# *A STUDY OF THE MAGNITUDE OF HIV/AIDS AND ITS IMPACT ON NAGA SOCIETY*

**A THESIS SUBMITTED IN FULFILLMENT OF THE REQUIREMENT FOR AWARD OF THE DEGREE OF DOCTOR OF PHILOSOPHY IN SOCIOLOGY**

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**Hqrs: Lumami**

**2014**

Dedicated to

Mom & Dad

*For their endless love, support and encouragement*

# ACKNOWLEDGEMENT

First and foremost, I offer my sincerest gratitude to my Supervisor as well as my Mentor, Prof. A. Lanunungsang Ao Pro Vice-Chancellor Nagaland University, Meriema, who has supported me throughout my research works with his patience and knowledge whilst allowing me the room to work in my own way. I extend my profound thanks for his valuable advice, wise comments and suggestions on my research works which have been priceless.

I would also like to thank all the faculty members of the Department of Sociology, Nagaland University, Lumami for their advices, support, encouragement and guidance throughout my research period.

My sincere thanks also goes to all the hosts and guides who provided me all the necessary arrangements and made me comfortably stay during my field work exercise in all the districts of Nagaland. Special and heartily thanks to Mr. Alemba (Pastor) Ao Baptist Church Phek, Mr. Chingmak ECS, Mr. Imo Counsellor Civil Hospital Tuensang, Mr. Timothy and his family Peren, Miss. Thrisila Kiphire, Mr. Along Longleng, Mrs. Toinali Zunheboto, Mrs. Nzanbeni Wokha, Mrs. Akangchila and Uncle Imcha Dimapur, Mr. Amongba Mon and Miss. Akumienla Jamir Kohima. I pray that almighty God will bless them richly for their good deeds.

I must express my gratitude and indebtedness to all my Co-Research Scholars especially to Mr. Velhou Koza for the continued support and encouragement.

Completing this work would have been all the more difficult were it not for the support and friendship provided by all the respondents from – PLWHA'S , NGO Fraternity, NSACS, all the religious organisations, all the Jail officials of Prison Department; Nagaland, Jail Inmates from Central Jail Dimapur, District Jails and Sub-Jails of Nagaland, Students and youth from different sections both High Schools, Colleges and Dropouts, Doctors and other Medical Staff, Administrators and Law Enforcing Agencies and Care Centres/Homes of Nagaland, who have contributed positively towards the success of my research work. I am indebted to them for their help.

Words cannot express how grateful I am to my parents and Siblings for all the sacrifices that they've made on my behalf. Their prayer for me was what sustained me thus far.

I would also like to thank all my friends who supported me on writing my Thesis and incented me to strive towards my goal. Big thanks to Aien Ozukum and my dear fiancé Moa for being my support pillars.

Finally, I would like to thank University Grants Commission for Providing me 'Rajiv Gandhi National Fellowship for ST Candidates' funded by Ministry of Social Justice & Empowerment and Ministry of Tribal Affairs which allowed me to undertake this research.

L.Merensangla

# CONTENTS

**LIST OF ABBREVIATIONS:**

| | |
|---|---|
| AIDS: | Acquired Immuno Deficiency Syndrome |
| ANC: | Anti Natal Care |
| ART: | Anti Retroviral Therapy |
| CHCs: | Community Health Centres |
| CBOs: | Community Based Organisations |
| DAPCU: | District AIDS Prevention and Control Units |
| DFID: | Department for International Development |
| G.Clients: | General clients |
| GFATM: | The Global Fund to Fight AIDS, Tuberculosis and Malaria |
| HIV: | Human Immuno Virus |
| HRG: | High Risk Group |
| ICTCs: | Integrated Counselling and Testing Centre |
| IDU: | Injecting Drug User |
| IEC: | Information, Education and Communication |
| NACO: | National AIDS Control Organisation |
| NACP: | National AIDS Control Programme |
| NGO: | Non Governmental Organisation |
| NSACS: | Nagaland State AIDS Control Society |
| ORW: | Out Reach Worker |
| PLWHA: | People Living with HIV |
| PPTCT: | Prevention of Parent to Child Transmission |
| STI: | Sexually Transmitted Disease |
| TI: | Targeted Intervention |
| UN: | United Nations |
| UNAIDS: | Joint United Nations Programme on HIV/AIDS |

| | |
|---|---|
| UNDP: | United Nation Development Programme |
| UNICEF: | United Nation International Children's Emergency Fund |
| UNFPA: | The United Nations Population Fund |
| NBCC: | Nagaland Baptist Church Council |
| WHO: | World Health Organisation |

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# CHAPTER - 1

# INTRODUCTION

## 1.1: INTRODUCTION

HIV/AIDS is a global phenomenon. It is an epidemic of the modern world that affects the social, health, cultural, social, psychological, economic, religious aspects of a human life. It affects the young, the old and is gender blind. AIDS is a long, often painful and fatal disease that develops in people up to a decade or more after they have been infected by the Human Immuno Deficiency Virus (HIV). AIDS is the last stage of HIV infection. It has got no cure, no effective treatment and no vaccine for its prevention till date .The only vaccine available against AIDS today is education.

HIV stands for Human Immuno Deficiency Virus and it is responsible for causing AIDS- the Acquired Immuno Deficiency Syndrome. The origin of this disease is not known but the first case was identified in America in 1981.It was initially reported among the homosexuals and was therefore labeled the 'gay plague'. The term AIDS was coined in 1982 and its definition was revised on 1st September, 1987 by the Centre for Disease Control (CDC) "as a disability or life-threatening illness caused by the Human Immuno Deficiency Virus (HIV) characterized by HIV encephalopathy, HIV wasting syndrome or certain disease due to immuno deficiency in a person with laboratory evidences for HIV infection with or without certain other causes of immuno deficiency" (CDC 1987).[1]

AIDS was first recognized as a disease in the 1980's. Since then it has spread throughout the world. AIDS brings with it a unique social history. It has been identified by the mainstream society as a behaviour-related disease that affects others.[2] Although the disease is no longer restricted to groups that have been traditionally marginalized in this country, the psychological reactions in society stubbornly remain resistant to catching up with reality.

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[1] Jette Nielson and Bjorn Melgaard on their paper 'The Economic and Security Dimensions of HIV/AIDS in Asia'

[2] Mc Dowell, Josh: The Turning Point: Facing HIV/AIDS. San Bernadino California, Here's Life Press, 1987.

When AIDS first emerged as a disease, few people could predict how the epidemic would evolve and fewer still could describe with any certainty the best ways of combating it. Now in the year 2014, it is known from experience that AIDS can devastate the whole region, knock decades of national development, widen the gulf between the rich and the poor nations and push already-stigmatized groups closer to the margins of society.

According to the World Health Organisation's 2013 Annual world health report, it is now the leading cause of death in Africa, responsible for one in five deaths. Globally, it is the fourth most common cause of death. However, there is a considerable variation in the pattern of the epidemic spread between countries, within countries and even locally. Consequently, there is also variation in the impact of the resulting illnesses and premature deaths.[3]

Since the dawn of mankind, no other disease has so menaced civilization as AIDS. The potential for mass destruction has never been as great as in the case of this disease. In no other disease all those affected so potentially capable of transmitting the infection for the duration of their lifetime. Furthermore, most of all those who were infected will probably succumb eventually to the disease of AIDS which will inexorably lead to their death within a few years. Over and above this, the frightful specter of the disease itself is the stigma, discrimination and degradation that are attendant on sufferers from it. It is therefore small wonder that there is no other disease which has been the subject of such misinformation and misunderstanding and which has led to so much of fear, superstition, prejudice and myth as AIDS.

The AIDS epidemic carries with it forces of destruction. It has the power to tear asunder husbands and wives, parents and children, to cause people to turn to one another, to turn away from one another and to perpetuate acts of indignity and inhumanity. It exacerbates poverty and renders the rich poor. The destructiveness of its forces is being felt in affected families and communities as the epidemic unfolds.

Since HIV hits active young adults, it could be described as the killer of the fittest. The population it leaves behind is less able to cope, because it has lost its most productive

[3] World Health Organisations 2013 Annual World Health Report

sector. HIV/AIDS will have a more complicated impact than it has previously been imagined. At different levels it can affect the individual as well as society. It can affect the individual psychologically, physically and socially. The impact on society can be economic, demographic and social.

AIDS is an epidemic of the modern world. From time immemorial, man has been a victim of infectious disorders and diseases. The infecting agents varied from period to period, place to place and society to society. In the past there used to be outbreaks of lethal diseases, assuming great epidemic and pandemic proportions in a limited time and took heavy toll on human life. During the 14$^{th}$ century and afterwards, the plague epidemic took away the lives of millions of people in the world. Scientific achievement and medical advancement checked many of the epidemics and discovered different medicines and vaccines to curtail many of these epidemics. As mankind marched towards a healthier generation, the expectations were met with a serious setback in the form of AIDS.

### 1.1.1 DEFINITION OF AIDS

In the beginning, AIDS was described as a disease complex in homosexual men. In 1982, the CDC in Atlanta defined a diagnosis of AIDS as "a person with a reliably diagnosed disease that is, at least, moderately indicative of an underlying cellular immune deficiency and one who has no known underlying cause of cellular immune deficiency nor any other cause of reduced resistance reported to be associated with the disease". John Starke and Rodney Dale defined AIDS as "a disease that results from infection with a virus called Human Immuno- Deficiency Virus (HIV) which spreads from person to person through body fluids". According to Schoub Barry AIDS is the "end stage disease manifestation of an infection with a virus called the Human Immuno- Deficiency Virus (HIV)". According to him, the virus infects mainly two systems of the body, the immune system and the central nervous system, and the disease manifestations are principally consequent on damage to these two systems.

The World Health Organisation has produced a clinical case definition for Africa (called the 'Bangui' case definition), which is also used in India. According to this, AIDS in an adult is defined by the existence of at least two of the major signs associated with at

least one minor sign in the absence of any known causes of immune-suppression or other recognized etiologies.

1. Major signs
   a) Weight loss of more than 10% of the body weight
   b) Chronic diarrhea persisting for more than one month
   c) Prolonged fever for more than one month
2. Minor signs
   a) Persistent cough for more than one month
   b) Generalized itchy skin lesions (dermatitis)
   c) Recurrent herpes zoster
   d) Oral candidiasis
   e) Chronic herpes simplex
   f) Generalized enlargement of lymph nodes

The recent definition identifies a virus called Human Immuno- Deficiency Virus (HIV) as a cause for AIDS, which weakens and inactivates the T-helper cells in the immune system and directly attacks other essential parts of the body like the central nervous system. In laymen's language, AIDS is the term used to refer to the physical condition resulting from the infection of HIV.

**Human Immuno- Deficiency Virus (HIV)**

The word virus is derived from the Latin word 'virus' meaning poison and also slimy material. It is still defined in most English dictionaries s a malignant or morbid poison. In medical circles the word 'virus' often overlaps with the word 'germ' in a vague and diffuse way to connote some infectious organisms. The word virus has now taken over by the computer world to denote an infectious corruption of data banks, which is transmissible between computers in epidemic and pandemic fashion.[4]

### 1.1.2: THEORIES ABOUT THE ORIGIN OF HIV/AIDS

[4] Esteban, Juan.L (1985). "Importance of western blot analysis in predicting infectivity of anti-HTLV-III positive blood"

Given the intense and unique social, political and human implications of AIDS, it is small wonder that questions surrounding the origin of this remarkable virus and its equally remarkable disease have fired the imagination ever since it was recognized is IDS a new or old disease? Did it first arise in Africa or USA? Where did the virus come from? These and other questions have been discussed , debated and argued at great depth in scientific and lay forums alike and still arouse considerable controversy. In reality the answers to these questions will have little relevance to the control or the management of the disease. In fact little is known about the origin of HIV. But the exact origin of AIDS will never be completely elicited. Some of the important views held by different team of scientists are analyzed as under.[5]

a) An international team of scientists, in 1985 had discovered the origin of HIV virus that causes AIDS in human. They suggest that the causative virus, known as HTLV-III may have originated in Africa. Simian retrovirus related to HTLV-III and designated as Simian T Lymphotrophic Virus type III have been isolated from healthy African Green monkeys. Antibodies to STLV-III have also been found in them. It has been postulated that somewhere, sometime this monkey must have bitten or scratched some African in this forest, infecting that person with retrovirus and it is from this virus that HIV, the causative agent of AIDS evolved. The team said that genetic tests show the main human virus, HIV-1, is closely related to a virus that infects chimps but does not make them sick. This would greatly help efforts to prevent and treat the disease in human.

Dr. Beatrice Hahn of the University of Alabama and colleagues made the discovery when analyzing frozen blood and tissue samples from a lab chimp named Marilyn, which died in 1985. Dr. Sarah Nelson-Jones and her team, which published the results in the journal nature, found in Marilyn a 'grand parent' virus to the human one. Similar viruses had been seen before in four chimps but the latest research confirmed that only Marilyn's sub-species, Pan Troglodytes, carried the virus that infects humans.

b) Another group of researchers are of the view that the AIDS virus originated in the laboratories where Polio vaccine were made and tested. The evidence for this theory is

[5] Thenpillil, Jose (2006) 'Socio-Cultural dimensions of the HIV/AIDS affected'

given in a research thesis published in ‘rolling stone’. In 1957 there was an outbreak of polio epidemic in “Belgian Kongo” now known as Zaire. Then scientists started research to find out a vaccine. In the Vistar institute of Philadelphia, Dr. Hilari was trying to grow polio virus in the kidney cells of American Green Monkeys. This theory gets more importance after the discovery that American Green Monkeys are carriers of AIDS virus.

If AIDS was originated in the 1950’s why it did not spread soon after that and why the virus which is detrimental to monkeys is fatal to man are some of the the criticism leveled against this theory. Prof. Montagnier gives an explaination for these criticisms. There is evidence that AIDS virus was there in the serum collected from Africa years before. The earliest serum specimen retrieved from archived frozen material, shown to be positive for HIV antibodies, was taken from a patient in 1959 in Kinshasha. Dr. Kawamura and his colleagues gave convincing evidence for this. They reported that over 3000 sera collected from South Africaan countries in 1966-67 were provided by WHO Serum Bank, National institure of Health, Japan. These were screened for HIV-1 and HIV-2. The results suggests that there were at least two cases of HIV-2 infection in the ivory coast in 1966 and two cases each in Nigeria and Gabon in 1967. Positive samples were confirmed by western blot test. No evidence of HIV-1 was found in the sera collected in these countries during this period. This clearly shows that HIV-2 has been present in Western Africa since 1966.

c) Another theory which is yet to be disproved and more likely to be true, is that the virus was confined to and affected only small groups of indigenous populations and with increasing mobility of populations and rapid industrialization, it has spread and became rampant

d) Germ warfare theory: The theory that HIV was produced by the American military as a germ warfare agent is based on a paper published by three German scientist in 1986. This report was taken up by many newspapers and strongly denied by the United States government. This theory has been criticized because the technology for genetic engineering did not exist in the early 1970’s when HIV was thought to have first start spreading. HIV would make a highly unsuitable pathogen for germ warfare, as there would be no means of protecting one’s own people.

A final word however has yet to be said about the origin of HIV. The debate about the origin of AIDS has not been helpful because it created bitterness and diverted attention from the important task of prevention. Kenneth Kaunda, the former President of Zambia, expressed it well when he said “It is not important to know where it came from but rather where it is going”.

### 1.1.3: EPIDEMIOLOGICAL DETAILS OF THE SPREAD OF HIV/AIDS AROUND THE GLOBE

The epidemiological details about the spread of HIV/AIDS in different countries can be seen below. The severity of the infection in the modern world and how it affects the humanity in general is projected. The extent of the spread of HIV is beyond human imagination especially in the developing countries of the world.**a. Africa**

**Table1.1: HIV prevalence in selected countries across sub-Saharan Africa in 2012**

| Country | HIV Prevalence (%) |
|---|---|
| Southern Africa: | |
| South Africa | 17.9 |
| Botswana | 23 |
| Swaziland | 26.5 |
| West Africa: | |
| Senegal | 0.5 |
| Cameroon | 4.5 |
| Nigeria | 3.1 |
| East Africa: | |
| Kenya | 6.1 |
| Uganda | 7.2 |
| Tanzania | 5.1 |

Source: UNAIDS (2013) ' Global Report 2013'

Sub-Saharan Africa has the most serious HIV and AIDS epidemic in the world. In 2012, roughly 25 million people were living with HIV, accounting for nearly 70 percent of the global total. In the same year, there were an estimated 1.6 million new HIV infections and 1.2 million AIDS-related deaths. As a result, the epidemic has had widespread social and economic

consequences, not only in the health sector but also in education, industry and the wider economy.

**b. Southern Africa**

Southern Africa is the worst affected region and widely regarded as the 'epicenter' of the global HIV epidemic. In 2012, Swaziland had the highest HIV prevalence rate of any country in the world (26.5 percent). HIV prevalence is also particularly high in Botswana (23 percent). With 6.1 million people living with HIV - a prevalence of 17.9 percent - South Africa has the largest HIV epidemic of any country. The remaining countries in southern Africa have HIV prevalence between 10 and 15 percent.[6]

Polygynous relationships, as well as multiple partners have been highlighted as key drivers of HIV transmission in these countries. Indeed, the sexual networks of men in particular are quite extensive and are accepted, even encouraged in many communities. Unemployment, labour migration, and displacement as a result of conflict have also contributed to the HIV epidemic in this region.[7]

**c. West Africa**

In comparison, West Africa has only been moderately affected by HIV and AIDS. For example, in Senegal, HIV prevalence is as low as 0.5 percent, whereas in Cameroon and Gabon it is an estimated 4.5 and 4 percent respectively. In Nigeria, HIV prevalence is also relatively low (3.1 percent). However, because of its large population (it is the most populous country in sub-Saharan Africa), this equates to around 3.4 million people living with HIV putting it only second behind South Africa in terms of absolute numbers.

In West Africa, the main driver of HIV transmission is sex work, accounting for between 10-32 percent of new infections, In Niger, in 2011, HIV prevalence among sex workers was 36 percent compared to just 0.8 percent for 15-49 year olds in the general

[6] UNAIDS (2013) ' Global Report 2013'
[7] Reiners, G. & Watkins, S. (2010) ' Polygyny and the spread of HIV in Sub Saharan Africa: A case of benign concurrency' AIDS

population. Natural disasters have also played a role in the spread of HIV in West Africa as well as other illnesses.[8]

**d. East Africa**

HIV prevalence in East Africa is generally moderate to high, and second behind southern Africa. However, general prevalence has been in decline for the past two decades. For example, Kenya has seen its HIV prevalence drop from a high of 14 percent to nearly 6 percent. Uganda and Tanzania also have prevalence over 5 percent, with the lowest seen in Madagascar (0.5 percent) and Mauritius (1.2 percent).[9]

Despite this progress, there are new areas of concern with HIV prevalence on the rise among vulnerable groups including people who inject drugs (PWIDs), prisoners and uniformed services (such as the armed forces and the police).[10]

**The impact of HIV and AIDS on sub-Saharan Africa**

HIV and AIDS have, and are still having, a widespread impact in many parts of sub-Saharan Africa[11].

1. Life expectancy: At the height of the HIV epidemic in sub-Saharan Africa, life expectancy is seen stagnating, even falling in some countries. The rapid scaling up of antiretroviral treatment in recent year, does not do any better and the worst affected countries still have particularly low life expectancies.

2. Households: In the most affected parts of sub-Saharan Africa, the HIV epidemic has had a tremendous impact on households. When the income earners fall too ill to work, they have to be cared for by other household members or extended family. Children can also be removed from school to provide care or to put to work to generate income. In the worst cases, households simply dissolve.

[8] UNAIDS (2013) ' Global Report 2013'
[9] UNAIDS (2013) ' Global Report 2013'
[10] UNAIDS (2013) ' Global Report 2013'
[11] UNAIDS (2013) ' Global Report 2013'

3. Healthcare: HIV and AIDS is seen putting serious pressure on the health sector, particularly on hospital resources. Moreover, there is a visibility of chronic shortage of healthcare workers, who themselves, are often living with HIV. However, in many parts of sub-Saharan Africa, antiretroviral treatment is relieving this burden.

4. Schools and Education: The epidemic has also impacted heavily on education. School attendance drops as children become sick or return home to look after affected family members. Many lose their parents to HIV and AIDS meaning they can no longer afford to go to school, or are required to work and generate income instead. The epidemic also impacts upon the already limited supply of teachers. However, education is regarded as key to tackling the spread of HIV. Moreover, it is cost-effective.

5. Labour and productivity: HIV and AIDS have had an enormous impact on labour and productivity. The vast majority of people living with HIV in this region are of working age (15-49 years old).

6. Economic development: The combined impact of the epidemic on households, healthcare, education and productivity has stalled, even reversed economic development in parts of sub-Saharan Africa.

**Regional overview of HIV transmission in Asia**

In the early mid-1980s, while other parts of the world were beginning to deal with serious HIV and AIDS epidemics, Asia remained relatively unaffected. By the early 1990s, however, AIDS epidemics had emerged in several Asian countries and by the end of the decade; HIV was spreading rapidly in many areas of the continent.

The diversity of the AIDS epidemic is even greater in Asia than in Africa. The epidemic is also more recent and many Asian countries lack accurate systems for monitoring the spread of HIV. This means that the estimates of HIV infection in Asia are often based on less information than in other regions. The lack of research and information on the nature and linkages between sexual networks in Asian countries also makes it difficult to predict the

future course of the HIV epidemic. Half of the world's population lives in Asia, so even small differences in the absolute numbers of people infected can make huge differences in the infection rates.[12]

Although it is useful to understand the overall impact that AIDS is having on the Asian region as a whole, there is no single 'Asian epidemic'; each country in the region faces a different situation. Progress has been made in countries such as Cambodia, Myanmar and Thailand, where there has been a 25 percent decline in HIV prevalence between 2001 and 2011. On the other hand, in Bangladesh, Indonesia, and the Philippines the number of people living with HIV has increased by more than 25 percent between 2001 and 2011. There are also huge variations within countries.[13] In China, for example, the six provinces with the highest HIV prevalence's account for 75.5 percent of the people living with HIV.[14]

Asia has had the largest AIDS-related death toll outside of sub-Saharan Africa. Some have warned that epidemics in Asia could escalate to the extent of rivaling those in some parts of Africa. Others, however, argue that Asia's epidemics are on a different trajectory to those found in Africa, as HIV infection in Asia is still largely concentrated among members of 'high-risk' groups.

**a. South East Asia**

**i) Cambodia**

Cambodia's HIV epidemic can be traced back to 1991. After an initial rapid increase, HIV infection levels declined after the late 1990s and by 2003 HIV prevalence was estimated at 1.2 percent. As of 2011, HIV prevalence has halved to 0.6 percent.[15] It's believed that interventions with sex workers, carried out by the government and non-governmental organisations (NGOs), played a role in this decline. The adoption of a '100 percent condom' policy that enforced condom use in brothels led to a substantial rise in condom use among sex workers and their clients and a drop in HIV infection levels among brothel-based sex workers.

[12] Thenpillil, Jose (2006) 'Socio-Cultural dimensions of the HIV/AIDS affected'
[13] UNAIDS (2012) ' Regional Fact Sheet 2012: Asia and the Pacific'
[14] UNGASS (2012) ' China: Global AIDS Response Country Progress Report
[15] UNGASS (2012) ' Cambodia: Global AIDS Response Country Progress Report'

The use of condoms rose from 40 percent in 1997 to 99 percent in 2009; however HIV prevalence among sex workers is high at 15 percent. UNAIDS estimate that without the prevention efforts, this figure would have been more than 50,000.[16]

However, ongoing concerns include low levels of condom use among MSM, an increase in sex workers occurring outside of brothels (making it harder to reach sex workers with interventions), and mother-to-child transmission of HIV – around one third of new infections occur through this route. HIV is mostly transmitted through heterosexual sex in Cambodia, and concerns are growing about the number of married women who are infected through their husband. Cambodia also deny HIV testing to people under 18 years of age without parental consent, which has shown to hamper HIV prevention efforts among young people globally.[17]

### i. Indonesia

Around 380,000 people are living with HIV in Indonesia, which has the fastest growing epidemic in Asia.[18] This number has risen sharply in recent years and is expected to more than double in 2014 if approaches to HIV prevention are not improved.[19] This rise is due to several factors including: the country's extensive sex industry; limited testing and treatment clinics; a highly mobile population; a rapidly growing population of people who inject drugs; the denial of sexual health and reproductive services to unmarried people; and the challenges created by major economic and natural crises (the Asian financial crisis heavily affected the country in 1997, and the 2004 Tsunami devastated parts of Northern Sumatra, the largest island in Indonesia).[20]

High levels of HIV infection are found amongst high-risk groups, such as injecting drug users, sex workers and their clients and to a lesser extent, men who have sex with men. In 2012, HIV prevalence was reported as high as 36 percent among people who inject drugs. However, local regulations often criminalize high-risk groups and it has been identified that some members of the National AIDS Commission, responsible for tackling HIV/AIDS in

[16] UNAIDS (2011) ' UNAIDS World AIDS Day Report 2011'
[17] UNGASS (2012) ' Cambodia: Global AIDS Response Country Progress Report'
[18] UNAIDS (2012) ' Global Report: UNAIDS Report on the Global AIDS Epidemic 2012'
[19] Jakarta Globe (2010, 7th October) ' The Thinker: The State of AIDS'
[20] UNESCO (2013) ' Young people and the law in Asia and the Pacific'

Indonesia, are failing to address the issue of HIV/AIDS among high-risk groups.[21] Additionally, campaigns to promote condom use among people who engage in high-risk sex have met resistance from some religious groups, who feel that condoms should only be promoted to married couples.[22]

In 2012, the Indonesian government issued compulsory licenses allowing local drug companies to legally bypass drug patents and make their own, cheaper versions for the treatment of HIV and Hepatitis.[23] This development will hopefully increase access to affordable ARV drugs. Currently only 24 percent of people with HIV in Indonesia have access to treatment, with coverage falling even lower among children; the number of children eligible for treatment who are receiving it is estimated to be as low as 11 percent.[24]

### ii. Lao People's Democratic Republic (Laos)

Despite being surrounded by countries that have relatively high HIV prevalence (Thailand, China, Vietnam, Cambodia and Myanmar), Laos has a comparatively small HIV epidemic, with HIV prevalence of 0.2 percent. There are various reasons for this: the government was quick to acknowledge HIV when it first emerged in the country, and took action to warn people about it; Laos has not seen the same level of large-scale migration that has occurred in other parts of Asia; there are relatively high rates of condom use among sex workers and their clients; and it's thought that very few people in the country inject drugs. However in recent years there has been an increase of HIV infection among the most vulnerable groups, especially MSM and migrant workers, with the main transmission route being 'unsafe sexual activity'.[25]

### iii. Malaysia

HIV and AIDS statistics from Malaysia show that an estimated 0.4 percent of the population are living with HIV. Although most people infected with HIV in the country are male, there has been a steep increase in the number of new cases among women. During the late 1990s women made up around 5 percent of new infections, compared to around 21 percent

[21] Jakarta Globe (2010, 7th October) ' The Thinker: The State of AIDS'
[22] PlusNews (2012, 26th July) ' INDONESIA: Condom controversy continues'
[23] The Guardian (2012) ' Indonesia in bold move to obtain cheap drugs for HIV'
[24] WH0 (2011) ' Progress report 2011: Global HIV/AIDS response'
[25] UNGASS (2012) ' Lao: Global AIDS Response Country Progress Report'

in 2011. Malaysia, like Indonesia, denies sexual health and reproductive services to unmarried people, perhaps accounting for increasing HIV infections among women.

Malaysia's epidemic is largely driven by injecting drug use, but heterosexual transmission is accounting for an increasing number of new infections. Recent trends have demonstrated a promising decrease in annual HIV infections, from 7,000 in 2002 to 3,479 in 2011. In 2006 the government launched a five-year strategic plan to tackle HIV, which includes drug substitution therapy and needle exchange programmes for drug users, which the government is still committed to in 2013. The Ministry of Health has also developed a training module to teach religious leaders about HIV, which is important in a country where the majority of people are Muslim. In 2011, 5,910 people died from AIDS in Malaysia.[26]

**iv. Myanmar (Burma)**

Myanmar is facing a serious epidemic - an estimated 220,000 of the population is infected with HIV. Myanmar's authoritarian military regime is widely condemned for its human rights abuses, and in 2005 these concerns led the global Fund to fight AIDS, TB & Malaria, to withdraw its proposed $98.4 million grants for the country. Prevention services for injecting drug users are severely lacking with needle exchange programmes operating in just a few locations. Drug users are dealt with heavy-handedly and crackdowns on drug production have led to a scarcity of opium and heroin. This has resulted in drug inhalation being replaced by injecting, as a more cost-effective way of drug consumption, carrying with it a higher risk of HIV transmission. In 2006 methadone substitution therapy was introduced in a small number of government locations. Furthermore, in some cities the HIV prevalence among MSM is extremely high with 23.5 percent of MSM infected with HIV in Yangon and 35 percent infected in Mandalay. However, in 2011 Myanmar implemented a four-year plan to use mass media as a tool for HIV education and reducing discrimination around HIV and AIDS.[27]

[26] UNGASS (2012) ' Malaysia: Global AIDS Response Country Progress Report'

[27] Asian Harm Reduction Network, 'Civil Society Reflections on 10 Years of Drug Control in Myanmar, Thailand and Vietnam: A Shadow Report' from International Harm Reduction Development Program, Open Society Institute (2009, March), 'At What Cost?: HIV and Human Rights Consequences of the Global War on Drugs'

### v. The Philippines

An estimated 19,000 people were living with HIV in The Philippines in 2011. The country has traditionally had a very low HIV prevalence, with under 0.1 percent of the population infected. Even in groups such as sex workers and MSM that are typically associated with higher levels of HIV, prevalence rates are only 0.3 and 2 percent respectively. In the case of sex workers, this is possibly due to efforts to screen and treat those selling sex since the early 1990s. However, when looking at The Philippines HIV epidemic as a whole, there has been a 1,490 percent increase in HIV diagnoses between 2005 and 2012.[28] Condom use is not the norm in paid sex, drug users commonly share injecting equipment in some areas leading to HIV prevalence among IDUs being 14 percent, and among Filipino youth there is evidence of complacency about AIDS.

### vi. Singapore

Although the number of people living with HIV in Singapore is relatively small, the country's status as an international travel and business hub, along with the high number of infections found in surrounding countries, make it possible that the country will experience a more serious epidemic in the future. The number of annual new infections has been rising in Singapore. In 2010, a record 441 people were newly diagnosed with HIV, compared to 357 in 2006. The majority of these new infections (54 percent) are diagnosed at a late-stage of HIV infection, by which point HIV treatment should already have started. To combat these rising figures, the government focuses on preventing mother-to-child transmission, but controversially, condom use is only 'emphasized to those at risk'.[29] Another controversial policy in Singapore is the strict law banning sex between men, which undermines efforts to promote safe sex among MSM. This is concerning considering the HIV prevalence among MSM is 3 percent.

### vii. Thailand

Thailand is an example of a country where a strong national commitment to tackling the HIV and AIDS epidemic has paid off, with an admirable history of HIV prevention efforts.

[28] UNAIDS (2012) ' Global Report: UNAIDS Report on the Global AIDS Epidemic 2012'
[29] UNGASS (2012) ' Singapore: Global AIDS Response Country Progress Report'

However, some of these past prevention successes are starting to be undermined by a current lack of HIV prevention and rising STD rates. New infections are highest among MSM and women who have become infected by their husbands or sexual partners. Increases in HIV prevalence among MSM is particularly marked in Bangkok, where HIV prevalence among this group has risen from 17.3 percent in 2003 to 31.3 percent in 2009; this is in comparison to the national average of 1.2 percent. An estimated 490,000 people are now living with HIV and AIDS in Thailand.[30]

### viii. Vietnam

Around 250,000 people are living with HIV and AIDS in Vietnam. Vietnam's epidemic is still in a concentrated phase; male injecting drug users, female sex workers and men who have sex with men are the groups primarily affected. The number of people living with HIV in Vietnam doubled between 2000 and 2005. This rise included a large increase in the number of people who became infected through injecting drug use.[31] Despite previous concerns about condom use among sex workers being worryingly low, in 2011 it was reported that 87 percent of sex workers used a condom with their last client. In 2013, a mathematical study was published which predicted an 80 percent decrease in annual HIV infections and great cost-savings, if every person had an annual HIV test, and those who tested positive were offered ARV immediately. The greatest results would be achieved if prevention efforts were targeted at high-risk groups. It is hoped this will encourage HIV prevention services to increase their current scope.

Laws that criminalised sex workers and drug users often cause people that fall under these groups to fear accessing HIV prevention services; in Vietnam, the enforcement of such laws has lead to the incarceration of people in detention centers. Reassuringly, laws that protect the rights of these groups have recently been implemented.[32]

Adults and children living with HIV in Vietnam still face high levels of stigma and discrimination. One reason for this is that HIV is often strongly associated with immorality. The connection between HIV and ‘social evils’ is exacerbated through the official use of this

[30] UNGASS (2012) ' Thailand: Global AIDS Response Country Progress Report'
[31] UNAIDS (2008) 'Report on the global AIDS epidemic'
[32] UNAIDS (2012) ' Alternative action on compulsory detention: Innovative responses in Asia'

type of language, with HIV and AIDS falling under the remit of the Government 'Department of Social Evils Prevention'. One reported result of this stigma is that people living with HIV remain untreated due to a fear of being seen taking medication, and their status being publicly discovered. In order to dispel myths and misconceptions about HIV life, prevention programmes have been introduced in secondary schools since 2009.[33]

**b. East Asia**

**i. China**

China's first AIDS case was reported in Beijing in 1985. Today, an estimated 780,000 people in China are living with HIV and it is feared this number will increase dramatically in future years, as HIV spreads from the groups most at risk to the general population. In 2011 an estimated 28,000 people died from AIDS in China. The six most affected provinces (Yunnan, Guangxi, Henan, Sichuan, Xingiang and Guangdong) represent 75.5 percent of the national reported number of HIV and AIDS cases.[34]

**ii. Japan**

In 2011, around 7,900 adults and children were living with HIV in Japan. Data released by the Japanese government in February 2007 showed that annual numbers of new HIV infections and AIDS cases had risen to an all time high in 2006, to 914 and 390 people respectively. In 2010, this number rose again: there were a total 1,075 new cases of people living with HIV registered that year. MSM are particularly affected as they accounted for 52 percent of annually reported HIV infections in 2010.[35]

**c.South Asia**

**i. Afghanistan**

Afghanistan is one of the world's leading producers of opium, and drugs are widely available. The use of opiates, such as heroin and opium, has seen a dramatic increase over the last four years with a 53 percent rise in the number of regular opium users and a 140 percent rise in the number of heroin users in the period 2005 to 2009.[36] Further to this, a study of three

[33] UNGASS (2012) ' Vietnam: Global AIDS Response Country Progress Report′
[34] UNGASS (2012) ' China: Global AIDS Response Country Progress Report'
[35] UNGASS (2012) ' Japan: Global AIDS Response Country Progress Report'
[36] UNODC (2009) ' Drug use in Afghanistan: 2009 survey'

major cities in 2009 found HIV prevalence among IDUs had more than doubled since 2006; this is now at 7 percent in 2011. As a result, Afghanistan is now considered to have a concentrated epidemic.

It is estimated that 8 percent of the adult population use drugs, yet only 10 percent of drug users access harm reduction services. Moreover, awareness of the risk of HIV transmission is low among this high risk group, particularly among young IDUs. In 2010, it was reported that 40 percent of IDUs are sharing injecting equipment. Prevalence among the general population is less than 0.1 percent, however, HIV surveillance is minimal. Conditions are in place for a generalised epidemic to develop, including high numbers of displaced people, high levels of illiteracy, low social status of women, and a shortage of health facilities. The epidemic among high risk groups must be curbed to avoid HIV bridging into the wider population.[37]

**ii. Bangladesh**

The first HIV/AIDS case in Bangladesh was reported in 1989. Since 1994, HIV infection levels have increased, although the problem is still relatively small scale, with around 7,700 people infected. It is nonetheless predicted that Bangladesh may gradually be heading towards an epidemic, unless a greater response is developed. At the moment HIV is mainly confined to groups such as IDUs, migrant workers and MSM, and it is reported that this focus on risk groups has led to a lack of urgency among policy makers in dealing with the problem. However, in Dhaka, harm reduction programmes have been credited with slowing the spread of HIV among people who inject drugs. HIV prevalence in this population rose from 1.4 percent in 2000 to 7 percent in 2007, but thereafter dropped to 1 percent in 2011, well below the levels observed in areas without prevention programmes.[38]

**iii. Nepal**

An estimated 49,000 people are living with HIV and AIDS in Nepal, including 0.3 percent of the adult population.[39] 4 out of 5 HIV infections are transmitted via unprotected sex, with the

[37] UNAIDS (2012) ' Global Report: UNAIDS Report on the Global AIDS Epidemic 2012'
[38] UNAIDS (2008) 'Report on the global AIDS epidemic'
[39] UNAIDS (2012) ' Global Report: UNAIDS Report on the Global AIDS Epidemic 2012'

rest a result of injecting drug use.[40] Seasonal labour migration is an important source of income for many Nepalese, but it is associated with a higher risk of HIV infection and nearly 30 percent of total HIV infections are among male seasonal migrants. Around 4.4 percent of all HIV cases in Nepal are among clients of sex workers and 14.4 percent are MSM. The Nepalese Government have responded to the epidemic despite political instability; in 2009 Prime Minister Madhav Kumar Nepal said the government would increase resources and actions for preventing, treating and controlling the country's epidemic. However, at the end of 2011 the proportion of eligible people receiving antiretroviral therapy was just 24 percent.[41]

**iv. Pakistan**

Pakistan's first reported case of HIV occurred in 1987. Until the late 1990s, most subsequent cases occurred in men who had become infected while living or working abroad. The most at risk populations in Pakistan include injecting drug users, sex workers and prisoners.[42] Despite a low adult HIV prevalence (0.1 percent), social and economic conditions in Pakistan – including poverty, low levels of education, and high levels of risk behaviour among IDUs and sex workers – are likely to facilitate the spread of HIV in coming years. HIV prevalence among IDUs has already significantly increased - from 10.8 percent in 2005 to 27.2 percent in 2011. Hijra (transgender) sex workers are also disproportionately affected by HIV/AIDS in Pakistan; HIV prevalence among this group is 5.2 percent.[43]

### 1.1.4 NATIONAL RESPONSE TO HIV/AIDS

India is painfully realizing the impossibility of achieving the dream of 'Health for all' in the foreseeable future. Practically all the governments from the time of independence are guilty of not giving general health, the attention and priority it needs. In the process, public health system has crumbled and is facing prospect of near integration, in certain segments.

The spread of HIV in the country is as diverse as the societal patterns between its different regions, states and metropolitan areas. In fact, India's epidemics are made up of number of epidemics, and in some places they occur within the same state. The epidemics vary

[40] UNGASS (2012) ' Nepal: Global AIDS Response Country Progress Report'
[41] UNGASS (2012) ' Nepal: Global AIDS Response Country Progress Report
[42] UNGASS (2007) 'Country progress report: Pakistan'
[43] UNGASS (2012) ' Pakistan: Global AIDS Response Country Progress Report'

from states with mainly heterosexual transmission of HIV, to some states where injecting drug use is the main route of HIV transmission. 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. Both tracking the epidemic and implementing effective programmes pose a serious challenge to the authorities and communities in India.[44]

In India, the spread of HIV has been uneven. Although much of India has a low rate of 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. India has recently seen a broadening of the epidemic across the southern and the western states as well as concentration of HIV among the injecting drug users in the North eastern states. The AIDS epidemic in India consists of a number of local epidemics. Around 70% of India's population lives in rural areas once thought to be relatively immune to the epidemic. Studies however suggest that HIV has begun to spread in rural areas as well. The epidemic is now moving beyond its initial focus among sex workers and injecting drug users and is shifting towards the general populace; making women and young people the most vulnerable for HIV infection.

In India, as elsewhere, AIDS is perceived as a disease of 'others' – of people living on the margins of society, whose lifestyles are considered 'perverted' and 'sinful'. Discrimination, stigmatization and Denial (DSD) are the expected outcomes of such values, affecting life in families, communities, workplaces, schools and health care settings. Because of HIV/AIDS related DSD, appropriate policies and models of good practice remain underdeveloped. People living with HIV/AIDS continue to be burdened by poor care and inadequate services, whilst those with the power to help do little to make the situation better.

For India to respond effectively to this infection and limit the social and economic impact of HIV/AIDS, its effort need to be accelerated, intensified and expanded. With HIV prevalence doubling every one to two years in certain groups, there is still a narrow window of opportunity over the next few years to prevent the epidemic from becoming generalized and much harder to control. India's socio economic status, traditional social ills, cultural myths on sex and sexuality and a huge population of marginalized people make it extremely vulnerable

[44] Thenpillil, Jose (2006) 'Socio-Cultural dimensions of the HIV/AIDS affected'

to HIV/AIDS epidemic. In fact, the epidemic has become public health problem faced by the country since the independence.

India is experiencing a diverse HIV epidemic that affects states in different ways, and to different extents. India's most affected groups include injecting drug users, sex workers, truck drivers, migrant workers, and men who have sex with men. Some have predicted that India will soon be experiencing a 'generalised' epidemic, where the HIV prevalence rate - currently 0.3 percent among adults in India - rises above 1 percent. Others have played down current estimates of the numbers infected, and have argued that, because HIV transmission in India still largely occurs among risk groups, it is unlikely that HIV will spread widely among the general population. Regardless of the future path of India's epidemic, it is undeniable that AIDS is having a devastating impact, and that there are still many major issues – including stigma and poor availability of AIDS treatment – that urgently need to be addressed.[45]

When the first case of HIV was discovered in Chennai in 1986, the Indian government responded to the HIV epidemic immediately. Recognizing the seriousness of the situation, the government constituted a high-powered committee under the Ministry of Health and Family Welfare. Subsequently, a National AIDS Control Programme was launched in 1987. The programme activities covered surveillance, screening blood and blood products and health education.[46]

In 1991, the scope of NACP was expanded to focus on blood safety, prevention among high-risk populations, raising awareness in the general population, and improving surveillance. A semi-autonomous body, the National AIDS Control Organization (NACO), was established under the Ministry of Health and Family Welfare to implement this program. This "first phase" of the National AIDS Control Program lasted from 1992 -1999.[47] It focused on initiating a national commitment, increasing awareness and addressing blood safety. It achieved some of its objectives, notably increased awareness. Professional blood donations were banned by law. Screening of donated blood became almost universal by the end of this phase. However, performance across states remained variable. By 1999, the program had also

[45] UNAIDS (2010) 'UNAIDS report on the global AIDS epidemic'
[46] Thenpillil, Jose (2006) 'Socio-Cultural dimensions of the HIV/AIDS affected'
[47] NACO: HIV-Handouts, Byword editorial consultants, 2006.

established a decentralized mechanism to facilitate effective state-level responses, although substantial variation continued to exist in the level of commitment and capacity among states. Whereas states such as Tamil Nadu, Andhra Pradesh, and Manipur demonstrated a strong response and high level of political commitment, many other states, such as Bihar and Uttar Pradesh, have yet to reach these levels.

The second phase of the NACP began in 1999 and ended in March 2006. Under this phase, India continued to expand the program at the state level. Greater emphasis was placed on targeted interventions for the most at risk populations, preventive interventions among the general population, and involvement of NGOs and other sectors and line departments, such as education, transport and police. Capacity and accountability at the state level continues to be a major issue and has required sustained support. Interventions need to be scaled up to cover a higher percentage of the population, and monitoring and evaluation need further strengthening. In order to induce a sense of urgency, the classification of states has focused on the vulnerability of states, with states being classified as high and moderate prevalence (on the basis of HIV prevalence among high risk and general population groups) and high and moderate vulnerability (on the basis of demographic characteristics of the population).

While the government's response has been scaled up markedly over the last decade, major challenges remain in raising the overall effectiveness of state-level programs, expanding the participation of other sectors, and increasing safe behavior and reducing stigma associated with HIV-positive people among the population.

The Third Phase of NACP (NACP 3) program has dramatically scaling up targeted interventions in order to achieve a very high coverage of the most at risk groups. Under this phase, surveillance and strategic information management also receive a big boost. Partnerships with civil society organizations was at paramount in the implementation of the programme with special focus on involvement of community in the program planning and implementation.

On completion of NACP III, government of India has realized their strengthens and with the help of development partners and donor agencies, NACO has conducted consultations [they had a series of consultative workshops] with all the stakeholders including the

representatives from civil societies, community representatives, non-health departments and experts from public health and designed the program activities for NACP IV. The focus of this phase will be primarily on scaling up prevention through NGOs and sustaining the efforts and results gained in last 3 phases and integration with the health systems response to the epidemic e.g. through provision of ART, STI services, and treatment of opportunistic infections through the National Rural Health Mission. The focus of the World Bank support to the NACP IV is to further scale up and reach out with targeted prevention interventions to the most at risk population groups to contribute to the reduction in new infections.[48]

There are numerous Non-Governmental and Community Based Organizations (NGOs & CBOs) working on HIV/AIDS issues in India at the local, state, and national levels. Projects include targeted interventions with key populations; direct care of people living with HIV; general awareness campaigns; and care for children orphaned by AIDS. Funding for non-government and community-based groups comes from a variety of sources: the federal or state governments of India, international donors, and local contributions. Several CBOs have also piloted innovative approaches to tackling the stigma and discrimination that hinders access to effective HIV prevention, treatment and care services among populations most at risk.

India receives technical assistance and funding from a variety of UN partners and bilateral donors. DFID and the World Bank are pooling partners with NACO in the financing of NACP 3. The Bill and Melinda Gates Foundation's Avahan program, Clinton Health Access Initiative, DFID, GFATM, UNAIDS, UNFPA, UNICEF, UNDP and WHO.[49]

There is still a general lack of awareness about many things that affect people's lives. The people are as unaware of HIV/AIDS as they are of preventable diseases like malaria, tuberculosis and waterborne diseases. It is therefore, no wonder that HIV/AIDS is now regarded as just another disease. The fact that other diseases are curable and AIDS is not does not seem to matter much as long as one is not directly affected. The moment the HIV positive status is known, there is an inevitable panic reaction. Slowly but steadily the problem of AIDS is coming into the open as the biggest challenge to the 'Health for all' concept. The demands emanate from two fronts: the need for effective prevention methods and the urgency to sustain

[48] NACO (2012) ' Annual Report 2011-2012'
[49] NACO (2012) ' HIV Sentinel Surveillance 2010-2011, A Technical Brief'

the health promotion process. The advent of the HIV infection has created priorities for those working in the health promotion, health education and social welfare. And the physical aspects of AIDS and HIV are part of many people's lives. The broader social dimensions affect the human race.

Inequalities of wealth and power in society, which are largely the result of rapid industrialization that is not people centered, render a substantial number of the population inaccessible to basic resources and incapable of making the right choices to lead a satisfactory life.

High levels of male dominated rural to urban migration and also international migration for better economic remuneration not only disrupts family life but can also create a demand for sexual services in the places where the man lives.

Lack of proper housing, absence of spousal company in the case of married, stress of urban living and freedom from parental or social control motivate many single migrant men to seek paid sex or to share partners. On their annual trips to home these men are likely o put their partners at risk from infection. Mobile populations like those of truck drivers, army personnel and those in touring jobs are also under increased threat of HIV infection as their sexual encounters with strangers are likely to be high.

Demographic changes in recent times towards a younger population are also a critical factor in enhancing the risk of HIV infection in India. This trend coupled with delaying marriages, implies that a larger proportion of the population will engage in sexual activities mostly unsafe an unprotected and therefore at risk from HIV infection.

Several other aspects of the socio-cultural life of India are likely to be significant in understanding the impact of HIV/AIDS, particularly the implication for women. It is now generally acknowledged that women are vulnerable to HIV/AIDS and yet are often powerless to ensure needed behaviour change for protection against this infection. Women's health needs are generally neglected in India and few women have access to health care services. Therefore, there is a strong likelihood that prevalence of HIV and AIDS among women in India is under-recognized and under-reported.

A single AIDS related illness or death can devastate an entire household through the loss of family income, the strain caused by prohibitive medical costs, or the stigma attached to families affected by HIV. In some cases, surviving family members have been abandoned, abused or attacked, while struggling to cope with their own HIV related illness. As the number of individuals and households affected by HIV multiplies, the social impact of the epidemic both widens and deepens. The social support systems and traditional methods help face unprecedented challenges.

### 1.1.5 STATEMENT OF THE PROBLEM

Taking the above discussion into account, it can be said that HIV/AIDS epidemic is a complex and multidimensional phenomenon that has become a major health and social problem in the under developed and developing countries. The epidemic emerged in the early 1980'screating unprecedented challenges to human society in various dimensions of human life. Today, the HIV continues to spread across the globe irrespective of its geographical expanse causing huge increase in mortality and morbidity among children and adults along with severe consequences socially and economically at the most.

All over the world, HIV/AIDS is causing devastation destroying communities and families and taking away hope for the future. The impacts of HIV/AIDS are numerous. In the absence of a cure, and in most cases in the absence of adequate treatment, HIV/AIDS diminishes or destroys quality of life before it takes away life itself. Its psychological, social and economic impact on life quality affects family, friends and community. It affects production as well as household incomes and expenditures; it poses major problem for health system and care practices; it diminishes the capacity of societies' to provide essential services and plan for the future; and it threatens good governance and human security.

HIV/AIDS is having a dramatic effect on the lives of the individuals, families and communities. The daily threat of stigmatization and discrimination is on rise. HIV/AIDS has become one of the dominant social problems in contemporary society. It has acted as a spotlight exposing many iniquitous conditions in society. It has infected millions of people all over the world and affected not only the individuals dependent upon them but societies and

nations at large. No other epidemic has caused such damage to productive economic and social assets of countries and neutralized the fruits of decades of economic and social advancement.

The HIV/AIDS problem itself has become a vast and complete phenomenon in the world today. The present society is fragmented and has affected the system from its normal functioning. HIV/AIDS is yelling at society where physical, social, ethical, legal, economic, psychological and spiritual life is degrading day by day. It also reveals the tragic consequences of personal actions that endanger others.

There has been an alarming annual rise of new HIV cases in the North Eastern states from 5549 (new cases) in 2001 to 6460 (new cases) in 2011. The total number of HIV infected persons in the whole North East region is 63,049 cases with Manipur leading the list with 25369 cases and Sikkim recording the lowest with just 593 cases. This is just a contrast to the national trend where the overall decline rate in India is 57% recorded from 2001 to 2011.[50]

Nagaland, like any other North-Eastern State is in turmoil socially with a host of social problems cropping up. The emerging dominant social problem is the prevalence of HIV/AIDS in Nagaland.

According to Sentinel Surveillance Report 2014, Nagaland is the sixth state with highest prevalence of HIV/AIDS in the country with an alarming ratio of 0.88%. Country's figure stands comparatively lower at 0.37%.[51] HIV/AIDS epidemic is a complex and multidimensional phenomenon that has become a major health and social problem in the under developed and developing countries. The epidemic emerged in the early 1980's creating unprecedented challenges to human society in various dimensions of human life.[52] Today, HIV continues to spread across the globe irrespective of its geographical expanse causing huge increase in mortality and morbidity among children and adults along with severe consequences socially and economically at the most.

The first HIV case in Nagaland was detected in the year 1990 by ICMR among the IDUs. It has now been 24 years since the first case was detected. According to the Strategic

[50] Newmai News Network, June 3 2014 'North East AIDS cases show alarming trend'
[51] Sentinel Surveillance Report 2014, Nagaland State AIDS Control Society
[52] Thenpillil, Jose (2006) 'Socio-Cultural dimensions of the HIV/AIDS affected'

Information Management System (SIMS), there are 693 children infected with HIV in Nagaland and about 100 children orphaned by HIV/AIDS.

This phenomenon of high HIV prevalence in Nagaland state cannot be explained by mono-casual explanation but it should be seen within the framework of social, political, economic and cultural context of the state. One of the basic reasons is easy access to drug because of drug trafficking across the international border with Myanmar and the economic interest that lies there. The supply and the demand factor of drug i.e heroin when associated with other factors gave rise to high prevalence of Injecting Drug Users (IDUs) in late 1980s and 1990s. The increased unemployment along with the changing lifestyle of the youth also exaggerates the HIV/AIDS epidemic in the state. Out of frustration, family problems, pleasure seeking, IDU as a fashion and the lack of societal control, intravenous drug use emerged as a refuge for the restless youth. Many youngsters in the state start to indulge in drug abuse, gradually changing their lifestyles. Along with this, lack of political will and social unrest lead to increase in the prevalence of IDU. In the present scenario, it is observed that the spread of HIV infection is expanding beyond the IDU to the general population. Even though there are no red light areas in the state, the phenomenon of female sex workers or commercial sex workers has increased.

The problem of the HIV/AIDS pandemic is something that cannot be neglected, as the epidemic poses a challenge for the health of society. As the infection diffuses, the epidemic continues to affect the community, family and individual in different dimensions. The first wave of impact emerged on the infected persons and their families, partners and those who take care of them. It includes the trauma of diagnosis, community reaction (acceptance, stigma and discrimination), economic and emotional impact on their families, reaction of health care workers, illness and death.

HIV is affecting the families, the youth, the children, women and the entire society. People with HIV/AIDS face stigmatization and discrimination, which fuels the epidemic. HIV is a security threat because it threatens the economic, human, societal and even the traditional notions of security. It has become an alarming situation in Naga society. Naga society, which used to be confined and bound by traditional norms and values, has now been attacked by this

pandemic affecting the families, youths, gender- equality and the entire society needing proper attention.

In spite of the high prevalence rate of HIV/AIDS in the state, no intensive and systematic research studies have been carried out to monitor or assess the prevalence/incidence rate in the state. For the reasons stated above, we were convinced to undertake this given topic to study the magnitude of HIV/AIDS and its impact on Naga Society. As per the response of the respondents, the transmissibility of HIV is the greatest through the sexual route followed by the Intravenous drug use as the second most powerful route of HIV as stated in Table 3.1 in Chapter 3.

## 1.2: METHODOLOGICAL FRAMEWORK

The primary aim of this research is an effort to understand and explore the various aspects of HIV/AIDS in a long term perspective in the state considering characteristic such as household information, individual and family problems, disease history and health services utilization, rehabilitation and welfare measures. This involved an exhaustive study of the demographic characteristics and the details of the pandemic handled by the respondents i.e. both the affected and the general populace. Secondly, the identification of its impact was done by detecting the factors through field survey and comparing them across the various districts and the neighbouring states.

Keeping this in mind, the fundamental objectives of the study are:-

a) To identify and examine the factors and causes leading to the rapid rise of HIV/AIDS in Nagaland.

b) To study the impact of HIV/AIDS on Naga society

c) To examine the level of awareness and understanding about HIV/AIDS among the people in Nagaland and the initiatives taken by the government and NGOs

d) To create awareness education and suggest remedial measures towards controlling HIV/AIDS.

### 1.2.1: Scope/Significance of the Study

This research study on the magnitude of HIV/AIDS and its impact on Naga society is the first of its kind in Nagaland from sociological point of view. It aims at generating awareness about the pandemic of HIV/AIDS among cross-sections of people. The finding of the present study would serve as a valuable input for the church, government, NGO's, students and the society as a whole. It is also significant because it is directly related to the present scenario of Naga society where it will serve as a benefit to the PLHA's (People living with HIV/AIDS), the community, the family and the society. It is also an enrichment of literature in such fields and an indication of avenues for future research by the scholars.

### 1.2.2: Research Hypothesis

a) Poverty leads to prostitution resulting in HIV/AIDS.

b) Low level education and awareness are related to the spread of HIV/AIDS.

c) The progression of human society will be hindered if the rapid rise in HIV is allowed to continue unchecked.

### 1.2.3: Research Design

The exploratory and descriptive research design was adopted due to the nature of the study. Exploratory research provides insights into and comprehension of an issue or situation. Exploratory research is a type of research conducted because a problem has not been clearly defined. Exploratory research helps to determine the best research design, data collection method and selection of subjects. While descriptive research, also known as statistical research, describes data and characteristics about the population or phenomenon being studied. Descriptive research answers the questions who, what, where, when and how. Thus, on the basis of the above, the two research designs were appropriate for the present study as it was important to gauge the various causes that give rise to the pandemic and which eventually impacts the society as a whole.

The research study was based on stratified random sampling method. The study aimed at different categories of people from different walks of life. The study covers the entire state of Nagaland consisting of eleven districts viz. Dimapur, Kohima, Mokokchung, Wokha,

Phek, Mon, Longleng, Tuensang, Kiphire, Phek and Zunheboto. For this purpose, 400 respondents were selected randomly from every district as stated in Table 5.1 in Chapter 5. Some of the respondents were very helpful while some were made to understand the sole purpose of the research and assure them that the data so provided will be used for academic research only. Information was also gathered through e-mails and telephonic conversation in order to substantiate the data gathered.

**Table 1.2: Sample frame**

| Samples | No. | Justification (What they represent ) |
|---|---|---|
| Infected (PLHA) | 100 | They are the core group of this research study. To study the impact of HIV/AIDS |
| General population | 100 | To assess the people's response, opinion, knowledge, awareness, attitude and community participation |
| Jails | 11 | To analyze the services provided and their approach |
| Non –governmental organization | 40 | To estimate the organizations programme planning, delivery, implementation, monitoring, evaluation, achievements and expectations |
| Nagaland State AIDS Control Society | 09 | To evaluate the departmental initiatives |
| Religious organization | 50 | To review the knowledge, awareness, initiatives and the approach towards the pandemic |
| Doctors and medical staff (Hospital) | 40 | To review their approach as care givers |
| Administrators and Law enforcing agencies | 50 | To assess their initiatives, awareness and approach |
| Total Respondents | 400 | |

Table 1.2 shows the number of samples followed by justification of why they were incorporated in this research study. The respondents covers the young and the old, infected and

affected individuals and families, households, male and female, pastors, youth directors, police, Hindu Priest, Muslim, doctors, nurses, counselors, administrative officers and employees, NGO functionaries and employees, jailors, commercial sex workers etc. This study has tried to cover all the people from different segments of society in order to get as much as information related to the pandemic and its implications on the individual, the society and the community as a whole. The 400 respondents are the base of this research study and all their views and opinions are taken into consideration.

Due to the sensitivity of the issue of HIV/AIDS, the respondents were divided into two categories out of which 100 are PLWHAs (People Living with HIV/AIDS) and the remaining 300 respondents are the representative from schools and colleges, Religious organizations, Administration; Non Governmental Organization, Jails, Hospitals etc as stated in Table 5.1.

**Strategy of Data Collection**

Stage 1: Construction and finalization of questionnaires

On the basis of the data's collected from primary and secondary sources, several sets of questionnaires were constructed. Seeing the need of different set of questionnaires for different set of respondents, thorough extensive reviewing and testing of some questionnaires, the final sets of 9 (Nine) questionnaires were constructed as follows for data collection.

Set I : Questionnaire schedules for jails

This questionnaire consists of two parts comprising of 16 questions.

Set II : Questionnaire schedules for hospital/ medical practitioners

This questionnaire consists of two parts comprising of 13 questions.

Set III : Questionnaire schedules for law enforcing agencies/police personnel

This questionnaire consists of one part comprising of 17 questions.

Set IV : Questionnaire schedules for employees of Non Governmental Organizations/Care Centres. This questionnaire consists of two parts comprising of 18 questions.

Set V : Questionnaire schedules for PLHA

This questionnaire consists of two parts comprising of 16 questions.

Set VI : Questionnaire schedules for Religious Organization/churches

This questionnaire consists of two parts comprising of 13 questions.

Set VII : Questionnaire schedules for employees of NSACS (Nagaland State AIDS Control Society). This questionnaire consists of two parts comprising of 18 Questions.

Set VIII : Questionnaire Schedules for Legislators Forum on AIDS/ Directorate of Women Development/ Women Commission for Nagaland State / Family Planning Association of India: This questionnaire consists of two parts comprising of 18 questions.

Set IX : Questionnaire schedules for Non affected and infected population

This questionnaire consists of two parts comprising of 28 questions.

In order to cover up the study, two interview schedules have also been applied such as:-

1. Interview schedules for NGOs Chief Functionaries
2. Interview schedules for NSACS (Nagaland State AIDS Control Society)officials

A total of 400 questionnaires were printed and a sample copy of each set/category is attached in the appendix.

It is to be mentioned here that because of the vastness of the study area and the complexity of the subject itself, the field work could be completed only in two years i.e from 2009-2011. The researcher visited both the urban and rural areas of Nagaland in order to get access to the problem in every nook and corner of the state.

**Stage II: Collection of Primary and Secondary data**

Primary data was collected through interviews, group discussions as well as questionnaires schedules. Intensive field studies, participant observation and interaction with the cross section of people supplemented to the analysis by providing more primary data. For this purpose, information and data were collected from 400 respondents comprising of the PLWHA (People Living with HIV/AIDS), caretakers from different hospitals and care centers of Nagaland, jails, administrators and law enforcing agencies, NGOs working in the relevant field as well as members from different religious organizations were investigated. Members from various departments and organizations like the NSACS (Nagaland State AIDS Control Society), Directorate of Women Resource Development, FPAI (Family Planning Association of India), Nagaland Commission of Women, Legislature Forum on AIDS etc were interviewed as well.

Through the doctors, nurses, social workers, students, unemployed, drop outs, government officials, journalists, People Living With HIV/AIDS (PLWHA), police, church leaders, youths, lawyers, farmer, housewives etc. information on the prevalence of the HIV/AIDS and its statistics, services, awareness level and other necessary facts first hand information were ascertained. During the process some of the respondents were very helpful while some were made to understand the sole purpose of the research and assure them that the data so provided will be used for academic research only. Information was also gathered through e-mails and telephonic conversation in order to substantiate the data gathered.

Secondary data was drawn from the journals, books, magazines, newspapers, biographies, memoirs, reports, official documents, and relevant publication, websites etc. Three case studies were conducted in this research study which is elaborated in the chapters.

**1.2.4: Instrumentation**

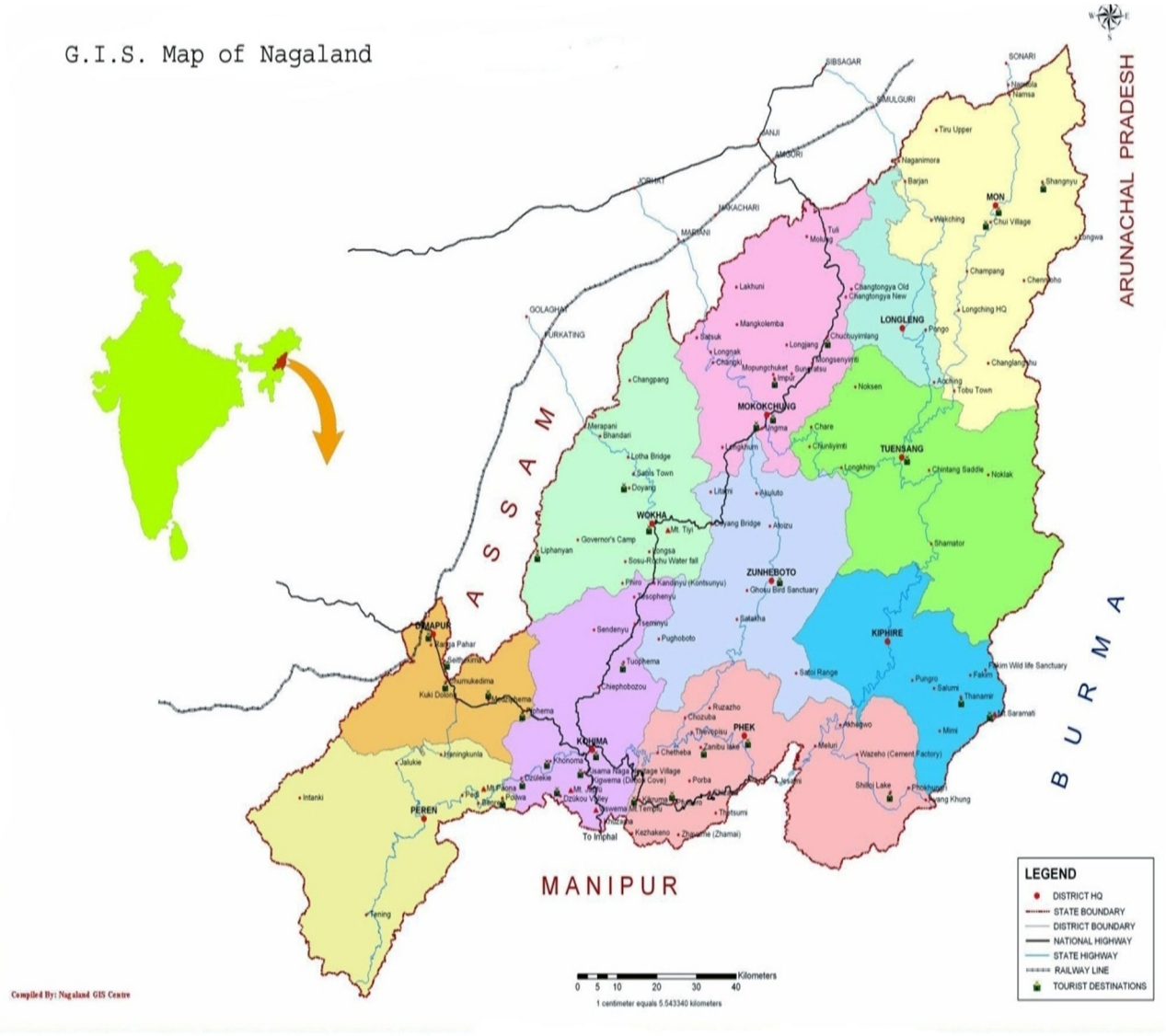
For effective and flawless data collection, survey method and case study methods were extensively used. Survey method was also extensively used for data collection. Considering the interviews as an appropriate method to use when exploring practitioners perspectives due to the qualitative nature of the information, it has been extensively used. Case study methods are used for an in-depth investigation of a single individual, group, or an event.

It provides a systematic way of looking at events, collecting data, analyzing information, and reporting the results. Three case studies have been included in this study. Thus, these methods have been widely used to extract the most relevant information and help in better analysis of the data. Questionnaire and interview schedules were also implemented extensively in the process.

### 1.2.5: Data Analysis Procedure

Coding of variables, cross checking, transferring of data marked the procedural aspects of the data Analysis, keeping in mind that coding of variables in quantitative research is very critical for better interpretation of results. Age, total experience, designation, team size, total duration and total value of the research work were all coded and were entered into the computer. The questions and responses were coded and entered in the computer using Microsoft Excel software. Manual tabulation method was applied on the data to get the results analyzed. The data collected from various sources was systematically processed, classified, and computed, results of which are presented in subsequent chapters.

## 1.3: AREA OF STUDY




**Profile of the study area**

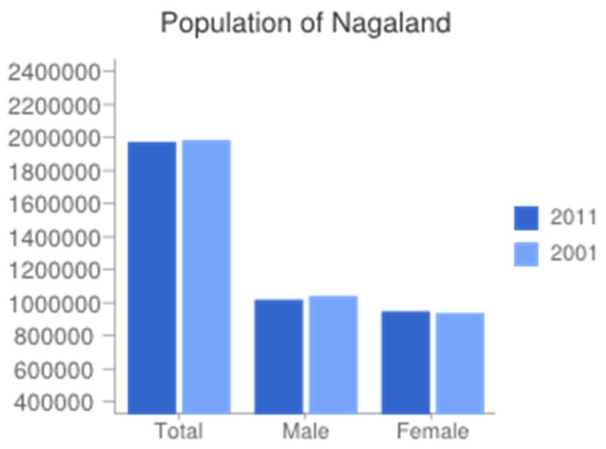
Nagaland became the 16th state of the Indian Union on 1 December 1963. Nagaland is situated on the easternmost region of India Nagaland is originally a tribal state covering an area of 16,579 sq.km approximately. It is one of the North Eastern states of India, sharing an international boundary with Myanmar on its extreme South west. The state lies between 25.6'N and 27.4'N latitudes and between 95.20'E and 95.15'E longitudes. Nagaland is bounded by the states of Assam in the west, Myanmar (Burma) in the east, Arunachal Pradesh and parts of Assam in the north and Manipur in the south. The state is mostly mountainous except those

areas bordering Assam valley. Mount Saramati is the highest peak with a height of 3,840 metres and its range forms a natural barrier between Nagaland and Burma.

Geopolitically, Nagaland is a sensitive state as China lies close to it in the north, Bangladesh on the west with Myanmar alongside, Thailand on the east where the valley of Bangladesh, Myanmar and Thailand merge together forming a common valley known as the 'Golden Triangle' which is located close on the heels of Nagaland. This valley serves as a central meeting point for these three nations with their respective smuggled goods of all kinds of merchandise.

As per details from Census 2011, Nagaland has a population of 19,80,602, out of which 10,25, 707 are male and 9,54, 895 are female as on March 1, 2011 according to the Provisional Population Totals of Nagaland for Census 2011. Its population is widely diversed and has 16 tribes living in the state.

**Figure 1.1: Population of Nagaland**




Source: *www.census2011.co.in/census/state/**nagaland**.html*

The gender ratio in Nagaland's population however is the least as compared to other North eastern states. The sex ratio is greater in the rural population as compared to urban. Literacy in Nagaland has undergone an extremely positive improvement in the last decade. The literacy rate in Nagaland stands at 80.11 %which is higher than the National average of 70.04%. There is a marked improvement from 66.59% in 2001 and 61.65% in 1991. In 2011,

the total literate population rose from 1, 132, 323 in 2001 to 1, 357, 579 in 2011.[53] The literacy rate of total urban population is 90.21% with urban male and urban female literacy rate of 92.11% and 88.10% respectively.

**Table 1.3: District wise population and literacy rate of Nagaland**

| District | Population | Literacy rate |
|---|---|---|
| Dimapur | 379769 | 85.44 % |
| Kiphire | 74033 | 71.1 % |
| Kohima | 270063 | 85.58 % |
| Longleng | 50593 | 73.1 % |
| Mokokchung | 193171 | 92.68 % |
| Mon | 250671 | 56.6 % |
| Peren | 94954 | 79 .00% |
| Phek | 163294 | 79.13 % |
| Tuensang | 196801 | 73.7 % |
| Wokha | 166239 | 87.6 % |
| Zunheboto | 141014 | 86.26 % |

Source: *www.census2011.co.in/census/state/**nagaland**.html*

Mokokchung district has the highest literacy rate of 92.68 followed by Wokha with a percentage of 87.6%. Out of the total population of Nagaland, 28.86% people live in urban regions. The total figure of population living in urban areas is 570, 966 of which 299, 177 are males and while remaining 271, 789 are females. The urban population in the last 10 years has increased by 28.86%. Nagaland has 11 administrative districts. The state has only one airport in its biggest city Dimapur. The state capital of Nagaland is Kohima. It is one of the few states in India to have English as its official language. Due to its variation in its culture, about 20 languages are spoken in the state, Nagamese being the widely used one.

The present study on the magnitude of HIV/AIDS and its impact is concentrated on the entire state of Nagaland which has 11 administrative districts viz, Kohima, Dimapur,

[53] Census of India 2011, Provisional Population Totals Paper 2, Volume II of 2011- Rural Urban Distribution, Nagaland Series 14

Mokokchung, Tuensang, Wokha, Zunheboto, Phek, Kiphire, Mon, Longleng and Peren. According to the latest Technical Report, India HIV estimates from NACO, Nagaland is at 0.88% prevalence rate much higher than the national prevalence rate at 0.37%.[54] The highest prevalent state at ANC sites in the country with an estimated HIV prevalence rate of 0.88. Dimapur, the gateway to Nagaland records the highest number of HIV prevalence rate in the state followed by Tuensang and Kohima.[55]

**Table 1.4: HIV test undertaken among general clients attending ICTC centres**

| District | Number of clients receiving pre-test counseling/information | Number of clients tested for HIV | Number of clients testing HIV positive (after 3 specified tests) | Number of clients receiving post-test counseling |
|---|---|---|---|---|
| Dimapur | 7181 | 7178 | 453 | 7175 |
| Kiphire | 1047 | 1047 | 25 | 1047 |
| Kohima | 5433 | 5399 | 137 | 5399 |
| Longleng | 919 | 919 | 6 | 919 |
| Mokokchung | 7390 | 7387 | 40 | 7380 |
| Mon | 3772 | 3772 | 7 | 3772 |
| Peren | 2174 | 2174 | 12 | 2174 |
| Phek | 1537 | 1536 | 10 | 1536 |
| Tuensang | 4499 | 4475 | 97 | 4480 |
| Wokha | 2642 | 2642 | 11 | 2642 |
| Zunheboto | 2281 | 2281 | 10 | 2281 |
| Nagaland | 38875 | 38810 | 808 | 38805 |

Source: NSACS 2014

Table 1.4 shows the total number of people (excluding pregnant women) undergoing HIV testing in the state from April 2013 to September 2013 is 38810 out of which 808 were detected with HIV after 3 specified tests. The highest number of ICTC attendees is in Mokokchung, where a total of 7390 clients attended the ICTCs and 7387 clients underwent HIV testing. Comparing the number of testing done in Dimapur and Mokokchung, the number of clients found positive is alarmingly high in Dimapur. The lowest number of testing done is

[54] M&E Bulletin April – September 2013
[55] M&E Bulletin April – September 2013

recorded in Longleng with just 919 clients attending the 3 ICTCs situated in Longleng district, PHC Tamlu and PHC Yongyah.

Out of the 38810 client who were tested for HIV, 23551 were males and 15259 females. The number of positivity is higher in females with 2.61% as compared to the male positivity rate of 1.74%. The overall data showing the ICTC status and the AIDS cases and related deaths in Nagaland[56] so far are projected below:-

**Table 1.5: ICTC Status**

| Particulars | 2014-15 | | | Cumulative since 2006 | | |
|---|---|---|---|---|---|---|
| | G.Clients | ANC | Total | G.Clients | ANC | Total |
| Blood screened | 13336 | 3197 | 16533 | 521562 | 150851 | 672413 |
| HIV positive | 294 | 36 | 330 | 14970 | 1593 | 16563 |

Source: NSACS 2014

**Table 1.6: HIV status of Children in Nagaland**

| Particulars | 2014-15 | | | Cumulative since 2007 | | |
|---|---|---|---|---|---|---|
| | Male | Female | Total | Male | Female | Total |
| Blood screened | 198 | 215 | 413 | 10614 | 10704 | 21318 |
| HIV positive | 7 | 9 | 16 | 291 | 308 | 599 |

Source: NSACS 2014

**Table 1.7: AIDS Case Surveillance – Since 1994**

| AIDS case reported | 2014-15 | Cumulative | AIDS related deaths | | 2014-15 | Cumulative |
|---|---|---|---|---|---|---|
| | | | Adult | Male | 9 | 406 |
| | | | | Female | 9 | 309 |
| Male | 68 | 2974 | Children | Male | 1 | 34 |
| Female | 69 | 2545 | | Female | 0 | 28 |
| Total | 137 | 5519 | Total | | 19 | 777 |

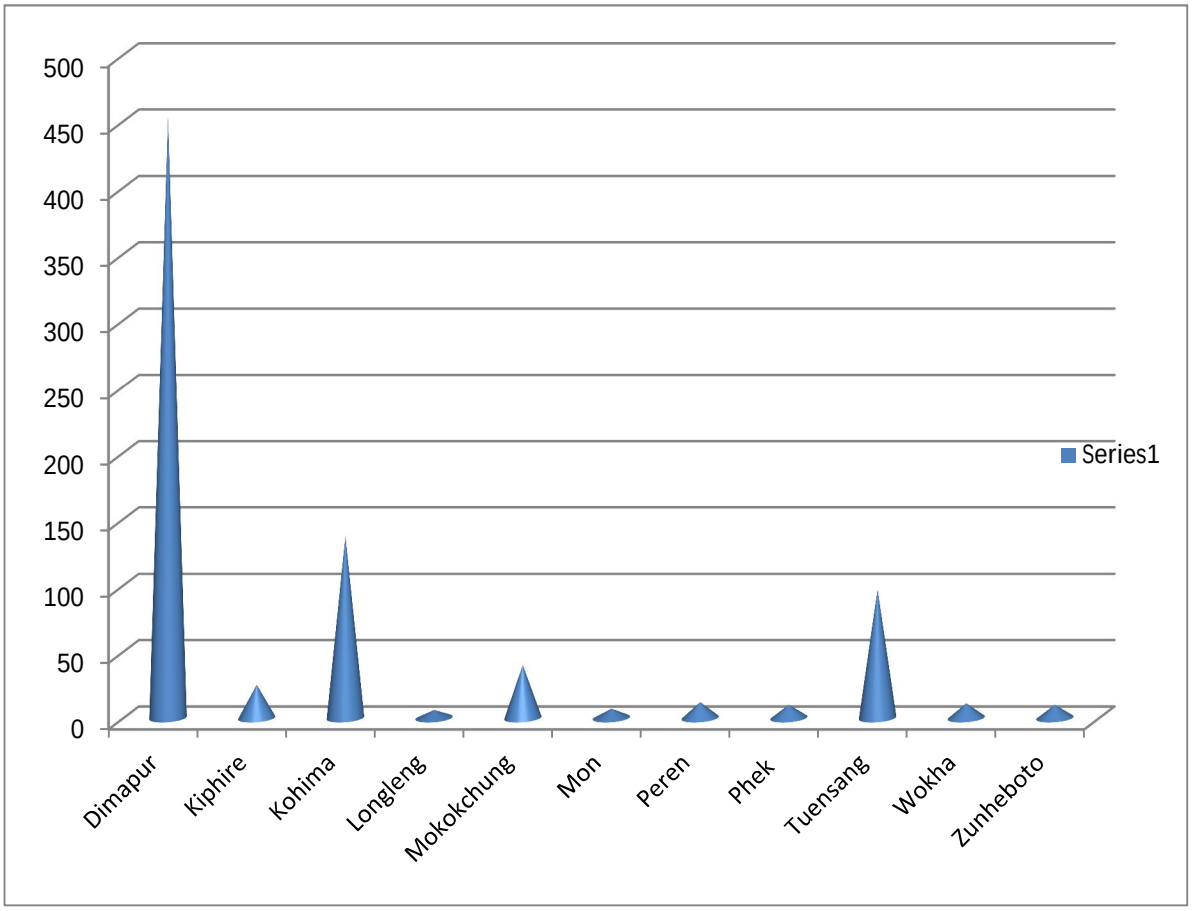
Source: NSACS 2014

Figure 1.2 below shows the prevalence of HIV/AIDS in different districts of Nagaland with Dimapur making the lead followed by Kohima and Tuensang. The rate of positivity is the highest in Dimapur with 453 followed by Kohima, Kiphire and Tuensang at 25, 137 and 97 respectively. The high rate of positivity in Kiphire is because though the number of clients

[56] Nagaland State AIDS Control Society

undergoing HIV testing is low at 1047 clients, 25 were found to be HIV positive. Comparing to this, the other districts like Phek, Peren, Wokha and Zunheboto where the clients tested are more than Kiphire but positivity is lower than Kiphire. If we look at the HIV positive detected then Dimapur records the highest number with 453, followed by Kohima at 137 and Tuensang at 97.

**Figure 1.2: District wise trend of HIV positivity among general clients**




In the first half of 2014, the HIV/AIDS scenario in Nagaland still shows new detection every month at an average of 130-140 cases even after numerous awareness and sensitization programs organized and supported by State AIDS Control Society and various other organizations. The issue of stigma and discrimination remain at large.

## 1.5 PROFILE OF THE RESPONDENTS

These profiles of the respondents are the results based on the data collected for the study. It includes age, gender, marital status, educational qualification, religion and occupational status. The profiles are divided into two categories i.e PLWHA respondents in one set and the general respondents in another. Seeing the sensitivity of the issue of PLWHA and also being the core group to be studied upon, it was important to divide the respondents into two categories; the first set comprises of 100 PLWHA respondents and the second set comprising of 300 respondents.

**Table 1.8: Categories of respondents**

| Primary classification of Respondents | Nos |
|---|---|
| Infected (PLHA) | 100 |
| General population | 100 |
| Jails | 11 |
| Non –governmental organization | 40 |
| Nagaland State AIDS Control Society | 09 |
| Religious organization | 50 |
| Doctors and medical staff (Hospital) | 40 |
| Administrators and Law enforcing agencies | 50 |
| Total | 400 |

Table 1.8 given above, presents the selection of the respondents. The respondents comprises of Students and College goers, Drop Outs, Religious Organizations, Administration; Non –Governmental Organization, Jails, Hospitals, Individuals etc Various law enforcing agencies like the police were also taken into account in this present study. The total sample size

has provided valuable insights in order to grasp the idea of the problem of HIV/AIDS and how it has tremendous impact on society irrespective of tribe, place, age, religion, gender etc.

**Table 1.9: Distribution of the PLWHA respondents by Gender and Age**

| Gender | Frequency | Age group | % |
|---|---|---|---|
| Female | 46 | Below 24 | 11 |
| | | 25-34 | 47 |
| Male | 54 | 35-44 | 37 |
| | | 45-54 | 5 |
| | | 55 and above | X |
| Total | 100 | Total | 100% |

From the table 1.9, it is clear that there are 46 PLWHA female respondents and 54 PLWHA male respondents. Comparatively female PLWHAs are no lesser than the male percentage of the HIV infected males. This depicts that HIV/AIDS does not distinguish between gender and age groups. It is therefore gender blind and infects those who resort to high risk behaviours.

It is evident from the table 1.9 that the maximum number of respondents belongs to the age group 25-34, followed by the age group 35-44. Even though the age group below 24 has only 11 respondents, it signifies the age where people develop themselves in term of social and economic aspects of the life. It is also the age where people generally face several problems like stress, frustration, intensified conflict and crisis in adjustment, pleasure in taking risk and experimenting new things, a stage of search for one's self-marked and intimate peer affiliation and clique formation at a later stage. They are easily hooked by the HIV/AIDS epidemic.

**Table 1.10: Distribution of the PLWHA respondents by their marital status**

| Marital status | % |
|---|---|
| Married | 70 |
| Unmarried | 28 |
| Divorced | 2 |
| Total | 100 |

With regard to the marital status, table 1.10 shows that 70 were found to be married, 28 were unmarried and 2 respondents were found to be divorced. This study portrays the high level of prevalence rates of HIV/AIDS among married couples. This also indicates a situation where HIV/AIDS hampers the sanctity of marriages and goes up to the extent of mistrust and divorce among the married couples.

**Table 1.11: Distribution of the PLWHA respondents by their educational level**

| Educational qualification | No of person | Total |
|---|---|---|
| X and below<br>V<br>VII<br>VIII<br>IX<br>X | <br>2<br>4<br>13<br>3<br>27 | 49 |
| Higher secondary level | 8 | 8 |
| Graduation level<br>B.A<br>B.COM | <br>16<br>2 | 18 |
| Post Graduation | 1 | 1 |
| No response | 24 | 24 |
| Total | 100 | 100 |

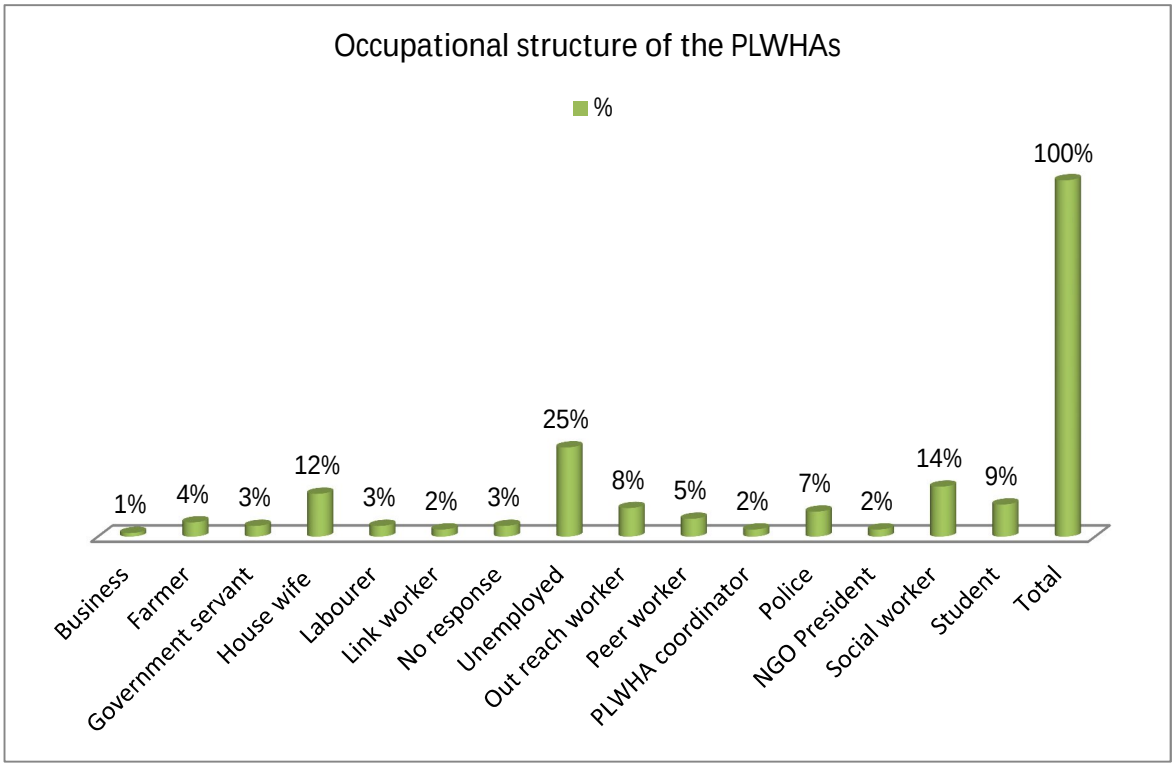
Table 1.11 given above indicates the educational qualification of the PLWHA respondents. Out of the 100 PLWHA respondents, there is only one respondent who has a master degree and 24 respondents didn't respond to this query. A large proportion of PLWHA respondents have the educational qualification up to X and below. The PLWHA respondent across the education criteria under graduation level could be still considered as vulnerable to the HIV/AIDS pandemic.

**Table 1.12: Distribution of the PLWHA respondents by religion**

| Religion | % |
|---|---|
| Christians | 82 |
| Hindu | 5 |
| Muslim | 6 |
| No response | 7 |
| Total | 100 |

From the table 1.12, it is evident that the respondent comprises a majority of Christians. Nagaland being a Christian state, and the data portrayed in this table is not taken by surprise. Out of the 100 respondents there were only 5 Hindus and 6 Muslims and the remaining 7 did not respond.

**Figure 1.3: Distribution of the PLWHA respondents by their occupation**




Occupational status is one of the criteria for determining the socio-economic position of the respondents. When people are less educated and less paid, they cannot meet their family needs and finds it hard to support the everyday existence. They become sick of life and get hooked up in drugs and thereby seek for sexual pleasure. From figure 1.3, it is evident that the respondents are distributed among a wide spectrum of occupational status. However 3 respondents didn't respond and 25 respondents were found to be unemployed.

Due to the complexity of the study, two different sets of respondents were classified. One set comprised of the 100 PLWHAs exclusively while the other set consists of 300 respondents comprising of all the people from different walks of life.

Table 1.13 below highlights the gender and age of the general respondents. It is clear that 115 respondents out of 300 were males and the rest i.e. 185 comprised of the women folk. It is seen here that the unmarried 175 respondents constituted the bulk followed by 123 married respondents. One respondent each constituted the divorced and the NR category.

**Table 1.13: Distribution of the profile of general respondents**

| Gender | | Marital status | | | |
|---|---|---|---|---|---|
| Male | Female | Married | Unmarried | Divorced | NR |
| 115 | 185 | 123 | 175 | 1 | 1 |

*NR = No Response

**Table 1.14: Religion wise distribution of general respondents**

| Religion | | | |
|---|---|---|---|
| Christian | Hindu | Muslim | Others |
| 292 (97.4%) | 3 (1.00%) | 3 (1.00%) | 2 (0.6%) |

Table 1.14 portrays a total of 292 respondents Christians out of the 300 respondents with a percentage of 97.4% and 1% each were Hindus and Muslims. The remaining 0.6% were placed in the others category.

**Table 1.15: Distribution of the general respondents by age**

| Age group | No. of person |
|---|---|
| 15-24 | 39 |
| 25-34 | 148 |
| 35-44 | 35 |
| 45-54 | 41 |
| 55 and above | 37 |
| Total | 300 |

Table 1.15 projects the age group of the general respondents. The age group 25-34 had more respondents in comparison to the other age groups.

**Table 1.16: Distribution of the respondents by educational level**

| Education | No of person |
|---|---|
| Upto X | 31 |
| XII | 32 |
| BA/B.Sc/B.th/BD/B.Com | 151 |
| M.Com/M.Div/M.Sc/M.th/MA/MSW | 41 |
| LLB | 2 |
| MBBS | 15 |
| GNM/B.SC Nursing | 20 |
| MD | 1 |
| Ph.d | 5 |
| No response | 2 |
| | 300 |

Literacy rate in Nagaland has seen an upward trend. According to the 2011 census, Nagaland has a literacy rate of 80.11 %. The literacy rate of total urban population is 90.21% with urban male and urban female literacy rate of 92.11% and 88.10% respectively. In actual numbers, total literates in Nagaland stands at 1,342,434 of which males were 723,957 and females were 618,477. In Table 1.17, it is reflected that the highest respondents are those who have graduated or are undertaking a bachelor's degree course. Except for 2 respondents who failed to give their educational qualification, remaining respondents comprised of those who were studying or studied up to X and XII, master degrees and varied professional courses.

## 1.5 CHAPTERISATION

This thesis comprises of 6 (Six) chapters. A brief description of all the chapters are given below:-

Chapter one 'Introduction' is an introductory part which depicts the global and the national scenario of HIV/AIDS. It is further followed by an explanation on the definition of HIV/AIDS and theories about its origin. Statement of the problem of the research study and the methodologies implemented throughout the research are incorporated thereafter. The methodological framework covers the objectives, hypothesis, research design, instrumentation and data analysis procedures. Detailed explanation of the study area and the profiles of the respondents mark the end of the chapter.

Chapter two is the 'Review of Literature' that gives an overview of the review of literatures related to the selected field of study. This chapter gives a theoretical base for the research and describes, summarizes and clarifies the literatures reviewed. Altogether there are about 200 books reviewed.

Chapter three deals with the 'Causes and Impact of the Spread of HIV/AIDS in Nagaland' and seeks to portray the modes of HIV transmission in Nagaland. It depicts the ways in which HIV is transmitted in the state and the factors facilitating transmission are described. The chapter begins with an examination of 100 (One hundred) respondents who are infected with the virus. They are addressed here as People Living with HIV/AIDS (PLWHA). Here the data are presented to support the findings and recommendations of the study. This chapter also provides a comprehensive overview of the impact of HIV/AIDS in Naga society. It has been 24 years since then AIDS emerged as a major health and social emergency in Nagaland, the epidemic has had a serious, and in many places and devastating effect on human development. Nagaland is in the grip of the HIV/AIDS pandemic with an increasing number of infections. Nagaland is one of the six high HIV-prevalence states in the country. The present study has used the existing data that was collected through the primary and the secondary sources. It indicates the scenarios of HIV spread in Naga families and how it impacts on their psycho social and economic life.

The fourth chapter 'Agencies of HIV/AIDS control measures' presents the agencies of control measures towards the pandemic in Naga society. In a state like Nagaland, it has been considered necessary to look into the role of the religious organizations, the intervention by governmental as well as nongovernmental organizations, schools and other institutions of learning, the family and the individuals etc. These agencies are the backbone towards the

controlling of the epidemic. A critical evaluation of the HIV control machineries has been evaluated to bring about a qualitative research thesis.

Chapter five deals with the 'Magnitude of HIV/AIDS: A District wise Comparative Analysis' brings about a comparative analysis of the magnitude of HIV/AIDS between the eleven districts of Nagaland. It looks into the Socio-economic considerations, seriousness of the issue, educational considerations, people's response and human rights issues. This chapter stands to make a critical analysis.

Chapter six presents the major finding of the study, observation and suggestion in the form of recommendation marks the end of the chapter.

Various theories on the emergence of HIV/AIDS and the epidemiological details of its spread around the globe not excluding India discussed above, depicts the seriousness of the pandemic and how it evolved over time, hampering the social and economic fabric of the present era. The evolution of HIV/AIDS and the implications brought about around the world, shows how devastating it can be. The various methods applied in this research work brought about satisfactory results which are projected in the subsequent chapters. Basing on the review of literature that forms the base of the research work, this study produces a concerned piece of research work.

# CHAPTER - 2

# REVIEW OF LITERATURES

Literature Review is "a systematic, explicit, and reproducible method for identifying, evaluating, and synthesizing the existing body of completed and recorded work produced by researchers, scholars, and practitioners." Review of Literature is an evaluative report of information found in the literature related to the selected area of study. A review of literature provides theoretical knowledge and leads to sources of information on various themes and thus leading to discovery of new theories. It leads us to the world of what has so far and what needs to be done in a particular area of research. In this study, thematic method of review of literature is presented under different themes as mentioned below.

## 2.1 INTRODUCTION

In the last three decades since HIV/AIDS was first identified, the body of research into the epidemic has been steadily growing. At the present juncture, research covers a wide range of topics ranging from strictly medical studies to the social and demographic implications of the study as well as to research into interventions and best practices that may help to halt the spread of the problem. This chapter provides an overview of the stigma in the HIV/AIDS epidemic, HIV related studies conducted in India and in other countries and the impact of HIV/AIDS on the role of the elderly.

The statistics about the impact of HIV/AIDS worldwide are overwhelming. Estimates of the United Nations Agency for AIDS (UNAIDS) indicate that over 40 million people were living with HIV/AIDS in 2005, that nearly 25 million people have died of AIDS since the disease was first discovered in the 1980's, and that more than 15.6 million children under 15, have lost either their mother, their father or both parents as a direct result of AIDS (UNAIDS, 2005).

## 2.2 STIGMA IN THE HIV/AIDS EPIDEMIC

Although stigma is considered a major barrier to effective responses to the HIV/AIDS epidemic, stigma reduction efforts are relegated to the bottom of AIDS program priorities.

The complexity of HIV/AIDS related stigma is often cited as a primary reason for the limited response to this pervasive phenomenon. Systematically, the scientific literature on HIV/AIDS related stigma to document the current state of research, identify gaps in the available evidence, and highlight promising strategies to address stigma is reviewed here. The following are the key challenges under this theme each defining, measuring, and reducing HIV/AIDS related stigma as well as assessing the impact of stigma on the effectiveness of HIV prevention and treatment programs. HIV/AIDS related stigma (H/A stigma) is invoked as a persistent and pernicious problem in any discussion about effective responses to the epidemic. In addition to devastating the familial, social, and economic lives of individuals, H/A stigma is cited as a major barrier to accessing prevention, care, and treatment services. Despite widespread recognition of the differential treatment of persons living with HIV/AIDS (PLHA) by society and its institutions, over the first 25 years of the epidemic, community, national, and global actors have only had limited success in alleviating the deleterious effects of H/A stigma. In describing a sustained response to the HIV/AIDS epidemic, Peter Piot, Executive Director of UNAIDS (2003), 'AIDS: from crisis management to sustained strategic response', identifies tackling stigma and discrimination as one of five key imperatives for success. At the same time, Piot notes that stigma reduction efforts are relegated to the bottom of AIDS program priorities, often without funding to support such activities.

Much of the rhetoric and literature has cited the complexity of H/A stigma and its diversity in different cultural settings as the primary reasons for the limited response to this pervasive phenomenon by Parker R, Aggelton P (2002) in his book 'HIV and AIDS-related stigma and discrimination: a conceptual framework and implications for action'. The complexity of the phenomenon has led to difficulties and disagreement about how to define HIV/AIDS stigma and sometimes, to an erroneous conflation of stigma with its related concept of discrimination. The manifestation of HIV/AIDS stigma not only varies by cultural/national setting, but also by whether one is considering intrapersonal versus societal levels of stigma. The variability in manifestations of stigma by setting and level has led to difficulty in measuring the extent of stigma, assessing the impact of stigma on the effectiveness of HIV prevention/treatment programs, and devising interventions to reduce

stigma. These four challenges – defining, measuring, assessing impact of, and reducing stigma – among others have hampered local and global efforts to address H/A stigma.

By acknowledging the role of social processes and power in the promulgation of stigma, a more precise understanding and definition of discrimination emerges. Discrimination focuses attention on the individual and social producers of stigmatization rather than the recipients of stigma as stated by Link BG, Phelan JC (2001) in 'Conceptualizing stigma'.

Discrimination is a consequence of stigma and defined as "when, in the absence of objective justification, a distinction is made against a person that results in that person being treated unfairly and unjustly on the basis of belonging or being perceived to belong, to a particular group"- Castro A, Farmer P (2005) 'Understanding and addressing AIDS-related stigma: from anthropological theory to clinical practice in Haiti'. Stigmatized groups, including PLHAs, are in this way systematically disadvantaged in a variety of ways including in income, education, housing status, medical treatment and health.

Pinel EC (1999) 'Stigma consciousness: the psychological legacy of social stereotypes' talks about conceptualizing stigma as a combination of individual and social phenomenon underscores the importance of addressing self-imposed, individual, as well as structural (or institutional) discrimination. Self-imposed discrimination occurs when an individual comes to expect the application of a stereotype to him/herself and out of fear of the expectant rejection and resignation, a priori acts as if discrimination has already been imposed. Individual discrimination refers to more obvious and overt discrimination taking place between two people.

According to Link BG and Phelan J (2001) in 'Conceptualizing stigma', structural discrimination refers to accumulated institutional practices that work to disadvantage stigmatized groups, and can work in the absence of individual prejudice and discrimination. Like in other stigmatized medical conditions, most research and intervention for H/A stigma has targeted self-imposed and some aspects of individual discrimination, largely excluding the structural dimensions of discrimination.

Link BG, Phelan J (2001) 'Conceptualizing stigma' offers a broader conceptualization that elucidates both the socio-cognitive and the structural aspects of stigma and the relationship between them. In their conception, stigma exists when the following four interrelated components converge: 1) Individuals distinguish and label human differences, 2) Dominant cultural beliefs link labeled persons to undesirable characteristics (or negative stereotypes), 3) Labeled persons are placed in distinct categories to accomplish some degree of separation of "us" from "them," and 4) Labeled persons experience status loss and discrimination that lead to unequal outcomes. Stigmatization is entirely contingent on inequalities in social, economic, and political power that enable the four aforementioned components of stigma to unfold. Link and Phelan's conceptualization of stigma may serve as a good starting point for developing a comprehensive framework for H/A stigma, since no such framework was identified in this literature review.

## 2.3 HIV/AIDS AND EDUCATION

The focus on education to eradicate the prevalence of HIV/AIDS makes sense objectively and intuitively. Kelly (2003) opines that educational system is one major weapon because it reaches the majority of people and that almost every prevention effort depends on education and communication in some way or the other. Education is also necessary to combat the culture of silence, the stigmatization and the discrimination that is associated with HIV/AIDS (UNESCO, 2002)

The responsibility of promoting change through the education system falls on the shoulder of the teachers. The role of teachers in combating HIV/AIDS are by creating preventive awareness of the disease by generating knowledge, promoting attitude development and change, and ensuring that children develop skills that will allow them to be comepetent and assertive in managing relationships and sexual issues (UNESCO, 2002).

Knowledge about HIV and AIDS is centered on disseminating information about the modes of transmission, means of prevention and behaviours that enhance susceptibility. Attitudes typically concern not only the overall attitude towards the disease, but also encourage tolerance and understanding of those that have been infected by HIV. The skills that children will need are frequently formulated very broadly (and therefore are often termed as life skills), in terms of communication, critical thinking, self-efficacy, among others. In

practice, however, a lot of the teaching about HIV/AIDS still focuses only on the knowledge dimension of HIV/AIDS (Action Aid, 2003).

Two separate qualitative studies by Chiwela and Mwape (1999) and Molambwe (2000) of Zambian teachers and HIV/AIDS clearly reveal that most teachers in the country have neither been trained to deal with HIV/AIDS nor have they provided with teaching/learning materials. As a result, teachers are not sufficiently knowledgeable on the topic to pass on correct and complete information to students. Teachers were also not aware of the need to use extra-curricular activities to teach HIV/AIDS instruction and when questioned about this they generally indicated that they did not see extra-curricular activities as a viable channel for teaching about HIV. The study also highlighted a lack of openness towards communicating about the epidemic, with teachers declaring they were uncomfortable talking about matters related to sex with their pupils and thus engaging in selective teaching of topics. Chiwela and Mwape (1999) also reported that teachers believe that young people who are exposed to sexual information will be more likely to engage in sexually permissive behaviour later on in life and thus argued against providing this information.

A qualitative study in India Verma, Sureender and Guruswamy (1997) which examined children and teachers' perception of AIDS and sex found a similar relationship between science teachers and less inhibition in talking about HIV/AIDS. This perception was shared by non-science teachers who declared that this was a topic that should be dealt with in science class rather than throughout the curriculum.

Given the pervasive impact on HIV and AIDS on society and communities and the dire predictions of what is still to come, there is no doubt that resources, human and otherwise needs to be mobilized to fight against the pandemic.

## 2.4 STUDIES CONDUCTED IN OTHER COUNTRIES

Jette Nielson and Bjorn Melgaard (2005) on their paper 'The economic and security dimensions of HIV/AIDS in Asia' talks about how the international community has come to realize that there are more aspects to the HIV/AIDS epidemic than health. In the worst affected countries of the world, HIV/AIDS has influenced all sectors of society by making economies stumbles and undermining human security. Asia hosts more than half the

world's population, it has substantial and increasing share of the global economy, and is home to large national defence forces, including three of the world's seven declared nuclear states. The finding says that if the HIV incidence rates continue to increase in Asia, the epidemic has the potential to hamper the economic prospects of billions as well as affect political and military stability. The HIV/AIDS epidemic in Asia has a substantial impact on rural household economy. The disease has a limited impact on the private business sector and is only starting to show on the health sector in the worst affected countries. With its potentially negative impact on household income, food and personal security, the epidemic could become a threat to human security and has the potential to undermine human development. Uniformed services continue to be vulnerable to HIV/AIDS and despite low prevalence rates among military and police, uniformed services especially personnels posted out must be targeted in HIV/AIDS awareness programmes.

David Wilkinson and his team (2000) made a study on 'An evaluation of the ministry of health/NGO home care programme for people with HIV/AIDS in Cambodia'. Cambodia has one of the fastest growing epidemics in Asia but also has an active government and NGO response. In 1998, the Cambodian ministry of health established a partnership with a group of NGO's to develop and deliver home care in Phnom Penh and in Battambang Province. The findings clearly shoe that home care has an impact at a number of levels. This has reduced the suffering of the People with HIV/AIDS, improved their quality of life and that of their caregivers' increased understanding of HIV/IADS to empower the poorest by giving social and economic support. The findings have also shown that the cost of delivering home care compared favorably with out patient services ad with home cares services in other countries.

Roy, C.M and Cain R (2001) in their article on 'The involvement of people living with HIV/AIDS in community based Organizations: contributions and constraints' paid attention on this neglected aspect. An important feature of the social and organizational response to the epidemic has been that many people living with HIV/AIDS have demanded to have a say in the development of policies and the delivery of services. Surprisingly little attention has been paid in the literature to this involvement. This paper is based on a participatory action research project that involves 70 people with HIV/AIDS in 15 focus group discussions. Findings from the study show the complexities of translating

organizational commitments to involve people with HIV/AIDS into practice. This paper outlines the organizational contributions of people with HIV, and examines the difficulties and obstacles to their meaningful interpretation. The paper concludes with a discussion of the challenges of user empowerment and with recommendations for policy and practice.

Dixon Patrick (2004), The Truth about AIDS, ACET International Alliance and Operation Mobilization, speaks about the specialty of AIDS virus, how people become infected and some life and death issues.

UNAIDS (2005) in its report on 'A scaled-up response to AIDS in Asia and Pacific' summarizes the AIDS challenge in Asian and Pacific countries. While some countries have already made their decision and begun to scale up effective AIDS programme, in others there is still hesitation. Using the best available evidence, it discusses the reasons why critical services currently reach only a fraction of those in need. It also outlines the action needed that will allow the region to seize this key moment of opportunity. The report observed that the growing political and financial support for AIDS efforts has been accompanied- and in some cases preceded- by stronger civil society engagement. Organizations of people living with HIV/AIDS are advocating for increased access to treatment and care, and working to alleviate the stigma associated with the disease.

In Cambodia, civil society organizations and people living with HIV/AIDS joined with the national government and international donors to develop a national AIDS plan. NGO's created by former drug users have initiated drug substitution programmes in India and organized harm reduction services in South East Asia. Sex worker advocacy groups have created and expanded programmes in Bangladesh, India, Cambodia and Thailand, while programmes for men who have sex with men (MSM) have emerged in Pakistan, Nepal, the Philippines and Thailand.

In some countries, the lawyers' collectives have taken up legal battles to fight instances of discrimination against people living with HIV. Finally, the report makes recommendations for urgent implementation of strategies known to work, by global, regional and national political leaders, by international donors, the UN system, civil society and other key stake holders in Asia and the Pacific. The report specifically recommended that the countries should increase support to civil society organizations' involvement in national

responses by identifying and implementing viable and effective mechanisms for financing, building capacity and promoting coordination of civil society organizations. These include, among others, legal recognition, tax incentives, streamlined contracting regulations and financial support to build effective and accountable community based organizations.

Gill, Peter; (2007), "The politics of AIDS", projects a debatable issue where he questions when AIDS is preventable, why millions have been infected. In order to avert this catastrophe, he calls upon individuals and institutions to fix responsibility for the catastrophe. In the book it debates how the earlier Bush administration, allied with the Christian right, has joined the Vatican in promoting abstinence and fidelity. Many African leaders have deliberately ignored the crisis and South Africa has even withheld life-saving drugs from its people. Britain has promoted concern for AIDS in Africa, but has neglected its duty at home. The main beneficiaries of the epidemic have been the big pharma drugs companies to protect their patents and profits at the expense of the poor. The efforts of Indian companies to break that stranglehold have been thwarted.

Kirson Weinberg (1970) Social problems in modern urban society deals with an urban society in which basic problems concerning the urban habitat challenges its viability, programs, experiments, polices and procedures which have been formulated to cope with these challenging urban predicaments.

Mc Dowell, Josh, (1987) The Turning Point: Facing HIV/AIDS, deals extensively with the origin of HIV/AIDS, methods of transmission and the factors behind its spread. It further illustrates on the role of the church, government and civil society, community, schools, family, individual etc.

WCC, Facing AIDS-The challenge, the churches response (1997), approaches the challenge from different perspectives: science, the socio-economic context, theology, ethics, human rights, the churches, pastoral care and education.

## 2.5 STUDIES CONDUCTED IN INDIA

Creating Resources for Empowerment in Action (CREA), New Delhi published a series of annotated bibliographies on Reproductive Health Research carried out during 1990-2000. These bibliographies are part of the Gender and Reproductive Health Research

Initiative' sponsored by the Ford Foundation. Six areas of concern in reproductive health were identified of which HIV/AIDS was one. The designated team searched on each of these areas. Accordingly a team comprising Dr. Vimala Nadkarni, Anita Rego and Deeksha Vasundhra prepared annotated bibliography on HIV/AIDS along with a critical review paper, which looked at the content gaps, methodological issues and ethical concerns in the research. This has culminated into inviting proposals for future.

Medical practitioners, social scientists, funding organizations, government organization and individuals have researched the two decade long epidemic widely. The existing research on HIV/AIDS in India has been grouped under the following categories and presented in the table below:-

**Table 2.1 Research on HIV/AIDS in India.**

| Sl.no | Themes of Research | No. of Studies (%) |
|---|---|---|
| 1. | Understanding and awareness of HIV/AIDS | 42 (35.0%) |
| 2. | Safer sexual practice and other modes of risk reduction | 18 (15.0%) |
| 3. | Biological and societal vulnerabilities to HIV/AIDS | 15 (12.5%) |
| 4. | Economic impact of HIV/AIDS | 03 (02.5%) |
| 5. | Disclosure, stigma and discrimination | 06 (05.0%) |
| 6. | Mental health issues including substance abuse | 13 (10.8%) |
| 7. | The rights of positive people | 01 (00.8%) |
| 8. | Prevention programmes and intervention | 15 (12.5%) |
| 9. | Mixed themes | 07 (05.9%) |
| | Total | 120 (100%) |

Source: CREA, New Delhi

The annotated bibliography lists 126 studies carried out during 1990-2000 on HIV/AIDS. State-wise 33 studies were conducted in Maharashtra, 21 in Delhi, 13 in Tamil Nadu, 12 in Karnataka, 8 in West Bengal and 5 each in Andhra Pradesh and Uttar Pradesh. It indicates 77% of the studies conducted in the above mentioned seven states only. Numbers of study conducted in the remaining states were below five and even no study was conducted in few states. Seven studies were conducting more than one state. City- wise 21 studies were conducted in Delhi, 17 in Mumbai, 11 in Chennai, 10 in Bengaluru and 8 in Kolkata. It means most of the studies were conducted in urban areas. Surprisingly numbers of study

conducted in Andhra Pradesh (5), Manipur (4) and Nagaland (1) are comparatively less in spite of their high HIV infection rate. There were six studies conducted in other countries

Mohammed Shaukat and Salil Panakadan (2009) in their paper "HIV/AIDS in India: Problem and Response" shows the epidemiological analysis of data and reports in India that the highest number of HIV infection have been reported in Maharashtra and Tamil Nadu and the highest rates among injecting drug users (IDUs) in the north eastern state of Manipur. It talks about the critical phase of prevention and care programmes where HIV infection is transcending the boundaries of high risk population and spreading into the general populace. It looks at HIV/AIDS prevention and control as a developmental issue with deep socio-economic implications and not merely a health issue. It touches all sections of population, both infected and affected, irrespective of their regional, economic or social status.

K.S. Rao, et.al (1995) conducted a study on "Awareness of HIV/AIDS among voluntary organizations in Andhra Pradesh" during 1988-91. The aim of the study was to access the knowledge about the transmission of HIV/AIDS, misconceptions and safe sexual behavior among voluntary organizations. A structured questionnaire was administered to different voluntary organization in Andhra Pradesh after conducting 27 HIV/AIDS health educational programmes for them. The majority of the participants were aware about HIV/AIDS and the associated aspects. Ignorance (61%) was reportedly higher among the rural youth even after the health education session. It is found that post-intervention had a significant impact on knowledge gain.

Jacob Happymon's (2003) book "HIV/AIDS as a security threat to India" basic proposition is that HIV/AIDS is a security threat to India. It talks about how a mild HIV/AIDS epidemic in the country could have adverse implications for the working age population of the country. While many of the think tanks in the world have made studies of how HIV/AIDS can adversely affect a country's security, in India, however, such studies are hard to come by. There has been a steady increase in the rate of HIV/AIDS infection in India. HIV/AIDS has now changed its 'focus group' and is increasingly concentrating on the general population and both the rural and the general areas. HIV/AIDS constitutes a human security threat where it destroys human security both at the individual and at the collective level because it causes individual suffering and death. HIV/AIDS victim contact other

opportunistic disease, falling prey to the normal Indian practice of making them social outcasts. It kills people at an extremely productive and reproductive age and creates demographic problems within the country. This human suffering which goes on to destroy a considerable proportion of a state's population constitutes a direct threat to that state's security. It projects HIV/AIDS as a threat to India's economic security and also argues about the societal security of the country. It is understood as a relative preservation of a society's time-honoured structures, time-tested institutions and the well being of its members which can also be jeopardized by the disease. People can be disengaged from their societies, AIDS orphans can take o criminal activities, intergovernmental discords can take place and social institutions like marriage can lose their present shape and form due to HIV/AIDS, leading to social instability and chaos.

AIDS is the leading infectious cause of adult deaths in the world and it has affected almost every country including India. The valuable lessons learnt in different countries show that HIV/AIDS can't be tackled by the government alone; it requires a broad multi-sectoral response. Within this partnership, NGO's are also making a significant contribution in HIV/AIDS prevention and care. So far India is concerned, National AIDS Control Organisation (NACO) recognizes the importance of NGO's participation and involves them in all the activities for the implementation of national AIDS control programme. However, is an exclusive reliance on NGO's a viable solution? Will NGO's be able to discharge their duties properly with limited finance? Are the beneficiaries happy with the services of NGO's?

Chopra Suhita, (1995), Condom, Aids and Sexuality, addresses the debate drawing on the most recent data of HIV/AIDS from various disciplines. It exposes the limitation of western prophylactic technologies in the third world settings. The book has too much criticism of modern medicine and its technological recommendation.

Banerjee, Nilotpal (1995) AIDS in Indian Society- To sail in the ocean, hints at AIDS as an infectious disease process where he projects the modes which are only acquired, primarily resulting in deficiency of the immunity status of man.

Thomas Gracious, (1994) 'AIDS in India, Myth and Reality' projects how almost every community in the world which has been faced with the problem of HIV/AIDS has first

reacted by denying the existence of the problem. The author attempts to bring out the present scenario of HIV/AIDS in India which clearly shows the already sown seeds of public health disaster. When a new and deadly disease appears, it becomes natural to know what it is all about, where it comes from, how it is transmitted, the magnitude of the problem, the implications it has on the health and social life of the people and the possibilities of its prevention, control and treatment.

Panda, Chatterjee Abdul, (2002), Living with the Aids virus- The epidemic and the response in India" exposes India living with the human immuno deficiency virus. Given the size of the country, its high population density and interstate migration, preventing the further spread of HIV as also providing care facilities to people with AIDS are both critical and mammoth tasks. It traces the evolution of the HIV epidemic in India and documents how the largest democracy in the world has responded to it. The legal issues related to HIV/AIDS in India are highlighted to assist in a more comprehensive understanding of the complex ethical and human dimensions involved. The strengths and weaknesses of the interventions and the socio-economic impact of HIV/AIDS in the country are analyzed, providing a deeper understanding of this epidemic in India.

Narain Jai. P (2004), 'AIDS in Asia: The challenge ahead' focuses on Asia in recognition of the tremendous importance of HIV/AIDS and presents it as an unprecedented health and development threat in the region. It highlights the various advances in HIV research, as well as the new initiatives and their applications throughout the developing world.

Mishra R.C (2005) portrays HIV/AIDS as a devastating force destroying communities and families and taking away hope for the future in his book **'**HIV/AIDS Education'. HIV/AIDS pandemic has become a human, social and economic disaster, with far-reaching implications and individuals, communities and countries. He opines that each year there are more and more new HIV infections, which shows that people either aren't learning the message about the dangers of HIV, or are unable or unwilling to act on it. Many people are dangerously ignorant about the virus. Mishra talks about education which has a key role to play both in preventing HIV/AIDS and in mitigating its effects on individuals, families, communities and society. As the disease has affected people from every nook and

corner of the world without any age or gender parity, it is essential that HIV/AIDS education ought to be aimed at all parts of society, not only those groups who are seen as particularly high risk.

Even if education were completely successful, it would still have to be an ongoing process, he says. Each generation, a new generation of people become adult and need to know how to protect themselves from infection. The older generations, who have hopefully already been educated, may need the message reinforced, and need to be kept informed, so that they are able to protect themselves and inform the younger ones.

'HIV/AIDS Education' is a book about the use of education's life sustaining power to fight against HIV/AIDS pandemic. It shows the centrality of education to HIV prevention and its use in reducing both the risk of HIV infection and people's vulnerability to HIV. It also points out the impact that AIDS is having on education systems and the remedies that need to be put in place to relieve the impact. The current strategies and trends in HIV/AIDS education for particular populations, including children, adults, women and adolescents are also discussed. The book speaks volumes on school based HIV/AIDS education, on primary education, on adult education, AIDS and girl education, HIV/AIDS and sex education, peer education, stigma and discrimination etc.

A.Wati, Health, Healing and Wholeness-Asian Theological Perspective on HIV/AIDS (2005), presents the Asian face of the Global HIV/AIDS scenario, poverty and the struggle for women to live. It highlights the gender and the vulnerability of individuals to HIV/AIDS.

Thenpillil, Jose; (2006) "Socio-Cultural dimensions of the HIV/AIDS affected", presents HIV/AIDS as not only a medical problem but also a socio-cultural one. The author has made a multi dimensional approach in dealing with the pandemic. He has analysed it from the medical, psychological, sociological, social work, cultural and ethical point of view.

The book covers the theories on the origin of HIV/AIDS, its global spread, its symptoms and various methods adopted in its diagnosis, sufferings undergone by persons living with HIV/AIDS socially, psychologically and economically, tips for behavioural

orientation to people in general and code of conduct to be imposed by NGO on themselves while caring for persons living with HIV/AIDS.

While describing the Indian situation, the author has clearly identified the reasons for its spread as socio- economic status, traditional social ills, cultural myths on sex and sexuality and a huge population of the marginalized. This book projects the disproportionately high HIV cases in the states of Karnataka, Tamil Nadu, Andhra Pradesh, Maharashtra and the North East states of India. States in the Southern and the Western are most advanced compared with the rest of India. Still the rate of HIV affected is high in these areas.

Factors such as the attitude of the society to premarital sex and to late marriages have significant bearings on the incidence of HIV/AIDS. It has been stated that HIV epidemic and its impact will only be overcome if men and women begin to forge partnerships of mutual respect, trust and of equitable sharing of the burdens of sadness, pain, care and support created by the epidemic. Changes in the individual relationship between men and women will occur only in the context of new social situation, which requires a radical assessment by societies.

By way of methodology, the author has showed an innovative approach in case study method and has shown throughout the study an overall empathetic approach without sacrificing objectivity.

**'**People living with HIV/AIDS' authored by Arunkumar M.C and Rajeev Irengbam (2009) makes a successful attempt to highlight every aspect of the life of the people living with HIV/AIDS. The book highlights the pandemic rise in mid 1990's in Manipur posing a challenge to human, as health is an indispensable ingredient and a major determinant of human development. It opines that to catch hold of the growth of the epidemic, plethora of preventive measures were taken up. As the infection diffuses the epidemic continues to affect the community at large, family and individual at different dimension. The first wave of impact falls on the infected persons and their families, partners and those who take care of them. It includes the trauma of diagnosis, community reaction, economic and emotional impact on their households, reaction of health care workers, illness and death.

The book is seen as an endeavour to contribute to the development of the quality of care and better understanding of the dynamics of needs of PLWHA in Manipur. With this as the backdrop, the main objectives of the book are to identify different types of care being provided and unmet needs of people living with HIV/AIDS and to identify the factors facilitating or inhibiting long term care of people living with HIV/AIDS within the family and the community settings. It also aims to give recommendation based on the study outcome, feasible strategies for policy consideration and provision of care and needs of people living with HIV/AIDS.

The book also explores the socio economic scenario of HIV infected persons, their family and individual problems, their disease history and health care service utilization, rehabilitation and welfare measures. The basic institutions related to HIV and current issues on HIV scenario have also been identified. It looked into three levels- PLWHA, family members as the informal caregiver to PLWHA and formal caregiver by administering semi-structured schedule.

It also highlights the major problem faced by the PLWHA and the family members of PLWHA i.e. the financial crunch. It is a problem which brags in every walk of life. It hinders the PLWHA in accessing the service on time and fulfilling their needs. The book illuminate on the various need for support and assistance by PLWHA. It unveils their need for outcome and employment, their need for support and assistance in terms of health and medication, nutrition and shelter, psychological support, social acceptance, human rights and legal rights. The same also goes for family members as the informal caregiver although there is no impact of the HIV status looking at the community level and at the workplace. The book reveals the calls for spiritual support and the PLWHA's need for nutritional supplement along with ART medicine. Government agency/organization, private agency/organization and NGOs are included within the domain of formal caregivers. These organizations have rendered various services to the PLWHA.

'HIV/AIDS and Indian youth' an article written by Anita Nath (2010) provides a comprehensive overview of the situation regarding HIV/AIDS among youth in India, and explores the possible strategies that could be effective in combating the spread of this disease. India is in the grip of the HIV/AIDS epidemic, with an increasing number of

infections being reported among youth, who comprise a quarter of the population but account for almost one-third of the HIV/AIDS burden. The prevalence in young women appears to be on the rise. Although the majority of youth are aware of the disease, a number of myths and misconceptions still prevail. Furthermore, or as a consequence, a higher percentage of young males report engaging in premarital sexual activity compared with females. Of late, sex tourism and its implications for the HIV/AIDS epidemic present an increasing concern. Indian youth appear to hold negative attitudes towards HIV testing and people living with HIV/AIDS.

The book "AIDS, NGO and GLOBALISATION" by Tarun Sukai (2010) is a modest attempt to discuss all these issues. It intends to focus on NGO's response to HIV/AIDS in India in general and West Bengal in particular. The case studies of various NGO's reflect the initiatives, programme execution strategies, successes and challenges faced by them in combating HIV/AIDS. The book highlights the significant role that the NGO's perform and a critical appraisal of their ability in the context of globalization.

The book opines that given the scale of epidemic, AIDS is now considered not only a health problem, but also a developmental and security threat. Moreover the epidemic is affecting developed and developing countries differently. Upto 95 percent of new infections now occur in developing countries, which are less equipped to respond the challenge effectively. Poverty, economic disparities, culture and gender related issues all contribute to India's vulnerability to HIV/AIDS and the enormous potential for the epidemic to spin out of control unless the problem is addressed properly. It says that the lessons learnt in different countries show that HIV/AIDS can be prevented with high political commitment, adequate financial and human resources and sustained interventions. It makes clear that HIV/AIDS can't be tackled by government alone; it requires a broad multi-sectoral response. Within this partnership, their significant contribution of the NGO's in HIV/AIDS prevention and care is stressed upon.

The author attempts to interpret the epidemic on the basis of scientific methodology. The book is divided into eleven chapters. It depicts global and national HIV/AIDS scenario and response to the epidemic in India. It also draws a socio-economic picture of West Bengal and its HIV/AIDS scenario and gives a state level over view of NGO's in HIV/AIDS care. It

also makes a portrayal on contribution of NGO's in HIV/AIDS prevention and care in West Bengal. The author devotes the literature to understand the role of NGO's in the context of globalization.

## 2.4 THE IMPACT OF HIV AND AIDS ON THE ROLE OF THE ELDERLY

The status of older adults in Africa occupies a small but rapidly expanding share of the global literature on ageing. The Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) pandemic has generated a new focus on the changing role of the elderly in communities that have been affected. In sub-Saharan Africa, where millions are projected to be infected with HIV and about two million deaths are recorded annually amongst the traditionally productive adults, such loss of parents and breadwinners means children and the elderly have had to take up unusual responsibilities.

The elderly population in Africa above 60 years in age is currently estimated to number slightly over 38 million, and is projected to reach between 203 and 212 million by 2050 (Help Age International 2002). Over the last decade the Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) epidemic has had a devastating impact on older women and men, especially in sub-Saharan Africa; with about two million deaths recorded annually and at least 13 million children have lost one or both parents. Alpaslan, et al (2005), 'Caring for AIDS orphans: The experiences of elderly grandmother caregivers and AIDS orphans'.

The rapid growth of population ageing in Africa and the impact of HIV and AIDS add another dimension to the role of older persons. HIV and AIDS affects older people in two main ways: the elderly are themselves infected with HIV, making them vulnerable to many health and socio-economic challenges Waysdorf, S.L., (2002), 'The aging of AIDS epidemic: Emerging legal and public health issues for elderly persons living with HIV/AIDS', The Elderly Law Journal , and it places a burden on them as carers since many have to care for their sick children and are often left to look after orphaned grandchildren who are also infected Rajaraman, D., Earleb, A. & Heymann, S. J., (2008), 'Working HIV care-givers in Botswana: Spill-over effects on work and family well-being', Community, Work & Family. The extended family used to be relied upon to provide subsistence and care for older persons.

The issue of the HIV and AIDS pandemic has generated a new focus on the changing role of the elderly in communities affected by AIDS. An estimated 22 million adults and children were living with HIV in sub-Saharan Africa at the end of 2007, and during that year an estimated 1.5 million Africans died from AIDS. The epidemic has left behind some 11.6 million orphaned African children (AVERT 2009). HIV and AIDS have resulted in a reversal of roles, where older persons are now providing subsistence and care to younger generations, Makiwane, M., Schneider, M. & Gopane, M., (2004), Experiences and needs of older persons in Mpumalanga, Human Sciences Research Council, Pretoria.. The African extended family has traditionally nursed its sick and absorbed its orphans without legal process Alpaslan & Mabuthu (2005). Many governments and major international donors have therefore reacted to growing evidence of the impact of HIV and AIDS on households by suggesting that 'traditional' coping mechanisms would minimize the impact and allow households and communities to absorb the loss of members (Economic Commission for Africa 2009). However, this is yet to be demonstrated, since there is growing evidence of multiple crises faced by those families now being headed by the elderly in Africa, Makiwane et al. (2004).

Many countries in sub-Saharan Africa have adopted the primary health care (PHC) approach, one of its worthy goals being provision of basic care for the elderly. However, PHC does not address the specific needs of the elderly since most nurses working in setting are not specifically trained to work with them. Care for the older person is not a priority in many countries, and most nursing schools and colleges do not offer courses in gerontology and geriatric care. For example, the National Qualification Framework of the South African Nursing Council excludes courses in gerontological nursing science or gerontology (including geriatrics). Also, ageist and sexist stereotypes perpetuate the myth that the elderly are asexual, Spearman, M.S. & Bolden, J.A., (2005), 'Identification of factors that reduce rates of detection of HIV/AIDS among women 50 years and older', Journal of African American Studies), evident in the fact that PHC providers do not ask the elderly specific question related to assessing risk behaviours for HIV and AIDS.

Whilst the global community is preoccupied with combating the HIV and AIDS pandemic, particularly amongst the middle-age group, there appears to be an under-reporting of its impact on the lives of the elderly (Help Age International 2007). It is important to

document the impact of HIV and AIDS on the elderly, particularly within the sub-Saharan African community where the burden of caring for the sick has shifted onto the shoulders of the elderly left in the community.

**Impact of HIV and AIDS on the health of the elderly**

Evidence suggests that HIV infection amongst the older population is on the increase, with more than 10% of HIV infection found amongst older adults, Manfredi, R., (2004), 'HIV disease and advanced age. Emerging epidemiological, clinical and management issues', Ageing Research Reviews ). The increase of AIDS in the elderly population suggests that they engage in activities that are risky for HIV infection. Reports on such behaviour amongst the elderly include frequent sexual relations with much younger people and reluctance to use condoms, being less concerned about being infected ignorance, and having multiple partners. According to 'Ramos Rodriguez, C., Baney, M., Morales, R.J., Parham., D. & Lago, M., (2000), International Conference on AIDS, New York, United States of America,13−14th July 1999 health care providers are not assessing the risk of HIV infection in this population. Many doctors incorrectly diagnose early AIDS symptoms in the elderly as pre-senility, because they do not suspect HIV in their older patients and miss the opportunity for testing .

A review conducted by 'Butt, A.A., Dascomb, K.K., Desalvo, K.B., Bazzano, L., Kissinger, P.J. & Szerlip, H.H., (2001), Human Immunodeficiency Virus infection in elderly patients, South African Medical Journal, suggests that women in sub-Saharan Africa of over 55 years of age have a seven times higher risk of sero-converting compared to people of a younger age, including men. Reports show that the severity of HIV and AIDS symptoms is more pronounced in the elderly population, leading to a poorer prognosis.

'Kipp, W., et al (2007), 'Caregivers in rural Uganda: The hidden reality', Health Care for Women International 28, 856−871' report that the health of older care-givers has deteriorated as a result of the physical and emotional stress of assisting their children. The physical impact of caring for the ill, such as backache, chest and leg pains, was attributed to the frequent changing, lifting and washing of adult patients.

In summary, HIV infection amongst the elderly population is on the increase. The elderly do not have the benefit of early diagnosis due to myths about their sexual activities. They are also outside the target populations for HIV prevention programmes.

**Social impact**

Studies show that HIV and AIDS attack mostly the reproductive and economically active section of the population, changing family composition by decimating the young adult population and creating elderly female-headed and child-headed families. The traditional support system for the elderly is hereby destabilized, Schatz (2007).

In sub-Saharan Africa alone millions of children grow up without parents and often live with grandparents (UNAIDS & UNICEF 2004). A review of the composition of households consisting of older adults in 24 countries of sub-Saharan Africa showed that 59% live with children and 46% with a grandchild, and that older adults are more likely to be living with double orphans (where both parent have died) in countries with high AIDS-related mortality 'Zimmer, Z. & Dayton, J., (2005), 'Older adults in sub-Saharan Africa living with children and grandchildren', Population Studies'. Reviews show that elderly-headed families cannot cope with the increasing number of orphans created by the disease. Social networks are reported to have collapsed due to the pressure of having to support orphaned children. Intra-familial relations become strained if conflict over custody arises or grandparents judge other family members to be negligent of the grandchildren, Alspaslan & Mabutho (2005).The roles of the elderly are seen to be changing to being care-givers of their adult children stricken with HIV and AIDS, guardians of their orphaned grandchildren, and surrogate parents for these grandchildren, which results in an increased burden of caring resting on the elderly.

In 'Sengonzi, R., (2007), 'The plight of older persons as caregivers to people infected/affected by HIV/AIDS: Evidence from Uganda', Journal of Cross Cultural Gerontology 22, increased social responsibility of the elderly is reported, due to prolonged travelling and absence from their homes to care for sick and orphaned grandchildren. This increase results in social isolation, because the elderly cannot afford the time or money to take part in social activities. Another reason for reducing participation in social activities is

fear of stigmatisation, as reported by Alpaslan and Mabutho (2005). Food insecurity is found to be prevalent in elderly households, and the care-giving responsibilities exacerbate the already compromised nutritional status of the elderly

**Economic impact**

The literature 'Kipp, W, et.al, (2007), 'Caregivers in rural Uganda: The hidden reality', Health Care for Women International' reveals that many persons affected by HIV and AIDS in sub-Saharan Africa remain at home, with the main burden of their care resting almost entirely on family members, who in most cases are elderly female. The literature also shows that whilst the economic consequences for the elderly who give care to the sick and orphans or have lost children to HIV and AIDS cannot be quantified, their impact is great.

The care-giving role of the elderly is such that it overwhelms their livelihood, forcing them to contend with various demands in terms of coping with increased health care costs, including debts incurred as a result of HIV and AIDS-related illnesses Okayo (2004) and meeting the transport and medical costs of ailing children paying school fees for orphaned grandchildren, and paying the funeral expenses of their family members. They also have to meet the costs of grandchildren (some of whom may be HIV positive) for whom they must now provide care.

Extended family members are not in a position to assist elderly care-givers, Alpaslan & Mabutho (2007) due to harsh economic conditions. Worst of all, the grandmothers are left without any inheritance from the deceased parents of AIDS orphans Alpaslan & Mabutho (2007). The elderly are seen as being financially abused.

The literature shows that the economic impact of HIV and AIDS on the elderly is overwhelming to them, and they seem to have no financial support. The least economically productive in society – the elderly – bear the financial burden of caring for the sick relatives and orphaned grandchildren left behind.

**Psychological impact**

The literature review on HIV and AIDS revealed various psychological impacts on the elderly. For those that are infected, experiences of hopelessness and loneliness, shame

and fear of being infected are documented. Otani, J., in his paper 'HIV/AIDS and older people', delivered on the 15th International Conference on AIDS, Bangkok, Thailand, 11−16th July 2004, is of the view that because of the myth that the elderly are asexual, infected elderly women feel humiliated by their sexuality and their own fear bars them from seeking health care and support since they fear stigmatization

Reports on caring activities show that the elderly worry about the impending death of adult children as well as the emotional stress of nursing terminally ill relatives and being infected during the process of caring. When the children eventually die, grandparents endure the trauma of the loss of family members and have to cope with the stigma associated with HIV and AIDS (Help Age International 2003), even long after the death of their children. Caring for grandchildren is also burdensome, since orphans often refuse to accept the authority of the older persons and the elderly experience problems in disciplining them.

In certain instances the elderly reduce participation in social activities, since they fear negative community reactions towards the HIV-positive grandchildren in their foster care. This is compounded by concerns over grieving children who must also cope with the community stigma attached to and often irrational fear surrounding AIDS (Alpaslan & Mabutho 2005: 277). In general, worsening psychological health of the elderly has been reported.

In summary, HIV/AIDS have a negative psychological impact on the well-being of the elderly who are either infected or affected by this pandemic. This negative impact manifests in many forms, including fear, trauma and grieving, isolation, hopelessness and stigmatization. HIV impacts on the elderly in two main ways: first, about 10% of the elderly are themselves infected with HIV, leading to their early death; and second, HIV/AIDS affect older persons as parents and/or relatives of persons infected by HIV and as care-givers. These indirect effects can manifest in a set of interrelated social, economic and psychological dimensions that could ultimately impact on the health and well-being of the elderly.

Many elderly persons are shouldering vital caring responsibilities for loved ones living with HIV and grandchildren orphaned by AIDS, which is a common practice in most African communities. Child fosterage is not a new phenomenon in Africa, as grandparents

and other elderly relatives have traditionally played a key role here, albeit in different forms across the continent. However, child fostering as a result of HIV and AIDS is crisis-led, since the older person has to meet the daily costs of living as well as funding their grandchildren's education without support from Government or their own children since most have been decimated by AIDS.

The cost of the illness for ailing HIV-infected persons drains the limited resources that elderly care-givers might have. The social impact of HIV and AIDS has in some cases led to loneliness, isolation and stigma in the lives of the elderly. In many instances the elderly, who are close relatives of HIV-infected persons, are depressed because of the looming death of a loved one in their midst. In the case of the elderly relatives, especially when they are the parents, this emotional toll could influence their ageing process, coming as it does at a stage in their lives when they are progressing to frailty.

The absence of national policies on ageing in many African countries exacerbates the poverty, poor health and psychological stress experienced by the elderly who are affected by HIV and AIDS. It is based on the above impacts found in the literature that the above recommendations are suggested for the elderly, the community, and Government.

These reviews of literatures have served a real purpose and has helped the researcher in so many arenas. It has acted as a guide and a very essential tool in understanding the problem of HIV/AIDS in a holistic manner. The above review of literature also outlined the main strengths and limitation of the research that has been conducted till date.

# CHAPTER - 3

# CAUSES AND IMPACT OF HIV/AIDS IN NAGALAND

This chapter seeks to portray the modes of HIV transmission in Nagaland. It depicts the ways in which HIV is transmitted in the state and the factors facilitating transmission are described as indicated in table 3.1. The chapter begins with an examination of 100 category of respondents who are infected with the virus. They are addressed here as People Living with HIV/AIDS (PLWHA).

This chapter also provides a comprehensive overview of the impact of HIV/AIDS in Naga society. HIV was first detected in the state in the year 1990 and it has been 24 years since AIDS emerged as a major health and social emergency in Nagaland, the epidemic has had a serious, and in many places and devastating effect on human development. Nagaland is in the grip of the HIV/AIDS pandemic with an increasing number of infections. Nagaland is one of the six high HIV-prevalence states in the country. This chapter includes the latest data that was collected through the primary and the secondary sources. It indicates the scenarios of HIV spread in Naga families and how it impacts on their psycho social and economic life.

One of the emerging social problem that have been penetrating the present Naga Society is the pandemic of HIV/AIDS and its consequences that comes attached with it. It has affected the individuals as well as the society. It is a complex social and health problem that poses as a threat to humanity.

## 3.1 CAUSES OF THE SPREAD OF HIV/AIDS IN NAGALAND

HIV/AIDS brings with it a unique social history. It is a complex and multi dimensional phenomenon that has become a major problem in every society. When AIDS first emerged as a disease in the year 1990 in Nagaland, few people could predict how the epidemic would evolve, and fewer still could describe with any certainty the best ways of combating it. It has now been 24 years since the first case was detected and the epidemic is still prevalent. It has created and is still creating unprecedented challenges to human society in various dimensions of human life.

HIV continues to spread across the state irrespective of its geographical expanse causing increase in mortality and morbidity among children and adults along with severe consequences socially and economically at the most. It threatens the basic social institutions at the individual, family and community level which in turn affect the economy, development initiatives and other associated linkages at the national level.

HIV transmission occurs through behaviors that pose a risk for exposure. Transmission is not limited to one particular race/ethnicity, gender, relationship or affiliation, or community membership.

Detailed epidemiological studies throughout the world and accepted medical opinion have shown that HIV can pass on to an individual through four routes namely[57]

1. Blood transfusion-Through transfusion of infected blood (unscreened blood).
2. Unprotected sexual contact with an infected person.
3. Pre–natal with infected mother to child transmission, through the birth process and breast-feeding.
4. Sharing of contaminated syringes and needles

According to the recent report by the NACO (National AIDS Control Society), Nagaland ranks the Sixth highest HIV prevalent state in the country. According to Sentinel Surveillance Report 2013, Nagaland has the prevalence of HIV/AIDS with an alarming ratio of 0.88% in the country where Dimapur records the highest prevalent rate of HIV. Here in this study a total number of 400 (Four hundred) respondents were interviewed out of which 100 (One Hundred) respondents were PLWHAs (People Living with HIV/AIDS).

**Table 3.1: Modes of transmission**

| Routes of transmission | Frequency | % |
|---|---|---|
| Infected blood transfusion | 8 | 8.00% |
| Sexual route | 49 | 49.00% |
| IDU | 22 | 22.00% |
| Infected Mother to child | 9 | 9.00% |
| Cannot say | 12 | 12.00% |
| Total | 100 | 100% |

[57] NACO: HIV-Handouts, Byword editorial consultants, 2006.

Table 3.1 and the figure 3.1 indicate the frequency of the 100 PLWHA respondents on how they got themselves infected with the virus. Although there were about 12% who were not sure through which route the HIV was transmitted to them, the rest 88% were sure of how they got themselves infected. While 49% of the total PLWHA were found to have contracted HIV through the sexual route, 22% of the respondents got infected through injecting drug use. This somehow indicates the high promiscuity and the intensive drug use in the region making it to the top in transmitting the virus. 9% and 8% of the 100 respondents inherited the virus through mother to child and through blood transfusion respectively. These two routes are comparatively very less in comparison to the two earlier routes of transmission.

**Figure 3.1: Proportion of routes of HIV transmission**

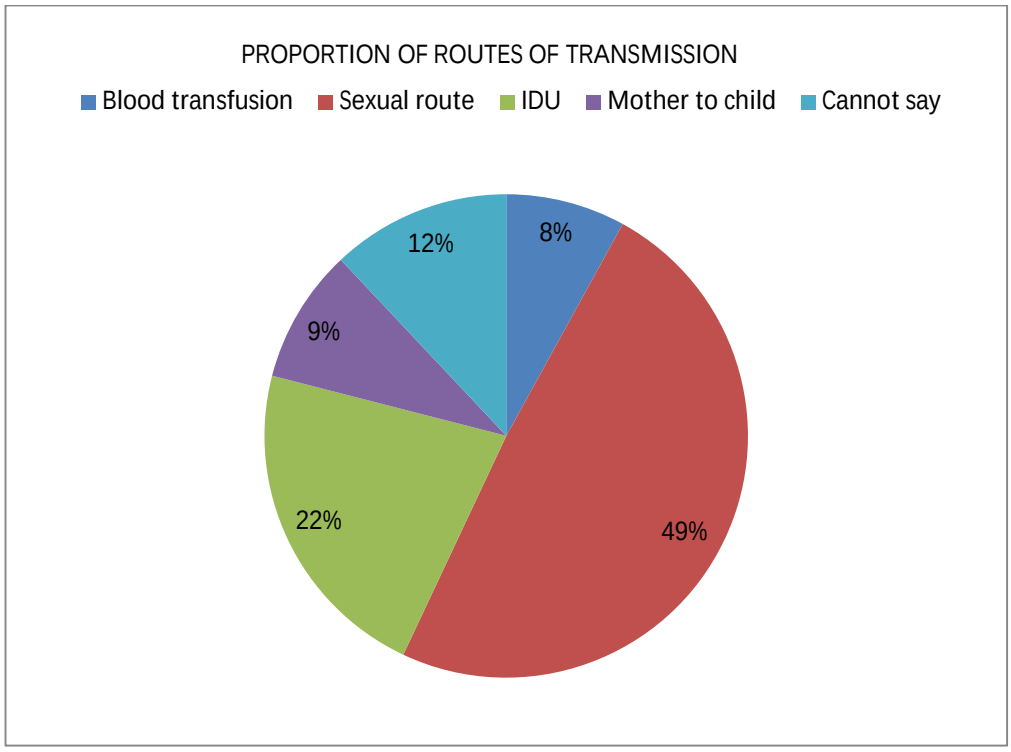



**Table 3.2: Number of HIV test undergone**

| No. of tests | Frequency | Percentage% | Total Respondents |
|---|---|---|---|
| Once | 23 | 23.00% | 100 |
| Twice | 29 | 29.00% | |
| Thrice | 35 | 35.00% | |
| More than thrice | 13 | 13.00% | |

The researcher wanted to know from the PLWHAs, the number of HIV tests undertaken for the confirmation that he/she is infected. Out of the 100 respondents, there were a maximum of 35% who went for tests at least thrice in order to confirm the HIV status.

**Table 3.3: District wise classification of HIV infected respondents**

| Sl.no | District | No. of respondents | Gender | | Routes of Transmission | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | M | F | a | b | c | d | e |
| 1. | Dimapur | 22 | 10 | 12 | 14 (63.63) | 1(4.54) | 5 (22.74) | - | 2 (9.09) |
| 2. | Kohima | 20 | 10 | 10 | 9 (45) | 1 (5) | 7(35) | 2(10) | 1 (5) |
| 3. | Tuensang | 15 | 8 | 7 | 7(46.69) | 1(6.66) | 5(33.33) | 1(6.66) | 1(6.66) |
| 4. | Mokokchung | 10 | 6 | 4 | 4 (40) | 1(10) | 4(40) | 1(10) | - |
| 5. | Zunheboto | 7 | 4 | 3 | 3(42.9) | - | 1(19.2) | - | 3(42.9) |
| 6. | Kiphire | 5 | 4 | 1 | 3(60) | 1(20) | - | - | 1(20) |
| 7. | Wokha | 5 | 4 | 1 | 2(40) | 1(20) | - | 1(20) | 1(20) |
| 8. | Mon | 5 | 2 | 3 | 3(60) | - | - | 2(40) | - |
| 9. | Phek | 5 | 3 | 2 | 2(40) | 1(20) | - | - | 2(40) |
| 10. | Peren | 3 | 1 | 2 | 1(33.4) | - | - | 1(33.3) | 1(33.3) |
| 11. | Longleng | 3 | 2 | 1 | 1(33.4) | 1(33.3) | - | 1(33.3) | - |
| | Total | 100 | 54 | 46 | 49% | 8% | 22% | 9% | 12% |

Note: The above initials refers to a. Sexual route b. Blood transfusion c. IDU d. Mother to child e. Cannot say
Numbers in brackets refer to percentage of the routes of transmission

Table 3.3 shows the district wise classification of HIV infected respondents with Dimapur taking the lead. Out of the 22 respondents from Dimapur, there were 10 males and 12 females out of which 63.63% of them were infected through risky sexual behaviour followed by 22.74% through intravenous drug use. The remaining districts are also not an exception because a majority of the PLWHAs got infected through the same route followed by intravenous drug use. Except for Zunheboto, Mon and Peren, the remaining districts has responded to have infected through blood transfusion. It is seen that Kohima tops in the category of contracting the infection through intravenous drug use. Kohima and Mon leads the infection caused from

mother to child with 10 and 40% respectively. In this study, it can be seen that 12% of the respondents are not sure and cannot say how they contracted the disease.

**Table 3.4: One's own reaction to HIV when tested positive**

| Feeling | Percentage% |
|---|---|
| Fear of Stigma | 88.00% |
| Scared of discrimination | 80.00% |
| Fear of Survival | 79.00% |
| Inferiority complex | 72.00% |
| Angry with Oneself | 71.00% |
| Acceptable | 30.00% |

Note: Since the respondents have marked more than an option, the percentage is analyzed point wise only.

It is evident from this study that there is a combination of so many feelings when a person is tested HIV positive. The mixed feelings indicate their sign of guiltiness' and remorse. Fear of stigmatization in society tops it all with a percentage of 88%. It can be seen that the respondents fear the stigmatization by society followed by discrimination which makes them fear for survival. They develop in themselves an inferiority complex and often get angry with oneself. Except for 30% who gently accepts his/her HIV status, 70% lives on with their feeling of regrets.

**Figure 3.2: Duration of HIV infection**

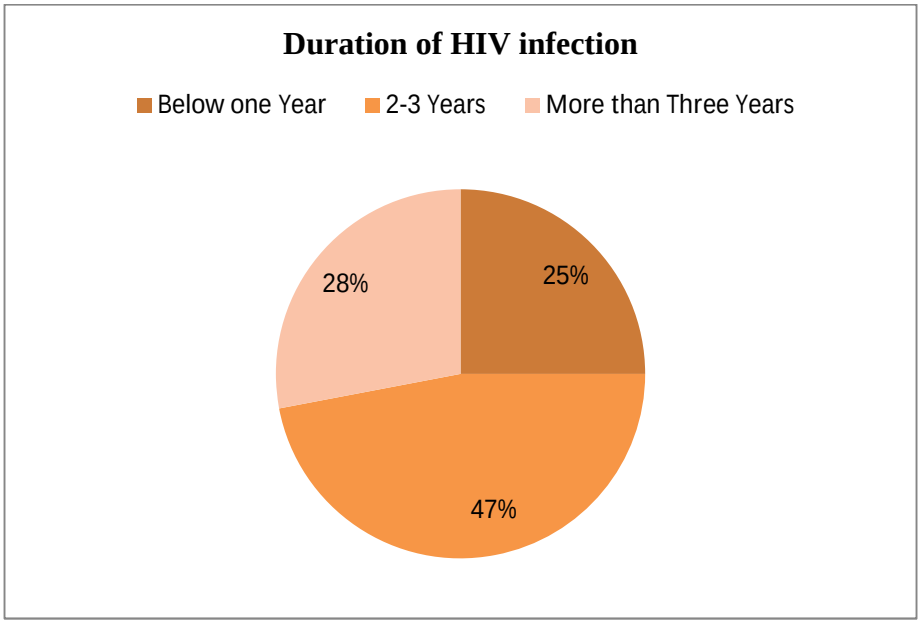


Figure 3.2 shows the duration of the HIV infection where out of the 100 PLWHA respondents, 47% opined that they have been infected with virus for at least two to three years. It also shows that 28% got infected since one year and 25% constitutes of having infected for more than three years.

On the basis of the data and information collected from respondents, it can hence be proved that there are four routes of HIV transmission supplemented by some various social factors that invoke them to get involved in high risk behaviour.

**1) Sexual route: Unprotected sexual contact with an infected person**

The chief route of HIV transmission is via sexual activity as table 3.1 projects. Out of the 100 respondents, there were 49% that were infected through unprotected sexual contact with an infected person. Specific sexual behaviours place people at risk of HIV infection. The virus is transmitted from an infected person to his or her partner (man to woman, woman to man and man to man and rarely from woman to woman). Heterosexual intercourse is the most common manner though in Nagaland, in which HIV is transmitted through normal heterosexual relations from men to women and women to men.

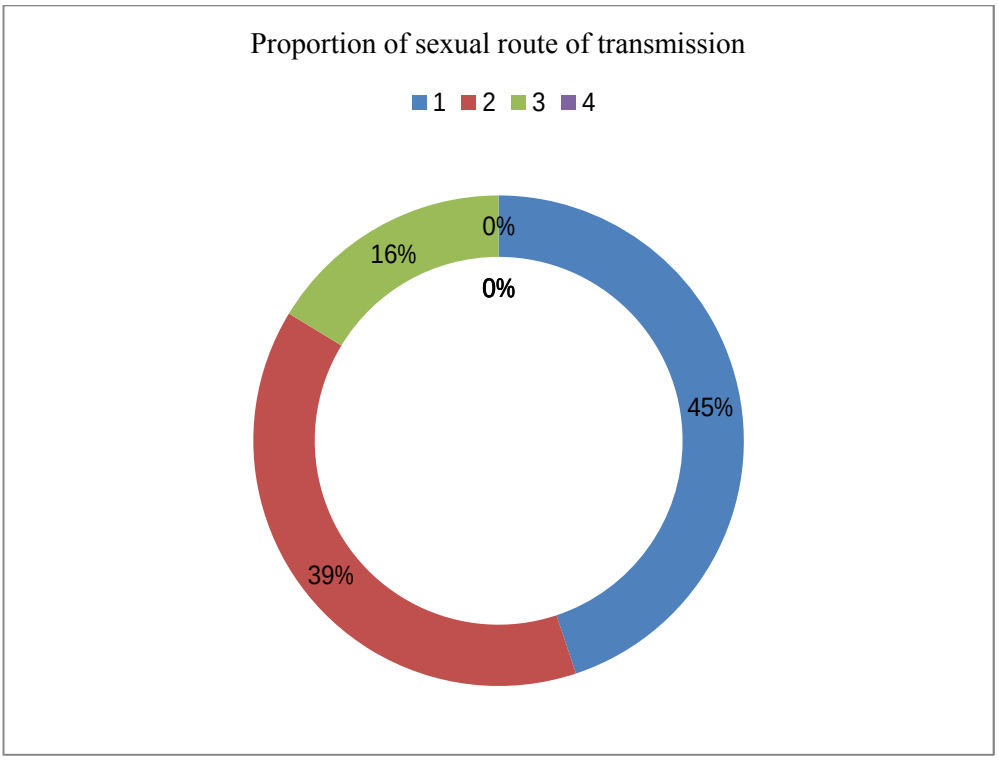
As per the response of the respondents, the transmissibility of HIV is far greater in the direction of male-female compared with female-male. Considering mechanistically, this difference in transmissibility is not surprising because study reveals that female are more vulnerable to infection.

**Table: 3:5 Proportion of sexual route of transmission**

| Sexual route of transmission | Frequency | % |
|---|---|---|
| Casual/non commercial, non regular partner | 22 | 45% |
| Regular partner/spouse | 19 | 39% |
| Commercial partner | 8 | 16% |
| Homosexual/bisexual | 0 | 0% |
| Total | 49 | 100% |

Note: Out of the total respondents, there were 49 respondents who got infected with HIV through the sexual route. Therefore a proportion of their sexual route is projected above

**Figure 3.3: Proportion of sexual route of transmission**




The transmission of HIV is still at large and transmission through the sexual route is alarmingly high. The different proportions of sexual routes are depicted in figure 3.2. The cases of sexual route of transmission by indulging in casual/non commercial, non-regular partner is very high with 45%.

Secondly 39% of the respondents who got infected through this route were unwilling at first to disclose their HIV status to their spouses/partners which increased their risk of transmission of the HIV virus resulting in higher number of transmission through having sex with regular partners/spouses. Heterosexual transmission of HIV is also supported by finding HIV positive status both in spouses of married couple and in separate cluster of individuals linked by sexual relations.

Thirdly, this study reveals that even though there are no specified red light areas in the state, the phenomenon of female sex workers or commercial sex workers has increased leading 16% of the respondents in contracting the virus.

After thoroughly analyzing and scrutinizing the response of the respondents, some major reasons can be summed up as the major causes of the outbreak of the pandemic and its spread in Nagaland. Though these factors do not directly lead the person to involve in risk behaviors, it helps to motivate persons who are used to these habits to indulge in perverse sexual acts.

**a) Migration**

The study reveals that with the onset of globalization and the consequent increase in job opportunities in cities, young Naga men and women are thronging to the already crowded Indian cities. Some respondents were of the opinion that when they reach a place where they do not abide by the strict social norms of their own communities, they often indulge in risky sexual behaviour and consequently found themselves to be HIV positive at a later stage. Casual/non commercial, non-regular partner takes the highest toll in table 3.2 with a percentage of 45 % leaving the life of the Naga youths at stake.

**b) Lack of sex education**

Rev. Dr. Jose Thenpillil (2006) opines that in the process of socialization, the imparting of sex education to an adolescent is very important.[58] But the concept and the thinking in the Naga society is that speaking about sex and its related topics are considered as a taboo. So parents and elders do not impart sex education to their children. The study reveals that none of the respondents ever received sex education from their parents or teachers. About 70% of the respondents were of the opinion that their source of sex education was only through books, journals, friends, television, newspaper, magazines, posters etc and the remaining 30 % had different opinions like from radio, health workers, IEC (Information, Education and Communication) materials etc

**c) Influence of modern media**

The advancement of science and technology brings in itself, various advantages and disadvantages. The influence of modern media on the psychosocial development of a person is clearly visible in the present Naga society. Television, internet etc has the potential to generate

[58] Thenpillil, Jose (2006) 'Socio-Cultural dimensions of the HIV/AIDS affected'

both positive and negative effects. Not all television programmes are bad but data showing the negative effects of exposure to violence, inappropriate sexuality and offensive languages are itself enough to pollute human mind. Along with its advantages, the introduction of internet has paved way to expose things that was not easily available way back. Reading pornographic literature and watching x rated movies are becoming common amongst the youngsters. It instills the urge and desire to experiment in real life. The source of sexual knowledge, reading of pornographic literature, watching x rated films influence people to indulge in risky sexual behaviour.

Out of 400 respondents, 47.25% were of the opinion that influence of modern media is one of the contributing factors to the rise of the epidemic. Social networking sites like the facebook, orkut, watsapp etc exposes a person to the outside world bringing each other nearer. But at the same time people misuse the technology. Time spent on social networking sites also increases the risk of teens smoking, drinking and using drugs according to National attitudes on substance abuse.[59]

**d) Modern lifestyle**

A respondent from Dimapur was of the opinion that the opening up of lounges and pubs in Dimapur where there is night life, young men and women, booze, weed etc is in a way contributing to the rise of HIV infection. This kind of lifestyle creates a kind of situation where it leads them to have sex with multiple partners making them one of the most vulnerable group responsible for the infection of HIV/AIDS. Peer pressure during adolescence leads young people to seek sexual adventure and exploration.

**e) Increased pre marital and extra marital affairs**

Increased pre marital sex among the youths is also becoming more prevalent. Most often young people do not have access to information on human sexuality. It is learnt that the natural curiosity tendency to experiment, seek sexual adventure and exploration, feeling of invulnerability and the strong peer pressure especially during adolescence results in taking decision to have sex before marriage. This early exploration acts as an agent in the rise of the

[59] http://losangeles.cbslocal.com/2012/04/02/usc-study-examines-whether-social-networking-exacerbates-risky-behaviour-among-teens/

epidemic because of their high risk behaviours. One of the main factor observed is, where adult guidance is lacking, youths are left to navigate their way alone into maturation.

Family and workplace play a crucial role in the relationship and behaviour of any individual. When a person lives away from the family, there is a possibility that he/she has to depend on friends or other associates whose influence will have greater impact on the life of that person. Where value ethics are no longer taught or rewarded, extra marital affairs among married peoples starts to sprout out. A married person living away from wife/husband and family for a longer period may develop tendency for extra marital relations. Family proximity to the workplace reduces the chances for risky/promiscuous sexual relationships. The lifestyle of the person is influenced not only by being away from the family but it also depends to a great extend with whom he stays when he/she is away. The place of stay influences the lifestyle of the individual. Sex partners hold a crucial role in the spread of the epidemic. It may be mentioned here that the police and other armed forces usually remains away from their wives and their absence leads some of the womenfolk to the start of extra marital affairs leaving them at high risk behaviour zone. And on the other hand, the husband's too seek to venture out and seek for partners to satisfy their gratification, thereby leaving them at risk too.

A recent article by 'International Research Journal of Medical Science' projects that there are rising numbers of pregnant women in Nagaland, "whose sexual behavior is not believed to be risky," but are testing to be HIV positive. This may be due to the infidelity of their spouses/sex partners.[60] Resorting to risky behaviour by having sex with a person other than their own life partner or with people whose sexual activities are not known, poses danger in the spread of the pandemic.

**f) Alcohol consumption**

Alcohol intake is another factor that leads to perverted sexual relations. Alcoholism has become a popular practice among the Nagas and it is acting as a menace to the society. It affects the social, health, economic, spiritual, psychological and the cultural aspect of society. It poses as a threat in Naga society by spreading its tentacles amongst the vulnerable sections

[60] International Research Journal of Medical Science (2013) 'Assessment of HIV/AIDS Sero Positivity in Nagaland'

of the population. Alcohol is a major factor that seeks extra marital affairs. It was revealed that many transport workers have the tendency to drink after the day's exhaustion and immerse themselves to experience the kick and derive some fun. Alcohol and the urge for sex are strongly co-related. The use of contraceptives in promiscuous sexual relationships is almost absent in case of the respondents that were infected with the epidemic. Though aware of the necessity, they did not bother about it or didn't use as they were in the influence of alcohol. This added to their risk of getting HIV infection.

**g) Fear of Stigma and Discrimination**

Stigma is a powerful tool of social control. It marginalizes, excludes and exercise power over individuals who show certain characteristic. Stigma and discrimination is caused by lack of understanding of HIV, how it is spread, lack of access to treatment, irresponsible media coverage of the epidemic, the fact that AIDS has no cure, and already existing prejudices related to sexuality, disease, drug use, and death. People living with HIV are often believed (and led to believe) to deserve their status as a result of their doing something inherently wrong. By so alienating and laying blame on others who are somehow different, people can somehow remove themselves from any risk and not confront the issue for the problem that it is.

While the societal rejection of certain group's e.g. homosexuals, injecting drug user. Commercial sex workers etc may predate HIV/AIDS; the pandemic has in many cases reinforced this stigma. For fear of rejection, stigma and discrimination that follows people who are infected usually do not disclose their identity, making them one of the high risk behavior agents. It does not always only occur to them, but also to others simply associated with them such as family members. Some of the factors observed that was responsible in contributing to HIV/AIDS related stigma in Nagaland are as follows:-

1. HIV/AIDS is a life threatening disease.

2. The disease's association with behaviours such as sex, injecting drug use etc. are already stigmatized in many societies.

3. People living with HIV/AIDS are often thought as being responsible for being infected and are often looked upon.

4. Religious and moral beliefs lead some people to believe that having HIV/AIDS is the result of moral fault (such as promiscuity or deviant sex) that deserves to be punished.

5. HIV/AIDS is considered as a punishment, horror, crime that reinforces and legitimizes stigmatization.

Denial goes hand in hand with discrimination. If one does not see themselves at risk, or see the potential for the epidemic to affect their community, they are at greater risk. Denial even takes the extreme form of not seeing the pandemic for the serious problem that it is. Either way, denial silences open conversation about the epidemic which hinders preventative measures.

Social stigma attached to sexually transmitted diseases particularly AIDS is enormous in the society. The people isolate the infected person to such an extent that the individual would prefer to run away from the house at least to save the family from social isolation.

This proves that the promiscuity relation is one of the factors, strongly responsible for the transmission of HIV. Table 3.1 shows that 49% of the respondents contracted the infection through the sexual route.

**2. Sharing of contaminated syringes and needles**

The risk of transmission of HIV infection is higher when previously used syringes and needles are reused without proper sterilization. This more likely happens amongst the intravenous drug users. Table 3:1 projects the Intravenous drug use as the second most powerful route of HIV transmission with a percentage of 22%. Among the drug users, the risk of being infected with HIV is closely linked both to the frequency of drug injection and sharing of needles and injections with previously used needles. The study reveals that many of the respondents started their drug use orally. But in due course of time, they cannot afford to buy drugs, which will be sufficient for oral dose. Injecting takes only a small amount of drugs.

Moreover, the action too is very quick. Sometimes police crackdown on drug smugglers and drug peddlers and heroin is not available in the market. So these respondents started injecting to save drugs and to save money.

Intravenous drug users have become a significant risk group for HIV and now play a major role in the transmission. The first HIV case in Nagaland was detected in the year 1990 by ICMR among the IDUs. Intravenous drug use is risk behaviour because most of the drug users frequently share needles and syringes to inject drugs. Contaminated blood particles are found to remain inside the previously used needles and syringes and thereby providing opportunities for HIV to transmit to the subsequent user of the same needles and syringes. Injecting of drugs is considered to be the principal mode of HIV transmission in North Eastern states of India, especially in neighboring Manipur.

One of the basic reasons is easy access to drug because of drug trafficking across the international border with Myanmar and the economic interest that lies there. The supply and the demand factor of drug i.e. heroin when associated with other factors gave rise to high prevalence of Injecting Drug Users (IDUs) in late 1980s and 1990s. Majority of the drug users do inject heroin. While doing so, they share the needles and syringes, thereby sharing a little amount of blood too. So, if one of the drug injecting partners has got the HIV infection, the other members of the group are also likely to get the infection through sharing of needles and syringes.

The increasing cases of HIV/AIDS in Nagaland are particularly based on intravenous drug use and unsafe sex, informs a study published in the International Research Journal of Medical Science. The study titled 'Assessment of HIV/AIDS Sero Positivity in Nagaland' states that the prevalence of infection among IDUs has been a cause of major concern.[61]

According to the 22 respondents who were infected through this route, they exposed why they shared needles and syringes. High levels of syringe sharing have serious implications for the transmission of HIV in the following areas:

a) Sense of urgency that comes with drug craving.

[61] International Research Journal of Medical Science (2013) 'Assessment of HIV/AIDS Sero Positivity in Nagaland'

b) Scarcity of needles and non availability of needles and syringes.

c) Refusal by the pharmacist to sell needles and syringes to young people.

d) Fear of police harassment and arrest with needles and syringes in their possession.

Moreover the study depicts the infection acquired through sharing of contaminated injecting equipments passes on to the non-injecting partners through unprotected sex. Because of the action of drugs, the drug users cannot take rational decision leading them to have unprotected sex and sell sex for money and drugs. In the process, one gets infected. Sexual behaviour and drug use is often inextricably linked. The present study reveals that 22% of the 100 respondents got infected with HIV through the sharing of contaminated needles and syringes. The most dangerous trend is that HIV spreads from this group of injecting drug users to the general public through heterosexual intercourse.

The increase in unemployment along with the changing lifestyle of the youth also exaggerates the HIV/AIDS epidemic in the state. Out of frustration, family problems, pleasure seeking, IDU as a fashion and the lack of societal control, intravenous drug use emerged as a refuge for the restless youth. Many youngsters in the state start to indulge in drug abuse, gradually changing their lifestyles. Along with this, lack of political will and social unrest lead to increase in the prevalence of IDU. In the present scenario, it is observed that the spread of HIV infection is expanding beyond the IDU to the general population.

Imti Longchar's article[62] in the local paper Morung express projects Pangsha, last of Nagaland's villages under Tuensang district, bordering Myanmar, as silently grappling with HIV/AIDS. In the early 1980's, this border area, inhabited by the Khiamniungan Nagas, connecting to Lahe and Khamti towns of the Naga areas in Myanmar, was notorious for illicit drug trafficking and gun running. This led to a high rise in the number of Injecting Drug Users (IDU). This was further confounded by unsafe pre-marital sex and an unaware population is now taking its toll. Data received from Nagaland State AIDS Control Society (NSACS) on Pangsha's HIV/AIDS scenario reveals that at least 104 people from Pangsha village area were

[62] Morung Express dated June 17, 2014 'IN PERIL: Pangsha grapples with HIV/AIDS'

tested HIV positive as recorded from 2006 till date. This figure was reported from the four villages under Pangsha area namely Pangsha Old, Pangsha New, Dan village (International Trade Centre) and Wontsoi, with a total population of hardly 6000. The villages are located a few kilometers apart with the nearest town Noklak located 30 km away. Out of the total tested positive, 58 are female and 46 male. Further, 48 of them are in the age group of 25-34 years of age, 39 between 15-24 years, 11 between 0-14 years and 6 between 35-50 years.

In neighbouring Manipur, high level of heterosexual HIV spread in predominantly injecting settings has been reported. Reports showed that HIV prevalence among spouses of HIV positive injectors increased from 5 to 45 percent over a period of five years. One percent prevalence of HIV among the general population is a high level of infection and indicates large scale hetero sexual spread.[63]

Health care workers are at small but real risk of acquiring HIV infection via accidents with needles and instruments contaminated with blood from infected patients. There has been a report in one of the hospital in state capital Kohima where a nurse contracted HIV through a needle stick injury to the finger while reshealthing a needle on a syringe containing fresh blood drawn from an arterial line of a HIV positive woman. Health care personnel therefore have to reconsider the adequacy of the precaution taken both in nursing of HIV positive patient and in handling the laboratory specimen.

**2) Pre–natal with infected mother to child transmission, through the birth process and breast-feeding**

The most biologically intimate association between two individuals is one between a mother and a fetus developing in her womb. It is clear, therefore, that with such close contact of fetal tissues and maternal tissues over a fairly gestation period of nine months, the risk of transmission of HIV infection from mother to infant is second only to the risk of acquiring infection from a blood transfusion. Mother to fetus or mothers to infant are the ways by which most of the children get HIV infection. Such transmissions can occur during pregnancy, at

[63] Sarkar, Anindya, Anne's article (2004) 'Drug related HIV in South and South-East Asia' edited by Jai.P. Narain in 'AIDS in Asia: The challenge ahead'

delivery or during postpartum period.[64] The risk of an HIV infected mother passing the virus to her baby is about 30%, the risk being greater if she has symptoms of AIDS.[65]

Table 3.1 shows the transmission of HIV from mother to child with a percentage of 9% out of the 100 respondents. The likelihood of transmission varies with the stage of HIV infection in the mother and consequently the level of virus in her blood [66] estimates of HIV infection rate in babies born to seropositive women range from 25% when the mothers are asymptomatic to 45%, when mothers have had a previous baby with the infection.[67] The overall risk of transmission from an infected mother to an infant is approximately 30% but with other modes of transmission, there are wide variations.

Only HIV infected women give birth to children with HIV infection. The women are infected first before they give birth to HIV infected children. The following categories of women are at increased risk of HIV infection:-

1) Injecting drug users through sharing of needles and syringes
2) Women having multi sex partners and unprotected sex
3) Women whose sexual partner or spouse are injecting drug user or HIV positive

French researchers have documented HIV transmission through breast feeding. HIV is present in breast milk.[68] Healthy babies have contracted the infection through imbibing contaminated breast milk. HIV infected infants generally show serious clinical symptoms by six months of age. The symptoms may resemble common problems but often do not respond to usual treatments when the child is infected with HIV. Though there is a risk of passing HIV through the breast milk, the benefits of breast feeding seems to outweigh the risk of HIV infection because breast milk contains many substances which protect an infant from various illnesses.

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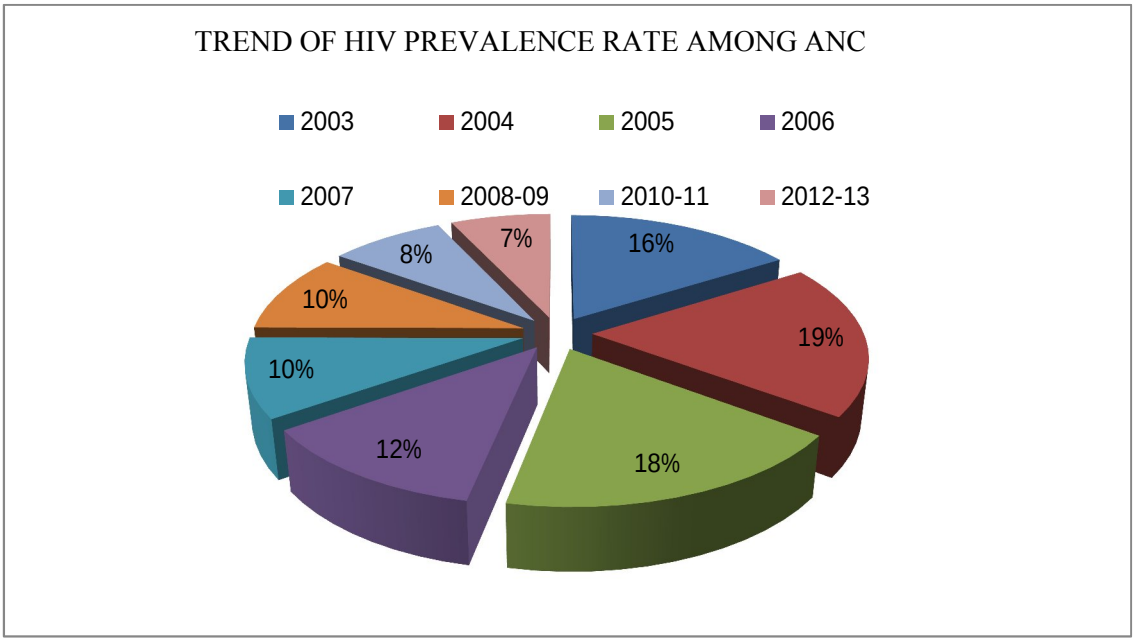
[64] Thenpillil, Jose (2006) 'Socio-Cultural dimensions of the HIV/AIDS affected'
[65] NSACS 'Why AIDS Prevention Education'(2010)
[66] Thenpillil, Jose (2006) 'Socio-Cultural dimensions of the HIV/AIDS affected'
[67] Goedert,James.J (1985) "Mother to infant transmission of HIV-1: Association with prematurity or low Anti-gp120"
[68] Sprecher,T.L (1987) "Isolation of AIDS virus from cell free breast milk of three healthy carriers"

In this study, it is projected in table 1.11 that out of the100 respondents there were 70 married PLWHA respondents including both male and female. Altogether they have 19 infected children. The positivity rate among the pregnant women in Nagaland as projected in the above figure from the year 2003 to 2013 shows an unequal distribution. The year 2005 displays the highest number of HIV prevalence rate among ANC with a percentage of 18%. This may be a result of highest turn out of HIV positive pregnant women for treatment or it may signify the highest rate of HIV prevalence rate during that year. The latest update in the year 2012-2013 shows a wide decrease with a percentage of 7% only. This maybe an outcome of the various programmes and projects implemented by the NACO in the state of Nagaland yielding lower prevalence rate of HIV among the ANC.[69]

**Figure 3.4: Trend of HIV prevalence rate among ANC**




Source: NSACS 2014

**4. Blood transfusion: Through transfusion of infected blood (unscreened blood)**

There is strong epidemiological evidence that HIV can be transmitted by transfusion of blood and blood products.[70] Screening of blood and blood products for HIV is now practical

[69] Nagaland State AIDS Control Society M &E BULLETIN 2013

[70] Esteban, Juan.L (1985). "Importance of western blot analysis in predicting infectivity of anti-HTLV-III positive blood"

though. One of the respondents was of the opinion that a woman was infected with HIV through transfusion of blood required as an emergency measure in complicated child birth in Nagaland. The present study revealed the transfusion of infected blood as one of the route of HIV transmission in the state. Out of the 100 respondents, 8% were infected through the transfusion of unscreened blood. Transmission of HIV infection through transfusion of blood from HIV infected individual is the most efficient route.

Fortunately this is the most easily preventable route of HIV transmission. National AIDS Control Organisation (NACO) has drawn up a comprehensive plan to combat the epidemic including the mandatory screening of blood at blood banks. NACO has opened up blood testing centres that are open both to the government and private blood banks. This is in fact contributing in curbing the pandemic.

A blood bank is a cache or bank of blood or blood components, gathered as a result of blood donation or collection, stored and preserved for later use in blood transfusion. The term 'blood bank' typically refers to a division in the hospital where the storage of blood products occurs and where proper testing is performed (to reduce the risk of ransfusion related adverse events).[71]

At present 8 district hospitals in Nagaland have blood banks to fulfill the mandatory screening of blood and blood products. The rationale behind it is to provide testing facilities to those banks. The government policy of the country requires blood banks to discard HIV positive blood without informing the donors about their HIV status on the grounds of maintain confidentiality and avoid stigmatization of people with HIV/AIDS.[72]

Out of the 100 respondents, 8 % got infected through the blood transfusion. Having a blood transfusion with HIV infected blood is the most dangerous situation for HIV infection to occur. Virtually every person who has had an HIV infected blood transfusion has become HIV infected. To clarify and make sure, the respondents were interviewed. 6 (Six) respondents were of the view that they underwent emergency blood transfusion at the time of

[71] en.m.wikipedia.org/wiki/Blood_Bank
[72] Mangla, Bhupesh (1993) "India; HIV positive blood donors"

child delivery, blood loss from accidental injury and 2 (Two) respondents got infected after they were transfused blood following surgical interventions.

The time period from the entry of the virus into the body till it can be detected by the usual test is known as window period.[73] The test has a window period of 6-12 weeks and hence, the test may not detect the HIV infection in blood collected from people who have recently acquired infection.

The risk of transmission of infection as a result of blood transfusion varies with the prevalence and incidence in the donor population, the proficiency with which infected potential donors are excluded from donation; the effectiveness of laboratory screening procedures, the ability to detect window period, virus inactivation, the susceptibility of the recipients and the number of blood units transferred.[74]

Out of the 100 respondents, 12 % cannot say how they were infected with HIV. It can be analyzed through their case study that they possessed the high risk behaviours like having multiple sex partners, having unprotected sexual activity, injecting drug use etc. Therefore they remain unsure as how they were infected with HIV. Only when they were tested they came to know about their HIV status. HIV cases has been gradually increasing among "vulnerable" population groups, including women, young people, high risk groups and bridge populations. Young people within the age group of 25-34 are contributing the highest number of HIV/AIDS patients in Nagaland state. In this age bracket, the present study displays that the highest mode of transmission is through the sexual route. The incidence of HIV/AIDS infection among STD clinic attendees and ante natal (transmission from mother to child) cases in "rural" Nagaland have also been increasing, thereby posing a major challenge for health managers.[75]

Both the epidemiological data and the present study indicate that sexual transmission of HIV is acting as a catalyst for a large scale generalized epidemic. A little decrease in the HIV/AIDS prevalence rate among IDUs making it the second most powerful route of

[73] NSACS 'Why AIDS Prevention Education'(2010)
[74] Lisam ,Khomdon Singh (2004)"HIV/AIDS and YOU"
[75] International Research Journal of Medical Science (2013) 'Assessment of HIV/AIDS Sero Positivity in Nagaland'

transmission, it however cannot be denied that this mode of transmission still remains the principle driver of the infection in Nagaland. Although inconsistent, the study informed that prevalence rates, for the most part, amongst attendees of Integrated Counseling and Testing Centres shows a declining trend. This, according to the study, indicates a slowing down of HIV transmissions.

Even after 24 years of the prevalence of the epidemic in the state of Nagaland, though efforts are being done by the State government, Nongovernmental Organisations, Community Based Organization etc. according to Sentinel Surveillance Report 2014, Nagaland is the sixth state with highest prevalence of HIV/AIDS in the country with an alarming ratio of 0.88%. If the general public is aware of the routes of transmission and the ways to avoid such risk it is easy to reduce the spread of HIV infection. For that a consorted effort synergy and co ordination has to be there from the part of the state government, educational institutions, various other agencies like the health and the law departments and all who are concerned with the promotion of health in the Naga society. A maximum effort in educating the general public about the ways of transmission of HIV infection should be put into and the necessary precaution and the necessity to change the risky behavioural patterns should be taken by the members of the society.

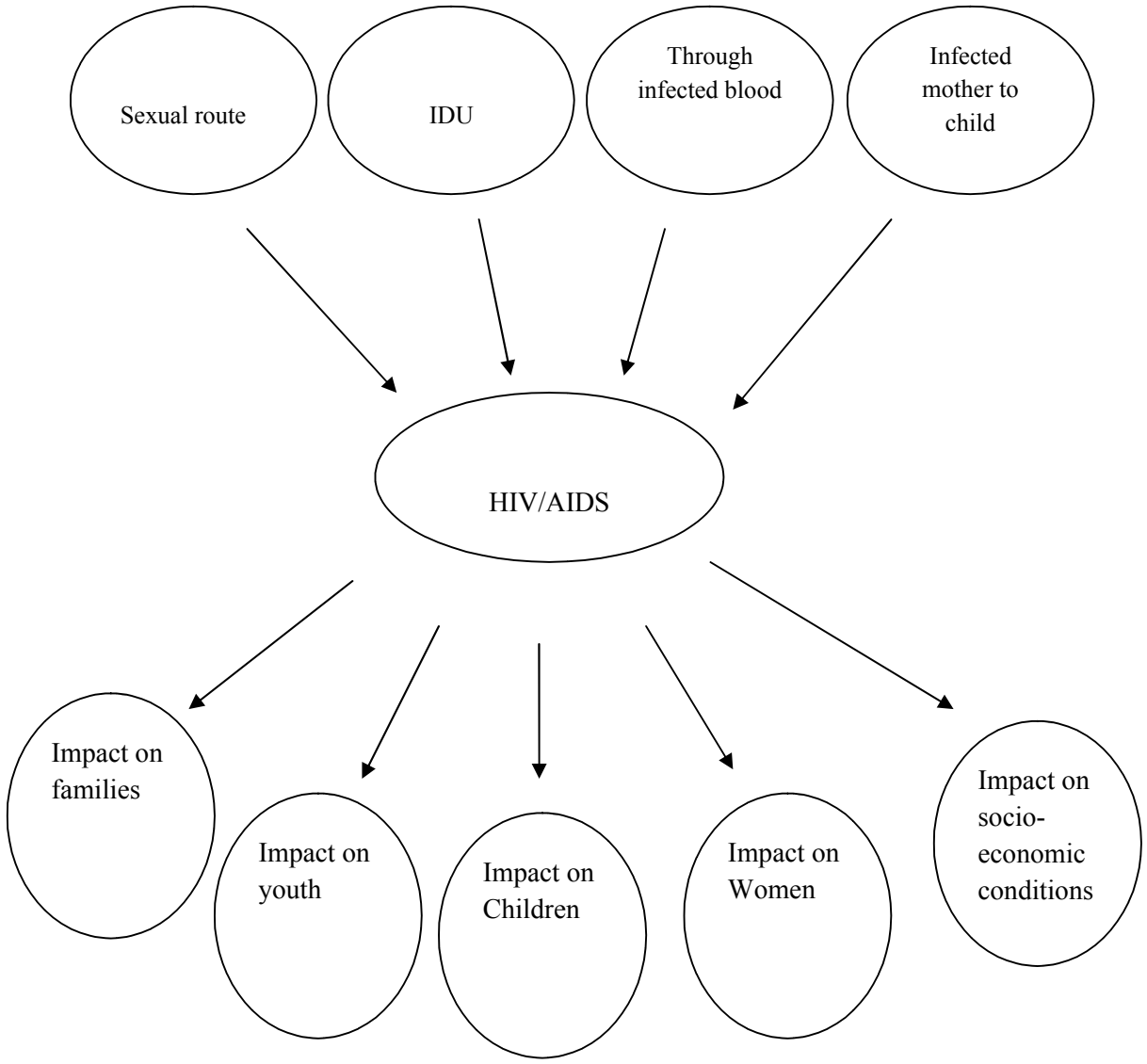
### 3.2 IMPACT OF HIV/AIDS ON NAGA SOCIETY

The impact of AIDS is still not fully understandable, particularly when the long term is considered. The epidemic comes in successive waves, with the first wave being HIV infection, followed several years later by a wave of opportunistic diseases, and later still by a wave of AIDS illness and then death. The final wave affects societies and economies at various levels from the family to the community.

The late Jonathan Mann's insight from the early1990s that AIDS shines a spotlight on human rights and societal issues [76] has been borne out in many ways, particularly in the epidemic's interactions with poverty, gender inequality and social exclusion. There is a deep interrelationship of AIDS with problems of human development

[76] Marks SP (2000) 'Jonathan Mann's legacy to the 21st century: The human rights imperative for public health'

**FIGURE 3.5: CAUSES OF HIV/AIDS AND ITS IMPACT**




The above figure 3.5 projects the causes of HIV/AIDS followed by its impact it on Naga society. HIV/AIDS has profound effects on individuals and society. The researcher has measured the social impact of HIV/AIDS at the individual, family and community levels in terms of socio-economic indices, morbidity and mortality.

The study focuses on the impact of HIV and AIDS on the household income and employment of the affected persons and their caregivers; level and pattern of household

consumption, savings and borrowings; education of the children of affected families; and health status and household expenditure on medical care. The social impact is also studied in terms of the stigma and discrimination faced by PLWHA and their families.

The social impact of HIV/AIDS range from expressions of shock and disbelief to social disintegration due to irrational fear, discrimination and stigmatization; changes in community life, cultural norms and practices and demographic changes. Such kind of social consequences often lead to the formation of Community Based Organisations (CBO) and fostering of civil society.

N.Jacob Zhimomi, MLA & Chairman, Development Authority of Nagaland said the prevalence and increase in the ratio of HIV/AIDS in the state is alarming and of great concern for the people of the state. He further added that it was ticking like a time bomb that could devastate the society one day.[77]

## IMPACT ON WOMEN

The impact of HIV/AIDS on women is particularly acute. Women are increasingly at risk from HIV. Though outwardly, Naga women seems to have enough freedom and choices in life the present study revealed that women often lack freedom of choices socially, economically and physically (health). Women have very less control over sexual matters and cannot question her husband's fidelity. Poverty, illiteracy, ignorance, gender inequality, unemployment, male migration, lack of economic opportunities forces women to exchange sex for money, food and favours to meet their basic essential needs. Therefore women bear the brunt of stigma and discrimination to a large extent.

This study reveals that an infected woman is often economically, culturally and socially disadvantaged and lack of equal access of treatment, financial support and education. As per the response from the respondents, women are mistakenly perceived as the main transmitter of sexually transmitted diseases. Together with the traditional beliefs about sex, blood and transmission of other diseases, these beliefs provide a basis for the further stigma of Naga women within the context of HIV/AIDS.

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[77] Morung Express Dimapur, April 13 2014.

It has been learnt that HIV positive women are treated differently from men in many cases. Men are likely to be 'excused' for their behaviour that resulted in their infection whereas women are not. In some cases, the husbands who infected them, abandons the wife living with HIV/AIDS. Rejection by wider family members is also common. Women, whose husband has died from the infection, have been blamed for their deaths.

**Table 3.6 Attitude of the family and relatives**

| Attitude | % |
|---|---|
| Not bothered | 6.00% |
| Acceptable | 21.00% |
| Caring as before | 4.00% |
| Shocked | 28.00% |
| Stigmatize | 9.00% |
| Angry | 32.00% |

On being asked, what was the response of the family members and relatives when the HIV infection was made known, there were various answers that popped up. Table 3.6 given below depicts a mixture of attitude showed towards them. 31% of their families and relatives were angry and was unable to accept their status while 28 % were shocked. 21% somehow accepted the fact that about their infection. This shows the mixed responses of the people surrounding the PLWHA fraternity. Some even goes upto the extent of stigmatizing and some did not even bother. This study proves that even though high awareness campaigns, advocacy etc. is initiated by various governmental, nongovernmental organizations, churches, schools etc, still there is something lacking in people towards understanding the plight of the infected people.

The responses of the family members towards the persons infected by HIV/AIDS clearly bring out the fact that there is much difference in dealing with them. The family wants to keep it a secret. This is because of the fear that the neighbours and the society at large will despise the infected person and the near and dear ones. The stigma associated to this infection and the fear of ostracisation by the society is the main reasons for this kind of attitude. People do not have a clear knowledge about the route of transmission and how it spreads. Insufficient knowledge and misconception always leads to immature kind of behaviour.

'Care' covers a range of services and activities including physical, clinical, psycho-social, emotional, spiritual, financial and practical care. While some provide care for spouses and family members out of love and compassion, this study exposed that the respondents' relatives and families were shocked, stigmatized and angry as seen in Table 4.1. This show that the Naga society still lacks in accepting and understanding the plight of the HIV women in society. There were responses from women respondents who were harassed by their in laws for spoiling the lives of their husbands though in truth it may be the men who had transmitted the virus to these innocent women.

In order to uncover the impact of HIV/AIDS and to prove our hypothesis, it was necessary to undertake at least three case studies and their experiences. They are reproduced here one after the another below:-

**Case study 1:** Respondent is a Naga woman of 35 years. She is married with three children: one girl and two boys. The time the interviewer met her, she was working as one of the outreach worker in the district organization of people living with HIV/AIDS.

She narrated her story how she came to know about her HIV infection. At the age of 26 years, she married one of the locals and they lived happily. After some years, she got pregnant and delivered a baby girl. Since the baby was born, she was constantly sick. They took her to many hospitals but was not getting better. At the age of four, some doctors suggested that they take her to Vellore for treatment. To their surprise the baby was tested HIV positive in Vellore. They could not believe their eyes and their fate. They wondered how all these happened. After coming back, the husband and wife were also suggested to go for blood test and they were also tested positive.

The respondent further revealed that her husband use to be an Injecting Drug User (IDU) before they were married. So this must be how they all got infected. The whole family kept the secret to themselves. The respondent herself told that the news of their infection was a major shock to her. She was sad but she was not in a position to react or show any hatred towards her husband. She herself knew that he was an IDU before they married but she did not think that it'll have this kind of implication in later stage of life. They took care of each other and the kid too.

In the later years two baby boys were born to them and she told that they are so far not showing signs of infection and even the test results proved negative. She didn't breast feed the babies but rather turned to artificial feeding. She then narrated the difficulties and the hardships that she and her family had to undergo nursing themselves as well as the eldest daughter. The husband was just a small business entrepreneur who on his small income could not meet the family's ends. She told that she herself as well as her husband and their daughter kept falling sick and contracted opportunistic infections from time to time. Soon her husband fall very sick and their infection came known to almost all the people in society.

The amount of stigma she experienced after their HIV status was declared was at time unbearable for the entire family. At some point of time their family was left in isolation and segregation was by some individuals.

Later she was invited by the district people living with HIV/AIDS forum to join them as an outreach worker. She accepted it and was working there at the time the interviewer met the respondent. She narrated how they were looked down by people and how it made them uncomfortable. They had to shift places in order to avoid the discrimination.

After intensive care, the husband succumbed to this disease and at present she is a single mother looking after their three children. The eldest daughter is presently being supported by churches and some NGOs as her income is too less to cover the family's expenditure.

**Case study 2:** The Respondent is a single grandfather of 71 years. He has three grandchildren aged 12, 9 and 6. He lost his son and daughter in law to HIV in the year 2009 and 2011 simultaneously. His son died at the age of 38 and his daughter in law at the age of 35. According to him both had high risk behaviours like injecting drug use and multiple sex partners before their marriage which makes it difficult to know how the infection was inherited.

Now that he lost them both and the grandchildren are left without parents, he looks after them. He is a retired government servant and his mearge pension money that he gets monthly gets insufficient. All the three children are infected with HIV which makes them get sick often and have to rush to hospital at least thrice a month.

His wife who used to be his support in looking after the grandchildren died of diabetes in 2012 making him really hard to look after them all by himself. Sometimes he feels really down with sorrow and sadness. He narrated the story of his eldest granddaughter who is stigmatized by her peer group at school. Sometimes she comes tear eyed from school saying no one wants to befriend her.

He is so worried about the future of the kids and wonders what will happen if he dies. There are relatives who comfort him but still he is living on the hope that there is some miraculous cure for their illness, so that they can live their lives as a normal human being.

Grandparents often forms the foundation of extended families, according to a UNICEF report in 2003 the percentage of orphans taken care of by grandparents in Namibia increased from 44% in 1992 to 61% in 2000.[78]

**Case study 3:** The respondent is a truck driver. He is 34 years of age and married with two children. Because of his work, he keeps travelling and remains away from home and family most of the time. Because of the long travels in the roads of Nagaland, during the rest hours he used to drink alcohol with other drivers. In the process, he became acquainted with lots of women and gets involved in having sex with multiple partners by and by. This became his daily routine when he was away from his family.

Beginning with the year 2010, he started falling sick almost frequently. He went to different doctors but still his health kept deteriorating. He even visited quacks that performed different rituals saying he was under the possession of some evil spirit. But this did not help too. Then one day he visited a government hospital in Nagaland who advised him to go for blood test. Before the test was conducted, the counselor based in the hospital took his case history and administered pre test counseling to him. Later he went for blood test and was diagnosed with HIV infection. His whole world collapsed. He was of the opinion that the post test counseling done after the test was little relieving. He was advised by the counselor to bring his wife and families for blood test too. And consequently, all the family members were diagnosed with the infection. The sense of guilt he felt was so much that he wanted to die. He

[78] UNICEF 2003, 'Community based studies on Gender and HIV/AIDS'

was guilty because it was all because of his extra marital affairs and having multiple sex partners that he got infected and later transmitted it to his family members too.

The respondent kept blaming himself for the entire episode and the mental agony of a person was seen in him. He did not have the courage to share and reveal his HIV status to his relatives and family members. He feared that if he reveals, the entire family will be ostracized by the society. The fear of stigma and discrimination attached to this pandemic is wide, which makes him scared to reveal that he and his family are infected with HIV.

At present the entire family is under the ART (Anti Retroviral Therapy). It is a treatment for HIV infected person. It does not cure the disease but it rather aims to increase the life expectancy, reduce opportunistic infection and may potentially reduce the likelihood that an infected individual transmits the virus to another. The respondent also tries to maintain a good diet as much as possible.

As seen in all the three case studies, HIV infection has profound implications on family relationships. Traditionally, when a person is ill, the family is seen to provide emotional, practical and social support. But the recent study has shown that HIV disease like any other serious illness, affects the family members both in their day-to-day functions and those in the long run. What distinguishes HIV disease from so many other illnesses is the associated social stigma.

Families are the caregivers to sick members. There is clear evidence of the importance of the role that the family plays in providing support and care for PLWHA. However not all family response is positive. Infected member of the families can find themselves stigmatized and discriminated against within the home.

It is clearly seen from the above experience of the respondent in case study 1, that stigma attaches itself strongly to women because of negative assumptions made about sexual risk behaviour—even when a women has not engaged in any - and its association with HIV. This study in Nagaland reveals the fact that the HIV-positive women who were infected by their husbands, faces more stigma and discrimination than men and were often blamed for their husbands' illnesses by their relatives and families. Women living with their husband's family frequently faced expulsion when the husband died, and many had trouble finding

anyone to care for them when they themselves became ill. It was also found that domestic violence and physical abuse rises when the woman falls ill.

The gender inequality as well is imbedded in many cultural traditions and Naga society is also not free from it. The domestic burden of AIDS care falls especially heavily on women because of their traditional roles as care givers and homemakers, deeply engrained social attitudes and insufficient social services. Caring for family members affected by AIDS is a compassionate undertaking, but it is learnt that it is also a burden that can limit educational and economic opportunities for women and girls.

From the above case studies, it is found that stigma, discrimination and collective denial makes the life of the individual and that of family members agonizing. Even in their daily lives they are faced with severed relationships, desertion and separation from family members and relatives and even physical isolation at home. Children of PLWHAs regardless of their HIV status often face social and physical isolation for example, separate sleeping arrangements. Due to irrational fears among parents of other children, they are instructed not to befriend the children of PLWHA as seen in case study 2.

The illness and resulting death of fathers, mothers, children and siblings changes the very structure of this primary building block and is further exacerbated by the additional financial constraints placed on the family.[79]The nodes of care within the immediate and extended family are impacted upon as the burden of care starts to exceed the levels of resilience within the family. Nuclear families are the most common in Naga society.

In some cases families are headed by only men or only women in the absence of a gender and families are starting to be constituted of mixed kin and blood. Single parent families are becoming more common as well. Families are headed by grandparents, in the absence of parental figures. The illness and resulting death of fathers, mothers, children and siblings changes the very structure of this primary building block and is further exacerbated by the additional financial constraints placed on the family. Borrowing from friends and relatives in order to sustain and taking loans, selling assets, using savings were also reported by the respondents which deeply affects the family life.

[79] Tomaszewski(2001), 'Mental health and HIV/AIDS: Social work practice issues [Trainer Manual]'

Traditional Naga families that have already developed internal ways of coping with crisis are mostly totally unprepared for the stress created by external pressures such as stigma. Whether the response is rejection or acceptance, families with a member discovered to have HIV infection or diagnosis with AIDS experience high levels of stress and disruption in all areas of family life.

Though the family system in Nagaland has the rich tradition of supporting and caring for the sick and the disabled, with regard to looking after and supporting those infected with HIV and persons with AIDS there are constraints. The main reason is the fear of contracting HIV and the social stigma attached to this infection. The ignorance of the people leads to misconceptions that lead to fear which in turn leads to discrimination. The discrimination by the members of the family increases the stress and this hastens the end of a person living with HIV/AIDS. Some of the respondents openly said that their family takes care of them but are treated as untouchables.

The magnitude of the social impact of HIV is clearly visible in all the three case studies. Case study one portrays the impact it has on women, another on the families and the other on the children. The amount of stigma and discrimination experienced are invariably high. There is actually a huge gap between understanding the problem and the negative response of the society and the individuals.

## IMPACT ON FAMILIES

Family is one of the primary building blocks of society and forms the net that holds communities together.[80] Families, by nature, are pre-existing networks of care and support and form a very important social resource in Nagaland's response to the challenges of HIV and AIDS. On the other hand, HIV and AIDS pose one of the greatest challenges to families in history. HIV and AIDS touches at the very heart of families, drawing them closer together or driving them further apart.

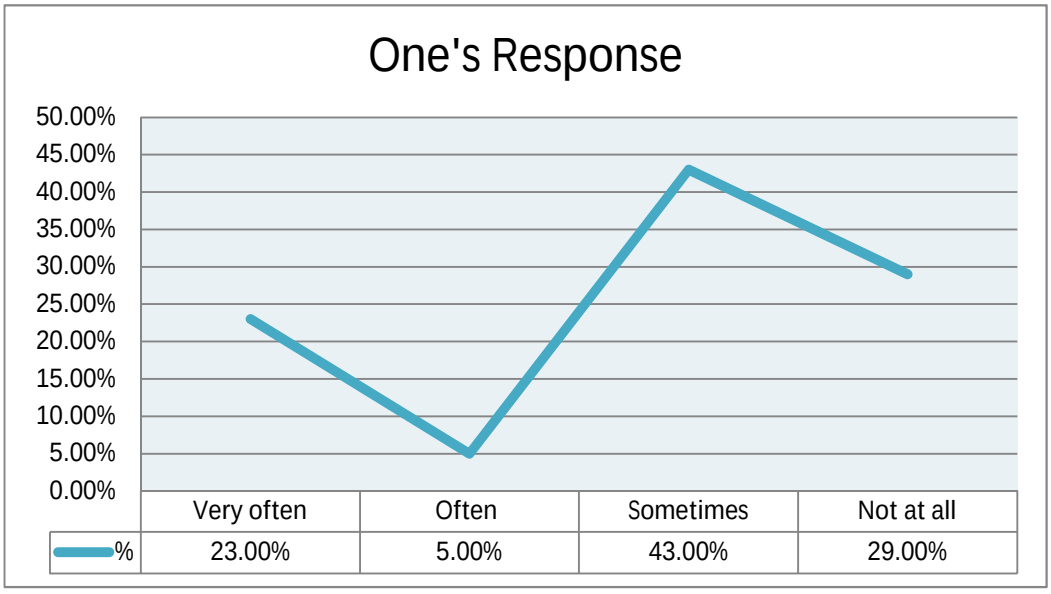
According to Carol Levine, "Family members are individuals by birth, adoption, marriage or declared commitment, share deep, personal connections and are mutually entitled

[80] Gronningsaeter (2004), 'Living conditions and quality of life among people living with HIV in Norway

and obligated to provide support of various kinds to the extent possible, especially in times of need".[81] The essential characteristics of these relationships are: permanence, commitment to mutuality of various forms of economic, social and emotional support and a level of intimacy. In the traditional marriage vows, there is the pledge to remain faithful even in times of sickness. Illness tests family strength and mutual commitment.[82]

In order to evaluate the impact of HIV/AIDS on families some case studies were done on families infected and affected with the epidemic. Two of the case studies related to it is elaborated below to understand the ground realities faced by them.

**Figure 3.6: One's own response**




In response to the question to one of the HIV infected respondent how one at times feel and whether they feel ashamed/shy to face the society, 43% of the respondents were of the view that sometimes they did feel ashamed because of their HIV status. While 29% were not at all ashamed. It was found (Refer Table 3.6) that 23% of the respondents very often feel uncomfortable to face the society. 5% opined they do often feel shy in inter mixing with people. Hence it is proved that due to the fear of stigma and discrimination faced in day to day life, they often feel uncomfortable in society.

[81] Levine, Carol (1992) 'AIDS and the changing concept of family', Milbank Quarterly
[82] Thenpillil, Jose (2006) 'Socio-Cultural dimensions of the HIV/AIDS affected'

**Table 3.7: Stigma and Discrimination faced by the respondents**

| Attitude of the people towards the PLWHAs | Total percentage |
|---|---|
| Isolation and segregation by some individuals | 22% |
| Affected ability to stay in a particular area | 17% |
| Denial of the use of public property | 15% |
| Unkind remarks and informing everyone about HIV status | 10% |
| Involuntary participation or refusal of the hospital/clinic staff to medically provide treatment | 10% |
| The forced relocation/transfer of job activities or fired from job because of HIV status | 6% |
| Refusal of bank loans, disability or life insurance because of the HIV status | 5% |
| Undesirable treatment in workplace | 5% |
| Special identification marks or board displayed in the bed head tickets or on the bed in Hospital | 2% |

The present study projects how stigma, discrimination and collective denial associated with HIV infection make the life of the individual and that of family members makes the PLWHA's agonizing. Through this study, it was revealed that HIV/AIDS related discrimination is on the rise and they are sometimes denied the right to health services or discriminated against in health settings too. Table 3.7 describes how it even goes upto the extent of isolating and segregating by the individuals and the community.

Societal rejection towards HIV infected people is an important issue that happens in Naga society. Stigma and discrimination by the community is very much visible. A feeling of alienation and frustration develops among the members of the family. A social institution like marriage is also losing its shape, its sanctity and form due to HIV/AIDS that leads to social instability and chaos.

## IMPACT ON YOUTH

Young people are the most threatened—globally accounting for half of all new cases of HIV—and the greatest hope for turning the tide against AIDS. The future of the epidemic will be shaped by their actions.[83] Table 1.11 reveals that the maximum number of respondents belongs to the age group 25-34, experience and the present study proves this. The few countries that have successfully decreased national HIV prevalence have achieved these gains mostly by encouraging safer behaviour choices among young people.[84] Several factors make youth particularly vulnerable to HIV infection including their age, biological and emotional development, and their financial dependence.

HIV/AIDS has affected the social life of the individuals especially the youths. Domestic violence and abuse tends to affect the life of the youths. Crimes among family members often go unreported. Usually it is informed that victims do not report the issue because it is a "private/personal matter." Because of the shame brought to the family, the study reveals frequent fights and quarrel in the family between the sibling and the parents. Abandonment by friends and family leads to depression and the victims feel denied and ignored by society.

With the advent of globalisation and western acculturation, premarital sex is rapidly becoming common among the Naga youths as well. The trend of premarital sexual activity is as high in smaller/lesser developed towns and rural areas as it is in larger urban areas, as observed from the proportion of adolescent girls from Tuensang, a district in Nagaland, reporting premarital sex to be as high as 23.3%. Early sexual activity is prevalent in the tribal community as Nagaland at the present juncture. One major observation is the rampant entry of young boys and girls in the various lounges and bars in Nagaland and resorting to anti social activities.

According to a PLWHA who is an injecting drug user of 29 years from Zunheboto, he stated that there is no healthy relationship between him and his parents because of his addiction as well as his HIV status. The study shows that he felt stigmatized and discriminated

[83] InterAction. (2005), 'AIDS: Overcoming the global epidemic'
[84] UNAIDS, 2004 'Report on the Global AIDS Epidemic'

as he is disliked by all his family members because he is often denied of his needs and requirements and also rejected by his family during decision making processes. Often he has to be admitted in hospital and the family members remains negative to his needs and wants. He often feels ignored and unwanted. Most of the time, he stated that he thinks of ending up his life too but with the help of the counselors and other social workers, his spirit is lifted up to some certain extend.

Yet another cause of concern is the problem of unemployment in the state of Nagaland, in which the Naga youths in order to survive throng to the cities and other big towns. Migration in search of new jobs may be the leading cause of contracting the infection. Some respondents were of the opinion that when they reach a place where they do not abide by the strict social norms of their own communities, they often indulge in risky sexual behaviour and consequently found themselves to be HIV positive at a later stage. The observations from this study may be representative of just the tip of an iceberg owing to the small sample size. Since there were youth participating in this study who were working in the cities, it is possible that youths within the state could also be involved in increasing the state's rise of the pandemic.

This study shows that Naga youths generally have the reliable information about sexual activity and its implications but they are often unlikely or unable to protect themselves appropriately as they demonstrate an inclination to sexual experimentation, often with multiple partners. These sexual behaviours, and sex in conjunction with drug and/or alcohol use, may increase the likelihood of becoming infected with HIV. In addition, young people's sense of invulnerability ("It can't happen to me"), combined with lack of experience, may leave them unaware of the consequences of their actions and therefore less likely to take precautions against risk of infection.

Young people have been impacted by the pandemic often indirectly. One of the young respondent of 25 years informed that often he gets mood swings and at times cannot control his temper thinking about all the implications of the infection. Such children often get violent and resort to crime as a way of getting back at society.

Another young female of the same age group who contracted the HIV infection from her parents keeps changing schools. When her peer groups comes to know of her HIV status, she was segregated from the rest of her friends, which makes her change the schools in order to keep herself away from shame. There has been responses from youths where they were rendered unemployed because they cannot or have completed schools or any vocational trainings. In this way young people continue to be at the growing center of the pandemic in society.

It is observed that fearing discrimination, around 28 percent men and 36 percent women have not disclosed their HIV-positive status in the community and as high as 75 percent have not disclosed the same in their workplace. The issue of stigma and discrimination remain at large. There have been reports of refusal to conduct funeral, refusal of treatment in Dimapur and transfer of a government employee from one district to another because of his HIV status. Discrimination even in workplace was noticed.

HIV/AIDS destroys human security both at an individual and at the collective level because it causes suffering and threat. It kills people at an extremely productive and reproductive age and creates demographic problems within the country. The respondents from the NGOs opined that they have lost at least 5-10 young people to this pandemic at their primetime. Society's time honored security, time tested institution and the well being of its members is jeopardized by the pandemic. People disengage from their societies and AIDS orphans take to criminal activities.

## IMPACT OF HIV AND AIDS ON CHILDREN

Children are highly valued in every society. They are the assurances of the continuation of the family lineage. Consequently a childless marriage is considered fruitless and incomplete. Unfortunately, according to the respondents 30-40% of their children was born and got infected with the virus. Though there were reported child deaths of about 10%, the remained sustained and goes through numerous sufferings and ailments. Deep emotional and psychological effects are experienced by the family, helplessly watching the children suffer. This trend threatens the survival of the human race in general and a small society like that of the Nagas in particular.

The HIV/AIDS pandemic poses major threats to the socio-economic and psychological welfare of the HIV affected and infected children. The pandemic adversely affect the household stability and sustainability, state of health and nutrition and increases the affected children's vulnerability to infection.

Children of PLWHAs, regardless of their HIV status, face social exclusion such as not being able to play with other children. There have been cases of children sending away to live with relatives in the case of the death of the parents. HIV orphans are on the rise in the state of Nagaland. Stigmatization by peer groups and classmates is clearly visible through the case studies conducted. On the education front, Children Living with HIV/AIDS (CLHA) has been supported financially and nutritionally by various NGOs, Governmental agencies and the religious organizations. But this does not fulfill all the needs of the HIV infected children. Orphaned HIV infected children often resorts to stealing and robbery. He is not fed well by his relatives and guardians and in order to fulfill his needs he resorts to small thefts and by and by becomes a regular thief.

The loss of parents can have profound emotional, economic, and developmental consequences for any child, especially in poor households. In Mokokchung, AIDS has produced the phenomenon of child-headed households, where the oldest daughter has to care for her siblings in the absence of adults- the grandparents. This situation will be worse in cases where some of the children and are in need of medical care.

Children who lose a parent to AIDS often suffer discrimination, isolation, and impoverishment. When both parents die, extended family or community members, primarily women, often take in these orphaned children. Even when cared for by others, studies reveal that they are still looked down and stigmatized. It was learnt that a girl of 14 years in Dimapur whose parents were both victims of HIV/AIDS committed suicide by hanging herself to death. She was in the ninth standard at the time of her death. Being an orphan, she was raised up by her grandparents but it was learnt that in schools and in other social gathering, friends use to stigmatise her by informing everybody about the parents HIV status. This can be one of the

reasons behind her death. The lone surviving member in this family now is her eldest sister whose HIV status is not known as of now.

So far in Nagaland, child prostitution is not visible though there is the prevalence of child labour. In this study Hypothesis 1 states that poverty leads to prostitution and thus leading to the HIV infection in Nagaland. Through this study it is seen that though in the case of adults, this hypothesis is proved right, it is not relevant here in the arena of the children as child prostitutes are not seen in the entire state of Nagaland. The children are mostly affected through the parents where at the demise of both the parents, the child is automatically placed under the care of their immediate relatives or in other families as helpers in order to earn a living and to sustain in life. Through this study, it was observed that some orphans were eventually placed in orphanages and put up for adoption. The growing need to open up more orphanages for children infected with the pandemic was proposed by a couple of respondents.

The underlying factor of this infection course on the HIV infected family and children is family disintegration, community ineptitude etc. in many parts of Nagaland, traditional structures which provides coping mechanism have disintegrated leaving no one to take care of the children. Fortunate orphans are taken up by their ageing grandparent who struggles to feed their grandchildren (See Case study 2). These old people do not afford nutritious food or an education for these children as they could be seen struggling with age related problems of health and even the depression of losing their own sons and daughters to HIV/AIDS. Grandparents strive hard to keep the family going.

## IMPACT ON SOCIO-ECONOMIC DEVELOPMENT

Today HIV/AIDS is considered as a major development and health problem in Nagaland. Though the scourge doesn't have much impact at the macro level, it does have effects on those who are economically productive hence disrupting development in the state at the micro level. The impact of HIV and AIDS on the household income and employment of the affected persons and their caregivers; level and pattern of household consumption, savings

and borrowings; education of the children of affected families; and health status and household expenditure on medical care can be seen.

Because of the very different roles and responsibilities assumed by men and women, an HIV-related illness in the family affects men and women differently, and its impact also varies depending on whether the person who falls ill is female or male. In many instances, when a man falls ill, there is likely to be a drop in disposable household income.

A productive person is defined to be someone aged between 15 to 65 years.[85] An adult therefore has approximately 50 years of productive work. In the case of death of the supporting parent, it results in lowered economic growth and thus hampers the daily life of the remaining household.

HIV/AIDS strikes people in their most productive years when they should be active in all the developmental sectors like in civil service, private and nongovernmental sectors. It is gender and age blind and brings about immense implication in the society.

**a) Impact of HIV status on income and employment**

**Table 3.8: Comparison of Work Force Participation Rate**

| Sl.no | Age group | WFPR | |
|---|---|---|---|
| | | HIV infected household | Non HIV household |
| 1. | 15-24 | 5% | 7% |
| 2. | 25-34 | 34% | 11% |
| 3. | 35-44 | 36% | 20% |
| 4. | 45-54 | 25% | 32% |
| 5. | 55 and above | X | 30% |
| 6. | Total | 100% | 100% |

The work force participation rate (WFPR) among the 25-34 and 35-44 years age group is higher in HIV households. This is represented by 34 and 36 percent among HIV households, against 11 and 20 percent respectively in non-HIV households. Comparatively,

[85] UNAIDS (2005) in its report on 'A scaled-up response to AIDS in Asia and Pacific'

through this study it is found that WFPR in above 45 years is higher in non HIV household. It is to be mentioned here that the employed respondents in HIV infected household here are mostly employed in nongovernmental organization. Such high proportions effectively indicate the felt need to earn more in order to meet the increasing financial burden experienced by the HIV households.

**b) Impact of HIV and AIDS on household consumption and savings**

Respondents disclosed the hardships the family had to undergo nursing themselves as well as the family. They kept falling sick and contracted opportunistic infections from time to time which made them rush to hospital at least thrice a month. This implies that the epidemic is not only increasing the number of poor but also adversely impacting the disparity within the poor across HIV and non-HIV households.

The burden of diseases increases as the stage of infection of PLWHA advances, causing tremendous financial burden on the family. Implications of having 'AIDS in the family' have been noticed in the family of the respondents. They range from increased medical costs and expenditures on funerals to withdrawal of family members from work or school to look after those who are ill. When a man becomes debilitated or dies from HIV/AIDS, his wife or partner loses her main source of economic and social support, as are other dependent members of his extended family.

There have been cases in Naga society too where women who are not allowed to own property, at the death of a spouse, lost her home and land. Practices such as levirate (widow inheritance) and women's limited access to productive resources and work opportunities compels widows to exchange sex for money, food or shelter. These women turned as Commercial sex workers (CSW), in order to earn and feed for herself and the family, which in turn leads to a higher risk of HIV transmission. While interacting with the CSWs mostly in Dimapur, the researcher was informed that they were compelled to resort to these immoral activities in order to sustain their livelihood. A CSW of 38 years informed that because of her husband's habit of drunkardness, he did not bring any money for the family but use to ask money from her instead to get his drinks. With no other sources of income, they were left with no other option or alternative than to take up this profession. Hence, it is proved

that poverty leads to prostitution and in the process; the practice of unsafe sex leads them to HIV infection

In another case, it was also informed to the researcher that there are reduced savings and investments for the HIV infected families as per the response from one of the infected respondent. Mostly money gets spend in health care and nutritional supplements.

Loss of income, additional care-related expenses, the reduced ability of caregivers to work, and mounting medical fees push affected households deeper into poverty. It is estimated that, on average, HIV-related care can absorb one-third of a household's monthly income.

Tapping into available savings and taking on more debt with high interest are usually the first options chosen by households struggling to pay for medical treatment or funerals. As debts mount, precious assets such as livestock and even land are sold, and as debt increases, the chance to recover and rebuild diminishes.

HIV epidemic is a complex phenomenon in the world today. It challenges the accepted ways of understanding health and human development in the Naga society and demands new forms of expertise and holistic responses. HIV is not only a product of human action but also a disease of the disadvantaged and uneven development.

Experience of the past decades in Nagaland shows that, along with the change in time, society changes. At the present juncture, Emile Durkheim's classification of social solidarity into 'mechanical' and organic solidarity as part of his theory of the development of societies in 'the division of labour in society' (1893) is very much relevant here. Mechanical solidarity normally operates in traditional and small scale societies. In simpler societies, solidarity is usually based on kinship ties of familial networks. Organic solidarity comes from the inter dependence that arises in specialization of work and the complementarities between people- a development which occurs in 'modern' and 'Industrial' societies. Naga people who used to be hardworking and simple people and confined within the four walls of the state bonded by the social norms of Naga society have witnessed a paradigm shift from mechanical to organic solidarity. Naga society seems to be more into organic solidarity that the mechanical solidarity. The traditional Naga society is transforming into a modern complex

technological culture. People migrate from rural to urban set up and expose themselves to popular culture. It is seen that the members of the urban families abandon their age old cultural values and gets adapted to the new popular culture. Loss of institutional command over the individuals and loss of moral values, ethical values and spiritual values that are seen in mechanical solidarity is vanishing day by day.

Stigma and discrimination are not only obstacles to HIV prevention, care and treatment for people living with HIV, but are among the epidemic's worst consequences. HIV-related stigma consists of negative attitudes towards those infected or suspected of being infected with HIV and those affected by AIDS by association, such as orphans or the children and families of people living with HIV.

Discrimination against People Living with HIV refers to any form of arbitrary distinction, exclusion or restriction affecting people because of their confirmed or suspected HIV-positive status. Both place a burden on human development by denying hundreds of thousands of people the chance of reaching their full potential. HIV-related stigma and discrimination are found in all parts of the world, but their manifestation varies from place to place. Half the participants in this study believed that punishment was an appropriate response towards those living with HIV, over half (56%) of the respondents were unwilling to be friends with HIV positive people and 73% thought that those living with HIV should be isolated. Stigmatizing attitudes tended to be associated with being male, older, married, less educated and unwilling to be tested for HIV. Such attitudes have serious implications.

Research in other parts of the country shows that to avoid stigma and discrimination some HIV-positive people refuse to get information about HIV and sexually transmitted diseases, staying away from health-care professionals and shunning those suspected of risk behaviour in an effort to blend in with community norms.[86] HIV-related stigma is frequently conflated with negative attitudes towards marginalized groups and may be reinforced by legislation and legal systems that attack basic human rights

HIV/AIDS has had a powerful impact on other epidemics. For example, AIDS is the primary force behind the global resurgence of tuberculosis. Determined responses in

[86] Lieber 2005, 'HIV/AIDS and Development in South Asia'

prevention, care, support and treatment can do much to reduce the epidemic's impact, and welcome surprises may be in store as antiretroviral treatment is rolled out around the world. Yet one thing is sure that no matter how the AIDS epidemic takes shape in any given country, its social and economic effects and particularly its erosion of human capital—will continue to grow for many years after prevalence begins to fall.

In order to combat stigma and discrimination, all levels of society needs be involved. The legal process requires its involvement at the international and national levels to ensure that the rights of HIV infected persons are protected. Measures needs to be put in place to ensure that this is enforced at the local level. In the end, education is the key. Stigma and discrimination is largely due to myths about HIV and its transmission. Education programs worldwide about the methods of HIV transmission (in particular the ways it is not transmitted)[87], ways in which one can protect oneself from infection and treatment options will go a long way in the battle against stigma and discrimination and thus the battle against the worldwide pandemic as a whole.

Many lives have been infected and destroyed by HIV/AIDS. The stigma and discrimination does not allow the PLWHAs to lead a normal life. It is seeping into the Naga families bringing intense implications. In order to mount a more meaningful response to HIV epidemic, this study suggest that there is an urgent need to actively involve various agencies like the NGOs, governmental agencies, law enforcing agencies, churches, individuals etc. to combat this menace in society. In the absence of increased joint initiatives, it is indicative that this problem will continue to cause untold human suffering and death affecting the whole social system.

[87] World Bank (2003), 'Considering HIV/AIDS in development assistance: A toolkit [Online]. Retrieved from www.worldbank.org/aids-econ/toolkit/intro.htm'

# CHAPTER – 4

# AGENCIES OF HIV CONTROL MEASURES

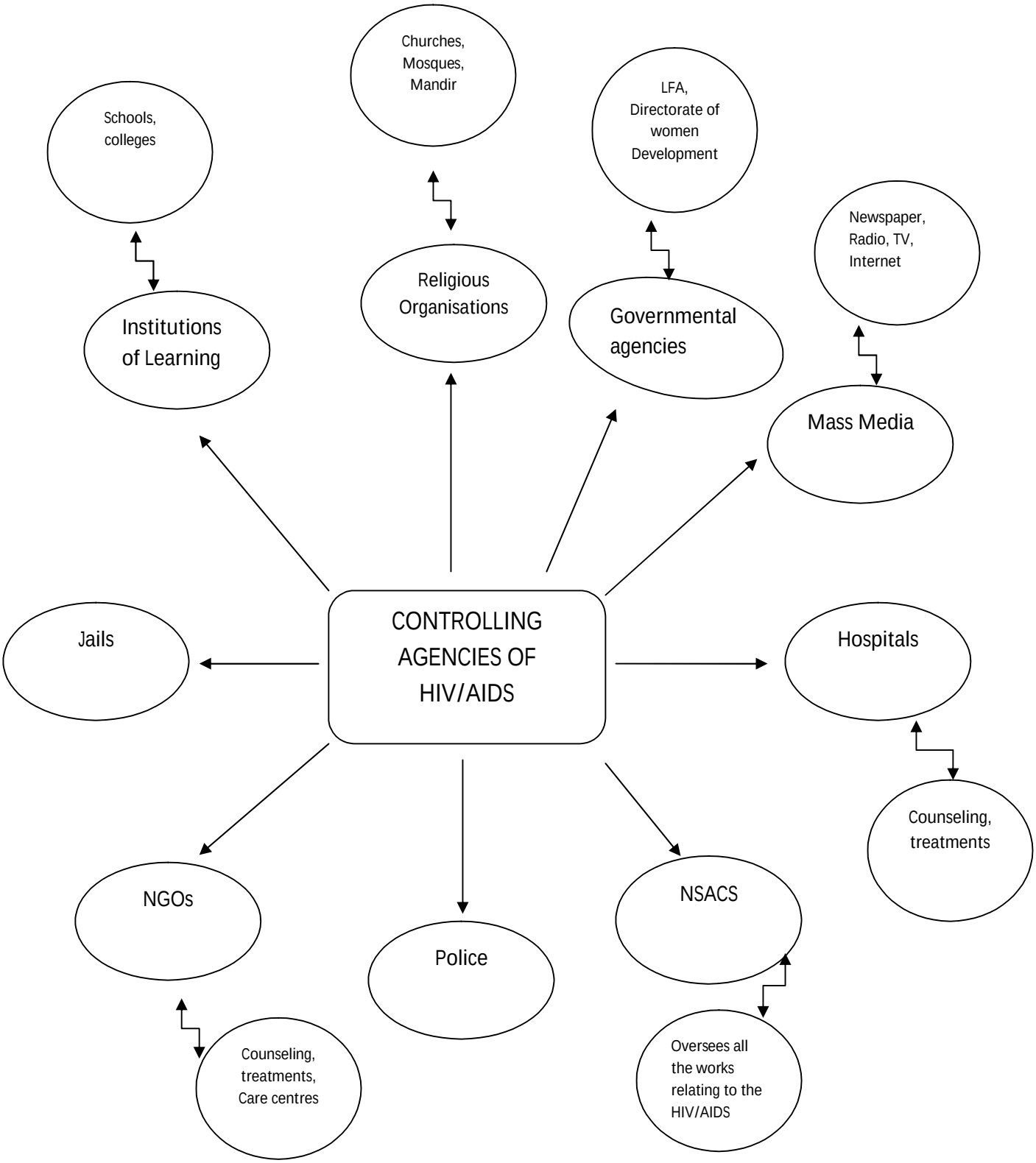
This chapter is an evaluation of the agencies of control measures towards the pandemic in Naga society. In a state like Nagaland, it has been considered necessary to look into the role of the religious organizations, the intervention by governmental as well as nongovernmental organizations, institutions of learning, the family and the individuals etc. These agencies are the backbone towards the controlling of the epidemic. A critical evaluation of the HIV control machineries has been undertaken to examine their contribution towards controlling HIV/AIDS.

HIV/AIDS has become one of the key social problems in the present era. There are various mechanisms in the whole of the state through which efforts are made to ensure that the growth of HIV infection is controlled. These mechanisms have a pivotal role to play regardless of how their approaches or strategies are. In achieving spontaneous control of HIV, various major agencies of HIV control measures as indicated in the following figure 4.1, has adopted different strategies according to how their field demands.

Some of the agencies that have been working towards controlling the pandemic are the learning institutions like the schools and colleges, religious organizations, the police and the administration; Non- governmental organization, jails, hospitals, individuals etc. While NGOs have a critical role to play in implementing various intervention programmes among the different population groups, the governmental agencies too has an overall responsibility to plan, co-ordinate, mobilize and facilitate various HIV/AIDS prevention, care and treatment activities. While ensuring the utmost efforts to access new AIDS drugs for the PLWHAs and also other intervention programmes, the government needs to aim at providing major opportunities to the HIV infected fraternity.

Experiences in global HIV pandemic portrays that HIV can be prevented if sound, rational and effective strategies are used. Therefore the role of mass media in disseminating vital informatics to the general populace about the pandemic, the role of law enforcing agencies and the role of individuals are considered to be of high importance.

**Figure 4.1: CONTROLLING AGENCIES OF HIV/AIDS**



## 4.1 : THE ROLE OF THE RELIGIOUS ORGANISATIONS

Religious organizations are considered to be one of the important agencies to halt HIV/AIDS. At the present juncture, humans have acquired more knowledge than any other time in history. Science, medicine and education are going places never before imagined. Human have bigger jets and cruise liners, faster computers etc but when there is personal or national tragedy, people flock to religious organizations like the churches, the mandirs and the mosques for prayers and counsellings. In times of hardship and tragedy, people tend to find solace in it. The religious organization keeps people grounded by providing bedrock of faith and answers to humanity's deepest needs. With all the weight and pressures of the world, people expect answers from them that no other institution provides. People's spiritual and emotional needs are fulfilled by the religious organizations. Therefore, the religious organizations hold an important place in controlling the pandemic.

This study covered various religious organizations like the Nagaland Baptist Churches Council (NBCC), Ao Baptist Arogo Mungdang (ABAM), various churches of Nagaland, Hindu Shiv Mandir and Mosque etc in order to assess the knowledge, awareness and initiatives. Religious beliefs among the most emotional and deeply felt needs of human beings.[88] In many cultures they come to form the most predominant influence in people's response to crisis in life. When an individual is unable to overcome a difficult situation with human effort and energy, there is always a tendency to depend on God, a supernatural power, to get relief and comfort this is especially true in cases of diseases and calamities as well.

In the case of fatal pandemic like HIV/AIDS, the dependence on God can be more because dependence on others will be less due to stigma and discrimination. On being asked whether the PLWHA respondents believed in the existence of God, this study found that there were 78.2% who thought that religion helped them in coping with HIV infection. The remaining 21.8 % respondents were of the opinion that they did not believe in the existence of God and did not help in coping HIV infection. This clearly shows the importance of

[88] Thenpillil, Jose (2006) 'Socio-Cultural dimensions of the HIV/AIDS affected'

religion and the roles of the religious organisations in the life of the PLWHAs and how it can be an important agency towards the control of the pandemic.

**Table 4.1: Classification of the respondents according to religion**

| Religion | % |
|---|---|
| **Christian Baptist** | 84.8% |
| **Christian Catholic** | 1.9% |
| **Hindu** | 3.8% |
| **Muslim** | 3.8% |
| **Others** | 5.7% |
| **Total** | 100% |

Nagaland being a Christian dominated state, most of the respondents from religious organizations was Christians with a percentage of 84.8% and 1.9 percent Catholic Christian as projected in table 4.1. The remaining comprised of the Hindu, Muslims and others. In this study we wanted to know the role of the religious organisation in the field of HIV/AIDS and their approaches towards HIV/AIDS, they stated that various seminars and awareness programmes on HIV/AIDS, counselling the people, conducting health camps, special prayer support, vocational trainings, financial support to PLWHA were given and nutritional support were also extended to the PLWHA. This shows the concern and understanding that the religious organizations have towards the PLWHA by extending help and support.

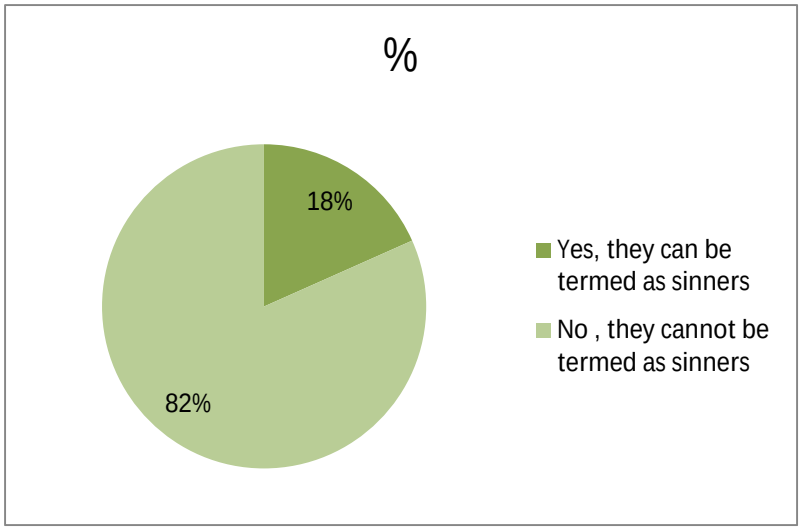
In response to whether there was a separate branch/cell to deal exclusively with the pandemic in their Church/organization/association set up, interesting answers cropped up. Table 4.2 depicts the response that they gave. While 15.1 opined that it is not necessary, a majority of the respondents with a percentage of 37.7% responded that they do have a separate cell followed by 28.3% respondents that it was under planning. These responses somehow portrays a mixed picture, while it is important to have a separate cell particularly

for the HIV infected, on the other hand it may look like they are put into isolation and segregated by the religious organizations.

**Table 4.2 Setting up of a separate cell**

| Opinions of having a separate cell | % |
|---|---|
| Yes, we have | 37.7% |
| Under planning | 28.3% |
| Not necessary | 15.1% |
| Difficult to put it into motion | 13.2% |
| Never thought of | 5.7% |
| Total | 100% |

**Figure 4.2: Can PLWHAs be termed as Sinners?**




The figure below projects the answers given out by the respondents and it somehow shows the attitude of the religious fraternity toward the pandemic as majority of the respondents i.e 82% opined that they are not sinners and should be welcomed and should not be discriminated at any costs. In the recent years, the participation level of the PLWHAs in religious organizations is on an upward trend. The prevalence of HIV/AIDS in the state is in its 24$^{th}$ year and the presence of PLWHA in the society and to get them involved within

the fraternity of the religious organization is quite a new experience. Through this study it was revealed that the religious organization play a vital role in moulding up an infected emotionally down HIV person. To cite an example, the Chang Baptist Church Tuensang[89] along with the Khiamnungian Baptist Church, Sangtam Baptist Church, Yimchunger Baptist Church and Ao Baptist Church take various initiatives to bring the HIV infected within their fold. They organize various programmes, seminars etc in order to see that the HIV infected people are not left out and see that they live a life as an unaffected person lives.

Prayers and other religious practices are signs of religiousity. People usually depend on the divine when there is no other way to escape from their physical ailment or any other difficulty. In order to know how far the respondents practiced their religion, questions were asked on prayer and religious practices. 72.8% of them said that they were comforted through prayer and religious rites and practices. The increased of the beliefs in prayer by the PLWHA respondents show that in the face of fatal disease, there is always a tendency to pray for God's intervention. Since there is no possible cure medically with regard to HIV/AIDS, the utter dependence of human beings on the divine protection is seen here.

In our attempts in discovering the opinion of the religious organization towards controlling the pandemic, the interviewer put a query how can bring the HIV+ community to the fold of the church/ organizations/ associations etc. In response to this, they have suggested the following:

a) Accept and accommodate them with empathy.
b) Religious organisations must plan and make programmes for their welfare.
c) Shun stigmatization and discrimination.
d) Encourage the PLWHA's to come forward without having an inferiority complex.
e) Proper health care delivery through the organisation's initiative.
f) Provide social support and encourage positive living.
g) Give guidance and hope through counseling.

[89] The Chang Baptist Church Tuensang plays a very important role in reaching out to the HIV population in Tuensang. The broad mindedness of the Pastor and the members of the church were noticed during the course of field work. So far no other church has taken initiatives like this church has taken.

h) Religious organisation should conduct seminars and programmes on HIV/AIDS

i) Let the PLWHA participate and invite free opinions and involvements in the church

j) Positive people are members of the religious organization as well.

k) Opportunities and equal privileges should be given in decision making and in worship too.

The PLWHAs have specific needs which the other members might not have. They may be afraid ashamed and afraid of active participation in the organisation's activities. Therefore the study suggests that they need to go forward and extend emotional and financial support as well in order to curb the pandemic.

The churches in Nagaland has started with a programme known as 'True Love Waits', where youths are given a platform to sign a pledge to abstain from sex till one gets married. This is in a way contributing to control the menace of HIV/AIDS in society.

Out of the 400 respondents, there were 50 respondents from religious organizations who were included in this research study from all over the state. 70% of them opined that they conduct seminars, awareness and advocacy programmes on HIV/AIDS and 80% of them were found to be actively involved in providing health, economic, physical and emotional support to the infected people. Setting up of a separate cell was found discouraging as 84 % of the respondents that that setting up of a it will hamper the social life of the HIV infected and it will instead ignite the fire of stigmatization. Though the religious organization did not deny the prevalence of stigma within the church fraternity, they were satisfied by 58% towards performing and contributing towards the control of the pandemic.

It is found that various religious organizations are actively participating in organizing seminars, awareness programmes and advocacy programmes. In addition to this, they also organises varied charity programs in aid of the people living with HIV/AIDS and contribute financially to the uplift of the PLWHA fraternity. Through this study, it is portrayed that religious organisations are so far responsive and are taking up various steps by conducting seminars, prayers, counsellings etc.

# CHAPTER-5
# MAGNITUDE OF HIV/AIDS: A DISTRICT WISE COMPARATIVE ANALYSIS

This chapter brings about a comparative analysis of the magnitude of HIV/AIDS and its impact on the entire state of Nagaland. It is a vibrant hill state located in the North Eastern region of India. It is basically a tribal state dominated by Christian population. Agriculture is the main economic activity where terrace and jhum cultivation are predominantly practiced through out the state of Nagaland. The major urban areas of Nagaland are Kohima, Dimapur, Mokokchung, Tuensang, Wokha, Zunheboto, Phek, Kiphire, Mon, Longleng and Peren. There are four urban agglomeration areas in the state: Dimapur-Chumukedima, Dimapur district, Greater Kohima, Kohima district, Mokokchung metropolitan area, Mokokchung district and Greater Wokha, Wokha district.[98] Major towns that are non- district headquarter includes Tuli town, Mangkolemba, Naganimora, Changtongya, Tizit, Tseminyu, Bhandari, Akuluto, Pfutsero, Aboi and Tobu. It looks into the socio-economic considerations, seriousness of the issue, educational considerations, people's response and human rights issues. District wise distribution indicating population and literacy rate are shown in table 1.4.

According to the latest Technical Report, India HIV estimates from NACO, Nagaland is at 0.88% prevalence rate which is much higher than the national prevalence rate at 0.37%.[99] For about two decades of the pandemic of HIV and AIDS, need for an effective response has been felt very strongly in all the districts of Nagaland. Human behavior being complex; widespread behavior changes are challenging to achieve. Understanding of the dynamics of HIV transmission cannot be separated from an understanding of the broader context of poverty, inequality and social exclusion which create conditions under which unsafe behavior flourishes HIV/AIDS is not a mere health issue but its occurrence is influenced by a number of socio-economic, cultural and ecological determinants.

Today, Nagaland is one of the six high HIV-prevalence states in the country. The other five highest prevalent states are Andhra Pradesh, Maharashtra, Karnataka, Tamil Nadu

[98] En.M.Wikipedia.org/wiki/Nagaland
[99] M&E Bulletin April – September 2013

and Manipur. The Indian Council of Medical Research (ICMR) detected the first HIV case among the injecting drug users (IDUs) in the state in the year 1990. In the same year, ICMR estimated 2,500 IDUs in Nagaland, with 50 percent HIV prevalence among them. The state comes under the category of generalised epidemic because of the high HIV-prevalence among the antenatal clinics (ANC) group. The highest prevalent state at ANC sites in the country with an estimated HIV prevalence rate of 0.88 %.

Neighboring Manipur is also burning with the pandemic and also with the menace of drug addiction.[100] The intravenous drug constitutes a large portion of population. The easy route of drug trafficking from the neighboring countries, the geographical proximity of the region to golden triangle super added by the transient fun, curiosity and unemployment etc have turned the beautiful hilly region to a living hell. Easy flow of drug from the golden triangle adjacent to the north eastern region of India has come to stay. This puts Nagaland in the danger zone too and we can witness its implication at the present moment.[101]

**a. Seriousness of the issue:**

HIV/AIDS affects people from all walks of life. Earlier, society considered that only a few categories of people get infected and they were referred to as risk groups. Now this trend is no more prevalent in Naga society. HIV makes no distinction whatsoever with regard to the people who get infected. Without any consideration, it has infected and affected all sections of people in the entire state of Nagaland. There is no religious or economic barrier on HIV because HIV itself is blind to race ethnicity, gender, religion, age and class of a person it invades, the social, political and economic organization of a society gives the virus greater access to society's disadvantaged sector. A productive person is defined to be someone aged between 15 to 65 years.[102] An adult therefore has approximately 50 years of productive work. In the case of death of the supporting parent, it results in lowered economic growth and thus hampers the daily life of the remaining household.

HIV/AIDS strikes people in their most productive years when they should be active in all the developmental sectors like in civil service, private and nongovernmental sectors.

[100] Banerjee, Niotpal (2000) 'AIDS in Indian Society, To sail in the ocean'
[101] Lisam ,Khomdon Singh (2004)"HIV/AIDS and YOU"
[102] UNAIDS (2005) in its report on 'A scaled-up response to AIDS in Asia and Pacific'

There are various mechanisms in the whole of the state through which efforts are made to ensure that the growth of HIV infection is controlled. Institutions like the schools and colleges, Religious organizations, Police and administration; Non Governmental Organization, Jails, Hospitals, individuals etc. play a vital role in curbing the pandemic.

Table 5.1 shows the classification of 400 respondents into district wise classification of the respondents.

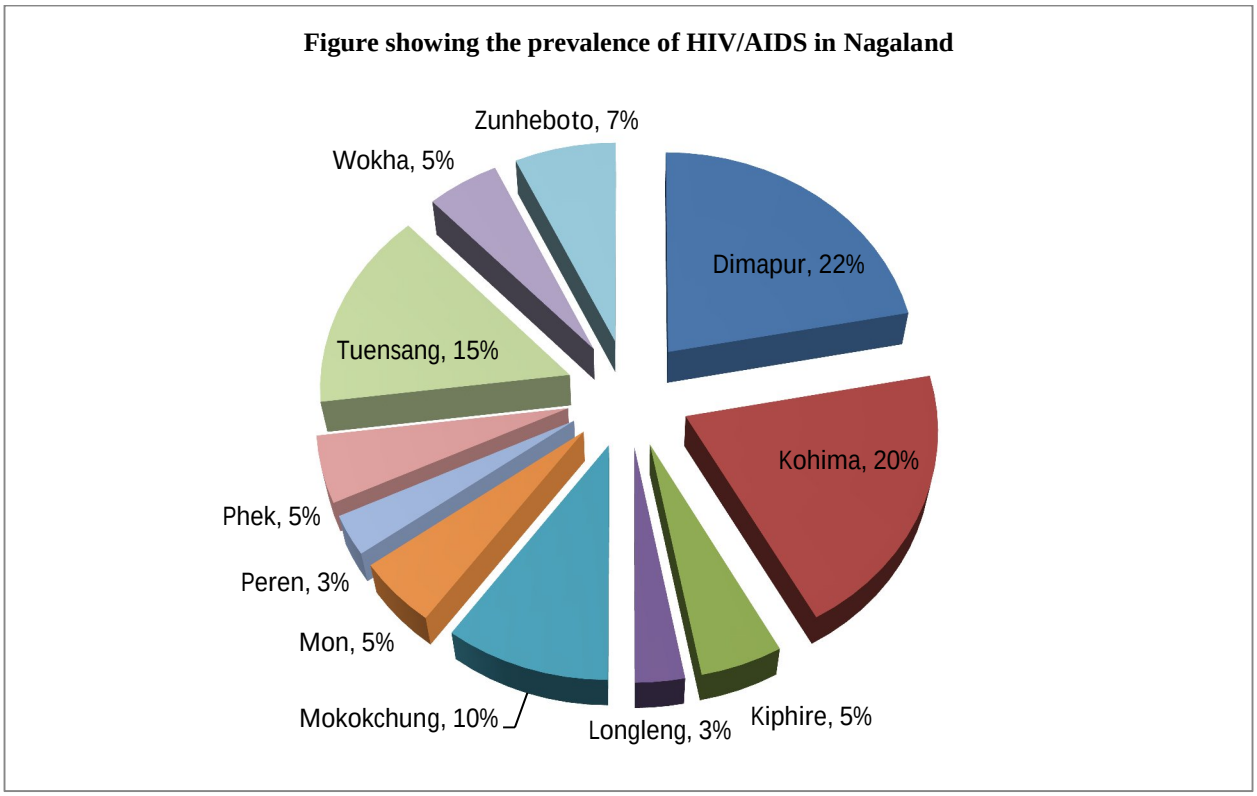
**Table 5.1: District wise classification of organization and respondents selected**

| District | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | Total respondent |
|---|---|---|---|---|---|---|---|---|---|
| Kohima | 20 | 10 | 1 | 4 | 9 | 4 | 5 | 5 | 58 |
| Dimapur | 22 | 10 | 1 | 4 | - | 4 | 5 | 5 | 51 |
| Tuensang | 15 | 10 | 1 | 4 | - | 4 | 5 | 5 | 44 |
| Mokokchung | 10 | 10 | 1 | 4 | - | 4 | 5 | 5 | 39 |
| Zunheboto | 7 | 8 | 1 | 4 | - | 4 | 5 | 5 | 34 |
| Phek | 5 | 9 | 1 | 4 | - | 4 | 4 | 4 | 31 |
| Mon | 5 | 9 | 1 | 4 | - | 4 | 4 | 4 | 31 |
| Wokha | 5 | 9 | 1 | 3 | - | 3 | 5 | 5 | 31 |
| Kiphire | 5 | 8 | 1 | 3 | - | 3 | 4 | 4 | 28 |
| Peren | 3 | 9 | 1 | 3 | - | 3 | 4 | 4 | 27 |
| Longleng | 3 | 8 | 1 | 3 | - | 3 | 4 | 4 | 26 |
| Total | 100 | 100 | 11 | 40 | 9 | 40 | 50 | 50 | 400 |

Note: 1= PLWHA, 2=General population, 3 = Jails, 4 = NGO, 5 = NSACS, 6 = Hospitals, 7 = Religious organization 8= administrators and law enforcing

Kohima, the state capital had the highest number of respondents. Out of 400 respondents, Kohima had 58 respondents. The main office of NSACS is in Kohima, so they were placed under the respondents belonging to Kohima. A total of 51 respondents were selected from Dimapur out of which the highest number of PLWHAs were from the district itself, students, college goers, educate unemployed youths, drop outs, government employees, jailor, employees of NGOs, counselors, nurses, doctors, lab technicians, police and pastors. The least number or respondents were from Longleng.

**Figure 5.1: District wise prevalence of HIV/AIDS**




According to the above given figure 5.1, the eleven districts of Nagaland are all infected and affected with HIV/AIDS. The prevalence rates vary from district to district. An overview of the HIV prevalence can be gathered from figure 5.1. Dimapur, the gateway to Nagaland records the highest number of HIV prevalence rate in the state followed by Tuensang and Kohima.[103]. Through this study, it is found that one of the reasons why Dimapur ranks first is because of its strategic location. Dimapur, the gateway to Nagaland is

[103] M&E Bulletin April – September 2013

the only place in the state that has been reached by railway and airport connectivity in Nagaland. Because of the easy conveyance, people throng to Dimapur and there is inter mingling of people from so many races and tribes. Dimapur being cosmopolitan in nature, people not only from the state but even from the neighbouring states like Assam, Manipur etc. gets easy access to this town thereby making it more susceptible to the pandemic. It is the centre of almost all business and commercial activities besides being inhabited by almost 60% of the non- tribals, who are mostly immigrants and many situations, be it good or bad begins from there. Dimapur is considered to be one of the fastest growing cities in the North East India.

In addition, poverty is also considered to be another major factor that leads to prostitution resulting in increased prevalence of HIV/AIDS cases. Dimapur, which lies just next to Assam has easy access to alcohol and the opening up of so many lounges and bars where young boys and girls party, gives birth to high risk behaviours.

Kohima follows the lead with a percentage of 20% followed by Tuensang with a percentage of 15%. As per the response of one of the director of an NGO said; this high rise in percentage in Tuensang must be due to the people's attitude in coming forward to do blood test which is different in other districts. In comparison with Tuensang very less people fear to even go for blood test because of the stigma and discrimination attached with the pandemic. If we view it from another angle, the 5% prevalence rate of the Mon district is comparatively very less. On a brighter note, it can also be due to the effect of qualitative awareness programmes or it may also be due to the low level education and awareness related to the spread of HIV/AIDS. The progression of human society will be hindered if the rapid rise in HIV is allowed to continue unchecked.

Even a mild HIV/AIDS epidemic in the state has an adverse implication for the working age population. While there is no comprehensive study that has mapped the economic costs and losses, it is sufficiently clear by now looking closely at the issue that HIV/AIDS does have both long term and short term adverse implications on the Indian economy. HIV/AIDS is a state health, social and economic problem.

The direct or the indirect cost of treating an AIDS can be quantified and there is reduced savings and investments for families compared to the high expenditure incurred in the management of HIV and AIDS. This includes paying for medical bills and in arranging nutritional supplements.

**Table: 5.2 District wise Gender and Age Group Classification**

| District | Gender | | Classification of age of 400 respondents | | | | |
|---|---|---|---|---|---|---|---|
| | Male 169 | Female 231 | Below 24 50 | 25-34 195 | 35-44 72 | 45-54 46 | 55 and above 37 |
| Dimapur | 22 | 29 | 6 | 17 | 13 | 8 | 7 |
| Kohima | 25 | 33 | 7 | 28 | 10 | 7 | 6 |
| Kiphire | 11 | 17 | 3 | 13 | 6 | 4 | 2 |
| Longleng | 09 | 17 | 4 | 15 | 5 | 2 | - |
| Mokokchung | 14 | 25 | 6 | 18 | 9 | 4 | 2 |
| Mon | 12 | 19 | 2 | 19 | 7 | 2 | 1 |
| Peren | 09 | 18 | 6 | 11 | 4 | 3 | 3 |
| Phek | 15 | 16 | 3 | 18 | 6 | 2 | 2 |
| Tuensang | 20 | 24 | 7 | 23 | 2 | 7 | 5 |
| Wokha | 13 | 18 | 5 | 15 | 6 | 4 | 1 |
| Zunheboto | 17 | 15 | 1 | 20 | 4 | 1 | 8 |
| Total | 400 Respondents | | | | | | |

Table 5.2 and figure 5.2 classifies the respondents according to two broad categories viz gender and age group. The sex ratio in Nagaland according to 2011 census is 931 females against 1000 males. In this study out of all the 400 respondents, Kohima had the highest number of male and female respondents. This depicts the broadmindedness of the people in voicing out their opinions in comparison with the people from other districts who were reluctant to express their views. The table also indicates that the age group 25-34 has the

highest number of respondents. This is an age when a person is young, vibrant and expressive.

**Figure 5.2: Gender wise distribution of respondents.**

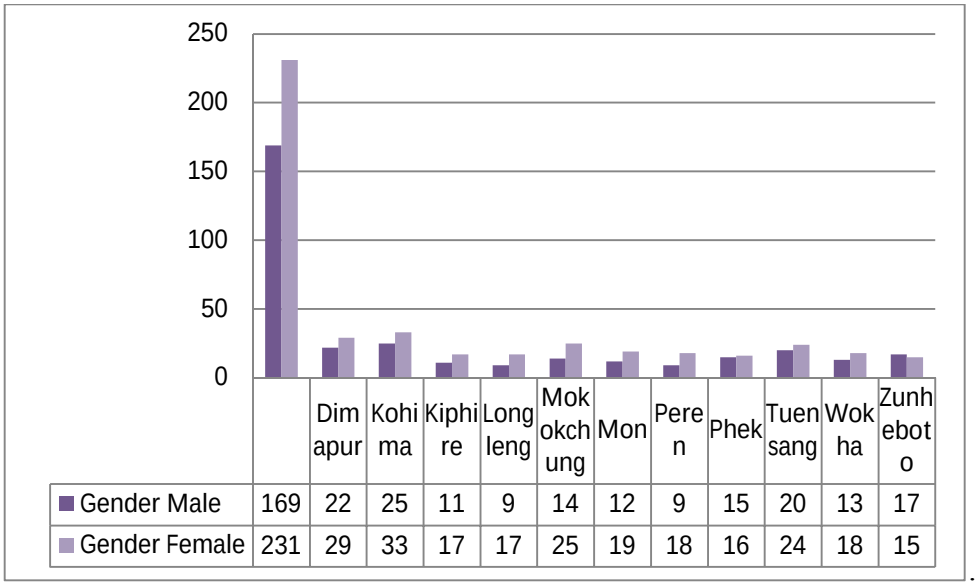



**Table: 5.3 Educational Profiles of the Respondents**

| **Educational qualification** | **Frequency** | **Percent** |
|---|---|---|
| Under Matriculate | 47 | 11.75% |
| Matriculate | 57 | 14.25% |
| Higher Secondary | 46 | 11.50% |
| Graduate | 176 | 44.00% |
| Post Graduate | 42 | 10.50% |
| Not available | 32 | 08.00% |
| Total | 400 | 100% |

According to 2011 census, Nagaland has a high literacy rate of 80.11% which is above the national level of 74.04%. Majority of the people in the state speak English which is the official language of the state. The male literacy rate is 83.29% and the female percentage is 76.69%.[104] Table 5.3 below represents the educational profile of the respondents. It can be seen that 44% of the total respondents are graduates though details of educational

[104] Aye, N. Khashito (2012) Nagaland GK

qualification of 8% were not available. The focus on education to eradicate the prevalence of HIV/AIDS makes sense objectively and intuitively. Kelly (2003) opines that educational system is one major weapon because it reaches the majority of people and that almost every prevention effort depends on education and communication in some way or the other. Education is also necessary to combat the culture of silence, the stigmatization and the discrimination that is associated with HIV/AIDS (UNESCO, 2002)

**b. Treatment and services**

The treatment and services available have been discussed in the earlier chapter and there is no doubt about the service centres that are available in all the 11 districts of the state.There are 56 Integrated Counseling and Testing Centres (ICTC), 10 Mobile ICTC, 45 FICTC- Public Health Centres, 1 Public Private Practitioners, 4 PPTCT, 53 NGO (Targeted Intervention), 12 District Suraksha RTI/STI Clinics and 52 TI NGO STI clinics, 48 FICTCs, 8 Blood Banks, 5 ARTCs, 1 ART+, 8 LACs: ARTC Dimapur, Mokokchung, Tuensang, Kiphire, Zunheboto, ART+ Kohima, LAC: District Hospital Wokha, District Hospital Phek, District Hospital Mon, District Hospital Longleng, LAC- CHC: Noklak and Tuli, LAC-Police Referral Hospital, Chumukedima, LAC-CHC Jalukie and 13 OST Centres. It is found that there are STI (Sexually Transmitted Infection) service delivery in all the eleven districts in Nagaland. National Rural Health Mission (NRHM) also helps in providing kits for testing. It is seen that focus has been emphasized on ICTC referrals, linkages and partner management. There are 8 blood banks across the state viz Dimapur, Kohima, Mokokchung, Mon, Phek, Tuensang, Wokha and Zunheboto.

If we closely look at the treatments and services available, it is found that all the facilities are based in urban settings only. The service providers should not neglect the rural areas where HIV epidemic is on rise. Longleng, Kiphire and Peren, have no blood bank installed yet and the government should see that all the districts avail the same facilities and there should be equality amongst all the districts.

**c. Role of the NGOs**

In this study various NGOs were taken into account; the Family Planning Association of India (FPAI) Kohima, Bethesda Youth Welfare Centre (BYWC) Dimapur and Wokha, North Eastern Drug/HIV training Centre (NEDHIV) Dimapur, Kripa Foundation Kohima,

Kekhrie Foundation Kohima, Kohima Network of Positive People (KNP+), Care Counselling Centre Mokokchung, Mokokchung Network of Positive People (MNP+), Tribal Farmers Association Peren, Shansham Organisation Mon, Yingli Mission Society Longleng, Integrated Development Society Tuensang, International Border Area People's Welfare Association Kiphire, Eureka Life Foundation Phek and Akimbo Society Zunheboto.

**Table 5.4 District wise response of the NGOs**

| Response | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Satisfied with the present job in NGOs** | 50% | 59% | 60% | 49% | 60% | 45% | 56% | 59% | 65% | 49% | 58% |
| **Provision of co curricular activities to the HIV positive** | 70% | 68% | 43% | 40% | 65% | 52% | 45% | 50% | 71% | 51% | 60% |
| **Special consideration for female clients** | 60% | 65% | 56% | 40% | 55% | 51% | 43% | 50% | 65% | 50% | 53% |
| **Special consideration for Children living with HIV/AIDS** | 54% | 59% | 52% | 40% | 52% | 49% | 50% | 52% | 68% | 48% | 49% |
| **Provision of vocational training to target population** | 60% | 65% | 45% | 55% | 65% | 54% | 53% | 49% | 67% | 52% | 56% |
| **Prevalence of stigma and discrimination** | 80% | 76% | 65% | 54% | 78% | 56% | 65% | 61% | 64% | 55% | 53% |
| **Any positive steps taken by the organization in combating the pandemic** | 70% | 65% | 55% | 59% | 69% | 43% | 52% | 59% | 62% | 50% | 51% |

Note: 1= Dimapur, 2=Kohima, 3=Kiphire, 4=Longleng, 5=Mokokchung, 6=Mon, 7=Peren, 8=Phek,, 9= Tuensang, 10=Wokha, 11=Zunheboto

Job satisfaction of the NGO's working in the field of HIV/AIDS seems to be higher in Integrated Development Society Tuensang (Refer table 5.4). They stated that they enjoy being a part of the fight against this pandemic and are truly devoted towards fighting against the pandemic. It is found through the study that the provision of co-curricular activities like carom, table tennis, television, other recreational activities to the PLWHAs is more again in the same Integrated Development Society, Tuensang followed by Kripa foundation Kohima.

Special consideration for female PLWHAs and Children infected with HIV are available in all the districts but Kohima and Tuensang is in the forefront providing special nutritional support and free medications etc. Provision of vocational trainings to the target population like tailoring, wood carving, handicraft, knitting etc is more again in Tuensang.

Hence, it is proved that in comparison with other NGOs, Integrated Development Society is one of the best NGO in working towards the control of the pandemic. The treatment and care provided in its care centre is incomparable with the NGOs from other districts.

**d. Initiatives of the religious organization across the state.**

This study covered a lot of religious organizations. Being a Christian state a majority of the religious organization are Christian based organizations and churches. Except for one percent each from Hindu and Muslim based religious organization. 50 respondents from various religious organization were selected in order to review their knowledge, awareness, understanding, initiatives and approach towards the pandemic and the PLWHAs. Table 5.5 indicates the district wise responses on community participation from various religious organization. Here, Ao Baptist Church Dimapur and Chang Baptist Church Tuensang is in the forefront providing the PLWHAs free access to the place of worship and their suggestions are valued and implemented. They are given enough opportunity to interact and share and as well as provide avenues to utilize their potentials.

**Table 5.5: District wise responses on community participation from various religious organization**

| Response | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **PLWHAs have free access to the place of worship** | 90% | 95% | 80% | 85% | 82% | 65% | 76% | 64% | 94% | 65% | 70% |
| **PLWHAs suggestion are valued and implemented** | 80% | 76% | 65% | 64% | 78% | 56% | 65% | 61% | 64% | 65% | 63% |
| **PLWHAs are given opportunity to share and interact** | 70% | 68% | 43% | 52% | 76% | 52% | 45% | 50% | 83% | 51% | 60% |
| **PLWHAs have continuous communication and consultation with the church full time members** | 60% | 65% | 56% | 40% | 55% | 51% | 43% | 50% | 65% | 50% | 64% |
| **PLWHAs are provided avenues to utilize their potentials** | 64% | 59% | 52% | 40% | 52% | 49% | 50% | 52% | 68% | 48% | 61% |

Note: 1= Dimapur, 2=Kohima, 3=Kiphire, 4=Longleng, 5=Mokokchung, 6=Mon, 7=Peren, 8=Phek,, 9= Tuensang, 10=Wokha, 11=Zunheboto

Table 5.6 portrays the performance appraisal observed by religious organizations. It is found that they are not satisfied with the way Naga society reacts to HIV/AIDS. They opines that stigma should be done away at all costs. They are of the opinion that the police, civil administration and the NGOs are positively contributing towards the control of the pandemic.

**Table 5.6: Performance appraisal observed by religious organizations**

| Response | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Satisfied with the way Naga society reacts to HIV/AIDS | 30% | 34% | 21% | 36% | 33% | 43% | 45% | 32% | 20% | 34% | 32% |
| The positive response and approach of the religious organisation in controlling the pandemic | 70% | 68% | 53% | 52% | 76% | 52% | 65% | 50% | 83% | 51% | 60% |
| Law enforcing agencies like the police, civil administration etc are satisfactorily performing their duties to combat and prevent HIV/AIDS in Nagaland | 50% | 55% | 52% | 40% | 53% | 51% | 43% | 50% | 65% | 50% | 64% |
| The NGOs are positively contributing towards the control of the pandemic | 64% | 63% | 52% | 40% | 52% | 49% | 50% | 62% | 88% | 48% | 61% |

Note: 1= Dimapur, 2=Kohima, 3=Kiphire, 4=Longleng, 5=Mokokchung, 6=Mon, 7=Peren, 8=Phek,, 9= Tuensang, 10=Wokha, 11=Zunheboto

e. **People's Responses**

**Table 5.7: PLWHA's view on people's response and initiatives**

| Sl. no | Response | 1 | 2 | 3 | 4 | 5 | Total % |
|---|---|---|---|---|---|---|---|
| 1. | Satisfied with the community's approach and response | 46% | 10% | 18% | 18% | 8% | 100% |
| 2. | The prevalence of stigma and discrimination in Naga society | 15% | 2% | 16% | 46% | 21% | 100% |
| 3. | The positive role and approach of the church towards the PLWHAs | 7% | 4% | 15% | 70% | 4% | 100% |
| 4. | Satisfied with the initiatives undertaken by NGOs working in this field | 14% | 6% | 7% | 57% | 16% | 100% |
| 5. | Satisfied with the initiatives undertaken by the government | 15% | 7% | 38% | 34% | 6% | 100% |

Note: 1= Disagree, 2= Strongly disagree, 3= Adequate impression, 4= Agree, 5= Strongly agree

Table 5.7 projects the responses from the PLWHA respondents clearly shows their view on the responses and the initiatives of the Naga community, the churches, the NGOs and the Government when the respondents were asked about the attitude of the community towards them, 46% totally disagreed that they were at all satisfied. This depicts the poor approach and understanding level of the Naga community towards the pandemic.

In query to the prevalence of stigma and discrimination 46% agreed that it is very much prevalent thus making them afraid to come out of their own cocoon. Somehow they were satisfied with the positive role and approaches of the church. The respondents also opined that the NGOs and the governmental organizations that were entrusted to work in this field were somehow doing their best and 57% were satisfied with the working of the NGOs

and 38% of the total respondents had adequate impression on the initiatives undertaken by the government. One of the most interesting eye opener through this study is that there is no denial of the magnitude of the pandemic in Nagaland that is hampering the social fabric and economic development of the area.

Hukatoli Chophy, an administrator, Legislators Forum of AIDS said HIV/AIDS is preventable, but it has to start from within every individual. She viewed that women become vulnerable to the disease because of lack of education and awareness, low status and violence against them. She stated the means to prevent the disease from spreading was education and awareness.

An official once remarked, "AIDS has become a celebrity cause for fund raising dinners, fashion shows, concerts etc…" which is very much relevant in the district. Awareness programmes should be concentrated not only in the urban areas set up but due importance should be given to people residing in rural areas too.

Stigma and discrimination is highly prevalent in all the districts of Nagaland. The stigma associated with the pandemic causes infected individuals and families to conceal and/or deny their illness. Some of the common responses of both individuals and families are guilt, shame, anger and blame. The breakdown of the traditional family structure is the most common consequence of the pandemic of HIV/AIDS.

There has been case of stigmatization in a hospital of Nagaland. A lady patient was kept in isolation and segregation because of her HIV status. It was disclosed to the interviewer by one of the staff of the hospital. The involuntary participation of the hospital staff was clearly visible, it was informed.

Religious organisations are so far responsive and are taking up various steps by conducting seminars, prayers and counsellings.

**f. Human rights issues**

The strong focus in the 1980s on the human rights of people living with HIV/AIDS also helped lead to increased understanding in the 1990s of the importance of human rights as a factor in determining people's vulnerability to HIV infection and their consequent risk of

acquiring HIV infection as well the probability of their accessing appropriate care and support.[105] The interaction between HIV/AIDS and human rights is most often illustrated through the impact on the lives of individuals of neglect, denial, and violation of their rights in the context of the HIV/AIDS epidemic. This applies, albeit in different ways, to women, men, and children infected with, affected by, and vulnerable to HIV.

People living with HIV/AIDS, their friends and relatives, their communities, national and international policy- and decision makers, health professionals, and the public at large all, to varying degrees, understand the fundamental linkages between HIV/AIDS and human rights.[106] The importance of bringing HIV/AIDS policies and programs in line with international human rights law is generally acknowledged but, unfortunately, rarely carried out in reality. Policymakers, program managers, and service providers must become more comfortable using human rights norms and standards to guide and limit the actions taken by or on behalf of governments in all matters affecting the response to HIV/AIDS. This requires genuine attention to building their capacity to recognize and promote the synergy between health and human rights and to appreciate more fully the potential gains when health interventions are guided by human rights principles. Those involved in HIV/AIDS advocacy must become more familiar with the practicalities of genuinely using international human rights law when they strive to hold governments accountable. For human rights to remain relevant to legal and policy work in HIV/AIDS, the contact between the conceptual work being done on the linkage between HIV/AIDS and human rights and the realities faced by those working in advocacy and in policy and program design must be ongoing; it is the mutually supportive--although occasionally mutually challenging--interaction between these groups that will help keep this work vital and useful.

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[105] D Tarantola. Risk and vulnerability reduction in the HIV/AIDS pandemic. Current Issues in Public Health 1995;1:176-9; S Gruskin, D Tarantola. HIV/AIDS, Health and Human Rights. In: P Lamptey, H Gayle, P Mane, (eds). HIV/AIDS Prevention and Care Programs in Resource-Constrained Settings: A Handbook for the Design and Management of Programs. Arlington, Virginia: Family Health International, 2000.

[106] Human Rights Internet. Human rights and HIV/AIDS: effective community responses. Ottawa: International Human Rights Documentation Network, 1998. R Cohen, L Wiseberg. Double jeopardy-threat to life and human rights: discrimination against persons with AIDS. Cambridge, MA: Human Rights Internet, 1990.

**Figure 5.3: District wise contribution level**

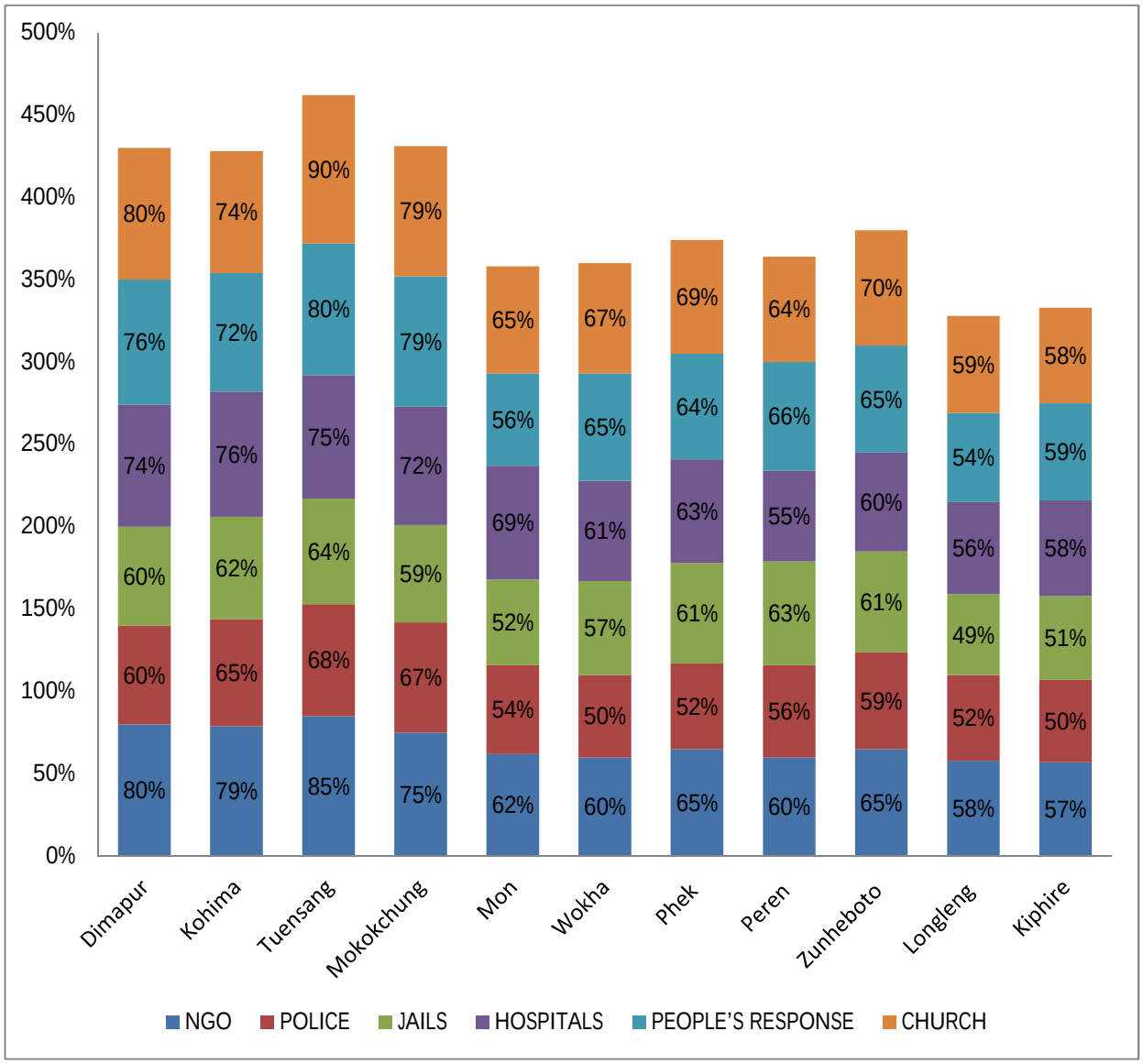


Table 5.8 shows the district wise percentage of their contribution towards the control of the pandemic of HIV/AIDS. As per the data analysis, the Integrated Development Society, Tuensang, an NGO in Tuensang is seen to be performing the best with a percentage of 85% in combating the pandemic. Law enforcing agencies in Tuensang like the police is seen to be contributing well with a percentage of 68% towards the control of the pandemic. These results are the projected through the data and information given out by the respondents during the field work conducted by the researcher.

Table 5.8 also shows the district jail Tuensang with 64% as effectively working the best in comparison with other districts. Hospitals of Kohima with a percentage of 76% is learnt to have the modern infrastructure and availability of proper treatment and care services. People's responses is far better in Tuensang with 80% than in other districts and as stated earlier, the churches in Tuensang district are striving hard with a percentage of 90% towards the uplift of the HIV infected and also towards the total eradication of the pandemic.

The present HIV/AIDS scenario in Nagaland may probably require a lot of social action. At present too less action programmes on AIDS related issues are seen in the district. Given this lukewarm approach, social action is the only method that may bring about changes in the HIV/AIDS prevention and control programmes and the care and treatment for the already infected in the district.

The creation of NACO funded ICTC, PPTCT, STD/STI Clinics, ART Centre and NGOs of both TI and Care and Support Projects is considered to be one of the achievements in this field. The role of the churches, community participation, civil societies, law enforcing agencies etc. is not very satisfactory in some districts but not all. The government is spending and pumping in some chunks of aid towards controlling the pandemic. Therefore proper utilization of funds is the need of the hour.

Mass media represents the most readily available and potentially most economic means of imparting information about HIV/AIDS. Therefore by adopting a responsible attitude in reporting about HIV/AIDS, avoiding inaccuracies and distortions that may generate misconceptions, the media should raise awareness and concern on the pandemic.

To sum up, it can be said that although all the different agencies in different districts of Nagaland working towards controlling the HIV/AIDS pandemic have different ways of approaches, they are all working towards the same goal i.e. to curb its further growth. Therefore there is an urgent need from the each and every member of the society to lift the deathly veil of denial, stigma and discrimination at the individual, social, legislative and political levels.

# Chapter 6

## SUMMARY AND CONCLUSION

HIV/AIDS is not only a health problem but it is also a developmental issue that raises economic and social causes and consequences. The pandemic impacts all aspects of development from education to human rights to economic development. This study claims that the epidemic cannot be tackled only through medical interventions. It involves a multi sectoral approach other than health. The impact of HIV/AIDS presents unprecedented challenges to policy makers, public health officials, social welfare workers, students, administrators, family, churches and others working at the community and individual levels. The tremendous impact placed on the family unit, the impact on women as partners, mothers and care givers are some of the problems that call for fresh thinking and new approaches.

HIV epidemic is a complex phenomenon in the world today. It challenges the accepted ways of understanding health and human development in the society and demands new forms of expertise and holistic responses. HIV is not only a product of human action but also a disease of disadvantage and uneven development. The present study depicts that the issue is divided and the responses to the epidemic are polarized because responses have not adopted a holistic approach. Gender discussion focuses on women and excludes men, economic calculations are separated from realities and prevention is divided form care. Given the magnitude of the pandemic and its heavy personal, social and economic cost, existing efforts to respond to HIV/AIDS must much further be developed and supported. Only through considered, concerted, co-ordinated action and only through a holistic approach, will it be possible for our society to cope with the complex and interrelated consequences of HIV/AIDS.

In view of the above statement, an attempt has been made to study and evaluate the present scenario of the pandemic of HIV/AIDS from a sociological point of view in Nagaland covering the entire eleven districts in the state of Nagaland. Primary data was collected through interviews, group discussions as well as questionnaire schedules. Intensive field studies, participant observation and interaction with the cross section of people supplemented to the analysis by providing more primary data. For this purpose, information and data were collected from 400 respondents comprising of two categories viz. 100 PLWHA and 300 general

populations. Secondary data was drawn from the journals, books, magazines, newspapers, biographies, memoirs, reports, official documents, and relevant publications, websites etc.

The thesis is presented in six chapters which speaks different inter related issues. The first chapter carries the introduction to the research study and the entire framework of this research study. It also defines AIDS supported by various theories and definition, followed by literature review based on thematic method with four sub units in the second chapter. The third chapter discusses the causes and the impact of HIV/AIDS in Naga society where sexual route was found to be one of the main routes in transmitting HIV (Refer Figure 3.1). Dimapur district takes the lead with highest HIV prevalence with a percentage of 22% (Refer Figure: 5.1).

The fourth chapter projects the Institutions like the schools and colleges, Religious organizations, Police and administration; Non Governmental Organization, Jails, Hospitals, individuals etc. who play a vital role in curbing the pandemic and are considered to be the agencies of HIV control measures. The fifth chapter evaluates the magnitude of HIV/AIDS and a district wise comparative analysis towards controlling the infection all over the state, in order to examine the level of awareness and understanding about HIV/AIDS among the people in Nagaland and the initiatives taken by the government and NGOs. The concluding chapter marks the findings, suggestions and recommendations for further research have been included.

## 7.1 MAJOR FINDINGS

Keeping in view, the specific objectives in our mind as stated in chapter one, we have gathered a huge amount of secondary information as well as primary data from the field of study covering the entire state of Nagaland. Data collected from the field have been carefully examined and placed them in different tables and figures. Out of the available information of both secondary and primary in nature, various results have been emerged that are placed in different chapters and on the basis of data. Following are the major findings that are found to be recordable which are indicated theme-wise as below:-

1. **Impact of HIV status on Income and Employment**

The work force participation rate (WFPR) among the 25-34 and 35-44 years age group is higher in HIV households (Refer Table 3.5). This is represented by 34 and 36 percent among HIV households, against 11 and 20 percent respectively in non-HIV households.

Comparatively, through this study it is found that WFPR in above 45 years is higher in non HIV household. It is to be mentioned here that the employed respondents in HIV infected household here are mostly employed in nongovernmental organization. Such high proportions effectively indicate the felt need to earn more in order to meet the increasing financial burden experienced by the HIV households.

2. **Impact of HIV and AIDS on Household Consumption and Savings**

Respondents disclosed the hardships the family had to undergo nursing themselves as well as the family. They kept falling sick and contracted opportunistic infections from time to time which made them rush to hospital at least thrice a month (Refer case studies 1, 3). This implies that the epidemic is not only increasing the number of poor but also adversely impacting the disparity within the poor across HIV and non-HIV households. The burden of diseases increases as the stage of infection of PLWHA advances, causing tremendous financial burden on the family.

3. **Impact of HIV and AIDS on children and education**

Orphans are on the rise in the state of Nagaland. Stigmatization by peer groups and classmates is clearly visible through the case studies conducted (Refer Case study 2). On the education front, Children Living with HIV/AIDS (CLHA) has been supported financially and nutritionally by various NGOs, Governmental agencies and the religious organizations.

4. **Stigma, discrimination and coping mechanism**

It is observed that fearing discrimination, around 28 percent men and 36 percent women have not disclosed their HIV-positive status in the community and as high as 75 percent have not disclosed the same in their workplace. The issue of stigma and discrimination remain at large. There have been reports of refusal to conduct funeral, refusal of treatment in Dimapur and transfer of a government employee from one district to another because of his HIV status. Discrimination even in workplace is prevalent.

The prevalence of stigma and discrimination is highly visible through out the state. Therefore, PLHAs (People Living with HIV/AIDS) are terribly afraid to come out of their

cocoon and feels scared to reveal their HIV status too. They were much reluctant even to fill up the questionnaire mainly because of the fear of stigma and rejection. Though after much assurance by the researcher, they agreed to fill up the required information. Refusal to disclose HIV status is found to be one of the most critical issue facilitating the spread of HIV/AIDS in Naga Society.

5. **Impact on women**

The impact on HIV/AIDS on women is particularly acute. Women are often economically, culturally and socially disadvantaged and lack of equal access of treatment, financial support and education. In a number of cases, women are mistakenly perceived as the main transmitter of sexually transmitted diseases. Together with the traditional beliefs about sex, blood and transmission of other diseases, these beliefs provide a basis for the further stigma of women within the context of HIV/AIDS.

HIV positive women are treated differently from men in many cases. Men are likely to be 'excused' for their behaviour that resulted in their infection whereas women are not. In some cases, the husbands who infected them abandon women living with HIV/AIDS. Rejection by wider family members is also common. Women, whose husband has died from the infection, have been blamed for their deaths.

6. **Impact on families**

In some cases families are headed by only men or only women in the absence of a gender and families are starting to be constituted of mixed kin and blood. Single parent families are becoming more common as well. Families are headed by grandparents, in the absence of parental figures. The illness and resulting death of fathers, mothers, children and siblings changes the very structure of this primary building block and is further exacerbated by the additional financial constraints placed on the family.

7. **HIV/AIDS as a human security threat**

HIV/AIDS destroys human security both at an individual and at the collective level because it causes suffering and threat. It kills people at an extremely productive and reproductive age and creates demographic problems within the country

8. **HIV/AIDS: A threat to societal security**

Society's time honored security, time tested institution and the well being of its members is jeopardized by the pandemic. People disengage from their societies and AIDS orphans take to criminal activities. A social institution like marriage is losing its shape, its sanctity and form due to HIV/AIDS that leads to social instability and chaos.

9. **Route of maximum transmission of HIV in Nagaland**

The chief route of HIV transmission is via sexual activity. Pre marital and extra marital affairs pave the way for high risk behaviours in transmitting HIV. Alcohol and other drugs used to cope with the pressures of life further increases the chance of unprotected sexual contacts (Refer Table 3.1). Dimapur records the highest number of HIV prevalence rate. Majority of them have been infected through sexual route (Refer Table 3.3).

10. **Social factors responsible for the spread of HIV**

This study shows migration, lack of proper sex education, influence of modern media, modern lifestyle, increased pre-marital amongst youth and extra marital affairs among married couples, alcohol consumption, fear of stigma and discrimination as some of the factors solely responsible for the growth of HIV infection in Naga society (Chapter 3).

11. **Role of religious organizations**

Religious organizations are considered to be one of the important agencies to halt HIV/AIDS in Naga society. They are so far responsive and are taking up various initiatives by conducting seminars, prayers and counsellings (Chapter 4).

12. **Role of law enforcing agencies**

This study reveals that law enforcing agencies like the police, village councils and the ward councils are putting a check at places where people hang out and resort to anti-social and immoral activities which put the young people with high risk behaviour.

13. **Role of Non- governmental organizations and civil bodies**

This study shows that many organizations, civil bodies and association are working hard towards the complete eradication and prevention of HIV/AIDS. It was also observed during the

field work that the NGOs particularly those working in the field of HIV/AIDS are hesitant and unwilling to supplement the exact statistics and figure enrolled under their organization of the HIV+ as well as to give out their activities report, for reasons best known to them.

14. **Role of the government**

There are many service centers under NSACS in Nagaland to provide treatment services, supported by NACO. It is seen that the government is spending lots of money on awareness programmes and other related programmes. But most of it are concentrated in the rural areas only.

15. **HIV/AIDS is a silent killer**

The epidemic progresses incrementally and silently, but in the end its impact is cumulative and is likely to be severe. Just as the causes of HIV/AIDS are complex so are the responses. There is no single policy prescription that will change the outcome of the epidemic. This study clearly reveals that HIV/AIDS affects people from all walks of life irrespective of tribe, gender, sex, age, occupation etc.

16. **HIV/AIDS: Health and a human problem**

HIV/AIDS epidemic manifest itself both as a specific health problem and a pervasive human one. Even a mild HIVAIDS impact in the state could have adverse implication for the population of the state viz individuals and households and the society as a whole.

17. **HIV/AIDS is a flexible social problem**

It is not possible to ascribe trends specifically to HIV/AIDS. It keeps changing even after numerous awareness and sensitization programs organized and supported by State AIDS Control Society, churches and various other organizations. In fact it is the ignorance, poverty and stigma prevalent in the society that boost to the epidemic.

18. **Role of educational institutions.**

Through this study it is seen that there is no particular subject or the inclusion of education of HIV/AIDS in school curriculum in Nagaland though seminars and awareness are conducted from time to time to impart education on the pandemic of HIV/AIDS.

19. **Role of mass media**

Mass media is seen as playing an important role in disseminating information regarding HIV/IDS in Nagaland. Print media like the newspapers eg. Nagaland Post, Morung Express, Eastern Mirror, Tir Yimyim, Ao Milen, Capi etc.play a vital role in passing information and knowledge to all sections of Naga society. These newspapers are found to be a key player in disemminating awareness on the pandemic and has served a great purpose to all the eleven districts in the state. For instance Tir Yimyim one of the leading Ao newspaper in local language, reaches out to the people even to those who are not well versed in English. Radio and television also takes the lead in imparting awareness to one and all. All India Radio Kohima and All India Radio Mokokchung put on air programmes regarding HIV/AIDS in English, Nagamese and all the local dialects thus reaching the people even at the grassroot level. Local channels all over Nagaland too broadcast educational programmes that is in many ways effective in penetrating through the general populace. The display of hoardings and banners in public places, road sides' etc. providing awareness on HIV/AIDS seems to play a big role in reaching out to the people in society.

20. **Role of family**

As per this study, the contribution level of the family in controlling this pandemic is not satisfactory. Family, being the basic institution in grooming up a person's life and as one of the agents of social control, has a great responsibility towards controlling the pandemic.

21. **People's response**

Most of the general respondents view the prevention and control of HIV/AIDS as the sole responsibility of the health services only.

22. **Education and awareness**

Education and awareness are seen as the only two means to put a check on HIV growth. Once a person is infected, there is no cure to HIV. Therefore, various NGO's, associations, churches and the government are spreading awareness in their best possible ways though more efforts are needed in order to reach each and every corner of Nagaland.

## 7.2 Suggestions, Recommendations and Conclusion

In a traditional society like Nagaland, it can be seen that in order to find a solution to a problem, it has to start from the individual itself and within the family set up and then the community and the state. HIV/AIDS is preventable, but it has to start from within every individual. Family is considered as one of the basic institution for socialization of a child. Therefore parents and guardians should also be encouraged to educate their wards on HIV/AIDS.

Through this study, it was felt that there is a growing need to open up more orphanages for children infected with the pandemic. The HIV/AIDS pandemic poses major threats to the socio-economic and psychological welfare of the HIV affected and infected children. Fortunate orphans are taken up by their ageing grandparent who struggles to feed their grandchildren but not all the children are lucky enough and are automatically placed under the care of their immediate relatives or in other families as helpers in order to earn a living and to sustain in life.

The NGOs and the government alone cannot find any break through therefore in order to bring change, all members and organizations of the society should work hand in hand. The focus groups should be changed from the high risk groups to all the general populace because every person is at risk. There should be an increased Concentration on the general population both in the rural and the urban areas. It should be ensured that there is strategic use and smooth flow of external donor funds and the Government and the NGOs need to spend the funds wisely towards the control of the pandemic.

More sensible sentinel surveillance programmes which include rural areas, private health sectors etc should be done, so that people know where they stand. The surveillance data should be made available to the general masses so that they are aware of how the pandemic is affecting their own society.

There is an immense importance of sex education and HIV/AIDS education in primary, middle, high school, higher secondary, college and in master's level too. As education is considered as the only available weapon available today to halt the pandemic, importance should be given in this field.

All religions ought to talk openly about issues relating to HIV/AIDS. HIV/AIDS information should be communicated through religious bodies extensively. Extensive counseling, prayers and organizing programmes and seminars on HIV/AIDS should be one of the priorities that all the religious organizations need to take up.

The mass media represents the most readily available and potentially most economical means of imparting information about HIV/AIDS. Along with other forms of communication, the mass media effectively raise public awareness and concern about HIV/AIDS. Considering the mass media to play an important role in disseminating information regarding HIV/AIDS in Nagaland, more emphasis should be given.

Stigma and discrimination is caused by lack of understanding of HIV, how it is spread, lack of access to treatment, irresponsible media coverage of the epidemic, the fact that AIDS has no cure, and already existing prejudices related to sexuality, disease, drug use, and death. Therefore it is highly suggested that stigma against HIV/AIDS victims should be eliminated, if not than it can help stem the tide of the "epidemic."

One major observation is the rampant entry of young boys and girls in the various lounges and bars in Nagaland. Therefore it is suggested that age bar be made a compulsory initiative so as to prevent young people from engaging in high risk behaviour.

PLWHA's should come together and share their thoughts, ideas, problems and reason out together to explore possible solutions. These meetings will usually help people deal with their HIV status; help people disclose their status to their families and generate family support.

The prevention and control of HIV/AIDS should not be seen as the sole responsibility of the health services. Commitment and action is required at all levels including individual, family, health personnel, media etc.

## Recommendations

HIV/AIDS has become the greatest threat to society's survival. Concerning the sexual route of transmission as the root cause, School systems should make programs available that will enable and encourage young people to stay away from high risk behaviours that ultimately leads to HIV. School health councils that include representatives from the schools, the NGOs and the government can facilitate the development of a broad base of community expertise and input. It has been found that in our state, except for the programmes held from time to time on HIV/AIDS, there is no such set up.

The development of school district policies on HIV/AIDS education can be an important first step in developing a successful HIV/AIDS educational program. Sex education should be imparted and it should be added in the curriculum. Imparting sex education with proper guidance will instill the knowledge of the pandemic and will try to keep themselves away from the menace and its implications. Incorporation of life skills in schools and colleges is a basic necessity. Since society is still very apprehensive of talking about sex; there is need for young people to have adequate information about going into pre-marital sex. There should be promotion of better understanding of sex and sexuality. A better understanding needs to be promoted in the community about gender relations, sex and sexuality through dialogue, discussion and other participatory methods. Parents need to be counseled through family life education programmes and other life building skills to handle better and address risk reduction in their young children.

A comprehensive and culturally sensitive prevention programme linked with primary health care, counseling and social services, trainings, seminars and programmes that facilitate community participation should be devised.

It is highly recommended that a close coordination between the NGOs and the government should be established to bring about effective results in the fight against this pandemic. In addition to this, there should be timely evaluation of the activities, the levels of implementation and close supervision of the service providers in order to make the programmes more successful.The government should also see that all the necessary infrastructure are in place, be it in hospitals, care centres and schools

Mass media sources such as television programmes, radio, newspapers and magazines, advertisements in hoardings and banners are identified as the channels for HIV information. Enhancing the content and the penetration of HIV/AIDS campaigns within various channels of the media can be an important strategy in disseminating more HIV knowledge and reducing HIV related discrimination.

HIV/AIDS growth should be checked especially in districts like Dimapur, Kohima, Tuensang etc. where the prevalence rate is much higher than the other districts. Education and awareness should be given out reaching out even to the core. House to house campaign should be adopted.

**LIMITATIONS OF THE STUDY**

Some of the limitations of this study are:-

1. Due to the vast area of study, there were time constraints to cover up the entire study field. It consumed a lot of time exclusively for field work purposes and to effectively get hold of accurate data.

2. The sensitivity of the problem posed as a hurdle especially during the period of field work. The feeling of inferiority complex of almost all the PLWHA respondents made it difficult for the researcher to interact freely with them. Though after repeated meetings, the researcher and the respondents felt comfortable and was able to built rapport, thereby extracting the important information's needed to the fullest.

3. Many a times the researcher faced non- cooperation from the respondents. Most of them gave their hectic time schedules as the reason while some did not want to spend time in interviewing. Often there were loss of questionnaires too and it had to be given again for the respondent to fill up the details.

4. In some organizations, they were reluctant to furnish the details. Though they maintained the organizations records, they were hesitant and unwilling to supplement the exact statistics and figure enrolled under their organization of the HIV+ as well as to give out their activities report, because of their protocol as well as their fear of leakage of the organizational data.

5. While interacting with the PLWHA respondents, the fear of stigma and discrimination was seen and felt. There were so many questions like 'What if' that kept them disturbed.

**NEED FOR FURTHER RESEARCH**

The problem of HIV/AIDS as dynamic in character, there is a need for continued research on HIV/AIDS not only at the international, national and state level but also at the local and the grass root level as well. Therefore some of the areas where further research can be implemented are:-

a) There is a growing need for inter disciplinary approach towards the study of the problem of HIV/AIDS. More systematic and qualitative research should be initiated. A series of study can be initiated through environmental approach religious approach, mass media, government intervention etc.

b) The analysis of the social and cultural context of early initiation into sex life, high risk behaviour and sexual abuse and exploitation in the state..

As stated earlier, the first identification of HIV in India was found in the industrial city of Chennai. It can be said that urbanization has been the major contributing factor in the spread of HIV within the country which has reached the state of Nagaland by and by. The occupants of large slums are stripped off their basic necessities of life like shelther, clean water, sanitation, health and safe environment. The life of people in such horrendous living condition increases peoples' need for companionship, sexual satisfaction, drugs and alcohol. The HIV epidemic widens and deepens poverty by its serious economic impact on individuals, households and different sectors.

HIV/AIDS is becoming more of a global crisis everyday. Perhaps, nowhere is the need for reproductive health services more urgent than in the fight against it. With the growth in population, HIV continues to still spread in Nagaland unevenly in different districts. The present study has proved that the problem of HIV is hampering the societal growth. It has infact affected the individuals, the family, the relatives and the society in general. This study projects that Naga society is still traditional in its attitude towards the HIV infected population. Stigma

and discrimination should be eliminated because everyone has the right to be protected from discrimination of any kind related to HIV/AIDS status.

Humanity is locked in a millennia-old battle to the death of diseases. The 2014 outbreak of Ebola reminds us that as our society gets crowded with more population and travel gets easier, the risks in the various disease outbreak even grow higher. The Spanish flu of 1918, carried around the world by soldiers bound or returning from the butchery of Europe's battlegrounds, killed between 50 and 100 million people- many more than the people who died in the first world war itself, and maybe more than the people who have died in any war. Therefore, for the future, every person needs to be alert and prepared because problems like HIV and Ebola is likely to bring immense devastation to the human species.

New knowledge and new ways of applying existing knowledge about the virus and its spread is crucial. The greatest impact is likely to come from combining just three aspects: better knowledge and awareness; a better understanding of the plight of the HIV infected people; and putting an end to the stigma and discrimination leashed out to the PLWHAs. It is said that education is the only vaccine available against AIDS since date.

Social research on HIV/AIDS is of critical importance to the design of effective intervention for prevention as well as to their evaluation. Prevention of HIV through behavioral change is and will be for the foreseeable future, the only way to stop its spread. HIV/AIDS poses as a threat to younger generation which requires the utmost attention of the administrators, students, family, educationist, social scientist, social workers, churches as well as we as individuals. The impact of HIV/AIDS presents unprecedented challenges to policy makers, public health officials, social welfare workers and others working at the international, national, community and individual levels.

Given the magnitude of the pandemic and its heavy personal, social and economic cost, existing efforts to respond to HIV/AIDS must be developed and supported. Only through considered, concerted and coordinated action will it be possible for the Naga society to cope with the complex and inter related consequences of HIV/AIDS.

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3. The Times of India
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    - AIDS (STI, STD are preventable and curable)
    - AIDS awareness-Role of panchayats
    - Living positively with HIV/AIDS
    - What every family and community has a right to know about
    - Living with hope
    - HIV…Women get it, too.
    - Sentinel Surveillance for HIV infection-An analysis report
    - Stop wondering, get tested
    - Living with HIV feelings
    - Teens and HIV and other STDs
    - Anyone can get AIDS
    - Treatment Literacy Antiretroviral Treatment
    - Learning for life- A guide to family health and life skills education

## ANNEXURE I: QUESTIONNAIRES

The purpose of this questionnaire is purely for academic data collection in order to pursue Ph. D degree on "The magnitude of HIV/AIDS and its impact on Naga Society". The questionnaire for this research work has been formulated with the help of the supervisor comprising of nine sets. It indicates the number of respondents from different categories of people and different institution and organization. The various set of questionnaire are as follows.

## SET I: QUESTIONNAIRE SCHEDULES FOR JAILS

### *A. Socio-Demographic information*

- Name:
- Age:
- Sex:
- Educational Level:
- Religion:
- Tribe/Community:
- Designation:
- Monthly income:
- Marital Status-

### B. *Knowledge, awareness and attitude on HIV/AIDS*

(Please tick √ against the suitable answers)

**1.** At present how many jail inmates are there? Can you please specify the male: female ratio?
Total inmates Male Female

**2.** Is there a specific cell/branch in your jail particularly with cases relating to HIV/ AIDS?

Yes Never thought of Under planning Not necessary

**3.** Are there any Public Health Provisions regarding HIV/AIDS for the inmates?

Yes No

**4.** In your jail set up, have you ever come across an inmate who is HIV+?

Yes No

**5.** What are the strategies employed for the identification of a person with HIV/AIDS in your jail?

Interrogate him/her

Compulsory Blood Testing

Some other means

**6.** So far how many cases relating to HIV/AIDS has been dealt with?

**7.** What is the extend of co-ordination with the NGOs and the medical agency regarding the epidemic?

Excellent Very Good Good Fair Poor

**8.** Have you observed stigma and discrimination among the co-workers, if an inmate is HIV+?

Refusal of opportunity

Unfair labour practices

Stigma for the PLHA

Informing everyone about his status

Denial of access to jail programmes

Isolation and segregation of HIV+ detainees and inmates

Denial of rights to participate in group work

**9.** If an inmate is HIV+, do you think leaving him in complete isolation is the solution?

Yes No

**10.** Do you organize awareness programmes and Seminars on HIV/AIDS and STI within the jail premises?

Yes No

If yes, then how frequently?

Monthly Quarterly Yearly Occasionally

**11**. Is there any Injecting Drug Users among the jail inmates?

Yes No How many

Do you have any overdose record in your jail history?

Yes No How many

Do you conduct any sessions for safer injection?

Yes No

**C. *Services***

**12.** Is there a compounder /Doctor attached to your jail?

Yes No

How often do the compounder /Doctor visit the jail inmates?

Everyday Once a week Once a month Only when the patient is sick

What are his roles and responsibilities?

In case an inmate happens to be HIV+, where do you refer him?

Refer him/her to ICTC

Refer him/her to NGOs

Leave him/her unattended

**D. *Opinion poll***

**13.** What are the difficulties faced by you while dealing with People Living with

HIV/AIDS (PLHA)?

Trained Counsellor/Personnels

Space congestion

Medical facilities

Feeling of stigma and

Discrimination

**14.** How do you rate your Performance/contribution level in combating the pandemic?

Give any one of the judgment given below.

Superb Excellent Effective Fair Good Cannot say

**15.** According to you, who has the greatest responsibility in fighting against the pandemic of HIV/AIDS lies upon….Rate 1,2,3,4,5,6,7,8,9 according to your priorities inside the box.

| Sl.no | Head | Rating |
|---|---|---|
| 1. | General population | |
| 2. | Medical practitioners | |
| 3. | NGOs/Social workers | |
| 4. | Churches | |
| 5. | Administrators and law enforcing agencies | |
| 6. | Educational institutions | |
| 7. | Other governmental agencies | |
| 8. | Media | |
| 9. | All of these | |

**16.** Please provide 3 (three) important suggestion in order to combat HIV/AIDS in Naga society.

## SET II: QUESTIONNAIRE SCHEDULES FOR HOSPITALS/MEDICAL PRACTITIONERS

***B. Socio-Demographic information***

- Name:
- Age:
- Sex:
- Educational Level:
- Religion:

- Tribe/Community:
- Designation :
- Length of service:
- Monthly income:
- Marital Status-

**PART-I**

Please tick (√) the correct response to the following questions

**1.** HIV/AIDS is a state health and social problem. Compared to ten years back, do you think that the situation in Nagaland is…

Better today Worse today About the same

**2.** Is there a specific cell/branch in your hospital/clinic to deal particularly with the epidemic of HIV/AIDS?

Yes No

If yes, please specify

**3.** Approximately, during the last five years, how many cases have been detected in your hospital so far?

Nos. Male Female

**4.** What are the services, facilities and treatment available for the HIV+ patients in your hospital?

**a)** Counselling

**b)** ART

**c)** Blood test

**d)** Special nutritional facilities

**e)** Others

**5.** Is there a separate ward/cabin exclusively for the HIV+ patients?

Yes Never thought of Not necessary Under process

**6.** Is there any special criteria or recommendation or any protocol for admitting HIV+ people in the hospital?

**a)** Special admission criteria's

**b)** Exemption from hospital fees

**c)** Separate isolated rooms for PLHAs

**d)** Recommendation from some high officials

**e)** Do's and Don't rules particularly for PLHAs

**7.** In the process of providing treatment, have you noticed any kind of stigma among the co-workers?

Yes No

**a)** Denial of the use of appropriate diagnostic equipment to a person with HIV

**b)** Informing everyone about his HIV status

**c)** The forced relocation of an individual because of his HIV+ status

**d)** Involuntary participation or refusal of the staff to medically treat HIV+ person

**e)** The compulsory quarantine isolation and segregation of HIV+ individuals

**f)** Special identification marks or board displayed in the bed head tickets or on the bed

**8.** What are the steps taken up exclusively by your hospital/clinic in combating the disease?

**a)** Awareness campaigns

**b)** Health camps for PLHAs

**c)** Advocacy programmes

**d)** Seminars on prevention of HIV

**e)** Availability of quality service

**f)** Capacity building and training of medical and paramedical professionals in the management of HIV/AIDS patients

**9.** Is there any special provision/consideration for female PLHAs?

**a)** Cost/financial liabilities

**b)** Special Nutritional support

**c)** Free medication

**d)** Others

**PART II**

Please circle your response to each item. Rate each aspect of the statement on a 1-5 scale.1 equals "Disagree" and 2 equals "strongly disagree" representing the lowest and most negative impression.3 represents an adequate impression.4 equals "agree" and 5 equals "strongly agree" representing the highest and most positive impression on the scale.

***A. People's Response***

| Response | | Disagree | Strongly disagree | Adequate Impression | Agree | Strongly Agree |
|---|---|---|---|---|---|---|
| **1.** | The hospital/clinic is satisfied with the way Naga society response and approaches to HIV/AIDS | 1 | 2 | 3 | 4 | 5 |
| **2.** | Stigma and discrimination is prevalent in Naga society | 1 | 2 | 3 | 4 | 5 |
| **3.** | The positive response and approach of the church in controlling the pandemic | 1 | 2 | 3 | 4 | 5 |
| **4.** | Law enforcing agencies like the police, civil administration etc are satisfactorily performing their duties to combat and prevent HIV/AIDS in Nagaland | 1 | 2 | 3 | 4 | 5 |
| **5.** | The NGOs are positively contributing towards the control of the pandemic | 1 | 2 | 3 | 4 | 5 |

***B. Quality of services***

| | | | | | | |
|---|---|---|---|---|---|---|
| **1.** | The Hospital/clinic offers satisfactory and quality services | 1 | 2 | 3 | 4 | 5 |
| **2.** | The Hospital/clinic provides stigma free zone | 1 | 2 | 3 | 4 | 5 |
| **3.** | The Hospital/clinic provides clean and healthy treatment facilities to PLHAs | 1 | 2 | 3 | 4 | 5 |
| **4.** | The Hospital/clinic provides security and opportunity for the PLHAs personal growth | 1 | 2 | 3 | 4 | 5 |
| **5.** | The Hospital/clinic provides the opportunity to the PLHAs to use and develop one's creativity | 1 | 2 | 3 | 4 | 5 |
| **6.** | Constitutional protection is provided against discrimination to PLHAs | 1 | 2 | 3 | 4 | 5 |
| **7.** | Constitutional rights to PLHAs on free speech are provided | 1 | 2 | 3 | 4 | 5 |
| **8.** | PLHAs grievances and issues are handled effectively | 1 | 2 | 3 | 4 | 5 |
| **9.** | There is adequate infrastructure so as the clients avail quality services | 1 | 2 | 3 | 4 | 5 |
| **10.** | Provision of drugs for treatment of common opportunistic infection including Tuberculosis | 1 | 2 | 3 | 4 | 5 |

***C. Community participation***

| | | | | | | |
|---|---|---|---|---|---|---|
| **1.** | PLHAs have free access to the Hospital/clinic | 1 | 2 | 3 | 4 | 5 |
| **2.** | PLHAs suggestion are valued and implemented | 1 | 2 | 3 | 4 | 5 |
| **3.** | PLHAs are given opportunity to share, interact and voice their dissatisfaction | 1 | 2 | 3 | 4 | 5 |
| **4.** | PLHAs have continuous communication and | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | consultation with the staff | 1 | 2 | 3 | 4 | 5 |
| **5.** | PLHAs are provided avenues to utilize their potentials | 1 | 2 | 3 | 4 | 5 |
| **6.** | PLHAs are co-operative most of the time | 1 | 2 | 3 | 4 | 5 |

**10.** According to you, who has the greatest responsibility in fighting against the pandemic of HIV/AIDS lies upon….Rate 1,2,3,4,5,6,7,8,9 according to your priorities inside the box.

| **Sl.no** | Head | Rating |
|---|---|---|
| **1.** | General population | |
| **2.** | Medical practitioners | |
| **3.** | NGOs/Social workers | |
| **4.** | Churches | |
| **5.** | Administrators and law enforcing agencies | |
| **6.** | Educational institutions | |
| **7.** | Other governmental agencies | |
| **8.** | Media | |
| **9.** | All of these | |

**11.** How do you rate your hospital/clinic's Performance/contribution level in combating the pandemic? Give any one of the judgment given below.

Superb Excellent Effective Fair Good Cannot say

**12.** What are the difficulties faced by you while dealing with People Living with HIV/AIDS (PLHA)? Yes No

**a)** Non-cooperation of the patient and his/her attendants

**b)**Lack of trained personnel/counsellors

**c)** Social stigma & discrimination

**d)** Improper medical facilities

**e)** Indifferent people's response

**f)** Space congestion

**13.** Please provide 3 (three) important suggestion in order to combat HIV/AIDS in Naga society.

## SET III: QUESTIONNAIRE SCHEDULES FOR LAW ENFORCING AGENCIES/POLICE PERSONNELS

### *C. Socio-Demographic information*

- Name:
- Age:
- Sex:
- Educational Level:
- Religion:
- Tribe/Community:
- Location of the PS :
- Designation:
- Marital Status-

Please tick (√) the correct response to the following questions. Your response, feedback is sincerely appreciated.

**1.** Have you heard about HIV/AIDS?

**2.** Have you ever come across a case dealing with HIV/AIDS?

Yes No

During the last 5 years, how many cases relating to HIV/AIDS have been dealt with?

**3.** Is there a specific cell/branch in your police station to deal particularly with cases relating to HIV/AIDS?

**a)** Yes, there is

**b)** Never realized

**c)** Proposed earlier but not sanctioned

**d)** Under planning

**e)** Don't feel the need of it

**4.** Are there any Public Health Law provisions regarding HIV/AIDS in your district?

**a)** Yes, there is

**b)** No idea

**c)** Cannot remember

**d)** Never thought about it

**5.** During the last five years, has any FIR been reported and filed by any person when hospital employees or emergency medical workers refused to care for a person with HIV infection or AIDS?

**a)** Once

**b)** Twice

**c)** Thrice

**d**) More than thrice

**e)** Cannot remember

**f)** No idea

**6.** During the past five years, has any FIR been reported and filed when a person's job activities were limited or changed or a person got fired from his/her job just because he/she is HIV+?

**a)** Once

**b)** Twice

**c)** Thrice

**d)** More than thrice

**e)** Cannot remember

**f)** No idea

**7.** In the past five years, were any youngsters caught practicing immoral activities?

Yes No If yes, how many

During the interrogation, do you create awareness on HIV/AIDS or resort to physical beating

Awareness on HIV/AIDS

Physical beating

Out of these, is there any record of person (s) with HIV+ status?

Yes No If yes, how many

**8.** Is there any special rules and policy within your working fraternity to go for compulsory blood test for HIV?

Yes Under planning Never thought about it Don't feel the need of it

**9.** Is there any kind of stigma and discrimination related to HIV/AIDS prevalent within your working arena?

**a)** Isolation from the group

**b)** Refusal of basic necessities

**c)** Informing everyone about his status

**d)** Unfair punishment/detention

**e)** Isolation and segregation of HIV+ detainees and inmates

**10.** If a person is arrested with condoms (which are considered as one of the safety

precaution in controlling the pandemic), do you impose fines and penalties on the particular person ?

**a)** Face fines/penalty

**b)** Leave him unpunished after interrogation

**c)** Put him in a lock-up directly

**d)** Cannot say

**11.** Is condom demonstration considered a necessity among the jawans?

Yes Never thought of Not necessary Cannot say

**12.** Do you organize awareness programmes and Seminars on HIV/AIDS and STI within your Department?

Yes No

If yes, then how frequently?

Monthly Quarterly Yearly Occasionally

**13.** What is the extend of co-ordination with the NGOs and the medical agency regarding the epidemic?

Excellent Very Good Good Fair Poor

**14.** How do you rate your Performance/contribution level in combating the pandemic? Give any one of the judgment given below.

Superb Excellent Effective Fair Good Cannot say

**15.** What are the difficulties faced by you while dealing with People Living with HIV/AIDS (PLHA)? Yes No

**a)** Identification of PLHA

**b)** Absence of separate cell for PLHA

**c)** Social stigma & discrimination

**d)** Improper medical facilities

**e)** Trained personnel to deal with this

**16.** According to you, who has the greatest responsibility in fighting against the pandemic of HIV/AIDS lies upon….Rate 1,2,3,4,5,6,7,8,9 according to your priorities inside the box.

| **Sl.no** | Head | Rating |
|---|---|---|
| **1.** | General population | |
| **2.** | Medical practitioners | |
| **3.** | NGOs/Social workers | |
| **4.** | Churches | |
| **5.** | Administrators and law enforcing agencies | |
| **6.** | Educational institutions | |
| **7.** | Other governmental agencies | |
| **8.** | Media | |
| **9.** | All of these | |

**17.** Please provide 3 (three) important suggestion in order to combat HIV/AIDS in Naga society.

## SET IV: QUESTIONNAIRE SCHEDULES FOR EMPLOYEES OF NON-GOVERNMENTAL ORGANIZATIONS/ CARE CENTRES

### *D. Socio-Demographic information*

- Name
- Age:
- Sex:
- Educational Level:
- Religion:

- Tribe/Community:
- Length of service :
- Monthly income:
- Marital Status-

**PART I**

Please tick (√) the correct response to the following questions. Your response, feedback is sincerely appreciated.

**1.** How were you appointed in this job?

**a)** Through interview

**b)** Through some employees consideration

**c)** Promotion

**d)** Other reasons

**2.** Was any Induction/Orientation/Training conducted after you were selected in this organization?
Yes No

If yes, then give a tick against the correct response

**a)** Social problems particularly about the pandemic

**b)** Organizational issues (Rules and regulation, objectives, history of the organization etc)

**c)** Work designation

**d)** Communication skills

**e)** Others

**3.** Are you satisfied with the present job in the organization/society?

**a)** Not much, it was by a matter of chance

**b)** No other option

**c)** Social work is my ultimate interest

**d)** Cannot say

***B.Programme Delivery***

**4.** Does the centre provide co-curricular activities to the target population?

**a)** Television

**b)** Library

**c)** Table tennis

**d)** Carom

**e)** Other recreational activities

**5.** Is there any special consideration/provision for female clients?

Yes No

**a)** Cost/financial liabilities

**b)** Special Nutritional support

**c)** Free medication

**d)** Others

**6.** Is there any special consideration/provision for CLHAs?

Yes No

a) Cost/financial liabilities

b) Special Nutritional support

c) Free medication

d) Others

**7.** In addition, does the centre provide any vocational training to the target population?

**a)** Tailoring

**b)** Woodcarving

**c)** Handicraft

**d)** Knitting

**e)** Flower making

**f)** Bamboo works

**g)** Others

**8.** Do you think that stigma and discrimination relating to HIV/AIDS is prevalent in Naga society?

Yes No

If yes, Please place a tick mark against the suitable options below

**a)** Isolation and segregation of HIV+ individuals

**b)** Informing everyone about a person's HIV status

**c)** The forced relocation of an individual because of his HIV+ status

**d)** Denial of the use of appropriate diagnostic equipment to a person with HIV

**e)** Involuntary participation or refusal of the hospital staff to medically treat HIV+ person

**f)** Special identification marks or board displayed in the bed head tickets or on the bed in hospitals/clinics

**g)** Denial of rights to participate in group work

**h)** Refusal of opportunity

**i)** Unfair labour practices

**j)** Refusal of the concerned church members to conduct funerals

**k)** Denial of burial in public cemetery

**l)** No free movement in public places, markets, churches

**m)** Undesirable treatment to PLHAs at workplace

**n)** Others

**9.** What are the steps taken up exclusively by your organisation in combating the disease?

**a)** Awareness campaigns

**b)** Health camps for PLHAs

**c)** Advocacy programmes

**d)** Seminars on prevention of HIV

**e)** Availability of quality service

**f)** Capacity building and training of medical and paramedical professionals in the management of HIV/AIDS patients

**e)** Others

**C. <u>Expectations</u>**

**10.** What are your expectations from the Educational institutions?

**11.** What are your expectations from the Family institution?

**12**. What are your expectations from the Community?

**13.** What are your expectations from the Law Enforcing Agencies?

**14.** What are your expectations from the Church?

**15.** According to you, who has the greatest responsibility in fighting against the of HIV/AIDS lies upon….Rate 1,2,3,4,5,6,7,8,9 according to your priorities inside the box.

| **Sl.no** | Head | Rating |
|---|---|---|
| **1.** | General population | |
| **2.** | Medical practitioners | |
| **3.** | NGOs/Social workers | |
| **4.** | Churches | |
| **5.** | Administrators and law enforcing agencies | |
| **6.** | Educational institutions | |
| **7.** | Other governmental agencies | |

| | | |
|---|---|---|
| **8.** | Media | |
| **9.** | All of these | |

**PART II**

Please circle your response to each item. Rate each aspect of the statement on a 1-5 scale.1 equals "Disagree" and 2 equals "strongly disagree" representing the lowest and most negative impression.3 represents an adequate impression.4 equals "agree" and 5 equals "strongly agree" representing the highest and most positive impression on the scale.

***A. People's Response***

| | Response | Disagree | Strongly disagree | Adequate impression | Agree | Strongly agree |
|---|---|---|---|---|---|---|
| **1.** | The centre is satisfied with the way Naga society reacts to Drug Abuse & HIV/AIDS | 1 | 2 | 3 | 4 | 5 |
| **2.** | Stigma and discrimination is prevalent in Naga society | 1 | 2 | 3 | 4 | 5 |
| **3.** | The positive response and approach of the church in controlling the pandemic | 1 | 2 | 3 | 4 | 5 |
| **4.** | Law enforcing agencies like the police, civil administration etc are satisfactorily performing their duties to combat and prevent HIV/AIDS in Nagaland | 1 | 2 | 3 | 4 | 5 |

***E. Quality of services***

| | | | | | | |
|---|---|---|---|---|---|---|
| **1.** | The centre offers satisfactory and quality services | 1 | 2 | 3 | 4 | 5 |
| **2.** | The centre provides stigma free zone | 1 | 2 | 3 | 4 | 5 |
| **3.** | The centre provides clean and healthy treatment facilities | 1 | 2 | 3 | 4 | 5 |
| **4.** | The centre provides security and opportunity for the client's personal growth | 1 | 2 | 3 | 4 | 5 |
| **5.** | The centre provides the opportunity to the clients to use and develop one's creativity | 1 | 2 | 3 | 4 | 5 |
| **6.** | Constitutional protection is provided against discrimination | 1 | 2 | 3 | 4 | 5 |
| **7.** | Constitutional rights to clients on free speech are provided | 1 | 2 | 3 | 4 | 5 |
| **8.** | Client's grievances and issues are handled effectively | 1 | 2 | 3 | 4 | 5 |
| **9.** | There is adequate infrastructure so as the clients avail quality services | 1 | 2 | 3 | 4 | 5 |
| **10.** | Home based care facilities are provided | 1 | 2 | 3 | 4 | 5 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **11.** | The centre provides youth friendly services | 1 | 2 | 3 | 4 | 5 |
| **12.** | Referral linkage with Community Health Centre, Primary Health Centre, Hospitals etc | 1 | 2 | 3 | 4 | 5 |
| **13.** | Resourcing, encouraging and fostering the formation of Self Help group ,counseling, peer support and advocacy | 1 | 2 | 3 | 4 | 5 |

***C. Organizational Analysis***

| | | | | | | |
|---|---|---|---|---|---|---|
| **1.** | The staff receive capacity building trainings monthly | 1 | 2 | 3 | 4 | 5 |
| **2.** | The staff are sensitive to the issue and need of the community | 1 | 2 | 3 | 4 | 5 |

***D.Community participation***

| | | | | | | |
|---|---|---|---|---|---|---|
| **1.** | Clients have free access to the DIC | 1 | 2 | 3 | 4 | 5 |
| **2.** | Clients suggestion are valued and implemented | 1 | 2 | 3 | 4 | 5 |
| **3.** | Clients are given opportunity to share, interact and voice their dissatisfaction | 1 | 2 | 3 | 4 | 5 |
| **4.** | Clients have continuous communication and consultation with the staff | 1 | 2 | 3 | 4 | 5 |
| **5.** | Clients are provided avenues to utilize their potentials | 1 | 2 | 3 | 4 | 5 |
| **6.** | Inclusion of PLHAs in all levels of policy development, implementation and decision making | 1 | 2 | 3 | 4 | 5 |

**16.** How do you rate your Performance/contribution level in combating the pandemic?

Give any one of the judgment given below.

Superb Excellent Effective Fair Good Cannot say

**17.** What are the difficulties faced by you while dealing with People Living with HIV/AIDS (PLHA)?

**18.** Is there any comments/suggestion you may like to add regarding HIV/AIDS?

## SET V: QUESTIONNAIRE SCHEDULES FOR PEOPLE LIVING WITH HIV/AIDS (PLHA)

***F. Socio-Demographic information***

- Name (in code) :

- Age:
- Sex:
- Educational Level:
- Religion:
- Tribe/Community:
- Designation :
- Monthly income:
- Marital Status-
- If married. How many children?

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**PART I**

***B. Individual status***

(Please tick √ against the suitable answers)

**1.** How many times did you go through the test for the disease?

Once Twice Thrice More than thrice

**2.** How long have you been infected with the virus?

**a)** Below one year

**b)** 2-3 years

**c)** More than three years

**3.** How were you infected with the virus?

**a)** Blood transfusion

**b)** Sexual route

**c)** IDU

**d)** Parent to child

**e)** Cannot say

**4.** If married, are the children infected too?

Yes No

**5.** What was your first reaction when your status was declared?

**a)** Inferiority complex

**b)** Fear of survival

**c)** Fear of stigma

**d)** Scared of discrimination

**e)** Acceptable

**f)** Angry with oneself

**6.** What is the attitude of your family and relatives after you were infected with the virus?

**a)** Not bothered

**b)** Acceptable

**c)** Angry

**d)** Shocked

**e)** Stigmatize

**f)** Caring as before

**7.** Do you at times feel ashamed/shy to face the society?

Very often Often Sometimes Not at all

**8.** Would you like to spend more time with your family, friends or prefer to be alone?

**a)** Family

**b)** Friends

**c)** Alone

**9.** Have you availed any kind of treatment?

Yes No

From where do you avail the medicines/services/facilities/treatment?

**a)** Hospitals/Clinics

**b)** Care Centers

**c)** Pharmacies

Do you get it free of cost or through cash?

**a)** Free of cost

**b)** Cash

**10.** If you are staying in a hospice/care centre, are you satisfied with the following facilities?

**a)** Nutritional support

**b)** Clothing

**c)** Medical treatment

**d)** Recreational facilities

**e)** Drinking water

**f)** Toilet facilities

**11.** What is the attitude of the hospital/clinic employees in the process of providing treatment?

**a)** Very friendly

**b)** Friendly

**c)** Co-operative

**d)** Reluctant

**e)** With feeling of stigma

f) Normal

***C. <u>Religious/spiritual status</u>***

(Please tick √ against the suitable answers)

**12.** Do you believe in the existence of God?

Yes No

Do you ever pray to God?

**a)** Sometimes

**b)** Everyday

**c)** Never

**d)** Cannot say

**13.** Are u a registered member of the church?

Yes No

Do you ever taken part in religious/church activities?

**a)** Sometimes

**b)** Never given the privilege

**c)** No response

***G. <u>Human Rights issues</u>***

(Please tick √ against the suitable answers)

**14.** Do you face stigma and discrimination in your daily lives?

**a)** Denial of the use of public property

**b)** Unkind remarks and informing everyone about your HIV status

**c)** The forced relocation/transfer of job activities or fired from job because of your status

**d)** Involuntary participation or refusal of the hospital/clinic staff to medically provide treatment

**e)** Isolation and segregation by some individuals

**f)** Special identification marks or board displayed in the bed head tickets or on the bed in Hospital

**g)** Refusal of bank loans disability or life insurance because of your status

**h)** Affected ability to stay in your area

**i)** Undesirable treatment in your workplace

**PART II**

Please circle your response to each item. Rate each aspect of the statement on a 1-5 scale.1 equals "Disagree" and 2 equals "strongly disagree" representing the lowest and most negative impression.3 represents an adequate impression.4 equals "agree" and 5 equals "strongly agree" representing the highest and most positive impression on the scale.

***H. People's Response and initiatives***

| | Response | Disagree | Strongly disagree | Adequate impression | Agree | Strongly agree |
|---|---|---|---|---|---|---|
| **1.** | You are satisfied with the community's approach and response | 1 | 2 | 3 | 4 | 5 |
| **2.** | Stigma and discrimination is prevalent in Naga society | 1 | 2 | 3 | 4 | 5 |
| **3.** | The positive role and approach of the church towards the PLHAs | 1 | 2 | 3 | 4 | 5 |
| **4.** | You are satisfied with the initiatives undertaken by NGOs working in this field | 1 | 2 | 3 | 4 | 5 |
| **5.** | You are satisfied with the initiatives undertaken by the government | 1 | 2 | 3 | 4 | 5 |

***I. Quality of services***

| | | | | | | |
|---|---|---|---|---|---|---|
| **1.** | The Care centre/DIC/Hospital offers satisfactory and quality services | 1 | 2 | 3 | 4 | 5 |
| **2.** | The Care centre/DIC/Hospital provides stigma free zone | 1 | 2 | 3 | 4 | 5 |
| **3.** | The Care centre/DIC/Hospital provides clean and healthy treatment facilities | 1 | 2 | 3 | 4 | 5 |
| **4.** | The Care centre/DIC/Hospital provides security and opportunity for the client's personal growth | 1 | 2 | 3 | 4 | 5 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **5.** | The Care centre/DIC/Hospital provides the opportunity to the clients to use and develop one's creativity | 1 | 2 | 3 | 4 | 5 |
| **6.** | Constitutional protection is provided against discrimination | 1 | 2 | 3 | 4 | 5 |
| **7.** | Constitutional rights to clients on free speech are provided | 1 | 2 | 3 | 4 | 5 |
| **8.** | Client's grievances and issues are handled effectively | 1 | 2 | 3 | 4 | 5 |
| **9.** | There is adequate infrastructure so as the clients avail quality services | 1 | 2 | 3 | 4 | 5 |

***J. Community participation***

| | | | | | | |
|---|---|---|---|---|---|---|
| **1.** | You have free access to the Care centre/DIC/Hospital | 1 | 2 | 3 | 4 | 5 |
| **2.** | Your suggestion are valued and implemented | 1 | 2 | 3 | 4 | 5 |
| **3.** | You are given an opportunity to share, interact and voice your dissatisfaction | 1 | 2 | 3 | 4 | 5 |
| **4.** | You have continuous communication and consultation with the staff of the Care centre/DIC/Hospital | 1 | 2 | 3 | 4 | 5 |
| **5.** | You are provided avenues to utilize your potentials | 1 | 2 | 3 | 4 | 5 |
| **6.** | The Care centre/DIC/Hospital encourage you to communicate your problems (work/personal) with them | 1 | 2 | 3 | 4 | 5 |

**15.** What are your future desires?

**16.** Please provide 5 suggestions

## SET VI: QUESTIONNAIRE SCHEDULES FOR RELIGIOUS ORGANIZATIONS/CHURCHES

### *A. Socio-Demographic information*

- Name:
- Age:
- Sex:
- Educational Level:
- Religion/Denomination:
- Tribe/Community:
- Church/Association
- Designation:
- Marital Status-

**PART-I**

Please tick (√) the correct response to the following questions. Your response, feedback is sincerely appreciated.

### *K. Knowledge, Awareness & Initiatives*

**1.** Since when have you heard about the prevalence of HIV/AIDS in Naga society?

**a)** 10 years back

**b)** 5 years back

**c)** 2 years back

**d)** Just recently

**e)** Haven't heard at all

**2.** Is your church aware about the pandemic that has penetrated the church, the home and the community?

**a)** Absolutely

**b)** Upto some certain extend

**c)** Not sure

**d)** Cannot say

**3.** What are the strategies employed for the identification of a person with HIV/AIDS within your church?

Yes No

**a)** Counselling a person

**b)** Through the coordination with NGO

**c)** Through the coordination with hospitals/clinics

**d)** Some other means

**4.** Do you think that some of your church members might be infected with the virus?

Of course Might be Not at all No idea

**5**. Is there any positive involvement of the church in the field of HIV/AIDS?

**a)** Seminars and awareness programmes on HIV/AIDS

**b)** Counselling the people

**c)** Health camps

**d)** Special prayer support for People Living with HIV/AIDS

**e)** Vocational trainings for People Living with HIV/AIDS

**f)** Financial support to People Living with HIV/AIDS

**g)** Nutritional support to People Living with HIV/AIDS

**6**. Is there a separate branch/cell to deal exclusively with the pandemic in your Church/organization/association set up?

**a)** Yes, we have

**b)** Under planning

**c)** Not necessary

**d)** Difficult to put it into motion

**e)** Never thought of

**7.** Do the PLHAs encouraged participating in the following…?

**a)** Economic Decision of the church/association

**b)** Church Decision

**c)** Social Decision

**d)** Planning and execution of the Church/association programmes

**e)** Worship service

**8.** Have you noticed any sort of stigma and discrimination against the PLHAs in your church fraternity in the following areas…?

**a)** Isolation and segregation of HIV+ peopleCTIO

**b)** Informing everyone about a person's status

**c)** Refusal of basic necessities

**d)** Involuntary participation or refusal of the church members to work together with PLHAs

**e)** Refusal to conduct funerals

**f)** Denial of burial

**g)** No free movement in the church

**9.** Can PLHAs be termed as Sinners?

Yes No

**10.** In your opinion, how can you bring the HIV+ community to the fold of the church?

Suggest means.

**11.** How do you rate your Church's Performance/contribution level in combating the pandemic? Give any one of the judgment given below.

Superb Excellent Effective Fair Good Cannot say

## PART II

Please circle your response to each item. Rate each aspect of the statement on a 1-5 scale.1 equals "Disagree" and 2 equals "strongly disagree" representing the lowest and most negative impression.3 represents an adequate impression.4 equals "agree" and 5 equals "strongly agree" representing the highest and most positive impression on the scale.

***A. Performance appraisal***

| | Performance | Disagree | Strongly disagree | Adequate impression | Agree | Strongly agree |
|---|---|---|---|---|---|---|
| 1. | The Church is satisfied with the way Naga society reacts to HIV/AIDS | 1 | 2 | 3 | 4 | 5 |

| | | | | | | |
|---|---|---|---|---|---|---|
| 2. | Stigma and discrimination is prevalent in Naga society | 1 | 2 | 3 | 4 | 5 |
| 3. | The positive response and approach of the church in controlling the pandemic | 1 | 2 | 3 | 4 | 5 |
| 4. | Law enforcing agencies like the police, civil administration etc are satisfactorily performing their duties to combat and prevent HIV/AIDS in Nagaland | 1 | 2 | 3 | 4 | 5 |
| 5. | The NGOs are positively contributing towards the control of the pandemic | 1 | 2 | 3 | 4 | 5 |

***B. Community participation***

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. | PLHAs have free access to the Church | 1 | 2 | 3 | 4 | 5 |
| 2. | PLHAs suggestion are valued and implemented | 1 | 2 | 3 | 4 | 5 |
| 3. | PLHAs are given opportunity to share and interact | 1 | 2 | 3 | 4 | 5 |
| 4. | PLHAs have continuous communication and consultation with the church full time members | 1 | 2 | 3 | 4 | 5 |
| 5. | PLHAs are provided avenues to utilize their potentials | 1 | 2 | 3 | 4 | 5 |

**12.** What are the difficulties faced by you while dealing with People Living with

HIV/AIDS (PLHA)? Yes No

Identification of PLHA

Absence of separate cell for PLHA

Social stigma & discrimination

Trained personnel / counselors

Non-cooperation of the PLHAs

**13.** According to you, who has the greatest responsibility in fighting against the pandemic of HIV/AIDS lies upon….Rate 1,2,3,4,5,6,7,8,9 according to your priorities inside the box.

| Sl.no | Head | Rating |
|---|---|---|
| 1. | General population | |
| 2. | Medical practitioners | |
| 3. | NGOs/Social workers | |
| 4. | Churches | |
| 5. | Administrators and law enforcing agencies | |
| 6. | Educational institutions | |
| 7. | Other governmental agencies | |
| 8. | Media | |
| 9. | All of these | |

**14.** Please provide 3 (three) important suggestion in order to combat HIV/AIDS in Naga society.

**SET VII: QUESTIONNAIRE SCHEDULES FOR EMPLOYEES OF NSACS**

***L. Socio-Demographic information***

- Name:
- Age:
- Sex:

- Educational Level:
- Religion:
- Tribe/Community:
- Length of service :
- Monthly income:
- Marital Status-

**PART I**

***A. Organizational Analysis***

Please tick (√) the correct response to the following questions. Your response, feedback is sincerely appreciated.

**3.** How were you appointed in this organization?
**a)** Through interview

**b)** Through some employees consideration

**c)** Promotion

**d)** Other reasons

**4.** Was any Induction/Orientation/Training conducted after you were selected in this organization?
Yes No

If yes, then give a tick against the correct response

**f)** Social problems particularly about the pandemic

**g)** Organizational issues (Rules and regulation, objectives)

**h)** Work designation

**i)** Communication /Counselling skills

**j)** Others

**3.** Are you satisfied with the present job in the organization/society?

**a)** Excellent job satisfaction

**b)** Satisfactory

**c)** Quite OK

**d)** Not at all satisfied

**e)** Cannot say

**4.** Is there any workplace policy included in your protocol particularly for the PLHAs?

Yes No

**5.** Is there 'No discrimination' policy in place exclusively for the PLHAs?

Yes No

**6.** Is there any work related remuneration and allowance including social security and social insurance benefits exclusively for the PLHAs?

Yes No

**7.** Is there any special programmes or policies in place for Children Living with HIV/AIDS (CLHA)?

Yes No

**8.** Is there any special programmes or policies in place for women PLHAs?

Yes No

***C. <u>Opinion Poll</u>***

**10.** HIV/AIDS is a state health, social and economic problem .Compared to ten years ago, do you think the situation in Nagaland is…

Better today Worse today About the same Cannot say

**11.** How serious a problem do you think about AIDS in Nagaland today? Is it…

**a)** Negligible

**b)** Highly alarming

**c)** Somewhat serious

**d)** Not too serious

**e)** Not at all serious

**f)** Cannot say

**12.** How do you rate your satisfaction level with the response and approach of the Naga society towards HIV/AIDS as well as the attitude towards People Living with HIV/AIDS (PLHA)?

Satisfactory Not at all satisfactory Fair Poor Cannot say

**13.** Do you think that stigma and discrimination relating to HIV/AIDS is prevalent in Naga society?

Yes No

If yes, Please place a tick mark against the suitable options below

**o)** Isolation and segregation of HIV+ individuals

**p)** Informing everyone about a person's HIV status

**q)** The forced relocation of an individual because of his HIV+ status

**r)** Denial of the use of appropriate diagnostic equipment to a person with HIV

**s)** Involuntary participation or refusal of the hospital staff to medically treat HIV+

**t)** Special identification marks or board displayed in the bed head tickets or on the bed in hospitals/clinics

**u)** Denial of rights to participate in group work

**v)** Refusal of opportunity

**w)** Unfair labour practices

**x)** Refusal of the concerned church members to conduct funerals

**y)** Denial of burial in public cemetery

**z)** No free movement in public places, markets, churches

**aa)** Undesirable treatment to PLHAs at workplace

**14.** In your opinion, what are the main factors or causes of the upward trend of the pandemic in Nagaland?

**15.** Do you consider the pandemic as a hindrance to social development?

Yes No Cannot say

**16.** Is HIV/AIDS in any way affecting the economic condition of the family?

Yes No Cannot say

**17.** How do you rate the performance and effort level of the law enforcing agencies in the prevention of HIV/AIDS in Nagaland?

Excellent Satisfactory Fair Good Poor Cannot say

**18.** How do you rate the contribution of the NGOs of Nagaland towards the control of the pandemic?

Excellent Effective Satisfactory Fair Poor Cannot say

## PART II

Please circle your response to each item. Rate each aspect of the statement on a 1-5 scale.1 equals "Disagree" and 2 equals "strongly disagree" representing the lowest and most negative impression.3 represents an adequate impression.4 equals "agree" and 5 equals "strongly agree" representing the highest and most positive impression on the scale.

***A. People's Response***

| | Response | Disagree | Strongly disagree | Adequate impression | Agree | Strongly agree |
|---|---|---|---|---|---|---|
| **1.** | The department is satisfied with the way Naga society response towards Drug Abuse & HIV/AIDS | 1 | 2 | 3 | 4 | 5 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **2.** | Stigma and discrimination is prevalent in Naga society | 1 | 2 | 3 | 4 | 5 |
| **3.** | The positive response and approach of the church in controlling the pandemic | 1 | 2 | 3 | 4 | 5 |
| **4.** | Law enforcing agencies like the police, civil administration etc are satisfactorily performing their duties to combat and prevent HIV/AIDS in Nagaland | 1 | 2 | 3 | 4 | 5 |
| **5.** | The NGOs are playing a vital role in controlling the pandemic | 1 | 2 | 3 | 4 | 5 |

***M. Quality of services***

| | | | | | | |
|---|---|---|---|---|---|---|
| **1.** | The department offers satisfactory and quality services | 1 | 2 | 3 | 4 | 5 |
| **2.** | The department provides stigma free zone | 1 | 2 | 3 | 4 | 5 |
| **3.** | The department provides clean and healthy treatment facilities | 1 | 2 | 3 | 4 | 5 |
| **4.** | The department provides security and opportunity for the client's personal growth | 1 | 2 | 3 | 4 | 5 |
| **5.** | The department provides the opportunity to the clients to use and develop one's creativity | 1 | 2 | 3 | 4 | 5 |
| **6.** | Constitutional protection is provided against discrimination | 1 | 2 | 3 | 4 | 5 |
| **7.** | Constitutional rights to clients on free speech are provided | 1 | 2 | 3 | 4 | 5 |
| **8.** | PLHAs grievances and issues are handled effectively | 1 | 2 | 3 | 4 | 5 |
| **9.** | There is adequate infrastructure so as the clients avail quality services | 1 | 2 | 3 | 4 | 5 |
| **10.** | Home based Care facilities are provided | 1 | 2 | 3 | 4 | 5 |
| **11.** | The department provides youth friendly services | 1 | 2 | 3 | 4 | 5 |
| **12.** | Referral linkage with Community Health Centre, Primary Health Centre, Hospitals etc | 1 | 2 | 3 | 4 | 5 |
| **13.** | Resourcing, encouraging and fostering the formation of Self Help group ,counselling, peer support and advocacy | 1 | 2 | 3 | 4 | 5 |

***C. Organizational Analysis***

| | | | | | | |
|---|---|---|---|---|---|---|
| **1.** | The staff receive capacity building trainings time to time | 1 | 2 | 3 | 4 | 5 |
| **2.** | The staff are sensitive to the issue and need of the community | 1 | 2 | 3 | 4 | 5 |

***D.Community participation***

| | | | | | | |
|---|---|---|---|---|---|---|
| **1.** | PLHAs have free access to the department | 1 | 2 | 3 | 4 | 5 |
| **2.** | PLHAs suggestion are valued and implemented | 1 | 2 | 3 | 4 | 5 |
| **3.** | PLHAs are given opportunity to share, interact and voice their dissatisfaction | 1 | 2 | 3 | 4 | 5 |
| **4.** | PLHAs have continuous communication and consultation with the staff | 1 | 2 | 3 | 4 | 5 |
| **5.** | PLHAs are provided avenues to utilize their potentials | 1 | 2 | 3 | 4 | 5 |
| **6.** | Inclusion of PLHAs in all levels of policy development, implementation and decision making | 1 | 2 | 3 | 4 | 5 |

**B. Expectations**

**19.** What are your expectations from the NGOs working under your department?

**20.** What are your expectations from the Educational institutions?

**21.** What are your expectations from the Family institution?

**22.** What are your expectations from the Community?

**23.** What are your expectations from the Law Enforcing Agencies?

**24.** What are your expectations from the Church?

**25.** According to you, who has the greatest responsibility in fighting against the of HIV/AIDS lies upon….Rate 1,2,3,4,5,6,7,8,9 according to your priorities inside the box.

| Sl.no | Head | Rating |
|---|---|---|
| 1. | General population | |
| 2. | Medical practitioners | |
| 3. | NGOs/Social workers | |
| 4. | Churches | |
| 5. | Administrators and law enforcing agencies | |
| 6. | Educational institutions | |
| 7. | Other governmental agencies | |
| 8. | Media | |
| 9. | All of these | |

**26.** How do you rate your Performance/contribution level in combating the pandemic?

Give any one of the judgment given below.

Superb Excellent Effective Fair Good Cannot say

**27.** Is there any comments/suggestion you may like to add regarding HIV/AIDS?

## SET VIII: QUESTIONNAIRE SCHEDULES FOR GOVERNMENTAL AGENCIES

### ***A. Socio-Demographic information***

- Name:
- Age:
- Sex:
- Educational Level:
- Religion:
- Tribe/Community:
- Department:
- Length of service :
- Monthly income:
- Marital Status-

**PART I**

### ***B. Background of the Department/Forum/Association***

1. Name of the Department/Forum/Commission/Association:
2. Date of its inception:
3. Prime objectives of the Department/Forum/Commission:

### C. ***Awareness & Knowledge***

(Place a tick mark against the suitable answers)

**1.** Since when have you heard about the prevalence of HIV/AIDS in Naga society?

**a)** 10 years back

**b)** 5 years back

**c)** 2 years back

**d)** Just recently

**e)** Haven't heard at all

**2.** HIV/AIDS is a state health, social and economic problem .Compared to ten years ago, do you think the situation in Nagaland is…

Better today Worse today About the same Cannot say

**3.** How serious a problem do you think about AIDS in Nagaland today? Is it…

**a)** Negligible

**b)** Highly alarming

**c)** Somewhat serious

**d)** Not too serious

**e)** Not at all serious

**f)** Cannot say

**4.** How do you rate your satisfaction level with the response and approach of the Naga society towards HIV/AIDS as well as the attitude towards People Living with HIV/AIDS (PLHA)?

Satisfactory Not at all satisfactory Fair Poor Cannot saY

**5.** Do you think that stigma and discrimination relating to HIV/AIDS is prevalent in Naga society?

Yes No

If yes, Please place a tick mark against the suitable options below

**bb)** Isolation and segregation of HIV+ individuals

**cc)** Informing everyone about a person's HIV status

**dd)** The forced relocation of an individual because of his HIV+ status

**ee)** Denial of the use of appropriate diagnostic equipment to a person with HIV

**ff)** Involuntary participation or refusal of the staff to medically treat HIV=

**gg)** Special identification marks or board displayed in the bed head tickets or on the bed in hospitals/clinics

**hh)** Denial of rights to participate in group work

**ii)** Refusal of opportunity ( Job, bank loans, promotions etc)

**jj)** Unfair labour practices

**kk)** Refusal of the concerned church members to conduct funerals

**ll)** Denial of burial in public cemetery

**mm)** No free movement in public places, markets, churches

**nn)** Undesirable treatment to PLHAs at workplace

**7.** In your opinion, what are the main factors or causes of the upward trend of the pandemic in Nagaland?

**8.** Is HIV/AIDS in any way affecting the economic condition of the family?

Yes No

**9.** Do you consider the pandemic as a hindrance to social development?

Yes No

***D. Programme contents***

**10.** What has your department/forum/commission/Association been doing so far in controlling the epidemic?

**11.** What are the strategies and approaches employed by your department/ forum/

Association/ commission to reach out the people infected with the virus?

Yes No

**a)** Nutritional support to People Living with HIV/AIDS

**b)** Vocational trainings for People Living with HIV/AIDS

**c)** Financial support to People Living with HIV/AIDS

**d)** Emotional support to People Living with HIV/AIDS

**e)** Other means

**12.** Are there any initiatives undertaken by your department to generate awareness among the people?

**a)** Seminars and awareness programmes on HIV/AIDS

**b)** Counselling the people

**c)** Health camps

**13.** Is there any programmes or policies in place for Children Living with HIV/AIDS (CLHA)

Yes Never thought of Under planning

**E. *Performance Appraisal***

**14.** How do you rate the performance and effort level of the law enforcing agencies in the prevention of HIV/AIDS in Nagaland?

Excellent Satisfactory Fair Good Poor Cannot say

**15.** How do you rate the contribution of the NGOs of Nagaland towards the control of the pandemic?

Excellent Effective Satisfactory Fair Poor Cannot say

**16.** According to you, who has the greatest responsibility in fighting against the pandemic of HIV/AIDS lies upon….Rate 1,2,3,4,5,6,7,8,9 according to your priorities inside the

box.

| Sl.no | Head | Rating |
|---|---|---|
| **1.** | General population | |
| **2.** | Medical practitioners | |
| **3.** | NGOs/Social workers | |
| **4.** | Churches | |
| **5.** | Administrators and law enforcing agencies | |
| **6.** | Educational institutions | |
| **7.** | Other governmental agencies | |
| **8.** | Media | |
| **9.** | All of these | |

**17.** How do you rate your Performance/contribution level in combating the pandemic?

Give any one of the judgment given below.

Superb Excellent Effective Fair Good Cannot say

**18.** Please provide 3 (three) important suggestion in order to combat HIV/AIDS in Naga society.

## SET IX: QUESTIONAIRE SCHEDULES FOR NON-INFECTED & AFFECTED POPULATION

***N. Socio-Demographic information***

- Name:
- Age:
- Sex:
- Educational Level:
- Religion:
- Tribe/Community:
- Occupation :
- Monthly income:
- Marital Status-
- If married, How many children?

***O. <u>Knowledge, awareness and attitude on HIV/AIDS</u>***

(Place a tick mark against the suitable answers)

1. Since when have you heard about the prevalence of HIV/AIDS in Naga society?

**a)** 10 years back

**b)** 5 years back

**c)** 2 years back

**d)** Just recently

**e)** Haven't heard at all

**2.** AIDS stands for *Acquired Immuno Deficiency Syndrome.* Do you feel scared or afraid of it?

**a)** Very much

**b)** Not much

**c)** Cannot say

**4.** By just looking at a person, can you know his/her HIV status?

Yes No Cannot say

**5.** HIV can be transmitted through four of the following routes? Put a tick mark against the right statement.

**a)** Having sex with an infected partner

**b)** Through sharing of contaminated needles/syringes

**c)** Hugging a person living with HIV

**d)** From infected parent to child

**e)** Sharing clothes used by a person who is HIV+

**f)** Blood transfusion from an infected person

**g)** Use of swimming pools with an HIV+

**h)** Sharing of toilets and bathrooms

**g)** None of these

**6.** Is any of your family members infected with the virus?

Yes No

**7.** Whom do you think are most vulnerable to contract HIV/AIDS?

a) Men

b) Women

c) Young Boys

d) Young Girls

e) All of these

**8.** Is HIV/AIDS curable?

Yes Not sure No Cannot say

**9.** Can you hug and shake hands with a HIV positive person?

Absolutely Of courseNo Cannot say

**10.** Can you share meal with an HIV positive person?

Absolutely Of courseNo Cannot say

**11.** What is your source of information on HIV/AIDS?

(Place a tick mark against the suitable answers)

**a)** Friends

**b)** Parents

**c)** Teacher

**d)** Radio

**e)** Television

**f)** Newspaper

**g)** Magazine

**h)** Posters

**i)** IEC materials

**j)** Non-governmental organization

**k)** Government Health worker

**l)** Others

**12.** In Nagaland, have you seen Advertisements, shows, IEC (Information Education Communication) materials dealing with HIV/AIDS?

**a)** Once

**b)** Often

**c)** Sometimes

**d)** Heard but never saw

**e)** Cannot remember

**13.** Have you ever attended Awareness programmes and seminars on HIV/AIDS in Nagaland?

a) Once

b) Twice

c) Thrice

d) More than thrice

**14.** How do you rate the performance level of awareness programmes, seminars, ads, shows etc in the prevention of HIV/AIDS in Naga society?

Excellent Effective Fair Good Poor Cannot say

***C. Opinion Poll***

**15.** HIV/AIDS is a state health, social and economic problem .Compared to ten years ago, do you think the situation in Nagaland is…

Better today Worse today About the same Cannot say

**16.** How serious a problem do you think about AIDS in Nagaland today? Is it…

**a)** Negligible

**b)** Highly alarming

**c)** Somewhat serious

**d)** Not too serious

**e)** Not at all serious

**f)** Cannot say

**17.** How do you rate your satisfaction level with the response and approach of the Naga society towards HIV/AIDS as well as the attitude towards People Living with HIV/AIDS (PLHA)?

Satisfactory Not at all satisfactory Fair Poor Cannot say

**18.** Do you think that stigma and discrimination relating to HIV/AIDS is prevalent in Naga society?

Yes No

If yes, Please place a tick mark against the suitable options below

Isolation and segregation of HIV+ individuals ☐

☐

Informing everyone about a person's HIV status

The forced relocation of an individual because of his HIV+ status

Denial of the use of appropriate diagnostic equipment to a person with HIV

Involuntary participation or refusal of the hospital staff to medically treat HIV=

Special identification marks or board displayed in the bed head tickets or on the bed in hospitals/clinics

Denial of rights to participate in group work

Refusal of opportunity

Unfair labour practices

Refusal of the concerned church members to conduct funerals

Denial of burial in public cemetery

No free movement in public places, markets, churches

Undesirable treatment to PLHAs at workplace

19. In your opinion, what are the main factors or causes of the upward trend of the pandemic in Nagaland

20. Do you consider the pandemic as a hindrance to social development?

Yes No

**21.** Is HIV/AIDS in any way affecting the economic condition of the family?

Yes No

**22.** How do you rate the performance and effort level of the law enforcing agencies in the prevention of HIV/AIDS in Nagaland?

Excellent Satisfactory Fair Good Poor Cannot say

**23.** How do you rate the contribution of the NGOs of Nagaland towards the control of the pandemic?

Excellent Effective Satisfactory Fair Poor Cannot say

**24.** Are you satisfied with the initiatives taken up by the state government towards the control of the pandemic?

**a)** The setting up of a particular forum ( E.g. Legislature forum on AIDS) in combating the pandemic

**b)** The clear-cut policies, delegation of administrative powers of the department

**c)** The initiatives and financial contribution of the politicians/policy makers

**d)** The sense of responsibility and accountability towards the pandemic of the government

**e)** The equal distribution of resources all over Nagaland for controlling the pandemic

**f)** Planning and its flexibility in adjusting to the changing situation

**g)** The carefully designed interventions to reach different population at risk ☐

**25.** According to you, who has the greatest responsibility in fighting against the pandemic of HIV/AIDS lies upon….Rate 1,2,3,4,5,6,7,8,9 according to your priorities inside the box.

| Sl.no | Head | Rating |
|---|---|---|
| 1. | General population | |
| 2. | Medical practitioners | |
| 3. | NGOs/Social workers | |
| 4. | Churches | |
| 5. | Administrators and law enforcing agencies | |
| 6. | Educational institutions | |
| 7. | Other governmental agencies | |
| 8. | Media | |
| 9. | All of these | |

**26.** What would you specifically suggest to prevent HIV/AIDS in Nagaland?

**a)** Family
**b)** Church/Religion
**c)** NGOs
**d)** Schools/Colleges
**e)** Political leaders and law framers
**f)** Police and administrators

**27.** How do you rate your Performance/contribution level in combating the pandemic?

Give any one of the judgment given below.

Superb Excellent Effective Fair Good Cannot say

**28.** Is there any comments/suggestion you may like to add regarding HIV/AIDS?

## ANNEXURE II: INTERVIEW SCHEDULES

The purpose of this questionnaire is purely for academic data collection in order to pursue Ph. D degree on "The magnitude of HIV/AIDS and its impact on Naga Society". The interview schedules for this research work have been formulated with the help of the supervisor comprising of two sets.

## INTERVIEW SCHEDULES FOR DIRECTOR/CHIEF FUNCTIONARY OF NON-GOVERNMENTAL ORGANIZATIONS

### *P. Socio-Demographic information*

- Name:
- Age:
- Sex: Male Female
- Educational Level:
- Religion:
- Tribe/Community:
- Length of service :
- Monthly income:
- Marital Status-

**PART I**

***B. Background of the Society:***

Name of the Society

Date of its inception:

Funding agency:

***C.Programme analysis***

**1.** What are the scope and vision of your organization?

**2.** What is the present magnitude of HIV/AIDS under your area coverage?

**3.** Name some of the controlling systems that your department has adopted to monitor the activities of the NGOs?

**4.** How do you monitor the working system of the workers under your supervision?

**5.** What are the different methodologies applied in controlling the workers under your supervision?

**6.** Upto what extend is the level of co-ordination with various other departments (Police,hospitals,clinics etc)

**7.** Can you elaborate on your organizations programme planning, implementation, monitoring, evaluation and achievements?

***D.Programme Delivery***

**8.** Approximately, during the last five years, how many cases have been detected in your centre so far?

Nos Male Female

If you can, please supplement their age group (in nos).

Below 20 20-30 30-40 40-50 Above 50

**9.** In a day at an average, how many target audience visits your centre?

Less than 10 10-20 20-30 More than 30

**10.** Does the centre provide co-curricular activities to the target population?

**a)** Television

**b)** Library

**c)** Table tennis

**d)** Carom

**e)** Other recreational activities

**11.** Is there any special consideration/provision for female clients?

Yes No

**a)** Cost/financial liabilities

**b)** Special Nutritional support

**c)** Free medication

**d)** Others

**12.** In addition, does the centre provide any vocational training to the target population?

**h)** Tailoring
**i)** Woodcarving
**j)** Handicraft
**k)** Knitting
**l)** Flower making
**m)** Bamboo works
**n)** Others

**13.** Do you think that stigma and discrimination relating to HIV/AIDS is prevalent in

Naga society?

Yes No

If yes, Please place a tick mark against the suitable options below

Isolation and segregation of HIV+ individuals

Informing everyone about a person's HIV status

The forced relocation of an individual because of his HIV+ status

Denial of the use of appropriate diagnostic equipment to a person with HIV

Involuntary participation or refusal of the hospital staff to medically treat HIV+ person

Special identification marks or board displayed in the bed head tickets or on the bed in hospitals/clinics

Denial of rights to participate in group work

Refusal of opportunity

Unfair labour practices

Refusal of the concerned church members to conduct funerals

Denial of burial in public cemetery

No free movement in public places, markets, churches

Undesirable treatment to PLHAs at workplace

**14.** What are the steps taken up exclusively by your organisation in combating the disease?

**a)** Awareness campaigns

**b)** Health camps for PLHAs

**c)** Advocacy programmes

**d)** Seminars on prevention of HIV

**e)** Availability of quality service

**f)** Capacity building and training of medical and paramedical professionals in the management of HIV/AIDS patients

**D. <u>Expectations</u>**

**15.** What are your expectations from the employees working under your supervision?

**16.** What are your expectations from the Educational institutions?

**17.** What are your expectations from the Family institution?

**18.** What are your expectations from the Community

**19.** What are your expectations from the Law Enforcing Agencies?

**20.** What are your expectations from the Church?

**PART II**

Please circle your response to each item. Rate each aspect of the statement on a 1-5 scale.1 equals "Disagree" and 2 equals "strongly disagree" representing the lowest and most negative impression.3 represents an adequate impression.4 equals "agree" and 5 equals "strongly agree" representing the highest and most positive impression on the scale.

***A. People's Response***

| | Response | Disagree | Strongly disagree | Adequate impression | Agree | Strongly disagree |
|---|---|---|---|---|---|---|
| **1.** | The centre is satisfied with the way Naga society reacts to Drug Abuse & HIV/AIDS | 1 | 2 | 3 | 4 | 5 |
| **2.** | Stigma and discrimination is prevalent in Naga society | 1 | 2 | 3 | 4 | 5 |
| **3.** | The positive response and approach of the church in controlling the pandemic | 1 | 2 | 3 | 4 | 5 |
| **4.** | Law enforcing agencies like the police, civil administration etc are satisfactorily performing their duties to combat and prevent HIV/AIDS in Nagaland | 1 | 2 | 3 | 4 | 5 |

***Q. Quality of services***

| | | | | | | |
|---|---|---|---|---|---|---|
| **1.** | The centre offers satisfactory and quality services | 1 | 2 | 3 | 4 | 5 |
| **2.** | The centre provides stigma free zone | 1 | 2 | 3 | 4 | 5 |
| **3.** | The centre provides clean and healthy treatment facilities | 1 | 2 | 3 | 4 | 5 |
| **4.** | The centre provides security and opportunity for the client's personal growth | 1 | 2 | 3 | 4 | 5 |
| **5.** | The centre provides the opportunity to the clients to use and develop one's creativity | 1 | 2 | 3 | 4 | 5 |
| **6.** | Constitutional protection is provided against discrimination | 1 | 2 | 3 | 4 | 5 |
| **7.** | Constitutional rights to clients on free speech are provided | 1 | 2 | 3 | 4 | 5 |
| **8.** | Client's grievances and issues are handled effectively | 1 | 2 | 3 | 4 | 5 |
| **9.** | There is adequate infrastructure so as the clients avail quality services | 1 | 2 | 3 | 4 | 5 |
| **10.** | Home based care facilities are provided | 1 | 2 | 3 | 4 | 5 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **11.** | The centre provides youth friendly services | 1 | 2 | 3 | 4 | 5 |
| **12.** | Referral linkage with Community Health Centre, Primary Health Centre, Hospitals etc | 1 | 2 | 3 | 4 | 5 |
| **13.** | Resourcing, encouraging and fostering the formation of Self Help group ,counseling, peer support and advocacy | 1 | 2 | 3 | 4 | 5 |

***C. Organizational Analysis***

| | | | | | | |
|---|---|---|---|---|---|---|
| **1.** | The staff receive capacity building trainings monthly | 1 | 2 | 3 | 4 | 5 |
| **2.** | The staff are sensitive to the issue and need of the community | 1 | 2 | 3 | 4 | 5 |

***D.Community participation***

| | | | | | | |
|---|---|---|---|---|---|---|
| **1.** | Clients have free access to the DIC | 1 | 2 | 3 | 4 | 5 |
| **2.** | Clients suggestion are valued and implemented | 1 | 2 | 3 | 4 | 5 |
| **3.** | Clients are given opportunity to share, interact and voice their dissatisfaction | 1 | 2 | 3 | 4 | 5 |
| **4.** | Clients have continuous communication and consultation with the staff | 1 | 2 | 3 | 4 | 5 |
| **5.** | Clients are provided avenues to utilize their potentials | 1 | 2 | 3 | 4 | 5 |
| **6.** | Inclusion of PLHAs in all levels of policy development, implementation and decision making | 1 | 2 | 3 | 4 | 5 |

**21.** According to you, who has the greatest responsibility in fighting against the

of HIV/AIDS lies upon….Rate 1,2,3,4,5,6,7,8,9 according to your priorities inside

the box.

| **Sl.no** | Head | Rating |
|---|---|---|
| **1.** | General population | |
| **2.** | Medical practitioners | |
| **3.** | NGOs/Social workers | |
| **4.** | Churches | |
| **5.** | Administrators and law enforcing agencies | |
| **6.** | Educational institutions | |
| **7.** | Other governmental agencies | |
| **8.** | Media | |
| **9.** | All of these | |

**22.** How do you rate your Performance/contribution level in combating the pandemic?

Give any one of the judgment given below.

Superb Excellent Effective Fair Good Cannot say

**23.** Is there any comments/suggestion you may like to add regarding HIV/AIDS?

## INTERVIEW SCHEDULES FOR OFFICIALS OF NSACS

***A) Socio-Demographic information***

- Name:
- Age:
- Sex:
- Educational Level:
- Religion:
- Tribe/Community:
- Length of service :
- Monthly income:
- Marital Status-

**PART I**

***B. Background of the Society:***

Name of the Society:

Date of its inception:

Funding agency:

Number of projects under the society:

Prime objectives :

***C.Programme analysis***

**8.** What are the scope and vision of the society?

**9.** What is the present magnitude of HIV/AIDS in Nagaland ?

**10.** What are some of the control measures that your society has undertaken towards the control of this pandemic?

**11.** How do you monitor the working system of the NGOs under your supervision?

**12.** What are the different methodologies applied in controlling the NGOs under your supervision?

**13.** Upto what extend is the level of co-ordination with various other departments (Police,hospitals,clinics etc)

**14.** What are your personal opinion on Nagaland State AIDS Control Society (NSACS), its programme planning, implementation, monitoring, evaluation and achievements?

***D. Organizational Analysis***

**8.** Is there any workplace policy included in your protocol particularly for the PLHAs?

Yes No

**9.** Is there 'No discrimination' policy in place exclusively for the PLHAs?

Yes No

**10.** Is there any work related remuneration and allowance including social security and social insurance benefits exclusively for the PLHAs?

Yes No

**11.** Is there any special programmes or policies in place for Children Living with HIV/AIDS (CLHA)?

Yes No

**E. *Expectations***

**12.** What are your expectations from the NGOs working under your supervision?

**13.** What are your expectations from the Educational institutions?

**14.** What are your expectations from the Family institution?

**15.** What are your expectations from the Community?

**16.** What are your expectations from the Law Enforcing Agencies?

**17.** What are your expectations from the Church?

**18.** What are the difficulties faced by you while dealing with People Living with HIV/AIDS (PLHA)

**19.** How do you rate your Performance/contribution level in combating the pandemic?

Give any one of the judgment given below.

Superb Excellent Effective Fair Good Cannot say

**PART II**

Please circle your response to each item. Rate each aspect of the statement on a 1-5 scale.1 equals "Disagree" and 2 equals "strongly disagree" representing the lowest and most negative impression.3 represents an adequate impression.4 equals "agree" and 5 equals "strongly agree" representing the highest and most positive impression on the scale.

***A. People's Response***

| | Response | Disagree | Strongly disagree | Adequate impression | Agree | Strongly disagree |
|---|---|---|---|---|---|---|
| **1.** | The Oganisation is satisfied with the way Naga society response towards Drug Abuse & HIV/AIDS | 1 | 2 | 3 | 4 | 5 |
| **2.** | Stigma and discrimination is prevalent in Naga society | 1 | 2 | 3 | 4 | 5 |
| **3.** | The positive response and approach of the church in controlling the pandemic | 1 | 2 | 3 | 4 | 5 |
| **4.** | Law enforcing agencies like the police, civil administration etc are satisfactorily performing their duties to combat and prevent HIV/AIDS in Nagaland | 1 | 2 | 3 | 4 | 5 |
| **5.** | The NGOs are playing a vital role in controlling the pandemic | 1 | 2 | 3 | 4 | 5 |

***R. Quality of services***

| | | | | | | |
|---|---|---|---|---|---|---|
| **1.** | The organization offers satisfactory and quality services | 1 | 2 | 3 | 4 | 5 |
| **2.** | The organization provides stigma free zone | 1 | 2 | 3 | 4 | 5 |
| **3.** | The organization provides clean and healthy treatment facilities | 1 | 2 | 3 | 4 | 5 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **4.** | The organization provides security and opportunity for the client's personal growth | 1 | 2 | 3 | 4 | 5 |
| **5.** | The organization provides the opportunity to the clients to use and develop one's creativity | 1 | 2 | 3 | 4 | 5 |
| **6.** | Constitutional protection is provided against discrimination | 1 | 2 | 3 | 4 | 5 |
| **7.** | Constitutional rights to clients on free speech are provided | 1 | 2 | 3 | 4 | 5 |
| **8.** | PLHAs grievances and issues are handled effectively | 1 | 2 | 3 | 4 | 5 |
| **9.** | There is adequate infrastructure so as the clients avail quality services | 1 | 2 | 3 | 4 | 5 |
| **10.** | Home based Care facilities are provided | 1 | 2 | 3 | 4 | 5 |
| **11.** | The organization provides youth friendly services | 1 | 2 | 3 | 4 | 5 |
| **12.** | Referral linkage with Community Health Centre, Primary Health Centre, Hospitals etc | 1 | 2 | 3 | 4 | 5 |
| **13.** | Resourcing, encouraging and fostering the formation of Self Help group ,counseling, peer support and advocacy | 1 | 2 | 3 | 4 | 5 |

***C. Organizational Analysis***

| | | | | | | |
|---|---|---|---|---|---|---|
| **1.** | The staff receive capacity building trainings monthly | 1 | 2 | 3 | 4 | 5 |
| **2.** | The staff are sensitive to the issue and need of the community | 1 | 2 | 3 | 4 | 5 |

***D.Community participation***

| | | | | | | |
|---|---|---|---|---|---|---|
| **1.** | PLHAs have free access to the organisation | 1 | 2 | 3 | 4 | 5 |
| **2.** | PLHAs suggestion are valued and implemented | 1 | 2 | 3 | 4 | 5 |
| **3.** | PLHAs are given opportunity to share, interact and voice their dissatisfaction | 1 | 2 | 3 | 4 | 5 |
| **4.** | PLHAs have continuous communication and consultation with the staff | 1 | 2 | 3 | 4 | 5 |
| **5.** | PLHAs are provided avenues to utilize their potentials | 1 | 2 | 3 | 4 | 5 |
| **6.** | Inclusion of PLHAs in all levels of policy development, implementation and decision making | 1 | 2 | 3 | 4 | 5 |

**20.** According to you, who has the greatest responsibility in fighting against the of HIV/AIDS lies upon….Rate 1,2,3,4,5,6,7,8,9 according to your priorities inside the box.

| Sl.no | Head | Rating |
|---|---|---|
| 1. | General population | |

| | | |
|---|---|---|
| 2. | Medical practitioners | |
| 3. | NGOs/Social workers | |
| 4. | Churches | |
| 5. | Administrators and law enforcing agencies | |
| 6. | Educational institutions | |
| 7. | Other governmental agencies | |
| 8. | Media | |
| 9. | All of these | |

**21.** How do you rate your Performance/contribution level in combating the pandemic?

Give any one of the judgment given below.

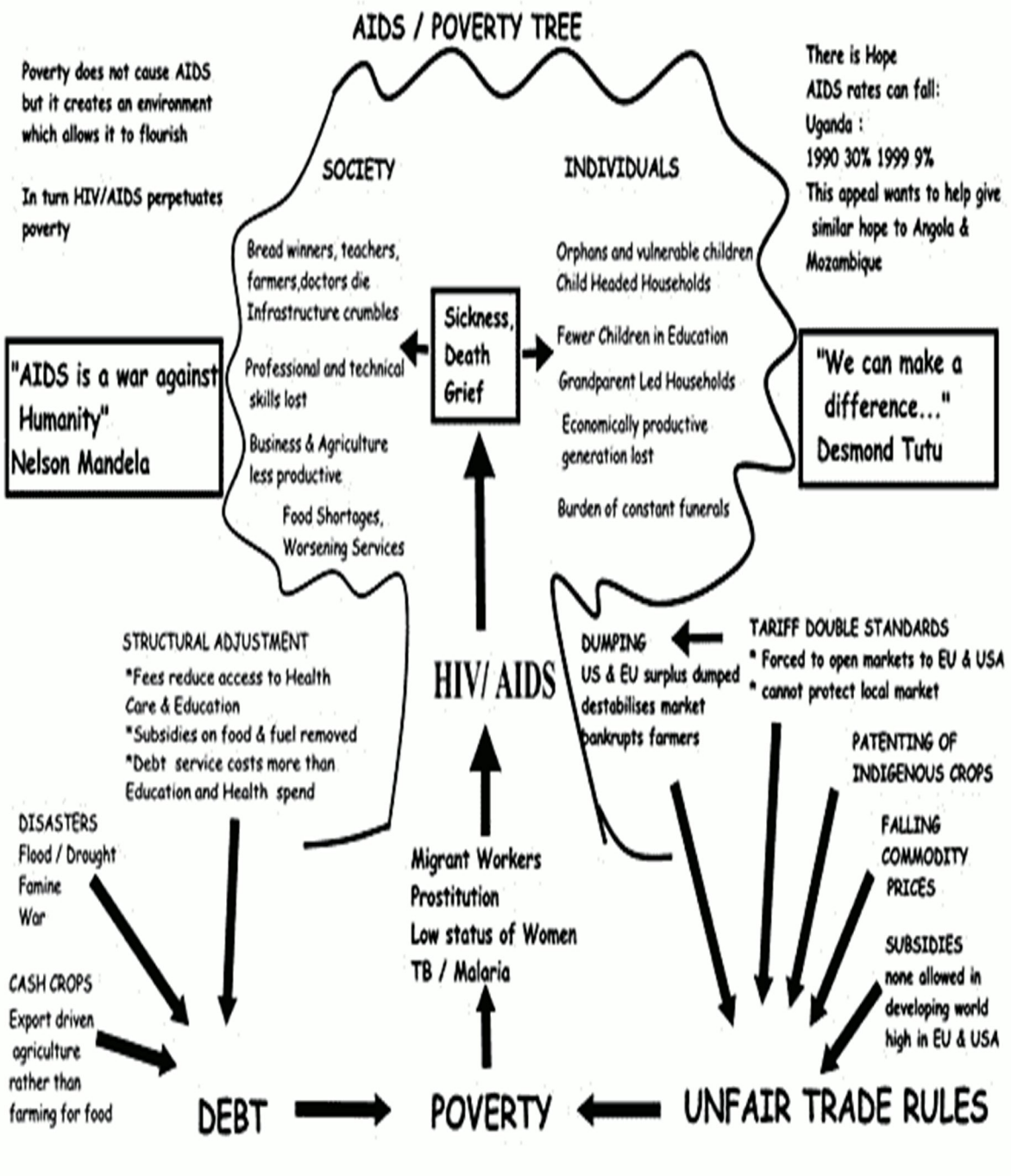
Superb Excellent Effective Fair Good Cannot say

**22.** Is there any comments/suggestion you may like to add regarding HIV/AIDS?

## *Photos*

*PICTURE 1: Red Ribbon Tree*

*Picture 2: Commemoration of the '31st International Candle Light Service' on 18th May 2014 in Mokokchung on the theme 'Keeping the light on HIV'.*




*Picture 8: AIDS poverty tree*