CHAPTER VII

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The basic premise of the study has been that every society has its own specific ways of interpreting, understanding and responding to the issues of health and disease. In other words, every society has its own beliefs and practices concerning health and disease and evolves its own systems of medicine. These beliefs and practices are transmitted from one generation to another through socialisation process. The references and definitions of what is good health and what are sound health practices are learnt through the socialisation process. There are dos and don’ts a child learns within the family, peer groups, community and school/college. While the family, peer groups, community and mass media engage in informal socialisation of the child, the school/college socialises formally or officially aspects of health and disease. It is these varying roles of different agents of socialisation that the study explored. It aimed to examine the linkages between socialisation, health practices and HIV/AIDS awareness among the undergraduate students within the socio-cultural context of Manipur. The main purpose of the study has been to understand how under-graduate students view, interpret and respond to health and disease from a multi-disciplinary perspective.

Both primary and secondary sources are used in order to provide an objective empirical support to the study. Though the focus has been mainly on perceptions of students in under-graduate colleges of Manipur, the data is also collected from various other respondents such as parents and teachers. The study uses a semi-structured interview schedule to collect data on health beliefs, awareness/knowledge and behaviours relating to HIV/AIDS from the
students. Separate interview guides are used to collect data from parents and teachers of the students. Interviews are also conducted with the local traditional healers.

Three colleges, namely, D.M.College of Arts, Thoubal College and South East Manipur College, are selected from three different districts which have high, medium and low prevalence of the HIV epidemic in the state, i.e., Imphal, Thoubal (both in valley areas) and Chandel (in hill area) districts respectively. In all, 155 students, 81 men and 74 women students are interviewed. Of which, 54.2 percent are from the rural and 45.8 percent are from the urban areas of residence. Further, the sample distribution has 67.1 percent of Meiteis and 32.9 percent of tribal students. The higher proportion of the Meitei students was accidental and study mainly tried to include an equal proportion of the men and women students and also the rural and urban students.

Summary and Implications of the findings

Given the nature of HIV/AIDS epidemic in India, two different types of HIV epidemic are observed. In the North-Eastern states, the epidemic spread mainly through IDUs whereas it is mainly spread through sexual transmission in the rest of the country. A matter of concern is the spread of HIV among the general population, particularly among women, who do not engage in high-risk behaviours and whose chances of contracting the virus were once considered low. In the case of Manipur, what is worrisome is that eventhough HIV/AIDS prevalence has seen a decline trend among the IDUs, but it has penetrated into the general population. The infection has now spread to the female sexual partners of IDUs and their children. A matter of grave concern is that the highest proportion of HIV positive
in the state come from 21-30 years of age group (43.26 percent) followed by 31-40 years age group (35.61 percent). This age group 21-40 years, constitutes those who are at the peak productive period of their lives. Again, high prevalence of HIV in the age group 21-30 years shows the vulnerability of the college going youth to the epidemic.

It is clear from the study that most of the students in general are aware of the basic knowledge of HIV/AIDS. Almost all the students (irrespective of their gender, place of residence and caste/tribe category) have reported that they have heard about HIV/AIDS. Media, particularly, radio is the most common source of information for the students. Interestingly, studies conducted in different parts of the country have also reported radio as the most important source of information regarding HIV/AIDS (Lal et al., 2008; Sodhi and Mehta, 1997).

A majority of the students are aware of at least two/three correct modes of HIV transmission as well as ways to protect from the virus. Most of the students named sexual route and sharing of syringe as the dominant modes of HIV transmission. An important finding is that nearly 10 percent of the sample knew just one correct mode (8.4 percent) or nil (1.9 percent). However, a vast majority of the students are aware that there is no cure for HIV/AIDS as yet. It is also interesting to note that a considerable proportion (14.2 percent) of students do not know whether there is a cure for HIV/AIDS or not.

However, what is striking in the present study is the poor knowledge of students about the difference between HIV and AIDS, their acronyms and people who are at risk. It is important to note here that students know someone with HIV/AIDS within their family,
community and relatives, eventhough they do not know the difference between HIV and AIDS. Only 38.7 percent of the students knew the difference between HIV and AIDS. However, it is surprising to know that a majority (60.6 percent) have reported that they know someone who has HIV or have died from AIDS. This reflects a serious gap in the way students are getting exposed to the disease and its effects on the general well being within the society.

When awareness levels of men and women students is compared in all the aspects of HIV/AIDS, men are found to more aware than the women. Similarly, students coming from urban areas and those who belong to Meitei community are more aware compared to students from rural areas and the tribal community. This may be due to differences in the level of HIV/AIDS education or information access among different groups and regions, thus pointing to the need of for targeted educational/awareness effort. Besides, HIV/AIDS prevention initiatives in tribal and rural areas may consider the overall marginalisation of the tribal population and its impact on the transmission of HIV (Thomas, 1997). It appears that there are ethnic patterns of social marginalisation and risk behaviours. It was also indicated during the Assessment of HIV Programme Needs in North Eastern States of India (NACO, 2005) that in Manipur, most of the awareness campaigns have failed to reach the rural and hilly districts and have restricted to district headquarters.

It is in the family that the child receives information about health, hygiene and disease, etc. In the study, it is found that a majority of the students reported that they received some kind of awareness about health and disease, in general, from their parents. However, the proportion of students who received information about HIV/AIDS, in particular, from their parents is very few. What is
important to note is that there are certain variations in the way the family transmits knowledge about health and disease to their children according to their place of residence and ethnic group. For instance, among those who stated that their parents did not transmit any information about health and disease, the proportion of women is slightly more than the men. All those who have stated that they did not receive any kind of awareness from their parents are from the rural areas. This may be because of the lack of parental education among the students from rural areas. Many of the parents of the rural students are disadvantaged in terms of accessing information about health and disease as many of them are non-literates. Similarly, those who mentioned that they did not receive any kind of information from their parents are mostly from tribal communities. It may be pointed out that most of the tribals are also rural dwellers, which corroborates the finding that most rural students are less informed about health and disease than their urban and non-tribal counter-parts. Thus, lack of education and literacy among the rural and tribal households may tend to perpetuate myths and ignorance of the diseases, in general, and of HIV/AIDS in particular.

However, it is interesting to note that all the students, irrespective of their gender, place of residence and ethnicity, also reported that they received some information about health and disease while they were at school. Information received in school ranges from basic health and hygiene, balanced diet, importance of regular exercise, early sleep and early rising habits, etc. to communicable diseases and disease like HIV/AIDS. However, at the college, students reported that they hardly receive any information/awareness about health and disease, particularly about HIV/AIDS. It is also found that there are no proper and well organised
HIV/AIDS awareness programmes to inform the students in all the three colleges that are included in the sample. Except the AIDS awareness programmes through NSS scheme which is not so well organised and regularly, nothing is done to inform the students about the risks of HIV/AIDS. Almost all the teachers from whom information were collected also expressed their disappointment for not taking up adequate programmes/measures in the colleges to inform the students about the risks of HIV/AIDS.

The study shows that there is very little communication between the students and their parents or teachers. Due to shyness and cultural factors and lack of knowledge about HIV/AIDS on the part of the parents, the students stated that they could not discuss HIV/AIDS with their parents. However, the most important reason for not discussing with teachers was the lack of time on the part of the teachers. Other factors like shyness and non-inclusion of the HIV/AIDS in the syllabus are also the reasons for lack of any interaction between the students and teachers regarding awareness towards HIV/AIDS.

An important issue emerging from the foregoing discussion is that despite the seriousness of HIV/AIDS situation and many awareness campaigns, most parents feel uncomfortable talking with their children about HIV/AIDS and other sex related issues. Only 20 percent of students in the study received information about HIV/AIDS from their parents. It may be understood that the conservative family environments in the Manipur society or in the South Asian societies, in general, act as cultural impediments to discuss tabooed subjects such as sex, drugs, etc. South Asian societies are gerontocratic as well, wherein the elderly are respected and are not displeased by talk or deeds. Thus, any socially undesirable topics are avoided during
interactions with the elderly. Elders also avoid discussing these topics because it is believed that there is age-specificity towards knowing or not knowing of particular topics. Certainly, matters of sex are not discussed during adolescence as it is felt that it is not the 'right' age to discuss and the matters of 'drugs' are not broached as they are socially undesirable and not socially acceptable to the traditional family cultures and values.

Even the schools and teachers are found to be not transacting any issues relating to HIV/AIDS in the way they should have been in a state like Manipur where HIV/AIDS is in alarming proportions. For instance, AIDS education has not yet been fully included in the formal curriculum in schools and colleges while the reported proportion of HIV positive among the school and college going age group, 11-30 years is 48.92 percent. The State has 800 High and Higher Secondary Schools, and only 225 schools have been covered by School AIDS Education (MACS, Annual Report 2006-2007). Moreover, the topic of AIDS has been introduced in schools as a part of biology lessons since past few years. However, school teachers often skip the chapters or assign it as a self-learning assignment to the students (NACO, 2005). The data also supports this view. It may also be explained in terms of the traditional conservative attitudes of teachers and the social taboos that govern individual or group behaviours.

The most significant finding from the study is that a sizeable number of students mentioned that they rely heavily on their peers in the school/college for information on various subjects and aspects of life. It is in these informal settings within the schools and colleges that issues relating to 'taboos' of the society such as sex, drugs, HIV/AIDS are discussed. About 40 percent of the students reported that they discuss issues pertaining to HIV/AIDS with their friends. However,
due to shyness, they never talked/ discussed HIV/AIDS with the friends of opposite sex. It is important to note the role of peer groups among the college youth in AIDS awareness in this context. Peers may be agents of change and spearhead advocacy for HIV/AIDS education among students, community members, parents, etc. (NCERT, 1994). In Gujarat, UNICEF joined hands with health authorities and non-governmental partners to establish a cadre of HIV/AIDS peer educators in three districts of the state. Today, a formidable 14,000-plus peer educators continuously spread messages on prevention in remote villages within the three districts (Gulati, 2007).

Most importantly, some parents have expressed their desire/acceptance for participation of their children in sex/AIDS education. They believed that the society requires sex/AIDS education. According to them, the children should be well informed about the important aspects of HIV/AIDS and sex/AIDS education should be given formally in schools so that adolescents are not misguided by their peers and other influences. Both parents and teachers also expressed their desire to share the responsibility in generating AIDS awareness among the students. It is interesting to note here that parents and many other organisations in different parts of India fear that sex education under the guise of AIDS awareness and prevention would certainly encourage indulgence in sex and would have adverse impact on individuals and society. However, through sex education, we can create awareness about the hazards of the unsafe sexual practices. It helps younger generation to develop skills to protect themselves against sexual abuse, exploitation, unintended pregnancies, promiscuity, STDs and HIV/AIDS (Mangla, 2004). Schools may be key settings for educating children about HIV/AIDS and for halting the further spread of the HIV infection. Success in carrying out this
function depends upon reaching children and young adults in time to reinforce positive health behaviours and alter the behaviours that place young people at risk (Schenker and Nyirenda, 2002).

Surprisingly, though a majority of the students revealed that they don’t consult the traditional healers, they stated that they do believe in the kind of treatment given by these traditional healers. Here, it may be noted that a large section of the Meitei society believes that Maibas and Maibis (the traditional healers) can cure various diseases by giving herbal medicines and they hold important positions in the society. In the villages far away from urban centres where medical facilities are not available, people mostly rely on the indigenous medicinal herbs with which they treat all kinds of diseases. Those villages near the urban centres have access to modern medical facilities. What is interesting is that many parents reported that the beliefs held earlier about the causes of a particular disease do not affect understanding of a disease like HIV/AIDS. Thus, even though the role of traditional healers represented one of the major factors in health care and treatment of diseases in earlier times, there is no evidence of the involvement of traditional healers in the treatment of HIV positive persons or AIDS patients in Manipur.

It is found that a majority of the students are sympathetic towards HIV positive persons and are against isolating them from social life. However, this favourable attitude towards HIV positive patients was not observed among college students in Nashik (Ganguli et al., 2002). It may thus, be safely pointed out that in Manipur people in general and college students in particular, have accepted the presence or existence of HIV/AIDS infected amidst them. Moreover, a majority have reported that they don’t have any problem when HIV positive students attend the college. They have expressed that HIV is
not transmitted by sitting together, gathering, touching each other, etc. It is important to note that there are differences in attitudes of students according to their ethnic background and places of residence.

At the same time, however, there are a few students who have expressed their fear that if the HIV positive students attend the college, the virus may spread to other uninfected students. It is the responses of this section of students which needs to be understood carefully. While a majority of the students have expressed their willingness to share a meal with an HIV positive person or AIDS patient, a few have reported that they would do so only if the person is known to them. This may be an acceptable and expected behaviour pattern among individuals or groups to maintain a distance with a totally stranger in an interaction situation. Given the larger middle class composition of the sample of students in the study, it may even be more justified as the middle classes have a particular indifference and non-indulgence with even the neighbours in an urban context. What is of concern, however, is that a small proportion of students have expressed their unwillingness to share a meal in fear of contracting the virus. There are differences among the students belonging to Meitei and tribal communities in this regard.

Surprisingly, almost all students have expressed that they would not keep it a secret when one of their family members gets infected with AIDS virus because keeping it a secret may further spread the virus to other uninfected persons. This may be a matter of good intent, but it is contradictory to the general belief that people infected with HIV are looked down with hatred/dislike and their family is ostracised by the locality/society, etc. In the study, a few students did express that the patients and their family may
experience a fear of loss and rejection and it is better not to reveal to anybody about the infection. However, experiences of a few HIV/AIDS patients with whom informal in-depth interviews are done substantiate this finding. It is revealed that HIV/AIDS-related stigma and discrimination does exist, take different forms and are manifested in different contexts. Overall, it may be concluded that the epidemic of HIV/AIDS has been accompanied by an epidemic of fear, ignorance, and denial, leading to stigmatisation of, and discrimination against people with HIV/AIDS and their family members (Mann, 1987). It is also a fact that it may bring catastrophic social and economic consequences.

**Conclusions**

The manner in which the young people are socialised depends upon the characteristics of the society. As Sharma and Hiramani (1988) suggest, development of the youth, his/her status, aspirations, opportunities and patterns of everyday life are determined by the nature of the society in which he/she lives. Thus, cultural norms, customs and values of a society are contributory factors in shaping the life style of youth. The life styles or patterns of living chosen by youth can be beneficial or detrimental to their health.

Exposure of the young people to the modern values has been contributing to the cultural gap between the parents and the young people (Sharma and Hiramani, 1988). Although the extent of the impact of such cultural gap on the family and society is a subject of debate, the fast growing network of mass media which facilitates spreading new values even in rural areas has been generating differences in life style and attitudes between generations.
Health of young people and the planning of appropriate services and education have a strong behavioural orientation which is best understood in the context of individual and group life styles (Alexander, 1999) (Emphasis added). The life styles of young people usually involve greater risk-taking behaviour than those of other groups in the population. Changes in the social and cultural system many a times reflect in his/her behaviour. Although risk-taking is a natural part of growing up, contribution of social, cultural and economic factors in developing such behaviour are significant. Risk-taking behaviour may constitute a health hazard in terms of taking into smoking, alcohol, drug using and unsafe sex. In addition, sexual abuse, gender inequalities and rapid changes in family and social structures may also affect health and development of young people (Gupta, 2001).

According to WHO (not dated), it is estimated that more than half of those newly infected with HIV today are between 15-29 years. This infection like other sexually transmitted infections is driven by individual behaviours. These behaviours in turn are driven by poverty, unemployment or homelessness which are often linked to the lack of education, alcohol and drug use (UNAIDS, 1997). In the present study, although most of them have heard of HIV/AIDS, many do not know the difference between HIV and AIDS, and which groups of people are at risk. A few of them do not know how HIV is transmitted or how to protect themselves. Besides, social and cultural norms leave them with little control over their exposure to AIDS virus.

According to UNAIDS (2000b), experimentation, discovery, emerging feelings and exploration of new behaviour and relationships are a normal part of adolescent development which exposes them to health risks. Some young people are at greater risk of HIV like those
who are out of the school, who live in the streets, who share needles with other injecting drug users, engage in commercial sex, or are sexually and physically abused (UNAIDS, 2000b). While youth is a time of exploring and discovering feelings and behaviours, they often lack the social skills, services and information necessary to avoid the high-risk behaviours (Benara, 1992). Further, college students are considered at greater risk of contracting HIV infection due to the lack of knowledge and their tendency to experiment high-risk behaviours, especially unsafe sexual practices and intravenous drug use because of curiosity and relatively more freedom in the colleges (Shailesh et al., 2004). Furthermore, many adolescents adopt high risk behaviour due to the numerous myths and lack of skills to deal with peer pressure. The reluctance on the part of parents and teachers as found in the study, to address the adolescents' sexual issues and their own ignorance regarding the various myths, misconceptions about HIV and AIDS leave only the medical practitioners and some voluntary agencies to fill the gap (Nayar, 2006).

Many adolescents do not have access to information about HIV/AIDS or may not have opportunities to develop skills that are required to turn this information into action. Frequently, they may not have access to services that take their specific needs into consideration. In countries where the predominant mode is heterosexual transmission, girls are often more vulnerable than boys, for both biological and social reasons. Conversely, in countries where the predominant routes of spread are men having sex with men or injecting drug use, boys are likely to be more at risk than girls. However, in case of Manipur, it is difficult to distinctly separate the vulnerability in terms of more or less among men or women because of increasing HIV transmission through sexual, homo or hetero, contacts. For instance, a healthy
woman may contract HIV from her husband/partner who is a drug addict.

Therefore, the lack of sustained campaign for healthy habits and awareness at the college may relapse an adolescent/youth into a sort of taken-for-granted behaviour. The college going student may assume that all is well with his/her behaviour and habits pertaining to health, hygiene and nutrition. As mentioned earlier, this combines with the very nature of adolescence and youth which leads the young students to experiment and taste the ‘new’ ways of life and living, declaring the symbolic ‘arrival’ of the adulthood. A young college going student confronts the dilemmas of family based restrictions regarding various social, cultural and health behaviours and also at the same time, may take pride of the fact that he/she is ‘growing up’ and that it is the time to exercise freedom, ‘to be one’s own’ and to ‘break away’ from the shackles of the home and parents. Thus, if colleges do not sustain the socialisation of a child/student in terms of health beliefs and disease and infection awareness, the child/student may tend to reinforce ignorance and myths of the society at large; rather than dealing with them as an informed individual or adolescent.

Notwithstanding the strengths of the study, there are a few limitations. For instance, the study could not cover a large sample representing all under-graduate college students in Manipur. Thus, there is a need for further research on a larger scale in the state. Further, the tribal students constitute only 32.9 percent of the total sample in the study. This under-representation may have introduced a few biases in favour of the Meiteis in the findings. Their views may have been interpreted as the dominant and majority perception which may increase the biases against the perceptions of tribal students. However, it is important to clarify that the major focus of sample
selection was on mainly selecting an equal proportion of men and women and rural and urban students. It may be noted that the distribution in terms of ethnic category (tribal and Meitei) have been used as an additional variable to explain the socio-cultural differences with a view to enhance the quality of understanding of the issue under research.

Further, there is a need to undertake indepth qualitative study of sexual beliefs and behaviour among the students since sexual behaviour has increasingly becoming the major route for HIV transmission and spread in Manipur. Such a study would provide useful information on the sexual behaviour and activities of the students which may help in preparing better to tackle the spread of HIV/AIDS. These areas and others may be identified as future areas of research combining the perspectives of the sociology of education, health, medicine and public health in India.