CHAPTER II

INTRA-VENOUS DRUG USER AND HIV/AIDS IN MANIPUR

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Global overview of HIV prevalence among the IDU population

A world-wide collation of data on IDUs yielded an estimate of their number at 13.2 million (0.3 per cent of the estimated 4 billion adult population) by the end of 2003. The majority of these, 10.3 million (78 per cent), live in developing countries. Further estimates suggest that the number of IDU for Western Europe are in the range of 1 to 1.4 million (9.41 per cent) and for Eastern Europe and Central Asia from 2.3 to 4.1 million (24.18 per cent). In South and South-East Asia estimates configure the number to be between 1.3 and 5.3 million (25.36 per cent). Estimates for East-Asia and Pacific range between 0.6 and 4 million (17.66 per cent). In North Africa and the Middle-East, the estimates go from 0.3 to 0.6 million and for sub-Saharan Africa the available figures indicate that about 9000 people are IDU. In the Americas, estimates for Latin America suggest between 0.7 and 1.3 million IDU and 21,000 to 35,000 in the Caribbean. In North America about 1.4 million people are IDU. Estimates for IDU in Australia and New Zealand are between 89,000 and 2,98,000.

Estimates of HIV among IDU were given for 84 countries and territories. HIV prevalence among IDU reported for the country as a whole or for the capital city of other site was less than 5 per cent in 43 countries and territories. For another set of 16 countries a national, capital city or other site prevalence was between 5 and 20 per cent. There were 25 countries that had an HIV prevalence of 20 per cent or more at a national, capital city or other site level, and of these 15 had at least one site with an HIV prevalence of 50 per cent or more (seven of these are in East, South and South-east Asia). Another set of 25 countries and territories with at least one report of HIV prevalence of 20 per cent or more at the ‘national’, ‘capital city’ or ‘other sites’ levels were: Belarus, Estonia, Kazakhstan, Russia, Ukraine (in Eastern Europe and Central Asia), Italy, Netherlands, Portugal, Serbia and Montenegro and Spain (in Western Europe), Libya (in North Africa and the Middle East), India, Indonesia, Malaysia, Myanmar, Nepal,
Thailand and Viet Nam (in South and South-east Asia), China (in East-Asia and Pacific), Argentina, Brazil and Uruguay (in Latin America), Puerto Rico Europe and Central Asia.

In Asia and Pacific, Injection Drug Users (IDU) and HIV prevalence among IDU in the age group of 15–64 years is 6,19,671. It can be classified into three categories-The Low, High and mid. South and South-east Asia. Eight countries in this region have an estimated IDU population greater than 100,000 (Bangladesh, India, Indonesia, Iran, Malaysia, Myanmar, Pakistan, and Vietnam) and seven states have an IDU prevalence among adults greater than 0.5 per cent: Brunei, Indonesia, Iran, Malaysia, Myanmar, Pakistan and Singapore. Six countries had reported less than 5 per cent HIV prevalence among the IDU (Bangladesh, Brunei Darussalam, Laos, Pakistan, Philippines and Singapore), whereas HIV prevalence of greater than 20 per cent were found for sites in India, Indonesia, Malaysia, Myanmar, Nepal, Thailand and Viet Nam. In India the highest HIV prevalence was found in Manipur State at 50 per cent to 81 per cent (WHO, 2002; Crofts. N., 2003). New Delhi reported a 45 per cent HIV prevalence among IDU (Reid. G, 2002; Dorabjee. J, Samson L., 2002), and in Mumbai HIV prevalence was reported as 7.4 per cent in 1998 (Dorabjee J, Samson L., 2002) and 24 per cent in 2000 (Reid. G, 2002). Unfortunately, much of the data lacked information on how the figures were derived.

2.2. HIV prevalence scenario in Manipur

Manipur is one of the six high prevalence states in India with HIV prevalence rate among pregnant women attending ANC being 1.3 per cent (Sentinel Surveillance, 2005). Manipur with hardly 0.2 per cent of India’s population is contributing nearly 8 per cent of India’s total HIV positive cases. More and more interior and hill areas are affected and many are yet to be covered. Estimated cases of HIV positives among the general population in the state are around 40,000. However, since the intervention project among the IDU (Rapid Intervention and Care (RIAC) has been taken up successfully in Manipur by Manipur AIDS Control Society (MACS), HIV prevalence rate among the IDU shows a declining trend from 1998 onwards with a seroprevalence rate of 72.78 in 1998, 66.02 in 2000, 56 per cent in 2001, 39.6 per cent in 2002, 30.7 per cent in 2003, 21 per cent in 2004, 24.1 in 2005 and 19.8 in 2006. There were no official figures available after 2006.
Though the sero-prevalence rate in Manipur has been brought down to 19.8 in 2006, it is still the highest in the world. The projected target is below 5 per cent by 2010 for any reported new infections.

Map 2.1.:  *The district wise HIV Infection in Manipur (Generated by N. Inaoba Singh based on the sero-surveillance report of the MACS, 2007)*

As the HIV/AIDS epidemic in Manipur penetrated into the general population from the Injecting Drug Users through sexual route, the situation among the women and children has become alarming. The infection has now spread to the female sexual partners of IDU and their children. We are now beginning to see recurrent waves of the HIV epidemic among women and children. Similarly, the prevalence rate among pregnant women has been on the higher side, 0.8 per cent in 1994, 1.32 per cent in 1997,
2.70 per cent in 1999, 2.04 per cent in 2001, 1.34 per cent in 2003, 1.67 per cent in 2004, 1.3 per cent in 2005 and 1.4 per cent in 2006. The trend has not stabilized.

Map 2.2: Distribution pattern of HIV infection in Manipur (Generated by N. Inaoba Singh based on the sero-surveillance report of the MACS, 2007)

In Manipur, out of 1,91,793 blood samples screened up to March 2007 the total number of HIV positives is 25,905. Among them, 6,110 are women. As per Sentinel Surveillance report 2006, the rate of HIV prevalence among the various categories of population is as follows:

1. Injecting Drug Users : 19.8 per cent
2. Female Sex Workers : 11.6 per cent
3. Men having sex with men: 12.4 per cent
4. Pregnant women : 1.4 per cent
5. STD patients : 4.8 per cent

Table 2.1: Surveillance Report from September 1986 to March 2007

<table>
<thead>
<tr>
<th>Sr. No.</th>
<th>Particulars</th>
<th>Sero-Surveillance</th>
<th>Sentinel Surveillance</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Total no. blood samples screened</td>
<td>1,27,164</td>
<td>64,629</td>
<td>1,91,793</td>
</tr>
<tr>
<td>2.</td>
<td>Total cumulative positive cases</td>
<td>19,997</td>
<td>5,908</td>
<td>25,905</td>
</tr>
<tr>
<td>3.</td>
<td>No. of females</td>
<td>6110</td>
<td>-</td>
<td>6110</td>
</tr>
<tr>
<td>4.</td>
<td>No. of AIDS cases</td>
<td>4030</td>
<td>-</td>
<td>4030</td>
</tr>
<tr>
<td>5.</td>
<td>No. of deaths</td>
<td>589</td>
<td>-</td>
<td>589</td>
</tr>
</tbody>
</table>

Source: MACS, Annual Report 2008

2.3. Drug addicts in HIV/AIDS web

The menace of drug abuse has engulfed HIV as intravenous drug users fall prey to HIV/AIDS. There are 200 million drug users in the world and 25 million users are in the age group of 15-19 years. (World Drug Report: 2007). According to report released by the United Nations Drug Control Programme (UNDCP) there were about 2.5 Million drug addicts in India by the end of 1997, of which only three lakhs had registered for treatment. In the North-Eastern part of the country the situation is more grim, one reason being the easy influx of drugs from the neighboring countries across the border. It has been established beyond doubt that sharing of needles by these habitual Intra-venous drug users encourages the spread of HIV infection. Our lawmakers and managers have once again failed to crack upon the lumpen elements of the society. The people in power appear quite indifferent to an early end to this menace.

Manipur has witnessed varied responses towards the issue targeting the IDU in particular. In the early days the response was all based in taking up punitive measures against the people who use drugs or were found selling drugs. Harassing, humiliating, shaving hair, blows with Chapals and painting their head with Haldi and taking them out on the streets as a mark of punishment was a routine feature. It was followed by
publishing pictures and details of users and peddlers in newspapers. Burning and destroying of houses and properties suspected to be of drug peddlers was also frequently observed.

It is not that the central ministers are not aware of the situation in the north-east. Union Health and Family Welfare Minister Shri A Ramdoss recently confirmed the same as he said that Manipur and Nagaland are among the “high HIV/AIDS prevalence” states while Arunachal Pradesh and Mizoram are termed “vulnerable”. India has 5.134 million HIV patients, where, 103,857 cases are said to be of full-blown AIDS on the last count. Statistics of the National AIDS Control Organization (NACO) reveal that 1,114 people died of AIDS till March (2004), because of drug abuse since 1984.

North East Region becomes rather vulnerable to thriving market of drug trafficking. The easy availability of heroin and other illicit drugs in the region are responsible for such a high addiction rate in this region, especially in Manipur. Apart from the conventional stuff such as ganja, alcohol opium, pharmaceutical drugs like Spasmoproyvon (SP), Phensedyl and other cough syrups, Nitrazepam, Dextroproxyphene are being increasingly used for “kicks”. It then shifts to injecting with needles shared by multiple users. This creates congenial environment for HIV transmission among the users. If Manipur is identified as a high-incidence zone for AIDS, Mizoram has hit the headlines in the newspapers for the death of more than 940 youths because of overdose of drugs.

Many significant changes have occurred since the onset of HIV/AIDS in Manipur as far as drugs and the response towards the issue of AIDS is concerned. Reports of ill-treatment by the community, harassing vulnerable groups such as sex workers and IDU by law enforcing agencies have reduced remarkably due to intervention programmes which are designed to prevent occurrence of such events. However, role of armed forces in drug abuse management remains ambiguous and contentious. Armed Organization Groups (AOG) members continue to be a strong force behind drug peddlers. These organizations also project a public front by punishing users. They would sometimes beat them and even shoot bullets on thighs or head if necessary. The drug addicts were looked down by the people. The armed militants also involved in the drive against drug addicts a
asked the addicts to surrender to organizations working against drugs lest they would be killed. There were at least 200 reported cases of bullet shots received by drug addicts and fired by armed militants for failing to abide by their command.

There were also reports of ‘death penalty’ to drug pusher by an AOG during this period. There is a sharp increase in the seizure of pharmaceuticals drugs especially SP. It was reported in the Rapid Situational Assessment (RSA) conducted in 1999 that only about 1 per cent of the users in Imphal are pharmaceutical drug users including Dextropropoxyphine/ Spasmoproxivon popularly known as SP in the street (Singh. Dhaneswar, and Sharma. Mukta, 2000). In November 2004 it was reported that since Narcotic Drugs and Psychotropic Substances Act (NDPSA) was enforced, 800 cases were registered and 550 charge sheets were submitted. However, only 36 drug peddlers were convicted. A sharp decline in the infection rate among IDU is also reported in this period (from above 705 to below 30 per cent as reported by the MACS in September, 2004).

2.4. Drug abuse and HIV/AIDS in Northeast with special reference to Manipur

The northeastern region accounts for less than 3 per cent of nation's 1 billion plus population while it is home to more than 30 per cent of the country's total intravenous drug users. The number of injecting drug users in the northeast is more than 2 lakh, a majority of whom are believed to be infected with HIV/AIDS. More than half of the drug users of the region are in Manipur alone. In terms of HIV infection, northeast region alone has a total number of 1.01 lakh HIV positive people with more than 20,000 injecting drug users, raising serious concerns about the spread of the disease through injecting drug use. Sharing of needles by drug users in the northeast rather than promiscuous sex has led to a quantum increase in the number of AIDS cases. Drug use is a powerful source of stigma and discrimination, and people who have acquired HIV through injecting drug use face a double stigma. They are marginalized and discriminated against on the basis of their drug use as well as their HIV status. They may also face stigma and discrimination on the basis of their race or sexual orientation. Therefore, for many, drug use is often inter-related with discrimination, lack of economic and social empowerment, and minority status. (National Institute of Social Defense, 2005:3)
2.4.1. Golden Triangle and menace of drug use in Manipur

Geographical proximity of the state with Golden Triangle and its market potential have played a crucial role in the existing IDU-HIV/AIDS crisis in the state. The crackdown of drugs in international market in the Mexican region has made an impact on the South-Asia drug manufactures. The stringent laws in Thailand and neighboring countries of the Golden Triangle had compelled the peddler to change its trade route/course. In these countries, drug addicts as well as peddler and dealers were hanged to send out a strong message. This compelled dealers to use alternative routes to transit drugs to rest of the globe. Consequently, Manipur and other states in North-East India became the safer drug routes for the traders to reach the international market.

The previous route for supply of drugs from golden triangle to other parts of the world happened to be Thailand and other Asian countries. Now, the preferred route is Indo-Myanmar passing through Moreh-Imphal-Dimapur-Guwahati-Kolkata. From there, drugs are exported to the rest of the world.

The cost of one kilogram of Heroin was just Rs.1,000,00/-only in the ‘70s. The smugglers made huge profits out of drug trade. Sometimes they earned three times of the capital investment. Moreover, one kilogram of Heroin was given as free/commission for taking three kilograms to the international market. This allowed business men to earn quick money. The peddlers were not concerned about the damage and loss of human life because of heroin trade. The common people as well as the peddlers were also not fully aware of the ill effects of Heroin at that time. They only knew that ‘it is a white powder which is very expensive in the international market’.

The traffickers did not know about the quality of Heroin. So, the suppliers were asked to confirm about the quality of drug at the time of selling heroin. Heroin normally takes seven seconds to show its effect after consumption. The buyers were allowed to inject on the spot to confirm its quality. It also serves as a measure to check the originality of the white powder i.e. Heroin. This mode of testing was a norm while buying the drug. Most of the pioneer businessmen of Heroin were young people from Manipur and became addicts due to such practices.
The clever trader wanted to have their own captive market. The local business men introduced it to the local youths by administering the dose for testing. It was free for the first three dosages. The first reported use of drugs in Manipur was in 1975. They used drugs orally as smack and continued doing so till 1985. Heroin was available at every nook and corner of the state that one could access easily. It was even available at tea stalls or pan shops.

The heroin is the most purified form of morphine which includes four steps of purification involving a chemical process. It is very addictive. Individuals having used it for three to four times fall victim to its addiction. The addicts find it difficult to tolerate its withdrawal syndrome viz. its strong urge, nausea, dizziness, lethargy, pain and restlessness. Their minds are always preoccupied, planning how to get their next dose. Most addicts require three to four dosages a day depending on the extent of addiction. They are desperate to get money to buy drugs to get rid of the withdrawal syndrome. Many steal household items like Khudeng, Samuk, Phanek, Khusai etc. to get money to buy drugs. Subsequently, drug related crimes have increased in the state. There was a reported case of murder in Singjamei by a drug addict to get money for drugs. Crimes relating to addiction keep growing in numbers. There were no effective laws to control the addicts.

Community Based Organizations [CBOs] started working against drugs in the state from early 1990s after there were many reported cases of crimes due to drug addiction. There were number of organizations involved in controlling the menace of drug addiction such as Meira Paibi and armed groups. The addicts were caught by these organizations from different areas and kept in makeshift camps in school premises, stadium and public halls. Their heads were shaved and they were forced to stand at public places, holding placards confessing that they were drug users and displaying many similar insinuating statements. This was display of public anger. Organizers of such protests thought public humiliation will force the addicts to give up drugs. It was intended with the idea to injure the psyche of drug addicts but it only compounded their problems.
In 1985, Narcotics Drugs and Psychotropic Substances Act came into force. Under this act, any person carrying 25 mg of heroin can be caught and released after assurance for treatment. If he carries more than 25 mg, he can be kept in jail for three years and fine one lakh and if caught for two times, he will be imprisoned for twenty years. This act has empowered the police force. They started intensive drive to control it. The massive drive to catch peddler, dealer and users slowly gained momentum. Small shopkeepers were afraid to sell Heroin openly. Any person found with needle/syringe and mark of injection on the arms and legs were caught by the police on the charge of being a drug user.

The drug addicts moved together from one secret location to another after the police crackdown. They have stopped carrying needles and syringes with them. They kept the needles and syringe in a secluded place known to everyone in the group. A secret language or code was used for sharing. Needle sharing among the users helped addicts to evolve a sense of oneness among them. They would communicate to each other through symbols and sign language to share information about hiding joints and tool kit used for injecting. The same syringe and needle was repeatedly used by many users. This helped them from being caught by the anti-drug activists and subsequently nurtured a strong bonding among them.

Pharmacists were also convinced to become part of the drive against the drug addicts. They were requested not to give syringes without prescription. Local Meira Paibi started catching addicts and called them as Hidak Kappa Mee (drug injectors) and sent them to police custody.

De-addiction centers started in 1982 in India. There were just 20 centers all over India. There were some NGOs working on drug addicts in Churachandpur and

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1 Narcotics Drugs and Psychotropic Substances Act, 1985: An Act to consolidate and amend the law relating to narcotic drugs, to make stringent provisions for the control and regulation of operations relating to narcotic drugs and psychotropic substances [*] to provide for the forfeiture of property derived from, or used in, illicit traffic in narcotic drugs and psychotropic substances, to implement the provisions of the International Conventions on Narcotic Drugs and Psychotropic Substances[. and for matters connected therewith.

Canchipur. Drug addicts from various parts of Manipur were brought to these de-addiction camps. The families were forced to pay a maintenance fee for keeping the addicts in the camp. The addicts were kept in a room of 6X5 feet dimension. Their hands and legs were folded with chains. They were offered just one meal through the day. They were provided with a mug to urinate. They were never brought out of their dingy rooms. The condition of these victims of drug abuse was like that of a prisoner in solitary confinement. These camps did not have competent persons to handle such cases. It was the most inhuman state of captivity. The addicts were tortured and beaten badly in these camps. Dated methods were used to induce fear among the addicts in the camps. The perpetrators argued that instilled fear will prevent them from using drugs again. The inmates were provided with minimum doses of Heroin to sustain in extreme cases when the victims could not live without drugs and showed severe withdrawal symptoms. There were fifty inmates on an average at a given time in these camps. It was an unethical approach. There was much criticism about the inhuman treatment of such victims (Personal Communication with Dr Khomdon, ex-project Director, MACS).

For a long time; HIV/AIDS was considered as European and American disease by the medical fraternity and government in Manipur. In a meeting with eminent doctors, the agenda for HIV was carried at the end and ended with a remark that it is not worth discussing in Regional Institute of Medical Science, Imphal. It was only after the first six cases of HIV were detected in 1990 from the blood samples of IDU in the state that the seriousness of the issue of the impending HIV epidemic was taken seriousness by health professionals. Dr. Khomdon also stated in his interview that it was only after this that those addicts who were kept in the jail were tested for HIV and those diagnosed to be HIV positive were isolated from the group.

Newspapers started carrying reports of HIV in the state from the early 1990s. It influenced the people and the government. It was due to this pressure that Law enforcing agencies like police started taking action against drug addicts but drug peddlers were by far left alone. Drug addicts were caught everyday and kept in police custody. Later, they were sent to jail. More than 500 addicts were kept inside the jail on charges of having consumed drugs in a day as per the records of the IG prison at that time.
Because of the past experience of those who were kept in drug de-addiction centers earlier, The Manipur AIDS Control Society initially failed to pursue addicts to come to their camps. Most drug addicts were apprehensive of the kind of treatment that they may receive in those camps. There were hardly any NGOs who were trained to handle cases of drug addiction and HIV related issues in Manipur. The scenario changed after the State AIDS Control Society started rescuing these inmates from prison like camps and gave an alternative friendly approach to them with harm reduction strategy. The agency started mobilizing for the establishment of professional NGOs in the state in the first phase of the intervention. In the first phase only six NGOs located at Imphal were made functional with complete financial and technical support from Manipur AIDS Control Society. It gradually gained momentum and the number of active NGOs in the state has now reached up to forty four.

MACS started massive campaign with counseling and testing for HIV. It was found that 75 per cent of the addicts shared syringes as mentioned earlier. In 1984, HIV prevalence among IDU was reported to be 50 per cent but in six months the reported figures shot to 80.7 per cent. This was one of the highest ever reported in the World in a short period of time. There were only five other cities in the world reporting similar prevalence trends among the IDU. In the process, Manipur acquired international prominence as AIDS capital.

Government and social welfare organizations approached Ministry of Health and Family Welfare for a detoxification drive in 1992. It was after this that harms reduction strategies were introduced in state of Manipur. NGO expansion also started simultaneously. There were 6-12 rehabilitation centers in the entire country at that time. The addicts were reported to relapse when they continued to live in their respective social environment. There were reports of 80 per cent cases of relapse in Manipur and 90 per cent cases in Churachandpur district alone. In 1995-96, the drive for detoxification was further intensified. National AIDS control Society started its intervention programmes under the World Bank funding. The needle syringe exchange programme was started; it was not successful in the beginning. Many persons and civil societies were against this proposed intervention strategy. They argued that such a strategy will encourage drug use.
However, against numerous odds, in October-November 1996; the Harm Reduction programme was started. It was promoted through a strong media campaign and a series of meetings and advocacy workshop with MLAs, bureaucrats and agencies. Harm reduction was now being enforced as a government sponsored programme. Initially seven to Eight NGOs were involved and were given a target of 5000 IDU who were to be
approached and introduced to the programme with the intent of becoming partners in the process of detoxification through a scientific understanding. The programme is pursued with enthusiasm till date. Former MACS Director informed during the researcher that intervention programmes currently running in Manipur now involved 45 NGOs with a target population of 21,000. Success of this programme as per the former director can be measured by the fact that the HIV prevalence rate has decreased to 19 per cent. This intervention programme, when launched was reportedly at that time the first and the biggest targeted Harms reduction intervention in South-east Asia.

2.4.2. Drug trafficking, geography and polity of Manipur

Manipur is situated in the easternmost part of the north-eastern hilly region of India. It is landlocked isolated hilly state having a distinct geographical entity. It is almost rectangular in shape with a valley encircled by hill ranges. The valley spread over an area of 2.007 Km², which is about 9 per cent of the total area of the state.

The total area of the state is 22,327 square kilometers, which constitute only 0.68 per cent of the total area of the Indian Union and is the smallest state in India. In terms of population, the state has recorded 2,293,896 persons including estimated population of 3-sub divisions of Senapati district in 2001, which represents only 0.22 per cent of the total population of India.

The state is bounded on the north by Nagaland, on the east by Surma Tract and upper Chindwin of Myanmar, on the south of Chin Hills (Myanmar) and Mizoram and on the west by Cachar District of Assam. According to the physical feature, the state may broadly be divided into two parts, viz., the hills and the Valley.

The hills comprise of five districts, namely Senapati, Tamenglong, Churachandpur, Chandel and Ukhrul; while the districts of Bishnupur, Thoubal, Imphal west and Imphal East fall in the valley.

North East region of India consists of seven states Assam, Arunachal Pradesh, Mizoram, Nagaland, Meghalaya, Manipur and Tripura. It has a long international border with Bangladesh on the west, Myanmar (Burma) in the east and China and Bhutan on the north. It is connected with the rest of the country through narrow passage. Assam serves
as a gateway for the other six states to reach to other parts of India, Nagaland and Manipur forms a major drug route from the “Golden Triangle” (Burma) with high prevalence of needle sharing habit among the injecting drug user (IDU). Moreover, the rise in drug smuggling and trafficking makes people vulnerable to various social problems.

The North Eastern Region comprises about 7.8 per cent of India’s land area, with 3.7 per cent of its total population. It is strategically located, bound by Chinese occupied Tibet and Bhutan to the North and West, Myanmar to the East and Bangladesh to the West and South, connected to mainland India by a narrow corridor in North Bengal. Specifically, the States of Mizoram, Manipur, Nagaland and Arunachal Pradesh share long borders with Myanmar to the East, across hilly, forested, thinly populated terrain. This critical location has had major implications for HIV-AIDS problem in the North Eastern Region. The NE States with the exception of Assam and Tripura are characterized by low population density (range 10 per sq. km in Arunachal Pradesh to 284 in Assam, compared with 267 at all-India level). Terrain is largely hilly, forested, with very poor road communications. Population is largely tribal living in small thinly populated villages. Rail communication is very poor, being limited to a few railheads connected by circuitous, long, poorly served routes. The only entry to the NE Region is...
through Guwahati in Assam. Road transport alone has to meet more than 95 per cent of
the transportation needs of the area, all the States being connected to mainland India
through Guwahati.

Map 2.5: Drug Trafficking Routes

The above factors, namely, location of the NER in relation to Myanmar, terrain, and
population characteristics have had major implications for the problem of HIV in this
region.

Manipur is experiencing an epidemic among young urban men, but there are
factors peculiar to this state that increase susceptibility. Manipur is geographically
isolated and culturally distinct from mainland India. It became part of the Indian union
only in 1949, after a brief period of independence following the departure of the British.
The relationship between Manipur and India even after its merger remained partly
colonial. The area remained starved of investment until it achieved statehood in 1972.
However, since then it has seen little in the way of development. It is this lack of
economic activity combined with disrupted livelihoods which underlies the high levels of
youth unemployment; and it is youth unemployment which underlies the huge numbers of people who have become injecting drug users. The state is now witnessing as the highest HIV prevalence state in India in terms of the population density.

Map 2.6: International Drug Routes.
Source: The Drugs

The other factors which encourage the use of drugs like morphine, Heroin and cocaine in the state as stated earlier in the chapter is easy availability due to its proximity to Myanmar (with which it shares a long border) and the Golden Triangle. Indeed, nowadays, the main drug-smuggling routes pass through Manipur and some of them have entry points in Imphal and Moreh. Opposition forces in the area suggest that these activities exist with at least tacit and perhaps active co-operation from politicians, state officials, and local civil servants as well as elements in the security force- some of whom
are outsiders and seek assignments to Manipur as an opportunity to make money to supplement their salaries.

The epidemic is geographically localized in relation to the rest of India, and it is not clear that this risk environment is one which will facilitate bridges of infection to the general population of the state or even to the Indian union as a whole (Barnett and Whiteside, 1996)

Myanmar, Thailand and Laos are notoriously known as the “Golden Triangle”. It takes ten kilos of opium to make one kilo of morphine, out of which an equal amount of Heroin can be derived. I have already stated that the production of Heroin in the “Golden Triangle” started increasing following the Crackdown on the Mexican Centers in the late 70s. By 1986, it accounted for over 20 per cent of the U.S.A. market. One of the interesting aspects of which drug trafficking is the “Fallout” of the drugs en route and stoppages where the peddlers/traffickers stayed for taking rest on the way to their

Map 2.7.: Trafficking in heroin and morphine seizures, 2005 (countries reporting seizures* of more than 10 kg)


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destination and selling drugs or involving people on the way to use drugs. Hence, Russia and China which do not produce heroin reported cases of addiction, when their territory was used as transit points.

Therefore, it seems quite natural that Manipur, which has a free border with Myanmar, receives surplus amounts of pure heroin for onward marketing. The cost of heroin increases depending on the distance from the source of manufacture. As a result, the chances of impurity also increase with the distance. The pure heroin can be taken in both injectible form (also known as “fixing”) and by smoking or “chasing”, whereas the impure form (brown sugar) can be just smoked or “chased”.

In the late 70s, major forms of addiction in Manipur were mild tranquillizers and methaqualone. Injectable morphine and pethidine were next to be used. Even in 1980, only 1 per cent of the addict in Manipur used to smoke heroin. Gradually, heroin substituted for other psychoactive drugs.

Heroin is sold in packets of different sizes costing between Rs. 20-50, and sometimes even for more per dose. It is readily available in Moreh town, North AOC, Checkon, Hatta, Lilong, Moijing, Churachandpur.

2.4.3. Injecting drug user and trafficking link

The IDU are also involved with casual sex with their sex partners. It is frequently recorded that a large number of HIV infected are also drug users or sex partners of drug users. Most of the women soliciting sex work are internally trafficked and are generally refugees from Bangladesh. There is insufficient data on internally trafficked drug addicts. The evidence that is available is relatively conflicting. A study conducted by Nedan Foundation in 2003 documented 60 sex workers coming from Bangladesh active in Dimapur, Nagaland bordering Assam. The study concluded that 50 per cent of the CSWs are not addicted to drugs. Contrary to this HIV/AIDS activist, researchers and popular opinion suggests that drug consumption among girls, particularly those going to schools and colleges of whom many are involved in the sex trade is on the rise. However, there is no documented study that can validate the assumption.
Trafficking in North East regions occurs at two levels there is the internal trafficking of children and women from conflict affected rural areas for domestic work and prostitution. Secondly, on an international level, there is trafficking of women to other South East Asian countries like Bhutan, Bangkok via Myanmar (Burma). The underprivileged sections of the society are deprived of basic livelihood. The local recruiters are able to woo them with initial incentives in kind or cash. They start using drugs in due course. Gradually, they become regular drug addicts and their mobility from one place to another gains momentum. The CSW network in the region is always on the lookout for such vulnerable women and girls. They use these opportunities to circulate the CSW from one city to other so as to gain more customers.

2.5. Culture and vulnerability of drug addiction in Manipur

Important contributions have been made by epidemiological research in establishing various transmission routes and causes for HIV infection. At the same time, there is very little information available about various social and cultural factors that influence unsafe behavior causing HIV. Social and economic conditions and societal/cultural features have to be analyzed in turn, first for various social and cultural attributes, then as interwoven groups of causes and effects.

Culture, often appropriated as an exotic collective, was believed by many to exist only in certain parts of the world. This was a myth that is repeatedly and conclusively challenged by anthropology. Human lives as lived in a day to day basis are end product of cultural practices and socially stipulated norms. It is this understanding that brings anthropological epistemologies in developing strategies for challenging further spread of HIV/AIDS. According to Yoder (1997), beliefs are used often as a proxy for culture, such that beliefs and knowledge of illness become the focus of “culturally appropriate” messages and interventions. In fact, the term belief is often contrasted with knowledge such that “belief is used to connote ideas that are erroneous from the perspective of biomedicine and that constitute obstacles to appropriate behavior” (Pelto and Pelto, 1997:148). Therefore, when “culture” and “belief” are coupled as in cultural belief, the resulting negative biomedical appropriation of the term becomes evident. As a consequence, culture is objectified and believed to be processed by non-health education.
campaigns that seek information about local idioms of expression to better communicate health message" (Yoder, 1997: 138). It is thus reasoned that individual practices or behaviors found in these groups could be labeled cultural and often appropriated as a barrier. Given this premise, “barrier” often becomes the coupling metaphor with culture. This by implication distracts epidemiologists from looking at positive belief systems and other cultural attributes that may facilitate transfer of appropriate messages.

There are three major themes that characterize perceptions about these notions of culture. First, culture is fossilized historical artifacts, which leads to such definitions as “culture is to a society what memory is to individual” (Kluckhohn, 1954). Second, culture is the observable aspect of individual behavior that is understood better by locating behaviors (particularly those that are unfamiliar) within individual beliefs. Such beliefs are distinguished from knowledge since the knowledge Attitude Practice Behavior (KAPB) model places these domains in separate locations on a parallel continuum. In fact, belief and knowledge are thus constructed as a binarism and belief invariably becomes a code for culture (Good, 1994), a barrier that must be overcome. A third theme is that culture is people’s ability to Control/dominate their environment. Thus the onus of responsibility for adopting requisite behavior rests in the individual. The assumption is that everyone desires to, and is capable of, changing their environment to suit their needs. Each of these domains is an aspect of culture.

The cultural politics of AIDS has caused the mobilization of many of these facets of culture with varying degrees of success. Mobilization of ethnographers to study these same risk groups has served a reductive function in terms of how culture is understood and conceptualized. “Despite their intention to break with the dominant public health models, most anthropologists are not really willing to distance themselves from the methodology and theorizing of what is perceived as ‘real’ science in public health” (Bibeau, 1997:247). This problem is evident in the tendency to create epidemiological categories, thus reducing culture to identifications of negative individual health practices in a subgroup of the population later generalized to be the definition of the larger group’s culture for instance intravenous drug users in their respective religious
and linguistic settings. Institutions that are recognized as universal become important research categories for locating vulnerability within existing social systems.

2.5.1. Impact of marriage on HIV/AIDS risk behaviors among impoverished couples

Institution of marriage is an integral and near universal component of culture. Various studies have advocated mapping of impact of marriage on HIV/AIDS risk behavior whenever possible, it is considered important by many to compare risk probabilities experienced by unmarried women in the sample with that of married women. This can be used to assess whether there is a protective influence of the formal commitment of marriage in this high-risk group. Prior studies among normative samples have generally demonstrated a positive impact of marriage on health (Waldron et. al., 1996). It has been suggested that marriage regulates conduct and encourages healthy behaviors (Anson, 1989; Umberson, 1987, 1992). Some of these studies on impoverished, highly stressed married couples also had history of severe substance abuse.

Some of these studies worked with the assumption that married couples will report fewer behaviors positively associated with HIV/AIDS risk such as multiple sex partners. These studies also looked into the possibility that marriage may not be protective in this sample. Marital status may, for instance, be relatively unrelated to the number of recent sex partners they report, or marriage may reduce condom use when such use would be warranted due to prior or current infidelity (Hirsch et. al., 2002), intravenous drug use (Seidlin et. al., 1993), unreported homosexual activities (Earl, 1990), or needle-sharing by one of the partners (Wells et. al., 1994). The greater trust and intimacy of marriage may increase some HIV/AIDS risk behavior such as more needle-sharing with the spouse. There is a belief or hope in the safety of monogamy even though one or both of the partners may not be “safe” due to prior or current risky practices (Hirsch et. al., 2002). Given this premise, the present study also looks into this factor to understand how individuals located in a different cultural setting respond to this presumable controlling attribute.
Mize et al., (2002) in another study report the effects of gender on HIV/AIDS risk behaviors and subsequent intervention strategies. Gender is an individual “within-subjects” variable in our sample of heterosexual couples. In research among at-risk men and women, Stein and Nyamathi (1999, 2000) found significant gender differences in behaviors and attitudes associated with AIDS risk. For example, Stein and Nyamathi (1999) found no relationship between stress and sexual risk behaviors for the men, whereas the relationship was powerful for the women. Stein and Nyamathi (2000) reported that men evaluated their risk of AIDS significantly lower than the women although they reported more sexual risk behaviors and equally risky injection drug use behaviors. The men also reported less HIV testing. These studies suggest that gender plays an important part in the perception of ‘risk’. Given that premise, HIV/AIDS message will have to incorporate this fact in deciding intervention modules. This consideration also guides data analysis in the present thesis.

2.6. Comprehending drug abuse

Various studies have demonstrated that in the intra-venous abuse, the nature of drugs that are consumed varies from time to time. In the first phase of substance abuse, the common drug consumed was Heroin. Then, when Heroin was not available, they started using pharmaceutical drugs like SP, N-10, and Cough syrup. They again took Heroin when their cost and availability was affordable to them. Many drugs pass through an epidemic cycle. Initially use is low. For some reason, not necessarily common to all substances, use begins to grow. Positive feedback kicks in, with existing users introducing new users to the substance, leading to a contagious spread. At that stage of the epidemic, drug use is virulent, and adding an additional user to the population could stimulate a chain reaction that eventually prompts the initiation of many others. Conversely, preventing one initiation may indirectly avert many others (Caulkins et al., 1999). The explosive growth stage does not continue forever. Eventually initiation declines, use stabilizes, and the epidemic moves into an endemic phase, usually with prevalence decaying slowly from its peak. There are various explanations for why epidemics peak and subside but one possibility is that when the drug’s negative effects become widely understood; fewer people want to start using the drug. In short, the drug...
acquires a negative reputation as being dangerous or linked with crime. There are two reasons why it takes time for such a negative reputation to develop. First, at the individual level, most users experience a honeymoon period of some years during which the drug brings them more pleasure than apparent harm. Second, at the population level, by the time the first users begin to manifest the ill effects of heavy use, they are surrounded by a sea of new light users who are still in their honeymoon period. Eventually the ratio of problem users to newer users increases because exit from heavy use is slow, but by the time harmful consequences are seen as a significant risk rather than a rare exception, several annual birth cohorts will have gone through their prime initiation years with the drug commonly available and perceived as relatively benign. Researchers (Musto, 1987; Kleinman, 1992) have long described these dynamics in qualitative terms.

Fig. 2.1: Flow chart of the LHY model (cf. Behrens et. al., 2000b)

More recently Everingham and Rydell (1994) and Behrens et. al. (1999, 2000) proposed a formal mathematical model Flow chart of the LHY model (cf. Behrens et. al.,
2000b) that captures these behaviors. Despite the model’s simplicity, it matches historical data on the US cocaine epidemic surprisingly well and yields important policy implications. Perhaps the most important and robust finding is that interventions early in an epidemic, during its contagious growth stage, can have a much greater impact on total use over the epidemic than can have comparable efforts later in the epidemic.

The above results are not surprising. With almost any positive feedback process, early intervention is powerful. Fighting forest fires is a familiar parallel from a different context. A principal implication of this simple observation is that law enforcement has an absolutely critical role in controlling the early stages of a drug epidemic. No other intervention mechanism has comparable capacity to focus on the early stages of an epidemic. Treatment is unhelpful for two reasons. First, during the explosive growth stage most users are in their honeymoon phase and are not interested in treatment. Second, removing problem users from the population would have a mixed impact on subsequent initiation. To the extent that removing heavy users erodes demand sufficiently that the market becomes sparse and inefficient, treatment may help. Harm reduction operates best when alternative substitutes are regularly used. This will happen only when drug to which an individual is addicted is not readily available. For this purpose effective legal and police control mechanisms need to be in place.

2.6.1. Legal context surrounding drug use

In some countries (e.g., China, Myanmar, India), drug users are required by law to register with the government and undertake medical treatment for their problem. A drug user who fails to register or refuses to take treatment may be sent to prison. Also, in some areas, individuals are required to report drug users to authorities, making it difficult for outreach workers to assist IDU in areas other than drug abuse treatment centers. Illegality of drug use presents a dilemma for governments in addressing the problem of HIV among IDU. In particular, it may be difficult for governments to approve harm reduction strategies because they are seen as condoning drug use. Some governments have been unwilling to address the issue head on due to legal constraints and the cultural context surrounding drug abuse. There has been some suggestion that non-government organizations (NGOs) may be able to provide some of these services in place of the
government. For example, in the U.S., private groups started implementing needle exchange programs even when possession laws were in effect. India has a vast network of NGOs and there is support for the idea of utilizing these networks for HIV intervention programs. However, NGOs may not provide a viable solution for other countries. For example, NGOs in Myanmar tend to be connected in some way to government departments (Stimson, 1994). Independent NGOs are rare, thereby limiting their capability to act on behalf of IDU.

**Drug enforcement policies:** Policies directed toward reducing drug supply and those toward reducing harm may be conflicting. Drug enforcement policies have the goal of reducing supply, which increases the price of drugs. As mentioned previously, drug users may switch to injection as a more efficient route of administration when supply of drugs are limited, an unintended and undesirable effect in terms of reducing risk of HIV infection. Also, in many countries, drug addiction is the responsibility of both law enforcement and the health sector, which can lead to conflicting aims and practices. Increased law enforcement efforts against drug use make it more difficult for health workers to provide services to IDU. In addition, in some countries, the government and/or the military is involved in the production and distribution of drugs, either taking an active role through direct involvement or a passive role in taking bribes to look the other way. This has implications as to how far governments are willing to go to control drug abuse.

**Reducing control costs and associated harms:** the choice before society is crucial concerning drugs and their prohibition. Prohibition reduces use, but creates high costs of control, including black markets. Legalization eliminates most costs of control, but risks greatly increased use and attendant problems. As Mark Kleiman (1992) puts it, you can choose your drug problem (one of use or one of control), but you can’t choose not to have a problem. With respect to most psychoactive substances except alcohol and nicotine, most countries have opted for prohibition. That typically means that what Weatherburn and Lind (1999) call ‘direct harms’ of use are modest whereas the ‘induced harms’ from control efforts are larger. Hence, reforms that simply reduced those induced harms, without doing anything to affect direct harms, could make a valuable contribution.
contrast, improving the administrative efficiency of tobacco excise tax collection would have minimal impact on the total social cost or harm associated with tobacco use.

Caulkins and Heymann, (2001) suggests that understanding the fundamental drug supply and supply control cost without additional cost is crucial in controlling the epidemic of drug addiction. In general, there is substantial variation in the drug sellers’ activities and the amount of harm generated by their conduct to others. The intensity of enforcement directed at the drug market in a particular region is a sharp example of diminishing returns/success (Caulkins, 2001) and sentencing laws to most problematic sellers for longest term does a poor job (Sculhofer, 1993; Human rights Watch, 1993). This could be improved with certain changes in the strategy with improvement in targeting so that the additional cost of targeting the mass drug sellers is significantly contained. It takes resources to target effectively. Sweeping the streets for low-level operatives is easier. But that fact that incarceration costs are large relative to investigation and adjudication costs may make such strategies viable. In effect, one would be calling for increased budgets for police and prosecution, but demanding that the criminal justice system arrest and convict fewer drug-offenders, thereby reducing incarceration costs.

Effective management of harm reduction and de-addiction programmes: Policies designed to curtail drug supply may have limited effectiveness, and in some cases may even cause a shift in drug transportation routes, thereby increasing the supply and use of drugs in areas around the new trade routes (Stimson, 1993; Stimson, 1996). For example, Mauritius experienced an increase in brown sugar heroin smoking in the 1980s as a consequence of becoming a drug trafficking country. New legislation and stricter enforcement of drug policies controlled this epidemic in 1987 and 1988. This was followed by a temporary reduction in the supply of heroin, but an increase in the consumption of alcohol and licit psychoactive drugs. Since 1991, heroin again has been on the rise, with the predominant route of administration through injecting (Stimson, 1996).

Drug enforcement policies which target specific substances also have had limited effectiveness, and can result in increased use of other drugs. For example, in India, as a result of active vigilance by the Excise Department and enforcement of strict legal
penalties on the heroin drug user population, there was a reduction in the supply of heroin and a corresponding increase in price. This brought about a decline in the number of exclusive heroin users, but these drug users instead switched to injecting synthetic opiates. While the injection of heroin decreased as a result of drug enforcement policies, overall injecting behavior did not change (Pal, et. al., 1990). This indicates that drug enforcement policies targeted at specific substances (such as opiates) may have the effect of decreasing use of that substance, but also have the effect of increasing use of other substances, resulting in no overall change in the extent of substance abuse.

Enforcement policies also influence drug trade routes. Prior to the 1980s there was very little use of opioid drugs or cocaine in West Africa. However, this area became an important trafficking route for cocaine from South America and heroin from South-East Asia en route for Europe and North America. Law enforcement efforts in Nigeria against transport and travelers originating in Nigeria have helped cause a shift in drug trade routes to the Cote d’Ivoire, Zambia and Zimbabwe (Stimson, 1993).

The policy of drug supply control has limited effectiveness in curtailing drug use. In fact, the final report issued by the WHO Multi-City Study group recommends that there needs to be a shift in commitment from law enforcement to strategies which focus on public health and social conditions in responding to the problem of drug injecting (WHO, 1994).

Involvement of the law enforcing agencies is very important both for effective management of harm reduction and de-addiction programmes. When law enforcement seeks to suppress drug use, its greatest curse is the amazing adaptability of drug markets. Push down in one place, and they pop up somewhere else, whether the displacement is physical (one location to another), temporal, or in terms of tactics (shut down street markets, and dealers switch to beeper-based delivery methods). When law enforcement seeks to suppress drug-related harm, its greatest ally is the amazing adaptability of drug markets. That is, law enforcement can turn the markets’ resilience to great advantage (Dorn & South, 1990). The difference is that markets have an intrinsic desire to meet demand (i.e. to provide whatever quantity of drugs is desired at the going price). Trying to block that desire is like trying to sweep back a flood. But markets have no similar
innate need to create externalities (harms suffered by others). By definition, market participants are indifferent to the level of externalities. In principle, all that sellers are careful about is its delivery i.e. the product and making profits. So if they can make a little more money by changing their tactics in a way that harms others, they will. But conversely, if they can make a little more money by changing tactics in ways that reduces harm to others, they will. Pragmatically, sellers may care about the welfare of others, including their customers, but the central point remains. Sellers are primarily motivated by something other than thwarting harm reduction. To borrow the terminology of competitive games, when law enforcement tries to reduce use, law enforcement and drug suppliers are in what amounts to almost a zero sum game, and the market will resist every effort by law enforcement to achieve its goal of reducing use. But when law enforcement tries to reduce harm, the game is no longer at zero sums.

There are ways of manipulating the market into achieving more of what law enforcement wants (less harm) without inducing push-backs by the market. The reason this is possible is that different distribution methods and tactics produce more or less harm per unit delivered or per dollar the sellers make. Shifting the market from its current form into a form that generates less harm per unit produced and distributed while keeping the quantity delivered constant will reduce total harm.

Given this theoretical premise and experience of previous researches cited here, the empirical study draws inference and inspiration from these works. documented in the following chapters

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