

## The North-Eastern States' Profile



### **Regional Profile**

North East India comprises eight states: Assam, Arunachal Pradesh, Sikkim, Meghalaya, Nagaland, Manipur, Mizoram and Tripura. With the exception of Assam, Sikkim and Meghalaya, all states have one or more high-burden districts (Category A – NACO classification). Overall, 23 districts in Manipur, Nagaland, Mizoram, Arunachal Pradesh and Tripura are designated high-burden districts. The region shares long porous borders with Burma, Bangladesh, Nepal, and China with cross-border movement made easy due to ethnic similarities. It has a significant impoverished tribal population. Unemployment is very high, especially among the youth. Although most of the seven states have literacy rates higher than India's average, school dropout rates remain high. All states in the region except Assam depend on the national road transport network for goods supply. Political and social

---

\* National AIDS Control Program – III envisages district level planning and implementation of all the programmatic initiatives. For the purpose of planning and implementation of NACP-III, all the districts in the country are classified into four categories based on HIV prevalence in the districts among different population groups for three consecutive years. The definitions of the four categories are as follows:

**Category A:** More than 1% ANC prevalence in district in any of the sites in the last 3 years.

**Category B:** Less than 1% ANC prevalence in all the sites during last 3 years with more than 5% prevalence in any HRG site (STD/FSW/MSM/IDU).

**Category C:** Less than 1% ANC prevalence in all sites during last 3 years with less than 5% in all HRG sites, with known hot spots (Migrants, truckers, large aggregation of factory workers, tourist etc).

**Category D:** Less than 1% ANC prevalence in all sites during last 3 years with less than 5% in all HRG sites with no known hot spots **OR** no or poor HIV data.

(ANC: Ante-natal Clinic; HRG: High Risk Group; STD: Sexually Transmitted Disease; FSW: Female Sex Worker; MSM: Men who have Sex with Men; IDU: Injecting Drug User.)

turmoil, ethnic unrest, insurgency, and security forces are omnipresent. Students, workers and truckers move freely within the North East (NE) and major local industries attract migrant labor and support services including sex workers. Its proximity to the “Golden Triangle” in Southeast Asia has drawn the NE into the drug route. Intravenous drug abuse is rampant in these areas. Heroin and Spasmoproxicon are commonly used intravenously. Needle/syringe sharing and unprotected sex are common. Sex workers are street-based and interact with people on the move. These factors heavily affect the HIV epidemic in this region.

### **HIV/AIDS Situation in the North-Eastern States**

Manipur and Nagaland are among India’s top HIV ‘hotspots’ and Mizoram is fast catching up. 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. It has one of India’s highest prevalence rates at 1.7 % of the general population (National Family Health Survey 3, 2007), 19.8% among IDUs and 4.8% among STI clinic attendees (National AIDS Control Organization, 2007). The disease is both a public health problem and has broad social and economic overtones: 60% of people living with AIDS and related diseases are between the ages 21-30 years; life after the contraction of the infection is short, AIDS survival is limited and other epidemics have followed.

The risk patterns are similar in almost all the NE states, but HIV is spreading at different rates. The situation in Mizoram (1072 drug deaths since the 1990s) and Nagaland is not unlike Manipur a few years ago. In Myanmar, bordering Nagaland, the HIV prevalence among pregnant women antenatal clinic attendees is 5%. The NE’s public health care system is inadequate and overburdened. Rural areas, where drug/HIV deaths are occurring, have even fewer facilities, leaving it up to communities and religious institutions to respond in whatever way they can. Families in desperation encourage alcohol use to rid intravenous drug users of their injecting habits, buy drugs to inject at home to limit equipment sharing, or place youth addicts in church-run bare-bones detoxification centers in remote areas. The situation is worsened by discrimination and stigma, which are increasingly pushing HIV underground. Discussing sexual behavior is taboo, and a majority of HIV-positive people go home to families and communities with their deaths rarely recorded in official registers.

Considering all these factors and the role that this region is going to play in the future of HIV epidemic of India, NACO has accorded it the highest priority and started its first branch office, North Eastern Regional Office in Guwahati on February 22, 2008 to oversee the HIV activities in the northeast. Since the start up of this office, implementation of NACP-III has grown. Administrative issues like recruitment of personnel and tracking funding pipelines have been streamlined and programs are being rolled out in a timely fashion. The most visible change is the accountability of State AIDS Control Societies towards their programs. Another positive change has been the increase in ART and community care centers in the region.

Based on the topography and connectivity, antiretroviral therapy centers have started in all the eight north eastern states with emphasis on the high burden districts. Currently, there are 17 functional ART centers in the area providing ART to more than 6,000 eligible HIV patients.

The Kolkata Consulate's engagement in the NE is to promote regional stability, wherein HIV/AIDS is a key component along with conflict resolution and human rights. USG contacts echo concerns about the health, economic and social fall-out, and invite US expertise in research, communications, patient care and hospice. NACO has been requesting USG help to combat HIV epidemic in this region.

### ***USG Activities in the North East States***

The USG has initiated a program to partner with local, indigenous NGOs in Manipur and Nagaland to provide comprehensive home-based care and support for people living with HIV/AIDS. The project caters to about 2,000 people living with HIV/AIDS, many of them young widows. The USG is also providing technical support to the local governments, UN organizations and other partners in the areas of surveillance, care and support, and district planning.

At the request of NACO, USG has provided technical support on instructional design to the training institutes, SACS, UN agencies and others engaged in capacity-building activities across the NE. Essentially linking training to performance, the workshops on instruction design have already had a cascading effect across the region.