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INCIDENCE OF AIDS AND ITS SOCIAL IMPLICATION IN MANIPUR

*A short term project report submitted to the Institute
of social change and Development, Guwahati.*

By

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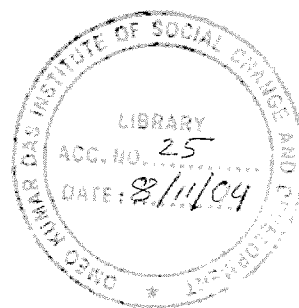
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This is to certify that the report entitled "Incidence of AIDS And Its Social Implications In Manipur " which is being submitted to the " Institute of Social Change And Development, Guwahati is based on bonafide research work carried out by Mr. N. Gokul chandra Singh, a short-term Junior Research Fellowship Rajiv Gandhi Scholar during the period from 28.9.1993 to 28.3.1994 under my guidance and supervision. No part of this report has been submitted to any other institution for any purpose.

Mr. N. Gokul chandra Singh worked hard and sincerely.
I wish him success in life.

(DR.T. Shyamacharan Singh)

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A C K N O W L E D G E M E N T S

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(N. GOKUL CHANDRA)

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CHAPTER - ONE

INTRODUCTION

O N E

I N T R O D U C T I O N

(I)

The Acquired Immune Deficiency Syndrome, commonly shortened to AIDS, is a newly detected disease which has indeed established a pandemic situation. It is caused by a virus which destroys the body's natural defence mechanism known as immune system. As a result, the body becomes incapable of exerting defence against a variety of other infections which are always lurking in and around the body. It was during the period of October, 1980 to May 1981 that five young active male homosexuals were noted with history of high fever, dyspnoea, cough and oral candidiasis, the symptomatic indication of either Pneumocystis Carinii Pneumonia (a type of lung infection) or Kaposi's Sarcoma (a type of cancer). Since the syndrome was recognised among the homosexuals not only in the USA but subsequently in Europe and Australia. It was called gay related immunodeficiency or GRID. A little later, cases of the disease were identified among drug addicts, especially intravenous drug users. Within a short time it was established that the causative organism of mysterious disease was a virus and the name AIDS, the acronym of acquired immune deficiency syndrome was first described in 1981 in the United States of America. Soon the

search for its causative organism began earnestly both in Europe and America. It was recognised that the causative Virus belonged to the subfamily Lentivirinae of the family Retroviridae and in May 1986 the International Committee on the Taxonomy of viruses recommended the name, Human Immuno Deficiency Virus (HIV). The virus attacks T-4 lymphocytes also known as T-cells. These cells are responsible for some of the most crucial immunological responses needed to combat foreign agents by the host. That is why even a simple opportunistic disease becomes fatal to the host of HIV.

(II)

Recognition of AIDS as a new disease does not mean it was entirely a new syndrome. In fact, immunodeficiencies of three types had been known earlier. Genetic or hereditary deficiency is passed on from parents to the newborns in the form of a defective gene. This gene does not allow the full complement of immune mechanism to function in these persons. Secondly, there is deliberately induced immunodeficiency, generally done before transplantation of organs such as kidneys so as to prevent the recipients from rejecting the transplants. Thirdly, acquired immuno deficiency was known to exist earlier in African countries

and other tropical, economically developing countries, in Asia including India the factors for which were attributed to old diseases caused by parasites compounded by malnutrition. But the new disease which was recognised in 1981 in the USA is quite different from the above mentioned three types of immunodeficiencies. Moreover, antiquity and evolution of this recently discovered disease is still shrouded in obscurity. Retrospective serological studies on stored sera from some countries in Africa demonstrated evidence of HIV seropositive during the mid 1960s. There have been suspects of its existence in the U.S. in 1968, in Zaire and Manchester (England) in 1959. Speculations have been persisted that it could have started between 1940s and 1950s, two to three decades before it was recognised as new. But the question as to where and when AIDS could have exactly started remain uncertain.

Another suggestion regarding the origin of HIV is based on the assumption that both HIV-1 and HIV-2 had somehow entered the human population from non-human primates, the likely origin of HIV-1 be the similar virus from chimpanzee and HIV-2 from the sooty mangabeys. For instance live poliovirus vaccine is produced in monkey kidney cells and it seems that the monkey virus could have jumped into human together with the poliovirus vaccine. Similarly, chimpanzees, being the closest non-human primates,

have been used for experimentation with human viruses, During the course of such cross immunisation, simian virus may have entered to humans. These hypotheses are yet to be scientifically proven. In March 1992 a paper appeared in Lancet, a reputed British journal, relates that if a few retroviral particles were to be present in the live polio vaccine, it would not infect children, particularly as the vaccine is given orally. Khorshed M Pavri (1992), however, proposes an alternative suggestion. It refers to the possible use of much larger and continued doses of the live polio vaccine by adult male homosexuals as a prophylactic means against recurrent viral infection. In such case probability of entering monkey virus to human through polio vaccine cannot be rejected straight-forward. In absence of any evidence this hypothesis will remain a conjecture only. Whatever the ways the disease may have entered to or developed in human kind, the reasons for its pandemic situation may be attributed to increase in sexual promiscuity, emancipation of gays in Western World, rapid air travel, massive use of blood transfusion unscrupulous trade in blood and blood products, selling of organs, and the increase in intravenous drug users.

(III)

The Acquired Immuno Deficiency Syndrome has, now, become

the most dreaded disease in many countries. The matter of more serious concern is the want of remedy. At the moment there is no medicine, no vaccine by which the disease can either be cured or be prevented. In the meanwhile the disease has been spreading like a wildfire. At this juncture Kenneth Kaunda (ex President of Zambia, who had already lost one son to AIDS, has rightly stated "what is more important than knowing where the disease came from is where it is going". In the absence of curative measure "only the tool to divert from the impending catastrophe is mass education on etiology of the disease. It is now learnt that greatest concentration of the virus (HIV) is found in blood, semen and cerebrospinal fluid, in lower concentration in tears, saliva, breast milk, colostrum, urine, cervical and vaginal secretions. Apart from it, the virus is also found in brain tissue, lymph nodes, and bone marrow cells. Modes of transmission of these virus depend on exposure to body fluids from an infected person, quantity of virus, route of exposure and the duration of exposure. The most effective modes of transmission known today are :

- i) sexual transmission, homosexual, bisexual and heterosexual with the carriers, male or female.
- ii) transfusion of contaminated blood or blood products.

- iii) sharing of contaminated syringes, razors, etc.
- iv) affected pregnant woman to her fetus, possibly breast feeding by the infected mother.

No reliable evidence of transmission through the air, water, casual contact, sharing of food and insect bite, etc. has so far been reported.

(IV)

Global scenario of AIDS phenomenon may be viewed into three broad patterns of infection. The first pattern, typified by North America, Europe, Australia, New Zealand, involves areas where the major groups infected are homosexual and bisexual men, intravenous drug-users and few heterosexual individuals. The second pattern is represented by Africa and Haiti where major mode of transmission appears to be heterosexual from man to woman, vice versa, unscreened blood transfusion few intra venous drug users and lack of proper medical precaution, e.g. reuse of contaminated syringe, etc. In this area infants are also found to be infected through parents. The third pattern is also known as Asian pattern. Exposure to HIV in this area is mainly due to use of blood and blood products from industrialized countries, and also through people who had sexual contact with men and women

from AIDS prone countries. Further multiplication is enhanced by sexual promiscuity and intra-venous drug injection. It seems that the virus entered the Asian population relatively recently, compared to America, Europe and Africa.

(V)

In India awareness of AIDS started in 1985 during which Indian Council of Medical Research initiated screening of high risk groups for HIV antibodies. Very soon, on April 1986, ten prostitutes in Madras City were detected as HIV seropositive by Centre for Advanced Research in Virology, Christian Medical College, Vellore and National Institute of virology, Pune. The first patient of full blown AIDS was reported in May 1986 in Bombay, the source of infection of which was traced to blood transfusion during a coronary bypass surgery in the USA, prior to the introduction of HIV screening in the country. Another case, associated with a blood product given to a haemophilic patient in the USA, was also detected in Tamil Nadu during Dec. 1986. The fact that known cases of AIDS had somehow relation with foreign countries and also more cases of the disease were recognised in foreigners who came to India led to the misconception of AIDS as foreign disease that was menacing only in developed countries and certain parts of Africa. Continued investigation, however,

mainstay for their family. The apprehension is that when the society lose these young people in a few years time, the state will be badly hit socially and economically. It has posed a threat of social imbalance, likely to be resulted from fear and discrimination against the HIV infected persons. Unfortunately, the people of this strike torn state of Manipur look unaware or rather ignorant of this tickling time bomb. It is high time to extend all possible efforts by every section and department to arrest the countdown and save the nation from explosion.

Keeping the aforesaid view in mind an investigation was carried out during the period from 28 Sept 1993 to 28 March 1994 to reveal the upto date AIDS situation in Manipur and the surveillance activities taken up so far in the state. Emphasis was also given to assess the rate of awareness of AIDS among the common people including drug addicts and female commercial sex workers. Outcome of the study are being discussed in the chapters that followed. A shortfall of this time bound study was its short period of investigation, incompatible for its large scope crippled/coupled with financial shortage. It was, in fact, an onerous task. Lack of detail in the data may, therefore, be encountered here and there. Despite the shortcomings, efforts have been made to depict the authentic situation of AIDS prevailing in Manipur in brief.

CHAPTER - TWO

METHOD

T W O

M E T H O D

The data under the present study may be divided into three main categories, such as (i) incidence of AIDS in Manipur, (ii) awareness among common people, and (iii) awareness among the risky groups. Bulk of the information, for highlighting the prevailing situation of AIDS in Manipur have been obtained from the AIDS CELL, MEDICAL DIRECTORATE, RESEARCH & DEVELOPMENT WING, IMPHAL. A questionnaire schedule proforma was also filled in by visiting the said AIDS CELL in order to assess the activities of this cell. Awareness among the common people was examined by distributing questionnaire schedules among the students & lecturers of different colleges in Imphal and also by random interview of patients and attendants who came to the Regional Medical College and Hospital, Imphal. This was done in a view to include individuals belonging to different sections from different places of Manipur in the sample. Illiterates were, however, avoided from the interview due to inconvenience and also because of the fact that they were mostly aged persons from remote areas, where poster campaign and other awareness activities have never or hardly reached.

Risky groups appropriately refer to drug addicts,

especially intra-venous drug users, and female commercial sex workers in the context of Manipur. Sodomy and bisexuality are out of picture. Heterosexual is the means for sexual transmission of HIV through promiscuous relationship. Assessment of awareness among the drug addicts was done by visiting non governmental rehabilitation centres and de-addiction camps. It is unfortunate that many of the addicts could not be interviewed, either the addicts didn't like themselves to be interviewed or the authorities disallowed to do so because of their own reasons. More difficult than talking to drug addicts was the hunt of commercial sex workers. In Manipur, unlike in many towns and cities of the country, there is no licensed prostitution nor any open red light area. Although prostitution is socially forbidden, it has now become a secret resort of earning for a number of women. It is a very difficult task to identify/recognise a prostitute or a pimp among the people, especially these days due to wake of insurgents' activities of punishing the pimps and drug traffickers by shooting on the limbs, sometime taking the life. It doesn't mean that the business is completely checked, but more careful than before. That's why it is risky to track down to sex business. Even a false or mistaken approach to an already known person may lead to dire consequences. Somehow

the present investigator could manage to talk to fifteen (15) female commercial sex workers from Imphal and Churachandpur Districts after paying their demand money and repeated coaxings through a person. Thus the sample size of the risky groups is somewhat small. But this will certainly throw light upon the points investigated for.

CHAPTER - THREE

INCIDENCE OF AIDS IN MANIPUR

T H R E E

I N C I D E N C E O F A I D S I N M A N I P U R

25 The pioneering venture to unveil the invasion of AIDS and HIV in Manipur was taken up by the "AIDS CELL, MEDICAL DIRECTORATE, , Research and Development Wing, Lamphel, Imphal. This surveillance cell was established in the year 1986 under the financial assistance from World Bank through the NACO (National AIDS Control Organisation). Main aim of the surveillance cell is to educate the people about etiology of the disease, the causative factors and preventive measures, as there is no cure of the disease so far. Regular activities conducted by this surveillance Centre are blood examination of the risky groups such as intravenous drug users (IDUS), commercial sex workers, commercial blood donors, random serological screening of common people, mobile awareness campaign, organisation of talk and quiz competition at academic institutions, poster display, pamphlet distribution and street play, etc.

The surveillance cell is now equipped with laboratory facility where blood examination is carried out by ELISA (Enzyme Linked Immunosorbent Assay) test, rapid slide test, indirect test using SERODIA antisera of Japan. Very recently, in May '94, equipments and kits required for western blot test of

confirmation have been procured. Before the introduction of western blot test, rapid indirect test, SERODIA and ELISA test had been used as first step method of screening the suspectants. Those samples which were found to be positive by ELISA test were further sent to the National Institute of Cholera and Enteric Diseases (NICEDE), Calcutta for western blot test of confirmation. It usually took about one to three months, occasionally more depending upon availability of kits, to obtain western blot results from Calcutta. Thus, an HIV carrier could not be immediately confirmed in this state sometimes ago.

Achievement of the surveillance centre is immense. In the year it was established 371 blood samples were examined. More and more samples were examined in the succeeding years amounting to 2697 samples by the end of 1989, but none was found to be sero-positive. Real breakthrough occurred in 1990 during which 3147 samples were examined and a considerable number, 961, of them were found to be sero-positive. Among the sero-positives 910 were represented by intravenous drug users, 22 commercial blood donors, 28 STD (sexually transmitted disease) patients and another person of unknown habit. In the same year four cases of AIDS, 3 males and 1 female, were also reported. In the year that followed (i.e. 1991) 2223 suspectants were examined of which 422 (382 intravenous drug users, 22 commercial blood donors, 1 blood

recipient, 6 STD patients, 2 antinatal cases and 9 persons of unknown habit) were identified as sero-positive. In addition to above said sero-surveillance, sentinel survey (blood samples obtained from different patients who came to the Hospitals and examined secretly) had also been introduced in 1991 in which 5 individuals out of 1267 examined were identified as sero-positive. During 1992, 3409 suspectants and 6391 sentinels had been examined out of which 255 intravenous drug users, 34 blood donors, 14 STD patients, 7 antinatal cases, and 41 persons of unknown habit had been detected to be HIV positive. As many as 115 sentinels were also found to be sero-positive. In the following year (i.e. 1993) 4204 blood samples of suspectants and 2196 sentinel samples had been screened. Among them 153 intravenous drug users, 59 blood donors, 6 blood recipients, 7 STD patients, 1 antenatal case, 28 cases of unknown habit and 200 sentinels were detected to be HIV positive. Eight cases of full blown AIDS (all men) have also reported. During the first two months of 1994, the surveillance cell examined 1103 samples of which 173 intravenous drug users, 29 blood donors, 1 blood recipient, 8 STD patients, 22 unknown habits have been known to be sero-positiv, 26 out of 35 sentinels were also sero-positive. Six cases of AIDS, 5 males and 1 female, have also been reported. Thus since the establishment of the surveillance cell

till February (1994) 26,671 samples have been screened of which 2567 are known to be sero-positive. Reported number of AIDS' victim rose up to 16 males and 2 females, amongst whom 7 males and the two femals had been succumbed to the disease. Detail of the sero-positives are 1873 (72.96% of the sero-positives) intravenous drug users, 166 (6.47%) blood donors, (0.31%) 8 blood recipients, 63(2.45%) STD cases, 10(0.39%) antenatal cases, 101 (3.93%) unknown cases and 346 (13.48%) sentinels.

What is learned till February 1994 is that intravenous drug users stand for the bulk of the sero-positives. The matter of serious concern is the alarmingly high number of sero-positive among the commercial blood donors (166) the consequence of which is reflected by the eight cases blood recipients. Transmission through promiscuous sex relationship or sex business rose upto 63 unknown cases. It is also alarming that 10 children have acquired the disease through mother. Unfortunately we do not have detail knowledge of the habits of the parents of afflicted children. A more recent information, obtained from the surveillance cell, relates that the number of known sero-positive rose upto 2756 by the end of April '94 (2567 in Feb.) and 40 cases of AIDS including 17 deaths.

Yearwise trend of HIV detection from 1990 to 1993 reveal

a gradual decline from 30.54% (961 positive out of 3147 tested) in 1990 to 6.04% in 1993 through 18.98% in 1991 and 10.3% in 1993. Among the sentinels, the trend is increasing from 0.39% in 1991 to 13.15% in 1993 through 1.8% in 1992. It seems that while identification of HIV carriers among suspected groups is commendably progressed, there is accelerating tendency of spreading among the common people. Till February 1994, 13.23% of suspected groups and 3.84% of the sentinels (old sample 3.22% and new sample 5.59%) are recognised as HIV carrier. Altogether 9.62% of the tested samples are sero-positive (table 1 to 3).

It may not be out of place to mention that the type of HIV so far invading in Manipur is HIV-1. Very recently (during many '94) evidence of HIV -2 in two persons has also been reported. HIV-2 has been recognised mainly in the countries of Western Africa. However, some serological evidence of the activities of HIV-2 has been recorded in many countries including India (especially in Bombay - Pune region). But HIV-2 has not yet been fully isolated from India. The evidence of appearance of this comparatively rare virus in Manipur has further enhanced the anxiety among the people.

Age and sexwise sero-positive cases during September 1986 to February 1994 are illustrated in table 4. this table reveals

that 67.13% of the sero-positive individuals is represented by the age group of 21 to 30 years. This is successively followed by the age group of 11 to 20 years with a frequency of 21.52%, 31 to 40 years (9.77%), 41 and above (1.49%) and 0 to 10 years (0.09%) this is true in both the sexes. It appears that most of the afflicted ones are individuals of 11 to 30 years of age. Two females representing the age group 0-10 year with a frequency of 0.09% belong to the antenatal case. It is also noteworthy that almost all (95.87%) of the infected ones are males. The number of sero-positive females is remarkably few (4.13%), in compare to that of males. It should, however, be noted that the data maintained by the State AIDS Cell (or surveillance Cell) do not specify the sexwise number of individuals examined. Only the pooled of the two sexes are given. That's why it is difficult to assess the actual sexwise rate of afflicted individual as well as sex difference in this regard. One can confidently assert that the samples examined, so far, by the surveillance cell are mostly represented by males. In other words the number of females in the samples must be comparatively very few. This must be the reason of remarkably few number of afflicted female. Obviously, any serious attempt to account for sexual variation from table 4 would be misleading. By saying so it does not mean that the number of afflicted female must be in parity with that of male.

Higher number of HIV carrier among males is, no doubt, very much acceptable in any society where males enjoy relatively more freedom out door life than females, especially during adolescence and pre-marital period. It is not unusual that boys are more prone to untoward activities than girls and the state of Manipur is not an exception.

Districtwise distribution of identified HIV carrier (up to Feb. 1994 without sentinel samples) is shown in table 5. It is evident that the most populous Imphal district shows the highest number of (1411) of HIV carrier, followed by Churachandpur (327), Thoubal (154), Chandel (115) Bishnupur (95), Senapati (60), Ukhrul (56) and Tamenglong (3) districts in order. Although Imphal stands for the highest number of HIV carriers, rate of infections, which is estimated from the total number of individual examined, is very low (only 10.96%) if not the lowest, when compare to other districts. Ukhrul district stands for the most concentrated area of HIV carrier, that is 35.22% of the individuals tested are found to be sero-positive. Churachandpur district, which is popularly known for its drug peddlers and female commercial sex workers, shows the rate of HIV infection as 33.03% . In Chandel district 24.01% of the examined individuals are identified to be sero-positive. Incidence in Senapati

district (23.17%) is also high when compare to Bishnupur (15.37%) and Thoubal (11.30%) districts. Tamenglong which is the most backward of all the districts has the lowest concentration of HIV (7.67%). The number of individuals tested from Tamenglong district, of course, is comparatively very few, only 39, and no HIV positive female has been found. It is learned from the table that higher concentration of HIV carriers is observed in the hilly districts, especially Ukhrul, Churachandpur, Chandel and Senapati, than in the valley districts. It seems that tribal people are more affected than the non-tribals of the valley. Reasons for higher concentration of HIV carriers in the hilly districts may be attributed to their topography and poor economic conditions. Bordering to Burma (Myanmar), Chandel and Churachandpur districts are rendezvous of drug smugglers while Senapati and Ukhrul are situated on the way of transporting the stuff to other states either through National Highway or secret routes. More stress life style and poverty in the hilly areas may have made the despaired youths opted for more easier money making business, many of them admitting to more miserable life by becoming drug addicts. It has already been mentioned that males are more prone to untoward activities than females. Sexwise incidence of HIV in the eight districts of Manipur is again displayed in table 5. Males exceed females with large margins in

all districts. HIV infection among males ranges from 7.69% in Tamenglong to 33.96 in Ukhrul while that of females ranges from 0 in Tamenglong to 2.70% in Senapati district. It may, therefore, be assumed that transmission of HIV through promiscuous relationship or commercial female sex workers is less significant in Manipur.

Table - 1

Trend of HIV/AIDS in Manipur (upto Feb. '94)

Year	<u>Sero Surveillance</u>		<u>Sent. Surv(old)</u>		<u>Sent. Surv(New)</u>		<u>AIDS cases (Reported)</u>
	<u>Screened</u>	<u>+VC</u>	<u>Screened</u>	<u>+VC</u>	<u>Screened</u>	<u>+VC</u>	
1990	3147	916(30.54%)	-	-	-	-	4(3 males, 1 female)
1991	2223	422(18.98%)	1267	5(0.39%)	-	-	-
1992	3409	351(10.03%)	6391	115(1.80%)	-	-	-
1993	4204	254(6.04%)	1034	136(13.15%)	1162	65(5.59%)	8 male
1994 (upto Feb)	1103	233(21.12%)	34	25(73.53%)	-	-	6 (5 male, 1 female)
	16,783	2,221(13.23%)	8726	281(3.22%)	1162	65(5.59%)	18 (16 male, 2 female)

AIDS Cases No. of Death (reported) 9.
(7 male; 2 female)

Table - 2

Mode of Transmission of HIV (upto Feb. '94)

Year	No. of IDUs	Nos.of bl. Doner	Nos. of bl. Receipient	Nos. of STD	Nos. of Anti-nental mother	Other
1990	910	22	0	28	0	1
1991	382	22	1	6	2	9
1992	255	34	0	14	7	41
1993	153	59	6	7	1	28
1994 (upto Feb)	173	29	1	8	0	22
	1873	166	8	63	10	101

Table - 3

Particulars of HIV carriers in Manipur (upto Feb. '94)

A. Sero-Surveillance

<u>Sl.No.</u>	<u>Particulars</u>	<u>Positive</u>	<u>P.C. of total positive</u>
1.	IDUS	1873	72.96
2.	Blood donors	166	6.47
3.	Blood recipient	8	0.31
4.	Antenatal	10	0.39
5.	STD	63	2.45
6.	Others	101	3.39
B.	Sentinal	346	13.48
		2567	100.00

Table - 4

Age groups of the HIV carriers

A. Sero-Surveillance :

Age group	Male	PC	Female	PC	Total	PC
0 - 10	-	-	2	0.08	2	0.08
11 - 20	454	17.69	24	0.93	478	18.62
21 - 30	1441	56.13	50	1.95	1491	58.08
31 - 40	211	8.22	6	0.23	217	8.45
41 +	28	1.09	5	0.19	33	1.29
Sentinel	327	12.74	19	0.74	346	13.48
	2461	95.87	106	4.13	2567	100.00

Table - 5

Districtwise and Sexwise Distribution of Sero-positive Cases.
(Sept. '86 upto Feb. 1994)

Sl. District No.	No. of Screened	Male	PC	Female	PC	Total	PC
1. Imphal	12876	1379	10.71	32	0.25	1411	10.96
2. Thoubal	1363	152	11.15	2	0.15	154	11.30
3. Bishnupur	618	94	15.21	1	0.16	95	15.37
4. Chura-chandpur	990	301	30.40	26	2.63	327	33.03
5. Senapati	259	53	20.46	7	2.70	60	23.17
6. Ukhrul	159	54	33.96	2	1.26	56	35.22
7. Chandel	479	98	20.46	17	3.55	115	24.01
8. Tamenglong	39	3	7.69	0	-	3	7.69
	16783	2134	12.71	87	0.52	2221	13.23

CHAPTER - FOUR

AWARENESS OF AIDS AMONG COMMON PEOPLE

F O U R

AWARENESS OF AIDS AMONG THE COMMON PEOPLE

AIDS is a very serious disease because there is as yet no cure that works, and most AIDS patients die within five years. It affects people of all ages, but most AIDS victims have been relatively young. It can spread rapidly in a community depending on the actions and behaviour of the people in that community. Prevention is the only means for anything incurable, and prevention from AIDS needs a combine effort of people of all sections regardless of age and sex. But how far the people of Manipur, a place now recognised as one of the epicentres of AIDS in India, are aware of this fact? How far the people of this state are prepared to control this wildfire from the impending inferno? An assessment in this regard has been done by examination of 915 individuals, 609 males and 306 females, through questionnaire schedules. Method of sampling has already been discussed in the preceded chapter, 'Method'.

Tables 6 to 9 display districtwise distribution, communities, age and sex, and literacy of the individuals included in the sample. Major portion of the sample (77.38%) has been obtained from the most populous Imphal district, followed successively by Thoubal (12.46%), Bishnupur (4.26%) Churachandpur (3.28%), Senapati (1.64%), Ukhrul (0.66) and

Chandel (0.33%) . Not a single individual representative of Tamenglong district was met. Communities covered in the sampling are the Meitei (representing 91.48%), Meitei Brahmin (0.66%), Schedule tribes (7.21%) and non Manipuri (0.66%) such as Marawari and Punjabi etc. It has been shown above that almost two third of the sample is composed of males. For the matter of convenience the individuals have been arranged into five different age groups as shown in table 8. Most of them belong to 21 to 25 years of age (40.33%). Age group 20 years and below stands for the second highest frequency (27.87%); 26 to 30 years is represented by 16.07% and those of groups 31 to 35, 36 and above are 6.23% and 9.51% respectively. Majority of the individuals are of B.A./B.Sc./Bo.Com. standard (42.95%), followed successively by P.U.C. or 12 standard (37.7%), below matriculation (14.10%); M.A./M.Sc./M.Com. above (3.93%) and Diploma Degree holder in Engineering (1.31%). Thus, the sample is constituted by literate individuals of different age groups of both the sexes belonging to different communities from different districts of Manipur. Doctors, medical practitioners and students have been intentionally excluded from the sampling. Because awareness test among them would be less meaningful when the attempt was meant for common people. Degree of understanding about the disease among the people has been measured basing on the response of three main questions such as what is AIDS, what is HIV and modes

of spreading the virus.

Findings of the investigation on awareness among the people in general are displayed in the form of tables (10 to 13). Not a single person who has not heard of AIDS was encountered. But only 14.78% of the males and 18.63% females could correctly explain the full form of the acronym AIDS (Acquired Immuno Deficiency Syndrome), 6.9% males and 1.96% females explain the acronym with slight error. It is amazing that majority of them, 77.83% males and 79.41% females, have heard of the disease but unable to explain the acronym, also they lack complete knowledge of the disease. Very few of them, 0.49% males only, misunderstood the disease. They deny the existence of the disease. To them the disease is a rumour, more artificial than real. Notable points may be briefly recapitulated this way that everybody has heard of AIDS but only 16.07% fully know the disease while almost 80 percent (78.36% for the two sexes) do not have the full knowledge.

When ask 'what is HIV', the causative virus of the disease, only 9.36% of the males and 3.92% females are able to express the full meaning of the abbreviation, i.e. HIV, satisfactorily. Some more of them, 10.84% males and 12.7% females, also know that HIV is the causative virus but they

committed slight error in telling the full meaning. 14.29% of the males and 24.51% females failed to tell full form of HIV although they have heard of it. Surprisingly, 65.02% males and 58.82% females responded that they have not heard of HIV although they have heard of AIDS. It has been mentioned that 0.49% of the males denied the existence of the disease, the same persons expressed absurdity about HIV.

Table 12 further specifies the academic standard of the persons who have not heard of HIV. It has been learned from table 11 also that as many as 62.95% (for the two sexes) of the sample have reported they have not heard of HIV. This large section is represented by the whole of the under matric, P.U.C. or 12 standard individuals plus 10.84% males and 11.76% females of B.A./B.Sc./E.Com. (graduate) standard.

Majority of the graduate students, 29.56% males and 36.27% females, diploma, degree holders and all the post graduate and higher degree holders know HIV. It appears that although everybody has heard of AIDS more fuller knowledge about its causative virus etc. is known to higher educated groups. It doubtlessly signifies the importance of education in the awareness of AIDS. A reason, if not the sole one, for inability to tell what is HIV by the youngsters of upto 12 standard may be

attributed to their exiting stage of adolescence. The period of wondering his or her own self. During this emotionally dominated stage of adolescence many youths are unaware or rather ignore many facts of life. This may, therefore, be a reason for their negligence to HIV.

With regard to knowledge of different modes/ways of HIV transmission, there are many persons who can tell all the postulated ways of transmission (see Introduction) correctly although they fail to tell the full form of AIDS and HIV correctly. On the other hand, some persons who can tell the full meanings of AIDS and HIV fail to explain the modes of transmission of the virus. A comparison of table 11 and 13 reflects this phenomenon. When only 9.36% males and 3.92% females could tell the full meaning of HIV, 11.82% males and 5.86% know all the different modes of HIV's transmission. That means there are persons who have the knowledge of the virus' transmission but unaware of the name of the virus. A number of persons, 18.72% males and 32.35% females, are also able to tell almost all but not all, the different ways of HIV's transmission. A few persons, 1.48% males and 0.98% females completely mistaken the disease's transmission, such as highly contagious water borne or airborne or transmission through insect bite without any mention of the conventional ways. It is disheartening to learn that majority of

the people(67.985 males and 60.78% females) take the disease so casually that they even do not bother to know how the disease is transmitted.

Preceding discussion made it clear that people of Manipur have heard of AIDS, but very few of them have the required knowledge on the etiology of the disease. More than 60% do not have the essential knowledge about the disease. People may have heard of the disease through the radio, T.V., poster as well as from other activities taken up by the State AIDS surveillance cell to educate the people. But the achievement is not satisfactory. The magnitude of educative activities, so far taken up, is very far from adequate, as reflected by the result. More wider, serious and frequent educative activities are urgently required. The strides of the danger is still on its way as the people are yet to be fully educated about the control of the disease. It may be pertinent to mention here that the state of Manipur has never experienced a stable government since her annexation into India. The by products of political instability, such as social restlessness, uncontrolled corruption, price rise, ever increasing unemployment problems of the educated youths surmounting to wake of drug smuggling and insurgency have induced the people of Manipur a habit of carelessness of many unavoidable obligations.

In the midst of insecure and uncertainty coupled with Armed Forces Special Power Act and insurgents' activities, earning for day to day's livelihood and search for time to time's survival by hook or crook have become the main concern of the people of Manipur. This must be one of the important factors for mass negligence about the onslaught of AIDS by the people of Manipur. By saying so it does not mean that the people are completely careless. Casual observations in the R.M.C. Hospital reveal that most of the patients stops buying blood from strangers without testing for HIV. Preference is given to relatives' blood and known friends, etc. In most of the latter case, transfusion is done even without screening for HIV, especially in emergency cases. Hospital bears no responsibility for any risk of transfusing such unscreened blood. Moreover, the hospital has no restriction that all the bloods must be screened before transfusion. Most often testing for HIV before transfusion has been the choice of the patient or patients's party. By and large the risk of entering the virus from blood transfusion in the hospital is higher among the patients who have little or no knowledge of the disease, mostly from the far flung remote areas. Briefly speaking possibility by transmitting the disease through blood transfusion in the hospitals still prevails in Manipur.

Table - 6

Districtwise distribution of the individuals covered
in the investigation of AIDS awareness.

<u>District</u>	<u>Male</u>	<u>PC</u>	<u>Female</u>	<u>PC</u>	<u>Total</u>	<u>PC</u>
Imphal	465	76.35	243	79.45	708	77.38
Thoubal	78	12.81	36	11.76	380	12.46
Churachandpur	18	2.96	12	3.92	30	3.28
Bishenpur	30	4.93	9	2.94	39	4.26
Ukhrul	3	0.49	3	0.98	6	0.66
Senapati	12	1.97	3	0.98	15	1.64
Chandel	3	0.49	-	-	3	0.33
Tamenglong	-	-	-	-	-	-
Total	609	100.00	306	100.00	<u>915</u>	100.00

Table - 7

The communities covered in the investigation.

<u>Community</u>	<u>Male</u>	<u>PC</u>	<u>Female</u>	<u>PC</u>	<u>Total</u>	<u>PC</u>
Meetei	555	91.13	282	92.16	837	91.48
Meetei Brahman	6	0.99	-	-	6	0.66
Non Manipuri	3	0.47	3	0.98	6	0.66
Schedule Tribe	45	7.39	21	6.86	66	7.21
Total	609	100.00	306	100.00	915	100.00

Table - 8

Age groups of the individuals covered in the investigation.

<u>Age group</u>	<u>Male</u>	<u>PC</u>	<u>Female</u>	<u>PC</u>	<u>Total</u>	<u>PC</u>
Below - 20	120	19.70	135	44.12	255	27.87
21 - 25	234	38.43	135	44.12	369	40.33
26 - 30	114	18.72	33	10.78	147	16.07
31 - 35	57	9.36	-	-	57	6.23
36 and above	84	13.79	3	0.98	87	9.51
Total	609	100.00	306	100.00	915	100.00

Table - 9

Literacy of the individuals covered in the investigation.

<u>Category</u>	<u>Male</u>	<u>PC</u>	<u>Female</u>	<u>PC</u>	<u>Total</u>	<u>PC</u>
Under matric	117	19.21	12	3.92	129	14.10
12 standard	213	34.98	132	43.14	345	37.70
BA/BSc/TDC	246	40.39	147	48.04	393	42.95
Diloma/Degree holders (Engineering)	12	1.97	-	-	12	1.31
MA/MSc and above	21	3.45	15	4.90	36	3.93
Total	609	100.00	306	100.00	915	99.99

Table - 10

Response from the individuals on the question of AIDS.

Category	Male	PC	Female	PC	Total	PC
A. Yes						
Absolute	90	14.78	57	18.63	147	16.07
Convincing	42	6.90	6	1.96	48	4.25
Heard of it but unable to explain	474	77.83	243	79.41	717	78.36
Wrong sense	3	0.49	-	-	3	0.33
B. No	-	-	-	-	-	-
Total	609	100.00	306	100.00	915	100.00

Table - 11

Response from the individuals on the question of HIV.

Category	Male	PC	Female	PC	Total	PC
A. Yes						
Absolute	57	9.36	12	3.92	69	7.54
Convincing	66	10.84	39	12.75	105	11.48
Heard of it but unable to explain	87	14.29	75	24.51	162	17.70
Wrong sense	3	0.49	-	-	3	0.33
B. No	396	65.02	180	58.82	576	62.95
Total	609	100.00	306	100.00	915	100.00

Table - 12

HIV awareness based on Educational Qualification

	<u>Category</u>	<u>Male</u>	<u>PC</u>	<u>Female</u>	<u>PC</u>	<u>Total</u>	<u>PC</u>
A. Known	Under matric	-	-	-	-	-	-
	Matric to P.U.	-	-	-	-	-	-
	BA/BSc/TDC	180	29.56	111	36.27	291	31.80
	Diploma/Other	12	1.97	-	-	12	1.31
	MA/MSc and above	21	3.45	15	4.90	36	3.93
Total		213	34.98	126	41.17	339	37.04
B. Un-known	Under matric	117	19.21	12	3.92	129	14.10
	Matric to P.U.	213	34.98	132	43.14	345	37.70
	BA/BSc/TDC	66	10.84	36	11.76	102	11.15
	MA/MSc and above	-	-	-	-	-	-
G. Total		609	100.00	306	99.99	915	99.99

Table - 13

Response from the individuals in respect of different
modes of HIV's transmission.

<u>Category</u>	<u>Male</u>	<u>PC</u>	<u>Female</u>	<u>PC</u>	<u>Total</u>	<u>PC</u>
Absolute	72	11.82	18	5.88	90	9.84
Convincing	114	18.72	99	32.35	213	23.28
No. Reply	414	67.98	186	60.78	600	65.57
Wrong sense	9	1.48	3	0.98	12	1.31
Total	609	100.00	306	99.99	915	100.00

CHAPTER - FIVE

AWARENESS OF AIDS AMONG RISKY GROUPS

F I V E

AWARENESS AMONG RISKY GROUPS

North Eastern India with its hilly terrain and long international borders has become an ideal place for drug traffickers of the golden triangle, connecting through a secret forest route in Myanmar. On the way of exploring new market places the youths of Manipur, being situated at the crossroad of Myanmar and India, have been caught in a nightmare. Easy availability of "Heroin" (popularly known as No.4) here and there and "the tricky free of cost method of introduction" to the beginners have suddenly converted a population of youths into drug addicts. In the wake of realisation of the menace, HIV has again added salt to the wound; many addicts have already been invaded by the virus. The most plausible reason for the high incidence of HIV in Manipur has been attributed to the dreaded practice of sharing syringes by the intra venous drug abusers. It is only when the fume burns into flame that few panicky health workers and social thinkers go wild in search of measures to check the fire from inferno. A sign of hope seen today is that there are now as many as 46 (fortysix) non governmental de-addiction/rehabilitation centres for the drug addicts. Among them fourteen (14) centres get financial assistance from the Govt. of India, eleven (11) others have also been recommended by the State

Government to the centre for financial support, while other 20 centres are under inspection for recommendation. There is only one centre run with financial assistance from the State Government. These de-addiction/rehabilitation centres have boarding facilities where the addicts under treatment are accommodated for different periods, depending upon seriousness of the case, usually minimum three months.

In an attempt to reveal the predominant method of drug abuse and also to assess awareness of AIDS among the abusers, the present investigator visited four non government drug de-addiction and rehabilitation centres in Imphal District. They are (i) Dawn (2) Kripa (3) Yaiphakol and (4) Divine Light. Out of them the Yaiphakol is the only centre meant for females only. The others are for males only. It has been mentioned in Chapter Two "METHOD" that the authorities of these rehabilitation centres restricted interview with the addicts putting up in their centres because of their own reasons, mainly to prevent from possible development of emotional ostracism among the addicts. Many addicts did not want themselves to be interviewed. Nevertheless, some were very bold and responded well without hesitation in their own capacity. Seventyeight (78) such addicts (72 males and 6 females) have been interviewed. The females addicts have been

obtained from the Yaiphakol. Their age ranges from below 20 years of age to above 36 years. Majority of them fall within 21 to 30 years of age (see table 14), 43.59% for the age group 21 to 25 years and 34.62% for 26 to 30 years' group. 7.69% of the individuals belong to below 20 years, 8.97% represent 31 to 35 years age group and 5.13% represent 36 years and above. All the drug addicts, covered in the present study, are educated. Majority of them is represented by students who are reading in or already passed B.A./B.Sc./B.Com. standard (42.31%). 25.64% have crossed matriculation and now reading in or read upto 12 standard, 32.05% represent those who are reading in or unable to pass matric.

There are different methods of abusing /consuming drugs. They may be taken orally in the form of tablet, syrup or solution or as smoke, nasally by sniffing, and in the form of injection given to the veins. Some addicts are adapted to all these methods. Most of the addicts started taking on to drugs either by smoking or by taking orally. The thirst for more and more larger doses develops thereon in order to get the desired effect of the drug. At this stage the addicts, usually switch on to injecting the substance into the veins. The later method is not only fast in its action but also more effective and

economically advantageous.

Few addicts, who cannot smoke or sniff the substance, have initiated to the habit by direct injection (of course, in very low doses) while accompanying their addicted friends. In the present sample of 72 addicts, 12(15.38%) are found to be habituated to either oral consumption or as smoke. These individuals have never tested to injection. It is disheartening to find that 66 individuals out of 72 (84.62%) are intravenous drug users. Among them 35 (44.87%) addicts are not acquainted to smoking or oral consumption whereas the remaining 31 (39.74%) are habituated to all kinds of drug abuse. The number of female addicts is very few, only six. Four of them belong to oral consumer, smoker and the remaining two are IDUS who also use all the other methods of drug abuse.

With regard to the period of practice, 1 (one) out of the 78 addicts under the study reported that he had started the dreaded habit of drug abuse in 1979, seven years before the establishment of the State AIDS surveillance cell (see table 17). Similarly, altogether 32 addicts have started their career before the existence of the State AIDS surveillance cell in 1986. The remaining 46 addicts belong to the period from 1986 to 1993. The oldest female addict in the present sample started her abusing

practice in 1988. In short, the present sample consists of addicts who started drug abuse in the years since 1979 till 1993. All of them responded that they had heard of AIDS recently, none of the male addicts, however, replied to the question of HIV. It's not sure whether they know it or not. All the females on the other hand responded clearly that they didn't heard of the term "HIV" at the time of interview. The question on sharing of needle/syringes among the IDUS, was also unanswered. The two females, however, replied that they maintained their own syringes and they never shared it to others. Incomplete response from the addicts has enabled us to arrive at a concrete conclusion regarding the awareness of AIDS among the drug addicts. Nevertheless, the nature of response instigates us to feel that the drug addicts still lack the essential knowledge of AIDS. It seems that almost all of them do not know the meaning of HIV, although they have heard of AIDS and know a little about it.

Of course, they are now beginning to understand the risk of their dreaded practice. It may be noted that many of the IDUS started the practice long time before the existence of the State AIDS surveillance cell. Naturally many of them have already committed to the practice of sharing unsterilised syringes among them. AIDS' awareness campaign and other

activities are too late to many of the IDUS. Consequently, the factor for high incidence of HIV in Manipur has been attributed to the practice of injecting drug to the veins. This hypothesis still holds true. What is learned from the present study is that very few (the two females) of the addicts have, knowingly or unknowingly, maintained the safety method of drug injection by keeping their own syringe. Drug addicts in Manipur are beginning to know the risk of catching HIV/AIDS in their habit of drug abuse. However, many of them still do not have the fuller knowledge of AIDS and HIV.

During a visit to the R.D.O. (Rural Development Organisation), Imphal West, where one of the most well organised drug de-addiction and rehabilitation centres in Manipur is attached therewith along with a project entitled "community based AIDS prevention and control project", the present investigator met three sero-positive drug addicted youths. They are one Metei boy, a tribal boy and a tribal girl, the latter two hail from Churachandpur district while the former is from Imphal. All of them are in their twenties and unmarried,. It was learned from the authorities of the RDD that all the three were then drug free, they had successfully given up drugs and they were under the watchful eyes of the counsellors. During the

course of casual talk with the investigator, they disclosed that they were sero-positive. They expressed their sorrowful and despaired mentality on knowing that they could no longer live a normal healthy life. One of the two boys even attempted to commit suicide, it was told. But the constant advice of the counsellors and the doctors of the RDO made them capable to imbibe their emotion. All the three admitted to the investigator that what they were today was the consequence of their sinful activities and promised not to involve in any more sinful activity in future. They decided not to enter a wedlock life. Remaining part of their life would be devoted to the welfare of mankind, especially to save the younger generation from drug addiction. It was learned that all of them took active role in AIDS awareness campaigns conducted by the RDO fearlessly exposing themselves as the victims.

Another silent and effective way of spreading HIV in Manipur must be through extra marital or promiscuous sexual relationship of men and women (heterosexual). Most probably the disease entered the state through men and women who had sexual relationship with afflicted people from outside Manipur. They may be the students studying in other cities of India who pay visits to red light areas. There are evidences of becoming drug addicts among many Manipuri students who had studied in Delhi, Ahmedabad,

Pune, Madras, etc. Bus and truck drivers who used to move from place to place, from state to state, are also possible transporter of HIV. No wonder, many of the drivers are addicted to alcohol and prone to prostitutes. Thirdly, men and women drug traffickers probably serve as a channel of HIV from neighbouring Myanmar to Manipur along with the drugs. There is a very close association between the two business of drugs and sex. Women take an active role in trafficking drugs from Myanmar to Manipur, then to other states and also to peddle the stuff in different places of the state. That is why sex business is relatively higher in the drug trading areas. One will find more open and free female sex workers in the border areas of Manipur and Myanmar especially at Moreh. Any visitor to Moreh will find many young Burmese and nearby tribal females adopting to sex business with more freedom.

Educational excursion trips of school and college students to Moreh has become a frequent phenomenon in Manipur. The real benefit of such excursions in the name of academic purpose, is to buy foreign goods at considerably low prices from this area. It is, however, unfortunate that many students, especially boys, most often go out of their teacher in charge's control. Many of such boys who are very curious of sex, being at their adolescence, steal chance to attend the prostitutes. This is

an undeniably known fact. It may be remembered that although almost everybody has heard of AIDS, more than 60% of the people still do not have the essential knowledge to prevent from it. It was evident that none of the students of upto 12 standard was able to tell the modes of transmission of HIV. Consequently they are more vulnerable to the disease. In such circumstances, uncontrolled academic excursion to Moreh has posed a serious threat of enhancing HIVS' incidence in Manipur.

Thus the routes of HIV's arrival at Manipur may be briefly divided into two, such as western and eastern. Western route refers to entrance of the virus from other HIV endemic areas of India through easy going students and the like. Eastern route points to Myanmar and the activities involved in drug smuggle. Sharing of contaminated syringe and needles by intravenous drug addicts and promiscuous heterosexual practice gear up the spreading of virus in a rapid progress. In the meanwhile influx of virus through the aforesaid routes in the manners already mentioned is still an ongoing process. The combined action of all these practices must be responsible for unbelievably high incidence of HIV in this small state, Manipur.

An attempt has also been made to reveal how far the female sex commercial workers are aware of the risk of their

business. With a great difficulty fifteen (15) such females have been interviewed by the investigator. Information obtained from them are shown in table 18. Seven of them (four Meiteis and 3 tribals) are inhabitants of Imphal town and eight (2 Meiteis and 6 tribals) inhabitants of Churachandpur town. Their age ranges from 16 to 35 years. Two of them (all tribal) are below 20 years of age, 9 (3 Meiteis, 6 tribals) between 21 to 25 and 4 (3 Meiteis and 1 tribal) between 31 to 35. Seven of them (6 tribals and 1 Meitei) are unmarried girls, 3 (tribals) of the eight married women live with their husbands, 3 (Meiteis) belong to broken families who have separated from their husband, and the remaining 2 (Meiteis) are widows. Among the married women only one has no child while the others have one to six children. Four of them are illiterate, seven (7) have education but below matric, two are metriculate, two of them have crossed even 12 standard. Three of them reported that they used to drink alcohol occasionally in accordance with preference of the clients. Two young unmarried girls are drug addicts, intra venous drug users. They sell themselves, especially when they have not money to buy drugs. The other women have no such habits. Almost all of them disclosed that poverty and despair have led them down to take resort of this business. Six of them entered to this profession only one year ago. Four of them have been indulging in it for

the last two years, three of them for three years, and two for five years. Nobody was able to tell tentative number of clients per day. There have been many clientless days, while on the other hand some of them have, occasionally, entertained as many as three clients per day. Two young drug addicted girls, however, reported that they very often, went out in search of any client, especially during the strain of drug shortage. With regard to the age of the clients, two of them have, so far entertained young boys of between 20 to 30 years only, the remaining 13 females have entertained clients of all ages, beyond 20 years of age. Some of them declined to disclose the number of clients so far entertained, while some could not tell the exact number. Concerning the knowledge of AIDS, all of them have heard of this disease but only two of them could tell the full form of the acronym. The latter two also know the meaning of HIV. While the rest have not heard of it. They have neither been tested for HIV nor called on any doctor for any complain possibly developed from their business. They, of course, called on the doctors for other ailments not related, as they said, to their business. It is a very difficult task for them to disclose their identity to the doctors. None of these fifteen sex workers have ever used any protective device or none of the clients have ever attempted to use condoms during the process. The fact that is that neither

the female sex workers nor their male clients are aware of the dangers of their activities or it may be that they do not believe in the messages of AIDS imparted by the Government or non Governmental organisations. That's why they are fearless and do not bother for the impending danger. The impression is that risky persons are still beyond control, the possibility of transmitting HIV through sexual contact is still at large. Secret nature of the sex business in Manipur and the absence of licensed brothel has handicapped the health workers to carry out direct necessary actions, as doing in Metropolitan cities of India, such as regular medical check up of the female sex workers, educative campaign and distribution of condoms in red light areas. Although a ray of hope to check transmission of HIV through sharing of contaminated syringes by IDUS is now seen in Manipur, a more silent way of transmission through sexual contact is at large.

Table - 14

Age groups of the drug addicts (78) covered
in the investigation.

Age group	Male	%	Female	%	Total	%
Below - 20	4	5.56	2	33.33	6	7.69
21 - 25	32	44.44	2	33.33	34	43.59
26 - 30	27	37.50	-	-	27	34.62
31 - 35	6	8.33	1	16.67	7	8.97
36 and above	3	4.17	1	16.67	4	5.13
Total	72	100.00	6	100.00	78	100.00

Table - 15

Educational Qualification of the Drug Addicts

Category	Male	%	Female	%	Total	%
Under matric	20	27.80	5	83.30	25	32.05
XIIth Standrad	20	27.80	-	-	20	25.64
BA/BSc/TDC	32	44.40	1	16.70	33	42.31
MA/MSc/MCom	-	-	-	-	-	-
Total	72	100.00	6	100.00	78	100.00

Table - 16

Types of drug abuse and the frequencies of the addicts.

Analysis of different method of drug uses.

Category	Male	%	Female	%	Total	%
Oral/smoking	8	11.11	4	66.77	12	15.38
IDUs	35	48.61	-	-	35	44.87
Both above	29	40.28	2	33.33	31	39.74
Total	72	100.00	6	100.00	78	99.99

Table - 17

Year of commencement of drug abusing habit and awareness
of AIDS among the addicts.

Year	M	F	Heard of AIDS	Heard of HIV	Syringe/needle shared	Syringe not shared
1979	1		ALL	No	No	Two females
80	4		All the females have not heard of it.	response/ answer from the males.	response/ answer	IDUS responded that maintained their own syringe and they had never shared to others.
81	3					
82	6					
83	7					
84	5					
85	6					
86	5					
87	8					
88	7	1				
89	8					
90	4	1				
91	3	1				
92	3	1				
93	2	2				

Table - 18

Detail of 15 (fifteen) commercial sex workers and awareness of
AIDS/HIV among them

1	2	3	4	5	6	
Place	Community	Age group	Marital Status	No. of children for married	Literacy	
	Meetei (4)	16-20 yrs.(2)	Unmarried (7)	Nil - (1)	Illiterate (4)	
Imphal	Tribal (3)	21-25 yrs.(9)	Husband alive (3)	1 child (3)	Below matric (7)	
		31-35 yrs.(4)	Separated from husband (3)	2 children (1)	Below XIIth standard (2)	
			widow (2)	3 children (1)	Below graduate (2)	
Chura-				4 children (1)		
chandpur	Tribal (6)			5 children (1)		
	Meetei (2)			6 children (1)		
7	8	9	10	11	12	13
Drug habit	Period of practice	Average No. of client per day	Age of the clients	Knowledge of AIDS/HIV	Preventive Device	Medical check up
Since						
Occasional	1 yr. ago (6)	Uncertain	20-30 yrs.(2)	Heard of	Use of	Regular (nil)
		to max.3 (13)	20 above (6)	AIDS (15)	condom (nil)	
Alcohol(3)	2 yrs. ago(4)	Depend upon				
IDUS (2)	3 yrs. ago(3)	drugs (2)	25 above (7)	Heard of	Any other(nil)	
	5 yrs. ago(2)			HIV (2)		Sometimes(nil)

CHAPTER - SIX

CONCLUSION

S I X

C O N C L U S I O N

Acquired immune deficiency syndrome, "AIDS", is a disease caused by a virus which destroys the body's natural defence mechanism. As a result, the body becomes incapable of providing defence against a variety of other infections which are always lurking in and around the body. This disease which was first discovered in USA during 1980 is no longer a distant threat. Its causative virus, named "Human Immunodeficiency Virus" (HIV, has crossed our doorstep leaving in its wake a dark shadow of fear, misery and uncertain future. The state of Manipur which is situated on the northeastern border of India is said to have contributed 16% of the India's total seropositive (HIV carrier) cases.

The AIDS cell, Medical Directorate, Research and Development Wing, Imphal, since its establishment in 1986 has examined as many as 26,671 blood samples till the end of February 1994. Of them 2,567 have been identified as sero positive. In other-words 9.62% of the individuals examined are found to be carriers of the AIDS' virus, HIV. Most of these sero-positive individuals are intra-venous drug abusers or IDUS (72.9%) and the rest is made up by 6.47% commercial blood donors, 0.31% blood

recipients, 0.39% antenatal cases (from mother to baby), 2.45% STD (sexually transmitted diseases) patients, 13.48% sentinels (patients of different types whose blood samples were secretly examined) and 3.93% individuals of unknown habit. Most of the afflicted individuals are youths in their teenage (21.52%) and twenties (67.13%). Although the most populous Imphal district stands for the highest number of afflicted individual, concentration of HIV (number of sero-positive out of total individuals examined) is higher in the hilly districts, especially Ukhrul (35.22%), Churachandpur (33.03%), Chandel (24.00%) and Senapati (23.17%). Concentration is comparatively lower in the valley districts such as Bishnupur (15.37%), Thoubal (11.30%) and Imphal (10.96%). The lowest of all is shown by the most backward and remote district, Tamenglong (7.69%). The State AIDS' cell is now well equipped with laboratory facilities where quick indirect test, SERODIA of Japan, ELISA (enzyme immunosorbant assay) and Western blot tests are carried out. Latest information obtained from this cell relates that the number of sero-positive individuals rises upto 2756 by the end of April, 1994 and the number of full blown AIDS rises upto forty (40) by April 1994 from 18 during Feb. '94 amongst whom seventeen (17) have been succumbed to the disease. So far, HIV-1 type has been considered to be causative virus of the disease in this

area. The AIDS' cell has recently declared evidence of HIV-2 type in two individuals during May '94. HIV-2 has been recognised mainly in the countries of Western Africa. Some serological evidence of the activity of HIV-2 has also been recorded in few countries including Bombay and Pune region of India.

- * Where do these viruses come from ?
- * What are the possible factors for such rapid multiplication of HIV ?
- * How far the common people and the risky groups are aware of the impending danger ?
- * What will happen when so many youths, the vital members of a society, will have to die in the near future ?

These are some of the pertinent points that everybody would like to know.

Entrance of the virus to this hilly state may have occurred from two main directions, viz. Western and Eastern routes. Western route refers to the mainland India, especially HIV endemic metropolitan cities. At any time everybody will find a number of Manipuri students studying in these areas. It is

plausible that some of them might have attended to female commercial sex workers of these areas and they caught HIV from such females. There are many Manipuri students who have become drug addict after their exposure to the cities, like Bombay, Madras, Ahmedabad, Delhi, etc. Similarly, drivers (truck & Bus), travellers who move from one state to other are also probable importers of HIV in Manipur.

Eastern route points to entrance of the virus from South-east Asia through Myanmar along with drugs, especially Heroin No. 4, from the abominable golden triangle". On the way of exploring new market places for the produce of "golden triangle" through secret forest route in Myanmar, the north-eastern part of India, with its hilly terrain and long international border, has been discovered to be a convenient place of the drug traffickers. The two business of sex and drugs are closely associated. Women take a major role in transportation and peddling the stuff to different places. One will find a number of female commercial sex workers carrying on their business openly in the border trading area of Manipur and Myanmar, e.g. Moreh. Frequent excursion trips of academic institutions (school and college) to this area, are, therefore, not completely free from the danger of catching HIV. It is a known fact that very often teenage boy students, who are

callous and curious about sex but have no required knowledge of AIDS, go out of their teacher in-charge's control and steal opportunity to attend to the female commercial sex workers. Thus, drug traffickers, traders of other goods in the border area and naughty youths who visited the place, etc. are the probable sources of HIV from eastern route.

Arrival of HIV at Manipur must be recent, a decade ago at the most. This assumption is based on relatively few known cases of full blown AIDS in compare to large number of sero-positives and the average incubation period, which is estimated to be around eight to ten years for adults. Threateningly high incidence of HIV, despite its recent arrival, in Manipur has been rightly attributed to sharing of needles/syringes by the intra venous drug abusers. It has been mentioned that 72.9% of the sero-positives is represented by intra venous drug users (IDUS). It is also evident from the present investigation that many intra venous drug users started the dreaded practice long time before the establishment of the State AIDS' Cell in 1986, i.e. before the people of Manipur have heard of AIDS and HIV. In addition to sharing of contaminated needles/syringes among the IDUS, transfusion of unscreened bloods obtained mostly from commercial blood donors and promiscuous heterosexual relationships further

enhance the progress of HIV's multiplication in the state.

There are, at present, fourtysix non-governmental drug de-addiction and rehabilitation centres in Manipur where many addicts are trying hard to give up the dreaded habit of drug abuse under the guidance of counsellors and physicians. In the meantime insurgents' strict warning against drug abuse and punishment to disobedient addicts by shooting on the limbs, sometimes taking life, help to curve down drug activities a little. It doesn't mean that the Government machineries are silent in checking the drug menace. The culprits are, however, afraid of insurgent more than the security men. By and large a ray of hope to check the drug menace could be seen. With regard to awareness of AIDS among the common people, a sample survey reveals that almost all the people of this state have heard of AIDS. But only 9.84% was able to tell about the etiology of the disease satisfactorily, 23.28% of the individuals possessed the required knowledge of AIDS although they committed slight errors in explanation. It is discouraging to find that majority (65.57%) of them failed to tell about the causative virus and its different modes of transmission. Very few of them (1.31%) took the disease in a completely wrong sense, as if it were more artificial than reality. Recapitulating briefly, majority of the

common people do not have the required knowledge for AIDS' prevention. Similarly, all the 78 drug addicts and 15 female commercial sex workers included in the present study also lack essential knowledge for AIDS' prevention although they have heard of the disease. None of the female sex workers was found to employ preventive measure (such as use of condom) in their business; neither they call on the doctors for regular check up nor screened for HIV. Thus, promiscuous heterosexual relationship still poses a big threat for spreading HIV in a more silent and uncontrolled manner. Almost all the drug addicts (84.62%) included in the study are found to be intra-venous drug users. Only two females IDUS responded that they maintained their own separate syringes, while the rest didn't give any reply of this question. Hence the hypothesis of "sharing contaminated needles" by the IDUS as the factor for high incidence of HIV in Manipur still holds true.

Regarding the threat of probable loss of many youths in the near future any attempt to assess social implication cannot be made at the moment. Because, HIV positive individuals are kept unknown to the public by the authorities due to fear of ostracism likely to impose to the victims. Most of the parents, guardian or relatives and the victim themselves do not disclose their

identity. In such a situation dishonesty of the victims poses a threat of spoiling others. Of course, there are some sero-positive persons (like the three guys met by the present investigator) who have decided not to enter wedlock life and devote their remaining life to the activities to save younger generations from drug addiction and to prevent from catching AIDS. In any case, attempt to predict future situation of Manipur due to AIDS would be fairly speculative. One has to wait for the time to come.

To end up it may be briefly asserted that the threat of HIV and AIDS in Manipur has reached a state of concern by everybody. The people of this strike torn state, where life has become insecure in the midst of political instability, unemployment and insurgency, seem to pay little attention to the impending danger of AIDS. Despite the steps taken up by the state AIDS Cell and voluntary organisations to educate the people, the level of awareness among the people is, by far, not satisfactory. Naturally the fear of further increasing the transmission of HIV still looms very large. Many drug addicts in Manipur are found to be aware of the danger of sharing contaminated needles/syringes. Moreover, the rehabilitation centres have been imparting Yeoman's service to the drug addicts. There is still a hope that

transmission of HIV through sharing of contaminated syringes among the IDUS may be more checked than before. Unfortunately, the secret and unhealthy manner of sex business acts as another effective and silent way of transmitting the disease.

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A P P E N D I X

QUESTIONNAIRE SCHEDULE ON AWARENESS OF AIDS IN MANIPUR.

Sl.No.

A. i) Name of informant :

ii) Address : (iv) Sex :

iii) Age : v) Community : vi) Literacy :

vii) Marital status : viii) Occupation :

ix) Place of interview :

B. For Hospital/Health Centre

i) Ward : ii) Patient/Attendant : iii) Nature of Ailment :

iv) Blood transfusion : Necessary or not :

a) Done or yet to be done

b) Who was/will be the donor (Relative/friends/Commercial)

v) Will it be or was it screened for HIV or not.

vi) Quantity and type of blood.

vii) Price of the blood it purchase.

C. DO YOU KNOW :

i) What is AIDS ? Yes/No. if yes explain : (a) (b) (c) (d)

ii) What is HIV ? Yes/No. if yes explain : (a) (b) (c) (d)

iii) When did you heard of AIDS/HIV :

iv) From whom ?

v) What are the modes of transmission ? (a) (b) (c) (d)

vi) What are the precautions to check spreading of HIV/AIDS ?

vii) How would you treat if a relative (Son/daughter/.....) is known to be HIV positive or suffering from AIDS : (a)(b)(c)(d)

viii) In case of unmarried victim of HIV, would you try to advise him/her to marry. Yes/No.

ix) In case of married victim of HIV, would you try to advice to have issue or further issued. Yes/No.

- x) Do you have any idea of the remedial measures taken up by Government sponsored/private voluntary agencies ?
- xi) Do you think that the remedial measures taken up so far in Manipur are adequate to cope with situation or not ?
- xii) Any suggestion :

Note : Do you know

C: Code : (i) (ii) (v)

(a) Absolute (b) Convincing (c) Heard of it but
unable to explain (d) Wrong sense

C : Code : (vii)

- (a) I shall treat him/her as usual showing no difference to him/her.
- (b) I shall pay extra attention in a way to save him from mental depression.
- (c) Who cares, I shall leave the things to him/her. I shall involve in any matter.
- (d) I shall avoid him/her either by excommunication or sending him/her to jail/rehabilitation centre etc.

QUESTIONNAIRE SCHEDULE ON AIDS AWARENESS

- A. 1) Name of the Rehabilitation centre :
 ii) Year of establishment :
 iii) Chief Organiser :
 iv) No. of Counsellor/staff : v) No. of doctor :
 vi) No. of Nurse : vii) Funding Agencies :
 viii) No. of branch :
- B. 1. No. of addict as on ----- males-----Females -----
 2. Mode of admission to the centre.
 3. Which Age group is more dominant ?
 4. Do you identify HIV infected among the addicts.
 5. How many addicts are identify to have infected by HIV.
 6. Do you collect fees from patient if yes how much ?
 7. How long a patients can stay in this centre ?
 8. No. of seat capacity in this centre ?
 9. Which family/Economic groups more dominant among patient ?
 10. Wheather the addicts are screened for HIV and other
 mental attitudes before admitting to the centre ? Yes/No.
 11. Wheather the known HIV infected persons and other are
 to centre or not ?
 12. If yes, how do they HIV infected persons and other are
 educated ?
 13. Was there any case/cases of expired due to AIDS ? Yes/No.
 14. If yes, mention the year, sex and age of the deceased
 addict.

QUESTIONNAIRE SCHEDULE ON AIDS AWARENESS

CASE STUDY : ON DRUG ADDICT/HIV PATIENT.

- A.
- i) Name of the patient :
 - ii) Age :
 - iii) Sex :
 - iv) Educational qualification :
 - v) Occupation :
 - vi) Address :
 - vii) Parent's Name :
 - viii) Occupation of parent :
 - ix) Age:
 - x) Family members :
- B.
- 1) When did you taste the staff ?
 - 2) Who Introduced it to you ?
 - 3) Method of using : Smoking/IDUS/both
 - 4) When did you give if up ?
 - 5) When did you joint the Centre.
 - 6) Have you ever been examined for HIV of not.
 - 7) If yes, mention the examined centre and result
positive/Negative.

QUESTIONNAIRE SCHEDULE ON "INCIDENCE OF AIDS AND ITS SOCIAL IMPLICATION IN MANITLUP"

A. INSTITUTION/CENTRE

1. Name of the Centre :-----
2. Year of establishment :-----
3. Funding Agency(ies):-----
4. Mode of function:
(a) Head of Centre/Office:-----
(b) -----
5. Aim and object :

B. FACILITY.

- (a) Laboratory/Clinical facility : (b) Adequate or not :
- (c) Method(s) of Examination/diagnosis :
- (d) Type of examination of conducted in the centre :
- (e) Name(s) of the Auxillary centre(s)/laboratory where samples are sent for further diagnosis :
- (f) Time taken in doing so:
- (g) Reliability (i) Centre : (ii) locally : (iii) Out side :
- (h) Expenditure incurred to test a sample
(i) locally : (ii) Out side :

C. RECORD OF ACTIVITY

- (a) The first known report of HIV : Year, M/F, Age, Occupation :
- (b) The first known report of AIDS: Year, M/F, Age, Occupation :
- (c) Yearwise record surveillance's activity:

Year	Age groups	No. of persons tested	No. of HIV + ve persons	No. of person succumed to AIDS
		M F		

D. METHOD OF DATA COLLECTION EMPLOYED BY THE CENTRE.

- (a): (b): (c) :
- (d) Maintenance of Secrecy etc : (i) Whether the particulars of the victims are kept secret or not. Yes/No. If yes why ?
- (ii) Whether the results are disclosed to the tested individuals or not. Yes/No. If not why ?

- (iii) Whether the bio-data including economic status and other behavioural aspects like drug abuse/prostitution/experience of blood transfusion etc. of the victims are recorded or not-----

E. PREVENTIVE MEASURE.

- (a) Publicity(year wise record) please tick the relevant ones and mention the quantum by year if possible.
- (i) Poster Campaign :
- (ii) Media : Radio/News paper/T.V./ etc.
- (iii) Mobile awariness Campaign/meeting :
- (iv) Street play
- (v) Any other.
- (b) Rehabilitation if any :
- (i) Whether the centre feels the activities taken up by it are satisfactory or not:-----
- (ii) Does the centre fell that the services rendered by it are adequate to cope with the intensity of the problem in Manipur :-----
- (iii) What are the problems currently facing by the centre ? Please delineate.
- (iv) Any suggestion :-

QUESTIONNAIRE SCHEDULE ON AIDS AWARENESS

(COMMERCIAL SEX WORKERS)

- i) Community :
- ii) Age :
- iii) Academic status :
- iv) Marital status :
- v) Husband alive/dead :
- vi) No. of children :
- vii) Period of practice (since when) :
- viii) Number of clients per day/week :
- ix) Age group of the clients :
- x) Do you know/hear what is AIDS/HIV : yes/No.
- ix) Do the client use condoms : Yes/No.
- xii) Do you apply any other method to protect yourself from HIV : Yes/No. if yes mention the method :
- xiii) Do you use drugs/liquors : Yes/No. if yes : types :
- xiv) Do you go to doctors regularly : Yes/No.

