

CHAPTER – I

INTRODUCTION: CONCEPTUAL DISCUSSION

Chapter One

1.1 Introduction:

Although Man has made many breakthrough in safeguarding the health of mankind through many successful research, discoveries, inventions and eradication, there are many of the life threatening diseases like plague, cholera, polio mellitus and others, Yet, the HIV has become a major health hazard and a challenge to the modern civilized human world for the past over two decades. All our efforts have been made worldwide to prevent, and treat the onslaught of HIV on the mankind.

HIV/AIDS has quickly emerged as one of the most serious public health problems in the country with infections currently being reported in all states and territories. As we all know that HIV cannot be treated but the spread of it can be prevented. Yet, the numbers of new cases are ever on the increase, not only in few countries or in particular class/group of people, but in the general population worldwide. The WHO and the UNICEF(2005) reports do reveal that 8.8 billion population in the world are infected by HIV and among them 2.2 billion are women, and 15 per cent of the sufferers are children below the age of 14 years.

India has the largest number of people living with HIV/AIDS in Asia. Globally, it is second only to south African in terms of the overall number of people living with the disease. The highest HIV prevalence rates are found in Maharashtra, in the West Andhra Pradesh and Karnataka in the South, and Manipur and Nagaland in the North-East. (HIV/AIDS epidemiological Surveillance and Estimation report for a year 2005, NACO, April 2006).The first case of AIDS in India was detected in 1986. According to UNAIDS, estimates of 2001, 3.97 million Indians were HIV positive. However, due to the country's large population, the high

number of infections translates into a relatively low adult prevalence of 0.8 per cent. One per cent increase in prevalence could add 5 million new infections. Health officials concede that these estimates represent only a fraction of total AIDS morbidity in India. Some experts believe that the number of individuals infected with HIV/AIDS in India is actually much higher.

Globally, there were estimated 33million people infected with HIV in 2007 with 2.7 million new infections and 2 million HIV related deaths. (2008 UNAIDS Global Epidemic Update).

Table 1.1 Global Summary of the AIDS epidemic:

Number of people living with HIV in 2008	
Total	33.4 million(31.1million-35.8million)
Adults	31.3 million(29.2 million-33.7 million)
Women	15.7 million(14.2 million-17.2 million)
Children under 15 years	2.1 million(1.2 million-2.9 million)
People newly infected with HIV in 2008	
Total	2.7 million(2.4 million-3.0 million)
Adults	2.3 million(2.0 million-2.5 million)
Children under 15 years	430000(240000-610000)
AIDS related deaths in 2008	
Total	2.0 million (1.7 million- 2.4million)
Adults	1.7 million(1.4 million- 2.1 million)
Children under 15 years	280000(150000-410000)

(Source: UNAIDS Report, Dec-2008)

1.2 Beginnings of HIV/AIDS:

No one knows for certain how AIDS, or HIV, first began. From the very start of the epidemic, there has been considerable speculation about where the disease, and the viruses.

The deathly virus called HIV (Human Immune Deficiency Virus) which causes the disease AIDS was not before 25 years ago. AIDS caused by Virus and known as HIV was discovered first by an American Scientist (Virologist) of National Institute of Health, Bethesda USA, Dr. Robert Gallo.

The discovery of Robert made it possible to study the new virus in details. Effort of other Virologists and Nuclear Biologists like Max Essex and William Huggins as well as scientist in several other countries, helped in identifying the cause of this new disease. Viruses are basically parasites. It simply attack and finishes off the bodies control defence system itself i.e. immune system. Scientist are speculating that the ancestors of AIDS virus has been living in the African green monkeys which is found in Zaire and neighbouring countries in Africa have been found to be infected by the virus which could be as long as 5000 years. Some Zairian are known to kill the monkeys and eat or a bit from green Monkey. These activities could have brought AIDS- infected monkey blood in contact with human blood. Sudden appearance of the AIDS epidemic may be explained by either the mutation of an already existing virus or an old virus lying in dormant state and by increase in travelling, extensive migration of population due to civil war in Zaire, increased sexual mixing with the influx of population in large cities.

After the AIDS phenomenon manifested itself in America, Scientist who had some foreign sample of blood drawn from the Uganda in 1972 on an impulse tested them for AIDS. A big percentage is the mere positive.

Experts say that it is a sexually transmitted disease (STD) and therefore it finds its origin in human sex. Research results on this

available so far were not able to provide any accurate information as to how this disease finds its origin in human sexual activities .The reliable information available is that AIDS is caused by a virus called Human-Immune –Deficiency Syndrome, a virus which kills or impairs cells in the immune system, destroying the body’s ability to fight infections and cancers. The virus is transmitted horizontally and vertically. “Horizontally” transmission occurs during heterosexual intercourse and between men who have sex with men (MSM) when no barrier method (i.e.condom) is used during intercourse with an HIV infected person. It is also transmitted between injecting drug Users (IDU) from sharing infected needles.”Vertical” transmission occurs between mothers and their children during or after pregnancy.

According to Dr.Jonathan Mann, who was the head of WHO global program on AIDS, there are 3 epidemics in reality. These are the phases by which there occurs invasion of the community by the HIV/AIDS virus. In a large view, each of the community which is attacked by HIV/AIDS suffers by these 3 phases consequently.

- The First epidemic is the one of silent infection by HIV, which often gets completely unnoticed.
- The second epidemic phase starts after delay of many years. It is the epidemic of HIV/AIDS itself of which more than 10,000 cases had been reported worldwide by the end of June 1988.
- The third is called the epidemic of social, cultural economic and political reactions to AIDS which is not only worldwide but also considered “as central to the global AIDS challenges as the disease itself.”

It becomes everybody’s interest to know the origin of the disease whenever a new and deadly appears. However we do not know the origin of HIV, the virus which causes AIDS (Thomas, G.1994). The origin of

HIV/AIDS is unknown, although some studies suggest that it existed in Central Africa in mid 1960's.

1.3 History of HIV/AIDS in India:

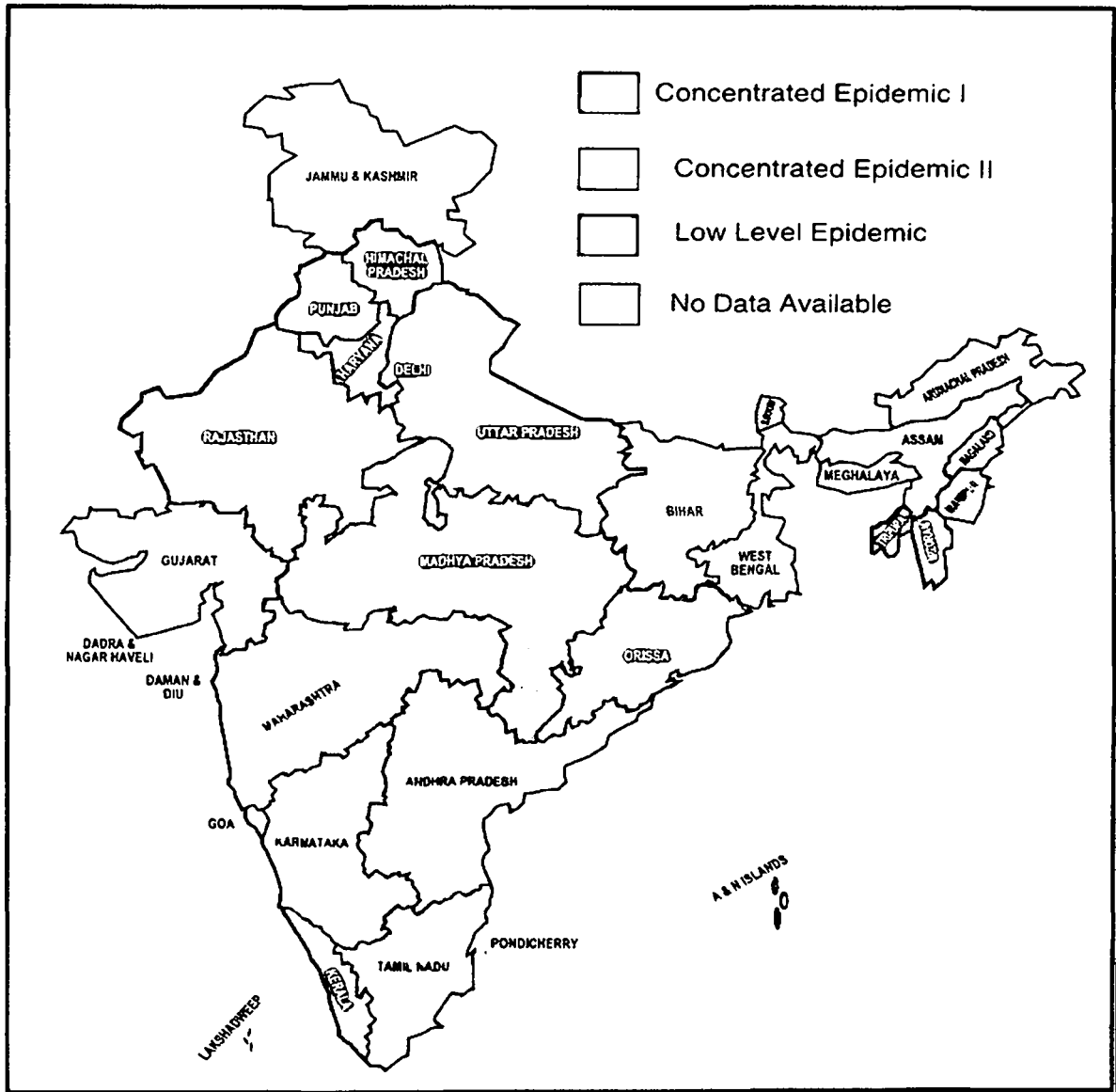
In India, 90 Per cent of the total reported AIDS cases in the country occur amongst the sexually active and economically productive age group of 15-45 years. Since the first case of HIV was discovered in Chennai 1986 and 50,000 cases of full blown AIDS cases in the count upto 2003 prevalence of HIV is estimated to be about 0.7 and officially 4 million people are affected.

The HIV/AIDS epidemic represents the most serious public health problem of India. The prevalence of the infection in all of the country highlights the spread from Urban to Rural areas and from high risk to general Population. India is one of the largest and most populated countries in the world, with over one billion inhabitants. Of this number, it's estimated that around 2.5 million people are currently living with HIV. Infection rates soared throughout the 1990s and have increased further in recent years. At the last count by National AIDS Control Organisation (NACO), there were over five million positive people in the country. HIV infection in India is currently concentrated among poor, marginalized groups, included commercial sex workers, truck drivers and migrant labourers, men who have sex with men and IDUs. Transmission of HIV within and from these groups drives the Epidemic, but the infection is spreading rapidly to general community. The epidemic continues to shift towards women and young people with about 25% of all HIV infections occurring in women. This adds to mother to child transmission and paediatric HIV (www.unicef.lcd.org).

India's socio-economic status, traditional social skills, cultural myths on sex and sex relating and a huge population or marginalised people make it extremely vulnerable to the HIV/AIDS epidemic. In fact, the epidemic

has become the most serious public health problem faced by the country since the independence. The Indian epidemic, in fact, is believed to be one of the fastest growing HIV/AIDS epidemics in the World.

Figure/Chart.1.1 HIV Prevalence in India



(Source:NACO,2006)

1.4 HIV Epidemic:

From the time HIV epidemic made its presence felt in the world, it has manifested itself in terms of extremely volatile, diverse and devastating impacts on human populations. HIV/AIDS has emerged as a major health problem and has serious effect on human development. The 2005 Human development report identifies AIDS as the factor inflicting the single greatest reversal in Human development history (UNDP, 2005). Therefore, efforts much made to mitigate its impacts and reinforce health, educational and social service systems in the world. Mitigation activities aim to repair or reduce the damage done by the AIDS epidemic to the individuals, their families, communities, institutions and the economic and social systems (UNDP, 2005). The people most directly affected by AIDS are those living with HIV/AIDS and their families. It is important to increase access to counselling and HIV testing facilities and to increase access to care and treatment. The health of the positive people is undermined by opportunistic infections such as Tuberculosis.

It is important to deal with HIV related stigma, discrimination and denial in various walks of life. The entire practice approach needs to be right based. It must be participatory, transparent and inclusive of the people affected by the epidemic. The global response stands at crossroads and for the first time the world possesses the means to reverse the epidemic. But, the success will require unprecedented willingness on the part of all actors in the global response to fulfil their potential, to embrace new ways of working with each other and to sustain the response over long term.

1.5 HIV/AIDS Situation in the North Eastern States:

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.

Table 1.2 AIDS Cases in NE Region (2003)

State	Population	AIDS cases	% of population
Assam	2,66,38,407	171	0.0006
Nagaland	19,88,636	370	0.018
Manipur	23,88,634	1238	0.051
Mizoram	8,91,058	51	0.0057
Meghalaya	23,06,069	8	0.0003
Sikkim	5,40,493	8	0.001
Tripura	31,91,168	4	0.001
Arunachal Pradesh	1,09,117	0	-----

Source: ISHA, 2003

The above table show, that the situation over a period of a decade is the same, i.e. Manipur is leading followed by Nagaland. Manipur and Nagaland are among India's top HIV hotspot. Manipur is a particularly alarming example of how rapidly HIV/AIDS spreads, affecting large numbers of people in the most productive phase of their lives.

1.5.1 Background of HIV transmission in the North Eastern Region:

When the first cases of HIV were reported in India beginning April 1986, specifically from Bombay and adjoining areas, there was a sense of complacency in the North Eastern States, that being geographically isolated as they were from mainland India, and with small isolated tribal communities, they were safe from HIV. Still, in line with national policy, HIV surveillance was initiated first at Guwahati Medical College and thereafter at Regional Medical College, Imphal, and other places in 1986.

1.5.2 Beginnings of HIV Transmission in the North Eastern Region:

Together with IV drugs, HIV entered the NE region. Most of the drug addicts who are youth share the needles. Initially needle sharing was practiced out of feelings of peer group sharing, and ignorance of HIV and disease risk. Since 1990, needle sharing became a compulsion, due to crackdown by police on drug addicts, on the strength of the "Prevention of Narcotic and Psychotropic Drug Abuse Act of 1985". As a result, in some States of the Region including Manipur, it became illegal to possess a needle and syringe, liable to land the possessor in prison, and illegal to sell a needle and syringe without doctor's prescription. Therefore, in spite of widespread awareness among youth, of HIV risk due to needle sharing (almost 85%), many, who would not like to do so, continued to share needles; in place of syringes, ink fillers were being fitted to the needles, which withdraw some blood into the ink filler after the drug is injected into the vein. These factors expose the entire group of addicts to HIV, even if one in the group is positive. HIV was introduced into the region since some of the addicts are drug traffickers, frequently visiting Myanmar and having regular contacts with addicts and sex workers. Once the HIV epidemic among sex workers was discovered in Thailand in late 1980s, they were screened. Those found HIV positive of Burmese

origin were deported back to Myanmar and drug traffickers from Manipur visiting them took the virus back with them to Manipur.

Thus, with combination of high risk behaviours, youth in Manipur were severely affected and the earliest to be affected by the HIV problem. Other States have had apparently a slower progression of drug abuse and HIV, but nevertheless face a major potential HIV epidemic, due to IV drug abuse catching up among the youth of these States also, (as drug traffickers facing

trouble in Manipur and Nagaland States turn their business to other States, finding a large youth population, good number with Westernized values, traditionally liberal attitudes to sex and free lifestyle, widespread unemployment, low skills development for productive employment entrepreneurship (although widely literate), and, in some tribal cultures, a cultural sanction for addictions (opium in parts of Arunachal Pradesh, rice brew in all States, etc)

1.5.3 Risk Groups and Pattern of Risk Behaviour in NE States:

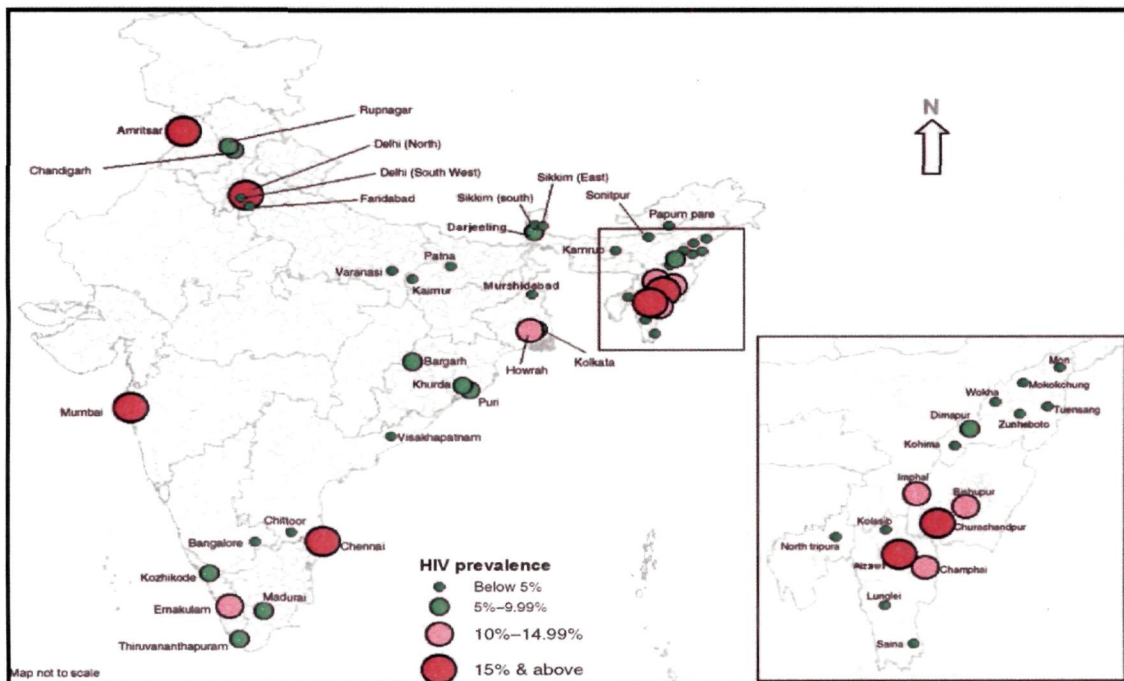
Keeping in view the major routes of transmission namely sexual route, blood and blood products transfusion, pre-natal (mother to child), and IV drug abuse with needle sharing, the following are the salient features of HIV transmission in the NER.

Projections of the State Government indicate that there are about 15000-20000 IV drug users in Manipur and about 8000 to 10000 drug users in Nagaland. Since drug abuse is confined largely to youth aged 15-30 years, this amounts to 8- 10% of youth population being IV drug users. In

Manipur, estimates show that at least 50% of IV drug abusers are HIV positive In Nagaland, overall, 13.6% of IV drug users were HIV positive. Surveys in small pockets have shown high prevalence - e.g in Tuensang District, 34 of 41 IV drug users tested were HIV positive.

Overall, in these two States, about 8-10% of youth (amounting to 1-2% of total population) uses IV drugs. Mizoram, Meghalaya, and parts of Arunachal Pradesh are less affected by IV drug abuse than Manipur or Nagaland. Other major risk groups in the respective States are also indicated. It was reported that commercial sex workers (CSWs) presented insignificant numbers in all the NE States. CSWs tended to concentrate along main inter-State roads and highways, largely to meet the needs of truck drivers travelling through the States. The major risk groups were as follows: a) Truck drivers in all States, b) immigrant labourers (Arunachal Pradesh and Meghalaya), c) mining labourers (Meghalaya), d) rickshaw pullers (Tripura), e) commercial blood donors (Assam, Manipur and Tripura where commercial blood donation either openly or covertly continued), and f) blood transfusion recipients (particularly in Assam which has a large number of private hospitals and nursing homes giving unscreened blood, Tripura, Meghalaya and Manipur where significant numbers of transfusions were being given at the State HQ, district HQ towns, and Community Health Centers). In Manipur, 10 pregnant women were found HIV positive, giving a sero-positivity rate of 1.6%, in this group.

Figure/Chart 1.2 (HIV prevalence among people who inject drugs, by site, India, 2007.



Data Source: Sentinel surveillance data, NACO, 2008 [37].)

1.6 The Indian Scenario; Vulnerable Groups

India has a population of 1.4 billion, around half of whom are adults in the sexually active age group. The first case in India was detected in 1986; since then HIV infection has been reported in all states and union territories. Every region of India is experiencing a snowballing increase in incidence of HIV. According to medical experts, given the present rate of increase in incidence of AIDS cases, 2 million people would die from AIDS-related cases in India by the turn of the century (Thomas, G.1994)

HIV prevalence, 2005-2006

The National Family Health Survey conducted between 2005 and 2006 measured HIV Prevalence among the general adult population of India.

Table 1.3 HIV Prevalence across Different Age Groups:

Age group	HIV prevalence (%)		
	Male	Female	Total
15-19	0.01	0.07	0.04
20-24	0.19	0.17	0.18
25-29	0.43	0.28	0.35
30-34	0.64	0.45	0.54
35-39	0.53	0.23	0.37
40-49	0.41	0.19	0.30
45-49	0.48	0.17	0.33
Total age 15-49	0.36	0.22	0.28

(Source; NFHS, 2005-2006)

The survey found the rate among men to be considerably higher than that among women. Prevalence is found to be higher in urban areas (0.35%) than in rural areas (0.25%).

India is coming under the concentrated category because it has surpassed the spread of 5% to its many sub populations but the prevalence of women attending urban ANC clinics is still less than 5% (Ramamurthy, V.2000).

In absolute terms individual vulnerability can be defined simply as who are not protected and in relative terms this can be defined as those who are exposed to a higher than average risk. In epidemiological words, this can be defined as to those who are higher risk of HIV infection and again this can be defined as those who are deprived of some or all social

rights or services in social context (Jonathan et al, 1994) .People living with HIV/AIDS come from incredibly diverse backgrounds, cultures and lifestyles.

There are various such vulnerable groups. These risk groups include;

- Injecting drug Use
- Commercial sex workers
- Truck drivers
- Men who have sex with men.(MSM) and
- Migrant workers

1.6.1 Injecting Drugs Use:

In the north east of India, HIV transmission is concentrated chiefly among drug injectors and their sexual partners, especially in the states of Manipur, Mizoram and Nagaland, all of which lie adjacent to the drug trafficking “Golden triangle” zone.

Harm reduction efforts (including needle and syringe exchange, as well as limited drug substitution programmes) were introduced in some states, such as Manipur. There, in 2003, the HIV prevalence among drug injectors was 24%, the lowest levels detected among injecting drugs users in that state. Elsewhere the epidemics among drug Injectors appear to be well established, with HIV prevalence having reached 14% in Nagaland in 2000-2003. But not only in the North east, there has been a sharp rise in HIV infections among drug injectors in the southern state of Tamil Nadu, where 39% were infected in 2003, compared with 25% in 2001. In Chennai, Tamil Nadu, almost 2/3rd (64%0 of injectors were HIV positive, according to sentinel surveillance done in 2003.

Millions of people worldwide are injecting drug users, and blood transfer through the sharing of drug taking equipments, particularly

infected needles, is an extremely effective way of transmitting HIV. The illegal nature of Injection drug use can also create barriers to accessing adequate treatment and prevention, such as needle exchange programmes making IDUs more vulnerable to HIV and its effects. The cross over with prostitution further means that they are in positions to transmit the virus between other of risk populations.

People take drugs, both legal and illegal, for a variety of reasons that will differ from person to person and from drug to drug. Individuals may enjoy the sense of detachment or euphoria that drugs create, their relaxing or energy inducing properties, the heightened alertness or sensitivity they produce, and their medicinal qualities. Peer pressure or habit may be other reasons, and if they are chemically dependent, addicts will feel they cannot operate without them. These reasons will depend on an individual's own background and socio-economic circumstances.

Study done by Sarkar and Panda, et al. on injecting drug users and National Highway users establishes the correlation between the use of Injection drugs and the existence of a national Highway system. It brings out the fact that in areas where there is no national high way system there is a consistently lower prevalence of injection drug use. The rate of HIV infection is consistent among IDUs, whether they are near a national highway system or not (Sarkar,K., Panda, S. et al. 1997).

A critical problem is the frequent re-use of syringe. A National AIDS Control Organisation (NACO) report shows that only 44 percent of IDUs consistently use safe injecting practices .In many areas, ignorance regarding HIV and the threat posed by needles sharing is another important contributing factor to the spread of the epidemic amongst injection drug users.

Ways IDUs are viewed :(RSA-1998)

By the society-

- Seen as people who lack determination
- People responsible for crimes
- As a bad influence
- Seen as people who are immoral
- As useless people
- As carriers of the infection

By the families-

- As people who lack determination
- Seen as a burden
- Many times the family members pay money to the police to keep them inside jail

By the police-

- A person responsible for crime
- As a means for getting money.

1.6.2 Commercial Sex Worker (CSWs)

Historically, the AIDS epidemic in India was first identified amongst sex workers and their clients, before other sections of society became affected. High HIV infection rate continues to be detected in India. The government estimates that 8% of sex workers nationally are infected with HIV, which almost nine times higher than overall HIV prevalence rate for Indian adults. What is more, studies of sex workers in individual areas have found much higher HIV prevalence rates such as 44% in Mumbai, and 26% in Mysore (Avert India, 2008)

In Asia, which contains some of the fastest growing AIDS epidemic in the world, it is believed that a high proportion of new HIV infections are transmitted during paid sex. In South and South- East Asian countries outside India, the United Nations estimates that sex workers

and their clients accounted for almost half of all people living with HIV in 2005. There are also fears that commercial sex is having an increasing influence on the AIDS epidemic in China. China's AIDS epidemic is expanding, and at the same time, it is thought that the demand for commercial sex by clients accounted for about 20% of people living with HIV nationally (Avert India, 2008).

Understanding over the CSWs is of more important because of the following reasons:

- Sex workers usually have a high number of sexual partners. This means that if they become infected with HIV, they can potentially pass it on to multiple clients.
- High rates of HIV have been found amongst individuals who sell in many different and diverse countries. Even where HIV prevalence is low amongst this group, it is usually higher than the rate found amongst the general adult population.
- Preventing HIV infections amongst those involved in the sex trade has been proven to be an instrumental part of many countries fight against AIDS.

Study on sex workers by Agrawal and Singh, et al. revealed that some IDUs are also sex workers, which can quickly link HIV transmission in the IDU networks to transmission in the larger high risk sexual networks.

1.6.3 Truck Drivers:

Truck drivers have been and continue to be an important source in the spread of HIV to epidemic proportions. They work long hours on the road and often spend several days in one place clearing customs or resolving mechanical problems. They turn to sex workers who are at high risk of being HIV/AIDS positive. As a result, the drivers have high rates of HIV. Their highly mobile lifestyle requires a lot of travel. At other stops over

town locations they visit other commercial male/female sex workers thereby potentially transmitting the virus. In addition, many of the truck drivers are married and also have girlfriends (commercial sex partner) who are likely to become infected with HIV and become a pool in their local communities.

A study was done by Kanjilal et al in 1998 of IIMR, which assessed the socio economic impact of HIV/AIDS epidemic among truckers on India trucking industry. They study various issues like social security benefits, health care and death benefits, loss in output, replacement investments, increase in number of accidents, and so on. As a result, they found that the total projected number of HIV-infected truckers in 2005 worked out to be between 0.3 million and 2.4 million (12%-20% of all truckers). They found as per their classification that the direct impact would be less significant on the industry due to non-existence of labour welfare policy. However, the epidemic is likely to aggravate the shortage of skilled driver triggering the indirect impacts such as loss in output and increase in accidents. Due to high demand elasticity, the burden of epidemic is less likely to be shifted to consumers and the smaller companies would probably be the hardest hit. The shortage would also likely to contribute towards industry's slow progress, towards desired technological change. While the impact of the epidemic has, for the most part, not yet been felt in the industry, it is very likely that it would become much more visible within the next five to ten years. Due to its fragmented and decentralized nature, the industry is highly vulnerable to external shocks. The study underlines the immediate need for intensive advocacy for cost effective strategies like workplace intervention.

1.6.4 Men Who Have Sex with Men (MSM):

Sex between men themselves label as gay, or as bisexual. In the context of the global AIDS epidemic, AIDS was first discovered among self

identified young gay men in U.S.A, and throughout the course of the global epidemic. The high levels of HIV infection have been found among MSM in many countries. Worldwide, it's estimated that sex between men accounts for between 5% and 10% of HIV infections. The situation varies between countries, however, and in much of the developed world- including the U.S.A, Canada, U.K, Australia and New Zealand- more people have become infected with HIV through male- male sex than through any other transmission route.

In Asia, HIV prevalence levels among MSM have reached as high as 18%in Andhra Pradesh, India, 15%in Phnom Penh, Cambodia, and 28%in Bangkok, Thailand-figures that are many times higher than those found among these countries overall populations. In Japan, around 60% of HIV positive people are MSM.

All the new MSM sites established in Andhra Pradesh and Orissa have shown high HIV prevalence, suggesting that there may be many pockets of high prevalence among MSM, which need to be detected. The report further states that, urban areas of the country such as Delhi, Pune, Bangalore, Surat, Rajkot and Kolkata recorded very high HIV prevalence among MSM. Overall, 21 districts have shown greater than 5% HIV prevalence among MSM (NACO 2008).

In many countries however, MSM are not so visible. Sex between men is stigmatised, officially denied and criminalized in various parts of the world. This adds to the vulnerability of MSM, making it difficult to monitor them, and making it near impossible to carry out relevant HIV prevention campaigns in some countries.

1.6.5 Migrant Workers:

Migration is also an important factor. People travel for all kinds of reasons; business, pleasure, fleeing from political persecution, seeking a better life, livelihood, etc. Migration is a geographical phenomenon that

seems to be a human necessity in every age. Men have a tendency to leave the areas in which life is difficult; they migrate to the areas where life may be easier and better. Migrants may suffer from new infection agents with them from their origin place and introduce them into their place of destination. Thus, with the movement of the people, diseases of various types also move from place to place. The NACO report on Migration and HIV, 2007 puts emphasis on the fact that the important source of HIV related Vulnerability is mobility and migration, mobility being defined as a change of location and migration being defined as a change of residence. It says that India, home to the third highest number of HIV positive people in the world, is characterised by widespread and fluid migration and mobility. The report states that more than 2 million Indians do not live in the place of their birth. Whereas mobility in other parts of the world is inhibited by national boundaries, there are few landmasses like the size of India with such a good transport infrastructure as this country. They further state the characteristic of Indian migrants as, once migrants reach their destination, language and other difficulties lead to feelings of discontinuity and transition that enhance loneliness and /or sexual risk taking the report further identifies the risk taking, which may be reinforced by lack of HIV/AIDS awareness, information and social support networks at both source, and destination points, which cumulatively contribute to a migrant's vulnerability. It brings out the fact that, spouses of migrants are also vulnerable to HIV if their husbands return on a regular basis and have become infected with HIV. Some wives also have their own sexual networks during their husbands' absence (NACO 2007).

Migration has added another dimension to the HIV epidemic in India. Industrialized states with relatively high HIV rates, such as Maharashtra, Gujarat and Andhra Pradesh, attract male and female

labour from all over the country, particularly from poorer states, which may soon lead to significantly higher HIV rates in these states as well.

Migration due to various factors such as eviction of tribal people from forests to be owned by government in Rajasthan or fatal ethnic clash in Manipur have also been documented as reasons why women are forced to take up prostitution as alternate means of living.

HIV continues to hit India pushing in third phase, badly affecting people hit by migration. There are various types of migration like; immigrants, temporary migrants, tourists, illegal migrants, returning nationals refugees, sex workers, asylum-seekers, students , workers, diplomats, etc.

Figure/Chart 1.3: States and Districts with high HIV Prevalence among Different Groups, 2007:

States with high HIV prevalence among Injecting Drugs User (IDU)	Maharashtra (24.4%), Manipur (7.9%), Tamil Nadu (16.6%), Punjab (13.8%), Delhi (10.1%), Chandigarh (8.6%), Kerala (7.9%), west Bengal (7.8%), Mizoram (7.5%), &Orissa (7.3%).
Number of Districts with >5%HIV prevalence among IDU	23 out of 49 districts with IDU sites.
Number of Districts with >15% HIV prevalence among IDU	7 out of 19 districts with IDU sites
States with high HIV prevalence among Men having with Men(MSM)	Karnataka (17.6%), Andhra Pradesh (17%), Manipur (16.4%), Maharashtra (11.8%), Delhi (11.7%), Gujarat (8.4%), Goa (7.9%), Orissa (7.4%). Tamil Nadu (6.6%) and West Bengal (5.6%)

Number of Districts with >5% HIV prevalence among MSM	21 out of 40 districts with MSM sites
Number of Districts with >15% HIV prevalence among MSM	9 out of 40 districts with MSM sites
States with high HIV prevalence among female sex worker (FSW)	Maharashtra (17.9%), Manipur 13.1%), Andhra Pradesh (9.7%), Nagaland (8.9%), Mizoram (7.2%), Gujarat (6.5%), west Bengal (5.9%), & Karnataka (5.3%)
Number of Districts with >5% HIV prevalence among FSW	47 out of 129 districts with FSW sites
Number of Districts with >15% HIV Prevalence among FSW	8 (FSW sites in Pune, Mumbai and Thane have shown > 30% HIV prevalence among FSW)

Source: "HIV Sentinel Surveillance and HIV Estimation in India 2007, A Technical brief", (NACO, Ministry of Health and family Welfare Government of India Oct, 2008)

If we see the HIV prevalence in the different states of India we find huge disparity in the patterns. There are few states which show very high rates of HIV prevalence while the other show very low. These states include Maharashtra, Gujarat, Manipur, Andhra Pradesh, Tamil Nadu, Karnataka, Nagaland, and Mizoram. Within the states also there is wide disparity among the various high risk groups in the HIV prevalence.

The state level, HIV prevalence among FSW is very high in Maharashtra (17.9%), followed by Manipur (13.1%), Andhra Pradesh (9.7%), Nagaland (8.9%) and Mizoram (7.2%). Among the other states ,

Gujarat, Karnataka, and West Bengal have HIV prevalence greater than 5% among FSW. FSW sites in Pune, Mumbai and Thane have shown > 30% HIV prevalence among FSW (NACO, 2008)

1.7 An Overview of the AIDS Epidemic

HIV/AIDS has proved to be one of the silent killers in the modern world. People fall prey to the disease more because of their lifestyles than any disorder. It is essential to understand what HIV is and AIDS. When the first cases were identified, AIDS has spread at an alarming rate. The extent of the AIDS Epidemic is projected to continue to escalate for some years. Most individuals infected with the AIDS virus are asymptomatic and do not know that they are infected; the potential for the further spread of the disease is staggering.

1.7.1 Understanding HIV/AIDS (HIV Scenario):

The Acquired Immuno deficiency Syndrome (AIDS) is a profound human tragedy and has been referred to as the “world’s most deadly undeclared war”. HIV/AIDS continue their devastating spread, affecting the lives of over 16,000 people each day with women, babies and young people being increasingly targeted. HIV poses one of the greatest health threats of modern times to mankind. More than 25 million people have died of AIDS since 1981. At the end of 2006, women accounted for 48% of the adults living with HIV worldwide with an estimated 17.7 million women living with HIV/AIDS. The epidemic is shifting toward women and young people with about 25 percent of all HIV infections occurring in women.

Human Immunodeficiency (HIV) is a blood borne and sexually transmitted organism that causes Acquired Immunodeficiency Syndrome (AIDS). Immunodeficiency is the weakening of the special body defence system that protects the body from being attacked by different disease (Cunningham, 1989). When a person has AIDS, their body has no more

strength to fight infection and many severe infections can attack them. Individual with HIV can remain healthy for length of time between a few years to more than ten years before developing AIDS.

The majority of individuals with AIDS have been infected through sexual intercourse. Kelly and Murphy ,(1992)described HIV as the most serious infectious disease epidemic of modern times worldwide and devastating to individuals, communities and countries most affected by it.

1.7.2 Modes of Transmission:

Understanding how HIV/AIDS spreads is important in order to predict where it will occur next, and it also helps to identify where education and preventive measures would be most effective.

Sexual intercourse- HIV/AIDS transmission is not easily communicable through normal day to day contact. The vast majority of HIV/AIDS infections are sexually transmitted, typically between men and women or men and men and in at least one case between women (Sharma, S. 2006).

Pregnancy related vertical transmission (Mother to child transmission, or MTCT)-HIV/ AIDS can also be transmitted from an infected mother to her child before or during birth. This is known as “Perinatal transmission”. This transmission can occur before as well as during delivery. Before birth, HIV may be transmitted across placenta to the developing foetus. During birth, HIV virus can be transmitted via mother’s blood or bodily secretions (fluid). But it is not necessary that the baby born from a HIV infected mother must be infected with HIV, it may take many factors in concern, like timing of the mothers HIV infections and her overall health condition. The other way of mother to child infection is through breast milk. A number of cases of transmission through breast milk have been noticed but it is believed that these were

typical occurrences in which mothers had received infected blood during transfusion immediately after giving birth (Thomas, G.1994).

Blood transfusions with unscreened or injected blood- Many people have become infected via blood transfusions, infected blood products, and by sharing of syringes and hypodermic needles. Therefore, in many part of the world, the routine screening for the antibodies of HIV/AIDS virus is done to make this kind of transmission rare. But this kind of transmission would be very common if no such screening is done and also HIV/AIDS infected people are more. In other case, there is the re-using of the needles that have not been properly sterilized. It was revealed in 1989 that about 40 young children and adults were infected by unsterilized needles and other medical equipments in USSR.

Table 1.4: Transmission Route Vs Numbers of AIDS Cases in India:

Transmission categories	Numbers	Percentage
Sexual	106,669	85%
Mother to child	4,755	4%
Blood and blood products	2,563	2%
Injecting drugs Users	2,930	2%
Others (not specified)	8,078	6%
Total	124,995	100%

(Source: Avert India, 2006)

The above table (1.4) clearly suggests that the main source of transmission of AIDS cases is the sexual route, universally. It is having the highest death toll in this category (85%). The other categories are

negligible as compared in terms of percentage, but it also has large number of deaths in thousands which cannot be neglected.

It has been observed that the chance of getting HIV infection is highest in case of sharing needles and in man to man sex in which the man is passive and the act is taking place at very early stages. The relative risk of HIV transmission from mother to child (during delivery) is much higher than other transmission. Even the unsafe vaginal intercourse is also having high risk of HIV transmission to the other partner. There is low risk of HIV transmission from the acts like oral sex, kissing as well as breast milk. Transmission from blood and blood products is high in those countries who have not adopted proper and compulsory HIV screening before or after blood collection and before blood transfusion.

1.7.3 Symptoms of HIV/AIDS:

The only way to determine for sure whether one is infected from HIV or not, has to go for HIV testing. One cannot rely on symptoms to know whether or not one is infected with HIV. Many people who are infected with HIV do not have any symptoms at all for many years.

Several of the signs and symptoms of HIV infection are common to other diseases. The important warning signs of HIV infection are rapid weight loss, dry cough, recurring fever or profuse nights sweats, profound and unexplained fatigue, swollen lymph glands in the armpit, groin , or neck: diarrhoea that lasts for more than a week, white spots or unusual blemishes on the tongue, in the mouth ,or in the throat, pneumonia, red , brown, pink, or purplish blotches on or under the skin or inside the mouth, nose , or eyelids, memory loss, depression and other neurological disorders. However, no one should assume he is infected if he has any of these symptoms. Each of these symptoms can be related to other illnesses. Again, the only way to determine whether one infected is to be tested for HIV infection.

1.8 HIV/AIDS: Myths and Misconception

Many people do not understand what HIV/AIDS is or how it spread, treated or prevented. This lack of understanding gives rise to incorrect beliefs about the virus, often derived from, and strengthened by, cultural and religious practices and traditions. Research conducted among 400 college students in India demonstrated that 55 percent of males and 68 percent of females knew that the disease was communicable and was spread by a virus, but only 9 percent knew a new exactly how it was transmitted.

A myth is a story which may not be true. Some myths may have started as true stories but as people told and re-told, they may have changed some parts, so they are less true. Innumerable myths exist about condoms carrying the virus. Many people still believe the myth that sex with a virgin or young girl can cure men of HIV/AIDS .In Botswana, where nearly 40 percent of the adults' population has the virus, this myth is particularly widespread, and some men deliberately seek out young girls for intercourse as a way of avoiding HIV infection. Another lesser-known myth is that sex with older woman can cleanse men of HIV/AIDS .This belief is said to result from perception that when women stop menstruating, they become clean again.

Myth and misconception about HIV/AIDS have been found since the very beginning of the pandemic. The myth stemmed largely from the lack of information on this relatively new disease only. One of the myths, one that claimed that HIV was a gay disease only, was strongly encouraged by the media. This exacerbated problems with prevention as misinformation was widely circulated. Since then, new myths have emerged .These myths have emerged despite the fact that there is now more accurate information on HIV. These new myths also create problems with prevention as people unknowingly put themselves at risk to contract the virus.

There are many contemporary myths and misconceptions about HIV prevention and transmission and they originate from many parts of the world. Some are about the demographics of the virus and claim that HIV/AIDS is a Black's Disease only or that it only affects IV drugs users. There is also the misconception in parts of Africa that there are young virgin prostitutes or special villages free from AIDS. There is also the speculation that HIV/AIDS is worse in Africa because Africans are hypersexual. Others come from theories on the origins of the virus. Some people think that HIV was sent by God as punishment for sin. Other myths and misconceptions are about prevention and transmission. Among these are the misconceptions that only promiscuous people contract HIV, that women cannot transmit HIV to men, that people with HIV look sickly or have body odours, and that HIV positive people do not need to use condoms during intercourse. This misconception is dangerous because infection with multiple strains of the virus can occur. People also believe that HIV can be transmitting through kissing, or eating from the plate of an infected person. A recent article documented a very popular myth among prostitutes in Malaysia. According to Sarawak AIDS Network, or SAN "prostitute and their customers shake up a can of coca cola and spray their genitals before sex." The belief is that the bubbles in the soda will kill the virus. Some people believe that HIV cannot be contracted from getting tattoos and body piercings based on the fact that HIV is unlikely to be transmitting via kissing.

There are other misconceptions like HIV/AIDS can spread by standing close, shaking hands, sharing clothes , utensils and toilets , living in the same room or inhaling sneezing or coughing of a HIV AIDS infected person. People from diverse religious backgrounds believe that there are lucky charms, magic potions or special rituals that can be used to prevent or cure the virus.

Therefore, it became very clear that this kind of myths and misconception are prevailing in all walks of life of many people. But these are seen in those people who are not having sufficient knowledge and self confidence regarding HIV/AIDS in general.

1.9 HIV/AIDS: Stigma and Discrimination

AIDS related to stigma and discrimination refers to prejudice, negative attitudes, abuse and maltreatment directed at people living with HIV and AIDS. They can result in being shunned by family, peers and the wider community; poor treatment in health care and education settings, an erosion of rights, psychological damage, and can negatively affect the success of testing and treatment. All these contribute to the way people react towards the infected.

Stigma not only makes it more difficult for people trying to come to terms with HIV and manage their illness on personal level, but it also interferes with attempts to fight the AIDS epidemic as a whole. On a national level, the stigma associated with HIV can deter government from taking fast, effective action against the epidemic, whilst on a personal level it can make individuals reluctant to access HIV, treatment, testing and care.

Factors that contribute to HIV AIDS related stigma:

- HIV/AIDS is a life threatening disease, and therefore people react to it in strong ways
- HIV infection is associated with behaviours (such as homosexuality, drug addiction, prostitution or promiscuity) that are already stigmatised in many societies.
- Most people become infected with HIV through sex which often carries moral baggage

- There is a lot of inaccurate information about how HIV is transmitted, creating irrational behaviour and misperceptions of personal risk
- HIV infection is often thought to be result of personal irresponsibility
- Religious or moral beliefs lead some people to believe that being infected with HIV is the result of moral fault (such as promiscuity or deviant sex) that deserves to be punished.

AIDS related stigma is not static. It changes over time as infection levels, knowledge of the disease and treatment availability vary. The WHO cites fear of stigma and discrimination as the main reason why people are reluctant to be tested, to disclose HIV status or to take antiretroviral drugs. Self stigma and fear of negative community reaction can hinder efforts to address the AIDS epidemic by perpetuating the wall of silence and shame surrounding the epidemic.

Research by the International Centre for research on Women (ICRW) found the possible consequences of HIV related stigma to be:

- Loss of income /Livelihood
- Loss of marriage and child bearing options
- Poor care within the health sector
- Withdrawal of care giving in the home
- Loss of hope and feeling of worthlessness
- Loss of reputation.

Lack of equal rights to inheritance of property has left many AIDS widows and orphans destitute and homeless, particularly in polygamous societies in Africa. When women are found to be infected, families and friends ostracize them as promiscuous and bad women. When women fall sick, it is often difficult and sometimes impossible to gain access to health care, treatment and support. Because of stigma and discrimination against AIDS widows and orphans, family members throw

them out of their homes and disinherit them of their property. This leaves few options to the widows and adult children to turn to risky behaviour and sex for survival (Elizabeth 2003).

1.9.1 Health Care Setting:

In health care settings people with HIV can experience stigma and discrimination such as refused medicines or access to facilities, receiving HIV testing without consent, and a lack of confidentiality. Such responses are often fuelled by ignorance of HIV transmission routes amongst doctors' midwives, nurses and hospital staff. That medical staff should perhaps have a better understanding of HIV which makes discrimination in health care settings all the more damaging.

Because of actual and perceived health related limitations as well as stigma and discrimination, people with chronic physical conditions such as HIV face a host of barriers when attempting to find and maintain employment (Hoffman, 1997; Roessler and Rumrill, 1998). Although HIV disease is now considered a chronic and manageable disease for many people (McReynolds, 1998), PLWA still experience debilitating disease related conditions as well as medication related side effects. Physical symptoms and daily physical changes that PLWHA experience significantly interfere with careers, life roles and quality of life (Antoni, 2002).

A study found that 25 percent of the people living with HIV /AIDS were refused medical treatment on the basis of their HIV positive status (UNDP, 2006). Globally, discrimination in these setting can be expressed in a variety of ways. The most commonly reported responses include a refusal to admit or treat HIV positive patients (Tirelli et al, 1990; Shisam, 1993), the tendency to neglect patients, the habit of testing for HIV without consent, and breaches of confidentiality (New South Wales Anti-discrimination Board, 1992; Birmingham and Kippax, 1998).

1.9.2 Employment:

In the workplace, people living with HIV may suffer stigma from their co-workers and employers, such as social isolation and ridicule, or experience discriminatory practices, such as termination or refusal of employment. Fear of an employer's reaction can cause a person living with HIV anxiety.

Potential problems associated with PLWHA seeking to obtain or hold a job include workplace discrimination. PLWHA are concerned that disclosure will prevent them from being hired or potentially increase their chances of being fired or treated badly by supervisors and co-worker (UNDP, 2006).

In poorer countries screening has also been reported as taking place, especially in industries where health benefits are available to employees. Employer-sponsored insurance schemes providing medical care and pensions for their workers have come under increasing pressure in countries that have been seriously affected by HIV and AIDS. Some employers have used this pressure to deny employment to people with HIV/AIDS.

1.9.3 Community:

Community level stigma and discrimination towards people living with HIV/AIDS is found all over the world. Community reaction to somebody living with HIV/AIDS can have a huge effect on that person's life. If the reactions is hostile, a person, may be ostracised and discriminated against and may be forced to leave their home, or change their daily activities such as shopping socialising or schooling.

In societies with cultural system that place greater emphasis on individualism, HIV/AIDS may be perceived as the result of personal irresponsibility and thus individuals are blamed for contracting the infection (Kegeles et.al 1989).In contrast, in societies where cultural

systems place greater emphasis on collectivism, HIV/AIDS may be perceived as bringing shame on the family and community (Panos 1990, Warwick et al .1998)

1.9.4 Family:

In the majority of developing countries, families are the primary caregiver when somebody falls ill. There is clear evidence that families play an important role in providing support and care for people living with HIV and AIDS. However, not all family responses are positive. HIV infected members of the family can find themselves stigmatised and discriminated against within the home.

An Indian study (Bharat, 1996) found that although a majority of those who had shared their HIV status with their families received care and support, it was largely men rather women who qualified for such care. Forms of discrimination against women with HIV included refusal shelter, being denied a share of household property, being denied access to treatment and care, and being blamed for husband HIV diagnosis, especially when the diagnosis was made soon after marriage. Other factors influencing whether people received support included the quality of past familial relationships, age, economic and educational status and the apparent or suspected source of infection.

The stigmatising nature of HIV/AIDS is its most stressful feature, burdening the family's coping system. As pointed out by Ankrah(1994),Bharat(1996),Hays et al(1994),and Mc Grath(1994), the fear of social stigma and damage to family prestige traumatised the people living with HIV/AIDS and their families , making the maintenance of secrecy over the HIV/AIDS diagnosis a central concern that they struggled with.

Experiences of discrimination and stigma evoked intense negative emotions and feelings of loneliness, isolation and rejection of the people

living with HIV/AIDS and their families. Believing that nothing could be done to change the way other think and feel, they opined that it is they who need to change and adjust.

HIV/AIDS status for a person has varied implications on the life of an individual. The person identified with HIV has to deal with many situations while living with HIV/AIDS. Stigma and discrimination will continue to exist so long as societies as a whole have a poor understanding of HIV/AIDS and the pain and suffering caused by negative attitudes and discriminatory practices.

1.10 Care and Support to HIV/AIDS

Care and support are based on an active concern for the well being of others and ourselves. People with HIV/AIDS, families and communities are involved in care and support. They all need support to face the challenges of illness. The aim of HIV/AIDS care and support is to improve the quality of life of people living with HIV/AIDS, their families and communities. Care and support are also important because they assist efforts to check the spread of HIV/AIDS.

Although AIDS is primarily a health issue, HIV/AIDS prevention and AIDS care cannot be left to the health sector alone. A multisectoral approach and communities are required because HIV/AIDS management demands more resources and skills than can be provided by the health sector alone. HIV/AIDS prevention and care programs need to involve the community, including a variety of sectors, especially education, religious, civic, community development and planning. As part of decentralization, AIDS concerns need to be actively understood in various local communities to facilitate community commitment and incorporation of knowledge of AIDS into local culture and organisation (Ngweshemi et al. 1997; 23)

Needs include access to common drug treatments for opportunistic diseases, consideration of their families by support children and spouses, help with food, clothing and finances, emotional, moral and spiritual support and empathy from the healthy members of the communities, comprehensive approach to care is thus required. People living with HIV/AIDS can live healthy and productive lives when they have access to information, care and support. Support means acceptance, affection, respect and love from friends and family and from the community. It also means supportive laws to protect against discrimination and stigmatization. Care includes moral support and access to necessary medical treatments, a healthy diet, and accommodation.

Counselling is a critical element in HIV/AIDS management as it helps infected and affected people adopt a life style conducive to good health, promoted behaviour which leads to quick recovery from illness and provides strategies to cope with dying and death. This is because the disease arouses diverse emotional reactions such as fear, denial loss grief, anxiety, anger, rejection, isolation, annoyance, blame apportioning, pity, self condemnation, depression and suicidal thoughts (WHO 1995). Counselling is meant for the physical, psychological, mental and social health and socio economic needs of the clients. Thus, the disease can be said to have many facets including personal, social, religious, political, legal and economic, not fully understood, but almost always chronic and fatal. The lack of understanding of the disease often results in conflicting and debatable information. Because the epidemic has diverse dimensions, counselling should be conducted by trained people with strict confidentiality; otherwise clients may withdraw from the services (Malungo 1999:1)

Family is the primary context in which illness occurs and in most traditional society's .The family system in India is expected to extend

care and support to HIV positive members in much the same way as in the African countries. Family economic security is also a significant factor in deciding care arrangements in illness. Although families are known to support their sick members even when impoverished the amount and type of care provided are affected by financial resources.

Widows fulfilled the needs for care and support for all the members. Children had greater needs, particularly care and support. Barring a few cases where women's emotional needs were satisfied within the Household and where children assisted in family roles and responsibilities, most women experienced neglect, loneliness and strain. Support is thus required for the family as a unit to enable it to function adequately in the face of HIV/AIDS epidemic. At the juncture, People with HIV will live full lives if the resources to help them are properly in place.

1.11 HIV Policies and Programmes in India

The spread of HIV/AIDS from the high risk groups to general population and from initial hot spots to new areas in India underlines the need for a comprehensive National AIDS Control Policy to effectively control the epidemic in the country. The HIV/AIDS policies and guidelines in India view the epidemic as a developmental problem rather than a mere public health issue. Among the preventive services are awareness generation, condom promotion, prevention of voluntary blood donation and access to safe blood. The policies also have guidelines on targeted interventions (TIs) for high risk groups like injecting drug users (IDUs) men having sex with men (MSM) female's sex workers (FSWs).

Apart from this, policies have extensive guidelines on the management of common opportunistic infections, malignancies among adult/adolescent PLHA and operational guidelines for ART centres to standardise ART services across the country. The National Policy on

blood banks ensures adequate supply of safe blood and blood components.

National AIDS Control Programme (NACP) was established in 1987. In 1992, the government set up the National AIDS Control Organisation (NACO), to oversee the formulation of policies, prevention work and support programs relating to HIV and AIDS.

NACO envisions an India where every person living with HIV has access to quality care and is treated with dignity. Effective prevention and support for HIV/AIDS is possible in an environment where human rights are respected and where those infected or affected by HIV/AIDS live a life without stigma and discrimination. The first phase of the program, NACP I (1992-1999) focussed on generating awareness, strengthening management capacity for HIV/AIDS, improving blood safety controlling STIs and building surveillance and clinical management capacity.

NACO II (1999-2000) focussed on targeted interventions for high risk groups; prevention strategies through voluntary counselling and testing (VCT) and prevention of Parent to child transmission (PPTCT); introduction of antiretroviral treatment (ART); and low cost strategies for care and support. Further, NACP II placed emphasis on institutional, strengthening, decentralization of service delivery and management reforms for state AIDS Controls Societies (SACS) and intersectoral collaboration. In 2002, the government adopted the National AIDS Prevention and Control Policy to prevent HIV/AIDS from spreading further and to reduce the impact of the epidemic on the general population. In 2006, the Paediatric AIDS Initiative was launched.

1.11.1 NACP phase III has started (2006-2011):

The overall goals of NACP-III is to halt and reverse the epidemic in India over the next five years by integrated programmes for prevention

,care and support and treatment. This will be achieved through a four – pronged strategy; prevent infections through saturation of coverage of high risk groups with targeted interventions and scaled up intervention to larger number of PLWHA, strengthen the infrastructure, systems and human resources in prevention, care, support and treatment programmes at district, state and national levels and strengthen the nationwide Strategic Information Management System.

The specific objective is to reduce the rate of incidence by 60 per cent in the first year of the programmes in high prevalence states to obtain the reversal of the epidemic and by 40 percent in the vulnerable states to stabilise the epidemic. Considering that more than 99 percent of the population in the country is free from infection, NACPIII places the highest priority on prevention efforts while, at the same time, seeks to integrate prevention with care, support and treatment. Sub populations that have the highest risk of exposure to HIV will receive the highest priority in the intervention programmes. These would include sex workers, MSM and IDUs. Second high priority in the intervention programmes is accorded to long distance truckers, prisoners: migrants (including refugees) and street children. In the general population, those who have the greater need for accessing prevention services, such as treatment of STIs, voluntary counselling and testing and condoms, will be next in the line of priority. NACPIII ensures that all persons who need treatment would have access to prophylaxis and management of opportunistic infections. People who need access to ART will also be assured first line ARV drugs. Prevention needs of children are addressed through universal provision of PPTCT services. Children who are infected are assured access to paediatric ART. NACP III is committed to address the needs of persons infected and affected by HIV, especially children. This will be done through the sectors and agencies involved in child protection and welfare. In mitigating the impact of HIV, support is also

drawn from welfare agencies providing nutritional support opportunities for income generation and other welfare services.

NACP III also plans to invest in community care centres to provide psycho-social support, outreach services, referrals and palliative care. Socio economic determinants that make a person vulnerable also increase the risk of exposure to HIV. NACP III 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.

1.12 Millennium Developments Goals & HIV/AIDS

The Millennium Development Goals (MDGs) as promulgated by the international community was to free all fellow men, women and children of the world of hunger, poor health and related burdens to free them from manifestations of all forms of oppressions. This call of the international community manifested itself in the form of eight concrete goals relating to eradication of hunger, poverty, ill health with a special focus on HIV/AIDS with an aim at achieving all these through a progressive partnership in ensuring a sustainable development.

In the Millennium Development Report 2008 of the United Nations the central theme is quite appropriately captured in the following expression "The MDGs encapsulate the development aspirations of the world as a whole. But they are not only development objectives, they encompass universally accepted human values and rights such as freedom from hunger, the right to basic education, the right to health and a responsibility to future generations".

With daily 7,500 new infections and nearly 5,500 deaths from HIV/AIDS the numbers are no less than staggering and such figures are attributed to the lack of preventive and treatment services to combat this menace. Nevertheless, the improvement in such facilities over the years

have registered victories, no doubt small, but definitely encouraging. With HIV declining from 3 million in 2001 to 2.7 million in 2007 we have taken a small step in the journey towards freedom. And with the expansion of antiretroviral treatment services, the number of people who die from AIDS has started to decline, from 2.2 million in 2005 to 2.0 million in 2007. However, largely because newly infected people survive longer, the number of people living with HIV rose from an estimated 29.5 million in 2001 to 33 million 2007. The vast majority of those living with HIV are in sub Saharan Africa followed by South Asia. Sample data and national surveys suggest that HIV prevention has been successful, particularly in reducing risky sexual behaviour.

In India, one of the largest and most populated countries in the world with more than one billion inhabitants, it is estimated that around 2.5 million Indians are currently living with HIV. HIV emerged later in India than it did in many other countries.

1.13 Factors Influencing HIV/AIDS in Manipur

Manipur is the eastern most state of India. Imphal is the capital city. The state has an area of 22,327 sq.km with a population of 2388638 of which 49%(i.e. 1170432) are female with 59.70% literacy rate (2001census).The state share borders with Nagaland in the north, Mizoram in the south, Assam in the west and a 385kms long International border with Myanmar (formerly Burma).The state is organized into nine administrative districts namely, Imphal East, Imphal West, Thoubal, Bishnupur, Ukhrul, Senapati, Tamenglong, and Churachandpur district. The population consists of 38 ethnic groups speaking different dialects following different religions, having diverse cultures and traditions. There are 29 Schedule Tribes (ST) and seven Schedule Castes (SC) having their own distinct dialects, tradition and culture.

Table.1.5 Surveillance Report (September 1986 to March 2008)

Particulars	Sero-surveillance	Sentinel surveillance	Total
Total no. blood samples screened	1,78,340	64,629	2,42,969
Total cumulative HIV positive cases	23,239	5903	29,147
No.of females	7513	-	7513
No.of AIDS cases	4294	-	4294
No.of deaths	617	-	617

Source: Surveillance Report of Manipur (MACS)

Manipur is one of the six high prevalence states in India. Out of 2,42,969 blood samples screened up to March 2008, the cumulative number of HIV positives is 29,147. Among them, 7513 are women.

Manipuri women hold a higher and more liberal position than other patriarchal societies in the country. Increased social acceptance of women's participation in different activities, more access to education, less restriction on travel and outdoor activities is witnessed in the last few decades. Manipuri women are also making history in the field of sports in the national and international level and also they made important contributions to arts and culture.

Socio-economic Profile:

Agriculture is the main occupation and largest source of livelihood for more than 70% of the total population of the state. Embroidery, handicrafts and weaving still remain as domestic and small industries.

Failure of state run industries and cooperatives has resulted into a tremendous loss in income and employment in the last few decades.

Political Situation:

Manipur is considered a sensitive and disturbed border state by the Indian Government and by the so called 'North East Analysis, that the foreigners entering into Manipur must possess a travel certificate from the Regional Registration Office, Government of India.

The armed conflict between the state and various armed nationalist groups is impacting with dire consequences on socio- economic development, in maintenance of law and order.

In spite of all the issues, there is intensive strikes, *bandhs*, protest rallies by different departments and different pressure groups against human right violation by state or federal security forces, no timely payment of salaries, pension, corruption etc. had been the day to day law and order situation.

The ethnic groups have diverse political aspirations and have been striving for their group identity. Some ethnic groups are also in the process of developing a new nation-state identity.

1.13.1 Manipur and HIV/AIDS: An Overview

Manipur is the worst HIV/AIDS affected state in the country that 12239 persons in the state are known to be HIV infected (Macs, Oct 2001) of which 1609 are female. Since the beginning of Epidemiological analysis in September 1986, Injecting Drug Users have constituted the highest risk group of HIV infection through sharing of unsterilized injecting equipments. According to Technical Resource Group on IDUs (TRG, 1996) 40% of the Drug Users in Manipur has been married. Fortunately, the rate of HIV Infection among IDUs is decreasing from 72% in 1994 to 59% in 2001 as a result of prevention works by NGOs

and the state wide outreach Intervention among IDUs undertaken by MACS since 1998. However, the rate of HIV infection is rapidly increasing among the wives of IDUs and the women in general.

Table 1.6 Estimate HIV Prevalence in India and Manipur in 2007:

	India	Manipur
PLWHA	2.47 millions	42,000
HIV prevalence rate	.36/1000	1.3/1000
Among male(14-49yrs)	.36/1000	1.59/1000
Among female (14-49yrs)	.22/1000	.76/1000
Among male (15-24yrs)	.09/1000	.38/1000
Among female (15-24 yrs)	.11/1000	.39/1000

(Source: Sentinel Surveillance MACS 2007)

Table 1.7 Epidemiological Data of HIV/AIDS in Manipur March, 2009

No.of blood sample screened	310527
No.of cases found positive	31972
No.of female positive	8053
No.of AIDS cases	4363
No.of Death cases	625
Seropositivity rate per 100 samples	10.3

Source: Sentinel Surveillance MACS, 2009

Table 1.8 Distribution between Age & Sex of HIV+ Cases in Manipur in May 2008

Age group	Male	Female	Total	%
0-10	866	782	1648	6.96
11-29	921	407	1330	5.61
21-30	6680	3533	10213	53.10
31-40	5963	2499	8462	35.71
41 and above	1443	598	2041	8.61

Source: Sentinel Surveillance MACS, 2008

Poor Access to Health Care and Drug Rehabilitation Facilities:

Access to quality health care in Manipur, is greatly influenced by geographical, cultural, economic and political factors. Health care needs of persons living with HIV are also influenced by additional factors like health care provider, knowledge, attitude belief and practise toward HIV/AIDS., and overall availability of health social service facilities.

1.14 Impact of HIV on Women

The impact of HIV/AIDS on women has been referred to as “triple jeopardy” (Bennett, 1990). This addresses the key role gender, roles that women are generally expected to fulfill: productive, reproductive, and community .HIV/AIDS affects women as individuals’ mothers and caregivers in these socially defined roles.

Women as mothers with HIV/AIDS are affected in

- Firstly, many mothers of young adults are fearful of their children becoming infected with HIV but often lack the skills to sexuality openly with them
- Secondly, more and more mothers have to care for their young and adult children as well as the partners of their children when they become sick
- Finally, for a mother who is HIV positive there is the risk of transmitting HIV to her child, during pregnancy, during birth or after birth through breast feeding.

Women's status has an important and direct influence on their vulnerability to HIV infection. As with other sexually transmitted disease, women are more likely than men to get HIV from infected men. Women constitute one third of the estimated HIV infected persons in the world.

Women in Painful Dilemma:

The issue of safe sex can present women with another painful dilemma. In many parts of the world fertility is a paramount value, and a women's only path to social status and self fulfilment is through childbearing. But in the AIDS era and particularly in communities with a high level of HIV infection, women find themselves against infection and the desire as also the social imperative – to have children. In essence, this means they are faced with a lonely and agonizing choice between physical survival and social acceptance.

Anger:

AIDS causes anger in the PLWHA. They are angry at the media; angry at having their carriers suddenly going away, at a time when they were at the pinnacle of success; at being rejected by friends and family and angry of having this illness. Anger aggravates a loss of control and a loss of independence.

There is a withdrawal from all social communications when the anger is towards ones religion. Anger of the family members may be directed towards healthcare providers by blaming them for not looking after them.

Blame:

It is unfortunate reality that when the first case of HIV/AIDS is identified within a family, the blame is most often attributed to the women, even if the evidence contradicts this. There is fear that her family, because of her perceived past behaviour, will abandon her. She is forced to keep quiet and she is not a position to argue her case. The stigma and discrimination associated with this disease, thus, often rests with woman.

The widow is very often blamed for the son's death and told to leave the home, but some of them are not welcome in their natal homes too. And then they faced the prospect of being without a roof over their head. Number of women being widowed by AIDS, do little to show how being widowed in this way compound already traumatic experience, widowhood.

Different attitudes may compound for young widows whose husbands have died of AIDS, adding to the cumulative stigma that they face. They have to cope with issues facing all widows, intense isolation and loneliness. In some communities they may fear having their property

grabbed or seized. They may be blamed for the death of their husband or they themselves feel guilt at having survived, irrespective of who transmitted the infection. Without access to ART treatment, can amount to a death sentence, placing young widows in a unique state of transition which they must make arrangements for the care of their children after they die as well as care for any HIV Positive children who may die before them. The trauma of being widow is great enough in the best of circumstances but for a widow affected by HIV/AIDS, the additional psychological burden is particularly great.

Dependency:

In India, most women are dependent on their husbands, or his family for food, clothing, shelter and money. It is usually the male partner, who usually controls the financial matters at home. As a result of this, abstinence, faithfulness on man's part, which has now become the mainstay of protection against HIV disease, is totally the man's prerogative.

Burden and Bereavement:

From the time of her birth, the Indian psyche considers the female child, a burden, initially to her family, and later on, to her husband's family. The main aim of her biological family is to marry her off, as quickly as possible in order to ease this burden .After marriage, in case of the husband's death his property, provident fund (if any), remains with her husband's family and in many cases, the wife goes back to her own family, where she continues to be financial and emotional burden. Many such women are also forced into prostitution for a living. In fact, most women living on prostitution have a painful past, such of job, forced flesh trade through kidnapping, or sale, etc.

Pregnancy:

Women are considered to be the potential bearer of sons. It is a persistent Indian belief that the sons are the ones, who will grow up, and earn and look after the old parents while daughters are burden, who will have to be given away in the marriage .Even if a woman is HIV positive, she may be under pressure to produce a son, at risk to her own life and future, as well as that of her unborn child.

Women are more vulnerable to AIDS infection because;

- In India, the major spread of AIDS infection is heterosexual.
- HIV is more easily transmitted from men to women than vice-versa

For sociological and biological reasons women are twice as likely to contract HIV through vaginal intercourse as men. Young women are particularly vulnerable because their vaginal tracts have not fully matured, are easily torn and offer less protection from disease.

This is significant for widows for a number of reasons.94percent of the HIV positive women who reported to main research hospital in Mumbai in 1998, had been infected by their husbands.20% of these women, all below 30, and had previously been widowed by AIDS. Marriage at the young age therefore does not protect young women from infection and often means that girls are forced to stop their education. Lack of education has a bearing on the rate of infection amongst young women.

1.14.1 Reasons for Transmission:

The reasons for transmission of HIV disease to women are many:
Intercourse: World wide the cause of HIV infection among women is the prevalence of promiscuity involving heterosexual intercourse. This is a primary factor.

Sexually transmitted diseases (STDs): Sexually transmitted diseases, particularly those associated with genital ulcers and strongly associated with a increased risk for HIV infection.

Drug Abuse: Drug abuse in women is associated with sharing of unsterilized needles used for injecting drugs, and high risk sex behaviours with increased number of partners.

1.14.2 Factors affecting Women's Vulnerability to HIV Infection:

Socio-cultural Factors:

Women are burdened with domestic chores and child care responsibilities. They absorbed in the struggle to sustain the family physically and emotionally. Women are often unable to discuss sexual matters. It is not acceptable. It refers to her lack of power and limited control over personal and sexual relationships education and awareness of AIDS is scanty and it overemphasizes the notion of virginity.

In the developing countries, nearly all HIV infection reported among women has been acquired through heterosexually .Majority of the Indian women has been infected nor through their own behaviour but through that of their husbands.

In marriage, women lack control over their lives, forget alone over their husbands life outside the marriage. Extra marital relationships, intravenous drug abuse, and bisexual behaviour on the part of the husband are possible routes for entry of the virus into the marital union. For these women, sexual intercourse is not a question of choice, but rather a question of survival. The wife has hardly any say in when to have sexual intercourse, or how to protect herself from HIV infection, if the husband is infected. She also does not enjoy the freedom to choose whether to become mother, or to protect the life of an unborn child from forced abortion.

Economic Factors:

Women are financially dependent on men. They fear of being thrown out and disowned if they talk about the use of safe sex practices to reduce the risk of infection. Sometimes, unemployment, poverty added with the responsibility of taking care of her children or siblings drives her to become a commercial sex worker. Her risk of acquiring HIV infection greatly increases.

It is not coincidental that the counties in which the virus is now spreading fastest heterosexually are generally those in which women's status is low. Whenever, discrimination leaves women undereducated, unskilled, and unable to gain title to land or the other vital resources in their own names, and low in self esteem, it also leaves them especially vulnerable to HIV infection. Their access to vital information about the virus is limited, as is their choice of livelihood, and in hard times many find it necessary to trade sex for money, food or shelter.

The effects of HIV/AIDS multiply far beyond the infected individual. In a long run, it has the potential to affect whole sectors of the economy and societies as resources will be required for increasing number of people living with HIV/AIDS and for the care of increasing number of orphans. The socio economic condition of HIV affected women is also worse than women from general population.

1.15 Widows and AIDS

Biological, Socio-cultural and economic factors make women and young girls more vulnerable to HIV/AIDS. In India, the low status of women, poverty, early marriage, trafficking sex-work, migration, lack of education and highly gender discrimination are some of the factor responsible for increasing the vulnerability of women and girls of HIV infection.

AIDS Widows, alarmingly increasing its number in the state is a worrying state for their wards' future. Among the young an estimated 2.4 million in India who are known to be HIV positive are women. The majority of them around 80% contracted the disease from their husbands, a situation similar to South Africa. The Widows are the final victims of HIV/AIDS (NACO 2006).

Widows in every society face multiple and conflicting social challenges. Their status is defined by a diverse group of interrelated and intersectoral factors social, religious, cultural as well as economic, all of which not only isolate them from their families and community, but also leave them responsible for the care and support of their children. This is particularly true for India, where the life of an individual is governed by certain socio-cultural norms which determine a person's social standing as well as purpose and function in life. Widowhood coupled with economic vulnerability affects the well being of the children of widows. Lack of finance may impel the widow to withdraw her children from school and even send them out to work. They also suffer from ill health and malnutrition because of lack of means to access appropriate health care. Hill et.al (1981) and Morgan (1989) reported that high percentages of widows were immediately pushed into poverty by the death of husbands. Obbe (1993) found that widowhood in Uganda brings poverty which is worsened by the requirement for the widow to pay off the debts incurred while caring for her sick husband.

The trauma of being widows is great enough in the best of circumstances but for a widow affected By HIV/AIDS, the additional psychological burden is particularly great. Perceptions of responsibility and blame differ between different age groups and sex, but since the spread of AIDS is often seen as the result of women's immoral sexual behaviour, women are often blamed by all members of society, including other women. Attitudes may compound the psychological impact of

widowhood for young widows whose husbands have died of AIDS, adding to the cumulative stigma that they face.

The discrimination and stigma felt by widows affected by AIDS is not limited to psychological trauma but also affects their social economic status. Loss of husband's income may be compounded by ostracizing from the extended family which may have been the only economic and social support network available. Many women accused of bringing the virus into the husbands' home, have lost that home on his death. In such cases the widow, particularly if she has few skills, faces considerable difficulties in finding work, a new home and rebuilding her life. The socio-psychological problems that AIDS creates for the widows is unfortunate and that the multiple problems never come to the fore- a reaction to the stigma anger, denial and isolation.

AIDS Victims are Totally Deserted:

- Life long infection;
- Disease is lethal;
- No cure, no vaccine;
- People react differently when told of their HIV Positive status;
- Carries stigma, surrounded by myths and disinformation; and
- Tremendous costs both direct and indirect, thus adversely affecting the medical treatment.

1.15.1 Problems faced by Widows and its Consequences

The widows of partners with HIV/AIDS face negative, long term and severe problems. They seem to be derived from social economic, culture and emotional deprivation than from widowhood itself. The problems are not only manifold and severe but they are interrelated and affect each other. Widows whose husbands have died of AIDS are frequently blamed for their deaths because of promiscuity, whereas in the majority of cases,

it is the men who have enjoyed multiple sex partners but return home to be nursed when they fall ill. These widows may or may not be aware of their sero-positive (infected with the HIV/AIDS virus) status and may be rejected testing, fearing the consequences of a positive result, which, with no access to modern drugs can amount to a death sentence. Besides, the dying husband's health care will, in most cases, have used up all available financial resources so that the widow is unable to buy even the basic medicines or nutritious food needed to relieve her condition.

Familial and Social Deprivation:

There is a deep-felt conviction that the presence of widows is inauspicious. The HIV/AIDS label doubles the problems of widows to such an extent that they are not only considered as inauspicious but they are completely isolated and out caste from close kinsmen, ceremonies, parties and congregation. They are even thrown out of their homes and are compelled to be away from social milieu. Thus widows are forced into life which is colourless, hopeless and lonely. Many of India's AIDS widows are in their early to mid-20, in the role of caretakers for their children, or trying to survive as widows in a society that largely views them as a burden. Stigma and discrimination in relation to widows is much stronger who risk violence, abandonment, neglect (of health and material needs) destitution, ostracism from family and society. Stigmatizations are exacerbated by ritual and religious symbolism.

Economic Deprivation:

Most of the AIDS widows face difficulties in meeting the basic needs of minor children such as providing good food, clothing, and school fees. Lack of employment and education adds to the plight of these widows where many children are compelled to leave the school and join the work force to support, the family income. Here they fall victim to various

exploitations. The vulnerability of AIDS Widows daughters and child widows is especially severe, forcing them into unsuitable early marriage and early widowhood, life on the streets, prostitution and other high risk activities such as servile domestic service in the context of trafficking and spreading HIV/AIDS infection. The widows after death of their husbands who lose their property and have no inheritance rights nor legal or jurisprudential infrastructure which will guarantee those rights. Loss of health, body image, income, family and friend and time, widows worry about how they will be provided for financially and how they will take care of their children.

Emotional Deprivation:

The AIDS widow faces the problems adjustment due to individual hindrances like nervousness, moods of depression and morbidity. As they are doubled stigmatized of being widowed and HIV/AIDS carrier, the leading problem is loneliness and grief. Family difficulty and legal affairs are the further problems. In the male oriented society widows suffer from grief out of the blame for husband's death and suspecting her morality if she is in the reproductive age. The children of widows face the emotional problems of the fear that their fathers died of AIDS and their mother will also die soon.

Many a time these widows due to stigmatization do not have the courage to disclose about the cause of her husbands death even if she knows. The children also do not disclose out of the fear that they will face discrimination and solitude. They yearn for human touch but feel frightened of having intimate relationships and of being rejected. They suffers from anxiety depression anger, frustration, guilt, shock , fear, blame, loss of self esteem and some even attempt suicide.

The advent of HIV/AIDS has greatly coloured the incident of widowhood with many widows acquiring social labels as HIV carriers. These negative labels lead to discrimination and marginalization by:

1. In-laws, the wider community, health official and even some development workers.
2. Suspecting of having the HIV simply because they are widowed and are denied access to the resources of their deceased partner, on grounds that they are suspected to be dying soon.
3. Many AIDS impoverished widows fall victims to quarrels with their husbands family and are deprived of assets leaving them with no hope to begin a life of widowhood (AseruDA; Cndiru H: Candiu j.HIV positive women intervention in times of bereavement .Int conf AIDS).

1.15.2 Consequences:

Widows and their Families May Become Entrenched in Poverty

The interplay of a wide range of socio-economic problems resulting from HIV/AIDS often pushes AIDS widows and their families below the poverty threshold, directly threatening the survival and well being of their families. Even more importantly perhaps, female -headed households affected by AIDS become entrenched in poverty, as in addition to the loss of labour and cash income. Women have fewer legal rights than men, are often less literate than men, and have limited access to support services , credit, and inputs .The result is a marked increase in poverty among AIDS widows. This feminization of poverty, a key characteristic of the socio-economic impact of HIV/AIDS, has far-reaching consequences for rural societies and particularly youths, with girls/young women being most affected. Most widows are not aware of the existence of wills (testament) and they do not understand the rational behind the will that it is an absolute necessity for the survival and well

being of their families. Similarly, most women do not know how to open bank accounts and have to go about getting information with regard to their legal rights. If a widow is not wealthy and has children who are perceived as burdensome rather than an asset- daughters, handicapped or very young sons (unproductive mouths), the scene is set for hostile and abusive treatment of AIDS widows. Though it is estimated that 20% of rural households in India are de-facto female headed, few women own the title to their land, and even fewer actually exercise control over it.

Widow receives no moral or material support from her late husband's family or from the village; No one ever comes to see her. Attitude toward her and her inmates remains very negative, A widow can not ask for help from her husband's male relatives because she fears that their wives will suspect that she is sexually involved with them.

Widows and their Families may be Stigmatized and/or Ostracized:

The AIDS stigma, in particular, can sever the access. Widows would otherwise receive assistance from the extended family and the community. Much depends on how the husband's family reacts to the death of a son. Often, the widow is blamed for transmitting the disease to the son and is accused of promiscuity and immorality. Stigmatization may result in loss of respect within the extended family and the community, abuse and repression. Some widows are harassed and forced to leave their village and migrate to the towns where here they can escape from the stigma, earn their living as petty traders and remarry in anonymity. The situation is worse for widows who only have girl children, as the latter do not inherit land and property. Young woman/widows appear to be regarded as temporary members of their family, and where wives are often treated as secondary members of their husband's family, widowhood associated with HIV/AIDS creates an anomalous social being. In that case she is no longer under the protection of her natal family, nor

under the direct protection of her husband. Anomalous and therefore dangerous too because her sexuality is no longer controlled and contained by her husband/master and has drastically reduced possibilities for remarriage due to fears of infection when one is known to be widowed with HIV/AIDS partner.

AIDS widows, accused of murder and witchcraft, may be hounded from their homes and subjected to the most extreme forms of violence. A Help Age International Report from Tanzania revealed that some 500 older women, mostly widowed in the context of AIDS, were stoned to death or deliberately killed in 2000.

Widows May Develop a Crippling Anxiety over their Sero- Status and the Sero-Status of their Children.

If a man is known to have died of AIDS or if a widow suspects that her husband may have died of AIDS, the possibility of herself and/or her children being infected with HIV becomes “crippling”. The greatest anxiety of an AIDS widow over her sero-status concerns her children rather than herself. An AIDS widow who suspects she may infect cannot rely on herself. This makes her helpless, and in the absence of assistance from the extended family and community, there are often no alternatives open to her.

Widows who are aware about AIDS would turn to get information and counselling on HIV Testing. Due to lack of awareness most of them do not know there are testing facilities available in a nearby town. AIDS widows feel the need to know their sero-status but due to illiteracy and state of helplessness they are unable to consult and the service providers also do not reach out to them. Providing widows with information on HIV-testing and counselling is critical but may not be enough, however, as transport costs to the clinic can be prohibitively expensive

particularly considering that HIV testing requires at least two or three hospital visits.

➤ **Cultural Practices may Infect the Extended Family with HIV;**

In some African cultures, death does not end a marriage, and a widow is expected to move into a “levirate” arrangement with her brother-in-law (“levir”) or other male relative or heir nominated by his family. The children conceived are in the name of the dead man. In other ethnic groups she may be inherited by the heir. Many widows resist these practices, which are especially repugnant and also life threatening in the context of AIDS and polygamy. Refusal to comply may be answered with physical and sexual violence. While in earlier times such traditional practices effectively guaranteed the widow and her children protection, in recent decades, because of increasing poverty and the breakup of the extended family, widows discover that there is no protection or support, and, being pregnant by the male relative, they find themselves deserted and thrown out of the family homestead for good.

Levirate marriage system greatly facilitates the spread of HIV/AIDS and has the potential of infecting several families very rapidly. When widows are married with late husband’s brother, they risk infecting them as well as their co-wives. If any of the wives has children, they may also be infected to HIV .Some widows whose husbands have died may also be infected with HIV/AIDS if the brother -in-law is already infected.

➤ **Widow’s Dilemma in cultural Practices : Being established or being abandoned:**

Widows are challenged to protect their families. However, there is considerable resistance to change, particularly among male members. There is an ignorance regarding the disease. For instance, if a man who sees his late brother’s widow looking healthy may ignore the possibility that she may be HIV-positive.

What is more alarming, however, is the fact that even though some men are aware of the dangers of levirate marriage, they insist on marrying a widow at all cost. It appears that this may be linked to be property/ wealth left by her husband which his brother does not want to lose claim over it.

The fact that men insist on marrying widows even when they have good reason to suspect that they may be HIV-positive is puzzling. Most HIV/AIDS initiatives do not deal with the issue of such cultural practices as it is a private and sensitive matter.

Given the critical role that cultural practices play in the infection and/ or transmission of HIV/AIDS, there is a urgent need to address this. Sensitive men and women and help families find alternative coping strategies.

1.16 Role of NGOs

Non-Governmental organizations play an important role everywhere. A number of different population groups such as CSW, IDUs, those indulge in unprotected sex and with multiple partners and sexually transmitted diseases are at high risk of contracting HIV/AIDS .The marginalised high risk groups are more accessible to NGOs than to Government programmes. The role of NGOs is very important as;

- They are people oriented, and are better acquainted with and more sensitive to the requirements and concerns of those affected by HIV/AIDS.
- The close interpersonal interaction which NGOs have with people in the communities they work in is extremely beneficial for implementing the behaviour interventions essential for HIV/AIDS.
- NGOs often work in areas and regions which are not generally covered under government programmes.

- NGOs are more efficient and effective in the use of resources and can provide support directly to the people and the communities.

1.17.1 HIV/AIDS and the Law:

Rights are justified claims that individuals or groups can make upon other individuals or upon the society. PLHAs have the same right as HIV negative people – right to education, employment, health, travel, marriage, procreation, privacy, social security, scientific benefits, asylum etc.

Some existing Indian laws related to HIV/AIDS:

- Malignant act likely to spread infection of disease dangerous to life
- Drug and Cosmetic rule: screening of donated blood and organs for HIV
- Artificial insemination Act: appropriate HIV testing to be done before insemination
- Bio medical waste management regulations
- Requirements of notification to public health official of infectious disease.

Legal and ethical issues around HIV testing and screening

- Counselling and informed consent are essential requirements of HIV testing.
- No individual should be made to undergo mandatory testing for HIV
- No mandatory HIV testing should be imposed as a precondition for employment or for providing health care facilities during employment.
- In India it is aimed to get all antenatal mothers to be provided for counselling testing for HIV. The procedure is as follows in the PPTCT centre

- ❖ Mothers are counselled in a group
- ❖ They are given information on HIV infection and the advantages of testing
- ❖ They are told that they will be tested
- ❖ If they choose not to undergo the test, they cannot be forced to do so. They can only be tested after they have given voluntary informed consent.
- Results should be kept strictly confidential
- Provider initiative
 - Identify prospective client(s)
 - DOTs centre,STI clinics OPD,ANC clinic, Skin OPD,General clinics in PHCs and CHCs
 - Motivate the clients having following condition testing (STI, TB, chronic diarrhoea, weight loss, chronic fever, chronic cough, herpes zoster, oral candidiasis, recurrent oral ulcers and lymph adenopathy, pregnant women).

Legal and ethical issues around HIV and pregnancy

- HIV positive women and couples should have complete choice in making decisions regarding pregnancy and childbirth
- The risk involved of getting re- infected and also with a different strain of HIV during sexual contact is high and this must be mentioned to the couple when they plan to have a child
- Couples should be counselled for prevention of parent to child HIV transmission
- Educate on the following aspects
- Risks of HIV transmission to the baby
- Preventive services available to reduce risk of transmission under PPTCT programme

Legal and ethical issues around PLHAs access to health care

- No patients can be denied care and treatment on the basis of their HIV sero- status
- Intensive advocacy and sensitisation among doctors, nurses and other paramedical workers is needed to prevent discrimination against PHLAs
- Biomedical waste management –legal aspect detail act(all HCP must trained on Infection control and Medical Waste management)
- Strict enforcement of bio safety and infection control measures in the hospital is needed
- Treatment of AIDS cases do not require any specialized equipment other than what is necessary for treatment of opportunistic infections arising out of HIV/AIDS.

1.17 Global Programme on AIDS (GPA)

World Health Organisation has identified the following Key elements essential to protect human rights, ethics vis-à-vis HIV/AIDS and Laws (GPA, 1995:1-3).

Access to Information, Education and Health Services.

All people should have equal access to available information, health services and prevention methods that will enable them to reduce transmission of infection and receive counselling and care, if infected. Powerless sections must have equal share to these.

Consent for Testing:

Testing for HIV should be carried out on a voluntary basis after the individual has been informed of the nature and implications of the test and has consented to being tested during pre-test counselling. Special protection regarding voluntaries should be afforded to those legally not competent to give consent, for example minors and the mentally

disabled. Informed consent should also be obtained for participation in HIV related treatment and research. It is known that patients who have to undergo surgery, in many hospitals are being tested for HIV without consent, and are being sent away if found positive.

Confidentiality:

Confidentiality of HIV status should be ensured at all times, including during testing, treatment, notification and in the employment and health care setting. Any disclosure should be strictly justified on the basis of law and professional ethics.

Non-discrimination:

There should be no discrimination or restrictions of rights based on HIV status or suspicion of HIV status. People living with HIV/AIDS should have equal access to education, travel, employment, housing, health care and a non-discriminatory cremation or burial. Mandatory testing or disclosure of status should not be required to gain access to these.

There is a very peculiar kind of social discrimination in the case of HIV infection, not found in any other illness. People infected through the blood route are seen as being innocent victims and deserving care, while those infected by the sexual route are seen as immoral or guilty and, therefore, unworthy of care. A person injured by an accident is given the necessary medical care and family attention, without a thought regarding whether he/she was on the right or the wrong side of the road, a patient who suffers a heart attack is given due to medical and family attention irrespective of the factors that may have triggered the attack, whether these are stress at work due to nagging boss, or a raid in the house for suspected evasion of income tax or may be anything else. Persons infected by the HIV virus are also worthy of medical care and family love and attention, irrespective of how they got infected. Infected

persons must be protected legally from any discrimination arising from the source of infection.

Liberty and Freedom of Movement:

People living with HIV/AIDS should not be denied liberty or freedom of movement by arrest, detention, isolation, quarantine, compulsory hospitalisation, segregation or exile, except as justly imposed by law; or be denied the right to seek and enjoy asylum from persecution. Travel restrictions which discriminate solely on the basis of HIV status have no public health justification and violate human rights.

Right to Marry and Found a Family

Counselling infected persons must be an important part of the HIV/AIDS control programme. Infected persons must be helped to see the consequences of their decisions in life matters, upon themselves, upon those who care for them and upon society. Given proper counselling, they may be trusted to generally take responsible decisions regarding marriage, having children, and so on. Even if they do not do so, it will not be possible to impose preferred choices on them by law. This will only lead to a situation where people will conceal their infection status. This will have several other unhealthy repercussions for society. Even if the infection status is known after marriage, couples must encourage to live together by adopting safety measures even if their partner is infected. It should not be a cause of divorce. The remedy of divorce in such cases at the societal level will be far worse than the disease itself. Divorce could probably be sought on grounds of cruelty if the infected member deliberately insists on unsafe behaviour that puts the spouse to risk of infection. Under the Indian law, divorce could be granted if the partner is suffering from an incurable disease. As AIDS is incurable so far, it would legally qualify as a reason for granting divorce. As it is possible to prevent

the spread of infection by specific measures, there is no reason why a couple could not continue to live together.

Premarital and prenatal HIV testing should be voluntary and based on informed consent. Women should be advised of the risk of perinatal transmission and means to avoid such transmission. If pregnant, women living with HIV/AIDS should have equal access to assistance during pregnancy and after delivery. There should be no coerced abortions or involuntary sterilisation due to HIV status.

Premarital testing may provide a false sense of security. Infection status of an uninfected person need not be static. The risk of exposure to infection by the blood or sexual route can change one's infection status. Therefore, there is no point in making premarital testing mandatory. However, if one wants to voluntarily opt for may have a choice to do so.