arrange their assignments or engagements through direct contacts or through direct telephones, mobiles or agents or pimps and operate in hotels, circuits and guest-houses etc and give company to politicians, government officers, contractors etc who take them out for evening or week ends. Hence appeared that it is not economic factor alone that influences one to operate as a call-girl (Interview with Dr. Muanna, Director, Shalom, Churachandpur, Manipur: 2/6/2007).

Socio-economic impact of HIV/AIDS in Churachandpur district

The tribal Christian communities of the Churachandpur district of Manipur have a fairly long tradition of night life associated with the local church and voluntary organizations. Nevertheless, some of the church leaders conduct Crusade to reform HIV/AIDS. Since it is a very sensitive issue covering even private life and so people do not talk about it openly. But till then the researcher can feel it from the observations based on the questionnaire and the field study. So the conclusion is obvious. As some of the church leaders conduct Crusade to reform HIV/AIDS, for some of the church, compulsory blood test for newly married has been now a rampant practice in district because the so called Love is no longer blind. Since then, the song practice, choral practice and condolence meeting routinely that takes place till late into the night – sometimes throughout the night and the many festivals involving the widest kind of public partying means spreading of HIV/AIDS in most cases.

Thus for instance, the annual harvest *Kut* festival of Manipur has been reduced to a night-time celebration involving the widest kind of public partying. Under the cover of night and the influence of alcohol, such an event increases the risk of unprotected sex through which HIV could be transmitted. These community activities used to serve as useful social functions; and one may argue, they still do today. In fact, life style, customs and traditions are affected and these factors are one of the contributing factors for the spread of HIV/AIDS in the district which are generally an occasion for the youths to misuse and satisfy their whimsical desire.

Besides, parents are unable to control their children because peer pressure is stronger at their youthful stage than that of their parents. Excessive liberal social behaviour among many tribal societies leads to the breakdown of social control, leading to anomic conditions in the society. In such norm less situation, the youth remains directionless and fall victim to drugs and other bad habits. Curiosity and the easy availability of illegal drugs, drinks and sex partners at a fairly long tradition of night life associated with the local church and voluntary organizations made worse the minors and makes unguarded children at risk to drug abuse and HIV/AIDS. Under-supervised social responsibilities and obligations in the society, the churches become the breeding ground for social misfits.

Thus, many parents opposed fairly long tradition of night life associated with the local church and voluntary organizations though many a time an obligatory in the society. Ultimately, it is a known fact of economic loss to families to rehabilitate and provide medical treatment to the infected. The booming of rehabilitation centres appears to be for

further spreads of the virus or disease. It is also learned that negligence and ill-treatment of HIV/AIDS patients are that many a time their needs and service are not met. So rethinking of parents about pocket money to children and close tab on their peer group no longer based on neighbourhood or family ties but rather on HIV/AIDS sensitivity and so on(Interview with JT Mate, Senior Lecturer, Churachandpur, Manipur: 6/6/2008).

The other social impact of HIV/AIDS are various that the individual life of HIV/AIDS patients is hampered in the family and society and also consider that the infected HIV/AIDS persons are weaker, uglier, inferior and shy. Hence, after one gets HIV/AIDS in the family, the happiness of the entire family will be significantly reduced (see chapter4 table3).Nevertheless, the attitudes towards HIV/AIDS patients in Churachandpur district are normal.As such, the social impacts of HIV/AIDS in general are not that of discrimination or isolation, but rather it is that of affection, care and concern which may be attributed to the age old tribal traditional values combined with the teaching of Christian values and principles, which dominates each and every sphere of individual life.

Majority of the respondents (53%) are of the view that the individual life of HIV/AIDS patients is hampered in the family and society, whereas 44% of the respondents disagrees and the rest 3% of the respondents can not say anything nor have any idea at on these important issues (see chapter4 table 3).

Overwhelming majority of the respondents (57%) are also of the view that infected HIV/AIDS persons are weaker, uglier, inferior and diffident, whereas only 33%

of respondents disagrees and advocates that they are the same as other human being and the rest 10% remain indifferent.

Majority of the respondents (52%) asserted that the untimely demise of people in the age group of 15-50 are due to HIV/AIDS whereas 48% of the respondents disagree and advocates that one could die at any age.

Overwhelming majority of the respondents (60%) also advocated that HIV/AIDS in the district leads to many social problems, whereas only 40% of respondents are of the view that problems are common to all state or to all society.

Majority of the respondents (55%) are of the view that after one gets HIV/AIDS in the family, the happiness of the entire family will be significantly reduced, whereas 40% of the respondents disagrees and the rest 5% remain indifferent or have no idea.

In the district of Churachandpur, overwhelming majority of the respondents (57%) asserts that many widows and orphans are not due to HIV/AIDS, whereas less than half of the respondents (40%) are of the view that many widows and orphans are due to HIV/AIDS and the rest 3% become indifferent or have no idea.

People Living with HIV/AIDS have been facing social stigma in Churachandpur district – during funeral rituals and digging of graves – dead bodies covered up in plastics at Shalom – the very sight of Shalom vehicle in the neighbourhood raised suspicion – but social attitudes registered some changes recently, say, 2008 – some prospective clients now gain enough confidence to approach Government Hospital and NGOs for blood test.

"Only Grace" (ZMA) is a nascent orphanage established as "a safe home for children affected and infected by HIV/AIDS.[6]"(p.7). It is inaugurated on 31 May 2006 and founded by Miss Becky Bierly, USA. During my recent visit in July 2008, Only Grace has 11 resident children at Vengnuam (New Lamka) of Churachandpur.

Established in 1988, Drug De-addiction and Rehabilitation Centre (DDRC) is locally known as "Lametna mun" (Hope centre).[7] It is located at Bungmual, about 3 km west of Churachandpur town centre. The location of DDRC is an idyllic and tranquil area stretching over 3.72 acres of land that is owned by its parent organization, the Evangelical Baptist Convention (EBC).[8] Since 1995, the Centre received financial assistance from the Ministry of Social Justice and Empowerment with a capacity to accommodate 15 persons at a time. The staff strength of this "Hope Centre" is 12 – one Project Officer, four Counsellors, one Yoga Therapist one Nurse (full time), one Doctor (part time), one Accountant, one Ward Boy, one *Choukidar*, and one Peon.[9]

Majority of the respondents (53%) are of the view that the individual life of HIV/AIDS patients is hampered in the family and society, whereas (44%) of the respondents disagree and the rest (3%) of the respondents can not say anything nor have any idea on these important issues.

Overwhelming majority of the respondents (57%) agree and are of the view that infected HIV/AIDS persons are weaker, uglier, inferior and diffident, whereas only (33%) of respondents disagree and advocated that they are same as other human being and the rest 10% of the respondents can not say anything nor have any idea.

Majority of the respondents (52%) agree and are of the view that the untimely demise of people in the age group of 15-50 are due to HIV/AIDS whereas (48%) of the respondents disagree and advocated that one may die at any age.

Majority of the respondents (56%) asserted that relationship with other families is harmed only when there is misunderstanding but less than half of the respondents (42%) disagree and are of the view that after one gets HIV/AIDS in the family, the family's relationship with other families is harmed and the rest 2 % of the respondents has no idea.

Majority of the respondents (54%) are of the view that HIV/AIDS infected and uninfected persons have relationship problems whereas (46%) of the respondents disagree and asserted that HIV/AIDS is nothing but a virus, tiny and fragile.

Overwhelming majority of the respondents (60%) advocated that HIV/AIDS in the district lead to many social problems, whereas only 40% of respondents disagree and are of the view that problems are common to all region and state or to all society.

Majority of the respondents (56%) feel that higher incidence of HIV/AIDS patients leads to less income for the family and society but less than half of the respondents (40%) are of the view that income can be generated by each individual of the family members according to his capacity and the rest 4 % of the respondents has no idea and become indifferent.

Table 3: Socio-economic Impact of HIV/AIDS in Churachandpur district

	Yes	No	Can't say
The individual life of HIV/AIDS patients is hampered in the family and society.	53	44	03
Infected HIV/AIDS persons are weaker, uglier, inferior and diffident (assimilated).	57	33	10
Untimely demise of people in the age group of 15 to 50 are due to HIV/AIDS.	52	48	00
After one gets HIV/AIDS in the family, the family's relationship with other families is harmed.	56	42	02
HIV/AIDS infected and uninfected persons have relationship problems.	54	46	00
HIV/AIDS in the district leads to many social problems.	60	40	00
Higher incidence of HIV/AIDS patients leads to less income for the family and society.	56	40	04
Social, political, economic and religious practices will be a failure due to HIV/AIDS in the district.	52	46	02
After one gets HIV/AIDS in the family, the happiness of the entire family will be significantly reduced.	55	40	05
Many widows and orphans are due to HIV/AIDS.	56	40	04

Source: Field Work by the Author, April -June 2007, June-August 2008.

So far as many problems are concern, majority of the respondents (52%) are of the view that social, political, economic and religious practices will be a failure due to HIV/AIDS in the district but less than half of the respondents (46%) disagree and the rest 2 % of the respondents has no idea and become indifferent.

Majority of the respondents (55%) asserted that after one gets HIV/AIDS in the family, the happiness of the entire family will be significantly reduced, whereas 40% of the respondents disagree and the rest 5% of the respondents has no idea.

In the whole of Churachandpur district, majority of the respondent (56%) are of the view that many widows and orphans are due to HIV/AIDS but less than half of the respondents (40%) disagree and the rest 4% of the respondents become indifferent.

The people of Churachandpur district are generally aware of HIV/AIDS and their attitude towards the patient is quite normal and their approach towards the patient is also very humanitarian in accordance with Christian values and Principles besides the traditional values of the society since around 98% of the population are Christians. The people of the district as a whole are very conscious and quite aware of HIV/AIDS. Yet the degree of awareness varies depending on their social and educational background and literacy of the person. Few among the educated class had been aware of HIV/AIDS as early as 1984 even before the disease surface in India (1986) while some the illiterate of the district have come to know HIV/AIDS as late as1999 after a series of HIV/AIDS related deaths had occurred in Churachandpur district.

The data of table 4 below properly indicates that majority of the respondents (35%) agreed that if one gets HIV/AIDS, only self ought to be blame than any other source or persons. But 30% of the respondents asserted to blame friends whereas 20% are to blame family and the rest 14% would like to blame on relatives and only 1% are blaming other sources. From the data it is a crystal clear that no one is to be blamed for any infection except the carelessness of the person although family and society are also partly one of the causes for any HIV/AIDS infection in Churachandpur district.

Besides, majority of the respondents (54%) are also quite aware of the route of transmission of HIV/AIDS through sex, blood, needles or syringes or piercing

instruments, mother to child, and probably through deep kissing and that HIV/AIDS is not spread through casual contacts such as shaking hands, hugging, dry kissing, sneezing, sharing of toilets, soaps, towels etc

Table 4 Attitudes towards HIV/AIDS patients in Churachandpur district

1	Who is to blame if one gets HIV/AIDS?		Frequency	Percentage
	a	Self	35	35
	b	Family	20	20
	c	Friends	30	30
	d	Relatives	00	00
	e	Society	14	14
	f	Others	01	01
		Total	100	100
			Yes	No
2	HIV/AIDS patients should have separate clothing, utensils, toilet, toiletries, etc and be segregated from family & society		54	46
3	HIV/AIDS testing before marriage must be legalised		62	38
4	HIV/AIDS patients should get married and have children		69	31
5	HIV/AIDS children should continue their education and go to school, college and university		57	43
6	A student, a boy, a girl or others in a locality/village/ district infected with HIV/AIDS should be publicised		55	45
7	HIV/AIDS patient should not be allowed to inherit parental property		60	40
8	HIV/AIDS infected be employed in the religious, educational, Governmental, NGOs, agencies and other institutions		52	48
9	Church ministers should nullify any marriage on the ground that one of the couples is HIV/AIDS infected		54	46
10	HIV/AIDS related death should not be given a descent religious burial and be disposed off as fast as possible		40	60

Source Field Work by the Author April -June 2007 June-August 2008

Their attitude towards HIV/AIDS patients is quite normal in that they do not feel the need for separate clothing, latrines, utensils, toiletries etc for the HIV/AIDS patient whereas respondents of (46%) are unaware and disagree and feel the need to isolate or segregated HIV/AIDS patient from family and society

In regard to the testing of HIV/AIDS before marriage must be legalized, more than half of the respondents (62 %) asserted that it is better to prevent the spread of the disease through legal issue while minority respondent (38 %) feels that it need not be legalized as it is difficult to implement in a democratic country like India.

Moreover, majority of respondents (69 %) feels that the HIV/AIDS patient should also get married and have children because it is their private life and freedom to produce children whereas (31%) of the respondents disagree with them as they have chances to spread the disease if he or she knows the consequences of his or her action.

The attitude towards education of HIV/AIDS patient is positive as (57%) of the respondents feel that education is the basic need and the right of man and even children of pastors, church elders or ministers and prayerful families and teachers are not cent percent safe from HIV/AIDS whereas 43% of the respondents leaves education to the parents or patient concern about to go to school or college or university.

Majority of the respondents (55%) are of the view that publicly declaring for others knowledge about infection of a person with HIV/AIDS will only isolate and stigmatize the infected person and do not want its publicity. But less than half of the respondents (45 %) asserted that one honestly confess to his dear and loved one as for a precautionary measures or to avoid further spreading.

Regarding inheritance of parental property is concerned; more than half of the respondents (60%) are of the view that infection of HIV/AIDS is not the end of everything and asserts that no one is safe from contacting HIV/AIDS even those who are

of repute and belonging to low-risk groups of people leading disciplined life in society But 40% of the respondents asserted that there is no future for them in most cases

On the issues of employment in Governmental or Non-Governmental Organizations or agencies or institutions, majority of the respondents (52 %) are of the view that HIV/AIDS patients should be employed wherever possible to earn their own bread as long as they are fit and have the required qualifications, capacity and efficiency In fact, they feel that HIV/AIDS patient can be a model to others and treating themselves with proper care They can still rely on God and engage in positive activities till they die But minority of the respondents (48%) feels that they should not be employed for want of efficiency and to prevent contaminating the society and the tranquility of the organizations or agencies or institutions they work

Majority of the respondents (54%) are of the view that a pastor or church minister cannot nullify the marriage of HIV/AIDS patient if both of them agree and are willing to do so as their decision should be respected and the duty of a pastor or minister is to tie the knot as both of them have the right to live for life But 46 % of the respondents feel that it should be nullified to prevent producing HIV/AIDS infected children and it is the duty of pastor or minister to protect the innocent Christian from all harms

In relation to death, more than half of the respondents (60%) are of the view that even HIV/AIDS related death should be respected for the sake of the family members There is a need for decent burial with church ceremony for all persons even those people infected with HIV/AIDS But 40% of the respondents disagree Thus, the general attitudes towards HIV/AIDS patient is not that of discrimination or isolation rather it is

that of affection, care and concern which may be attributed to the age old tribal traditional values combined with the teaching of Christian values and principles.

Chapter- 4 Notes and references:-

1. This figure is based on available records of the Manipur State AIDS Control Society (MACS) and the Shalom Hospice Health Centre, Churachandpur.

2. Lisam, Dr. Khomdon (2006) "Changing Scenario of HIV/AIDS: Issues and Challenges" in *Souvenir – World AIDS Day 2006*, Manipur State AIDS Control Society (MACS), Lamphel, Imphal.

3. Interview with Dr. Vum Chin Pau, District AIDS Officer, at his office, CMO Complex, I.B. Road, Churachandpur, on 18 July 2008.

4."District-wise Distribution of HIVAIDS Positive Cases (Sero-Surveillance) in Manipur" p. 81 in *Statistical Abstracts of Manipur 2007*, published by Directorate of Economics & Statistics, Government of Manipur, Imphal; pp. 377 + iv.

5.A 4-paged unpublished mimeograph entitled, "Epidemiological Analysis of HIV/AIDS in Manipur" by Dr. Kh. Pramodkumar, Project Director, Manipur States AIDS Control Society, Research and Development Wing, Lamphelpat, Imphal – 795004, Manipur.

6. the Tri-Annual Report of Zomi Mothers' Association, April 2005–March 2008, Neilam's Avenue, Upper Chappel Lane, Churachandpur, pp. 24.

7 Interview with S Liana, Counsellor-cum-Warden, Drug De-addiction and Rahabilitation Centre (DDRC), Bungmual, Churachandpur, on 25 July 2008

8 A leaflet of LRRC (Lamka Rehabilitation and Research Centre) issued by the EBC

9 Interview with JT Mate, Senior Lecturer, Churachandpur, on 6th June 2008

10 Interview with S Liana, Counsellor-cum-Warden, Drug De-addiction and Rehabilitation Centre (DDRC), Bungmual, Churachandpur, on 25 July 2008

CHAPTER V

PREVENTIVE MEASURES AGAINST HIV/AIDS

1 Involvement of NGOs needs encouragement

The involvements of NGOs in Churachandpur district have been bulk and worth mentioning for the prevention of HIV/AIDS But still, some NGOs have done a lip service on HIV/AIDS prevention in the district just by servicing as distributing condom , leaflet and also by giving them mere awareness programme and did not last long whereas the contributions of true NGOs are ever incredible They have seminars, talks or lecture, workshop, seminar in the institutions of schools and colleges including round table conference, drama, video show, rallies, sport events, quiz competition, dissemination of messages and distribution of educational materials and so on to official gatherings or functions to promote safe behaviour

2 Churches and Philanthropic organizations needs to steps further

In recent past, Churches like Catholic, Presbyterian, Baptist, Lutheran, Salvation Army etc and Philanthropic organizations such as Young Mizo Association (YMA), Zou youth Organization (ZYO), Simte youth Organization (SYO), Young Paite You Association (YPA), Hmar Youth Association (HYA) etc, did not consider HIV/AIDS problem as their main task except the funeral or decent burial Hence, most of the institutions and organizations ignored such issues should be dealt with the government and the NGOs and just support verbally about their policy and planning

Besides, such institutions and organizations are also too busy for their own assigned work and some of the people themselves considered HIV/AIDS as bad people's disease and could not support them. But without the support of such institutions and organizations, the cases of HIV/AIDS that can not be fully solved in the near future.

If we are to tackle the problem of HIV infection and AIDS, it is essential that we study not only the virus itself but also all cultural practices that might contribute to its spread. With no immediate prospect of a widely available vaccine or cure for HIV, the key to prevent the AIDS epidemic lies in sexual behaviour and its modifications. But, human behaviour is rooted in the social and economic facts of individual lives. Thus, one-man, one woman or permanent single partner in sexual behaviour is often subjected to powerful and far-reaching constraints. In Churachandpur district, one reason for the rapid spread of HIV/AIDS is very likely to be the far higher incidence of other sexually transmitted diseases, which itself has not been satisfactorily explained, since very little research has been devoted to understanding it. The role played by sexual transmission and by the rate of partner change-promiscuity is extremely difficult to quantify.

The term promiscuity is a relative one, which can mean different things in different times and places. To understand the problem of HIV/AIDS, the people of Churachandpur district need to gain a perspective on why this promiscuity is happening; what are the forces, which at this particular point of time led many young people to take a large number of sexual partners. In fact, opportunities exist for slowing the HIV/AIDS epidemic in Churachandpur district. As fathers in the setting, take more responsibility to

provide care and support for other family members and the community. Then Plan activities for your community or place of work to observe World AIDS Day in the first November of every year. Such activities could include workshop, seminar, lecture, round table conference, drama, video show, rallies, sport events, quiz competition, dissemination of messages, distribution of educational materials, etc.

Many different activities can also help raise people awareness for the prevention of HIV/AIDS as follows:-

1. Assist the family and friends a person living with HIV. Find out what their needs are and provide emotional support to them.

2. Provide leadership by doing any of the above in our family, school, college, university, work place, and network of friends or community.

3. Discuss the roles that men and women play out in the society and educate the peers in locations where men get together socially or in the workplace regarding HIV/AIDS and about the responsibility of men in combating the epidemic.

4. Advocate the right of women to determine if, when and where sex takes place. Urge males to speak out openly about sexuality and the need for men to change their sexual behaviour, and provide them with simple messages on these issues, to be used in public forums or media interviews.

5. Support AIDS education in the workplace on a continuing basis so that HIV prevention can be discussed in depth. Promote discussions between fathers and sons

about sexuality, family planning and HIV/AIDS. Design easy-to-understand information, education, and communication (IEC) materials for boys and men focusing on their common concerns and health problems.

6. Establish programmes that encourage young and unmarried men to understand their roles as future parents and prepare them to be involved in parenthood, promoting planned fatherhood as a masculine ideal. Bring men together to talk about their concerns regarding care for their families and help them develop the skills to talk to- and listen to- their partners and children. Promote positive male role models in the youth media.

7. Educate young people about equal relationships between men and women and stress the unacceptability of sexual violence. Establish self-help groups for boys and men living with or affected by or orphaned as a result of HIV/AIDS. Fathers and future fathers should be encouraged to consider the potential impact of sexual behaviour on their partners and children.

8. Men also need to take a greater role in caring for family members with HIV or AIDS. Through your own activities and plans, join on to fight HIV because no one deserves to get AIDS and involve your families, institutions, communities and countries or state or district to enable them to say "no" to HIV/AIDS and enable them to protect themselves. Find out what people want to know about HIV/AIDS. Provide them with the information so that they can protect themselves.

9. Talk about the important role that HIV and AIDS education and information plays in preventing the spread of the epidemic. When talking to different people you could reinforce the need of people to have options for the prevention of all sexually transmitted diseases (STDs) including HIV/AIDS. Ignorant is not bliss on the issues of HIV/AIDS. Ignorance costs lives.

Nevertheless, we do not yet have a vaccine for HIV/AIDS but we do have a social vaccine or medicine. This vaccine consists of social mobilization to individual or groups or steps taken by Governmental or Non- Governmental Organization as follows: -

1. Increase awareness and promote tolerance and solidarity with people living with HIV/AIDS in the district.

2. Promote safety when it comes to sex, which means 100% condom use in all risk behavior.

3. Offer sex education and life skill training for youth both in out of school a strategy which proven to delay the age of first sexual intercourse, and to produce the number of different sexual partners.

4. Lastly allocate resource to care for those affected by the epidemic.

Immediate action will be required in the areas of partnership and political commitment. Governmental leadership, together with support from civil society, the religious communities, national and international communities, the private sectors, NGOs and Pharmaceutical companies will be the formula for success. Furthermore, we know that a coherent approach in prevention, a significant reduction of HIV transmission may

be achieved. There is solid evidence that, a community and national levels considerable results can be obtained with systematically applied programmes. A comprehensive place for prevention of HIV/AIDS must therefore include the following factors: -

a) Information, Education and peer counseling for young people.

b) Access to confidential, voluntary testing and counseling.

c) Safe blood or blood product supplies.

d) Promotion of Condom use and accessibility.

e) Treatment of the STDs, particularly for commercial sex workers (CSWs) both males and females.

f) Service and programmes aimed to reduce vulnerability of men who have sex with men (MSM), Intravenous Drugs Users (IDUs), street children and young people who are forces into the sex trade.

Furthermore, suggestions for the prevention of HIV/AIDS in Churachandpur district are also as given below:-

1. To ensure availability of treatment and rehabilitation services as part of the comprehensive primary health care services.

2. To create mass awakening among the people particularly the young people about the harmful effects of HIV/AIDS and its social, economic and developmental consequences.

3. To establish training centres for doctors, nurses, counselors, social workers, community leaders, volunteers etc on HIV/AIDS demand reduction.

4. To promote and support community participation for health promotion or AIDS education campaign.

5. To ensure physical, social and economic rehabilitation of the HIV/AIDS patient so that they may become useful member of the society.

6. To strengthen and use of peer network for information, education and counselling (IEC).

7. To create expansion of voluntary confidential testing and encouragement to become useful member of the society.

Last but not the least, the sobering facts about HIV/AIDS epidemic should continuously reminds us that denial and business as usual are totally unacceptable. Since the works are associated with the following: -

(a) Visibility to fight stigma.

(b) Empower vulnerable groups through social policies.

(c) Recognize the synergy between prevention and medical care.

(d) Design specific interventions for each vulnerable group.

(e) Create a strong community response.

(f) Focus on the youth, our future!

We can make a difference but real successes in the response to the epidemic and we must embrace our responsibility to establish partnership with infected or affected by widowed or orphaned as a result of HIV/AIDS. However, its worth to note that some of the steps of NGOs were found money oriented, too inadequate and inefficient and the people did not know how to report effectively. Drug peddlers were beyond control; one is arrested while the kingpins (Big fishes) are not apprehended. The steps taken by the Government are far from satisfactory.

For instance, NGOs like Shalom is much more realistic and effective in tackling the problems of HIV/AIDS when Drugs and sex addicts cannot be controlled by anyone. The Government machines did not take the real steps in the rural or remotest areas while the responses of the people are one of the most essential in the district are irresponsible, insufficient and unsatisfactory. In fact, the steps of the Government and the NGOs teachings are monotonous and do not have spiritual impetus.

(B) Intervention by Faith- Base Organizations:

Even at religious level, some churches like Evangelical Baptist Convention, Salvation Army, Catholic Church, United Pentecostal Church, Church of Christ, Reform Presbyterian Church, and Lutheran Church etc have taken the steps for the prevention of HIV/AIDS in Churachandpur district of Manipur. But some of them wind up the steps before they reach the real goal. Indeed, the Church response to HIV/AIDS in the district

was not a full response or a group response to HIV/AIDS. As such, no church in Churachandpur district makes proper budget to fight HIV/AIDS in the district to relief the church members or the community as a whole.

Socially, HIV/AIDS is considered as a behavioural disease and it is not accepted in the society since it is also related to individual sex issues. Indeed, the foundation of Christianity in Churachandpur district is not strong enough to save the youth and the present generation. AIDS among the youths or among the Christian churches are nothing but a sign of spiritual poverty and lack of understanding about the moral norms of the Society. The pressure of sudden contact with modern values through mass media like Television, Cable Television, Movies, Videos parlours, etc and the sudden invasions of outside culture are unexpected powering the society.

Thus in general, some churches and society in Churachandpur district reject or ignore its issues and leave it for Governmental or Non –governmental concerns. Yet, it is worth to note that individual response is good in church with gift and prayer. Furthermore, the church response did not give stigma on the issue of HIV/AIDS as behavioural diseases while orphants and widows are looked after by the NGOs. The churches of Catholic and Salvation Army in the district had done well as some of them truely sacrifice their life to ventilate the problem of HIV/AIDS in the district. But due to the prevalence of misguided youth such as fraud gang, organized Crime or militancy, open-minded people were sometime hampered in their activities. Then some churches in

Churachandpur district cannot and did not have HIV/AIDS programme except the churches of Catholic and Salvation Army

The Presbyterian churches bothered it and prayed for AIDS remedy and makes a small gift on the issues of HIV/AIDS but did not take up steps in the Synod level about its problems or issues as grim As the ignorant mass and the misguided people rule the whole district, the number of HIV/AIDS infection is increasing rapid or soaring up alarmingly The Church institutions are always important and have a very special role to play in the district To avoid HIV/AIDS, one should also make known to the public that all diseases are bad diseases and all death were good death except the death of Jesus Christ The problems of HIV/AIDS are not only treatment and counseling by doctors but also the society extending to moral values Christianity and the Churches have failed us terribly in Churachandpur Pseudo-Christianity has turned our religious institutions into communal and political institutions and churches have gone wrong towards unhealthy competitions

Hence like never before, the people are full of wants and needs and such factor worsened material lust or economic development rather than spirituality This situation is true of the young people and their better part of life become too grim So frustration, abuses and infecting other becomes a way of life as the problems of HIV/AIDS are not dealt with as it ought to be and is also yet to intensified with a conscious decision In practice, constant support and co-operation from the people at large is always lacking Perhaps, Christianity and moral values had failed and are beyond control where drug

kings, commercial sex workers and sex addicts are not apprehended. Particularly the response of the people in the rural area is too blind, too lousy and almost unthinkable about the ram pants or events of HIV/AIDS in the whole district.

To uplift the moral standard of the people i.e. to free people from immorality and easy money but to work hard and be satisfied with hard and honestly earned money, corruption starting from pseudo-Christians or Church leaders to Officials and down to the Grade IVs have infected our society with the worst immorality resulting to our present problems of God's curse affecting the rich and the poor alike must be remove as fast as possible.

By imaginatively devising institutional levels of interventions, NGOs in Manipur spearheaded the fight against the spread of HIV/AIDS. Government and faith communities have been at loggerhead over the thrust of the preventive schemes. Some Christian denominations – especially those of evangelical persuasion – stand against condom use for fear of unbridled promiscuity. As elsewhere, the Church in Churachandpur district underlines the imperatives of behaviour change, abstinence and fidelity to one partner. Despite the opposition of faith communities, a study by Sarkar *et al.* (1995) among 488 drug users in Manipur "reveals that certain specific messages on protective role of condom is effective for increasing safer sex behaviour" (p. 181). Unlike the condom issue, faith communities raise no contention against Anti-Retro Viral Therapy (ART).

Shalom Hospice Health Centre

Established in 1995, Shalom is one of the earliest HIV/AIDS related organisations to work in Churachandpur district. With a staff strength of about 100, it is also one of the largest NGO working in the field of HIV/AIDS[1]. At the top of the organisational pyramid stands the Director, followed by Programme Manager, Medical Officers, Project Coordinators, Nurses, Outreach Workers, Councillors, Social Workers and Peer Educators.

Initially Shalom was funded by Australian Agency for International Development (AusAID) while administrative and technical assistance is provided by EHA Delhi and Centre for Harm Reduction, Burnet Institute, Melbourne.[2]

Specific projects[3] undertaken by Shalom are as given below: –

1. 20-beded residential community care centre for PLWHAs
2. Interventions for IDUs and FSWs jointly executed by Shalom and ORCHID.
3. Pathway Project – Community Based Care and Support for PLWHAs and Consortium of Positive People Networks
4. Community Education, Training and Advocacy
5. Oral Substitution Therapy
6. Prevention of Parent to Child Transmission (PPTCT)
7. TB Treatment and Control Programme
8. Shalom Mid-Way Home (Drug Rehabilitation-cum-Treatment Centre)

Shalom has a wide range of service components:-[4]

1. Residential Palliative/ Hospice and OPD Care for PLWHAs
2. Syringe-Needle Exchange

3. Drug Detoxification
4. Beprenorphine Substitution Therapy
5. Condom Promotion
6. Drug/AIDS Education for Community, Youth and Affected Groups
7. Vocational Training for Female IDUs, FSWs, HIV infected and affected as well as socio-economically Under-privileged Women
8. Focus Group Meetings with CSWs, IDUs, PLWHAs and Affected Groups
9. Day Care Services for FSWs, Female IDUs and other Women at Risk
10. Workshops and Seminars – local, state and regional levels
11. Attending and presenting papers at International AIDS Conferences
12. Nutritional support for AIDS infected and affected families
13. Confidential HIV Testing, including Pre- and Post Test Conselling
14. Psycho-social Support, Spiritual Counselling and Pastoral Care for PLWHAs and affected families
15. Funeral and legal support and bereavement follow-up
16. Night Sheltered Accommodation Services for FSWs, Female IDUs and other women at risk
17. Community Home Based Care and Support for PLWHAs
18. Rehabilitation and Counselling Services for Drug Users and Alcoholics
19. Collaborative Research and Survey
20. Prevention of Parent to Child Transmission of HIV
21. STI/STD treatment for FSWs, IDUs and their sexual partners

There are about 20 People Living with HIV/AIDS, this is one of the best run Centre in Churachandpur. It extends support and health care to its clients. It has conducted 1,823 blood tests, of which 902 blood samples tested positive[5]. That means almost half (49.47) of the samples collected are HIV positive.

Medicines Sans Frontiers (MSF)

Popularly known as "Doctors without Borders", MSF is an international NGO started in 1971. It maintains offices in nineteen countries. In India, its area of operation covered the states of Jamu & Kashmir, Assam and Manipur. Since October 2004, MSF has initiated a project in Churachandpur at Thangzam Road (Chiengkonpang) and its Imphal office at Kwakeithel (Ningthemkon). At Churachandpur, MSF open on certain week days several mobile clinics , viz. – Mata clinic, Tuining clinic, Singngat clinic, Tuilaphai clinic, Chiangpi clinic and Lamka town clinic.[6] It renders free health care, treatment and counselling services. Apart from the District Hospital, this is the only organisation that provides ART for Churachandpur district. Another important service component of MSF is the prevention of parent to child HIV transmission.

Sahara

Started in 1978, Sahara is a therapeutic transitional community working with people irrespective of their beliefs, economic and social status.[7] It is a peer led organisation that works especially with people who face difficult situations due to substance use and HIV/AIDS. Out of 240 working staff, 90% are either ex-substance users or people living with HIV/AIDS, people who are uneducated but have been trained

to produce outstanding results[8]. Its operational areas are Delhi, Bombay, Pune, Nagaland and Manipur. It serves about 300,000 clients each year[9].

Sahara began its first project at Churachandpur in 1996 in collaboration with Lamka Rehabilitation and Research Centre (LRRC) [10]. Under this project, Sahara successfully implemented detoxification and rehabilitation programme for substance users in Churachandpur district. This project was suspended after a year due to the Zomi-Kuki ethnic conflict (1997-1998). Later in 1999 Sahara resumed its work in Churachandpur by establishing a residential care and rehabilitation programme. Sahara operates in 38 villages of Churachandpur district (including Singngat sub-divisional area) where it provides care and support to 450 injecting drug users[11]. At Churachandpur, Sahara has staff strength of 22 – two Project Coordinators, two Accountants, two Nurses, one Councillor, five Outreach Workers, nine Peer Educators and one part-time Doctor[12].

Sahara is registered under Manipur AIDS Control Society and has good linkages and network with other organisations of the same goal in and outside the state of Manipur[13]. Sahara also works closely with the Confederation of Indian Industry (CII) which is the head of most of the major business enterprises in the country. Sahara established a business enterprise called Renewal in the mid 1990s to give opportunity to clients – mostly former substance users and persons living with or affected by HIV/AIDS[14]. Some of the service components of Sahara are:-

1. Drug Treatment: residential, day care and crisis care, abscess management, medical care, detoxification outreach.

2. After Care: midway homes, vocational training, income generation, job placements, business enterprise.
3. HIV/AIDS & Substance User, project with the Transgender Community.
4. HIV/AIDS Care and Support: care homes, training, counselling, medical care, outreach, awareness.
5. Advocacy.
6. Research including a four year, four country study on AIDS.

Manipur Network of Positive People, Churachandpur

Manipur Network of Positive People, Churachandpur (MNP+CCP)[15] is founded on 24 January 2004. It has a registered membership of about 1000, and staff strength of 16 full-time employees[16]. MNP+CCP is actually a cluster of four organisational units which are give below:-

1. Treatment Counselling for HIV/AIDS – 3 employees funded by WHO through NACO, Delhi.
2. Access to Treatment – 4 employees funded by Global Fund for AIDS, TB and Malaria (GFATM), Geneva.
3. Treatment Preparedness (publicity about ART) – 3 employees funded by TIDES, USA.
4. System (to monitor all organisational activities and facilitate the effectiveness of the organisation by making a monthly review and report to Chennai Hqrs) – 6 employees funded by Avahan, Bill & Melinda Gates Foundation, USA.

It has institutional links with Indian Network for Positive People living with HIV/AIDS (INP+) Chennai, Manipur Network for Positive People (MNP+), Tribal Network of Churachandpur, and Manipur State AIDS Control Society (MACS), etc. The thrust areas of this body include treatment awareness, treatment education or treatment literacy. It also emphasises the importance of adherence to expert medical advice while administering Anti-Retro Viral drugs. This will reduce the chances of developing resistant viral strain.

Love in Action

Started on 6 July 2006, Love in Action is a project of the Reformed Presbyterian Church (RPC), Churachandpur[17]. This organisation exclusively deals with HIV/AIDS prevention and intervention. There are about 300 infected clients registered with Love in Action. Some of its service components are:-

- Prevention through awareness and training
- Support for Orphans and Vulnerable Children (OVC)
- "Mainstreaming"[18] HIV/AIDS
- Care and support for PLWHA, including a monthly nutritional support for 450 HIV infected persons – of which 200 are children and 250 are adults. The criteria for inclusion is need-based (i.e., economic background) as well as biological factor determined on the basis of the biomass of a client.

A distinctive feature of this NGO is its stress on the developmental aspects of HIV/AIDS infection and transmission. Love in Action went to the extent of commissioning a baseline survey of the socio-economic impact of families infected and

affected by HIV/AIDS. This organisation imparted Income Generating skills (IGS) to Self-Help Groups (SHG) formed by infected and affected members of the society. It also makes attempts to network with other community-based organisations and voluntary associations of Churachandpur.

It has staff strength of twenty-four, including 1 director, 2 zonal supervisors-cum-administrators, 4 counsellors in each of the four sectors, 4 social workers (team leaders), 8 grassroots workers, 2 nurses and 1 office assistant. Love in Action's operational area for active intervention is confined within a radius of about 30 kms from Churachandpur town. Its managed to cover only a limited number interior villages (like Singngat, Tipaimukh, etc.) in its awareness campaigns for prevention of HIV/AIDS[19].

Community Based Drugs and AIDS Programme (CBDAP)

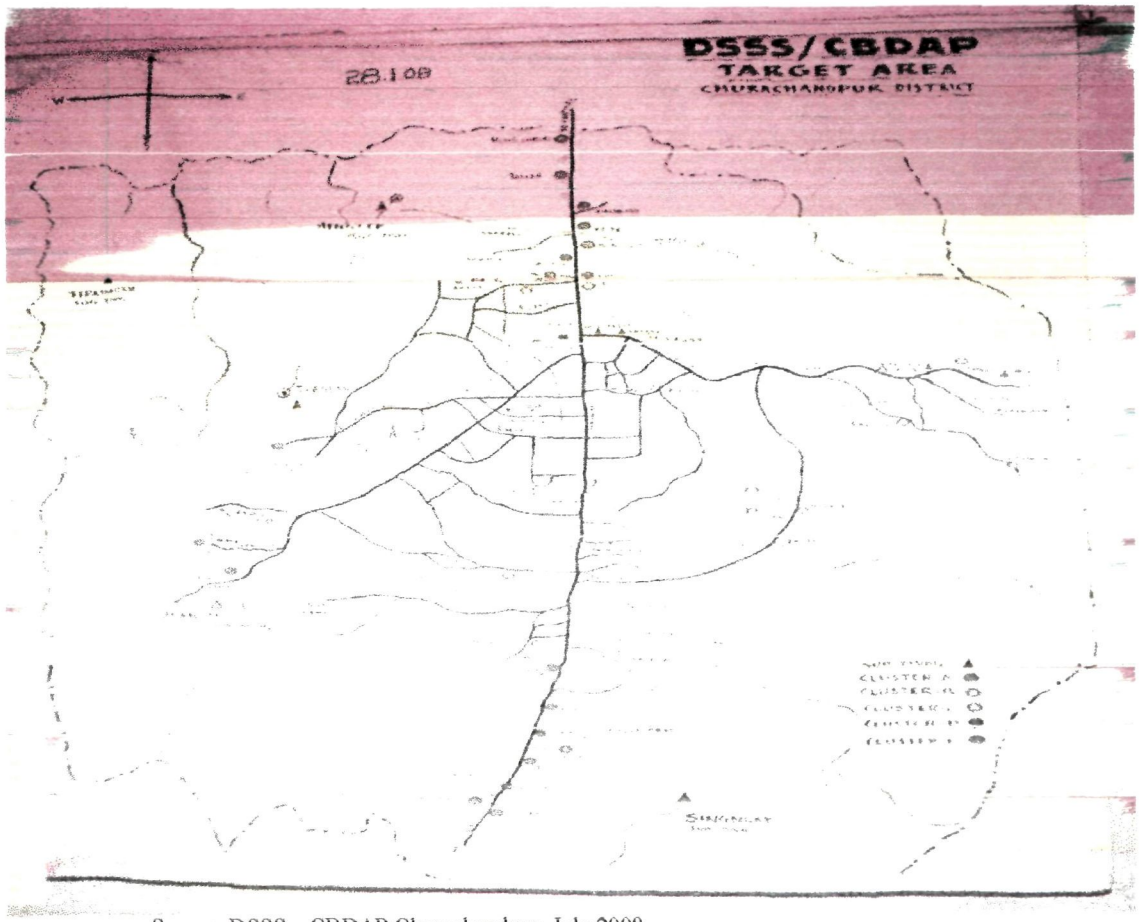
Community Based Drugs and AIDS Programme (CBDAP) is a project undertaken by the Diocesan Social Service Society (DSSS) [20], Imphal. Registered on 1 April 1981, the DSSS is an NGO which basically serves as the developmental wing of the Archdiocese of Imphal which initiates, co-ordinates, plans and formulates, implements, monitors and evaluates all the development projects. CBDAP is the HIV/AIDS intervention project of the Catholic Church in Manipur to contain and reduce the transmission of the virus primarily through behaviour change. The project objectives[21] outlined by CBDAP are:-

1. Increased knowledge and awareness about HIV/AIDS and drug abuse in the community
2. Increased community participation in the prevention initiatives

3. Women initiatives in addressing sexual health issues
4. Reduced stigma and discrimination towards the infected and affected in the community.

At present, the project does not include the whole of Manipur as its sphere of operation. It is being implemented in the three districts of Churachandpur, Ukhrul and Imphal East districts. The CBDAP is supported by the Federal Government of Germany through Caritus Germany.

Figure: Target areas of DSSS – CBDAP in Churachandpur district



Source: DSSS – CBDAP Churachandpur, July 2008.

MELC Care Project

Started on 1 August 2007, the HIV/AIDS Care Project is managed by the Manipur Evangelical Lutheran Church (MELC), Churachandpur, with funding from the Department of Mission and Development (DMD), Lutheran World Federation, Geneva[22]. It is a pilot project that caters primarily to the needs of under-served communities of Manipur. It has ten full-time workers on its payroll – including a Programme Coordinator and nine Community Mobilizers (CM). Each CM works hard to achieve a target of at least three clients per month. Prospective clients are secretively identified among IDUs by patiently cultivating personal contacts with them[23]. The next step is to persuade a prospective client for counselling sessions, followed by blood test. If the result indicates HIV positive, the Care Project networks with the Churachandpur District Hospital for a possible Anti-Retroviral Therapy which is administered completely free of cost at the sole ART Centre in the district.

The Care Project also conducts general awareness campaigns on HIV/AIDS in the Zou and other tribal languages. This Care Project prepares Leaflets in the local dialect and conducts seminars on HIV/AIDS[24]. In sync with the "healing ministry" of the Church, the Project has organised three advocacy seminars to sensitise Church leaders and pastors on the issue of HIV/AIDS in less than one year[25].

The stated goal of the Care Project is to provide knowledge on HIV/AIDS prevention, care and support in containment of HIV epidemic in Churachandpur, Manipur. It also seeks the involvement and participation of People Living with HIV/AIDS so as to reduce its stigma and discrimination. The Project highlights that "HIV

is a virus and not a moral condition[26]." Other short term and long term objectives[27] of the project are:-

1. To provide scientific knowledge on HIV/AIDS related issues.
2. To minimize gender imbalance.
3. To increase participation of different stakeholders.
4. To integrate Health Care system with the Faith Based Organization's through referrals.
5. To improve home based care, treatment and support.
6. To empower and enable them to negotiate for safer sexual practices.
7. To create an enabling environment and thereby reducing the impacts of HIV/AIDS at all levels.
8. Typical activities of the programme includes the following:
9. Training on Basic Knowledge of HIV/AIDS.
10. Training on HIV/AIDS gender.
11. Training on Home Care/Nursing Care.
12. Training on Sexual Health and Safer practices.
13. Community Awareness campaign.
14. Training and Counselling.
15. Advocacy Meeting.
16. Home visit and Medical support.
17. Referral.
18. Counselling activities.

The Care Project advocates the so-called ABC approach (i.e., Abstinence, Be faithful to one sexual partner, and Condom (using it).

SA Community Caring Programme (CCP)

The Community Caring Programme of the Salvation Army is an integrated church based organisation in response to HIV/AIDS. It began in 1991 as a voluntary organisation called Health and Educational Network, and got formalised in 1996 to its present form due to its stronger focus on HIV/AIDS[28]. The project has been funded by SA Netherlands for three years and also by Care and Support for Children Living with HIV/AIDS, Clinton Foundation, USA[29]. The Community Caring Programme has a staff strength of four full-time employees – one Programme Coordinator, one nurse, one Office Assistant, and one Counsellor. As of 2008, it has 40 clients which are all infected with HIV/AIDS, of which 30 are children and 10 are adults. Its service components include:-

1. Care and support for children living with HIV/AIDS linking to ART
2. Nutritional support
3. Psychological, emotional, social and spiritual support
4. Family counselling and training of caregivers who attend to affected families[30].

The Community Caring Programme sees the whole of Manipur as its area of operation, and it targets especially places where the Salvation Army Corps are located both in remote and urban areas.

GBC Home-based Care

Started on 1st January 1997, Home-based Care is a project under the administrative jurisdiction of the Grace Bible College (GBC), Churachandpur, which in

turn is owned by the Evangelical Baptist Convention (EBC). It targets People Living with HIV/AIDS and their affected families "living in Churachandpur and the neighbouring districts and states both within and outside India along the Indo-Myanmar border[31]." Its staff strength consists of 5 full-time workers and 1 part-timer[32]. The project was initially funded by Tear Fund, UK for a covenanted term of six years though it was later extended. Service components of Home-based Care include:-[33]

(a) Spiritual care and psycho-social support

(b) Nursing care

(c) Nutritional support for PLWHA

(d) Schooling support for children

(e) Training of family care givers

(f) Attendant assistance for sick and needy PLWHAs

(g) Facilitate the formation of Self-Help Groups for PLWHA

The Programme Coordinator of Home-based Care is to reach further remarked that the Nutritional Support for PLWHA proves very popular. At present, this service covers 65 infected clients of different age groups who receive certain food stuffs on a monthly basis[34]. The distributed nutritional items are rice, pulses, nutrila (made of soya bean), oatmeal, eggs, vegetable oil, etc. Home-based Care also supports 30 school children who were directly infected or indirectly affected by HIV/AIDS[35].

The main intention of Home-based Care is to reach PLWHA in and through the dark network of the local churches in the hill areas of Manipur. Theological graduates of GBC also provide trained and dedicated human resource to implement the programmes of

Home-based Care even in remote villages. The Programme Coordinator of Home-based Care claims that this project has strong linkages with at least 13 interior local churches[36]. Some of the clients here came from areas as far as the hills of Upper Burma and villages along Manipur-Mizoram border.

ORCHID

Orchid (Organised Response for Comprehensive HIV/AIDS Policy in the District of Churachandpur and Nagaland) is a harm reduction programme jointly started in 2005 by EBC and LRRC[37]. The project is funded by Emmanuel Hospital Association (EHA), Nehru Place, New Delhi. The staff strength of ORCHID is nineteen – one Project Director, one Project Coordinator, one Assistant Project Coordinator, two Nurses, one Accountant, four Outreach Workers and nine Peer Educators[38].

The primary objective of ORCHID is to reduce "the spread of HIV/AIDS among the IDUs and sex workers (SWs)[39]." This project is at the forefront of providing care and support to sex workers (SWs) in Churachandpur district. The clients register of ORCHID (January – July 2008) shows that it catered to 1883 injecting drug users, and 171 female sex workers.

The service components of ORCHID are as given below: –

1. Needle Syringe Exchange programmes
2. Abscess management and dressing of wounds
3. Managing overdoze among injecting drug users
4. Condom promotion and distribution (including female condom)
5. Treatment of Sexually Transmitted Disease

6. One to one advocacy with community leaders and one to ground advocacy with social organisations.

District AIDS Office

Began in 1990, the District AIDS Office, Churachandpur, was located within the Chief Medical Officer's Complex[40]. This public body was funded by Manipur AIDS Control Society (MACS), Imphal. It works through various NGOs within the district. Its service components incorporate the Needle & Syringe Exchange Programme (NSEP) implemented through NGOs. This also includes condom distribution.

Table 1: Sentinel Surveillance Reports, Manipur (August – October)[42]

Year	Number of Samples Screened	Number of Positives	Sero-positivity Rate (%)
1994	2392	256	10.70
1995	2361	268	11.35
1996	2117	354	16.72
1997	2235	322	14.40
1998	4329	496	11.46
1999	3361	468	13.92
2000	2799	372	13.29
2001	3950	527	13.34
2002	5250	437	8.32
2003	7600	551	7.25
2004	8000	480	6.02
2005	8100	489	6.04
2006	8100	418	5.16

The District AIDS Office participates in the Sentinel Surveillance Reports conducted by NACO and MACS in Churachandpur district. It was done annually by a random selection of 400 samples from antenatal clinics within a period of three months[41]. Unlike substance users, these pregnant women are considered low risk groups.

Voluntary Confidential Counselling and Testing Centre (VCCTC)

This is a flagship Government intervention to combat HIV/AIDS through voluntary confidential counselling, blood testing and administering of free ART, which is actually high-cost drug. The monthly cost of ART for a single client is estimated at about Rs.1000 at present[43]. If three dozes of ART are not adhered to regularly, there is a high risk of developing a "resistant viral strain". Hence, "adherence" or regular intake is the key to fighting the deadly virus.

Majority of the respondents (52 %) thinks that there is a need for the district administration to take up steps along with hospitals, clinics, dispensaries etc as far as the problems of HIV/AIDS are concerned since the steps taken for the prevention of HIV/AIDS in the whole district are quite unsatisfactory. The district administration (DC) being the Head of the district must shoulder many responsibilities, by making joint efforts with the concerned medical department or authorities reliable to the public, free people from misconceptions. But 48% of the respondents strongly advocated that the district administration has nothing to do with the problem of HIV/AIDS including the hospitals, clinics, dispensaries etc, since most problems or grim situations of HIV/AIDS are tackled by NGOs workers, doctors, nurses or health workers (see table 2 below).

Table 2: Preventive Measures of HIV/AIDS in Churachandpur district of Manipur

There is a need for the district administration to take up steps along with hospitals, clinics, dispensaries, etc.	Yes 52	No 48
The district administration needs to declare HIV/AIDS as a compulsory subject in educational and religious institutions	55	45
Parents need to tell their children about sex freely and frankly	53	47
Abolition of traditional festivals (Kut, Zomi National Day, YMA/club days, etc) at night will greatly help	54	46
Traditional customs and practices need to be reviewed to prevent HIV/AIDS	57	43
Holding of seminars, training, etc on HIV/AIDS with intellectuals-doctors, teachers, church elders, pastors, social workers, etc.	62	38
Being religious and spiritual can now prevent HIV/AIDS	60	40
Male or female condom promotion can prevent the problems of HIV/AIDS	58	42
Steps taken by Government and (MACS)and (CDA)with other NGOs in the district will effectively prevent HIV/AIDS and ensure that Churachandpur district becomes "No AIDS district or AIDS free district"	52	48
Ways to prevent or counter the menace of HIV/AIDS from the suggestions of the respondents for the people of Churachandpur district of Manipur.		

Source: Field Work by the Author April-June 2007, June-August 2008.

Overwhelming majority of the respondents (55%) are of the view that the district administration need not to declare HIV/AIDS as a compulsory subject in religious and educational institutions in the district for the prevention of HIV/AIDS, and that the Government and the NGOs are enough to look after these problems. But less than half of the respondents (45%) advocates that the district administration needs to declare HIV/AIDS as a compulsory subject in religious and educational institutions in the district

for the prevention of HIV/AIDS, so that adequate knowledge reaches the people of all age, sex and religion. Besides, religious and educational institutions are the centre of learning both physical and spiritual things.

Majority of the respondents (53%) feel that parents need to tell their children about sex with free and frankness in order to get proper knowledge and correct information about sexually transmitted disease (STDs) and HIV/AIDS and also to have desirable sexual health or safe sex education. But 47% the respondents advocate that the people of Churachandpur district were still ignorant in sex issues and giving sex education may lead to more STDs and HIV/AIDS out of curiosity. Sex is also considered as sacred and one of the greatest gifts of God and asserted that sex is not for misuse before the right person and partner. In fact, sex determination of foetus is also found illegal and morally condemned in the society.

Majority of the respondents (54%) are of the view that abolition of traditional customs and practices like Kut festivals, Laiharauba, Thabalchongba, Young Mizo Association (Y.M.A)., Young Paite Association (Y.P.A)., Zou Youth Organization (Z.Y.O)., Simte Youth Organization (S.Y.O.) etc Youth Club days celebration in the night is part of human life and these will not greatly help in the prevention of HIV/AIDS in district. The spread of HIV/AIDS is due to personal or individual behaviour and not the festivals. Westernization and the mindset of the people to imitate whatever advanced society does are the main factors rather than the traditional customs and practices. But less than half of the respondents (46%) asserted that traditional customs and practices

were often misused for chances of drugs, flesh trade or free sex, and many youths are not controlled in such festivals. Typical free social life styles in Kut festivals are glaring instances.

More than half of the respondents (57%) are of the view that traditional customs and practices need not be received in order to prevent the problems of HIV/AID. It is westernization that freely allows children to go to church or party and corrupt or demoralized many mindsets. But less than half of the respondents (43%) says that traditional customs and practices need to be received in order to prevent the problems of HIV/AIDS in Churachandpur district as such values has been often assimilated and misused by young and old alike and lead to immoral practices during free mixing conference,condolence,etc.

Overwhelming majority of the respondents (62%) think that holding of seminars, training, crusades etc on HIV/AIDS with the intellectuals such as doctors, teachers or lecturers, church elders, health and social workers etc can most effectively help in preventing HIV/AIDS in Churachandpur district as such groups can really convince the society and are also responsible to play an active role in churches, communities, organizations and so on. But 38% of the respondents assert that such intellectuals are less help in the society.

Majority of the respondents (60%) are of the view that no one is safe from contacting HIV/AIDS even those who are of repute and belonging to low-risk groups of people or religious family, leading disciplined life in society. But 40% of the respondents

assert that religious and spiritual life can only prevent the outbreak of HIV/AIDS problems.

Majority of the respondents (58%) strongly assert that male or female condom is known to very few people and that people do not have idea at all and the steps taken by Manipur AIDS Control Society for the prevention of HIV/AIDS in Churachandpur district are almost unknown in practice as they feel it is being done only in namesake. But less than half of the respondent (42%) still advocates that male or female condom is very effective in preventing HIV/AIDS in Churachandpur district since people are very much aware with the problems of HIV/AIDS.

More than half of the respondents (52%) are of the view that the steps taken by Manipur AIDS Control Society (MACS) and Churachandpur District AIDS Committee (CDAC) with other NGOs in the district will effectively prevent HIV/AIDS and ensure that Churachandpur district becomes "No AIDS district or AIDS free district". But 48% of the respondents strongly advocated that except their general awareness campaign along with distribution of condoms, needles or syringes, leaflets or booklets and mere lecture on the issue of HIV/AIDS in educational institutions, they are far from satisfactory though their rapid intervention and care project minimized the harm and the growth rate of HIV/AIDS in the district.

10. Ways to prevent the Menace of HIV/AIDS in Churachandpur district of Manipur:

From the suggestions of the respondents, there are a number of ways by which the combined efforts of the government, NGOs and local philanthropic organizations can help control the spread of HIV/AIDS as follows:-

(1) Formation of a forum for initiating holistic discussions on the dreaded disease. This forum may be constituted of the government, NGOs, local philanthropic organizations and churches with the objective to arrive at a plausible action plan.

(2) Organizing programmes and projects to sensitise the people about the disease. Setting up a separate department in the District Medical Hospital will go a long way in arresting the spread of the disease through identification and rehabilitation of the infected persons. On top of that, door-to-door campaigns, issuing of pamphlets and posters should be done to disseminate information about HIV/AIDS covering both rural as well as urban areas.

(3) Seminars should be organized in a regular manner to acquire up-to-date knowledge of the disease. Utmost care should be taken when dealing with or counselling IDUs, CSWs, call-girls, etc., and not terrorise them.

(4) Financial assistance must be made available by the government in a phase manner to all active NGOs to assist them in implementing schemes and projects.

(5) Employment opportunities should be created for the sustenance of the infected persons with rehabilitating conditions so as to prevent them from social stigmatization and discrimination.

(6) Moral building with the active leadership and involvement of the churches should be emphasized while dealing with HIV/AIDS patients. The role of the church is crucial as about ninety percent of the people in the district are Christians.

(7) Finally, it is believed that the non-involvement of local armed groups will facilitate free movement of the NGO workers, thereby, speeding up the work without any hindrance.

Majority of the respondents think that the following points are the best and the most effective method for the prevention of HIV/AIDS in Churachandpur district as given below: -

1. Confined special jail for drug-lords, peddlers, drug addicts and sex addicts including prostitutions or horrors.

2. Compulsory testing of HIV/AIDS from Governmental/Non-Governmental to fight on a war footing and to meet all the necessary finance till it is under control.

3. Injustice, partiality and nepotism on the part of the concerned authorities of HIV/AIDS should be removed.

4. To let the people who are genuine and deserving get their share in giving financial assistance as it should be used justly as giving loans and other benefits.

5. Not to disappoint people in their hope in giving facilities for the prevention of HIV/AIDS and other social evils.

6. Organize wide and open seminar for full awareness of HIV/AIDS and its consequences and exercising options in a conscious manner without influence among high-risk and low-risk groups.

7. Strong and effective family discipline must be maintained in family and society. If not at all, every family should be responsible to take care of their own family.

8. Governmental/Non Governmental organizations/agencies/institutions should always reach out people of all walks of life to rehabilitate high-risk groups of people and also to set up small group cells and more good counseling centres for self-reliance among the public or community.

9. Doctors and philanthropic organizations should always be positive to check regularly the health records of Commercial Sex Workers (CSWs), Drug addicts etc to isolate the full-blown AIDS.

10. All community leaders and all heads of the district should be united to fight the common problems of HIV/AIDS and the general public should strongly support their plea.

11. Devine values of Christianity or good moral values should be strongly emphasized to the Christian churches or to the society too.

12. Since IDUs, CSWs, Call- girls etc are the main spreader of HIV/AIDS in the district, all of them should be confined or kept in a rehabilitation centres or in a de-addiction centres under a well management of the Government and the NGOs. Then in-depth studies of the reality of the district to avoid IDUs, CSWs, Call-girls and promiscuous and teaching them moral lesson from the Bible.

13. Enforcement of law (Legal force) should be emphasis to arrest illicit drugs traffickers or sellers, illicit expose to skin movies in videos par lour, and heavy punishment on traced call-girls and so on unauthorized commercial sex workers.

14. New treatment and research programme should be established by the Government and the NGOs and targeted people especially at risk with further new campaigns. Also young people need to be targeted before they begin taking risk. It is easier to prevent risk taking behaviour before it becomes a life habit, than afterward.

15. Government and voluntary bodies should also build a safe house for HIV/AIDS patients who have nowhere to go, nowhere to live and establish a network for hundreds of infected and affected people. They should also open or establish more HIV/AIDS Research centres in collaboration with the Centre Government and foreign agencies for relevant, realistic and acceptable information, education and counseling. Then more rehabilitation and constructive centres should be well established in the respective sub-divisions of the district along with HIV testing centres. Such centres also are with the

recognition and help of the Government, NGOs and the philantropic organizations as an eye-opener to remove HIV/AIDS including STDs and any other social evils of the district.

16. An action plan of HIV/AIDS education should be strongly emphasised through a massive programme of public education that will involve the following: -

(a) Promotion of safer sexual and others behaviour that limit the spread of HIV/AIDS in Churachandpur district.

(b) Removing myths and misunderstanding about the transmission of HIV /AIDS in Churachandpur district.

(c) Foster a spirit of caring of caring and positive attitude towards HIV /AIDS.

(d) Protect the human rights and dignity of HIV /AIDS infected people.

(e) Encouragement of voluntary blood donation and HIV testing.

(f) Ensure confidentiality of HIV test results and promote confidentiality counseling and other support services to HIV/ AIDS infected people.

(g) Development of public support for the prevention of HIV/AIDS carried out by Government and voluntary bodies. Since each and every person can contribute as professional roles, community roles and also as family role as family members and parents.

(h) Besides, one should remember that family planning method of safer sex-using condom would not prevent the transmission of HIV/AIDS even to the young people. Adequate and relevant community education and awareness on moral living and behavioural change should rather be provided. Counseling and services should also be made available to individuals or to each society to make their own choice or decision for meeting their own special needs, which are socially, politically, culturally and religiously acceptable. In fact, lack of compassion and tolerance towards HIV infected people and people with AIDS will only drive or increase the disease underground and make it much more difficult to prevent or control. Thus, with proper care and support HIV infected persons can lead useful and productive lives for years and contribute to the further prevention.

(i) The district administration, NGOs and the philanthropic organizations such as YMA, YPA, ZYO, SYO, HYA, Village youth clubs or Authorities etc can help each other for the prevention of HIV/AIDS in Churachandpur district by having joint efforts and through Network-links with different Organizations within the district or outside to achieve a common goal through the programmes of HIV/AIDS awareness, prevention, active participation by organizing team work to prevent the menace AIDS.

(C) INTERVENTION BY GOVERNMENT:

So far as a preventive measures against HIV/AIDS is concerned in the district, the people generally co-operated with the government instructions and hence the Government and the established Non-Governmental Organizations (NGOs) in

Churachandpur district tried their best or whatever good or means to avoid HIV/AIDS in the district. Thus initially, both Government and most NGO have done well and people recognized the good NGOs exist in the whole of the district. So far as the steps taken by the Governmental Organizations are concerned, the Government of India had tried its best even in the remotest area. Particularly in the urban area, they established diagnosis or testing centres of HIV/AIDS in the Governmental hospitals. Yet, most of the health department in Churachandpur district is not well prepared nor they are 100% adequate to the awareness of HIV/AIDS. The danger of HIV/AIDS among them appears to be steeped in ignorance.

Besides, the Non-Governmental Organizations such as SHALOM and District AIDS Committee etc were also trying its best for the prevention of HIV/AIDS. Since then, such organizations had smoothly run rehabilitation centres, counseling centres and organized quite a numbers of seminars at the district level covering all the remote villages. They further give knowledge about HIV/AIDS and the correct use of condoms and safe behaviour. However, most of the funding on the issues of HIV/AIDS are the joint efforts of National and International such as NACO, Sahara, Shalom etc and some of them are due to the efforts of the State and the district such as Manipur AIDS Control Society and District AIDS Committee of Churachandpur district which were subjected to limitation of funding and were many a time far from satisfactory.

The Government, the NGOs and the Faith based organizations or the international agencies should actively seek partnership programmes or find further major research into long-term relationship as well as vaccines, cures and better way to prevent the spread of

HIV /AIDS. For instance, the Church is one of the largest non-governmental organization in many nation states and even globally. In many countries, the church has a long history of care provision, particularly so in developing nations or states. The church represents not only an effective resource organization, but also a powerful influence of behavioural change. The problem of HIV/AIDS is too vast or too great in many countries for governments or secular agencies to solve on their own. Thus, we all need to work together.

Chapter-5 Notes and references:-

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18. Interview with Vanlalhluna, Project Manager, Love in Action, Peace Lane, Churachandpur, on 23 July 2008.

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31. Leaflet of the GBC Home-based Care (undated), New Lamka, Churachandpur.

32. Interview with Thangbiaklian Hangzo, Project Coordinator, GBC Home-based Care, GBC Campus, New Lamka, Churachandpur, dated 16 July 2008.

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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 town 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 progress 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 be 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.

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APPENDIX- A

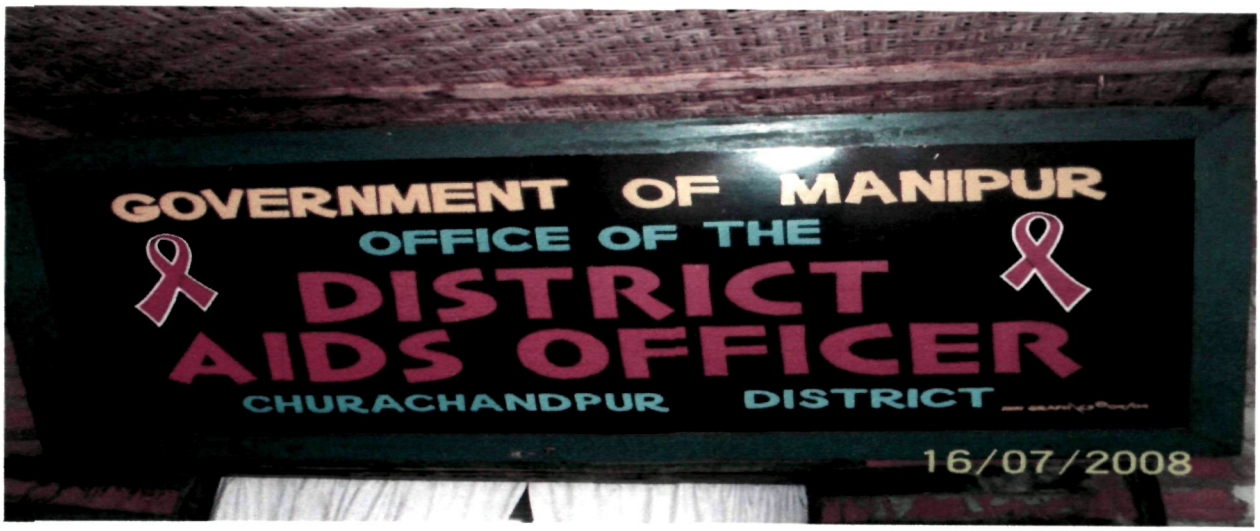

Plate 1: District AIDS Office Churachandpur

Plate 2: ART Centre, Churachandpur

Plate 3: The Researcher interviewing Dr.V.C Pau, District AIDS Officer at his Office, Churachandpur

APPENDIX- B

Plate 4: Shalom Offices

APPENDIX- B

Plate 5: Shalom Patient

Plate 6: Samaria Patients relaxing with the peer Educator(centre)

Plate 7: Samaria Staffs (Shalom Branch)

APPENDIX-C

Plate 8: Sahara Office, Zenhang Lamka

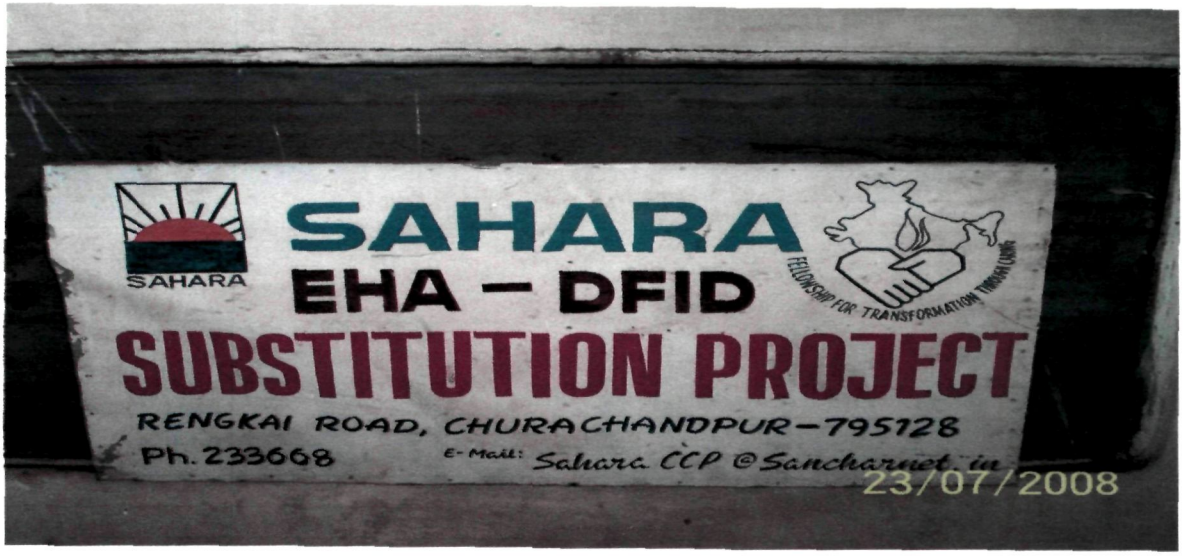

Plate 9: Sahara Offices

Plate 10: Sahara Patients

APPENDIX-C

Plate 11: Sahara patients in Group Discussion

Plate 12: Sahara patients attending awareness class of drugs and AIDS

Plate 13: Sahara Office, Rengkai, Churachandpur

Plate 14: The Research Scholar after interviewing with the Asst.Director at his Office

Plate 15: LRRC, Bungmual, Churachandpur

Plate 16: A Unit Of Children Home, Saikawt (Reformed Presbyterian Church N.E.I.).

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