INTRODUCTION

The problem of HIV/AIDS has confounded humanity for decades now. There are numerous studies that are trying to examine various dimension of the virus from different perspectives. One of the little explored areas because of the complexities of the issues involved is examining life histories of HIV positive intravenous drug users. Thematic life histories are a rich resource that takes one into the inner domain of the lives of those who are reluctant to share their personal experiences with general populations. It was in response to this felt need of research that this study of the HIV positive Intra-venous Drug User (IDU) is designed to provide insights into various aspects of lifestyle of IDU and its association with HIV/AIDS. The study broadly examines the extent of Prevalence of HIV/AIDS in Manipur. It then looks into

a) Anthropological perspectives on HIV/AIDS,
b) Cultural Imperatives and HIV/AIDS spread,
c) Association of HIV/AIDS with other social susceptibility factors namely geographical, economic, and others.
d) Detailed Narratives of HIV positive IDU are generated and examined for metanarratives that may emanate out it.
e) The study then attempts to infer from the catharsis that respondents go through in the course of stating their life histories.
f) In the light of the above in the final section of the thesis I attempt to reexamine some of the ongoing policy interventions and the possibilities of bringing in any fresh perspectives in the ongoing Harm reduction programme in the state.

A. HIV: A brief history

To begin any work on HIV/AIDS, it is important to review and understand recent information available on the subject. Many researchers argue that HIV is a Lentivirus that originated somewhere in Central Africa. Lentivirus belongs to a larger group of a retrovirus (generic name for the virus). The closest linkage that Lentivirus has is with the
Simian Immunodeficiency virus (SIV) that is known to affect monkeys (http://www.avert.org/origns.htm). Scientists speculate that retroviruses have been living in the African Green Monkeys for a long time that could be traced as far back as 50,000 years. It has been postulated that some African Green Monkeys, sometime, somewhere, must have bitten or scratched some Africans in the forest infecting the human being with the retroviruses. Some others believe that the virus manifested itself in some tribal population that eats monkeys’ meat and later spread to other people due to migration of the tribe. Hence, it is argued that certain organisms which have been living in some animal species without causing any trouble for its host, suddenly jumps the species and enters human chain causing mild or serious illness. The Scientists have established that the Lentivirus –literally implies a ‘slow virus’ as it takes a long time to have any adverse effects or to manifest itself in any form in the body.

It was only after the HIV manifested itself in the United States that the Scientists tested the frozen samples of the blood drawn from the Ugandans in 1972 and found a large percentage of them to be HIV positive. This was seven years before anyone had confirmed HIV as a deadly virus (Guy de The, 1984). It was only after its diagnosis in USA that researchers started working on its clinical aspects.

There are several other theories that have been propounded regarding the origin of HIV. One of the theories suggests that HIV has remained dormant in human species for a very long time and has recently become more virulent. They also talk of the possibility that the virus comes from the small and isolated ethnic group, which had acquired immunity to it and was thus not reported. But when it moved outside this group and reached people who had no such immunity, it becomes a killer disease. Another theory as already stated is that HIV originated among monkeys and was subsequently transmitted to humans. Speculations are also rife that HIV is a man made virus, produced in a germ warfare laboratory. The discovery of the putative virus fitted into theories about the transmission of the disease that saw it originating in Africa, from where it was said to have spread, perhaps via Haiti to the United States and the rest of the world. (Mehta and Sodhi, 2004:5)
Three of the earliest known instances of HIV Infection are:

a) A plasma sample taken in 1959 from an adult male living in what is now the Democratic Republic of Congo,

b) HIV found in tissue samples from an African-American teenager who died in ST. Louis in 1969 and

c) HIV found in tissue samples from a Norwegian sailor who died around 1976. (http://www.avert.org).

For a long time it was believed in the US that the strain of HIV that provoked the US AIDS epidemic and fueled the global scourge of the disease came to the continent from Africa via Haiti. This was assumed because the number of reported cases from Haiti came almost at the same time as was being reported from the US. Given racial prejudice that occupies stereotyped worldviews, it was believed that immigrants for Haiti were responsible for fuelling the epidemic in the US. Paul Farmer (1992) described how this myth resulted in the formation of the ‘Four-H-club’ that comprised of homosexuals, hemophiliacs, heroin users and Haitians as High Risk Groups of AIDS.

The Haiti controversy about origins or movement of the Virus to the US once again came to the surface in March 2007. In the fourteenth conference on Retroviruses and opportunistic Infections (CROI) in Los Angeles, Scientific evidence based on complex Genetic analysis were presented to suggest that HIV-1, group M, subtype B—the most commonly found strain among HIV positive in the US was brought to Haiti from Africa by a single person; sometime in 1966. It then spread from person to person on the Island and was probably transferred to the US anytime between 1969 and 1972 (Worobey, 2008).

The timing suggests that it was more likely to have been a Haitian immigrant or immigrants rather than US sex tourist returning from Haiti, since it did not become a destination for them until the 1970s. The research also pegs the beginning of the US AIDS epidemic to the late 1960s rather than the mid 70s as was previously assumed, and shows that the disaster was brewing for full 12 years before US public health authorities realized they had an epidemic on their hands. The strain of the virus that touched off the
US epidemic subsequently spread to Canada, Europe, Australia, and Japan. It was not clear previously how the virus got to the United States from central Africa, where it first surfaced in humans around 1930 after jumping species from chimpanzee to man. (Chong, 2007)

The debate as to where and when HIV was diagnosed for the first time may go on forever, but the fact is that managers of AIDS Control Programme in both Asia and Africa face an uphill task. They are confronted with the need to design IEC packages conveying appropriate messages to people belonging to diverse cultural and socio-economic backgrounds (Mehta and Sodhi, 2004:9)

A. 1. Global overview of injecting drug use and HIV infection among injecting drug users

UNODC (2006) estimates of IDU prevalence are available for 130 countries. It suggests that there are approximately 13.2 million Intravenous drug Users—the world over. Geographical mapping imply that there are over ten million (78 per cent) living in developing and transitional countries. The data indicates that approximately 1.3 million are living in Eastern Europe and Central Asia, and 5.3 million live in South and Southeast Asia alone. Another 2.3 million live in East-Asia and Pacific. Estimates of HIV prevalence were available for 78 countries. HIV prevalence among IDU of over 20 per cent was reported for at least one site in 25 countries and territories: Belarus, Estonia, Kazakhstan, Russia, Ukraine, Italy, Netherlands, Portugal, Serbia and Montenegro, Spain, Libya, India, Indonesia, Malaysia, Myanmar, Nepal, Thailand, Viet Nam, China, Argentina, Brazil, Uruguay, Puerto Rico, USA and Canada. These estimates paint a grim scenario and the fact that India is among those countries that have reported more than 20 per cent from one site makes it imperative to comprehend empirical situations locally.

The United Nations General Assembly Special Session on HIV/AIDS ‘Declaration of Commitment on HIV/AIDS’ acknowledged that ‘by the end of 2000, 36.1 million people across the globe were living with HIV/AIDS. It also categorically pointed that 90 per cent of these were living in developing countries’ (UNGASS, 2001). Ten per cent of the HIV/AIDS cases worldwide are attributed to injecting drug use (IDU) (UNAIDS, 2003). It is further estimated that up to 10 million people across the world are
injecting drugs. The report also draws attention to the fact that by the end of 1999; 136 countries had recorded cases of Intravenous drug use. Out of these 114 has reported HIV infections associated with IDU (UNAIDS, 2003).

UNAIDS (2003) has classified HIV epidemic into categories namely low-level, concentrated and generalized which defines the current status of the epidemic in a given territory. Several situations can be identified according to both the dimension of the epidemic and its prevalent routes of transmission. Thus, sub-Saharan Africa contains 70 per cent of the HIV/AIDS cases (over 26 million people living with HIV/AIDS) with heterosexual transmission as the main route (Morison L., 2001). However, China, Indonesia, Vietnam, several Asian republics, the Baltic States and North Africa have HIV epidemics driven by unsafe drug-injecting practices with additional HIV spread occurring through commercial sex work (UNAIDS, 2003). Furthermore, it has been recently estimated that in many countries in Europe, Asia, the Middle East and the Southern part of Latin America, the sharing of injecting equipment is the primary mode of transmission, accounting for 30–90 per cent of all reported infections (UNAIDS, 2003).

Estimates of the prevalence of IDU and related HIV infection are critical to planning intervention responses, and for establishing strategies for the coverage of harm reduction (e.g. needle exchange/distribution, substitution treatment) and provision of anti-retroviral treatment (ARV) for IDU. However, information on the number of IDU or the prevalence of HIV infection among them is still scarce in key countries (UNAIDS, 2003). In 2001, the UN Reference Group on HIV/AIDS Prevention and Care among IDU in Developing and Transitional Countries was established to advise UNAIDS and co-sponsors on relevant issues regarding the HIV epidemic among IDU in developing and transitional countries. The group seeks to enhance an evidence-based approach to HIV prevention and care among IDU. Among its mandates is to synthesize and disseminate evidence on international HIV epidemiology, surveillance and HIV prevention and care among IDU.

IDU tend to be particularly vulnerable to HIV infection because of their highly stigmatized and often hidden behavior. They become easily susceptible because of rapid way in which HIV spreads through the sharing of contaminated needles, syringes, and
other drug use equipment. The demand for drugs is relatively inelastic to price, whereas the demand for a specific type or preparation of a drug (such as the pure form of inhaled heroin) is price elastic. Therefore, a drug addict will continue to demand drugs until he or she is cured of his or her addiction, and when the cost of a particular drug increases (or the drug becomes scarce), the user quickly shifts to other cheaper substitutes, which are often injected. Based on data from UNAIDS, the World Bank estimates that 2 million to 3.5 million people in South Asia may have HIV because of unsafe methods of injectable drug use. This estimate is dominated by India, which has an estimated 2.45 million people living with HIV, with a 95 per cent confidence interval of 1.75 million to 3.15 million people living with HIV. (Markus Haacker and Mariam Claeson, 2009)

B. Approach to the Study

This study attempts to develop an understanding of addiction processes using ‘narratives’ provided by the HIV positive IDU. I attempted to use an approach in which Meta-narratives are constructed with the belief that in its construction respondents also went through their own catharsis. Uninterrupted conversations often provide insights into behavioural complexities that cannot be witnessed in any structured format of questioning. Conducting empirical enquiries with people living with stigma and at the margins of the society is a difficult task. To bring them to a level of comfort-where they can freely narrate their experiences is a learning treatise in itself. The Catharsis that proceeds with it is a tool that anthropological enquiry can use to arrive at any significant measures for any purposeful future intervention.

Catharsis is a Greek word meaning “purification” or “cleansing” derived from the ancient Greek gerund transliterated as *kathairein* “to purify, purge,” and adjective *katharos* “pure or clean” (ancient and modern Greek). (www.wikipedia.com)

The term Catharsis is also popularly used in Drama and Theatre. It refers to a sudden emotional breakdown or climax expressing deep sorrow, pity, laughter or any other form of deep emotion that would ultimately results in the restoration, renewal and revitalization for a renewed desire for living.

The Great Greek Philosopher Aristotle was one of the first to use the term ‘catharsis’ to refer to a form of emotional cleansing in his work *Poetics*. The term was
used to describe a literary effect, a sensation that would ideally overcome an audience as an aftereffect of watching a tragedy— a kind of an emotion release mechanism.

The term *catharsis* has been used for centuries as a medical term meaning a “purging.” It euphemistically refers to a purging of the bowels. A drug, herb, or other agent administered as a strong laxative is termed a *cathartic*. The inference is again of cleansing in this instance physiological and not emotional.

Freudian psychoanalysis has made frequent use of the term *catharsis*. It is now frequently used in modern psychotherapy. It describes the act of “expressing deep emotions often associated with events in the individual’s past which have never before been adequately expressed” (www.wikipedia.com). Commonly speaking Catharsis relates to emotional release that manifests itself while in conversation about the underlying causes of a problem. It can also describe the effect producing an outlet for violence by acting as a form of release for violent behavior. The concept has acquired significance in this study as it is being used as a tool for developing strategies for intervention. It is not used in traditional anthropological methodology. This may be due to element of subjectivity that goes both in the recording and interpretation of these conversations.

B. 1. Meta-narrative

The concept of meta-narrative is espoused in critical theory and in postmodernist discourse. It is used to refer to a master-or grand narrative. In essence it is an abstract idea that is supposed to be a comprehensive explanation of historical experience or knowledge. According to John Stephens, Meta-narrative, “is a global or totalizing cultural narrative schema which orders and explains knowledge and experience” (Stephens John, 1998). The prefix *Meta* means "beyond" and is here used to mean “about”, and a narrative is a story; therefore, a meta-narrative is a story *about* a story, encompassing and explaining other ‘little stories’ within totalizing schemas. This perspective provided the essential backdrop against which the data for this research work was generated.

Many scholars of Post modernism believe that Meta-narratives have lost their power to convince. They are, literally, stories that are told in order to legitimize various
versions of “the truth”. With the transition from modern to postmodern, Lyotard proposes that Meta-narratives should give way to ‘petits récits’, or more modest and “localized” narratives. Borrowing from the works of Wittgenstein and his theory of the “models of discourse” (Hans Bertens, 1995:124), Lyotard develops a theory of progressive politics that is grounded in the “cohabitation of a whole range of diverse and always locally legitimated language games” (Hans Bertens, 1995:124). Postmodernists attempt to replace meta-narratives by focusing on specific local contexts as well as the diversity of human experience. They argue for the existence of a “multiplicity of theoretical standpoints” (Michael A. Peters, 2001:7) rather than grand, all-encompassing theories.

It is important to note here that this research work constructs ‘meta-narratives’ from specific and local narratives. All the narratives with which one is working come from HIV positive men and women. They all live in Manipur and share cultural and physical contiguity. The versions of the ‘truth’ that this work is exploring are rooted in similar experiences (in this case injecting drugs often at a common site) though the route to these experiences may have varied from individual to individual. The need to arrive at a meta-narrative was perceived only with the intent of arriving at a broad comprehension of the larger question of relationship between addiction, local cultural practices and individual compulsions.

I may also add that Lyotard’s analysis of the postmodern condition has been criticized as being internally inconsistent. For example, thinkers like Alex Callinicos, (1991) and Jürgen Habermas (1981:3-14) argue that Lyotard’s description of the postmodern world as containing an “incredulity toward meta-narratives” approaches the construction of meta-narrative in itself. The idea of universal skepticism toward meta-narratives is a meta-narrative in itself. According to the post-structuralist view thinkers like Lyotard ‘criticize universal rules’ but create universal anti-postulates. “Like a post-modern neo-romanticist meta-narrative that intends to build up a ‘meta’ critic, or ‘meta’ discourse and a ‘meta’ belief holding up that Western science is just taxonomist, empiricist, utilitarian, assuming a supposed sovereignty around its own reason and pretending to be neutral, rigorous and universal” (Callinicos, 1991). These articulations suggest that post-modernist critique of meta-narrative is self-contradictory and samples another meta story.
The postmodern incredulity towards meta-narratives could be said to be self-refuting. If one is skeptical of universal narratives such as "truth", "knowledge", "right", or "wrong", then there is no basis for believing the "truth" that meta-narratives are being undermined. In this sense, this paradox of postmodernism is similar to the liar's paradox ("This statement is false."). Perhaps postmodernists, like Lyotard, are not offering us a utopian, teleological Meta-narrative, but in many respects their arguments are open to meta-narrative interpretation. They place much emphasis on the irrational, though in doing so apply the instruments of reason. Postmodernism is an anti-theory, but uses theoretical tools to make its case. The significance of this contradiction, however, is of course also open to interpretation. "Incredulity towards meta-narratives" does not mean a denial or abolishment of them. Rather, postmodernism involves a critical and skeptical attitude towards these totalizing schemas rather than a blind, unquestioned faith. (http://en.wikipedia.org/wiki/Metanarrative)

Given this critique, I interpret that it is possible to develop a text of meta-narratives for the understanding of problem of drug addiction because Intravenous drug users constitute a unique community. They develop a common language and use symbols to express their needs and instability of their condition. There is shared understanding and perspective on ‘need’ that is substantially different form other’s perception of ‘addiction’. The world of IDU commences another integrated identity when they are diagnosed to be HIV positive. There are communities within communities. The HIV positive IDU are a collective that is not only dependent on drugs but is doubly alienated. The possibility of reaching out to this community by developing a meta-narrative of shared experiences is far greater than relying on isolated stories.

The saga of addiction is closely associated with the notions of modernism as they were being understood by the youth in early eighties. To drink, wear western clothes, play western music, have lavish birthday bashes in which drinks were sometimes served laced with drugs was modern and fashionable. Youth joined to project an image of moving with the times but soon became victims. There are no reasonable explanations in the theory of modernization that explains this linkage. A society rooted in its traditional
value system was experiencing transitions that were sudden. Education in up market English and Missionary schools was important for the grooming of their children. Children from elite families were attending these schools and imbibing values that were earlier alien to their own culture. There was little or virtually no opposition to this new cult that was becoming symbolic of ‘being modern’. This was also due to the fact that ‘stimulants’ were always part of the traditional culture of the larger Manipur society. Various ethnic, religious and linguistic sub-groups shared common cultural practices.

Their cult of modernity as I am tempted to call it in the absence of another appropriate expression promoted a unique lifestyle and drugs became a natural accompaniment to this process. From fun, fashion and status statements, when drugs became a problem are difficult to ascertain on a time-scale. But soon the drug addicts became a community with its own distinct language, symbols, codes and principles of conduct that an outsider did not understand. It is important to evolve methodologies to be able to get as close as possible to them to understand their psychological, emotional, social and financial problems. Anthropological methodologies equip us with the necessary wherewithal to reach out to these people.

Besides that, as already noted, once these IDU become HIV positive they constitute a separate community within the community of IDU. It is very important to know how they try to change their lifestyle, control emotions and relate to the normal society after being diagnosed as HIV positive and facing the possibility of death at close quarters.

One of the important questions of this enquiry was to know how they conceal their status from others and try to live a normal life. For a comprehensive understanding, there is need to apply deconstruction theory and post modernist methodologies to appreciate the complexities embedded in ‘their’ mind/life. It was first and foremost for me to deconstruct any inhibitions that I may have had interacting with them. I had to clean my own ambiguities, prejudices and hence started deconstructing my own perceptive first before accepting the ‘others’ world view. It is with this conceptual framework that this study is pursued.
C. Research design

The present study is a systematic and scientific exploration of the factors responsible for linkages between IDU and high prevalence of HIV in the state. Some research questions can be summarized as follows:

1. What impact, native customs and cultural traditions have on the people?
2. What are the patterns of penetration and levels of awareness with regard to susceptibility to HIV among the Intra-venous Drug Users (IDU)?
3. What are the prevalent socializing practices and how these influence decision making with regard to use of drugs?
4. How do peer networks of IDU help in containing addiction or its prevention?
5. What role socio-economic factors if any, play in the spread of HIV/AIDS epidemic in Manipur?

On the basis of these research questions, the main hypotheses framed for the present study are as follows:

1. There is a direct linkage between Native cultural practices and customary usage of stimulants and drug use.
2. Needle sharing is not only about drug intake but about building closer bonding with the co-partners.
3. Cultural perspectives of Meitei, Kuki, Naga and Muslims living in the state of Manipur are not encouraging familial control on their children subjecting children to greater peer influence and innocent consumption of drugs.
4. Use of stimulants comprising of liquor, Biri, Khaini, Ganja, Talab etc are traditionally/commonly used in the festivals and functions/ceremonies and become natural precursors to drug use.
5. Locally constructed notions of modernity were instrumental in promoting the first phase of enhanced drug use in the state of Manipur.
6. Susceptibility to drug addiction has close linkages with the socio-economic status of the individuals.

The main objectives of the study

1. To explore deep structures and examine impact of geographical locations on susceptibility pattern.
2. To study and identify infection prone lifestyle of the people.
3. To examine levels of awareness about the epidemic and its impact on their personal and family lives.
4. To generate detailed narratives of the known IDU/HIV infected people to comprehend life events that were instrumental in vulnerability.
5. To locate these people in their networks and record a systematic demographic and cultural profile for evolving intervention strategies.
6. To present a comprehensive and empirical account of the socio-economic background of the HIV positive people known to be IDU.
7. To generate detailed accounts of cathartic emotions under the influence of drugs and without the influence of drugs whenever and wherever possible.
8. To generate meta-narratives drawing inferences from detailed narratives provided by the study.

C. 1. Research methodology

In most HIV related anthropological text; the predominant mode of studying the behavior and attitudes of persons with HIV/AIDS is largely researcher defined; self-report instruments- questionnaires, observations, focused group discussions, in-depth interviews. Qualitative research provides an in-depth understanding of a phenomenon from the perspectives of participants and in their own words. I opted to use narratives generated through extensive conversation sessions with the respondents. The interviews were conducted in three sessions, once when respondents were not under the influence of drugs, second time in groups when they were actually injecting drugs and third time in family setting. This was done with a view to elicit details that they may be reluctant to
share in one setting or the other. This also facilitated corroborating details provided in different narratives/conversations. It was reasoned that for generating meta-narratives, it was important that we sit through these separate sessions. There was a prepared interview guide but it served only to cross-check any details that long conversation session may have omitted. Structured questions were deliberately avoided as they disrupt flow of conversations. I did not work with any standard notions of generating data. It was free flowing conversations giving enough space to respondents to generate their catharsis at their own pace.

C.2. Sample

A purposive sample of HIV positive individuals was located through the assistance of Manipur AIDS Control Society (MACS), Lamphelpat. To reflect the diverse characteristic of individuals with HIV, a mix was sought in forms of gender, age, ethnic origin, education, employment, number of years that they have lived with HIV and Drug use. Respondents in the study were limited to individuals who:

a) were at least 17 years of age,

b) had been sero-positive for HIV for at least six months,

c) had been injecting drugs for at least six months and were using it in this manner at the time of study,

d) Were at a sufficient level of cognitive functioning to recall and articulate the impact of drug use on their HIV positive status.

e) were at a sufficient level of physical functioning to comfortably endure a 30-45 minute of conversation session and

f) Were located within geographical confines at Manipur.

C.3. Further classification of the sample

The final sample consisted of 200 Adults (127 men and 13 women), in the age group of 17-45. The sample consisted of diverse sections of Manipuri society. Fifty nine (29.5 per cent) respondents are Muslims, ninety (45 per cent) are Meitei, three (1.5 per cent) Scheduled Caste and forty eight (24 per cent) belong to different Scheduled Tribes.
in the region. Level of educational attainment ranged from middle, high school to completion of master’s degree. Forty respondents (20 per cent) were employed fulltime and eighty one (40.5 per cent) were engaged in part time jobs/manual works and rest of the respondents (39.5 per cent) are either students or never earned money. Respondents had been living with HIV from at least six months to 20 years. Most of them lived at a short distance from the city; few respondents are residents of rural areas. Some of them are home-bound. Research participants had been using Drugs for personal reasons from 1 to 10 years.

C.4. Rapport establishment

There are certain factors which act as barriers in rapport building with respondent in rural and hill area. The reasons could be cited as: a) respondents are not ready to disclose their problem. They believe that disclosing their weakness may create a bad image. They do not want to disclose it particularly because of their HIV status. So, they are not ready to share information, b) identifying and interviewing HIV positive person is a high risk task; they can not be located unless they come forward to give interview. c) HIV positive women in villages or hilly areas are mostly school drop outs. Awareness campaigns have hardly reached to this marginalized section of the society. They have low level of awareness about the disease such as its transmission from their husbands and its preventive measures. This may be because of:

1. Low accessibility: a) villages are separated very far from one another, b) long distance from the main roads i.e. from motorable road,

2. In the villages families are close units. They are also highly conscious of family prestige and image. In most cases, even when they know that a member of the family is positive, they will not share the information with others, keeping it a closely guarded secret.

3. The villagers whose HIV positive status is confirmed but they are not ready to accept it because of stigma attached to it.
C.5. Data collection and analysis

Data for this research thesis was collected from November 2005 to July 2007. The format of the interview followed Coyne and Gottlieb, (1996: 985) guidelines for retrieving what is considered to be of “personal significance of what has transpired in the lives of respondents”. Areas explored included respondents, history of drug use, how they use the drug for personal reasons and every other detail of their personal lives that they wanted to share with the researcher. The interviews were audio-taped where ever possible and transcribed verbatim.

Data were analyzed inductively using the constant comparative method (Glaser and Strauss, 1967), although the intent of the study was not to build grounded theory. According to this method, data analysis proceeds simultaneously with data collection. I compared a particular incident from an interview with another incident in the same set of data or in another set. A rough classification scheme emerged from this that enabled the transformation of this classification scheme into categories and properties that were exhaustive, mutually exclusive, conceptually clear, and sensitizing (Merrian, 1998). This process resulted in the findings that represent my interpretation of the impact that drug use has on the infection of HIV.

To ensure validity of this research, data source triangulation was employed. In addition, the findings were shared with other participants, for a “memory check”, to see if the perceptions rang “true”. I also shared the findings with two colleagues from one of the NGOs staff member to review their interpretations. Finally, a detailed account was kept of the decisions that guided the research so as to facilitate its replication.

C.6. Limitations of the study

The findings of this study are limited by the fact that a large number of participants/respondents are articulate but try to hide many of their factual experiences. Thus, irrespective of every effort made, there may lack of candor on the part of the participants and may impact interpretations made in the later part of the study.

The present sample irrespective of diversity in terms of representation of different ethnic groups, religions, socio-economic strata, gender, and diversity of geographical
locations in the state may not accurately represent the entire HIV positive IDU population currently living in the state.

Another limitation of the study is the political, law and order situation in the state of Manipur at the time of data collection. There is lack of information and non-availability of female respondents in rural and hill area. Manipuri society is very conservative except few ethnic communities. There is lots of social and gender disparity which hamper data collection. In rural area, women are still not given equal opportunity and their participation in social activities is based on culture, ethics, morality and family structure. They are mainly occupied with household chores and family maintenance. They are not much aware about their right like their female counterparts in urban centers. They could not get opportunity to share their opinion in the society.

In hill areas, they have an open society but they are culturally bound by the new Christian religion. However, they did not leave their tradition and norms. The culture which has been part of the society from generations allowed freedom in movement and personal selection of sexual partner. At the same time, they could not get rid of strict provisions of Christianity and its customs. So, women have reservations of sharing their personal and family matters/problems to stranger.

And, not being sero-positive for HIV, I am an “outsider” in the HIV/AIDS community. Although MACS endorsed my legitimacy as an ethically responsible researcher, respondents feelings about my “right” to engage in HIV-related research may have influenced their willingness, or ability, to be open with me.

C.7. Findings

Findings were derived inductively from the analysis of interviews transcripts of 200 HIV positive individuals. Each participant is represented in the text by a pseudonym. The purpose of this study was to explore the world of HIV positive IDU, providing them space to have their say or as we tend to call it ‘through their catharsis’ and infer from it future strategies for intervention. It is argued in the literature (WHO, 2006) that drug use promotes de-empowerment, delimitates social support and de-facilitates helping others. This research work attempted to reify this and using an open data generation methodology explored other hidden domains through the medium of respondent
catharsis. Case study method provided ample space to respondents to explore their own journeys. They were not only talking to us but were also talking to their own selves. They were asking questions and churning their emotions to come to terms with their own realities.

D. Review of literature

The use of the cannabis plant for a variety of purposes has long existed in India, its use for medicinal reasons, as well as its ability to bring about mood swings, is significant. Cannabis has been used along with other ingredients to treat rheumatism, migraine, malaria and cholera to relieve fluxes; facilitate surgical operations; to relax nerves; restore appetite; for general well-being; and it is also considered beneficial for the functioning of the heart and liver. Additionally, the cannabis plant provides food grain, oil seed and fiber for manufacture of fibrous products in select parts of India (Charles et al., 1999; Charles, 2001). The practice is also prevalent in many other countries of Asia (Li Hui Lin, 1975; Martin 1975, Fisher, Khan et al., 1975 and Charles, 2004).

The practice of using cannabis to alter consciousness and as part of religious and shamanistic rituals has also existed in India for centuries. For example, the drug has a strong religious association as a gift from Lord Shiva to his followers.

Opium has also been used for socio-cultural reasons in different parts of the country (Chopra et al., 1990), like that seen among the Rajputs in Rajasthan and Gujarat where it is commonly shared during cultural festivities (Masihi et al., 1996). However, it may be contended here that use of opium for medicinal purposes as compared to its use in social gatherings has been more common all over the country.

D.1. Social-cultural controls

Until the 1980s cannabis consumption does not appear to have been regarded as an issue of major social concern in India, with little or no official mention of excessive use. Prevalent socio-cultural regulations with regard to the form of use, mode of consumption, context of use and profile of users, ensured a system of use management that limited drug use within the country.
For instance, norms restricted the use of cannabis and opium to the adult male population. In the case of cannabis, this is a pattern documented in a number of countries including Cambodia, Vietnam, Thailand, Laos, China, Nepal and Pakistan. Even among the male adult population, there were restrictions on the context for consumption, with sanctioned use often linked or limited to specific religious and social occasions.

In India and Nepal, the use of cannabis appears to be linked to religious festivals like Shivaratri, Krishna Ashtami (birth of Lord Krishna) and participation in Bhajan sessions. Indeed, occasions like Holi, 'the festival of colors' is not complete without the sharing of Bhang—a drink made with cannabis. At such select occasions, women and youngsters were permitted to use Bhang and other items made from cannabis, including snacks, sweets and curry. Opium is also offered at the harvest festival in a ceremony called akha teej, intended to strengthen family marital clan bonds and put aside old feuds.

It is this specification regarding the profile of users and a desire for cultural confirmation that ensured the existence of mechanisms to control drug use. The provision made for women and children to consume cannabis products in select cultural contexts and in specified forms indicates a strong cultural acceptance for cannabis within India. Norms reaffirmed the cultural dimension of cannabis use and probably prevented excessive non-cultural use of cannabis. (Molly Charles et al, 2005)

An opium drink can be used to greet guests in social functions that include marriage celebrations, sealing a business deal or mourning the demise of a relative. In this case, culture permits opium consumption in the male adult population but, unlike with cannabis, there is no specific cultural sanction for women and youngsters to use the substance except for medicinal purposes.

Such sanctioned cultural use, and its occasion or context, produces a situation within which a drug’s mood-swing properties are not the sole focus of the practice. For example, in consumption during a celebration or get together, songs and social interaction form the binding force for consuming the substance, Consumption of Bhang during Holi calls for community participation from the decision to prepare the drink, through to making it, and finally its consumption in a group setting.
The pattern of consumption for smoking cannabis and opium also restricts drug use, because as a group activity the users only inhale a few times from the pipe. Moreover, smoking the pipe is but a part of social interaction and not the sole activity of the group. Sharing the drug is also not the result of any economic consideration as is sometimes seen in the case of heroin (Charles et. al., 1999).

D.2. Changes in pattern of drug use

The convergence of a number of important structural changes, at both national and international levels, around the time of the NDPS Act (1985), impacted on longstanding pattern of drug use within India.

Research suggests that tourism has contributed to a diversification of drug use patterns. In the mid and late 1970s, exposure to other cultures in both Nepal (Fisher, 1975) and India produced new forms of drug-taking behavior. Since the early 1980s, most major Indian cities have been introduced to new “foreign” drugs such as heroin. The interaction of young Indians with tourists has also facilitated an alteration in the relationships they later form with those drugs traditionally consumed (Charles et. al., 1999, Charles, 2001). This is seen in all parts of the country, although the process is more gradual in rural areas.

Such a rural-urban split can be explained by the impact of urbanization upon traditional patterns of drug use and management. Put simply, urban communities do not tend to adhere to traditions to the same degree as those in rural areas.

Indeed, the illicit drug trade has a significant, although complex, impact on drug use patterns within many parts of India. Shifts from opium to heroin use can be seen to depend on a number of inter-related factors. These include proximity to areas of illegal cultivation and processing, traditional regional drug use patterns and geographic accessibility. For example, there is illicit poppy cultivation in the North Eastern state of Arunachal Pradesh. Nonetheless, in a state with a history of cultural opium use and, due to the densely forested nature of the terrain, limited connectivity with the surrounding areas, drug use is limited to opium (Narcotics Control Bureau Report, 2001). In other parts of the North-East India (especially Manipur, Nagaland and Mizoram), circumstances are different. However, the combination of the easy availability of heroin from Myanmar and absence of cultural use of opium in these regions resulted in the
emergence of heroin use. In the states of Madhya Pradesh, Rajasthan and Uttar Pradesh, there is a history of cultural opium use with the demand long supplied by diversion from illicit cultivation. A study in Rajasthan in 1989 indicated that drug use was largely limited to opium and cannabis. Nonetheless, recent research shows that in the mid-1990s there was a shift from traditional drugs to heroin. It is significant that this change took place at a time when there was an increase in the illicit heroin traffic to India from Afghanistan via Pakistan (Charles, 2004).

Another study among opiate users in fourteen sites across India indicated the primary substance of abuse was heroin followed by Buprenorphine, a synthetic opiate. From the total sample of 4,948 drug users, around 43 per cent had injected drugs at the same time. (Molly Charles et al., 2005). In many cases, the drug of choice was Buprenorphine followed by Heroin and Propoxyphene. Among the injectors around 51 per cent in Amritsar (in the state of Punjab) were found to have shared needles at some time, with 15 per cent from Hyderabad, New Delhi, Dimapur, Trivandrum and Chennai reporting the same practice. The conditions for widespread transmission of HIV and other infections through drug use are therefore increasingly present in India.

Given the cultural acceptance of cannabis and opium, monitoring of the drug of initiation among users can be a useful process in identifying changing patterns of drug use across the country. For example, the 2002 Ministry of Social Justice and Empowerment Rapid Assessment Study revealed that within the majority of fourteen study sites respondents cited cannabis (40 per cent) followed by alcohol (33 per cent) to be the pre-dominant drugs of initiation. However, in Dimapur, a city from North Eastern region, for around 34 per cent of the sample the first drug of abuse was propoxyphene, followed by heroin for 30 per cent (Kumar, 2002).

**D.3. Linkage between HIV/AIDS and drug use**

HIV is transmitted among injecting drug user (IDU) primarily through the sharing of infected injecting equipment. Equipment includes needles, syringes, and other paraphernalia, such as “cookers” (spoons or containers for dissolving the drug), “cottons” (filters), and wash water use to rinse needles and syringes and dissolve drugs (McCoy and Inciardi, 1995; Chitwood et al., 1990). When drugs are injected intravenously,
contact between the paraphernalia and the user’s blood is virtually guaranteed (McCoy and Inciardi, 1995). In addition, certain sharing practices among IDU contribute to HIV risk. “Booting” is a process that uses a syringe to draw blood from the user’s arm, mixes the drawn blood with the drug already taken into the syringe, and injects the blood-drug mixture into the vein. Booting leaves traces of blood in the needle and syringe. Thus, subsequent users of the equipment are at risk. “Frontloading” and “backloading” also called syringe-mediated drug sharing refers to a practice where two or more IDU use one syringe to prepare the drug, and then divide it by squirting some of the solution into one or more additional syringes. The drug is transferred by either removing the needle of the recipient syringe (frontloading), or removing the plunger (backloading). Although these practices do not involve sharing of the actual needle or syringe, HIV can be transmitted if the syringe used for mixing has been previously contaminated (Stark, et. al., 1996).

In addition to injecting with syringes, IDU in some areas also use self-made equipment to inject their drugs. For instance, in parts of south-east Asia, IDU inject with blow-tubes, which are lengths of polythene tubes with needles attached; drip sets; eyedroppers or ink droppers with an attached needle, and disposable and glass syringes. In Mandalay, in 1989, 52 per cent of IDU reported using self-made equipment (Stimson, 1994). IDU in India have also been observed using ink-droppers as injecting equipment (Sarkar et. al., 1993). This self-made equipment is often in poor condition and difficult to sterilize.

Research has found that IDU in developing countries do share injecting equipment to a large extent. The WHO Multi-City Study of drug injecting, conducted from 1989-1992 provides extensive information on particular drug-related risk behaviors in Rio de Janeiro and Santos, Brazil, and Bangkok, Thailand, as well as in other cities in developed countries. Samples of drug injectors both from treatment facilities and from the street were taken, and extensive data gathered on drug sharing and sexual behavior. In Bangkok, 55 per cent of IDU reported sharing equipment on a monthly basis. Thirty per cent of IDU in Rio de Janeiro reported this behavior, and about 53 per cent in Santos shared equipment on at least a monthly basis (WHO, 1994). Researchers in India have also found evidence of extensive needle sharing among IDU. Samples of injecting drug users from Manipur and Nagaland report regular sharing of equipment in 83-96 per cent
of cases (Sarkar, et. al., 1993; Narain, 1994). Equipment sharing is also prevalent in Yunnan province, China, with 100 per cent of a sample of 282 injecting drug users reporting sharing (Zheng, et. al., 1994).

Given that injecting drugs with HIV-positive equipment virtually guarantees transmission of the virus, the important issue becomes exposure to infected equipment, and behavior or conditions facilitating exposure. One factor associated with rapid transmission of HIV among IDU is the presence of a mechanism for “efficient mixing,” where IDU have access to others’ injecting equipment (Des Jarlais, et. al., 1992). In parts of south-east Asia, sharing often occurs in drug injecting shops, where IDU pay a “professional injector” to inject them with the shop’s equipment. Shops tend to have only one set of equipment that is shared among the many IDU who attend each day (Stimson, 1994b). Other common injecting sites at which equipment is often shared include semi-public venues such as private dwellings, parks and other open spaces, graveyards, and under bridges (Stimson et. al., 1996). Prisons are also locations for efficient mixing in some areas, including Bangkok (Des Jarlais, 1992).

The venues for efficient mixing are similar to what are termed “shooting galleries” in the United States. Shooting galleries are locations, usually in urban areas, where IDU go to rent equipment when they do not have access to their own. Galleries are typically located in basement apartments, abandoned buildings, or in run-down apartments or hotel rooms (McCoy and Inciardi, 1995). IDU rent injecting equipment from the gallery operator, and return the equipment after use. This equipment is usually not disinfected or cleaned before renting it to the next user (McCoy and Inciardi, 1995). In cities that do not have shooting galleries, IDU may rent equipment from the individual who sells them their drug, and then return it afterward. This equipment is then passed on to the next IDU who purchases drugs from the dealer. Also, in cities where drug distribution and equipment is limited, IDU gather together in groups to purchase and share drugs, using the same equipment (Des Jarlais, et. al., 1992).

Researchers have found significant associations between exposure to HIV and use of shooting galleries. In Miami, one research worker systematically collected used needles and syringes from shooting galleries throughout the city (Chitwood, et. al.,
1990). Overall, 10 per cent of needles and syringes were found to contain the HIV-1 antibody. They also found that HIV was present even in needles on which no visible blood was present. In addition, laboratory tests indicate that HIV-1 may be present in other paraphernalia, including cookers, cottons and wash-water (McCoy, et. al., 1996a).

The probability of an IDU becoming infected with HIV varies depending on HIV seroprevalence in the particular population and sharing behavior. McCoy and Inciardi (1995) calculated probabilities of an IDU encountering an HIV-infected needle or syringe, given a 10 per cent seropositivity rate among IDU. A user shooting up just one time a day in a shooting gallery would have a 90 per cent chance of using an HIV-infected needle within 21.5 days. Shooting up three times a day reduces the amount of time for an encounter with a seropositive needle to 7 days, and those shooting up 5 times a day would encounter an infected needle in just 4 days. Although this type of HIV infection probability has not been calculated for sharing venues in developing countries, in some areas such as Myanmar, seroprevalence is so high among IDU that many new injectors become infected within 6 months of their first injection experience.

D.4. Intervention strategies

Researchers are convinced that the effective control is feasible only when the political leadership understands the dynamics of the spread of the virus. It is not only subject to individual behavior but processes of political and economic control. The cultural construction of social realities, in which individuals function, is critical to the understanding of the larger dimensions of the epidemic/pandemic.

D.4.1. NACO’s intervention programmes and its limitations

NACO has recently launched third phase of its programme for intervention, prevention and treatment of people suffering with HIV/AIDS. First phase of the programme was sketchy riddled with questions of morality, while planning strategies were constrained because of lack of sufficient funds. NACP-II by its own admission was focused on ‘five basic elements shown globally to be effective: behavior change communication/peer education, STD treatment, condom promotion/provision, enabling environment, and community mobilization’. In a review paper (Shalina Mehta and N. Inaoba Singh, 2007) use the phrase by ‘its own admission’ as one of the contributing
authors in the article was the erstwhile programme director of NACP. It was contended that to incorporate best practices from ‘globally effective’ strategies may be a good idea but to visualize it as the most effective means of bringing under control a pandemic known to be determined by social and cultural profile of communities and prevailing socialization practices leaves lot to be desired.

A review of the NACO programmes suggested that there was urgent ‘need to mount structural interventions that could substantially change environmental factors increasing risk (e.g., violence faced by sex workers) to organically foster a strong community-led response. The report also suggested that there was inadequate focus on male clients, and limited evaluation of effectiveness’. From the point of view of a Social scientist and in particular that of a cultural anthropologist, the first phase of the NACO in its naivety marginalized already stigmatized sections of the “high risk groups”. Many have persistently critiqued NACO’s ‘target approach’ for ‘targeting’ most vulnerable sections of the society. These programmes generated further stigma and diverted attention from the need to pursue effective strategies for what are now being termed as ‘carrier groups or bridge populations’. The review report talked about ‘limited focus on coverage and diffused programming with substantial interventions in non-priority groups’. Excessive focus on CSWs without paying much attention to their clients, inability to connect with the women in general, dithering over sex education programmes for long, continuing to harp on a value system as being self protective without adequate empirical documentation and most important of all failing to recognize local level safety nets devised by different cultural communities for protecting adolescents and vulnerable members has made the programme vague and less effective.

Another important deficit in India’s Health management is meager resource allocation for health care. We noted that the success stories from Thailand were primarily linked to massive investments that were made in the health care and management of HIV. The review article in Lancet (Chandrasekaran, Padma, Dallbetta, Gina, Loo, Virginia, and Rao, Sujata, 2006) records that ‘the estimated total amount spent on HIV/AIDS in India in 2004 was US $ 79 million (including Avahan funds) or about $0.15 per capita of the adult population. This spending compares with an estimated $1.74 per capita for Thailand or $0.28 per capita for China during the same period, but must be seen against
the backdrop of overall low general government expenditure on health in India of $7 per capita’. These observations acquire further significance in view of the fact that ‘80 per cent of health spending in India is private spending, and a single catastrophic illness puts a household into debt for perpetuity...........An Asian Development Bank/UNAIDS report estimates that AIDS could slow poverty reduction goals by 23 per cent between 2003-2015’ (Chandrasekaran, Padma, Dallbetta, Gina, Loo, Virginia, and Rao, Sujata, 2006).

It is important to note here that while the focus was on BCC, little investment was made in controlling opportunistic infections. Behavior change was regarded as a definite end product of intervention. The students of behavior studies often questioned the rationale behind this strategy. Empirical studies have suggested that human behavior is conditioned by prolong socializing practices. It is also governed by social norms that are evolved by communities over generations. Behaviour is a conditioning and any mediation requires negotiations. Who monitors these negotiations with what intent is critical for generating positive responses. To inform is an understandable proposition. What one can do to safeguard the physical being is another logical input. But to assume that the interventions so designed can actually change customary or habitual practices is a far fetched strategy.

D.4.2. Harm reduction

This section will describe some intervention strategies for preventing HIV in the injecting drug user population. Specific emphasis will be placed on intervention components that seem to be most effective in changing behavior of IDU. Most notably, many intervention programs have been successful in encouraging certain types of risk reduction among IDU. Injecting drug users can and do change their drug use behavior under certain circumstances. However, research indicates that while injecting drug users change their needle-sharing and cleaning practices, HIV prevention efforts have not been successful in the realm of sexual behavior, particularly with regard to condom use.

Risk or harm reduction interventions, on the other hand, involve encouraging safer injection behavior, but do not necessarily promote abstinence from injecting drug use. Generally, both demand and harm reduction interventions are implemented by public
health departments and/or private organizations concerned with the welfare of drug users. Drug supply reduction strategies are typically national-level policies which focus on enforcement of laws against drug production, trafficking, sale and use. (Frank B., 2000; Friedman et al. 2005, Schrag D, Xu F, et al. 2006; Ahern J, Stuber J, Galea S., 2007).

**D.4.2.1. Harm reduction strategies**

Des Jarlais (1995) summarized the argument for implementing harm reduction programs to prevent HIV among IDU. First, non-medical use of psychoactive drugs is inevitable in societies that have access to these drugs; therefore, drug policies cannot be based on the belief that drug use can be eliminated. Second, drug misuse will produce social and individual harms; therefore drug policies cannot be based on the belief that drug users will use drugs safely. Third, drug policies must be pragmatic; that is, they must be assessed on their results, not on whether they are sending correct, incorrect or mixed messages. Fourth, drug users are part of the larger society, and as such, should not be socially isolated from the community. And fifth, drug use leads to harms through a variety of mechanisms, all of which needs to be addressed in interventions.

In general, effective risk reduction programs for IDU implemented in both developed and developing countries include educational programs, drug abuse treatment, syringe exchange, over-the-counter syringe sale, and community outreach and bleach distribution programs (Des Jarlais et al., 1992; Des Jarlais, et al., 1995b). It has been recognized that education and information alone may not cause a reduction in risky behavior among IDU (Flowers, et al., 1991; Campbell and Waters 1987; Becker and Joseph, 1988). However, education combined with group interactions and exercises seems to be more effective (McCoy and Inciardi, 1995; Jemmott, et al., 1992). Behavior is difficult to change in individuals when it is habitual and reinforced by peers or community norms.

**D.4.2.2 Needle exchange programmes**

Needle exchanges are established in order to increase the availability of sterile injection equipment, and to remove contaminated needles from circulation among IDU participating in the program (Normand, et al., 1995). These programs are expected to increase the supply of needles and reduce the amount of sharing by IDU. Needle
exchanges also tend to include services such as education concerning risk behaviors, referral to drug treatment programs, and provision of condoms. Negative outcomes that may result from Needle Exchange Programmes (NEPs) include an increase in improperly discarded needles, an increase in drug injectors, or the perception that the government condones drug use. Needle exchange programs have been implemented in locations in a variety of developed countries. Two comprehensive reviews of literature which evaluated needle exchange programs in Australia, Canada, the Netherlands, Sweden, the United Kingdom and the United States were performed by the U.S. General Accounting Office (GAO), (1993) and the University of California at San Francisco in 1993 (Lurie, et. al., 1993). The GAO review concluded that needle exchange programs were successful in reaching injecting drug users and providing a link to drug treatment and other health services (Normand, et. al., 1995). It also found consistent evidence of a reduction in needle sharing and a reduction in the frequency in injecting drug use in two programs.

D.4.2.3. Bleach distribution

Use of bleach has long been recognized as an effective technique for sterilizing injecting equipment. Many bleach distribution programs are incorporated into needle exchange programs, and tend to rely on a community outreach approach. Bleach distribution programs in San Francisco and Chicago were instituted in the 1980s (Watters, 1987; Watters 1994; Wiebel et. al., 1990). Evaluations of these indicate increased use of bleach by program participants. In the San Francisco program, the per cent of IDU in the program that used bleach increased from 3 per cent to 76 per cent (Watters, 1994). Similarly, in Chicago, two-thirds of IDU in the program reported an increase in bleach use, and one-third of those reported always using bleach (Wiebel et. al., 1990). A bleach distribution program was also instituted in Churachandpur, Manipur, India. Bleach kits are distributed on the street by outreach workers. In the first year of the intervention, it was estimated that 790 of the town’s 800 IDU were reached, and knowledge of bleach as a disinfectant rose from 3 to 99 per cent in one year. Intention to use bleach also increased from 2 per cent to 79 per cent, and actual use of bleach increased from 31 per cent to 72 per cent after one year (Chatterjee et. al., 1996). For countries where sterile needles are difficult, if not impossible, to obtain for injecting drug
users (for both economic and political reasons), bleach distribution may be a viable and effective alternative.

D.4.2.4. Peer counseling and community outreach

As mentioned previously, outreach programs and utilization of peer counselors in intervention programs are not distinct interventions, as many harm reduction programs use these strategies. Outreach intervention has been successful in cities in the United States and Europe as well as in developing countries, resulting in marked decreases in needle-sharing (Des Jarlais, et. al., 1992). In Hong Kong, where HIV seroprevalence among IDU is very low, rehabilitated IDU are trained as interviewers and peer counselors to educate injectors on the street about harm reduction techniques. Analysis indicates a rising awareness of risk factors among these IDU and declining risk behavior (Ch’ien, 1994). Harm reduction programs in Churachandpur, Manipur and Kathmandu both incorporate community outreach strategies. As already mentioned, there are claims that this approach has been successful in reaching to 790 out of 800 IDU in Churachandpur. However, empirical evidence generated in the course of present research does not validate these claims. The low seroprevalence of HIV among IDU in Kathmandu has been partly attributed to a street-based outreach strategy (Mahajan and Singh, 1996). Bangkok has also experienced some success in risk reduction among IDU after instituting AIDS education programs in treatment centers and through community outreach. In 1989, 92 per cent of IDU interviewed reported that they had changed their behavior to reduce their risk for HIV (Choopanya et. al., 1991). In addition, 80 per cent said they obtain their injection equipment from a pharmacy instead of from other IDU. HIV prevalence in this population has stabilized since 1991 at about 37 per cent.

Another study of outreach efforts in Bangkok and Rio de Janeiro, Brazil identified behavior change among IDU, and found that social network factors were important in influencing this change (Des Jarlais, et. al., 1995a).

Another study conducted among IDU from Manipur, Nagaland, and Mizoram states in India found that the most important reasons cited by 60-90 per cent of injectors for initiating injecting drug use was peer pressure and the influence of friends (Sarkar, et. al., 1995a).
al., 1993). This shows the potential for successful behavior change using peer leaders to influence IDU (Fuller CM et al., 2007).

**D.4.2.5. Risk reduction in sexual behavior**

While evidence indicates that IDU have been able to change their drug using behavior to reduce their risk for HIV, there has been less success in changing their sexual behavior. Early studies from the UK, New York, San Francisco, Amsterdam, and Edinburgh indicate that all reported higher rates of risk reduction in needle sharing cleaning practices than in sexual behavior (Donoghoe, 1992; Van de Hoek et al. 1990; Morrison 1988; Hart et al., 1989). More recently, results from the WHO Multi-City Study found that among IDU interviewed in Rio de Janeiro only 29 per cent reported a change in sexual behavior, compared to 53 per cent who reported changes in drug injecting behavior due to concerns about AIDS (Des Jarlais, et al., 1995a). In addition, a study in Manipur found that widespread availability of HIV testing and awareness of HIV seropositivity was not associated with safer sex behavior. Of 787 IDU who was provided HIV testing and counseling, 93 per cent reported being aware of HIV transmission through sex, and 37 per cent tested positive for HIV. However, only 16.5 per cent of sexually active IDU had ever used condoms, even after testing and counseling (Sarkar et al., 1996).

Researchers recognize that HIV interventions targeted to IDU must incorporate specific sexual behavior components in order to reduce this type of risky behavior. In addition, interventions that include the partners of IDU in the sexual behavior component have met with some success (Des Jarlais, et al., 1992; Donoghoe 1992; McCoy and Inciardi, 1995; Auerbach, et al., 1994). In addition, a community-level intervention in California targeted women at high risk for HIV (injecting drug users, commercial sex workers, and sex partners of IDU). By the end of the study, women who had been exposed to the intervention were significantly more likely to report consistent condom use with both main partners and non-main partners (Corby and Wolitski, 1996).

**D.4.2.6. Demand reduction strategies**

The demand reduction strategy has a two-fold advantage in both reducing HIV risk and reducing drug abuse (Des Jarlais, 1992). Studies of methadone patients in New
York City have shown that those who entered methadone treatment early in the HIV epidemic were less likely to be HIV-positive than IDU who entered treatment later (Abdul-Quader, et. al., 1987; Schoenbaum, et. al., 1989). Other research has found an association between availability of methadone treatment and lower rates of HIV seropositivity (Rezza, et. al., 1988; Blix and Gronbladh, 1988). Methadone treatment has been associated with low levels of risk behavior among IDU in Hong Kong (Choi, et. al., 1996). Only 1-2 per cent of the 18,000 injectors interviewed reported sharing needles in the last month, and of those, the majority (58-81 per cent) stopped sharing after counseling at the clinics. In addition, Farrell, et. al., (1994) reviewed studies of methadone treatment results and concluded that long-term methadone prescription was an effective means to reduce injecting and sharing behavior and rates of HIV infection, as well as to reduce dependence on illicit opiates, criminal activity, and drug-related mortality.

Drug treatment programs that encourage abstinence have significant limitations. Methadone treatment is opiate-specific and does not eliminate injection of drugs other than heroin (including cocaine). Also, the relapse rate in drug treatment centers is very high. For example, in drug treatment centers in both Kunming in Yunnan Province, and in centers in Myanmar, the relapse rate has been reported to be between 80 and 85 per cent (McCoy et. al., 1996; Stimson, 1994). In addition, follow-up is relatively unsuccessful due to geographical distance and transport, and patient’s unwillingness to attend.

One particular factor that may impact the high relapse rate is mandatory treatment, where IDU are placed in treatment by law enforcement or families against their will. This raises not only ethical concerns, but questions of efficacy of HIV prevention through demand reduction. McCoy, et. al., (1996) studied the Kunming treatment center in Yunnan Province, China. Eighty per cent of the patients at this drug detoxification facility are mandated by law enforcement to go, and many report not necessarily wanting to stop their drug habit. As mentioned above, they observed an 80 per cent relapse rate within 2 years.
In Manipur, India, IDU are forced into treatment by law enforcement and family members (Sarkar, et. al., 1993). Since there are a limited number of beds in the few treatment facilities that do exist, prisons are often used as detoxification centers. Imprisonment has not induced large-scale behavior change, despite the fact that over 50 per cent of addicts have been in prison in their lifetime. Abstinence, rather than harm reduction, is emphasized and no counseling support is available. In one survey of 450 injectors interviewed, only 2 per cent expressed a desire to stop their drug habit because of imprisonment (Sarkar, et. al., 1993). Data on IDU in Manipur indicate a high level of knowledge about HIV transmission and safe injecting behavior compared to the general population (Sarkar, et. al., 1996). Sarkar (1996) showed in his study that many IDU wanted to stop sharing equipment, yet many others continued to practice unsafe needle sharing. This is attributed to non-availability, to the lack of rehabilitation facilities and adequate counseling (Sarkar, et. al., 1996).

Finally, treatment programs do not help those who refuse to go for treatment. They also tend to be expensive and take a long time to implement (WHO, 1993). Alternative approaches, including harm reduction strategies, may be equally or more effective than demand reduction programs. These include education on the need to reduce needle-sharing, instructions on cleaning and disinfecting injection equipment and bleach distribution and needle exchange programs (WHO, 1993).

D.5. Socio-cultural factors and drug use

J. Westermeyer, (1999) opined that various social and cultural groups use alcohol and drugs in diverse ways, from recreational use to sanctified use, from medicinal use to ritual use. Some groups officially forbid substance use through their laws or religious proscriptions but nonetheless tolerate use. Typically, a group forbids the use of some psychoactive substances and abides, or even prescribes, the use of other psychoactive substances. These patterns of use and nonuse have been well described in the literature; however, it is a great leap from describing the use of psychoactive substances within a particular group at a certain period of time to hypothesizing specific etiologic factors for substance abuse in the socio-cultural realm.
An even greater step lies in not merely hypothesizing such factors which is easy enough to do after a brief survey of the relevant literature, but in actually demonstrating conclusively that such etiologic factors do exist.

Since the use of culturally alien recreational drugs is often associated with people living more or less deviant lifestyles of thieves, artists, homosexuals, homeless, ravers etc, this class of people is exposed to a higher than normal level of scrutiny by the forces of law and order, making their chances of being caught in some sort of illegal act larger than the rest of the population. This expands the image of a nexus between drugs and deviance/crime (Cohen. Peter, 2000).

Poor people also have more reason to use and trade drugs in ways that help them adjust to adverse conditions, than richer people. Opiates for instance are a good downer, helping one to feel less social and mental pain—much better than alcohol can do that. Trading heroin provides some income for those who find no productive position in the labour market. Summarizing, the drug crime nexus is partly constructed via poverty, and is therefore related to more general issues of wealth distribution.

So, drugs are related to crime for a series of reasons that are not tackled easily. These reasons are deeply embedded in our cultures and economies, and we can only hope to modify the connection between drugs and crime in a series of small steps.

Prior to proceeding to the empirical discussion of HIV positive IDU in Manipur, it is important to emphasize criticality of the issue. Beyond doubt, HIV/AIDS is a health, social, economic and cultural issue. Its extension and outreach is riddled with questions of cross-border manipulations and broader implications of drug-trade. Global society as a broad category has came to visualize itself as a consumer centric, profit making, body in which ethical questions of extent of pain to which individuals are subjected is inconsequential. The trade practices are not negotiated on ethical notions of ‘global ground’. It is due to this premise that a state like Manipur which is in the proximity of ‘Golden Triangle’ has become susceptible to ‘Drug menace’ and high penetration of HIV. Politics of drug and accompanying cost of people’s health are guiding interceptors in the framing if research questions for this empirical enquiry.

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