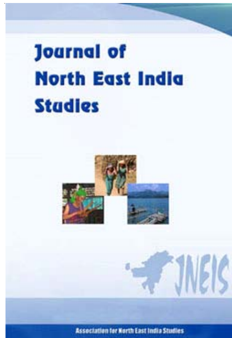


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# Spreading the Dreaded Virus: Social Dimension of HIV/AIDS in Churachandpur, Manipur

Johny Lalbiaklian

The problem of HIV/AIDS is not only a medical problem but it is increasingly recognised as a social problem. It is important to examine the many influences in the society that have a bearing on HIV/AIDS. Development of an appropriate respond to HIV/AIDS requires an understanding of the specific society, its history, its culture and its dynamic. Social issues surrounding the risk of HIV/AIDS and its infection are important ones that illuminate a number of social problems and value conflicts within the society. This paper attempts to address the social dimension of the causes and impact of HIV/AIDS in the district of Churachandpur, Manipur. It is observed that various social activities such as tribal festivals, youth activities and even faith-based festivals play significant role in contributing to the spread of the diseases among the youth. There are diverse responses with regard to the general attitudes towards the infectants where benevolent feeling and sympathy are shown by the families and society broadly.

**Keywords:** HIV/AIDS, Social Dimension, Churachandpur, Addiction, Transmission

## Introduction

Human Immunodeficiency Virus infection and Acquired Immune Deficiency Syndrome (HIV/AIDS) have been a major threat and challenge to the quality of life and humanity. It became one of the major concerns today. It affects people mostly during the prime days of their lives, causing tremendous suffering and great sorrow to millions of people in the world. Today, the HIV epidemic continues to grow alarmingly and invisibly, and the number of people diagnosed with AIDS is increasing rapidly. More people have become infected from the year 2003 than ever before and more people have died of AIDS than ever before. Joint United Nations Programme on HIV/AIDS (UNAIDS) has estimated that while 12.9 million people were living with HIV/AIDS in 1992, today we are having 42 million people living with HIV/AIDS in 2002 and it was predicted that by the end of 2010 about 114 million people will be living with HIV/AIDS in the world. This statistics masks the fact that 27.9 million

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people have already died of AIDS by December 2003 since the beginning of the epidemic, and they included men, women and children. The Second World War killed only 43 million people; the Hiroshima Atom Bomb has killed only 70,000 people. This implies that the impact of AIDS will be much dangerous and severe than the impact of Second World War.[1]

Today cases of HIV infection are reported in every state of India. Throughout the 1990s it was clear that although individual states and cities had separate epidemics, HIV had spread to the general population. Increasingly, cases of infection were observed among people that had previously been seen as *'low-risk'*, such as housewives and richer members of society.[2] In 2001, the government adopted the National AIDS Prevention and Control Policy. During that year, Prime Minister Atal Bihari Vajpayee addressed parliament and referred to HIV/AIDS as one of the most serious health challenges facing the country. The Prime Minister also met the Chief Ministers of the six high-prevalence states to plan the implementation of strategies for HIV/AIDS prevention.[3] But HIV had now spread extensively throughout the country.

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

**HIV/AIDS in Manipur**

Manipur, a landlocked state, borders Nagaland on the North, Assam on the West, Mizoram on the South, and Myanmar (Burma) on the East. In fact, 358-kilometer border that Manipur shares with Myanmar is the site of extensive drug trafficking. This drug trade brings high quality heroin into Manipur, which is the drug of choice for the majority of the state's Injecting Drug Users (IDUs). The prevalence of drug trade in Manipur is primarily due to its geographical proximity to Myanmar and the 'Golden Triangle' - the area where Myanmar, Thailand and Laos meet, and where heroin is refined in huge amount and sent to neighboring areas. Manipur's location on the route of National Highway 39 (N.H. 39) also makes it highly vulnerable to

drug trafficking. Studies show that the geographic presence of IDUs correlates clearly with the path of the national highway.[4]

The 'Golden Triangle' has been a major center of opium poppy cultivation since at least the 19th century, but in the last 15 to 20 years the centre of production has shifted as Thailand's production has drastically reduced and that of Myanmar has increased and bringing the center of production closer to Manipur. Cross-border trade is poorly monitored, and one of the main trade routes goes across the India-Myanmar border from Moreh (India) to Tamu (Myanmar). Users travel by truck inland to Mandalay to purchase heroin and test the drug which often results in needle sharing with traders. Article in *Bulletin on Narcotics (*1993) reported that knowledge of safe needle use is extremely low among Manipur's IDUs, and needles are rarely cleaned and commonly shared.[5] Most studies reported that education and awareness regarding safe injection techniques is lacking.

In the state of Manipur, HIV/AIDS is a grave concern and a great threat to human lives. It is devastating to know that Manipur with a population of about 2 million has 7,886 HIV infected people with 726 AIDS cases and 144 AIDS death.[6] This figure accounts for only reported cases, but the figure is far larger if we include those that are unidentified and unreported. Similarly, Churachandpur District of Manipur is no exception with a population of about 1, 76,184 of whom about 549 HIV are infected. Again, this figure accounts for only reported cases.[7]

A study in Churachandpur among IDUs[8] revealed that heroin was used by all IDUs and a majority of whom were males between the ages of 15-35 years. The education level of these youths was quite high, 78.5% having studied up to high school or pre-university levels. Unemployment accounted for 53% of the IDUs, out of which 34% were students. Earlier estimates stated that female IDUs constituted 5-8%.[9] Recent report indicates an increase to 10% (Sharma, 1999). The overall dropout rates from schools are very high. In the past few decades, HIV/AIDS does not affect the general population in Churachandpur district. It was limited to certain sections of the society called high-risk groups such as drug-users, commercial sex workers, prostitutes, call girls, immigrants etc.

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

the new threat.

**Causes of the of HIV/AIDS in Churachandpur**

HIV/AIDS is a massive killer disease of young people. Unfortunately this commonplace observation has a special significance in Churachandpur district of Manipur. The virus spread to Churachandpur district in the early 1990s and it has already taken its toll of over 480 lives.[1] As of November 2007 the minimalist official figure of deaths due to AIDS for Manipur is still as high as 608. The first case of HIV infection in Manipur was detected by MACS in 1990 from the blood samples of a group of six injecting drug users.[10] Though undetected till then, HIV must have already spread to Manipur by the 1980s. It is difficult to arrive at the exact figure of People Living with HIV/AIDS (PLWHA) in Churachandpur district. As of January 2008, the official statistics released by Manipur AIDS Control Society put the accumulative figure of persons living with HIV/AIDS at 1,899 for Churachandpur district. But Dr. Vum Chin Pau,[11] the District AIDS Officer, reveals that the number of clients on Anti-retroviral Therapy (ART) at the state-funded District Hospital is 1,069 and another 1355 at MSF, Churachandpur, till June 2008. This adds up to 2,424 infected persons.

Manipur State AIDS Control Society has been monitoring the growth rate of HIV infection in Churachandpur district for many years. In 2000, of the 186 blood samples, 56 tested positive (30.1%); in 2001, 42 tested positive out of 87 samples (48.2%); in 2002, 50 tested positive out of 296 (16.8%); in 2003, 70 tested positive out of 198 samples (35.3%); in 2004, 271 tested positive out of 664 (40.8%); and in 2005, 52 tested positive out of 150 blood samples (34.6%).[12]

The seriousness of sexual route transmission is measured by a limitation in sentinel surveillance conducted every year with pregnant women in antenatal clinics in Government hospitals. This shifting trend in the transmission route has been confirmed by the results of my field work. In a questionnaire about the riskiest group for HIV infection in Churachandpur district, 30% of the respondents identified drug users (including IDU) as the riskiest group. Nevertheless, the riskiest group for 70% of the respondents remains people associated with the sex trade – Commercial Sex Workers (CSWs), drivers, migrants, etc. (Table 1).

While 30% of the respondents grouped drug users as the riskiest group, 25% of them considered sex worker as the riskiest, and yet another 20% identified promiscuity as the riskiest factor. These figures are collected only for Churachandpur district; but they are broadly similar with the official statistics of MACS[5] for the entire state of Manipur from September 1986 – November 2007. According to MACS, IDUs constitute 43.24% out of the total HIV positives in the state, and the heterosexually promiscuous persons consist of 29.17% of the total HIV positive population.

A sociological enquiry into the issue will be able to throw some light on how HIV infection recently follows the sexual route in the 'hill society' of Churachandpur district. This approach considers the social behaviour and practices of the people living in an age of global media. Based on focus group discussion with youth and drug users, it has been found that there are linkages between the problems of youth unem-

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

| Sl. No. | The riskiest group for HIV/AIDS infection | Frequency (%) |
|---|---|---|
| 1 | Drug users | 10 |
| 2 | Intravenous Drug Users (IDUs) | 20 |
| 3 | Call girls | 4 |
| 4 | Commercial Sex Workers (CSWs) | 25 |
| 5 | Truck drivers | 1 |
| 6 | Auto drivers | 1 |
| 7 | Homosexuals | 1 |
| 8 | Lesbians | 0 |
| 9 | Bisexuals | 8 |
| 10 | Immigrants | 10 |
| 11 | Promiscuity | 20 |
| 12 | Others | 0 |

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

ployment, insurgency, peer pressure, weak family support and drug abuse. In other words, the spread of HIV/AIDS relates to the issue of overall socio-economic development in Manipur. The sexual transmission route of HIV lies at the intersection of obscene media, permissive society, drug trade, sex trade and gun trade. The tribal Christian communities of the district have a fairly long tradition of night life associated with the local church and voluntary organizations. Song practice, choral practice and condolence meeting routinely take place till late night – sometimes throughout the night.

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

Unregulated electronic media is not conducive to cultivation of self-restraint and abstinence. In Churachandpur, video parlours somehow came to be associated with promiscuity among the youngsters. Morally supported by pseudo-nationalist speech and evangelical morality, militants of Manipur imposed *bandh* on mainstream Hindi cinema, which was considered too obscene and lewd. This move ironically resulted in a boom for video parlours. Since it was difficult to regulate the small

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

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

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

screen video, the new parlours took to screening of pornographic films. These cheap shows implicitly sell very unconventional views on sex and sexuality. Then 55% of the respondents indicated the local video parlours in Churachandpur may have contributed to the spread of HIV through the sexual route.

Mobility of goods and people is a welcome change. Yet it has disorienting and de-stabilizing effects on the fabric of a tribal society. Due to its geographical location, Churachandpur lies on a porous Indo-Myanmar border. Illegal arms trade, drug traffic, immigrants and insurgents run the show. They all enjoyed mobility of movement comparable to automobile drivers and personnel of Indian defence establishment – the army, *sepoys* and paramilitary forces. In Churachandpur, most sex workers are found to be drug users originally generated by the drug trade across the border. Then defence personnel, who arrived here in pursuit of ever-moving militants, become the greatest patrons of the local sex trade. It is, therefore, multiplied by the activities of client-patron relationships. In fact, majority of the respondents(60%) strongly believed that youth programmes, social and even religious activities at night are a contributing factor for the spread of HIV/AIDS in the district which are generally occasion for the youth to misuse to satisfy their whimsical desire whereas less than half of the respondents (40%) disagree and are of the view that these groups in no way spread HIV/AIDS if they are disciplined and these factors are not related to spreading of HIV/AIDS.

More than half of the respondents (55 %) agree that Cable, Television, Video Parlours, movies or Lotteries and gambling contribute for the spread of HIV/AIDS in the district since all these demoralize the life of the people and advertise sexual activities or immoral practices and misbehaviour among the youth in particular since they are outside parental control- feel free and seek their own pleasure thereby leading to the spread of HIV/AIDS and are more exposed to multiple sex partners. Parents are unable to control their children because peer pressure is stronger at the fire of the youth than that of the parents. Besides, the whole Churachandpur district lives is a

typical free society of tribalism indirectly influenced by other culture and it is promoting spread of HIV/AIDS whereas ( 45%) of the respondents feels that these are not related to spreading of HIV/AIDS.

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

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

Overwhelming majority of the respondents (55%) advocated that insurgent groups have their own goals rather than preventing drinking, drug trafficking, prostitutions etc in order to control the wide spread of HIV/AIDS in the district, whereas (45%) of the respondents feel that insurgency also contribute to the spread of HIV/AIDS as they were indirectly promoting social imbalance and lawlessness in the district to increase their side income.

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

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

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

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

1. Negligence of children at an early age largely resulted in the production of family and society that lacks dynamic Christian principles.
2. Peer pressure among teenagers has been found stronger than parental influences upon them, resulting in the general disobedience of children to parental control.
3. Curiosity and the easy availability of illegal drugs, drinks and sex partners in the market place, made worse by the easy accessibility of pornographic movies to minors make unguarded children susceptible to drug abuse.
4. Parents' neglect of their children forfeit them the chance to strictly discipline their children when they go astray.
5. The ever-increasing basic needs and demands of modern life upon children are not met by some irresponsible parents.
6. Excessive liberal social behaviour among most tribal societies can lead to the breakdown of social control, leading to anomic conditions in the society. In such a norm less state, the youth remains directionless and hence fell victim to drugs and other bad habits.
7. Lack of knowledge about HIV/AIDS and its consequences are rampant in the district, along with the unchecked HIV/AIDS infected persons roaming the streets freely.
8. Lack of parental teaching about traditional and modern values among children. Generation gap between 'outdated' parents and modernized children can cause communication breakdown unless parents keep themselves abridge of the contemporary values and practices.
9. Social workers and religious leaders are lacking up-to-date knowledge to help meet parental needs in guiding their respective children to become good citizens or morally upright persons.
10. Lack of free and frank education on sex or HIV/AIDS. Many parents find it difficult to break the ice when it comes to talking about sex-related issues to their children.
11. Under-supervised social responsibilities and obligations in the society and the church become the breeding ground for social misfits.

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

1. Some of the wrong notion or view of the AIDS infected persons was that discharging of AIDS virus through masturbation and or passing the virus to others might relief themselves from HIV/AIDS. Hence, these wrong notions by the infected that infecting others may always reduce or cleanse HIV in them.
2. Encouragement of infected person to infect others by those affected with AIDS menace or promise of incentive (reward) to infected person by others has rampant practice in the district.
3. Some of the HIV/AIDS infected persons have the desire to infect others and neglect condom use. Hence, HIV/AIDS infection is still prevalent at large in the district.
4. Drug addiction is one of the most burning problem not only in Churachandpur

district but also a problem of everyone in the world today. The rate of addictions in every society, particularly in younger generation, is alarming us. Hence, some serious and sincere thoughts should be given for controlling and checking out a plan of action for immediate relief or de-addiction. Particularly in Churachandpur district, drug addicted women or girls are not looking for sexual pleasure or excitement but the drug in exchange for sex with the sex dealers or clients. As such, women become virtual slaves to both the drug itself and the sex dealers. Perhaps, these were the major source to support her habit when nothing more could be stolen in the family. Besides, some addicted persons also drugged minor boys and girls in order to stimulate them to do what they desired. Then several minor girls are exploited through drugs and continue illicit drugs and were also lured into call-girls or prostitutions. Hence, drug addiction, call girls and prostitutions are closely linked.

Indeed, prostitution is a hard work both in physical and emotional terms, still it is not surprising that quite a number of call-girls use one kind of drugs or another because drug dependent call-girls can take more clients than other prostitutes for earning a large amount of money to support a habit. Then they forced themselves almost on everymen in the secret place or room and accidentally become infected with HIV/AIDS when sex dealers or regular clients or someone else totally ignored the use of contraceptive devices or condoms. Unlike other call girls, most of the call girls in Churachandpur district are not from a well to do family or an elite group but hailed from a middle class or lower class family background. These call girls operate in secret and men with wealth go in more and more due to the secrecy involved. Nevertheless, some of these call girls are educated, sophisticated and aristocratic who are smartly dressed and mix freely in society. These call girls rarely entertain customers in their own living place. They make their assignments or engagements through direct contacts or through direct telephones, mobiles or agents or pimps and operate in hotels, circuits and guest-houses etc. and give company to politicians, government officers, contractors etc. who take them out for evening or week-ends. Hence it is not economic factor alone that influence one to operate as a call-girl (interview with Dr. Muanna, Director, Shalom, Churachandpur, Manipur on 2/6/2007).

**Socio-economic impact of HIV/AIDS in Churachandpur**

The social impact of HIV/AIDS varies. The individual life of HIV/AIDS patients is hampered in the family and society. It is considered that persons infected with HIV/AIDS are weaker, uglier, inferior and shy. Hence, after one gets HIV/AIDS in the family, the happiness of the entire family tends to significantly diminish. Nevertheless, the attitude towards HIV/AIDS patients in Churachandpur district is friendly and normal. As such the social impact of HIV/AIDS in general do not engender discrimination or isolation, rather it is that of affection, care and concern which may be attributed to the age-old traditional values of tribals combined with the teaching of Christian values and principles which dominates each and every sphere of individual life.

Majority of the respondents (53%) are of the view that the individual life of HIV/AIDS patients are hampered in the family and society, whereas 44% of the

respondents disagrees and the rest 3% of the respondents cannot say anything nor have any idea on these important issues. However, overwhelming majority of the respondents (57%) are also of the view that infected HIV/AIDS persons are weaker, uglier, inferior and diffident, whereas only lesser number (33%) of respondents disagrees and advocates that they are the same as other human being and the rest (10%) remains indifferent.

Majority of the respondents (52%) asserted that the untimely demise of people in the age group of 15-50 are due to HIV/AIDS whereas 48% of the respondents disagree and advocates that one could die at any age. Overwhelming majority of the respondents (60%) also advocated that HIV/AIDS in the district leads to many social problems, whereas only 40% of respondents are of the view that problems are common to all state or to all society.

Majority of the respondents (55%) are of the view that after one gets HIV/AIDS in the family, the happiness of the entire family will be significantly reduced, whereas 40% of the respondents disagrees and the rest 5% remain indifferent or have no idea. In Churachandpur district overwhelming majority of the respondents (57%) asserted that many widows and orphans are not due to HIV/AIDS, whereas less than half of the respondents (40%) are of the view that many widows and orphans are due to HIV/AIDS and the rest 3% become indifferent or have no idea. The respondents (56%) asserted that relationship with other families is harmed only when there is misunderstanding but less than half of the respondents (42%) disagree and are of the view that after one gets HIV/AIDS in the family, the family's relationship with other families is harmed and the rest 2 % of the respondents has no idea.

Many (54%) are of the view that HIV/AIDS infected and uninfected persons have relationship problems whereas (46%) of the respondents disagree and asserted that HIV/AIDS is nothing but a virus, tiny and fragile. Huge majority of the respondents (56%) feel that higher incidence of HIV/AIDS patients leads to less income for the family and society but less than half of the respondents (40%) are of the view that income can be generated by each individual of the family members according to his capacity and the rest 4 % of the respondents has no idea and become indifferent (Table 3).

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

'Only Grace' (Zomi Mother's Asociation) is a nascent orphanage established as 'a safe home for children affected and infected by HIV/AIDS.[13] It is founded by Becky Bierly from the United States of America and was inaugurated on 31 May 2006. In July 2008, 'Only Grace' has 11 resident children at Vengnuam (New Lamka) of Churachandpur.

Established in 1988, Drug De-addiction and Rehabilitation Centre (DDRC) is locally known as 'Lametnamun' (Hope centre).[14] It is located at Bungmual, about 3

km west of Churachandpur town. The location of DDRC is an idyllic and tranquil area stretching over 3.72 acres of land that is owned by its parent organization, the Evangelical Baptist Convention (EBC).[15] Since 1995 the Centre received financial assistance from the Ministry of Social Justice and Empowerment with a capacity to accommodate 15 persons at a time. The staff strength of 'Hope Centre' is 12 – one Project Officer, four Counsellors, one Yoga Therapist one Nurse (full time), one Doctor (part time), one Accountant, one Ward Boy, one *Choukidar*, and one Peon.[16]

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

| | Yes | No | Can't say |
|---|---|---|---|
| The individual life of HIV/AIDS patients is hampered in the family and society. | 53 | 44 | 3 |
| Infected HIV/AIDS persons are weaker, uglier, inferior and diffident (assimilated). | 57 | 33 | 10 |
| Untimely demise of people in the age group of 15 to 50 are due to HIV/AIDS. | 52 | 48 | 0 |
| After one gets HIV/AIDS in the family, the family's relationship with other families is harmed. | 56 | 42 | 2 |
| HIV/AIDS infected and uninfected persons have relationship problems. | 54 | 46 | 0 |
| HIV/AIDS in the district leads to many social problems. | 60 | 40 | 0 |
| Higher incidence of HIV/AIDS patients leads to less income for the family and society. | 56 | 40 | 4 |
| Social, political, economic and religious practices will be a failure due to HIV/AIDS in the district. | 52 | 46 | 2 |
| After one gets HIV/AIDS in the family, the happiness of the entire family will be significantly reduced. | 55 | 40 | 5 |
| Many widows and orphans are due to HIV/AIDS. | 56 | 40 | 4 |

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

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

The people of Churachandpur district are generally aware of HIV/AIDS and their attitude towards the patient is quite normal and their approach towards the patient is also very humanitarian in accordance with Christian values and principles besides the traditional values of the society since around 98% of the population are Christians. The people of the district as a whole are very conscious and quite aware of HIV/AIDS. Yet the degree of awareness varies depending on their social and educational background and literacy of the person. Few among the educated class had been aware of HIV/AIDS as early as 1984 even before the disease surface in India (1986) while some the illiterate of the district come to know HIV/AIDS only in the late 1990s after a series of HIV/AIDS related deaths had occurred in Churachandpur

district.

In the course of interview, majority of the respondents (35%) agreed that if one gets HIV/AIDS, only an individual ought to be blamed than any other source or persons. But 30% of the respondents blame friends whereas 20% blame family members and the rest 14% would like to blame other relatives and only 1% blame other sources. From the data it is a crystal clear that no one is to be blamed for any infection except the carelessness of the person although family and society are also partly one of the causes for any HIV/AIDS infection in Churachandpur district. Besides, majority of the respondents (54%) are also quite aware of the route of transmission of HIV/AIDS through sex, blood, needles or syringes or piercing instruments, mother to child, and probably through deep kissing and that HIV/AIDS is not spread through casual contacts such as shaking hands, hugging, dry kissing, sneezing, sharing of toilets, soaps, towels etc. (see Table 4).

**General Attitudes**

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

In regard to the testing of HIV/AIDS before marriage must be legalized, more than half of the respondents (62 %) asserted that it is better to prevent the spread of the disease through legal issue while minority respondent (38 %) feels that it need not be legalized as it is difficult to implement in a democratic country like India (Table 4).

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

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

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

Regarding inheritance of parental property is concerned; more than half of the respondents (60%) are of the view that infection of HIV/AIDS is not the end of everything and asserts that no one is safe from contacting HIV/AIDS even those who are of repute and belonging to low-risk groups of people leading disciplined life in society. But 40% of the respondents asserted that there is no future for them in most cases.

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

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

In relation to death, more than half of the respondents (60%) are of the view that even HIV/AIDS related death should be respected for the sake of the family members. There is a need for decent burial with church ceremony for all persons even those people infected with HIV/AIDS. But 40% of the respondents disagree. Thus, the general attitudes towards HIV/AIDS patient is not that of discrimination or isolation rather it is that of affection, care and concern which may be attributed to the age old tribal traditional values combined with the teaching of Christian values and principles.

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

In a community level, socio-economic impact of HIV/AIDS in the district is also related to economic loss of key productive members, transfer of responsibilities and costs onto community coping mechanism. Hence, community may be compelled to provide help or support in several ways when parents or earning members of the family become ill. But in a wider society level, the impact will concern issues such economic costs as a result of HIV infection among workers in various sectors, production affected as a result of depletion of labour force, burden on health care system

and problems at work places in the form of absenteeism. The situation at home may be unknown to family and co-workers. Absence from work may be difficult to explain without disclosing personal information that could place one's employment in jeopardy. Finally when death occurs, co-workers may be denied the opportunity to be supportive, and the grieving lover may not be excused from daily activities to mourn. As a further consequence, long-term potential impact of HIV/AIDS in the district might often deals with destitution, social unrest, political instability and so on.

*Table 4: Attitudes towards HIV/AIDS patients in Churachandpur district*

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

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

**Discussion and Conclusion**

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

Churachandpur district is extremely vulnerable to AIDS epidemic since many factors contributed to this vulnerability even when AIDS is confirmed to be transmitted

by sexual intercourse in most cases. Intravenous drug users were the primary causative factors, initially responsible for majority of HIV/AIDS infections. Huge proportions (50%) of the IDUs are estimated to be infected with HIV. But today, experts have now suggested that heterosexual intercourse or sexual transmission is a pre-dominant mode of HIV/AIDS transmissions in the district.

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

The frequency of various traditional customs and practices like *Kut* festivals, *Thabanchongba,* youth club days, *Zomi Nam* festivals etc. should also be minimized for time being, since such values are often misused by young and old alike and they frequently led to immoral practices.

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

Thus, preventive measures may also involve promoting safer sexual practices, better infection control practices in hospitals, sterilization of needles and syringes or piercing instruments for giving injections and setting up a rational blood transfusion programmes, improvement of blood transfusion service, check and control sexual transmission.

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

hospital beds, professional services, and hospice care is already significant and will grow from time to time.

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

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

Thus, two major changes in sexual behaviour are needed. They are reduction in the number of sexual partners and the move from high risk to low risk activities or no risk sexual activities. But it is crystal clear that complete abstinence for sex may be unrealistic. So promotion of safer sexual practices and counseling services to the individuals for their own choice to meet their needs should be propagated or widely discussed at the right time and at the right place. Indeed, prevention and control of HIV/AIDS transmission requires changes in certain behaviour in all times and in all

situations.

Information alone is insufficient to promote meaningful changes in risk behaviour. For instance, sex is a powerful motive and its activities are especially difficult to change through information provision alone. As such, moderate levels of fear will facilitate behaviour change and re-assured the community or society to be able to control the risk and its detrimental consequences. In short, risk perceptions are heavily influenced by social, political and cultural factors, such as social class membership or involvement in social milieu.

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