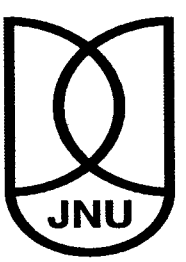
AN EXPLORATORY STUDY OF HIV-POSITIVE WOMEN INJECTING DRUG USERS (IDUs) IN CHURACHANDPUR TOWN, MANIPUR

Dissertation submitted to Jawaharlal Nehru University in partial fulfillment of the requirements for the award of the Degree of

MASTER OF PHILOSOPHY

LALTLANMAWII



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2007

In loving memory of my father

CENTRE OF SOCIAL MEDICINE & COMMUNITY HEALTH
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CERTIFICATE

The dissertation entitled, "**An exploratory Study of HIV-positive Women Injecting Drug Users (IDUs) in Churachandpur Town, Manipur**", submitted by Laltlanmawii is in partial fulfilment of the requirements for the award of Master of Philosophy of the University. The dissertation has not been previously submitted for any other degree of this University or any other University, and is her own work.

We recommend that this dissertation be placed before the examiners for evaluation for the award of M.Phil Degree of this University.

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Laltlanmawii

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List of Abbreviations

ANC - Ante-Natal Care

ART – Anti Retroviral Therapy

CBOs – Community Based Organisations

CCSA - Canadian Centre on Substance Abuse

CSWs – Community Sex Workers

DIC - Drop-In-Centre

HIV/AIDS – Human Immuno Deficiency Virus/ Acquired Immuno Deficiency Syndrome

IDUs - Injecting Drug Users

LSD- Lysergic Acid Diethylamide

MACS – Manipur AIDS Control Society

MSM- Men having Sex with Men

NSEP-National Syringe Exchange Programme

PLWHAs-People Living With HIV/AIDS

RIAC – Rapid Intervention and Care

NGOs - Non-Government Organisations

SCERT-State Council of Educational Research and Training

SHALOM-Society for HIV/AIDS and Lifeline Operation in Manipur

STIs - Sexually Transmitted Infections

UNODC - United Nations Office on Drugs and Crime

WHO - World Health Organisation

Chapter 1. Introduction

Socio-economic background of Manipur:

Manipur is a small state in the North-Eastern region of India, which consists of a population of 23.89 lakhs, (2001 census), and a land area of 22,327 Sq.Km. It lies land-locked, bordering Nagaland to the North, Assam to the West, Mizoram to the South and shares an international boundary of 358 kms. with Myanmar. The State has 9 (nine) Districts (Imphal West, Imphal East, Bishnupur, Thoubal, Churachandpur, Chandel, Ukhrul, Senapati and Tamenglong), 34 Community Development Blocks and 2182 villages. It also has two national highways, NH 39 and NH 53 which provide lifeline to the people. The core inhabitants of Manipur State are the Meiteis who reside mainly in the valley, while the surrounding hilly areas are mainly occupied by various other hill tribes. According to the Constitution of India, there are 29 recognized tribes in Manipur. The officially recognized tribes are - Aimol, Anal, Angami, Chiru, Chothe, Gangte, Hmar, Kabui, Kacha Naga, Koirao/Thangal, Koireng, Kom, Lamkang, Lushai (Mizo), Maram, Maring, Mao, Monsang, Moyon, Paite, Purum, Ralte, Salte, Sema, Simte, Tangkhul, Thadou, Vaiphei and Zou,

The total literacy rate has been recorded at 68.87% and the urban literacy level at 80% of the entire population. The average literacy rate is 77.87% for males and 59.70% for females. The male-female ration is at 978 females for every thousand males as against the corresponding figure of 933 for the country. The per capita income is Rs. 12,198.00 against the all-India figure of Rs.21,120.00 ($440). On the human development index, Manipur has fared quite well being ranked ninth at 0.536 and ranked third in terms of the gender disparity index at 0.815 according too 1991 status. However, today, the socio-economic condition of the state is severely handicapped

due to various problems such as insurgency, economic and political instability, lack of employment opportunities, ethnic conflicts, drug use and poverty.

In terms of employment, unemployment is widespread due to lack of development in the industrial sector, thus resulting in an increasing number of young people being exposed to substance/drug abuse. Manipur is predominantly an agrarian state and the industrial sector was never fully developed. According to the State Employment Exchange in 2003, the number of people applying for jobs had crossed one-sixth of the State's total population of 2.4 million and about 60% of job seekers belonged to the 15-34 age group, out of which 67% had the minimum matriculation qualification. There are about 300 doctors and 700 nurses who are unemployed in Manipur.

Although majority of the population still depend on agriculture for their livelihood, the sad fact is that nearly 80% of agricultural land remains unused for 6 months due to inadequate farming methods and lack of proper technology. Also, the State's economic condition is further crippled by the fact that it is unable to utilize the Central Funds which have been allocated for development purposes.

In terms of health infrastructure, Manipur has one Medical College (Regional Institute of Medical Sciences, an 883-bedded Teaching Hospital with Post Graduate Medical Education facility), one State Hospital (J.N. Hospital-200 bedded), seven District Hospitals (30-50 bedded), 16 Community Health Centres (30-bedded CHCs), 72 Primary Health Centres (PHCs), 420 Subcentres and 42 Dispensaries. Beside these, under the Family Welfare Department, the state has 31 Rural Family Welfare Centres, 4 Post Partum Centres, 2 Urban Family Welfare Centres and 275 Rural Family

Welfare Sub-Centres. The bed per population is 1:1200 and altogether, 724 doctors, 1286 nurses, 2012 paramedics are working in the Government Sector.

Fig 1. Map of Manipur Source: Manipur.nic.in

Substance Abuse and HIV/AIDS Scenario in Manipur:

Due to the geographical proximity of Manipur to Myanmar, districts which are close to the border became alternative major routes for illegal drug trafficking from the Golden Triangle in the late 70s and early 80s. The Golden Triangle (where Lao PDR,

Myanmar and Thailand meet) is notorious for its poppy cultivation, the raw source of production for heroin, and accounts for more than 20% of the World's Heroin production. In the 70s, drug use in Manipur had started in the form of mild tranquilisers and Methaqualone; this was followed by injectable morphine and Pethidine. There was an increase in drug use not only in Manipur, but other neighbouring states like Mizoram and Nagaland as well. This caused much negative attitude towards it from the community, and efforts were made to curb this growing trend. This resulted in supply reduction, but only made way for a new menace and that too in a deadlier form. In the 1980s, Heroin, commonly known as No.4 in its injectible form appeared and soon became the most popular drug. This was used along with other pharmaceutical drugs such as Spasmoproxyvon, Nitrazepam, Phensydle, cough syrup, and other substances like ganja, opium and alcohol. By that time, the number of IDUs had reached nearly 30-40,000 in Manipur and had reached an explosive situation by 1984.

In Manipur, the first HIV positive case was detected in February 1990, from among a cluster of Injecting Drug Users from blood samples collected during October 1989. Out of the six high prevalence states in India, Manipur is one of them with 1.67% HIV prevalence rate among pregnant mothers attending ANC. Although the population of Manipur hardly consists of 0.2% of the entire population of the country, it contributes to nearly 8% of the entire HIV positive cases in the country. At present, the official number of HIV positive cases in the state is estimated to be 24,608. However, the HIV/AIDS epidemic is now no longer confined to the Injecting Drug Users alone. The infection is also spreading to the sexual partners of these IDUs, especially their female partners and their children.

Drug Dependency, according to the WHO definition in 1992, is "a cluster of physiological, behavioural and cognitive phenomena of variable intensity, in which the use of a psychoactive drug (or drugs) takes on a high priority. The necessary descriptive characteristics are preoccupation with a desire to obtain and take the drug and persistent drug-seeking behaviour. Determinants and the problematic consequences of drug dependence may be biological, psychological or social, and usually interact."[1] From this perspective, we can see that the phenomenon of drug abuse is not only a process of dependency of the user on drugs alone, but a "series of interdependent processes which link together the profoundly personal aspects of the problem to its global dimensions."[2]

First and foremost is the relationship between the drug-dependent individual and the society in terms of health and rehabilitation services available, support from family and local organisations and the community in general. Secondly is the relationship between the drug user and the drug trafficking network, the supply side that in turn have a relationship with the producer of the drugs, in short, the network starting from the producer to the end-user.

The third relationship is the cause and effect relationship between the "casualties of drug-related dependence, crime and violence and those of war, famine, forced migration and the economic crises of the developed and developing countries."[3] This

[1] World Drug Report, United Nations International Drug Control Programme, Oxford University Press 1997, Page 11.
[2] World Drug Report, United Nations International Drug Control Programme, Oxford University Press 1997, Page 13

[3] World Drug Report, United Nations International Drug Control Programme, Oxford University Press 1997, Page 13

goes to show that there can be cases where problems of drug use is not only the cause, but can also be the effect of other problems in the society. The fourth element is the effect that government policies have and will have in terms of prevention of drug misuse, for instance, management of health care and welfare resources.

When we look at this picture, we can see that there is no single cause and effect relationship that can be pinpointed in order to explain the whole phenomenon. There is an intricate network of relationships, and in order to explain the profile of the women in the study, we will focus on the first and third relationship, the network of relationships between the user and society, that of support and services available and the changes in economy and society which have profound effects on the phenomenon of drug dependency among these women.

According to the study by UNODC on 'Substance Abuse Treatment and Care for Women', there available literature on substance abuse does not give a full picture of women in substance abuse nor does the research studies render justice towards gender issues. What these literatures indicate is that women are less likely than men to use illicit substances, and among adolescents this gender difference is very small. However, the real issue is that women are more likely than men to use pharmaceutical drugs, both medically and non-medically. A study by CCSA on 'Girls, Women and Substance Abuse' in Canada mentions that women are at a greater health risk and are more vulnerable to the physical health impacts of drug abuse, as well as the associated health risks that arise from it. The times when they are more vulnerable are during key transition periods in life like high school, etc. and these are missed by health care professionals and prevention programming planners. Most often, these drugs are taken

to reduce tension, to gain confidence, to cope with problems, etc. It also talks about how trauma, violence and physical abuse is linked to substance abuse...such situations can drive women into developing such habits so that they at least feel they can cope with reality. Especially as pregnant women and mothers, it describes the challenges that they face in the light of discrimination and negative attitudes towards them.

Research and public policy also often tend to focus on the dangers that such drug using women pose on their family and society, rather than focusing on the welfare and health needs of such women. Also, stigma and negative social attitudes influence, to a great extent, the level at which such women will come out and report their drug using problems so as to get rehabilitation.

Of illicit drug use, one of the most harmful modes is injecting drug use. Compared to men, women are at a greater risk of experiencing physical health complications. IDU is also a risk factor of transmission of blood-borne diseases such as HIV/AIDS. Apart from policy and prevention programmes, harm reduction and treatment services, the most important point that one needs to address is the misinformation and negative attitudes addressed towards women drug users. this will go a long way in reducing the problems faced by women drug abusers as they will be able to come out and learn more about the risks involved...it calls for a change in attitude towards such women.

Although the majority of substance users constitute of male users, the use of heroin has increased among women in different cities in India. According to a rapid assessment survey conducted by UNODC in 14 cities in India, from 2000-2001, the

mean percentage of women substance abusers constituted 7.9% out of the entire sample. Out of these, the main substances of abuse were heroin, alcohol, cannabis and painkillers. The typical profile of a woman substance abuser was a single, educated and employed individual. These women started abusing drugs at a very early age, and were also involved in early initiation of unsafe practices such as early initiation into sex and sharing of injecting equipment. In another study[4] which involved 75 women substance users in 3 cities in India, it found that these women used substances such as alcohol, heroin, mild tranquilizers and propoxyphine. Some even reported to using cannabis and cough syrup. The reasons cited for initiation into substance use were peer pressure, stress and tension, influence of spouse or partner. Nearly 50% of the women were involved in sex work as a source of income for drugs and about one-third were peddlers.

Drugs: Definitions and Classification

Drugs: In normal usage, a 'drug' can be defined as a "pharmaceutical preparation or naturally occurring substance which is used primarily to bring about a change in physiological and psychological or biochemical properties of the body that alters the physical and mental functioning of an individual."[5] In Medicine, a drug "refers to any substance with the potential to prevent or cure disease or enhance physical or mental welfare, and in Pharmacology to any chemical agent that alters the biochemical or physiological processes of tissues or organism."[6] So, normally drugs are substances

[4] P.Murthy, Women and Drug Abuse: the Problem in India(India, Ministry of Social Justice and Empowerment, and United nations International Drug Control Programme, Regional Office for South Asia, 2002).
[5] Paul, Madan C. Drugs and Substance Abuse Problems, Mittal Publications, 2005, page 213.
[6] Kishore, J. A Dictionary of Public Health, Century Publications, New Delhi, 2002, page 153.

which are either natural or man-made which are introduced into the human body that can bring about changes in the human body, either mentally or physically.

Drug Abuse and Substance Abuse: A Public Health Perspective

The history of drug use has shown us that though drugs have been used for better purposes, its misuse has been a parallel occurrence. When drugs are used to cure an illness, to prevent a disease or improve a health condition, we can say that it is being used for a proper cause. Generally, these are medically prescribed and their uses are legal. These are called legal drugs and include antibiotics, tranquilizers and painkillers. It is when drugs are used other than medical purposes in such a manner that it leads to excessive physical damage or, the improper mental functioning of an individual, then we can call it drug abuse. So, drug abuse is when:

1) a drug is used without medical reasons
2) the method, quantity and frequency in which it is taken leads to physical, mental, emotional and sociological problems.

Substance abuse refers to the use of substances when said use is causing detriment to the individual's physical health or causes the user legal, social, financial or other problems including endangering their lives or the lives of others. Substance abuse is not specific to illegal substances but people can also abuse legal substances which are bought or prescribed. Substance abuse can mean the abuse of any substance, which is not necessarily a drug such as alcohol. Substance abuse is rather an umbrella term and in normal usage, drug abuse is one form of substance abuse although both the terms are used interchangeably and is considered to mean one and the same thing. For the purpose of this study, the terms drug abuse and substance abuse will be used

interchangeably and understood to mean one and the same thing. However, for the purpose of clarity, the term 'substance abuse' will be defined separately. The third edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders in the 1980s first recognised substance abuse (including drug abuse)and substance dependence as separate conditions which are different from substance abuse alone by bringing in the issues of social and cultural dimensions. Today, the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) issued by the American Psychiatric Association defines substance abuse as:

- A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household)
2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)
3. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the

substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

In this context, substance abuse and drug abuse will be used to mean the misuse of narcotic drugs and drug users will refer to those who are dependent on such narcotic drugs without a proper medical prescription, to such an extent that it creates problems not only for the individual and his family but becomes a societal problem as a whole. From this perspective, one can say that drug abuse is not only a public health problem but a social problem as well.

Kinds of drugs misused:

According to Norman Imlah in her book, "Drugs in Modern Society", the normal classification of drugs abused falls within five groups which she has allocated in the following categories:

Category one: drugs with serious dependence properties and widespread abuse, such as Alcohol, LSD, Cannabis, Phenmetazine, Amphetamine, Opium and Heroin.

Category Two: Drugs with serious dependence properties but not abused on a widespread scale. These drugs include non barbiturates, sedatives, mescaline, morphine, Pethidine, Methadine.

Category Three: Drugs with less serious dependence properties but widespread abuse, for instance, Cocaine.

Category Four: Drugs with less serious dependence properties and without widespread abuse such as Codeine, Khat and Benezoiazepines

Category Five: Drugs that have not been shown to produce dependence such as Phenothiazines (Buty Relvnote), Raulaufia

This classification basically categorises drugs of abuse in terms of the seriousness of dependency from the social aspect. Normally, drugs of abuse can be commonly classified under five categories which are 1) Narcotics and Analgesics, 2) Stimulants, 3) Depressants, 4) Hallucinogens and 5) Cannabis and Cannabis products. Narcotics are drugs that depress the activity of the brain and central nervous system. They are basically used for the relief of pain, and if not misused, they bring relief to pain the most. These are divided into two broad groups the first being opium and its derivatives, and synthetic narcotics. The most common examples of narcotic drugs are Opium, Morphine, Codeine, Heroin, Brown Sugar and synthetic drugs like Methadone, Pethidine and Mepradine. Stimulants are those that directly stimulate the brain and activity of the central nervous system. Because of their effects on the brain, these are widely abused and are still increasing. Common examples are Amphetamines like Benzedrine, Dexedrine and Methedrine, Cocaine and Nicotene. Depressants on the other hand are those that slow down the activity of the brain such as Alcohol, Barbiturates and Tranquilisers. The fourth category is Hallucinogens or psychotomimetics as they cause perceptual distortion as well as distortion of normal hearing and functioning of the brain, and have the ability to produce conditions similar to psychotic states. These are also largely called psychedelic drugs and common drugs in this category include LSD (Lysergic Acid Diethylamide), Mesaline, Psilocybin and PCP (Phencyclidine). The fifth category is Cannabis and products derived from it. At present, the largest single type of drug abused in the world is Cannabis in its several forms. These include drugs such as Ganja, Hashish, Bhang and Charas.

Theories of insubordination and deviance:

According to a Canadian Study[7], women are at a greater health risk and are more vulnerable to the physical health impacts of drug abuse, as well as the associated health risks that arise from it. The times when they are more vulnerable are during key transition periods in life like high school, etc.. Most often, these drugs are taken to reduce tension, to gain confidence, to cope with problems, etc. trauma, violence and physical abuse is also linked to substance abuse and such situations can drive women into developing such habits so that they at least feel they can cope with reality. So what is it that makes a woman more vulnerable in the light of being a drug user in a patriarchal socio-cultural setting and what makes her seem doubly deviant compared to her male counterpart? In a patriarchal social setting, what places a woman in a more subordinate status and what exactly enforces her role as a mother, sister or nurturer while all other deviant roles apart from these pre-enforced roles make her doubly deviant?

According to Sherry B. Ortner, the devaluation of a woman occurs not because of the way biology confers a woman her status in society but the way in which every culture in a society evaluates female biology. Culture is the means by which man controls and evaluates nature and this universal evaluation of culture as superior to nature is the reason for the devaluation of women. Women are seen as closer to nature while men are seen as being more objective and less emotional, their thought processes being more abstract and general and less personal and particular. This makes them closer to

[7] Dell, C.A. & Poole, Nancy. Girls, Women and Substance Use, British Columbia Centre of Excellence for Women's Health, and Colleen Anne Dell, Ph.D., Canadian Centre on Substance Abuse, 2005

culture. So, according to Ortner, a woman's position is intermediary to culture, due to her biology, physiological processes, social roles and psychology.

In tracing the origins of oppression, Shulasmith Firestone argues that the sexual division of labour and the sexual class system is biologically rooted. She argues that the difference between men and women springs from a biological source, where men and women are created differently and not equally privileged right from the beginning. She says that there is dependence on men, for economic reasons, and this creates unequal power relationships and 'power psychology' which forms the basis for all future stratification systems. This sexual class system, according to her is the model for all other exploitive systems and needs to be eliminated. From both these arguments, we can see that be it cultural or biological, the position of a woman is seen as insubordinate to that of a man. This insubordination is both biologically ascribed and socially constructed, if we look into both theories. Although the root causes of insubordination are entirely different, the main image this brings out is that nature or culture has already subscribed a role or position for a woman, that as of a lesser sex who is weaker and of a lesser disposition.

Now, if we look into the deviancy theories, first we see from functionalist perspective of deviancy that deviancy is considered a normal phenomenon in society. Emile Durkheim had argued that deviant behaviour is a necessary function of society, which is inevitable and enforces collective sentiments and solidarity. Merton also argues that all members in a society share some values and sentiments, but since these are placed in different positions they do not have the same opportunities of realizing the

shared values. Deviancy occurs because of culture and society, and deviant behaviour arises from the 'fallacies' of society itself.

If we look into the Subcultural theories, they argue that certain groups develop their own distinctive norms and values which deviate from mainstream society. According to Cohen, the delinquent subculture actually imitates the values and norms of the larger prevailing culture, but then turns it upside down. Such people reject mainstream values which offer them little chance of success and substitute deviant values in terms of which they can be successful. This can also be a way of establishing identity and recognition among peers who are in the same subculture and once involved in such a subculture, it becomes extremely difficult to revert back to the mainstream culture.

One of the most insightful theories of deviance can be seen from the Interactionist perspective. The important thing is that from this perspective, one can look into the reasons why certain people are considered deviant, by focussing upon the interaction of the deviant and those who consider her deviant. It examines how and why certain people or groups are considered deviant and the effects of this on the future actions of the deviant person or group. It focuses on meanings which the actors involved in the situation develop within the process of interaction.

According to Becker's labelling theory, he argues that "deviance is not a quality that lies in behaviour itself, but in the interaction between the person who commits an act

and those who respond to it"[8]. After an individual is publicly labelled as deviant, this can lead to rejection from social groups initially. This denial can lead to the deviant socially accepting the label conferred on him and thus creating an identity by seeking acceptance in a deviant group. Rather than the continuous acts of the deviant individual, it is the reaction of mainstream society that actually forces the individual to assume a deviant identity. This can actually be used to explain the stigma associated with being an IDU in the society, especially for a woman, who already being seen as deviant by not taking up the prescribed role of a woman in society. This deviant identity, once accepted starts acting as a 'controlling one' in further enforcing it.

According to Lemert, the causes of deviance lie with the agents of social control rather than with the deviant. This can be specially applied to the cases of how extreme local vigilante groups and authorities try to enforce social control over deviant behaviour, in this case IDUs and prostitutes. Rather than having the desired effect of getting rid of the deviant behaviour, such extreme societal reaction can instead have a negative effect on the individual, thus enforcing a stronger attachment to her peers and the deviant subculture. This exactly is the barrier that prevents the deviant individual's rehabilitation back into mainstream society. The common mistake that agents of social control often make is that, rather than fighting against deviancy, or the object through which deviancy occurs, they tend to fight against the deviant person. So rather than creating solutions for it, it simply creates more problems instead. Social control starts not just at the societal level, but it actually stems from the family itself.

[8] Haralambos, M. Sociology: Themes and Perspectives, Oxford University Press, New Delhi, 2004, page 450.

Illicit-drug trafficking in Manipur:

The 'Golden Triangle' (where Burma, Thailand and Laos) meet is a major drug producing area with many ethnic groups involved in poppy cultivation. This area which covers about 2,25,000 Sq. kms. is inhabited by hill tribes who live in villages located on mountain ridges. Much of the area is mountainous and inaccessible except by footpaths. The main occupation of these backward tribes in this region is growing and selling of poppy and crude opium, it being the only source of proper income. Along the border that North East India shares with Burma, there are thought to be 19 illegal plants to refine opium into heroin. The refining process is aided by the fact that India is the largest producer in the world of acetic anhydride, the main chemical needed to produce heroin. Some are now calling this region the 'Golden Hexagon'. Because of its high morphine content which is about 90%, Heroin from Myanmar is highly rated in India. The purity and content of heroin from the Golden Triangle is never less than 70%. Compared to the inferior Indian variety which sells for Rs.50,000 to Rs.10,000 per kg., the Myanmarese heroin fetches around Rs. 2.5-3 lakhs per kg. On the 1,000 km Indian-Myanmarese border, Churachandpur and Moreh are the main problem areas. The main routes through which these drugs are smuggled are Tamu-Moreh-Imphal road, Mandaley-Tiddim-Churachandpur-North Manipur, Mandaley-Tiddim-Champhai-Aizawl and Imphal. Churachandpur also has a motorable road with Myanmar. Although narcotics agencies are aware that the smuggling of high grade heroin and other narcotics from the Golden Triangle and Kachin areas into India from Tamu in Myanmar, to Imphal via Moreh is increasing. But it is not possible to know the exact quantity of heroin smuggled due to absence of

large-scale seizures. The seizures are only of small amounts, and the only two major seizures of opium so far were in the late 80s by the Shillong Customs Collectorate. Those were at 490 kgs. and 630 kgs, in 1986 and 1987.

Although Myanmar was the No.1 producer of high-grade Heroin in the past, today the total production of it has gone down. Since 1998, opium poppy cultivation in the region decreased from an estimated 157,900 hectares to only 24,160 hectares in 2006. The Golden Triangle's share of world opium poppy cultivation has fallen from 66% in 1998 to only 12% in 2006. However, it is still the second largest producer of heroin after Afghanistan. But if this trend continues, Afghanistan would be the only Heroin producing country in the world.

Opium-poppy cultivation and production of heroin also fetches huge profits in the international markets for the drug lords in Myanmar. Various insurgent groups have links with the narcotic business and trafficking in the region of the Golden Triangle. Burmese rebels obtain cover and protection for their drug production and trafficking activities in exchange for training insurgency groups from the North East. Once the Burmese and North East insurgency groups linked up, the number of these groups proliferated with each group arming itself to the hilt.

In the case of Manipur, it had three insurgency groups until the 1980s. By the 1990s, this increased to 27 groups and now the number has increased to more than 35. It is the same in other states of North East India. Some insurgency groups in the North East are now trafficking drugs themselves. For these groups, it is also their source of sustenance and for purchase of arms.

The main entry point: Moreh Town

In Manipur, the first district affected by Heroin is presumed to be Churachandpur as it has a direct border with Myanmar. The Imphal-Tiddim road passes throughout Churachandpur right upto the Manipur-Myanmar border point at Behiang in the district. Via this route, drugs were directly smuggled into the region and this caused easy accessibility in the early eighties. However, the most important entry-point for all smuggled goods is Moreh Town in the neighbouring Chandel District.

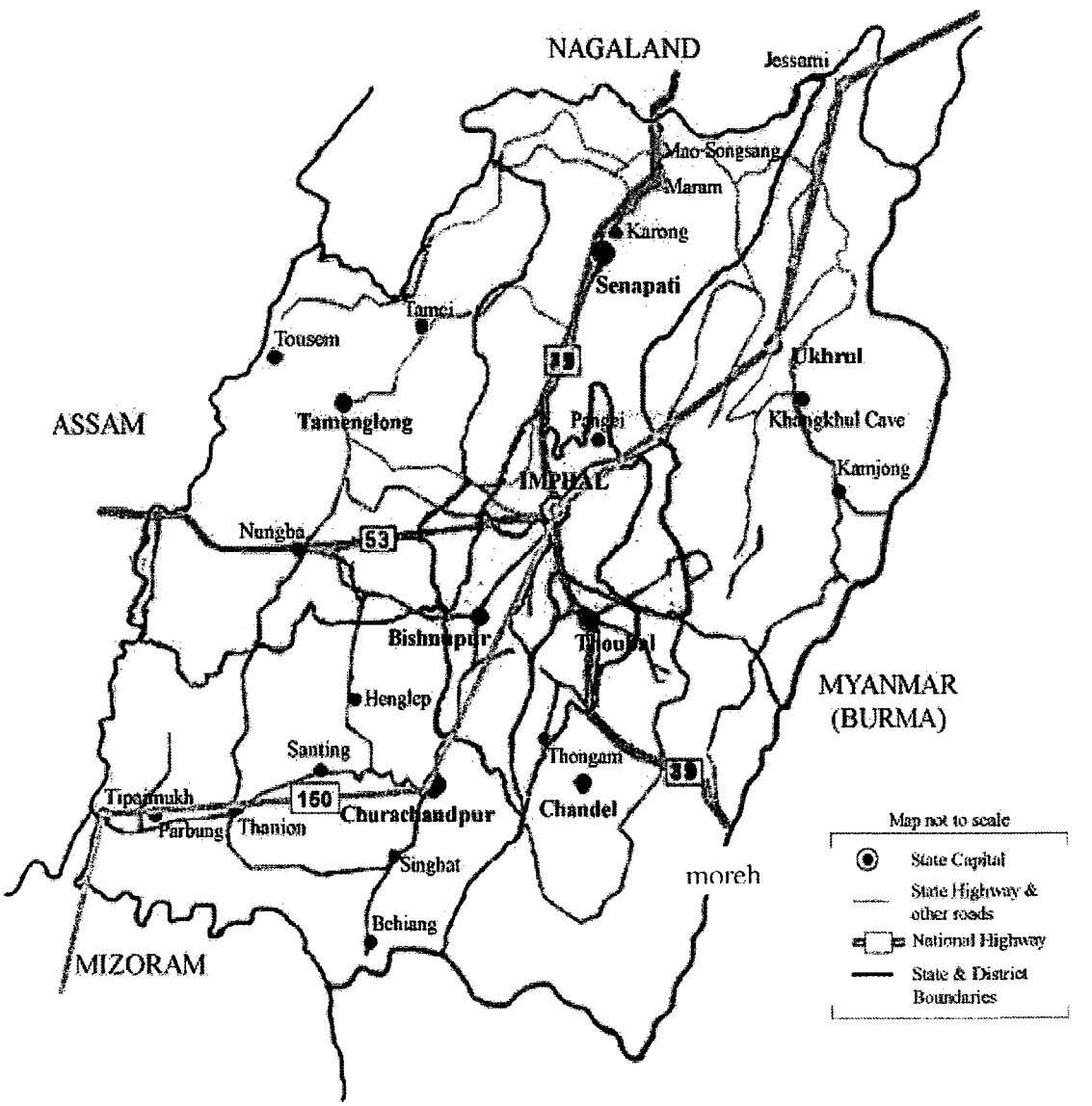


Fig 2. Map of Manipur showing route of NH-39 and NH-1 Source.www.satp.org

Moreh is about 109 kms. south east of Imphal on the Indo-Myanmar road (national highway 39) and is considered a major route of all smuggled goods. This place is

mainly inhabited by Chin-Kuki-Mizo tribals, but people from other communities such as Tamils, Punjabis and Meiteis also settle there. · Until the arrival of Indian repatriates, the main business was of local tribes bartering good items. But later, business flourished and this town became an important centre for smuggled goods including gold, precious stones and other contraband items. With formal trade flourishing, there came an increase in smuggling goods as well. Moreh became a new route for smuggling of narcotic drugs particularly heroin from different parts of Myanmar from then on. This however led to intensified checking at the Moreh-Imphal national highway. Although small traders who are not necessarily smuggling goods but deal in small trades to earn small profits suffer miserably at the hands of the authorities, smugglers or big business owners go scot free. Sometimes, there are cases where people are also forced to smuggle these drugs against their own will.

Although the exact amount of heroin smuggled is not known, in the late 80s, three States in the North East-Manipur, Mizoram and Nagaland- at least accounted for the smuggling of at least 20 kgs. of heroin everyday. Till today, the exact amount cannot be pinpointed as there are no major seizures and there are no official reports on the exact amount. Although most of the heroin is further smuggled into mainland India and into the West, it is presumed that in Manipur, at least 25% of the entire heroin smuggled in is consumed in the State itself. The addiction of heroin spread like wildfire among young people in the productive age group of 15 to 30, especially. Before the coming of heroin, methaqualone and morphine were commonly used by addicts in the region. The ganja grown in Manipur particularly Ukhrul District used to be in great demand in other states due to its superior quality. Although different narcotic drugs were seized by the authorities from time to time, though in small

amounts, the continuous use of narcotic drugs has greatly enhanced the illicit drug trafficking in the region. As drug use increased, the situation became alarming and this triggered massive campaigns against drug abuse. Although credit can be given to this movement, one cannot avoid discrediting some of the activities because from a sociological viewpoint, the attacks, although aimed at drug abuse, much abuse was rendered to the drug users themselves.

While some insurgent groups are believed to be involved in illicit drug trafficking, other insurgent groups took a strong anti-drug stance to the extent of burning opium crops (back in Myanmar and borders of Manipur) and even shooting unrepentant addicts. In Manipur, between 1990 and 1995, armed activists belonging to the underground organisations started shooting drugs users and alcoholics. In this way, hundreds of persons were shot at, even fatally, for consumption of alcohol and narcotic drugs. Peddlers and traffickers were not spared either. This act further drove the drug trafficking business and drug users to go underground, and rather than aiding in the demand and supply reduction, it hampered intervention programmes immensely.

Either way, the region is awash with drugs. States such as Manipur have some of the highest incidence of HIV/AIDS in the world because of the large number of intravenous drug users. Drugs are central to the financing of the insurgency groups and, as a result, drug kingpins operate with impunity. Drug trafficking and increased violence are inextricably linked. The inflow of heroin into the region also depended on the political situation in Myanmar in the early 90s. Because of the military coup and other factors including human rights violation and ineffectiveness in fighting

against opium warlords, there was a sharp cut back in its narcotic law enforcement. This had a serious effect in the inflow of heroin into Manipur and other areas.

Impact of Social Change: Ethnic Conflict, Migration and Urbanisation

The history of inter-ethnic relationship in Manipur reached a turning point when the ethnic clash between the Nagas and the Kukis broke out in 1992. The conflict, from the perspective of ecological view point, may be explained as the violent expression resulting from competition between the two communities who have exploited the same economic resource in the same ecosystem. It may also be viewed as an attempt made by a larger, stronger group to make its cultural habitat and ethnically homogeneous area by way of clearing the minority groups inhabiting the area. The conflict continued for about five years and came to a halt in the early part of 1997. Bloodshed also occurred at Churachandpur as a result of ethnic conflict between the Kukis and the Paites. The conflict started in June 1997 and continued till the early part of 1998. Such ethnic conflicts have brought about changes in the ethnic affiliation of some minor tribes such as, the Koms, the Chins etc. who at present, in spite of their earlier Naga affiliation have maintained neutrality without taking side either with the Nagas or the Kukis.

Apart from the further ethnic divide caused by this conflict, the other major effect this had on the people was that it led to many households being left homeless and landless and umemployed. Hundreds of families were left without any source of income, having lost the head of the family, either a father or husband. Apart from this happening, the other issue is the increase in migration and the consequent result of the urbanisation process. During the ethnic clashes, many villages from either side were

completely destroyed and razed to the ground. People lost all their belongings and for those who were left behind, there was nothing to do except look for a fresh start. Although the ethnic violence had stopped, villages and rural areas become unsafe. Many of the young boys became easy victims for recruitment into various armed factions of each community. As mentioned before, Manipur, and for that matter, Churachandpur is a multi-ethnic area. If we look at the growth of insurgency in the area, if one community take up arms for the 'protection' of their community, then it almost becomes inevitable for other communities not to do so. This starts a chain reaction and apart from the main insurgent groups, various communal armed factions spring up. The streets would be flooded with young boys carrying arms openly. This gives them a sense of power and security and constantly proves to be a source of menace to the common people. Many of these youths who are lured into the factions are forced to take drugs as a method of brainwashing them. Even during the ethnic clashes, numbers of young boys who are recruited are given drugs so as not to put them in a sober state. In that way, they can be brainwashed easily and under the influence of drugs, can kill someone easily and not otherwise. As a result of this, a number of young people also became dependent on narcotics.

The worst victims however are women as the burden is higher on them. Living in extreme poverty and dire circumstances, many of these women take to the drug distribution business, either as small peddlers or distributors. In the process, they themselves also become drug users sometimes. In some cases, since these women who come to the town are inexperienced and possess no proper qualification or skills, there is dearth of employment for them. Forced by destitution, many women take to sex work so as to provide for themselves and their families

The ethnic clash disrupted not only the social life, but it hampered the education of many to such an extent that there are people who entirely dropped out of school and stopped their education altogether. Many young people had their life disrupted and left with no proper education or employment. With the increase in migration to Churachandpur town due to these factors, there is also rapid increase in the process of urbanisation. There is a considerable increase in population, especially in Churachandpur Town as it is an urban area and people go to the town with the hope of securing jobs or some kind of employment. The town area is crowded and once vast areas of fields have been converted into residential areas. This sudden influx has also caused the town to become a booming trade centre, especially smuggled goods coming from the Myanmar border. Although the population is increasing, the availability of employment or employment opportunities does not necessarily increase. There is increasing problem of housing facilities as well. One other notable thing is that within a short span of time, new and large buildings have suddenly mushroomed and once rural areas or the urban sprawl have become more urbanised. This visible increase in the economic growth is questionable because the change is occurring without a visible growth in income incurring businesses or sources. What is happening is in the urban area, there is visible growth but this growth has not necessarily brought about development along with it.

Conceptualisation of the problem:

Unlike other parts of India, HIV/AIDS is closely associated with drug abuse in Manipur. Since September 1986, when the first HIV infection was reported in Manipur, till November 2006, there are 24,608 HIV positive cases. Out of these,

18,931 are males and 5,677 are females. Due to sharing of unsterilised injecting equipment, injecting drug users (IDUs) have constituted the highest risk group of HIV infection. Because of this, HIV infection has been a major problem among male IDUs. Manipur has an estimated number of 21,400 IDUs at present. As the intervention project among IDUs (RIAC project) has been successfully implemented by the State AIDS Control Society, Manipur, HIV prevalence rate among the IDUs has shown a declining trend from 1998 onwards with a sero-prevalence rate of 72.78% in 1998, 66.02% in 2000, 56.27% in 2001, 39.6% in 2002, 30.7% in 2003, 21.00% in 2004 and 24.1% in 2005. Even though the sero-prevalence rate has been brought down to 24.1%, it is still the highest sero-prevalence rate in the world. [9]

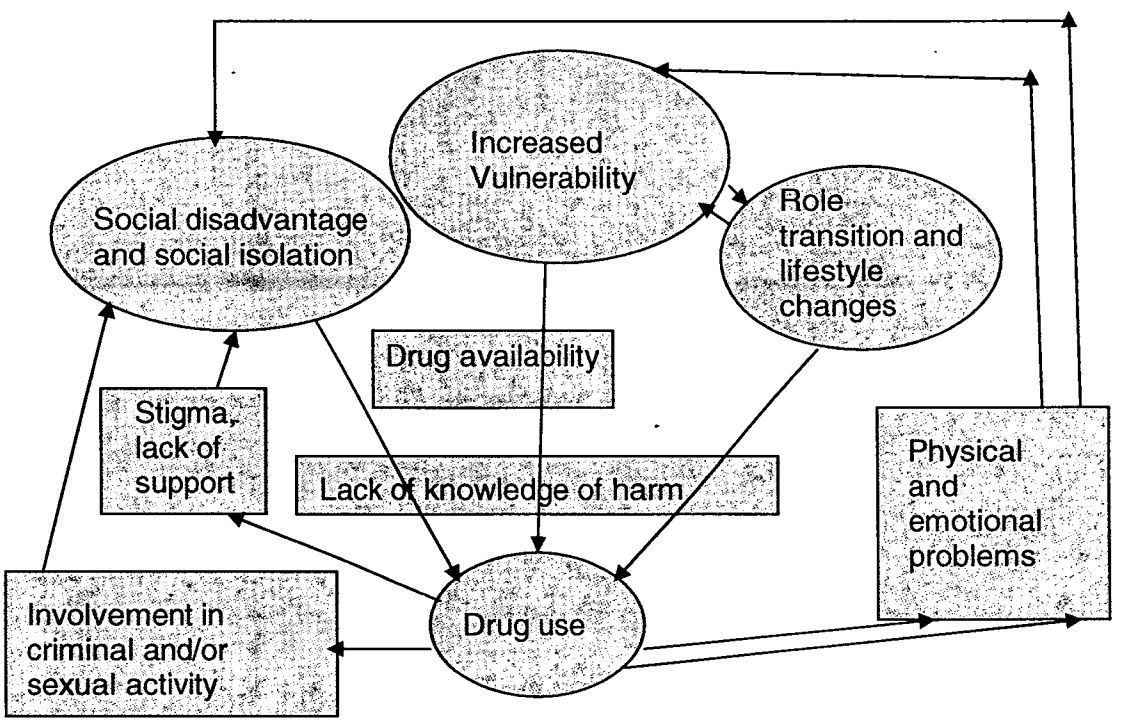
Out of the nine districts in Manipur, three hill districts namely Ukhrul, Chandel and Churachandpur have the highest sero-positivity rates at 31.07%, 28.56% and 23.02% respectively.[10] Churachandpur has the third highest sero-positivity rate out of the nine districts. Out of the estimated number of total 21,400 IDUs in Manipur, around 3000-3500 are estimated to be in Churachandpur. About 10% of these are women, which means about 300-350 female IDUs are there in Churachandpur. Compared to men, the number of female IDUs is much less. Because of these, they are relatively more neglected and when it comes to official statistics, there are no particular quantitative research statistics pertaining to female IDUs in Churachandpur. As a whole, the data on drug abuse among women in India is relatively scanty and most of the time, this phenomenon is widely believed to be non-existent. The same goes for female IDUs in Churachandpur. However, the phenomenon does exist and this is the first reason why it is considered a felt-need to study the topic.

[9] Status Report, National AIDS Control Programme, Manipur State AIDS Control Society, Manipur 2005-2006. page 3

[10] Epidemiological Analysis, Manipur State AIDS Control Society, Manipur, November 2006.

The complex issue of women and substance abuse can largely be seen from three perspectives: the first is that of women having a drug user in the family and having to deal with the complex issues arising from it; secondly, it is a micro perspective of being a female drug user in the family, and thirdly, it involves a larger perspective of being a female drug user in the Indian socio-cultural context.

Fig 3. Interacting factors leading to drug use among women



Source: "Women & Drug Use: The Problem in India", Page 46

Many families in Churachandpur, including those which are included in the study have drug users in the family. In such families, women are often mothers, wives, siblings or the children of male users in the family. Very often, it is the women who tend to shield such family members from society and the consequences that result

from such habits. In the process of trying to deal with this issue, women very often get involved in drug use themselves or get initiated to it in the process, as the experience of dealing with such problems can be very harrowing. This provides a big risk for women in such situations. Many female IDUs in Churachandpur are spouses of drug users who got initiated into drug use through their husbands. As a result, this would result in undesirable consequences either in domestic violence or sometimes the woman herself getting involved in sex work so as to support her and her husband's habit, and at the same time take care of the family.

Even though female IDUs constitute a small percentage of the total number of IDUs, one visible trend is that most of these female IDUs are also involved in prostitution or commercial sex work. Some do this to provide economic support to their families, or solely to support themselves. This puts them at a higher risk from sexually transmitted infections (STIs). As we know, the HIV virus is more readily transmitted sexually from an infected male partner to a female partner. For women, the risk of HIV infection during unprotected sex is 2 to 4 times to that of men. Also, these women are not in a position to negotiate safe sex for themselves. Most of the time, they face clients who refuse to use condoms, and they are put to physical abuse not only from their partners but even by the pimps themselves. This makes them more vulnerable and puts them at a higher risk of infection.

Like any other social system, the tribal communities in Churachandpur are close knit and closely regulated by social norms and conventions. The role of a woman is seen as that of a mother, wife and care-giver and expected to live out these traditional roles expected of a woman. The first issue is that women who are drug users are seen as

'doubly deviant' because "taking drugs is seen as both deviance from accepted social codes of behaviour and deviance from the traditional expectations of the female as wife, mother and family nurturer." Seen from the larger perspective of a patriarchal social system, this act of deviance becomes a bigger taboo. This act of labelling causes female drug users to be more stigmatised compared to their male counterparts. To add to this stigma, there is the phenomenon of triple stigma. Even though much work has been done to provide awareness about HIV/AIDS, the stigma associated with it still has not diminished. Female drug users who are both HIV positive and involved in prostitution as well face a triple stigma. In a small urban setting like Churachandpur Town, this makes such women social outcasts and would make it harder for them to get accepted back into society. For their male counterparts, the process of rehabilitation is a simpler process. But for these women, the process of being accepted back into society is often the longest and most difficult process and this makes it more difficult for them to get out of such situations.

Female entry into the drug trafficking scene is also "facilitated by the change in social and economic conditions" in Churachandpur, and Manipur as a whole. The long-term conflict caused by ethnic clashes and insurgency seems to contribute to the problem as well. Being in the direct route of drug trafficking, there is a higher availability of drugs coming from the Golden Triangle. Even though efforts are being made to curb this demand reduction, the case is not so. In fact, due to rash measures carried out by insurgency groups who threaten to shoot drug peddlers so as to curb the demand of drugs, this makes the situation worse for the women because this makes them doubly vulnerable. Though often seen as a male domain, the illegal drug distribution network is not solely a male-dominated business. Forced by dire economic circumstances,

many women (who are drug users themselves) are being forced into the drug trafficking trade in Churachandpur. Many of these women become small-time peddlers so as to support their families or themselves. Such women also become easier targets for harassment from so called 'social reforming' insurgent groups, local vigilante groups and even from the police. Women who are involved in such trade are often victims of these ethnic clashes, women who have lost their husbands in the ethnic violence or insurgency. Women sex workers are often harassed and forced into sexual intimidation by the military personnel who are there as a peacekeeping force. Poverty, intimidation and the lure of money forces these women to enter the drug distribution scene.

The Drug Rehabilitation Programme, when seen as a whole is also entirely biased. In Churachandpur itself, there is only one female Drop-In-Centre (DIC) for women drug users, and this is solely for drug users. For their male counterparts, there are various rehabilitation centres run by local ministries and NGOs. In fact, there are DICs and rehabilitation centres that cater to both men and women, however this discourages women drug users from using such facilities for fear of stigmatization. The female rehabilitation centres again do not have separate facilities for those women who are HIV positive. Apart from this setback, one very important aspect is that even though many women may get physically rehabilitated, these centres have a time constraint that allows inmates to stay only for a particular length of time, for instance six months or so. Sometimes, such centres will provide some form of occupational training like tailoring, knitting and so on. But for most of these women, who are both HIV positive and drug users, they come from either broken families or they are estranged from their families. So, after the period of rehabilitation is over, these women often

have nowhere to go and really have no way of supporting themselves once out from the centres. Since most of them are estranged from their families, they are back on the streets or go back to their old friends as they have nowhere else to go. Faced anew with hardship and financial problems, they again go back to their old ways and once they do that, it becomes even harder for them to come out of their old habits. Until and unless the social rehabilitation occurs, the process of rehabilitation cannot be complete.

Largely, injecting drug use is also an urban phenomenon. Even though there is no particular study done by the government to show the rural-urban ratio of injecting drug use, the phenomenon is more prevalent in urban areas. Again, there are no particular studies which focus on the tribal population, especially women so as to determine the extent of injecting drug use or the other issues which arise from such situation. An emerging trend about women and drug abuse that is seen at the global level is that global changes unfortunately favour the increase in drug use among women. One such change that has been noted is that of "the transition of women from the traditional roles of mother and homemaker to that of an economic provider for the family". The second reason is seen as due to the "emancipation and greater economic independence" of women. Although the situation in Churachandpur is rather similar to that of the first emerging trend, it cannot be true of the entire phenomena. Seen from the second perspective, what is happening is not emancipation and independence of women, but instead a deeper enslavement into the drug using and drug distribution scene, making women more dependent on the latter as a means of economic survival especially among tribal women.

This study is done in order to study the phenomenon of injecting drug use among HIV positive tribal women who are living in Churachandpur, so as to understand the problems faced by them and the consequences of being drug users and being HIV positive, in terms of:

1) stigma and discrimination
2) vulnerability due to risk behaviour
3) access to treatment and social rehabilitation

This would also help to understand the urban sociological factors that drive such women to engage in such 'deviant behaviour' and their plight from a larger perspective.

Area of Study:

In Churachandpur, the total number of HIV positive cases is 1493, which accounts for 7.81% of all the total cases in Manipur and as mentioned, ranks third in terms of sero-prevalence.

Table 1: Demographic profile of Churachandpur

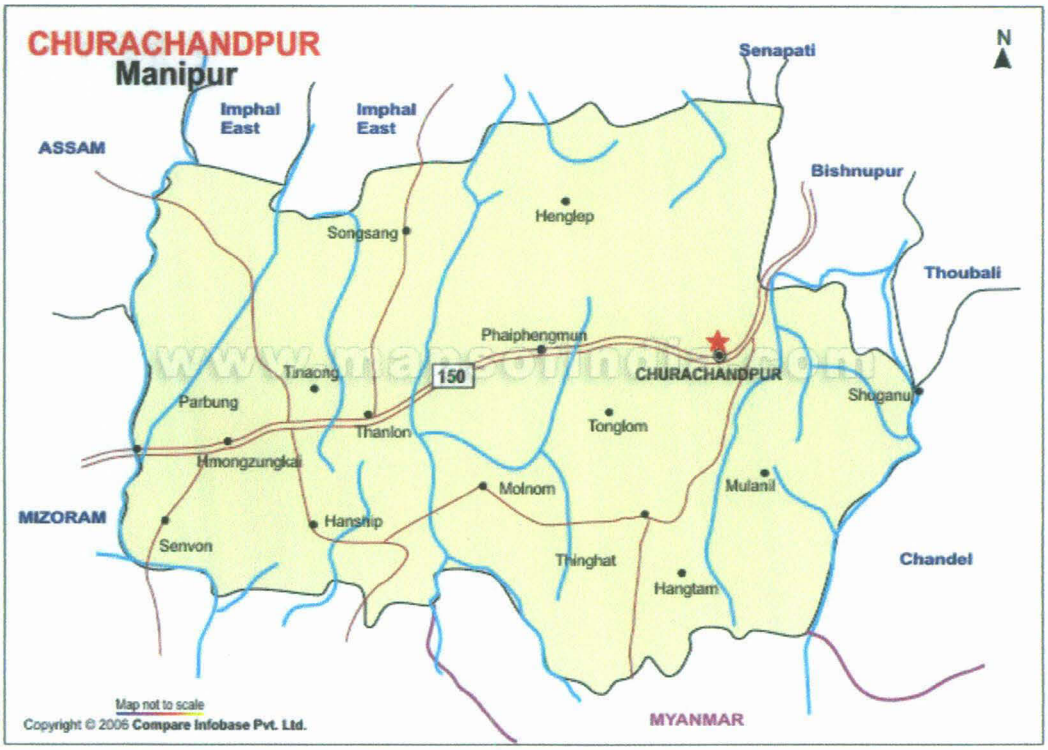
Area:	4570 km²	Rank 1/9
Literacy Rate (2001)	74.67%	Rank 3/9
Literacy by Gender	Male 84.98%	Female 64.40%
Population (2001 Census)	228,707	Rank 5/9

Population % to state population	9.57%	(2001 Census)
Sex Ratio	993 (2001 Census)	1004 (1961 Census)

Source: Census Reports, 2001

The area of study is Churachandpur Town of Churachandpur district. This area was chosen owing to it being one of the three prevalent urban sites.

Fig. 4. Map of Churachandpur



The second reason is because of familiarity of the locality and its environment by the researcher. There is a high number of IDUs in the area. Within this, there are also female IDUs although these are relatively neglected in terms of services available to them, compared to their male counterparts. If we look at the rehabilitation programme for IDUs in Churachandpur town, there is only one female DIC (drop-in-centre)

which is run by a local NGO (SHALOM), and this female DIC is one of the projects running under the Women's Programme, and is also recognised by MACS (Manipur AIDS Control Society). The female DIC which has been used as the basis of study is specifically meant for IDUs only and had about a 100 women registered at the time of study.

Methodology:

The study is a qualitative in-depth study, involving a small sample frame of HIV positive women IDUs. Since official statistics and other studies about HIV positive female IDUs specifically on tribal women are not available, an exploratory research design was used for the study. Before the study was conducted, an open-ended semi-structured interview schedule was formulated. Literature review based on secondary data such as articles and books were done initially. On arrival at the study area, an initial meeting was held along with the director of the NGO, Head of the Women's' Programme and female staff of the DIC.

Sampling frame: At the time of the study, the DIC had about a 100 women who were registered. Since the DIC is solely for drug users, all the drug users are not necessarily HIV positive. But, with the approval of the registered IDUs, their work and HIV positive status are recorded so that better medical treatment can be administered to them. However, this is not a mandatory requirement on the part of the IDUs. Their status is kept strictly confidential and they are registered on the basis of codes so that apart from the head of DIC staff, no one is aware of their status. From these 100 women registered, the head of the DIC staff shortlisted 30 women

who are current users, tested to be HIV positive and living in urban areas, which is Churachandpur Town itself. However, the identity of the 30 women is not revealed at this time. All the IDUs have code numbers and they were shortlisted by the DIC staff using their code numbers, thus concealing their identities. Out of these 30 women, using random sampling method, 15 women were randomly chosen. The female DIC staff then had a meeting with these 15 female IDUs and they were briefed about the study and the purpose of it. Even though none of them refused to participate in the study, informed consent was obtained from each of the 15 women before the researcher was introduced to them. After obtaining informed consent, an initial meeting was held with these 15 women and were introduced to the researcher.

Tools of research: The draft schedule was pre-tested at the DIC and modified. The initial first three weeks were spent at the female DIC so as to build rapport with the respondents and to have a better understanding of the environment and the functions of the DIC. Owing to the period of study being a holiday season, the respondents did not show up on an everyday basis, but in order to understand the conditions of the IDUs in general, participant and non-participant observationary tools were used in order to gain trust and confidence of those at the DIC. Once every week, a discussion was held with the DIC staff and other IDUs at the centre. Based on the interview schedule, an in-depth interview of 15 respondents was done within a span of three and a half months. The interviews take about 2 hours each and were done through several sittings. Majority of the interview took place in the counselling room at the DIC, and only the researcher and respondent were in the room while the interview was conducted. Some of the other interviews took place in the counselling room of the Women's Home, SHALOM. At the time of the pre-testing, the interview schedule

was modified and translated into a local dialect, Mizo. All the interviews were conducted in the Mizo dialect. After the interview, the information obtained is again translated into English for further use. Apart from these respondent interviews, the Director of the Organisation, Head of Women's Programme, two staff members each from male and female DICs of the Organisation, and one Peer Educator from the female DIC were interviewed.

Two Deputy Directors, Deputy Director of IEC and Deputy Director of Targeted Intervention from Manipur AIDS Control Society (MACS) were interviewed. Secondary Data such as Epidemiological Analysis, Status Report of Manipur and other relevant material was collected from MACS and the NGO.

Experiences of the Researcher:

During the time of field work, a number of problems occurred for the researcher. Since the time chosen for field work was towards the end of the year, the respondents were mobile most of the time. This means that they travelled constantly from one place to another owing to work mostly those in prostitution, moving from one place to another. This made it difficult to locate them and talk to them at the convenience of the researcher. One had to find them and carry out the interview at their own convenience. Even if they had to spend an hour to talk to the researcher, it would be a waste of time for them as it would affect their source of income. Since they are mostly daily earners who had to find enough clients to get enough money to feed their drug habit, taking time out to talk to the researcher posed to be a huge problem for them. As it was a holiday season, it was peak season for most of the respondents

involved in prostitution, they were in high demand in various parts of the district due to which it was rather problematic to find them. Most of the time, one had to call them beforehand, either through their peers and ask them when they would be free to talk.

Due to constant power failure and poor electrical facility, there was a lot of problem in communication and electronic documentation for the researcher. The ongoing conflict situation made the streets unsafe by dusk. Other situations such as bandhs and curfews caused a lot of problems in transportation, and caused restrictions for the researcher. So even if one so wished to, it was not possible to travel around at any point of time. Plans for interviews had to be rescheduled very often according to the prevailing situation.

Chapter 2. Women and Drug Dependency: Problems and Issues

Profile of the study in Churachandpur:

Socio-demographic profile of the respondents:-

As mentioned earlier, there is no such epidemiological survey or statistical data based on female IDUs alone in Churachandpur, Manipur. According to latest epidemiological data, the total number of IDUs in Manipur is estimated at 37,996.[11] Out of these, the total number of IDUs in Churachandpur is estimated to be around 3000-3500. About 10% of these are women, which means about 300-350 female IDUs are there in Churachandpur.[12] Approximately, there are about 9000 Commercial Sex Workers (CSWs) in the State and at present, 6900 of them are getting services through five NGOs. There is no official data on district-wise distribution of the number of CSWs in the State.

As evident from this, and as noted from the study by Murthy[13], owing to their small numbers and 'subordinate position in the drug culture', women with substance use problems may not show up in government official statistics. The reasons cited for this are lack of resources, lack of awareness and negative attitudes to women's substance use, methodological problems, and lack of information on women and gender differences.

[11] Status Report, National AIDS Control Programme, Manipur State AIDS Control Society, Manipur, 2005-2006, page 8.
[12] SHALOM Activity Reports, SHALOM, Churachandpur, Manipur, 2007
[13] P.Murthy, Women and Drug Abuse: the Problem in India(India, Ministry of Social Justice and Empowerment, and United nations International Drug Control Programme, Regional Office for South Asia, 2002).

From the statistics given above, we can see that the number of female IDUs is relatively very small. Further, the study focuses on women who are also HIV positive. The sample population of the study is 15 female IDUs who are also HIV positive and all the respondents, including their families, are urban residents of Churachandpur town, in Churachandpur District. Even though each of their families live in the town itself, most of the respondents are not living with their families. Most of them are estranged from their families; either because their families do not want them, or because of self guilt they do not stay with their families. Since the study also focuses on tribal women only, the respondents all belong to various hill tribes who live in the town.

Table 2. Age of respondents

Age group	No. of respondents
20-25	2
25-30	5
30-35	6
35-40	2
	15

These women married very young and all of them apart from two respondents, experienced failed marriages due to early marriage. During the time of the study, only one respondent was married. Most of them have children who do not stay with

them. Their children either stay with their husbands or their families or are estranged from them. Two of the respondents were allowed to see their children once in a while.

Table 3. Education of the Respondents

Level of Education	No. of respondents
No education	2
Below Matriculate	9
Matriculate	3
High School and above	1
	15

If we look at the educational status of the women, we can see that most of the women hardly have education at all. Although the two respondents have no education at all, they at least know how to read as well as write their names. In Table 3, only one respondent has education above higher secondary. The respondent did not finish college due to initiation into drug use. In general, the women are poorly educated and this is one reason which makes them more vulnerable as they are not aware of their rights nor are able to negotiate for themselves in many ways. Two respondents were actually state level football players.

According to a study by Reid and Costigan[14], there is an increase in substance use among Asian women and also an increased involvement of women injecting drug users in sex work in many Asian countries. Particularly for Asia, Eastern Europe and

[14] G.Reid and G.Costigan, Revisiting "The Hidden Epidemic": a Situation Assessment of Drug Use in Asia in the Context of HIV/AIDS (Fairfield, Victoria, Australia, Centre for Harm Reduction/Burnet Institute, 2002).

North America, the three intersecting elements of injecting drug use, sex work and unsafe sexual practices has become a significant factor in the increased risk of HIV among women.

Table 4. Source of Income for Drugs and Occupation

Occupation	No. of respondents
Peddler	2
Peddler and pimp	1
Sex worker	13
	15

Out of the 15 respondents, 13 women were engaged in sex work so as to support themselves. Out of these 13 women, two were also the main bread earners for their families. They support not only themselves but their families as well. One respondent was working as a pimp as well as drug peddler, while two are engaged in drug peddling as their main source of income. As we can see from this table, most of the IDUs are involved in sex work and very often, they say that they have to take alcohol so as to make themselves stress-free before meeting their clients. Most of the time, they need money aside for the first fix in the morning and have to find enough clients so that they will have enough money to procure drugs. However, one interesting find is that it does not necessarily mean that these women get involved in sex work because of their drug dependency; there are also cases where some women are already involved in prostitution as a means of occupation and then later on get initiated into drug use. So the pattern is not necessarily similar in all the cases. One sad thing that

comes to light is that these women are at the most poorly educated, thus unable to negotiate for their own rights even at home or out on the streets. During the interview, one respondent feels that they (sex workers) are not united and do not even know the importance of having unity. "*We should have some unity among us. The rate per client is Rs. 50 and the price has never increased. We sell ourselves at such a low price because some of the sex workers care only about their next fix and don't even care how much they get, as long as they get money they are happy*". What happens is that whenever these women try to increase the rate, there will be some who are willing to take lesser money so as to get more clients. This will again drive the rate down. So in any situation, the point is that they are helpless and unable to defend themselves. Even if they try, they just get harassed and beaten up by the clients or the pimps themselves.

Drug distribution is largely a male dominated area, but there are a number of women dealers too. However, these women involved in drug distribution are fairly at a lower level. Mostly, they buy it from large dealers who sell it from their homes. These dealers also allow the users (who are familiar to them) to inject drugs in their homes as well. What these peddlers do is, they sell it off again to other users in the streets. Such kinds of peddlers are called 'mobile peddlers', in local slang.

Drug Use Behaviour and problems faced:-

Table 5. How respondents come to know about drugs

Mode of introduction	No. of respondents

Observed neighbour taking drugs	6
Observed father/mother/sibling/husband taking drugs	3
Drugs frequently being sold in the locality	3
Was told by peer group about drugs	7
Was told drugs relieve pain/stress/mental worries	8

Table 5 talks about the way in which respondents came to know about drugs. The main reason how they became aware of drugs was through peer groups who were told that drugs relieve pain/stress/mental worries. Out of 15 women, 8 respondents said they were told about how drugs can relieve stress and mental worries. Mostly these respondents who heard about drugs first from their peers usually state this reason as well. 6 respondents had seen their neighbour taking drugs, while 3 out of 13 respondents had seen a family member either a mother, father or husband taking drugs. Also, 3 respondents admitted to drugs being frequently sold in the locality and they were well aware of it. Two of the respondents, who belonged to the first generation of heroin users back in the 1980s, admitted that drugs were seen as a new form of fashion, to be popular and to be accepted in the peer circle.

Table 6: Age of Initiation into Drug use and Mode of Initiation:

Age of Initiation	No. of Respondents	Mode of Initiation
20-25	6	Oral
25-30	1	Oral

20-25	1	Mainlining
25-30	4	Mainlining
30-35	3	Mainlining

In Table 6, we can see the age of initiation into drug use and the mode in which they were initiated. Basically, we can see that 7 out of these women were first initiated into drug use orally. They had their first initiation into drug use through oral mode. Majority of these women also started taking alcohol in the first place. It was only after that they started taking drugs, either orally or through mainlining. Most of these women who were introduced to drugs orally were between the age group of 20-25; they were in their early twenties when this happened. From this we can also see that the main modes of administration of drugs are smoking and injecting.

Out of the 15 respondents, 8 respondents admitted to being introduced to drugs directly through mainlining. 4 of these women belonged to the age-group of 25-30, three in the age group of 30-35 and 1 was in her early twenties when she was first initiated into drug use. By oral initiation, it generally means that the respondent started taking pharmaceutical drugs initially and then moved on to heroin. Out of the respondents orally initiated, two of the respondents first started smoking heroin.

None of these respondents, when introduced into mainlining, injected themselves but did so either with the help of a peer or the peddlers themselves. After the first time, it becomes relatively easier for them and they would inject themselves with their peers or by themselves. The first few trips were done in the presence of peers or peddlers but after that, depending on the situation, they inject themselves. Most of the time, these women admit that they usually do not inject themselves at home. The most common place for them is the peddler's house itself. Sometimes, they have to inject themselves in public latrines. Their favourite haunts are cemeteries. Although the DIC staff encourages them to turn in their used syringes, as this is part of the Harm Reduction Programme, which supplies them with needles and syringes, a number of them mentioned that they would just throw it away wherever they want.

Table 7: Types of substances abused:

Primary Drug: Heroin Secondary Drugs: Alcohol, Spasmoproxyvon, Alzolam, Relipen, Diazepam, Cough Syrup, Cannabis products

The primary substance of abuse is Heroin or No. 4 as it is commonly known. In local slang, it is also called *thawmhnaw* or *van* which actually means merchandise in two of the local dialects. In the streets, they usually never call it Heroin or No.4, but always refer to it by its slang name. The other substances which are usually abused are pharmaceutical drugs such as Spasmoproxyvon, Relipen, Alzolam, Diazepam and Cough Syrup. Cannabis in its various forms is also a common substance taken

alongside. But what most of the respondents admit is that, as long as Heroin is available, they do not take other drugs along with it. This is generally because according to them, the experience is entirely different and the high that Heroin gives is far better compared to other pharmaceutical drugs. Sometimes, due to local pressures, not only Heroin but even other drugs will be scarce. At such times, they resort to other drugs. All of them are poly-drug users in that sense. The common rule is that they never take Heroin and Alcohol together.

Table 8: Reasons for initiation into drug use

Reasons
Peer Pressure
Curiosity
Depression
Frustration
Disappointment
Broken family Background

The main reasons for initiation into drug use are peer pressure, curiosity, depression, frustration, disappointment and a broken family background. The most common reason for initiation into drug use was depression, frustration and disappointment. After being depressed and frustrated about their lives, sharing their problems with their friends and on being told that drugs reduce stress and mental worries, peer pressure would lead them to start taking drugs. Strangely, peer pressure was not the main reason cited for main initiation into drug use. They were more personal reasons which stem from other personal problems that only manifest itself in other forms. Three of the respondents stated that they took drugs out of curiosity. Two of the

respondents belonged to the first batch of early users and to them heroin was a new thing in the streets. It had just hit the streets at that time, and to be a user was thought to be fashionable. Not only that, the whole paraphernalia, the entire injecting equipment was new to them and they were curious to try it out. *"We actually thought that it was a really cool thing to take No.4. We never knew that it was addictive and that we could actually get stuck like this. At that time, it was a fashionable thing to do and the other kids used to envy us a lot"*, was what one of the respondents mentioned.

The first Hit:

When the respondents were asked whether they took drugs intravenously for the first time either by themselves or with the help of others, women responded that they injected themselves while they had their first injection with the help of someone. Most of the time they were in the presence of peers, where they injected together. After a while, people said that they injected themselves without the help of others. All of them have shared needles with someone at some point, but now that needles are more readily available and syringes are distributed by local rehabilitation centres, they hardly share needles anymore. Initially, especially in the early 80s and even till late 90s, there was not much awareness about the dangers of sharing injecting equipment. Friends would share equipment among themselves. There was no awareness of the dangers of diseases that can get transmitted through sharing of needles and such equipment such as HIV/AIDS. In this study, half of the respondents admitted to getting the kick straightaway the first time they used Heroin, while half of them said they experienced nausea and severe headache. But the circumstances

surrounding this first hit are such that, though those women had bad experiences in the first place, they were still tempted to give it another try. Usually, peers and peddlers would share drugs with them or give them free of cost for a few trials, but once they get addicted to it, they are asked to procure it for themselves. Most of the women do not have enough money to procure large dosages at one go, but would have to purchase them in small amounts. Those who can purchase larger doses would do so, especially in times of scarcity, and inject themselves at their own leisure.

Most of these women are hard-core users and the duration of use ranges from 3 to 11 years. Before mainlining, some of them had been addicted to pharmaceutical drugs for at least 3 years before going into mainlining and heroin. Table 9 shows us that the main sources of money for buying drugs are parent's money, stealing and self-support or own salary. All the women admitted to stealing at one point of time, either

Table 9. Source of money for buying drugs

Parents Money, Stealing, Self-support/Own Salary

from their families, relatives and other people. Some of them stole so much from their homes, getting their hands on anything they could steal so as to get money. They would sell all the valuables and even food items such as rice, to the extent that some of their families are driven to poverty. During the time of the study, most of these women were supporting themselves by engaging in sex work. Two of them are, as mentioned before peddlers, one being a pimp as well. One is also working as a peer educator. Other sources of income are selling charcoal, knitting, weaving, selling clothes, etc.

But the income from these other sources is almost negligible, and since these women can hardly focus on these things, sex work becomes the easiest option.

Depending on the amount of dosages taken, the average cost of one fix or one shot of heroin is about Rs.150. This is the price of a normal dose. Some users would use this for two doses, depending on the need. But the average amount of money spent on a daily dose is Rs. 300, although the real amount spent differs from person to person. Most of the time, they spend Rs. 500 daily for their normal doses. If they have more money to spend, they often take larger doses too. The dose also varies from person to person. But for hard-core users, they need at least 4-5 doses per day. Those who start with small doses take longer to increase their dosage, but those that start off with a large dose tend to take larger doses within a shorter period of time. The most important thing for these women is that, meeting their daily dosage is one thing, but they have to have enough money for the first fix in the morning. This is the most difficult time for them and very often, they would have problems if they cannot procure drugs at the right time. All other things such as health, nutrition, personal relationships and personal hygiene tend to become secondary priorities and the most important issue is procuring drugs for the next fix. For them, the question is always, "how will I get the next dose"?

Problems faced:

The main problems that these women face because of drug dependency and being HIV positive in a small town are:

- Financial hardships

- Family problems- broken families, family conflicts, tension, violence, problems of communication, separation from children, problems of shelter and housing
- Triple stigma – of being a drug user, sex worker and HIV positive,
- Job-related difficulties-due to poor educational qualifications and lack of professional skills
- Harassment from local pressure groups
- Emotional problems- depression, stress, mental trauma, worry

When we look at the family background of these 15 women, none of their families are so well off economically. Majority of their families are dependent on agriculture for their livelihood, i.e. farming. All the respondents have mothers who are housewives and not working. Those respondents who have a parent working in the government sector are either retired or they do not have a very high-paying job. The average income of the families range from Rs. 2000-Rs.6000 at the most. When asked if they are staying with their families, most respondents said that they are actually living with their families. Two respondents have families who are aware of their status as drug users and being involved in sex work, but these two women are supporting their families and adding income to their household.

On being asked why they did not continue their education, the reasons given were: loss of interest in studies, parents did not find it necessary for education, financial hardships in the family, early marriage, interest in sports and due to ethnic conflict. The most common reason was economic hardship and loss of interest in studies. Because of this, education could not be a priority. At the initial stage of drug use, all of them say that

they did not have good relationships with their parents. They were against their drug use behaviour, and since they started to steal things from the house, this caused more relationship problems. One respondent mentioned physical abuse by her father, because of which the family faced a number of problems. Another respondent had lost both parents and was living with her siblings and their families due to which there are constant problems in the household. Two respondents are staying with their families full time, but the rest of them do not really stay with their families all the time. Due to their drug habits and involvement in prostitution, they often travel from home to other places to look for clients. One respondent blames her family for the situation she is in because as there are no other users in the family, she felt they could not understand her and so could not help her the way she needed. In fact, she felt that there was not enough support from her family, who she feels cheated her by admitting her to a rehab centre while promising to send her away for further education.

Most of the respondents were married at an early age, which is the most vulnerable time as it is the period of transition. Mainly due to economic problems and since they are young, they are unable to adjust themselves in other families. This would result in failed marriages which would lead to disappointment and depression. Under some tribal marriage laws, a woman once married is not supposed to return to her maternal home as it is considered shameful for both the families. Being caught in the middle, with nowhere else to go, this would lead to a lot of disappointment. This can be a factor for drug use. At least 7 out of the total respondents were with partners who were drug users themselves at one point in their lives. While not being with their families, they stay with their partners.

Some of the health problems faced by these women are fever, diarrhoea, headache, cold, sexually transmitted diseases (STIs), tuberculosis, asthma and breathing problems and digestive problems. When asked their reaction on being aware of their HIV status for the first time, many said that they were in denial. Some refused to believe it and some of them even tried to commit suicide. None of their families are necessarily aware of the fact that they are HIV positive. Of course, some of the respondents said that their families suspected them to be HIV positive, but they do not necessarily ask nor does the respondent tell them about her status. Till the time of the study, some of the respondents said that their families are still not aware of the fact that they are HIV positive. On being asked of their reaction about their status at the time of the study, all the respondents answered that they have learnt to accept it. Some of them even went to the extent of saying that they deserve it because they had engaged in certain behaviour which carried the risk of contracting such kind of diseases. They blamed themselves and held themselves solely responsible for it. At the end, they have lots of guilt and self-blame which makes them more worried. Although the family does not insist, one respondent, who feels alienated from her family does not even eat food in the house with them because she feels that though her family does not mention anything, they feel uncomfortable with her. She also mentioned that her sister-in-law does not even allow her to touch her children for fear of her positive status.

The other question was, as being sex workers, whether they would ever disclose their status to their clients or not. The answer was that none of them would ever want to disclose their status to their clients because then that would stop them from getting any clients. Most of the time, these women are not able to negotiate safe sex for themselves. The clients would insist on unsafe sex and this would put them both at risk. More than

half of the women believe that they got infected through heterosexual transmission, either from their husbands, living partners or clients. The rest believe that the means of transmission is through sharing of needles and injecting equipment. Not all of the women are on Anti-Retroviral Therapy during the time of the study. This is because of ART not being readily available for everyone. It is limited as there is only one centre which distributes it. Also, the women are reluctant to go to the centre as they are afraid of being stigmatised. For all their health treatments, they go to the AIDS Hospice which is run by the organisation itself. After being aware of their status, all of them stopped taking any form of treatment from the District Hospital but started going to the Hospice instead because this is the only Hospice that provides services exclusively for people living with HIV/AIDS (PLWHAs). There is also constant worry about medical problems. Although the women were still relatively healthy during the time of study, many of them are constantly worried about the future and its uncertainties, who will look after them when they are sick and unable to work, or for those who have children, who will look after their children after they are gone.

In order to understand the reason why these women kept on continuing to take drugs, they were asked as to what were the reasons or factors that compelled them to do so. A few reasons were given for this, but the main reasons or factors which they gave were:

- constant availability of drugs,
- mental worries,
- lack of trust and support from family members whenever they are sober and try to make an effort to change,
- no back up or support,
- ignorance of bad effect,

- lack of family control during early adolescence,
- inability to stop,
- means of peer acceptance and
- inability to engage in sex work while being sober

All these reasons can be pulled together to form three main reasons why it is difficult for them to come out of the drug habit. Firstly, the dependency itself where not the body but the drug takes over the user and is conditioned by it; secondly, rejection by society, and thirdly, pull of peer subculture. Another question which was asked to the respondents was, given another chance and another period, would they have gotten involved with drugs if they were in an entirely different environmental setting. Except for one respondent, fourteen of them answered that they would have never been in such a situation if they had been in another setting where drugs are not easily accessible. However, one respondent said that since she had already started taking it, she was determined to go all the way and die with it.

Generally, although the rate of infection of HIV/AIDS among men is higher, the number of deaths actually resulting from it is higher among women. On gender and HIV/AIDS, an anthropological study[15] on women and AIDS in India states that HIV/AIDS is partly driven by attitudes which are related to gender roles. Like any other patriarchal society in India, HIV/AIDS in Churachandpur is also driven by gender norms which influence individual, societal risks and vulnerabilities towards the disease. In the research study, we can also determine what makes these women more vulnerable and at risk, and this can be actually extrapolated with the factors stated by the above anthropological study. What makes these women more vulnerable are:

[15] Sharma, Prarthi. Women and AIDS seen through a gender lens. The Indian anthropologist, Vol.35,No.1-2, March-Sept, 2005,page 87.

- Economic status
- Gender inequality
- Gender power relation
- Patriarchal construction of sexuality
- Sexual negotiation and sexual decision-making
- Social discrimination and stigma

This study also mentions that poverty and lack of adequate resources lead many unmarried and married women to exchange sexual favour for economic survival. Secondly, the lack of education and adequate economic resources, and dependence on male counterparts also make these women more vulnerable. Comparatively, although tribal societies tend to be much more liberal, there is hardly any cultural space for unmarried women too. A woman's identity is definitely linked to her marital status and her reproductive role. Once a woman is married and if the marriage fails, her status in society goes down and it is much harder for her to get married again. Being married early, early sexual experience also increase their vulnerability as they are emotionally inclined to be dependent.

Looking at all these factors, we can see that there is no one particular reason that can be pinpointed, but all of them interact in a complex manner. In the first place, the drug user is already perceived as deviant and thus is socially stigmatised and socially isolated. This in turn increases and compounds social disadvantage and leads to emotional problems, further enhancing vulnerability to continued drug use. Involvement in commercial sexual activity, coupled with being HIV positive in such a small town urban setting, characterised by lawlessness and conflict also adds fuel to the stigma and isolation. These factors, in combination with health problems and

inadequacy of health services all lead to feelings of hopelessness and helplessness in the user, and perpetuate the vicious cycle of social marginalisation and drug use.

Chapter 3. Discussion

As previously mentioned, the maximum number of transmission of HIV occurred among injecting drug users in Manipur. From the identification of the first cases of HIV in Manipur, this triggered a lot of negative reaction from the community. There started a series of compulsory approaches like mass arrest of drug users, compulsory imprisonment, refusal to sell needles and syringes to young people, compulsory HIV testing, establishment of private jails, shooting of drug addicts in the thighs, public humiliation of drug addicts, shaving of heads of drug users in public, etc. With such kind of negative attitude and measures on the part of the authorities and society led to users going underground. Partly because of this, it led to the sudden increase in the HIV prevalence from 1% in the beginning to a major jump of more than 50% in just six months afterwards. This further jumped to 80.7% by 1997. For the world outside, Manipur became not only a user state but 'the AIDS capital of India.' In the course of all this, Manipur has experimented with three preventive models of HIV transmission. In the initial stage, it was the Compulsory or Police Model which failed miserably. Secondly is the Abstinence Model. The third model is the Harm Reduction Model.

From 1990-97, it was the compulsory model which was implemented, followed by the 'abstinence model'. The outcome was that the relapse rate was more than 80%. In Churachandpur alone, the relapse rate was the highest at 90%. Then in 1995, some social workers and NGOs started a debate for introducing the Harm Reduction Model. This debate eventually resulted in the formation of Manipur State AIDS Policy in October 1996. A special project was launched under NACO (National AIDS Control Organisation) by November, 1998. This project was known as Rapid Intervention and Care (RIAC) Project. The main aim of the project was to prevent HIV

transmission among IDUs by stopping sharing of needle/syringe among them. This was done under the Needle and Syringe exchange Programme (NSEP). A distinct feature of the Manipur State AIDS Policy is that it boldly encouraged the introduction of Harm Reduction among drug users. The RIAC project eventually became the first and biggest project in the whole of South and South East Asia. After implementation of this project, the HIV seroprevalence among injecting drug users went down from 80.7% in 1997 to 21% in 2004. But the issue today is that the HIV epidemic has spread from injecting drug users to their female spouses, to the commercial sex workers, to the men having sex with men (MSM), migrant workers, truckers and patients with sexually transmitted diseases. Then there is also the epidemic spreading from mothers to new-borns. Today, the HIV prevalence rate among CSWs is around 12% and that of MSMs is 15%.

- ***Change in concept of HIV/AIDS***: Today, there is a major change in not only the pattern of the epidemic, but the concept of HIV/AIDS itself has changed over time. Pattern wise, we can see that is it is no longer confined to IDUs alone but spreading to their partners and to the general population. In the beginning of the epidemic, IDUs constituted the highest percentage of the total number of HIV infected population at 99%. Today, they constitute only 47.43%. One other notable change is that, according to the Deputy Director for Targeted Intervention of Manipur State AIDS Control Society, the concept of HIV/AIDS has changed from a fast killing disease to a chronic, manageable disease. Unlike the previous attitude towards the disease, with the introduction of medical services and medicine like Antiretroviral Therapy (ART), the situation is a whole lot better because now it is no more an alien

disease. Unlike before, today, people with HIV/AIDS are not expected to die so soon as there is treatment available.

- ***Social burden of women is higher***: Even within all this, the discrimination and stigmatisation is still widespread so people still hesitate to come forward for HIV Testing or voluntary counselling or to seek for help and support. Due to this, many of the young people especially women die unreported, specially those who are involved in sex work, they are compelled by conditions beyond their reach. This is also the case evident from an 'Assessment of Situation and Response' study done among CSWs in 2005 by the Population and health Institute in Imphal, Manipur. Within this scene, the problem of human trafficking has also started appearing now. Women with low socio-economic status, especially those who are victims of ethnic violence, are lured for jobs in other metropolitan areas. The psychosocial impact on women is also higher as they cannot utilise their rights and cannot divert themselves to other activities like their male counterparts. The case is not that of unavailability of resources, but that of inaccessibility. There is also the problem of tracing those women users who are not ready to come forward on their own. As soon as they go and stay in rural areas, then it is hard for the social workers to keep track of them. In terms of social rehabilitation, such women who go out from rehabilitation and go to rural areas, when they come back to the town, they fall back to their old ways. Very often, women see marriage as a solution to escape the problems at home, or think that they can leave their drug habits by it. But this is not necessarily the case, as they cannot actually adjust themselves in other families who might have higher expectations from them.

- ***Continuing reluctance of health care professionals to treat PLWHAs*** a problem: There is still a continuing reluctance of health care professionals to treat PLWHAs. As evident from the study in Churachandpur Town, those women who are HIV positive, on being aware of their status, immediately stop taking any sort of treatment from the District Hospital, but go to the AIDS Hospice instead.
- ***Beyond NGOs, the real need is CBOs***: Although NGOs are doing a good job for the community, the real need is that of CBOs. Through this, there can be a higher level of participation from the community and higher involvement on their part in creating awareness. Manipur being a multi-ethnic community, there can be better understanding by involving different communities which can reach out to their own people
- To change attitude, the need is primary intervention (for those who are not infected) and better facilities and resources (for those who are already infected).
- ***Inter-sectoral collaboration***: At present, the Manipur State AIDS Control Society in collaboration with SCERT is taking up the School AIDS Education Programme. 39% of the new infection occurs in the age group of 15-24 years so this step is taken as necessary. Also, in collaboration with the Home Department, the Government is also providing sensitization programmes and workshops to the police and security personnel through Manipur Police Training. There is also collaboration with the Laws, Ethics and Human Rights Department. However, the inter-sectoral collaboration receives various setbacks due to the following reasons such as: low priority for financial support to the health sector, insufficient remuneration and support

for health care professionals, serious managerial weaknesses in health sector in all levels and irregular and inadequate supplies of drugs, reagent and equipments.

"In a social situation in which drugs are easy to obtain and treated in many cases with scant respect and little real knowledge, it is not really surprising that drug abuse in general has become widespread. Such a situation is open to exploitation by criminal sections and by groups of people who, because of their own inherent need to depend on drugs, are anxious to create a situation that makes their own dependence more acceptable and supplies more easily available." In a society where there is easily availability and accessibility of drugs, the threat from the familiar dependency on them is inevitable. Drugs are not like fashionable things that can be dropped and picked up at one's will, because it eventually dominates those who take them and their behaviour.

In this situation we cannot say that, as mentioned before, there are only a few factors which actually cause this kind of behaviour to occur in society. In reality, there are various socio-economic issues which are all interrelated and there is a cause and effect relationship where one cannot really say which is the cause or effect. They all work together in a cycle, and once a society has a significant proportion of drug addicts in its midst, the situation becomes self-perpetuating, where it constantly involves the weaker members of each generation. The menace of drug abuse can only be eradicated by the rest of society's taking the necessary action to eliminate it, and not wait for those who are involved to give up their practices. Some of the various issues which can be discussed are as follows:

1. **Socio-economic issues**

- ***Problems of double stigma associated with drug use and HIV/AIDS and sex work***: The abuse of drugs has never really been seen as a female domain. Even in Churachandpur, even among the drug users themselves, male users still look down on women users. The platform for users is not all same. As mentioned before, drug use is considered deviant already. Apart from that, there is the stigma associated with being HIV positive. On top of that, women who are involved in sex workers belong to the lowest category in a patriarchal society like Churachandpur again. So there is not only a double stigma, but that of a triple stigma in this sense.
- ***Problem of social control***: the HIV/AIDS and Drugs Control Programme and women: If we look at the HIV/AIDS and Drugs Control Programme, there is no specific programme which caters to the needs of women IDUs alone. In one way, the programme is gender-biased as it is not sensitive to the needs of women. Men and women cannot be treated in the same way and there have to be separate facilities for them. In the State itself, there is no particular Drug Policy as such, and all harm minimisation and rehabilitation policies work under the guidance of the State AIDSs Policy. There has to be a separate Drugs policy that can effectively cater to the needs of women drug users, especially IDUs. This is in terms of health

care services and facilities. There are a few DICs in Manipur, but there are only about three of them in the state while the rest are for men or both for men and women. Women feel more stigmatised than men, and they are more stigmatised, so because of that there have to be separate facilities that deal solely with women.

Inadequate support, psychosocial impact higher on women than men: On drug dependency and women, we have mentioned that the first and foremost relationship within the network of users and other factors is that of , drug users and the help and support they get from families, relatives and the community as a whole in helping them give up their dependency. However, there is not enough support given to them on this front. Of course, it would be too much to expect all the families to accept and support them thoroughly, but at the communal level, there has to be more tolerance in dealing with such issues. In a conflict situation like Churachandpur, with low levels of opportunities for income and employment, women users have more problems finding employment, once they become sober. Even those in rehabilitation, once the period is over, the biggest hardship is that of an economic nature because there is no option for them. Another thing is that once they become users, their families do not trust them anymore and then it becomes difficult for them to get accepted back into their families again. Once they are labelled as users,

this takes a long time to disappear. This situation is also worsened by the fact that there are very low levels of success stories.

2. Urban Issues

- ***Changing trend in perspective on drugs***: There is also a changing trend in the perspective on drugs. Initially, when heroin first made its appearance, its harmful effects were not known widely. And since pharmaceutical drugs started becoming scarce, then heroin was considered a good option as it was widely available and accessible. In the beginning it was seen as fashion, a way to get accepted among peers. In other words, it was the 'in thing' to do and users considered themselves popular in the eyes of peers. The level of awareness on the harmful effects of drug misuse was not commonly known. Today, the situation is different. With the changes occurring both on the economic and social front, drugs are seen as a good way of income. Heroin is still the most common drug misused. Although the types of drugs misused have changed with time, it does not mean that the number of drug users is lesser. In fact with modes of administration being easier, the number of users does not necessarily decline with the passage of time. Today, illicit drug trafficking is seen as a good option for income and employment especially for those who are in dire economic hardship and have no way of providing for themselves. It has changed from a fashion trend to a business trend, and small-time drug lords have

come up. The sad thing is that, very often, these people work in collaboration with the authorities by paying bribes. Due to this, there is a very heavy setback in the efforts at demand and supply reduction. Sometimes, there are harsh attempts made at supply reduction. In Churachandpur, local vigilantes such as insurgents try to curb supplies by threatening to shoot peddlers and users if they were found on the streets. Due to the scarcity of drugs, users especially women face a number of problems in getting drugs. Then, users will resort to drugs and whatever is available. At such times, drug users get harassed and abused and this drives them underground and makes it harder for social workers to reach them.

- ***Changing economic and social issues***: Political unrest and unstable economic conditions also go a long way in worsening the situation. There is a lot of economic hardship. Churachandpur is eventually getting urbanised, and becomes a good trading point for merchandise coming from the Myanmar border. This makes trading in illicit drugs to become a booming business as ever. The rate of urbanisation is also noticeable with more people moving in due to rural areas becoming more unsafe due to insurgents and undesirable military activities. The level of population is increasing in the town, with more people seeking jobs, housing and employment, while the resources are not increasing at the same pace. Along with this so called growth, there is an increase in poverty also.

·Barriers in access to treatment:

For women drug users, and especially for IDUs, there are various barriers to treatment. The various barriers that can be identified are systemic, structural, socio-cultural and personal barriers. **Systemic barriers** are those that impede the development of services that respond to the needs of women specifically. In the first place, women are rather underrepresented in service areas. Women IDUs feel more comfortable in the presence of other women and they can open up to them better. With male workers, they find it harder to tell their problems and issues. There is an under-representation of female workers in these areas because of which there is less sensitivity. The treatment facilities have to be more comprehensive because women tend to have more problems than men, including the experiences of mental trauma and health, family responsibilities, child welfare services, etc.

Secondly there are those **structural barriers**, where policies and practices at the service or programme level which come in the way of women accessing substance abuse treatments. As against harm reduction programming, there are certain women who are not ready to seek pure abstinence. After a while, at the drop-in-centres, women are advised to go for Oral Substitution Therapy so as to make their withdrawal easier. But often, these women do so only when drugs are scarce and difficult to procure. This is because some do not see giving up drugs as the main priority. Also, the rigid programme schedules may sometimes discourage women from attending services. Since these centres have particular timings, the women may find it difficult to access them. In general, most female IDUs who are sex workers are more likely to

seek shelter at the end of the day. In Churachandpur, there is only one night shelter which caters to such services and this is the only one of its kind. There, refreshments and sanitation services are provided, and time is taken to counsel them while they are sober. But access to this shelter is available only through reference from the drop-in-centre. For many women, this might be discouraging as they often have pre-conceived notions about such service centres. Advocacy through peers is still needed to overcome this barrier.

Other barriers which prevent women from accessing such substance abuse centres are **social, cultural and personal barriers**. Most of the women IDUs come from very disadvantaged life circumstances characterised by poverty, lack of basic health care, low level of education, lack of access to household money and domestic violence. They have little power or resources to change their life circumstances. Such disadvantaged life circumstances is one reason. The second reason is stigma, shame and guilt. It is not just society that perceive them as deviant, but women substance abusers especially who are engaged in sex work tend to have a deeper sense of shame and guilt, about their substance abuse and failure to live up to the expectations that society expect of them. Those women with children feel ashamed for not being able to take care of their children. This further leads them to feel deviant from normal societal norms and might become a barrier for seeking help and treatment. In order to seek treatment, it means the woman is acknowledging her substance use and this can lead to a lot of fear of being labelled. Some women secretly try to access treatment for fear of being found out by their husbands or partners who might not be aware of their status as users or being HIV positive. One of the worst barriers is that substance use is often seen as a solution than a problem. For many women, who are living in conditions of

extreme distress, they may be so overwhelmed with life situations that they might find substance use as a way out from such situations. Sometimes a lot of women force themselves to believe that they can handle their problems themselves and might not lack confidence in the effectiveness of treatment.

As long as there is easy availability and accessibility of narcotic drugs in Churachandpur, it would be a difficult task to root out the problem of substance abuse. Especially in the case of women, we can see that because of various interrelated social factors and relationship networks, they are more vulnerable and are at a higher risk than their male counterparts. It will be an entirely difficult job to eradicate the entire supply or demand of heroin and other narcotics in the area. There has to be proper collaboration between the communities, anti-narcotic government agencies and State government machineries so that effective measures can be taken to not only minimise the harm caused by substance abuse and HIV/AIDS in the State, but to try and solve the problem altogether. For women substance users, who are both HIV positive and involved in commercial sex work in a small urban town, the stigma and discrimination will always be there although the intensity might change. But looking beyond this, there is a need for rehabilitation programmes which are not gender-biased, but sensitive to the needs of women, especially such women, both at community level and State level.

Illustration of Case Studies:

Case Study 1:

Mary was a small child when she lost her mother. Her father remarried again and had a son. Her father also died when she turned 7. She started staying with her uncle and all her cousins and brother went to school, but due to lack of money, she did not attend school. Her uncle used to deal in illicit drug trade, and as a child, she used to help out in packing the drugs. However, she was never aware of the real dangers of it. When she was 12, her stepbrother took her back to live with her but she was too big and refused to go to school. She stayed with her brother's family, but without any proper education and skills, she could not get employment as a young girl and became an economic burden for her brother's family. Relations with her sister-in-law got strained, because of that she eloped and ran away from home when she was 18. Soon her husband used to abuse her physically, and finally deserted her for someone else, so she was left alone, not knowing how to fend for herself. She went back to her brother's house, but her sister-in-law hated her and used to beat her a lot. Because of that, out of defiance, she started drinking and taking pills. Having no place to go and no means of support, she took to commercial sex work. Eventually she started taking heroin. She became dependent on heroin after the fifth administration. Then, she started selling illicit liquor and also continued to engage in sex work which gives some income apart from the liquor business which was frequented by peddlers, users and CSWs. Then, she met her second husband. Her second husband was already married and had two children already. They used to inject heroin together. Due to constant pressure from local police and vigilantes, her illicit liquor shop was shut down. By this time, she had become a

full-time addict and had no place to go. She started living on the streets or with some partners. Then, she was found by some social workers and admitted to a Women's Rehabilitation Centre and later, when she was 30 she came to know about her HIV positive status. After leaving the Centre, she tried going back to her family, but they suspected her and always thought she was out to steal something. They constantly thought all she wanted was to be free again and live life the same way she did before. Although she did not disclose to them that she is HIV positive, they do suspect that she is. So, she left her family and then started living with an old man, who already had five children. However, the man treats her with contempt and she even has to cook for herself separately and provide for herself. She stays with the man simply because he gives her a roof over her head but nothing else. She tries to earn money by making doormats, but she cannot do so as she feels weak all the time. Her husband is not aware of her status, but he suspects her when she goes out. He does not allow her to go to the DIC as he suspects she is taking treatment for HIV/AIDS from there. All her money goes for medical expenses and cannot buy anything for herself. The only clothes she has are the ones that the DIC gives to her. She has no other source of income and she says she is tempted to back to the streets and cried while saying this. Time and again, she has been admitted in the Women's Home. Due to better environment, she stays sober while she is there. But as soon as she gets out of there, she has no place to go and then goes back to her same friends and then goes into relapse again. She feels there is no hope for her, and cries while saying this. She has to look for work everyday so as to feed herself and get some money to pay for her medical expenses.

Although economic hardship drove her to resort to commercial sex work and injecting drug use, the main issue is that of early exposure to heroin. Although unaware of the

harmful effects of heroin, she lived in an environment which is awash with heroin. On top of that, her husband was an injecting drug user in whose company she used to inject. Continuous exposure to such an environment may cause a person not to just use substances such as drugs, but to make them take it continuously. Once being in such an environment, it is hard for an individual especially a woman to get accepted back into society. It is this social rehabilitation that is the most difficult to achieve.

Case Study 2:

Kim is a 22 year old IDU and sex worker. She is the only child and her parents divorced when she was 2 years old. Both parents remarried. First, she stayed with her father but her step-mother used to beat her while her father was away at work, out of depression, she started taking pills in high school, but she ran away from home to stay with her mother. Because of this, she stopped studying and did not continue her education again. While she was staying with her mother, she never used to take pills. But there was lack of communication between her and her step-father and he did not like them talking in their own dialect. This started created problems, so she ran away again and started staying with her aunt. First, she would steal money and sell things from the house to support her drug habit, and then she started to get involved in commercial sex work as she did not have a proper source of income. While she was staying with her aunt, she found a friend who introduced her to heroin. After her initial injection, she stayed with a lady-pimp. This pimp accused her of stealing her money and threatened her to never stay in the area again. Saying that, she locked her up in the house and kept her naked for one day and abused her physically. As soon as she found the chance, she ran away to Imphal and stayed there for sometime and continued to engage in sex work. Once in Imphal, two men asked her to stay with them, but they

took her to some remote area and raped her. She begged them to show mercy, so one of the men set her free at midnight. Later, she came to realise that they were policemen from BOC Imphal, and they did all that because they knew she was a CSW and also tribal. She was also arrested once by the police, harassed twice by pressure groups as well as by Meira Paibis in Imphal She was once admitted to SHALOM Women's Home, and it was after that that she became aware of her HIV positive status. She tried to commit suicide, but due to staff counselling and support, she did not kill herself. She has not been in her community for such a long time. None of her friends or clients really know which community she belongs to, as she takes different names wherever she goes. Her family is not aware of her HIV status and she does not tell her friends either for fear or stigma. Since she ran away from home, she has never had a good relationship with them again.

The important issues here are of economic and social nature, such as problems of broken family background, lack of guidance and social support, lack of educational skills, etc. All these factors work together that actually caused Kim to become a sex worker and eventually a drug user. She is young and inexperienced, and has no one to guide her. The other point is that of abuse that people like her face at the hands of different pressure groups. She is completely alienated not only from her family, but her entire community and since this does not give her any sense of identity at all, the normal thing for such people would be to try and find some sort of peer group to fit in. This eventually results in deeper entrenchment into the sub-culture of substance abuse and other deviant behaviour.

Annexure: Interview Schedule

Confidential

For Academic Purposes Only

An exploratory study of HIV +ve Women Injecting Drug Users (IDUs) in Churachandpur Town, Manipur

(To be disclosed to the respondents: This interview will take approximately 2 hours in each case. The interview will be kept strictly confidential and is to be conducted only with your informed consent, respecting your privacy and right. The purpose of the study is to gain more knowledge about the urban sociological factors responsible for drug-injecting behaviour among HIV +ive tribal women in this part of Manipur.)

Questionnaire

Date of Interview: _____

Time of Beginning the Interview: _____

Time of Ending the Interview: _____

Place of Interview: _____

Section I: Personal Details

1. Code Name: _____

2. Age: _____

3. Marital Status (single/married/separated/divorcee/widow): _____

4. Occupation: _____

5. Income (Regular/Non-regular): _____

6. Average income per month: Rs._____

7. Level of Education: _____

1. Education:

(i) What is your level of education? _____
- Below Matriculate : Upto class _____
- Matriculate
- Above matriculate

(ii) Why did you not continue your education after this?

_____

_____

(iii) Did you drop out of school? If so, why?

_____

_____

_____

(iv) What is the level of education of your family?
Father: _____
Mother: _____
Husband: _____
Sibling(s): _____
_____
_____

2. Occupation:

(i) Father's Occupation:

_____

(ii) Mother's Occupation:

_____

(iii) Husband *(if married)*:

_____

(iv) Average monthly income of the family:

_____

(iv) If employed, what is your average monthly income?

_____

(v) How much do you save on a monthly basis?

_____

3. Do you worry about meeting your medical expenses because of your HIV status? (Y/N)

If yes, how often do you worry?

_____

4. Do you have difficulty paying for your Drugs and/or HIV medication? (*are you able to incur the cost of your HIV/AIDS treatment?)*_____

2. Living Status:

1. Are you staying alone, or are you living with your family?

_____

_____

2. If you are staying with your family, is it a nuclear or joint family?

_____

_____

3. Do you and/or your family stay in your own house, or in a rented house? If in a rented house, what is the monthly rent?

_____

_____

4. Do you maintain a good relationship with your family? If yes or no, what is/are your reasons?

_____

_____

5. Are you married? (*Married means Church marriage or Court marriage)* or are you living with a partner(s) at the moment?

_____

_____

6. Are you a divorcee or separated from your husband/partner currently, or at any point of time in your life? (*If divorcee or widow, ask if she inherited any property. Did she leave the house without getting anything?)*

_____

_____

_____

7. What do you think are the factors (socio-cultural) that influence you to continue taking drugs?
Probes~
(ignorance of bad effect, over work/hard work, influence of friends, easy availability, frustration and mental worries, lack of family control, uncertain or bad economic

condition, bad working condition, sex problem, inadequate educational and occupational opportunities, cultural pressures supporting drug use, content of mass media, inability to stop)

8. Have you ever been denied any housing or employment opportunities because of your HIV status or drug use?

9. Have you ever been refused medical treatment because of your HIV status or drug use?
If so, where and when? How often has this happened to you? What do you think are the reasons that cause this?

10. Have you ever received any harassment (torture, beatings, police lock up etc) at the hands of pressure groups such as police, militants, vigilante groups or village defence etc.? How often has this happened?
Do your male counterparts (drug users) get the same treatment?

Section II: Drug Use/Behaviour and Problems faced

1. How did you come to know about drugs before you started using them?

Probes ~
- Observed neighbour taking drugs

- Observed father/mother/sibling/husband taking drugs
- Drugs frequently being sold in the locality
- Was told by peer group about drugs
- Was told by co-workers about drugs
- Was told that drugs relieve pain and mental worries, stress

2. When were you initiated into drug use? (Age) Oral: _____
   Mainlining: _____

3. What is your reason(s) for initiation into drug use? _____
   Probes~
   - Peer pressure
   - Curiosity
   - Depression
   - Frustration
   - Disappointment
   - Broken family background
   - Others

   _____

4. Did you start your drug use by mainlining or oral use?

_____

5. What kind of drugs did you use?
   Primary:

_____

   Secondary:

_____

   Poly-drug user:

_____

6. How did you start injecting, by yourself or with the help of someone?

_____

7. Do you inject by yourself, or with other people (friends)?

_____ _____

_____

8. Have you ever shared needles with someone?

_____

_____

9. How long have you been using drugs?

_____

10. What is your source(s) of money for buying drugs?

_____

Probes~

- Stealing
- Parent's money
- Own Salary
- Others

11. What is your source of procurement of drugs?

12. How much do you spend on drugs, on average, on a daily basis?

13. What is your average dose, daily/weekly?

14. Have you ever had an overdose? If yes, what treatment did you take?

15. Have you ever contemplated giving up drugs? If yes or no, what are your reasons?
(Have you ever been sober, during the past one year? If so, how long were you sober?)

16. Do you think that you will give up drugs by changing your environment?

17. What is the difference in the drug scene now, compared to how it was before?
(for instance, terms of price of drugs, availability, accessibility)

18. What are the main problems that you face after becoming a drug user?

Section III: Health Issues including HIV/AIDS

1. During the last one month/year, do you have any major health complaints? If so, what are your complaints?

2. Have you ever had any of these symptoms? *(Indication of STI)*
   - White discharge
   - Abdominal pain
   - Ulcer
   - Burning sensation during urination

3. Did you get treatment? If so, where did you get your treatment?

4. When did you come to know about your HIV status? Where and how did you get tested?

5. What was your initial reaction? What was the initial reaction of your family and friends? What is their attitude towards you today?

6. What do you think is the possible source of infection?

7. Do you think that your HIV status in any way, affect your ability to work/chances of getting clients? If yes or no, state the reasons.

8. Have you ever sought treatment at the Civil Hospital/Community Care Centre (hospice)/nursing home? If so, how long have you taken treatment? Are you happy with the medication and attitude of the health care workers? Do you think they are friendly, or do you feel discriminated by them?

9. Are you currently on ART? If so, how do you meet your medical expenses?

10. Do you get the ARVs free of cost, If so, where?

11. How much do you spend monthly on medical expenses (on HIV related illnesses), apart from the money spent on ARVs?

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