

CHAPTER I

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INTRODUCTION

1. Manipur Profile

Manipur is a small state with a population of only 27.21 lakhs (2011 Census) and a land area of 22,327 Sq. Km. having an international boundary of 358 Km. with Myanmar. Manipur with hardly 0.2% of India's population is contributing nearly 8% of India's total HIV positive cases. Manipur being the border state to Myanmar which comes under the notorious golden triangle having a long history of Psychotropic substance use with opium and cannabis and pharmaceutical drugs use such as Buprenorphine or a cocktail with Antihistamine injections or sedative injection preparations like the Benzodiazepines coupled with sharing of contaminated syringes and needles, unsafe sexual practices under the influence of drugs is one of the most important factors making Injectible Drug Users (IDU) as major sources of infection. Trapped in an insurgent-affected zone together with the poor health delivery systems, Manipur needs to perceive the epidemic as an impending disaster of colossal proportion. Manipuri people and society are apparently sitting close to the volcano. In fact, there is growing realisation that there indeed is an association between insurgency, high drug use and HIV/AIDS.

There is a lingering political conflict and HIV/AIDS in the North Eastern states of India especially in Manipur. For the ordinary people and communities living in this area every new day comes up with fresh agenda for survival negotiations. Coping and management of fear is the most important concern cutting across class region in this area. In a scenario where even the press has its mouths regulated by the might of the barrel, or where every scheme and sanction has to first pass through the filter of the revolutionary groups. It's about time the civil societies roll up its sleeves and show genuine concern for real issues. "Governments in most conflict-affected Zones are not responding adequately to the threat of HIV/AIDS, for want of commitment and capacity building". (Subramanian K. S, 2002)

Despite each political party having HIV/AIDS Mitigations as their political Manifestoes, they are pressed with more immediate security and political concern and have no time for the HIV/AIDS causes. HIV/AIDS how it has affected the political economy and overall development of the state, in spite of the common belief that insurgency as the sole bottlenecks to economic development. The number of young people, who are infected, is increasing day by day. In Manipuri society, AIDS is becoming a disease of the young people (MSACS).

2. HIV/AIDS and its reality

1. HIV/AIDS Stages, Modes of transmission and Prevention

The Acquired Immunodeficiency syndrome (AIDS) pandemic has become part of the contemporary global problems after its detection in the latter half of the 20th century. It is affecting the individual psycho-socio and political economy of all countries. Since the beginning of the pandemic, case definitions for Acquired Immunodeficiency Syndrome (AIDS) have undergone several revisions to respond to diagnostic and therapeutic advances and to improve standardization and comparability of surveillance data regarding persons at all stages of HIV disease.

The pandemic as it is defined by the American Centre for Disease Control (CDC); it is the presence of one of the 32 conditions indicative of severe immune-suppression associated with AIDS infection in an adult or adolescent aged 13 years or older. Professionals from all fields have joined hands as it hardly needs to be mentioned that the AIDS has transcended geographical, socio-economic and political boundaries to find a solution to the challenge of the present century. Varying degrees of research by Medical, Social and Pharmaceuticals has been conducted but till date there has not been a real solution to halt the pandemic.

The Human Immunodeficiency Virus (HIV)

A Virus is a small organism which cannot be seen through our naked eyes but through a powerful microscope. Unlike other germs, a virus can reproduce itself only through entering a living cell and replacing or taking over some of the cell materials

White blood cells called macrophages and lymphocytes play an important role in the Human Immunodeficiency Virus (HIV) infection. When HIV enters the body, it binds itself to the lymphocytes, a type of white cells also called "helper cells" because they "instruct" other cells to fight off "foreign" intruders such as germs. HIV can enter T4 cells because they have what is called a CD4 receptor which matches the virus' key. Once HIV has entered these cells, its genetic material, RNA (Ribonucleic Acid), must be changed to match the cells' DNA (Deoxyribonucleic Acid). This is achieved with the help of enzymes. The invaded cells then begin to reproduce the virus, making hundreds of copies of HIV bursting out of their cells into the blood and lymph of their carrier host. T4 cells die about 24 to 36 hours after being infected with HIV. Although the body is able to replace them, their numbers decrease over time. As these cells are key agents in the immune response to various infections, their depletion eventually causes a serious deficit in normal antibodies, thereby opening the host body to all kinds of opportunistic infection infections.

2.1.1 Stages of HIV infection

a. Window period

This period refers to the time between the first exposure to HIV and "Sero-conversion" that is the production of antibodies by the immune system in response to HIV infection. The person will not show any signs or symptoms at this point. The test result will be effective only after six week to six months from the initial contact.

b. Asymptomatic period

This is a period where HIV has already entered the human body and might already be there for several years. HIV works slowly and silently at this stage but started to destroy the T4 Cells. However there are no obvious signs and symptoms at the stage.

c. Symptomatic period

The host immune system is weakened by the killer virus at this stage and several of the HIV symptoms started to develop. Some of the most common symptoms include Diarrhoea, fever, drenching night sweats, persistent tiredness and several infections.

d. The stage of Acquired Immunodeficiency Syndrome

This is the last stages in HIV infection. Person living with HIV at this stage has a serious damage in the body Immune System. When a person is at this stage it would be marked by the emergence of several opportunistic infections like STI/STD's. All this infections are not directly caused by HIV but due to the consequences of HIV weakening the body immune system, thereby paving the way for other germs, bacteria and viruses.

2.1.2 Modes of HIV transmission

HIV can be transmitted from an infected person to someone else when there is an exchange of blood, semen or vaginal secretions. In addition, a baby born to an HIV-positive mother has a 14 to 25 per cent chance of being infected (The College of Family Physicians of Canada, 1995:23).

The Main modes of HIV transmissions are unprotected sexual intercourse with an infected partner, Injection or transfusion of contaminated blood or blood products, sharing of contaminated and unsterilized injecting equipment can also infect the other, Mother to child transmission (during pregnancy, at birth, and through breastfeeding), Occupational infections of healthcare or laboratory workers from contaminated needles pricking their bodies and came into contact with their blood also can infect them

a. Unprotected Sexual intercourse

Unprotected sexual intercourse with an infected partner was the most common form of infection during the past few years according to UNAIDS reports. Although receptive anal sex is estimated to produce the highest risk of infection, infection after a single insertive contact has also been described. The presence of other sexually transmitted infections also increases the risk of becoming infected with HIV.

b. Sharing of Contaminated Needles & Syringes

Sharing of unsterilized injecting equipment that has been previously used by someone who is infected is an important route of HIV transmission in many countries with a

high prevalence of intravenous drug users. In contrast to the accidental needle stick injury, the risk of transmission through sharing injection equipment is far higher. According to Bradley M., et al (2008) in a study on Global epidemiology of injecting drug use and HIV among people who inject drugs says that Injecting drug use is an increasingly important cause of HIV transmission in most countries worldwide.

c. Mother to child transmission

An HIV infected mother can transmit infection to child during pregnancy and delivery in 15-30% of cases. In 75% of the cases the transmission is during delivery. In India, several thousand HIV-infected babies are born every year. Despite effective intervention, the identification of HIV infected pregnant women prior to delivery is a major problem. According to study conducted by Athena P. K., et al, (2006) concludes that for non-breastfeeding populations, 50% of HIV infections are transmitted to the infant at the very end of pregnancy, near to the time of labor. Also they add that transmission of the infection to the infant through breastfeeding is one of the main challenges in fighting paediatric HIV/AIDS in the developing world.

d. Contaminated blood transfusion

HIV can be transmitted through contaminated blood transfusion. Some people have been infected through a transfusion of infected blood. These days, all the blood used for transfusions in high-income countries is tested for HIV and HIV infection though infection through blood transfusions is now extremely rare. Yet this is not the case in some middle- and low-income countries, where there is lack of adequate blood safety procedures and measures are in place.

2.1.3 Prevention of HIV transmission

For each route of transmission there are things that an individual can do to reduce or eliminate risk. According to Mayer K and Pizer H., (2009) there are also interventions that have been proven to work at the community, local and national level. Wherever there is HIV, all three routes of transmission will take place. However the number of infections resulting from each route will vary greatly between countries and

population groups. The share of resources allocated to each area should reflect the nature of the local epidemic - for example, if most infections occur among men who have sex with men then this group should be a primary target for prevention efforts.

According to UNAIDS guidelines for HIV prevention 2007 "Knowing the epidemic in a particular region or country is the first, essential step in identifying, selecting and funding the most appropriate and effective HIV prevention measures for that country or region." -

HIV prevention should be comprehensive, making use of all approaches known to be effective rather than just implementing one or a few select actions in isolation. Successful HIV prevention program not only give information, but also build skills and provide access to essential commodities such as condoms or sterile injecting equipment. It should be remembered that many people don't fit into only one "risk category". For example, injecting drug users need access to condoms and safer sex counseling as well as support to reduce the risk of transmission through blood.

HIV prevention needs to reach both people who are at risk of HIV infection and those who are already infected: People who do not have HIV need interventions that will enable them to protect themselves from becoming infected. According to Kalichman S. (ed) (2006) People who are already living with HIV need knowledge and support to protect their own health and to ensure that they don't transmit HIV to others - known as "positive prevention". Positive prevention has become increasingly important as improvements in treatment have led to a rise in the number of people living with HIV.

According to Richardson et al., (2004), counseling and testing are fundamental for HIV prevention. People living with HIV are less likely to transmit the virus to others if they know they are infected and if they have received counselling about safer behaviour. For example, a pregnant woman who has HIV will not be able to benefit from interventions to protect her child unless her infection is diagnosed. Those who discover they are not infected can also benefit, by receiving counselling on how to remain uninfected.

The availability and accessibility of antiretroviral treatment is crucial; it enables people living with HIV to enjoy longer, healthier lives, and as such acts as an incentive for HIV testing. Continued contact with health care workers also provides further opportunities for prevention messages and interventions. According to findings by Kennedy et al., (2007) suggest that HIV-positive people may be less likely to engage in risky behaviour if they are enrolled in treatment programmes.

a. Prevention of HIV from contaminated blood transfusion

It is a well known fact that HIV is transmitted through contaminated blood and blood products. Government and medical professional have strived hard to limit the virus from infecting more and more people through this channel. In India during the later part of the 20th century the Supreme Court has banned professional blood donors from donating blood. Also, the government through its various hospitals and blood banks has taken up a stringent measure to ensure that safe blood is available through the blood banks. Transfusion of infected blood or blood products is the most efficient of all ways to transmit HIV. However, the chances of this happening can be greatly reduced by screening all blood supplies for the virus, and by heat-treating blood products where possible. In addition, because screening is not quite 100% accurate, it is sensible to place some restrictions on who is eligible to donate, provided that these are justified by epidemiological evidence, and don't unnecessarily limit supply or fuel prejudice. As UNAIDS., (1997) and WHO (2002) pointed out that reducing the number of unnecessary transfusions also helps to minimize risk. The safety of medical procedures and other activities that involve contact with blood, such as tattooing and circumcision, can be improved by routinely sterilizing equipment. An even better option is to dispose of equipment after each use, and this is highly recommended if at all possible.

Health care workers themselves run a risk of HIV infection through contact with infected blood. The most effective way for staff to limit this risk is to practice universal precautions, which means acting as though every patient is potentially infected. Universal precautions include washing hands and using protective barriers for direct contact with blood and other body fluids. (WHO Universal precautionary

guidelines) Many resource-poor countries lack facilities for rigorously screening blood supplies. Takei T. et al., (2009) In addition a lot of countries have difficulty recruiting enough donors, and so have to resort to importing blood or paying their citizens to donate, which is not the best way to ensure safety.

b. Prevention of HIV from Contaminated Needles and Syringes

People, who share equipment to inject recreational drugs, have a very high risk of becoming infected with HIV from other drug users who have an HIV. Needle exchange programs have been shown to reduce the number of new HIV infections without encouraging drug use. These programs distribute clean needles and safely dispose off used ones, and also offer related services such as referrals to drug treatment centre's and HIV counseling and testing. According to WHO (2005) Needle exchanges are a necessary part of HIV prevention in any community that contains injecting drug users. Report made by WHO April (2004) also highlights the importance of community outreach for injecting drug users, small group counselling and other activities that encourage safer behaviour and access to available prevention options.

Despite the evidence that they do not encourage drug use, some authorities still refuse to support needle exchanges and other programs to help injecting drug users. Restrictions on pharmacies selling syringes without prescriptions, and on possession of drug paraphernalia, can also hamper HIV prevention programs by making it harder for drug users to avoid sharing equipment.

In much of the world the safety of medical procedures in general is compromised by lack of resources, and this may put both patients and staff at greater risk of HIV infection.

c. Prevention of HIV through Sexual Transmission

One can prevent HIV through sexual transmission by following these guidelines: Abstaining from sex, being faithful to one partner, using of male or female condoms consistently and correctly

Studies conducted by Lampthey and Price (1998) shows that there are a number of effective ways to encourage people to adopt safer sexual behavior, including media campaigns, social marketing, peer education and small group counseling. These activities should be carefully tailored to the needs and circumstances of the people they intend to help.

Findings by UNAIDS (2004) have shown that condoms, if used consistently and correctly, are highly effective at preventing HIV infection. Also there is no evidence that promoting condoms lead to increased sexual activity among young people. Therefore condoms should be made readily and consistently available to all those who need them.

However findings of Marston and King (2006) tell us that it is not easy for people to sustain changes in sexual behavior. In particular, young people often have difficulty remaining abstinent, and women in male-dominated societies are frequently unable to negotiate condom use, let alone abstinence. Many couples are compelled to have unprotected sex in order to have children. Other's associates condoms with promiscuity or lack of trust.

d. Prevention from Mother-to-child transmission

There are a number of things that can be done to help a pregnant woman with HIV to avoid passing her infection to her child. A course of antiretroviral drugs given to her during pregnancy and labor as well as to her newborn baby can greatly reduce the chances of the child becoming infected. Although the most effective treatment involves a combination of drugs taken over a long period, even a single dose of treatment can cut the transmission rate by half. Medical professionals also claim that a caesarean operation to deliver a baby through its mother's abdominal wall reduces the baby's exposure to its mother's body fluids and it lowers the risk of HIV transmission, but is likely to be recommended only if the mother has a high level of HIV in her blood, and if the benefit to her baby outweighs the risk of the intervention.

In much of the world a lack of drugs and medical facilities limits what can be done to prevent mother-to-child transmission of HIV. Antiretroviral drugs are not widely available in many resource-poor countries, caesarean section is often impractical, and many women lack the resources needed to avoid breastfeeding their babies. HIV/AIDS transmission from infected mother to child can be prevented by simple interventions such as antiretroviral transmission prophylaxis and elective caesarean section. This is also called the vertical transmission and in 10% of the time it can occur during the third trimester of pregnancy and another 10-15% of the time during breast feeding. This knowledge and understanding gives us an opportunity to prevent the spread from mother to child. It requires creating awareness among pregnant mothers to be treated themselves and approach hospitals which offer caesarean section for HIV infected women. HIV-related stigma is another obstacle in the prevention of mother-to-child transmission. Some women are afraid to attend clinics that distribute antiretroviral drugs, or to feed their babies formula, in case by doing so they reveal their HIV status.

II. Epidemiology Global and India

According to UNAIDS 2013, the total number of people living with HIV in 2012 is 35.3 million, among them there are 32.1 million Adults, 17.7 million Women 3.3 million Children under 15 years of age and a Total 2.3 million People newly infected with HIV in 2012, 2.3 million Adults, 260, 000 Children under 15 years of age and a Total 1.6 million AIDS-related deaths in 2012, 1.4 million Adults 210 000 Children under 15 years of age. Trends in new adult infections differ among regions. The epidemic continues to disproportionately affect sub-Saharan Africa, home to 70% of all new HIV infections in 2012. However, since 2001, the annual number of new HIV infections among adults in sub-Saharan Africa has declined by 34%. The most pronounced decline in new infections since 2001 (49%) has occurred in the Caribbean. New HIV infections have been on the rise in Eastern Europe and Central Asia in recent years despite declines in Ukraine. By contrast, new HIV infections continue to rise in the Middle East and North Africa.

Table 1.1 UNAIDS Global epidemiology update 2012

Countries/Continent	Adults and children living with HIV	Adults and children newly infected with HIV	Adult prevalence (15–49) [%]	Adult & child deaths due to AIDS
Sub-Saharan Africa	25.0 million [23.5–26.6]	1.6 million [1.4 – 1.8]	4.7% [4.4% – 5.0%]	1.2 million [1.1 – 1.3]
Middle East and North Africa	260,000 [200,000–380,000]	32,000 [22000–47000]	0.1% [0.1% – 0.2%]	17,000 [12 000 – 26 000]
South and South-East Asia	3.9 million [2.9 – 5.2]	270,000 [160,000–440,000]	0.3% [0.2% – 0.4%]	220,000 [150 000 – 310 000]
East Asia	880 000 [650 000 – 1.2]	81 000 [34,000–160 000]	<0.1% [<0.1% – 0.1%]	41 000 [25 000 – 64 000]
Latin America	1.5million [1.2 – 1.9]	86 000 [57 000 – 150 000]	0.4% [0.3% – 0.5%]	52 000 [35 000 – 75 000]
Caribbean	250 000 [220,000–280 000]	12000 [9400 – 14 000]	1.0% [0.9% – 1.1%]	11 000 [9400 – 14 000]
Eastern Europe and Central Asia	1.3 million [1.0 – 1.7]	130000 [89000–190 000]	0.7% [0.6% – 1.0%]	91 000 [66 000 – 120 000]
Western and Central Europe	860 000 [800 000 – 930 000]	29 000 [25 000 – 35 000]	0.2% [0.2% – 0.2%]	7600 [6900 – 8300]
North America	1.3million [980 000 – 1.9]	48000 [15000–100 000]	0.5% [0.4% – 0.8%]	20000 [16 000 – 27 000]
Oceania	51000 [43 000 – 59 000]	2100 [1500 – 2700]	0.2% [0.2% – 0.3%]	1200 [<1000 – 1800]
TOTAL	35.3 million [32.2–38.8]	2.3 million [1.9 – 2.7]	0.8% [0.7% - 0.9%]	1.6 million [1.4 – 1.9]

In South and south East Asia according to the UNAIDS 2012 reports 3.9 million people were living with HIV, including 270 000 who became newly infected last year. Asia's epidemic was at it peaked in the mid-1990s and annual HIV incidence has subsequently declined by more than half. Regionally, the epidemic has remained somewhat stable since 2000. In 2008, an estimated 330 000 AIDS-related deaths occurred in the continent. While the annual number of AIDS-related deaths in South and South-East Asia in 2008 was approximately 12% lower than the mortality peak in 2004, the rate of HIV-related mortality in East Asia continues to increase, with the number of deaths in 2008 more than three times higher than in 2000.

Asia is home to 60% of the world's population with diverse cultures and tradition ranked second only to sub-Saharan Africa in terms of the number of people living with HIV. According to estimates by UNAIDS India accounts for roughly half of Asia's HIV prevalence. With the exception of Thailand, every country in Asia has an adult HIV prevalence of less than 1%. Though Asia has a very large population, the low rate of HIV prevalence translates into a substantial portion of the global HIV

burden. Though the rate of HIV prevalence might be low, it cannot escape the epidemic's harmful consequences.

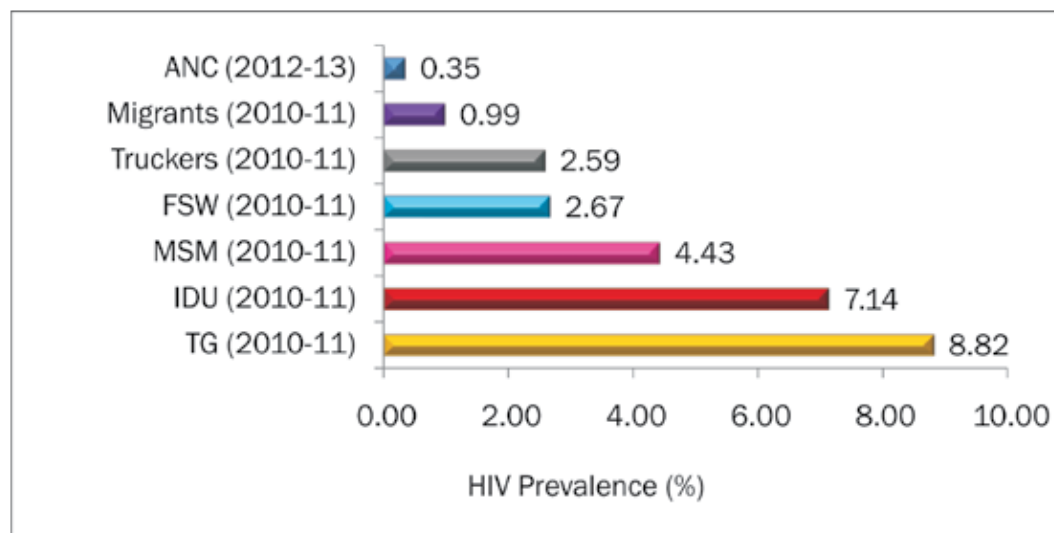
According to Commission on AIDS in Asia, 2008 states that the economic consequences of AIDS will force an additional 6 million households in Asia into poverty by 2015 unless national responses are significantly strengthened. Substantial improvements in HIV surveillance systems are evident in many countries. According to Wang et al., (2009)

Asia's epidemic has long been concentrated in specific populations, namely injecting drug users, men who have sex with men, sex workers and their clients. However, the epidemic in many parts of Asia is steadily expanding into lower-risk populations through transmission to the sexual partners of those most at risk.

HIV epidemic in India is concentrated among High Risk Groups and is heterogeneous in its distribution. The vulnerabilities that drive the epidemic are different in different parts of the country. Overall trends of HIV portray a declining epidemic at national level, though regional variations exist. The Department of AIDS Control has been monitoring levels and trends of HIV among different population groups to craft effective responses to control HIV/AIDS in India through the HIV Sentinel Surveillance System since 1998.

The thirteenth round of HIV Sentinel Surveillance (HSS) was implemented during 2012-2013 in 34 States and Union Territories in the country. The highest prevalence was recorded in Nagaland (0.88%), followed by Mizoram (0.68%), Manipur (0.64%), Andhra Pradesh (0.59%) and Karnataka (0.53%). Also, States like Chhattisgarh (0.51%), Gujarat (0.50%), Maharashtra (0.40%), Delhi (0.40%) and Punjab (0.37%) recorded HIV prevalence of more than the national average.

Table 1.2 National HIV Prevalence for ANC attendees (2012-13) and key risk groups (2010-11) (NACO Annual Report 2013-14)



III. Public Issue (Global Aspect)

The HIV since its detection in 1981 in the United States of America, it continues to baffle professionals from different fields. One by one it has engulfed populations in all countries of the world. HIV and AIDS have been widely recognized as the single greatest threat to sustainable development. For example, in sub-Saharan African countries, it has increased infant mortality and reduced life expectancy to levels not seen since the 1960s. Moreover, infant and child mortality rates are expected to double and even triple early in the next century. HIV/AIDS is a global problem requiring a global solution. It does not recognize boundaries of nationality, gender, age, occupation or sexual preference.

HIV continues to be a major global public health issue, having claimed more than 39 million lives so far. In 2013, 1.5 [1.4–1.7] million people died from HIV-related causes globally. There were approximately 35.0 [33.2–37.2] million people living with HIV at the end of 2013 with 2.1 [1.9–2.4] million people becoming newly infected with HIV in 2013 globally. Sub-Saharan Africa is the most affected region, with 24.7 [23.5–26.1] million people living with HIV in 2013. Also sub-Saharan Africa accounts for almost 70% of the global total of new HIV infections. In 2013,

12.9 million people living with HIV were receiving antiretroviral therapy (ART) globally, of which 11.7 million were receiving ART in low- and middle-income countries. The 11.7 million people on ART represent 36% [34–38%] of the 32.6 [30.8–34.7] million people living with HIV in low- and middle-income countries. Paediatric coverage is still lagging in low- and middle-income countries. In 2013 less than 1 in 4 children living with HIV had access to ART, compared to over 1 in 3 adults (WHO Fact Sheet No.360 updated 2014)

In spite of recent advances in treatment and care available in most developed countries, the HIV/AIDS pandemic continues to spread throughout the developing world. Structural inequalities continue to fuel the epidemic in all societies, and HIV infection has increasingly been concentrated in the poorest, most marginalized sectors of society in all countries. The relationship between HIV/AIDS and social and economic development has therefore become a central point in policy discussions about the most effective responses to the epidemic.

IV. Different Policies, Programmes and Strategies (Global Aspect)

Policies, Programmes and strategic plans on HIV/AIDS are the foundations for any meaningful and sustained response to the epidemic. A policy provides an operating framework for people whose jobs entail prevention, treatment, care, support and generally reducing the impact of the epidemic on the population. Policies can include principles on Human Rights for all and, specifically, the rights of persons living with HIV/AIDS. They can also include strategies for reducing vulnerability to HIV/AIDS for specific groups. A country's policy on HIV/AIDS is a useful guide to domestic and international resource allocation to support specific programs. Without a policy, those managing the response to HIV/AIDS have no sense of national direction. The policy directs the creation of strategic plans and the allocation of funds to activities aimed at achieving the stated objectives of the management of the HIV/AIDS situation

a) UNITED STATES OF AMERICA

On July 13, 2010, the White House released the National HIV/AIDS Strategy (NHAS). With a vision that United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination. The specific Goals of the National HIV/AIDS Strategy include reducing New HIV infections by 2015. Increasing Access to Care and Improving Health Outcomes for People Living with HIV by 2015. Reducing HIV-related health disparities and to improve access to prevention and care services for all Americans. The strategies action steps includes reducing new HIV infections, increasing access to care and improving health outcomes for people living with HIV, reducing HIV-related disparities and health inequities and achieving a more coordinated national response to the HIV epidemic

b) EUROPEAN UNION

The geographical scope of the action Plan on HIV/AIDS in the EU and neighbouring countries: 2014-2016 includes EU Member States, EEA/EFTA countries and neighbouring countries, namely the EU Enlargement countries, the European Neighbourhood Policy (ENP) countries, in particular the Eastern ones bordering the EU, as well as the Russian Federation. The overall objectives of the Commission is to contribute to reducing new HIV infections across all European countries, to improve access to prevention, treatment, care and support and improving the quality of life of people living with, affected by or most vulnerable to HIV/AIDS in the European Union and neighbouring countries.

Operational action plans are structured in six key issue areas: Politics, policies and involvement of civil society, wider society and stakeholders, Targeted and combination prevention and treatment, Priority regions and settings, Priority groups, improving knowledge by promoting research for the development of new or better

prevention, diagnostic and treatment solutions for HIV, co-infections and co-morbidity and regular Monitoring and evaluation.

c) SOUTH AFRICA

The South African National Strategic Plan on HIV, STIs and TB 2012-2016 is a framework to guide the activities of all partners whose work is relevant to HIV, sexually transmitted infections (STIs) and TB in South Africa. It provides goals and strategies for the country's response to the three diseases during the period 2012 to 2016. The NSP will guide the development of provincial strategic implementation plans, as well as sector implementation plans. The NSP vision is based on a 20-year vision for reversing the burden of disease from HIV, STIs and TB in South Africa. It includes zero new HIV and TB infections; zero new infections due to HIV transmission from mother to child; zero preventable deaths from HIV and TB; and zero discrimination associated with HIV, STIs and TB.

The NSP has five specific goals: reducing the number of new HIV infections by half; to ensure that at least 80% of people who are eligible for treatment for HIV are receiving it. (At least 70% should be alive and still on treatment after five years); halve the number of new TB infections and deaths from TB; to ensure that the rights of people living with HIV are protected; and halve stigma related to HIV and TB.

The NSP has identified a number of strategic objectives that will help South Africa to reach these goals. These are: to address social and structural factors that drive these epidemics that influence their impact, and that affect the way we care for affected people, to prevent new HIV, STIs and TB infections through a combination of interventions, to sustain health and wellness, primarily by reducing deaths and disability from HIV, AIDS and TB and to protect human rights of people living with HIV and improve their access to justice.

The guiding principles that will underpin the revised structures will include: Access to relevant information; 'Bottom-up' governance; Accountability and responsibility; Reporting; Transparency; and Meaningful involvement of people living with HIV and TB.

The NSP has identified four core strategic enablers for effective implementation: Effective and transparent governance and institutional arrangements; Effective communication; Monitoring, evaluation and research.

d) UGANDA

The goal of the National HIV prevention strategy for Uganda 2011-13 is to reduce new HIV infections countrywide by 30% based on the 2009 levels, which will achieve a 40% reduction of the projected new HIV infections in 2015. The strategy has specific goals that new HIV infections be reduced by 30% of the 2009 levels to achieve a 40% reduction of the projected new infections in 2015, PMTCT Rate Reduced to less than 10% by 2015 and 180,000 new HIV infections averted over 5 years. The expected outcomes are to increase coverage and utilization of HIV prevention services, increased adoption of safer sexual behaviour and reduced risky behaviours; a strengthened and sustainable enabling environment that mitigates underlying factors that drive the HIV epidemic; achieving a more coordinated HIV prevention response at all levels; strengthening information systems for HIV prevention.

The strategies and priority action includes: Increased coverage and utilization of HIV prevention services; Increased adoption of safer sexual behaviour and reduced risky behaviours; a strengthened and sustainable enabling environment that mitigates underlying factors that drive the HIV epidemic; achieving a more coordinated HIV prevention response at all levels and strengthened information systems for HIV prevention.

Monitoring and periodic evaluation of HIV prevention initiatives in this strategy will be essential to maintain an informed and strategically guided response. Progress in meeting the goals of the strategy will be reported on annually by the Uganda ADS Commission. Enhanced Monitoring and Evaluation will be necessary to ensure that HIV prevention efforts are aligned to the drivers of the epidemic based on effective approaches, and are on course to meet the targets set in the strategy.

e) JAMAICA

The vision statement of the national HIV/AIDS policy Jamaica may 2005 is to protect the rights of all Jamaicans including those infected with and affected by HIV/AIDS and to create an enabling environment free of stigma and discrimination and providing access to prevention knowledge and skills; treatment care and support and other services.

The specific objective includes: To reduce the number of new HIV infections through the establishment of a supportive policy/legislative environment that: To strengthen mechanisms for the treatment, care and support of persons living with and affected by HIV/AIDS through a policy and legal framework and enabling environment that: To mitigate the socio-economic impact of HIV/AIDS on individuals, families, communities and the nation through a policy and legal framework that: To foster enabling policy regulatory and legislative environment around HIV/ AIDS issues including strengthening and sustaining a comprehensive, multi sectoral response: To affirm the rights of persons living with and affected by HIV/AIDS and the rights of those most vulnerable to HIV/AIDS through an environment that

The Guiding Principle includes: Political Leadership and Commitment; Good Governance, Transparency and Accountability; Multisectoral Approach and Partnerships; Participation; Equity; Promotion and Protection of Human Rights.

The national AIDS policy Implementation plan includes: Management and Coordination; National HIV Research Agenda; Rights and Responsibilities of Stakeholders; Monitoring, Evaluation & Review of the Policy and moreover the national HIV/AIDS Policy shall be reviewed every five years and the goal and strategies will be reviewed to ensure relevance to the national HIV/AIDS situation.

The HIV/AIDS policy and implementation plan of action includes: That all organisations/workplaces have at least designated a focal point on HIV/AIDS with a working committee representing management and employees and a PLWHA. That all organisations/workplaces have a policy framework – guidelines or a full policy such as the National HIV/AIDS Policy, the National HIV/AIDS Workplace Policy, a

Sector Policy on HIV/AIDS or an adaptation. All organisation and workplace monitor and evaluate the HIV/AIDS policies and programme implementation. Proper follow up of non-discrimination, prevention, training and Care and support services.

f) THAILAND

The vision of Thailand National AIDS Strategy 2012-2016 is: To get to Zero New HIV Infections; to get to Zero AIDS-related Deaths; to get to Zero Stigma and Discrimination. The strategic goal includes: that new HIV infections be reduced by two-thirds; rate of vertical transmission of HIV less than 2%; Equal access to quality treatment, care, support and social protection for all people affected by HIV; AIDS related deaths reduced by half ; TB deaths among people living with HIV reduced by half; All laws and policies which obstruct equal access to prevention, treatment and care services are revised; Human Rights and gender specific needs are addressed in all HIV responses; Stigma and discrimination of PLHIV and key affected populations reduced by half

The national Strategic Direction includes: Innovation and Change; by expanding rights based and gender sensitive comprehensive prevention services for populations with risk behaviour with highest number of HIV infections; the protection of social and legal environment; Creating a sense of ownership at the local level in the expansion of prevention and control of AIDS; implement a new generation of strategic information to inform and guide the national response at all levels and to harmonize and optimize interventions and programs focusing on.

Optimization and consolidation strategy will includes: Prevention of Mother to Child Transmission (PMTCT); Prevention among Young People; Condom Programming; Blood Safety and Universal Precaution; Treatment, Care and Support ; Care and Support for Children Affected by AIDS; Stigma and Discrimination; Public Communication

g) CAMBODA

The guiding principles of the national strategic plan for comprehensive & multi-sectoral response to HIV/AIDS III (2011-2015) includes: Universal Access; Evidence based and cost-effective; Greater Involvement of People Living with or affected by HIV and AIDS (GIPA); Rights-based; Gender –equitable; Multisectoral; Linked to poverty and overall development planning.

The national strategic goals includes: To reduce the number of new HIV infections through scaled targeted prevention; To increase care and support to people living with and affected by HIV and AIDS and to alleviate the socioeconomic and human impact of AIDS on the individual, family, community and society.

The Specific Objectives and Interventions, by Strategies are: To increase coverage, quality and effectiveness of prevention interventions; to increase coverage and quality of comprehensive and integrated treatment, care and support services addressing the needs of a concentrated epidemic; to increase coverage, quality and effectiveness of interventions to mitigate the impact of HIV and AIDS; to ensure effective leadership and management by government and other actors for implementation of the national response to HIV and AIDS, at national and sub-national levels; ensure a supportive legal and public policy environment for the national response to HIV and AIDS; to ensure availability and use of strategic information for decision-making through monitoring, evaluation and research and to ensure sustained, predictable financing and cost-effective resource allocation for the national response.

h) CHINA

The guiding principles of China's National Medium-and Long-Term Strategic Plan for HIV/AIDS Prevention and Control is to slow down the HIV/AIDS epidemic through substantiated prevention and control efforts and help to achieve the goal of national socio-economic development; to implement the strategies and measures, Strengthen leadership, enhance coordination among sectors and mobilize all the entire society. Implementation of a comprehensive approach, scientific research and international cooperation is actively encouraged; to strengthen health education,

behavioural change and Standardize STD management; and all the prevention and control work must take the local situation and realities into consideration.

In March, 2006, the State Council of the People's Republic of China officially announced the first legislation directly aimed at controlling HIV/AIDS: the AIDS Prevention and Control Regulations. These regulations, together with the Five-Year Action Plan to Control HIV/AIDS (2006–2010), are an important step in the development of government policy related to the care and prevention of HIV/AIDS.

The Chinese government “Four Free and One Care” policy for AIDS control includes: Free antiretroviral drugs to AIDS patients who are rural residents or people without insurance living in urban areas; Free voluntary counselling and testing; Free drugs to HIV-infected pregnant women to prevent mother-to-child transmission, and HIV testing of newborn babies; Free schooling for AIDS orphans and Care and economic assistance to the households of people living with HIV/AIDS.

i) HONGKONG

The vision of HIV/AIDS Strategies for Hong Kong 2012-2016 is Zero new HIV infections, zero discrimination, and zero AIDS-related deaths.

The guiding principles are: Diversified approaches are to be combined strategically based on latest evidence with regard to epidemiology, research findings and programme response to actively address the heterogeneous and evolving needs of communities at higher risk of HIV infection; Available resources are to be targeted to reduce those risk behaviours and underlying vulnerabilities of priority communities which can bring down new HIV infections; Priority areas for action are widely shared, owned and regularly reviewed by stakeholders; Services that reach marginalized communities are sensitive to their human rights; Effective responses are made sustainable, brought to scale, and are flexible enough to make continuous improvement as the situation evolves; Policies and programmes are coordinated among agencies, optimized to engage and empower community members, and guided by strategic information; The environment is conducive to universal access of HIV prevention, treatment, care and support, especially by the communities most

vulnerable to HIV infection and Monitoring and evaluation forms an integral part of the local AIDS programme.

The specific goal is to sustain the reduction of new HIV/AIDS patients and ensure universal access to quality and non-discriminatory prevention, treatment, care and support services. The objectives are: to empower communities most affected by HIV to reduce their risk behaviours and underlying vulnerabilities; to ensure sustainable resources and adequate numbers of trained personnel for provision of quality and non-discriminatory services and to move towards an increasingly results-based implementation of prevention, treatment, care and support services. The strategies spell out priority areas for action which includes: scaling up HIV prevention in priority communities; maintaining holistic and quality HIV treatment, care and support; Foster an environment which supports safer sex, harm reduction and anti-discrimination; Drive strategically informed and accountable interventions and enhance partnership and capacity for an effective response within Hong Kong and the nearby region.

j) AUSTRALIA

The vision of Australia HIV strategy 2012-15 is to work towards the virtual Elimination of HIV Transmission in NSW By 2020.

The goals and Targets by 2015 includes: to reduce the transmission of HIV among gay and other homosexually active men by 60%, and by 80% by 2020; Reduce heterosexual transmission of HIV and transmission of HIV among Aboriginal populations by 50%; Sustain the virtual elimination of mother-to-child HIV transmission; Sustain the virtual elimination of HIV transmission in the sex industry; Sustain the virtual elimination of HIV transmission among people who inject drugs; Reduce the average time between HIV infection and diagnosis from 4 ½ years to 1 ½ years; Increase to 90% the proportion of people living with HIV on antiretroviral treatment and Sustain the virtual elimination of HIV related deaths.

The strategies set out priority areas for action: Maintain high levels of safe behaviours; Intensify HIV prevention with priority populations; Improve access to the

needle and syringe program; Promote HIV testing; make it easier to have an HIV test; Promote treatment uptake, make access to treatment easy; Provide treatment, care and support services in the community; Improve the health and well-being of people living with HIV; Continue to invest in surveillance and research to inform the response. The strategy also identified priority populations such as people living with HIV; Gay and other homosexually active men;_Aboriginal people; Sex workers; People who inject drugs; People from culturally and linguistically diverse backgrounds. The strategy is guided by the following principles Partnership, Bipartisanship, Greater involvement of PLHA and Harm Minimization.

V. Indian context

The National AIDS Control Program in India was prepared by the Ministry of Health and family welfare, Government of India under the aegis of National AIDS Control Organisation (NACO). During the span of time it has undergone several changes since its inception in the year 1992. The 1st NACP was initially designed for five year 1992-1997 but due to various difficulties in program, planning and implementation it was extended for another two years till 1999 when the 2nd NACP finally rolls out. The main focus of the 1st NACP was mass campaign on awareness. Likewise the 2nd NACP was also designed for five years 1999-2004 and it has undergone dramatic changes focusing on prevention intervention among targeted populations, institutional strengthening and inter sectoral collaboration. The 2nd NACP was also extended initially for two years till 2006 and was further again extended for one more year till 2007. Finally the 3rd NACP rolls out for another five years 2007-2012 with the main focus of halting and reversing the HIV/AIDS epidemic in India by the year 2012 following the strategy of unified three ones, one Agreed Action Framework, one National HIV/AIDS Coordinating Authority and one agreed National M&E System. The National AIDS Control Program Phase- IV (2002-2017) aims to accelerate the process of reversal and further strengthen the epidemic response in India through a cautious and well defined integration process over the next five years. It continues to give emphasis on Unified three ones with additionally focusing on Quality, Innovation and Integration, partnership with comprehensive care, support and

treatment. NACP IV being a very ambitious project, it didn't really take off until writing of this thesis though.

a) National AIDS Control Program – Phase I {(1992 – 1997)-1999}

In order to combat HIV/AIDS epidemic effectively, the Government of India established National AIDS Control Organization (NACO) in 1992. Although the 1st phase of the National AIDS Control Program was for five years, due to slow implementation in the initial period it was extended to March, 1999. The National AIDS control program phase 1 was funded by World Bank and a strong WHO Global Program on AIDS (GPA) support. The ultimate objective of the project was to slow the spread of HIV to reduce future morbidity, mortality, and the impact of AIDS by initiating and establishing a comprehensive multisectoral program.

The various components of the first phase were (a) Program management (b) Intersectoral collaboration (c) HIV and AIDS surveillance (d) Targeted interventions among high risk groups (e) Condom Programming (f) Sexually Transmitted Disease (STD) Program (g) Blood safety program (h) Information, education and communication (I.E.C) (i) Impact reduction

Awareness levels that were almost insignificant have increased to about 70-80% in urban areas even though the level of awareness in rural areas remains low at about 30%; Modernization and strengthening of blood banks; introduction of licensing system of blood banks and gradual phasing out of professional blood donors; and availability of good quality condoms through social marketing has made a significant increase in its use.

Despite the overwhelming rise in the awareness level of the people about HIV and AIDS it resulted in creating a fear psychosis about the virus. The experience of the past five years (1992-1997) revealed that IEC has miserably failed to meet the objectives spelt out. It can be alleged that no substantial effort has been made to reach to the general population to raise awareness, knowledge and understanding of HIV and AIDS issues even when many of the medical and paramedical staff are ignorant about the basic facts of HIV and AIDS. The impact of HIV and AIDS due to lack of

proper planning and implementation of the program and lack of professionalism in it heightened the level of stigma already attached to it.

b) The National AIDS Control Program – Phase – II [(1999-2004)-2006]-07]

The National AIDS control program phase 2 was sanctioned initially for 5 years (1999-2004) but was extended for two years (1999-2006) and was again extended till 2007 when the third phase finally took off. In November 1999, the second National AIDS Control Project (NACP) was launched with World Bank credit support of USD 191 million. Based on the experience gained in Tamil Nadu and a few other states along with the evolving trends of the HIV/AIDS epidemic, the focus shifted from raising awareness to changing behaviour, decentralization of program implementation at the state level and greater involvement of NGOs. The policy and strategic shift was reflected in the two key objectives of NACP II. Reducing the spread of HIV infection in India, Increasing India's capacity to respond to HIV/AIDS on a long-term basis, Achieving condom use of not less than 90% among high risk categories like commercial sex workers, truck drivers etc., and Achieving awareness level of not less than 90% among the youth and others in the reproductive age groups, Reducing blood borne diseases and transmission of HIV to less than 1% of total transmission. It supports decentralization of service delivery to the States and Municipalities and a new facilitating role for National AIDS Control Organization. Program delivery was more flexible, evidence-based and participatory to rely on local Program implementation plans. Protection of human rights by encouraging voluntary counselling and testing and discouraging mandatory testing would be a priority; it also supports structural and evidence-based annual reviews and ongoing operational research; and also encourage management reforms, such as better managed State level AIDS Control Societies and improved drug and equipment procurement practices.

Various components of NACP phase – ii includes: Prioritizing targeted interventions for populations at high risk group; Preventive interventions for the general population; Low Cost care and support for people living with HIV/AIDS; Institutional strengthening and Inter-sectoral collaboration.

While the success of NACP II could not be undermined but there are complexities to be understood. There are complexities of the epidemic and its exact dimensions which have to be understood especially in the Northern and North Eastern states of the country. There is a frequent change of Project Directors (PDs) of State AIDS Control Societies (SACS) and other senior program managers at the state level which weakened the thrust and focus of interventions. In some highly vulnerable States, Project Directors were either saddled with additional non-HIV responsibilities or given SACS charge as additional responsibility. A large number of functional positions in the SACS remained vacant. These factors contributed to an uneven implementation of the program.

Notwithstanding a significant step-up of the overall resource availability for HIV/AIDS program, India's per capita financial investment on HIV prevention, control, care and support remains one of the lowest in the world. To scale up activities and interventions in prevention, care and treatment, a much higher level of investment is required.

The experience of NACP-I and NACP-II, consultations, studies and assessments led to a consensus on the goal, objectives and strategies for NACP-III adhering to the larger Millennium development goal.

c) The National AIDS Control Program Phase- III (2007-2012)

The overall goal of NACP-III is to halt and reverse the epidemic in India over the next 5 years by integrating programs for prevention, care, support and treatment. This will be achieved through a four-pronged strategy: Prevention of new infections in high risk groups and general population through: Saturation of coverage of high risk groups with targeted interventions (TIs), Scaled up interventions in the general population, Providing greater care, support and treatment to larger number of PLHA, Strengthening the infrastructure, systems and human resources in prevention, care, support and treatment program at the district, state and national level and Strengthening the nationwide Strategic Information Management System.

The specific objective is to reduce new infection as estimated in the first year of the program by: Sixty per cent (60%) in high prevalence states so as to obtain the reversal of the epidemic; and Forty per cent (40%) in the vulnerable states so as to stabilize the epidemic.

The goal, objectives and strategies of NACP-III will be informed by the following guiding principles: The unifying credo of Three Ones, i.e., one Agreed Action Framework, one National HIV/AIDS Coordinating Authority and one agreed National M&E System.

NACP-III would evolve mechanisms to be put in place at all levels to address issues related to human rights and ethics. Particular focus would be on the fundamental rights of PLHA and their active involvement as important partners in prevention, care, support and treatment initiatives. Civil society representation and participation in planning and implementation of NACP-III would receive priority since it is essential for promoting social ownership and community involvement. Creation of an enabling environment wherein those infected and affected by HIV could lead a life of dignity. This will be the corner-stone of all interventions. Stigma and discrimination associated with HIV/AIDS, which continues to pose a big challenge to policy planners and program implementers in prevention, care and treatment efforts will be aggressively addressed. Having regard to the spirit behind “universal access”, NACP-III will scale up efforts and activities for providing HIV prevention, care, support, and treatment services. For making the implementation mechanism more responsive, proactive and dynamic, the HRD strategy of NACO and SACS will be based on qualification, competence, commitment and continuity. Strategic and program interventions will be evidence-based and result-oriented with scope for innovations and flexibility. Priority will be accorded to specific local contexts.

NACP-III seeks to learn from the lessons of the previous two phases of program implementation and build on the strengths thereof. Its priorities and thrust areas have been drawn up accordingly and include the following:

Considering that more than 99% of the population in the country is free from infection, NACP-III will place the highest priority on preventive efforts to all types of population while, at the same time, seeking to integrate prevention with care, support and treatment. Prevention needs of children will be addressed through universal provision of PPTCT services. Children who are infected will be assured access to paediatric ART. It will also make efforts to address the needs of persons infected and affected by HIV, especially children. It will invest in community care centres to provide psycho-social support, outreach services, referrals and palliative care. It will work with other agencies involved in vulnerability reduction such as women's groups, youth groups, trade unions etc. to integrate HIV prevention into their activities. Mainstreaming and partnerships will be the key approach to facilitate multi-sectoral response engaging a wide range of stakeholders. Private sector, civil society organizations, PLHA networks and government departments would all play crucial role in prevention, care, support, treatment and service delivery. Technical and financial resources of the development partners will be leveraged to achieve the objectives of the program.

d) The National AIDS Control Program Phase- IV (2012-2017)

The aim of NACP IV is to accelerate the process of reversal and further strengthen the epidemic response in India through a cautious and well defined integration process over the next five years.

The goal is to accelerate reversal and integrate response. The objectives are: to reduce new infections by 50% (2007 Baseline of NACP III); to provide comprehensive care and support to all persons living with HIV/AIDS and treatment services for all those who require it.

The key strategies includes: Intensifying and consolidating prevention services, with a focus on HRGs and vulnerable population; Increasing access and promoting comprehensive care, support and treatment; Expanding IEC services for (a) general population and (b) high risk groups with a focus on behaviour change and demand

generation; Building capacities at national, state, district and facility levels and Strengthening Strategic Information Management Systems.

The Guiding principles for NACP- IV will continue to be: Continued emphasis on three ones - one Agreed Action Framework, one National HIV/AIDS Coordinating Authority and one Agreed National M&E System; Equity; Gender; Respect for the rights of the PLHIV; Civil society representation and participation; Improved public private partnerships; Evidence based and result oriented programme implementation.

The Cross-cutting Areas of Focus will be on Quality, Innovation, Integration, Leveraging Partnerships, Stigma and Discrimination. Key priorities under NACP- IV are: Preventing new infections by sustaining the reach of current interventions and effectively addressing emerging epidemics; Prevention of Parent to Child transmission; Focusing on IEC strategies for behaviour change in HRG, awareness among general population and demand generation for HIV services; Providing comprehensive care, support and treatment to eligible PLHIV; Reducing stigma and discrimination through Greater involvement of PLHA (GIPA); De-centralizing rollout of services including technical support; Ensuring effective use of strategic information at all levels of programme; Building capacities of NGO and civil society partners especially in states with emerging epidemics; Integrating HIV services with health systems in a phased manner; Mainstreaming of HIV/ AIDS activities with all key central/state level Ministries/ departments will be given a high priority and resources of the respective departments will be leveraged. Social protection and insurance mechanisms for PLHIV will be strengthened.

Some New Initiatives under NACP-IV includes: Differential strategies for districts based on data triangulation with due weightage to vulnerabilities; Scale up of programmes to target key vulnerabilities a. Scale up of Opioid Substitution Therapy (OST) for IDUs b. Scale up and strengthening of Migrant Interventions at Source, Transit & Destinations including roll out of Migrant Tracking System for effective outreach c. Establishment and scale up of interventions for Transgenders (TGs) by bringing in community participation and focused strategies to address their vulnerabilities d. Employer-Led Model for addressing vulnerabilities among migrant

labour e. Female Condom Programme; Scale up of Multi-Drug Regimen for Prevention of Parent to Child Transmission (PPTCT) in keeping with international protocols; Social protection for marginalised populations through mainstreaming and earmarking budgets for HIV among concerned government departments; Establishment of Metro Blood Banks and Plasma Fractionation Centre; Launch of Third Line ART and scale up of first and second Line ART and Demand promotion strategies specially using mid-media, e.g., National Folk Media Campaign & Red Ribbon Express and buses [in convergence with the National Rural Health Mission(NRHM

VI. North East Level

The North Eastern Region, comprising the seven States of Assam, Arunachal Pradesh, Manipur, Meghalaya, Mizoram, Nagaland and Tripura, is an extensive area, (about 7.8% of India's land area) with 3.7% of total population. It is strategically located, bound by Chinese occupied Tibet and Bhutan to the North and West, Myanmar to the East and Bangladesh to the West and South, connected to mainland India by a narrow corridor in North Bengal. Specifically, the States of Mizoram, Manipur, Nagaland and Arunachal Pradesh share long borders with Myanmar to the East, across hilly, forested, thinly populated terrain. This critical location has had major implications for HIV/AIDS problem in the North Eastern Region.

HIV surveillance was initiated first at Guwahati Medical College and thereafter at Regional Medical College, Imphal, and other places in 1986. Beginning with the first case of HIV detected in Manipur, there has been a steep rise in number of cases detected and prevalence of HIV among specific risk groups in certain States of the Region. The startling escalation in number of HIV cases led to the discovery of IV drug abuse as the chief cause of the HIV problem in the Region.

One high HIV prevalence states Nagaland and low prevalence state of Assam has been included in the selection for policy discussion.

The Assam State HIV/AIDS Prevention and Control Policy aims to halt and reverse the AIDS epidemic in the State to zero transmission rate and to reduce the impact of

the epidemic at all levels of general population. The specific objectives of the policy are: To reiterate strongly the Government's firm commitment to prevent the spread of HIV infection and to reduce personal and social impact; To ensure right to privacy and confidentiality of people living with HIV/AIDS (PLHA); To ensure an environment free of discrimination for people living with HIV/AIDS and protection of human rights, including right to access healthcare system both at the government and private sectors; To ensure prevention of hospital acquired infections for a safe environment; To ensure information, treatment and support to the people under care and custody of the State; To strengthen safe blood transfusion system both at the Government and private institutions; To mainstream AIDS Prevention and Control Programme with partnership development; To ensure HIV/AIDS related information, education and communication (IEC) at all levels; To promote strategies for risk reduction from drug addiction and unsafe sex; To prevent women, children and other socially weaker groups from becoming vulnerable to HIV infection by improving health education, legal status and economic empowerment; To promote mapping and surveillance for adequate intervention and estimation of the burden of infection in the State; To promote proper Monitoring and Evaluation system and to ensure accountability; To develop appropriate legal framework.

The state of Assam has been included as it is highly vulnerable state for HIV transmission because of the following reasons: It is the gate-way of North-eastern states; It is surrounded by two high prevalence states of Manipur and Nagaland; Large number of female migrants from other north-eastern states, West Bengal, Nepal who has come to Assam for Employment and has taken to sex work; High-prevalence of other Sexual Transmitted Infections, stigma and social discrimination, inequity, high prevalence of risky sexual behavior among young people, existence of mobile and hidden nature of female sex workers, drug abuse, injecting drug use, illegal drug trafficking, etc are also responsible for increased vulnerability of the state.

Nagaland as per 2014 Sentinel Surveillance Report has recorded the highest prevalence of HIV & AIDS in the country with an alarming ratio of 0.88 per cent against country's figure stands at 0.37 per cent. The state has 10 'A' category districts. It has now been 17 years since the first HIV/AIDS positive case was

detected in the year 1990 amongst the IDUs by ICMR. The programme is implemented through Nagaland State AIDS Control Society headed by Project Director and 3 Deputy Directors and other supporting officers and staff totaling 60, with the launching of NACP III, There are 14 NGO doing Targeted Intervention Programme in the State.

The goal is to halt and reverse the HIV/AIDS epidemic. The objectives include: Prevention of new infection in the high risk groups and general population through; Saturation of coverage of high risk groups with targeted intervention (TIs); Scaled up intervention in general population; Providing greater care and support and treatment to the large number of people living with HIV / AIDS; Strengthening the infrastructure, system and human resource in prevention, care, support, & treatment programmes at the district, state and National level; Strengthening a nation – wide Strategic Information Management System.

Over the years the trend of epidemic has moved from high risk behavioral group to general population and from urban to rural areas. Sexual routes of transmission have taken predominance with 78.73% followed by infected needles and syringes with 12.21 %.

Surveillance report shows that the most vulnerable population is in the age group between 15-29 years.

State AIDS Council: State AIDS Council has been formed with Chief Minister as the Chairman. Nagaland Legislative Forum Secretariat has been established with a consultant. 58 Legislatures have contributed Rs. 50,000/- (Rupees Fifty Thousand) each from Local Area Development Plan fund (LAPDF) for Nagaland Legislative Forum activities.

Eleven DACPUs have been formed which will operate within the District Health Society sharing the administrative health financial structure of NRHM and will implement the programme at district level.

VII. Manipur

As the first few cases of HIV infection of the country were reported in 1986, the Manipur State Government also took serious note of the problem and initiated a series of important measures to tackle the epidemic. The first HIV/AIDS cases in Manipur were detected in 1989 from a blood sample collected from among IDU's in 1988. With the formation of the high-powered National AIDS Committee in 1986, Government of India launched National AIDS Control Program in 1987. In the year 1989 with the support of WHO, many other activities were initiated which were mainly focused on the reinforcement of program management capacities as well as targeted IEC and Surveillance activities. Actual preventive activities like implementation of IDU focused prevention intervention, education and awareness program, blood safety measures, control of hospital infection, condom promotion to prevent HIV/AIDS, strengthening of clinical services for both STD and HIV/AIDS gained momentum only in 1992.

Commitment of the state for development with other key societal actors being willing participant (i.e. political settlement is committed to development) for HIV/AIDS mitigation. Capacity of the state to implement policies effectively and this capacity being determined by other constituent capacities like the Institutional, technical and political. State AIDS Cells were created in Manipur for effective implementation and management of National AIDS Control Program. In 1996 the Manipur State AIDS Cell (MSACS) became Manipur State AIDS Control Society registered under Societies Act and it became an autonomous body with objectives of reducing the spread of HIV infection in the state and to increase the state capacity to deal with the epidemic in the long term. Most of the programmes launched in the field of HIV/AIDS are with the help of MSAC, NACO and NGOs. The external agencies gave more emphasis on Prevention with minimum attention on treatment, care and support.

For combating the menace of HIV/AIDS in Manipur, Manipur State AIDS Policy 1996 was launched with following objectives: a) to prevent the spread of HIV infection, both at the community at large and in the health care environment. b) To promote better understanding of HIV infection in order to protect and support those who are at risk of or vulnerable to infection. c) To ensure that treatment and support services both for those infected with HIV and for their family are easily available and accessible. d) To ensure that services are efficient, effective and evaluated. e) To mobilize and unify intersectoral action, community initiatives and NGO/CBO support network for better co-operation among the participating agencies against AIDS.

The State AIDS Policy has policies on various dimensions such as a) Policies on Information Education and Communication, b) Policy on school AIDS education. C) Policy on Blood Safety, d) Policy On Medical Care, e) Policy on Std And Reproductive Health, f) Policy On Drug Abuse Treatment Service, g) Policy On Hospital Infection Control, h) Policy On Intervention Measures, i) Policy On Employment, j) Policy On Antibody Testing, k) Policy on Confidentiality, l) Policy In The Prisons/Jails, m) Policy On Social Service Research, n) Policy On Non Discrimination Provision, o) Policy On Training And p) Policy On Appropriate Legal Framework. In order to facilitate speedy and proper implementation of the AIDS control programme, the State Government created appropriate bodies such as State AIDS Committee (SAC) with State Empowered Committee (SEC), and State Level AIDS Co-ordination Committee (SCC). It also created grass root infrastructure by creating District AIDS Committee (DAC). Despite all these efforts, the situation is getting worse.

3. Statement of the problem

The growing menace created by the HIV and AIDS (human immunodeficiency virus/acquired immunodeficiency syndrome) has alarmed not only the public health officials but also the general community. HIV and AIDS are more than a health problem and its impact reaches far beyond the health sector with severe economic and

social consequences. HIV and AIDS affect individuals, families and communities at the micro-level whereas it equally affects the various sectors of the economy at the macro-level.

Attention must be paid to HIV/AIDS related activities as part of overall development policy. It is essential to have impact on the factors that sustain the HIV epidemic and contribute to its progress and to integrate the social and health policy goals and resource requirement that the epidemic calls for more clearly into development policy. Factors that give rise to the epidemic accelerate its spread and makes its effect worse like lack of institutional capacity, poverty, low level of education, social inequality, conflicts, discrimination, gender inequality and both sex trade and sexual violence. HIV/AIDS has its widespread effects on society, culture, individuals and families.

Worldwide, most of those infected by HIV/AIDS are working men and women, the mainstay of families, communities, enterprises and economies. The epidemic is changing the dynamics of the labour force -- experienced, skilled workers are dying, children are being forced to work and a greater burden is being placed on women. The traditional domestic and nurturing roles of women mean that they bear most of the burden of care. This not only adds to their workload but also undermines the vital productive, reproductive and community roles they play. According to UNDCP, 2002 Poverty contributes to the spread of HIV, and women make up 70% of the world's poor, reflecting their limited access to employment, property, credit and income.

According to Vijay P., et al., 2006²⁹ on their study on “The macroeconomic and sectoral Impact of HIV/AIDS in India: A CGE Analysis” sponsored by UNDP they use multisectoral, neo-classical type price-driven CGE model. The overall structure of the model is similar to the one presented in Arndt, C and Lewis, J. D. (2001). While they formulate the details of their model, they have taken an eclectic approach keeping in mind the institutional features peculiar to the Indian economy.

The model has five production sectors: agriculture, tourism, manufacturing, services and health care, and three factors of production : land, capital and composite labour, which in turn, is a nested constant elasticity of substitution (CES) aggregation of non-

educated (unskilled), secondary educated (semi-skilled) and higher educated (skilled) labour (CGE classification)

The five-sector CGE model of the Indian economy as described above is used to generate a ‘no-AIDS’ reference scenario and a ‘with-AIDS’ scenario for the 14-year period, 2002-03 to 2015-16, wherein a comparison of the latter with respect to the former yields an estimate of the macro-economic and sectoral impacts of the HIV epidemic in India. In the ‘with-AIDS’ scenario, the following impacts of AIDS on the key variables are found there is slower growth rate of population and supply of labour by the skill categories, resulting from the AIDS-related deaths, there is lower labor productivity of workers with HIV reflected in a lower effective labor input, there is a decline in sectoral growth rates, initially, i.e., from 2002-03 to 2011-12, to 0.8 times the ‘no-AIDS’ growth rate, and, finally, during the height of the epidemic, i.e., from 2012-13 to 2015-16, to 0.7 times the ‘no-AIDS’ growth rate, the share of health services spending of the HIV households increases by an additional 10 percent of total consumption expenditure, at the expense of other non-food expenditures, there is an increase in the health expenditure of the government by 10 percent from 2002-03 to 2011-12, and by 15 percent from 2012-13 to 2015-16. The growth rates of supplies of labour of all the three skill types decline in the ‘with-AIDS’ scenario. The decline is at maximum for the unskilled labour, followed by that of semi-skilled and skilled labour given in the table

Table 1.3: Macro-economic and sectoral impact of HIV/AIDS in India: A CGE analysis

	Average annual growth rates for 2002-03 to 2015-16 (in percent)		Diff. from ‘no-AIDS’ scenario in percentage points ‘with-AIDS’ scenario
	‘with-AIDS’ scenario	‘no-AIDS’ reference scenario	
Labour supply	1.70	2.01	-0.31
Unskilled labour	0.69	1.03	-0.34
Semi-skilled labour	3.18	3.49	-0.31
Skilled labour	4.46	4.68	-0.22
Wage rate (real)	5.07	5.17	-0.10
Unskilled labour	4.21	4.28	-0.07
Semi-skilled labour	3.82	3.86	-0.05
Skilled labour	3.60	3.63	-0.03
Real GDP	7.34	8.21	-0.86
Real GDP per capita	6.13	6.68	-0.55
Government saving (percent of GDP)	-2.26	-1.59	-0.67
Household saving (percent of GDP)	27.86	29.01	-1.15
Investment (percent of GDP)	27.95	29.11	-1.16

The increase in health expenditure of the households and the government results in a fall in their savings which then ultimately cut out the amount of investment. This fall in investment slow down the pace of growth, and, hence, labour demand to shrink. The fall in labour demand outstrips the AIDS-induced fall in labour supply in case of all the three skill types of labour, and all the wage rates, therefore, decline, though unequally (Table). The slowdown in economic growth is manifested in a decline in the growth of real aggregate GDP as well as in the growth of per capita GDP. The former decreased, on an average, by 0.86 percentage points, while the latter declined, on an average, by 0.55 percentage points in the 'with-AIDS' scenario compared to the 'no-AIDS' scenario. Hence, the survivors of the epidemic are not "indifferent" or "better-off". They are in fact "worse-off", as the lower per capita incomes shown in the Table below. Household income growth rates for the entire groups decline, though unequally. The decline in the household income growth rate is steepest for rural nonagricultural self employed, followed by that of rural agricultural labour, rural non-agricultural labour rural agricultural self employed and urban casual labour. These household groups are the ones which derive their incomes mainly from unskilled labour, which, among the three labour types, is affected most adversely by the HIV epidemic.

Dandona L, et al 2009, conducted composite economic analysis of HIV prevention interventions to inform efficient utilization of resources in India. They obtained output and economic cost data for the 2005-2006 fiscal year from a representative sample of 128 public-funded HIV prevention programmes of 14 types in Andhra Pradesh state of India. Using data from various sources and developed a model to estimate the number of HIV infections averted. They estimated the additional HIV infections that could be averted if each intervention reached optimal coverage and the associated cost. The results of the analysis show that in a year, 9688 HIV infections were averted by public-funded HIV prevention interventions in Andhra Pradesh. Scaling-up interventions to the optimal level would require US\$38.8 million annually, 2.8 times the US\$13.8 million economic cost in 2005-2006. This could increase the number of HIV infections averted by 2.4-fold, if with higher resources there were many-fold increases in the proportional allocation for programmes for migrant labourers, men

who have sex with men and voluntary counselling and testing, and reduction of the high proportion for mass media campaigns to one-third of the 2005-2006 proportion of resource utilization. If the proportions of resource allocation for interventions remained similar to 2005-2006, the higher resources would avert 54% of the additional avertable HIV infections. The analysis concludes that the recent four-fold increase in public funding for HIV/AIDS control in India should be adequate to scale-up HIV prevention interventions to an optimal level in Andhra Pradesh, but the prevention would be suboptimal if additional investments were not preferentially directed to some particular interventions

4. Limitations of the study

Most of the organization which was studied has a poor documentation reports, this compels the researcher to dig out information through primary sources. Due to constant general strikes most of the organisation couldn't functions their day to day activities according to their monthly plans. There was difficulty accessing the IDU's in such situation where police vigilance was high. Police was acting as moral guardians to the society. It is important to note that the outcome of the study may not be generalised everywhere in the state of Manipur as only a handful of beneficiaries (60) were interviewed. Collecting primary data was a little different and difficult. Contacting and eliciting information from HIV +ve people and most of them drug users was an uphill task. Often under sedation, they were unable to respond, necessitating repeat question. Similarly, collecting information from the politicians was also not free from problems. In the first instance few of them were unwilling to sit for interview. Following considerable persuasion they would be cooperative but will not allow the interview to go on for long, this in turn gave hurdle in analysis to understand actual commitment.

The present study considered only those NGO which are in active for the last five years and having a good track record in HIV/AIDS mitigation. During the course only twelve (12) organisations were selected and the outcome cannot be generalised for the whole Manipur or elsewhere in India. There was difficulty in accessing Assembly proceedings report as the said document was available only up to the year 2010

though Assembly sitting was continuously held up to date. Content analysis of the said report has been done only up to 2010 as government records were not available.

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