

Chapter 15

The social context of risk and protection amongst young people and women in Churachandpur, India

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Abstract

This chapter reports on two community-based studies of the social context of risk and protection among youth and the impact of AIDS on women and their families in Manipur in Northeast India. The studies were conducted in Churachandpur town and surrounding districts with largely tribal populations. The state of Manipur has a high prevalence of HIV, which is mostly transmitted through injecting drug use. However there is increasing concern about the risk of sexual transmission, especially amongst the general population of youth. The impact of AIDS on women and families is also of growing concern. Two qualitative studies were carried out to identify risk and sexual practices amongst general youth and to describe the social and economic effects of HIV and AIDS on women and their families. The studies were conducted as part of the SHALOM project, a community based program providing a range of services including home detoxification, a needle exchange program, and a home-based care program for people who are ill with AIDS. Peer-researchers conducted the studies using a combination of focus-group discussions and in-depth interviews. The youth study involved 17 focus groups and 12 in-depth interviews with men and women aged between 15 and 25 years, and the women's study included two focus-group discussions and 30 in-depth interviews with a range of women between 16 and 70 years of age. Among young people, the level of knowledge about HIV/AIDS and other STDs is relatively high, sexual activity at an early age appears to be common and the main barriers to protection against HIV and other STDs are related to social factors rather than to a lack of knowledge. For women and their families, the main effects of HIV/AIDS are the loss of economic security; increasing burden of work and responsibilities for caring for sick partners; and other diseases such as tuberculosis which affect the wider family including children.

Sexual intercourse is very common in our society. Most lovers have sexual relationships. It is in fact sexual desire first and love comes second! (a young unmarried man)

During premarital sex only about 3 out of 100 would use condoms...they would use only for prevention of pregnancy (a young unmarried woman)

With AIDS, our dreams have been turned upside down (a grandmother)

The two studies reported in this paper focus on the wider social context of risk and protection for HIV/AIDS among young people, and women and their families. The studies were carried

out in partnership between the first author, peer researchers and managers of the SHALOM project, in the town and surrounding district of Churachandpur, in the Northeast state of Manipur, India¹. Churachandpur has a population of approximately 37,000 people, most of whom are members of one of the many tribal communities which reside in this area. More than 10 different languages are spoken and the tribal communities are largely of Christian religion (Dena 1991; Sharma 1992; Khai 1995). The state of Manipur is one of the epicentres of the AIDS epidemic in India. Transmission in Manipur, unlike other areas of high prevalence, has been primarily through injecting drug use (Sarkar *et al.* 1991; Sarkar *et al.* 1993; Jain, John and Keusch 1994; Panda *et al.* 1994; Narain *et al.* 1994; Panda *et al.* 1994; Sarker *et al.* 1995; Hangzo *et al.* 1997). However, a number of quantitative studies carried out by SHALOM, a community based care program in Churachandpur, and ICMR (Indian Council for Medical Research) as well as consultations with youth, indicate that young people in the general population are increasingly at risk through heterosexual contact (Eichler 1996; Thomas and Bandyopadhyay 1999). Additionally, there is increasing evidence that although until recently most people affected by HIV were young men, women are now being affected both through their partners and through HIV within the wider community (Gifford 1997). In this paper, we discuss the main findings from two studies undertaken in collaboration with SHALOM, a community based program offering a range of services addressing the needs of people with HIV and AIDS. SHALOM has taken a leading role in addressing the AIDS epidemic in the state and is noted especially for its innovative programs which include home detoxification, home care for people who are ill with AIDS-related conditions, a needle exchange program and a number of youth education programs. It also offers HIV testing and counselling, and has recently developed a program specifically to meet the needs of women. The youth sexuality study and the women's impact study both grew out of a need to better understand the social context of risk and protection for these two populations. In the following sections, we first report on the youth study and then focus our attention on the women's study. In the final section, we show how the wider social and cultural context directly relates to behavioural risk factors and how this wider context must be taken into account in programs that focus on behavioural change.

The youth study: the social context of protection and risk for sexual transmission of HIV/AIDS and other STDs

Until recently, most of the research into the social and behavioural risks associated with transmission of HIV has focused primarily on the use of injecting drugs amongst the youth in Manipur (Sarkar *et al.* 1993; Sarker *et al.* 1995; Eichler 1996). However, as a result of the youth education programs carried out by SHALOM, concerns were raised about the very real risks of sexual transmission. Through community-based work with young people in schools,

¹ The SHALOM project is a community-based project which grew out of the local response to the impact of HIV/AIDS and is now fully supported and funded by government and community resources. SHALOM has from its beginning been a partnership between many community organizations and the Emmanuel Hospital Association, with technical assistance from the MacFarlane Burnett Centre for Medical Research, International Health Unit in Melbourne. The project has also received AusAID funding. The authorship of this paper reflects only a few of the many people who made these studies possible. We would like to thank all the young people who participated in the research including those who carried out interviews, and the women who participated and so generously gave their time, their thoughts and most importantly, their personal experiences to us. Thank you especially to Grace, Rody, the Tusing Family and the SHALOM staff for support in the field, and to Peter Deutchman and Tamara Kwartang for back-up technical support for this study.

it became evident that some who were not engaged in injecting drug use had sexual partners who were injecting drugs. This, coupled with evidence that it is common for young people to engage in sexual intercourse and to frequently change partners, suggests that many of them may be at high risk of contracting STDs including HIV. While there have been a number of studies about risk behaviour, including sexual behaviour, among people who inject drugs (Sarkar *et al.* 1993; Sarker. *et al.* 1995; Eichler 1996), no research has focused on sexual behaviour and risk of STDs including HIV among youth who are not injecting drugs. This study was designed to gather descriptive information about sexual activity and the nature of sexual relationships, knowledge about HIV/AIDS and STDs, and factors that act as barriers to harm reduction and prevention. The specific objectives of this qualitative study were to describe the nature of heterosexual relationships between young men and women, their frequency and the role of sexual behaviour within these relationships; to describe what young people understand about transmission and prevention of HIV and other STDs; to identify the barriers perceived by young people to prevention and treatment for STDs including HIV; and to elicit strategies for prevention that young people believe would be acceptable, practicable and effective.

Study design and methods

The methods used in this study were a combination of focus-group discussions and individual in-depth interviews conducted by trained peer interviewers, with young people between the ages of 15 and 25 years from different backgrounds. Focus groups are a good method for getting people to express a range of different opinions about a topic (Murphy, Cockburn and Murphy 1992), and in-depth interviews are good for eliciting information that people feel is too private to talk about in a group (Bernard 1988). For a study about sexual behaviour, the combination of both methods is particularly good because it allows us to gather information on group norms as well as information about the more private aspects of sexuality and risk. The study took place between April 1996 and April 1997 and a total of 17 focus groups and 12 in-depth interviews were carried out. Both focus-group discussions and individual interviews were guided by the use of a theme list (Hudelson 1994; Gifford 1998a), which was developed through a series of consultations with youth in the community, through church groups and through schools. The theme list was piloted and revised. Trained peer interviewers carried out the interviews and focus-group discussions. Analysis of the data took place both in Churachandpur and in Australia; the teaching materials and approaches were then used to train the peer interviewers. Notes were taken summarizing each group discussion and interview and these were analysed for major themes that emerged (Hudelson 1994; Gifford 1998b). Only the issues that were most commonly raised by participants in this study are summarized below.

The main findings

We began the focus group discussions by asking young people to describe the kinds of relationships they had with each other, how they went about meeting members of the opposite sex, when a girl or boy was first likely to have sex and the contexts of sexual activities. We were interested in the importance of boyfriend-girlfriend relationships and the place of sexual activity within them.

Relationships between boys and girls

When asked to discuss boy-girl relationships, all participants said that it is very common to have a girlfriend or boyfriend. One participant said 'People without a boy or girlfriend are looked down on'. The reasons for it being common to have a boyfriend or girlfriend focused on tribal culture being a very free society which encourages much fellowship and mixing among girls and boys. Participants said it is natural for girls and boys to mix. They gave examples of all the schools being co-educational and there being many student organizations in every college and school, for example the Hmar and Paite student organizations, all of which sponsor conferences and games where boys and girls mix. Churches were also described as playing a big role, with many youth activities, such as singing, that strengthened fellowship between girls and boys. Most young people said they join the choirs and go to church. Thus, boys and girls have many opportunities to meet and mingle. Indeed, very few if any social activities are regarded as being only for boys or girls.

As it is common for young people to have a boyfriend or girlfriend, it is also common for these relationships to include sexual activity including sexual intercourse. Asked when boys and girls usually had their first sexual intercourse, most participants said at the age of about 13 to 16 years. A few participants said girls were likely to start younger because girls matured earlier than boys. Thus, although Churachandpur is a Christian community and premarital sex is formally not allowed, and condemned by the churches, sexual activity among young people is common.

When participants were asked about the kinds of relationship they had and how long they tended to last, most said that relations last for between three and twelve months. A relationship lasting more than three years is believed likely to lead to marriage. Participants said that frequent change of partners is common and both boys and girls said that it is common to have more than one relationship at the same time. Boys were more likely to admit to having more than one girlfriend at a time. However, while girls also acknowledged that this is not uncommon, they were more likely to believe that their own boyfriends are faithful and that girls are less inclined to have more than one boyfriend at a time. Thus, it appears that girls think that their partners are faithful to them when in fact they may not be. This has important implications for the practice of 'safe sex'. Having more than one partner at a time may be less common in the more rural villages. One participant from a rural village explained that it was not common to have more than one relationship at a time because in the small community everyone knows everyone.

The kinds of relationship that young people describe vary. Girls were more likely than boys to say that sex only took place within a 'love relationship'. An important question arises about the extent to which a girl may consider a relationship to be one of love whereas her boyfriend may consider it to be for casual friendship and sex. Some girls explained that even if they knew the relationship was not a love relationship, they did not want to refuse a boy's request for sex because they were afraid they might lose the boy and thus lose the possibility of the relationship turning into love. Some young people explained that boys from richer families were more likely to be successful in attracting girls to have sex with them because, although the boys were only interested in sex, the girls hoped it would lead to a good marriage for them. This point is particularly important in a society where there are very few wealthy families and where poverty is the lot of many families. Thus, some young people in our study believe that wealthy boys may have a higher level of sexual activity.

The above findings raise a number of important issues: first, that there are strong social expectations among young people to have a girlfriend or boyfriend, and a young person who does not is likely to be looked down on. Second, many boys and girls begin their sexual

relationships at early ages, before sexual health education may be introduced into their school curriculum. This means that many may be engaging in unsafe sexual behaviour, partly because they have not had the opportunity to learn how to protect themselves. Third, girls and boys have frequent changes of partner and some have more than one partner at a time. Girls tend to believe that they are a boy's only girlfriend when in fact he may have more than one. This is important because of the low levels of knowledge and concern about STDs, and the fact that girls are more likely than boys to have sex in what they believe is a love relationship; they may therefore be less likely to protect themselves from STDs, because they believe there is no need to protect yourself if you are in love. Furthermore, girls tend to emphasize prevention of pregnancy in relationships by using the pill or the IUD, neither of which protects against STDs.

The context of sex

After exploring the nature of boy-girl relationships, we wanted to know about the specific social activities that lead to sex. Many participants, both boys and girls, explained that drinking the local alcohol *Zu*, a rice beer, was related to sexual activity. Young people gather at night and on Sunday afternoons, in or around the house of the seller of *Zu*, a favourite place for boys and girls to meet. Many sexual relationships begin here because, as they drink *Zu* together, the girls get drunk faster than the boys and many of the boys initiate sexual activities.

Other common places that people meet and where sex is initiated are the many social gatherings. Lamka is known for its many social activities and conferences and it is common for many of the young people to arrive drunk, especially the young men. Sex is commonly initiated after these activities end. Other meeting places connected to sexual activity are the traditional funeral services called *Lengkhwm*, where single girls and boys between the ages of 16 and 30 years sing all night long until morning, for the entire time that the body is in the house. Few older or married people attend, but it is common for up to 200 young people to attend these all-night *Lengkhwm* and for both boys and girls to drink *Zu* all night. Boys and girls come to the *Lengkhwm* in mixed groups; boys mostly bring girls with them, either their girlfriend or someone who lives near their house. While it is rarer for girls and boys to come on their own, it does occur and it is common for single girls and boys to find partners at *Lengkhwm*. Thus, the freedom they have for the whole night, coupled with the drinking of *Zu*, provides many opportunities for sexual activity.

The tribal festivals were also mentioned as important events for meeting each other. Participants mentioned one of the largest such festivals, *Kut*, where boys and girls often drink, mix freely during the long nights and again, have many opportunities for sexual relationships to develop. Other events commonly mentioned occurred on Christmas Eve when all-night church services and Christmas Eve parties are popular. Parents will allow children, especially at Christmas, to have parties in their homes, and these often-unsupervised gatherings afford numerous sexual opportunities.

Other places mentioned, where boys and girls meet, but not where sexual activity takes place, are the cinema hall, video hall, hotels, *pan* shops, open spaces and schools. Some said that they lie to their parents about where they are going if they are to meet friends of the opposite sex. They tell their parents that they are going to church but then go to meet their friends.

We asked about types of sexual activities including casual sex, paid sex and extramarital sex. Casual sex was mentioned by many participants as being very common: 'you don't need a boy or girlfriend to have sex'. There were mixed opinions about extramarital sex; a number of participants said that extramarital sex was practised and one

person explained that this was especially the case among 'high officials'. About a quarter of participants said that paid sex was common, especially for boys in hostels and colleges. During all these conversations, the young men emphasized that for boys, having sex was considered important because it was 'very manly'.

Thus, there was strong agreement that premarital sex was very common and there were many social activities that provide opportunities for these encounters. The drinking of *Zu* seems to facilitate sexual activity for boys in particular and there appears to be considerable social pressure to engage in sex as it is part of 'becoming a man'. In sum, for the participants in this study, having a girlfriend or boyfriend is socially very important, having sex is very common and there are many social activities, coupled with the drinking of *Zu*, which facilitate sexual activity.

Young people's knowledge about HIV/AIDS and STDs

We asked participants what they knew about the causes of HIV and AIDS, their prevention and treatment, and then about other STDs. Overall, participants had a good knowledge of HIV and AIDS but less knowledge of other STDs. Most saw HIV as a virus or referred to it more generally as a 'disease'. The routes of transmission mentioned most frequently were sexual intercourse, blood transfusion, mother to child, and sharing of needles. Other less commonly mentioned routes were sharing a toothbrush, razor blades, sex with an infected person, sex with a street girl and sex with prostitutes. However, when asked about prevention, only about half of the focus groups and half of the individuals interviewed mentioned the use of condoms. Two people said oral sex could prevent infection. No one mentioned not sharing needles. Other methods of prevention mentioned by at least one participant included sex education in schools, masturbation, locking up AIDS patients, cleaning oneself regularly, having only one partner, sex without intercourse; infected persons should not fall in love, boys should stop having sex with prostitutes, and prostitutes should be killed or locked up. A wide range of preventive strategies was mentioned with little common agreement about the use of condoms and no one mentioning clean needles.

When asked about treatment for HIV/AIDS very few people were able to give a clear answer. Some said that HIV/AIDS was incurable, that treatment would only prolong the infection and that most treatment was not effective. One participant said 'For AIDS, you don't need to go anywhere because you are going to die anyway'.

There was far less knowledge about other STDs. When asked about different kinds of STDs, most commented that they knew of *dadu*, the local term for venereal disease, with other common responses being VD, syphilis, and HIV/AIDS. Less common responses mentioned by at least one person included colour blindness, gonorrhoea, and haemophilia. The most common response about routes of transmission was sex with prostitutes, and general sexual intercourse was the second most common response. Other responses included having more than one partner, bad hygiene and irregularity of menses. Only about half of the focus groups and half of the individual interviews mentioned condoms as the best form of prevention. A significant number explicitly stated that they did not know how to prevent STDs. The variety of responses about prevention included oral sex, washing oneself, having only one partner or only having sex with a known person, and going to the doctor. Learning more about STDs was also mentioned. There were no responses about treatment because people had no knowledge of this. But they did say that confidential treatment was important because Churachandpur is a small community and they did not want to go to their own doctors for fear of others finding out. Participants were not able to name any symptoms or any specific STDs. It is important that there was very little knowledge about STDs, few knew how to recognize symptoms and no one knew anything about treatment. Thus, while young

people appear to know quite a lot about HIV, how it is transmitted and how to prevent it, they know far less about other STDs. Furthermore, it is uncertain how much they think they may be at risk of either HIV or other STDs. They appear to equate HIV with intravenous drug use, and given the reluctance to use condoms, the real risks of HIV may be a lot greater than young people perceive them to be. There is a worrying lack of knowledge and indeed, concern about STDs. Young people tend to associate STDs with prostitutes and girls say that you can avoid STDs by having sex with a person you know well (love affairs). Because of the lack of knowledge, the lack of concern and the fact that boys say they have more casual sex, while girls think that their boyfriends associate only with them, young people may be at particularly high risk of STDs. There may also be a significant rate of undetected STDs among these young people as they do not appear to know much about the symptoms.

What about condoms?

We asked young people to talk more specifically about condoms. Do they know about them? Do they use them? Why or why not? A response by many participants was that most people do not use condoms. The reasons for this varied but included opinions that condoms reduce pleasure, genuine lovers do not use condoms, people are too shy to buy condoms because people will know they are having sex outside marriage, people do not use condoms because they are not convenient, people who carry condoms are laughed at by others, people do not use condoms because they think there is not much danger, condoms should be free, and people use condoms, pills, and IUDs to prevent pregnancy.

What emerges here is that the problem of condom use for young people is not that they lack knowledge about their use to prevent STDs including HIV. Instead, other factors that acted as barriers to their use were identified as being more important. For example, participants explained that sex is not something that is planned. Instead, it just flows from previous social activities of young people. There is also a shyness about condom use, which can become especially 'shameful' for boys if they do not know how to put the condom on. Thus, boys risk 'failure' if they do not get the condom on at the right moment in the right way. Finally, young people found it very difficult to buy a condom because if they went to the chemist, everyone knew that they were having sex outside of marriage. Several participants said condoms should be sold in the *pan* shops. Young men said the only situations where condoms are used are when men visit prostitutes, or if they know the date and time they are going to have sex, which is more likely with married people.

In sum, there are a number of important barriers to condom use, none of which appear to be related to a lack of knowledge. Instead, there appears to be strong social pressure not to carry condoms and not to buy condoms. For boys, a condom is also seen to spoil the fun and worse, may be the cause of a very shameful encounter should the boy fail to put it on correctly.

Other important issues

The end of the interviews and focus groups was reserved for wider discussions about other issues including health services. Regarding health services, participants said that young people are too shy to go to the District Hospital and the Christian Hospital for sexual health problems because of the small size of the community and the fact that people will most likely find out. They said they would prefer to go to a 'local named doctor'. These doctors often do not have formally recognized qualifications but are preferred because they are not from the locality, and are non-tribals from outside the district. However, it was also important to go to an experienced person such as nurses and trained health workers. Private clinics are

considered more reliable and preferable to public clinics or hospitals. Males wanted to see male doctors and females preferred female doctors. For information about STDs and HIV/AIDS, participants said they would prefer to talk to young mothers or fathers whom they know well, or to close friends. Some participants mentioned the need for a confidential communication system. Health education in schools was seen as important. It was mentioned that parents did not talk about sex.

Social context, risk and protection

A number of important themes emerged from this research indicating that lack of knowledge is probably not a major barrier to young people's practice of safe sex. Rather, the wider social context of sexual practice is likely to influence safe or unsafe behaviour. The main issues identified by young people in our study were as follows.

Having a boyfriend or girlfriend is socially very important; sexual relationships before marriage are very common; there are many opportunities for sexual activity among youth but there are few opportunities to acquire condoms. Sexual activity begins for many between 15 and 16 years of age, but also earlier for a considerable number.

There appear to be good levels of knowledge about HIV/AIDS and condoms; there is very little awareness about other STDs. In fact, young people appear unconcerned about the risks of contracting STDs. Girls know less than boys about STDs; young people think STDs are not common and are only acquired from sex with prostitutes.

Barriers other than lack of knowledge hinder the use of condoms among youth; these barriers include embarrassment, fear of being seen buying condoms, and lack of skill and confidence in negotiating condom use with a partner and in their actual use.

Boys believe that people may have more than one partner at a time; girls believe that people only have one partner at a time. Girls are more concerned to prevent pregnancy than to protect themselves from STDs; they are more likely to be in love before they have sex or to have sex in the hope that the relationship will develop into a love affair. Boys are more likely to admit to having sex for pleasure.

Some participants are confused about the concept of safe sex and think it means refraining from sexual intercourse with a stranger or washing with warm water after intercourse.

The women's study: the social impact of HIV/AIDS on women and their families

Turning now to the women's study, again we find that the wider social context of women is important for understanding issues of risk and protection for HIV/AIDS. The descriptive study among women focused primarily on the experiences and needs of women affected by HIV, and on the social and economic effect that this disease has on their daily life. The background to this study is based on evidence that women are increasingly becoming exposed to HIV through their sexual partners, greater numbers of women are injecting heroin and other drugs, and many women are employed in a complex and growing industry of commercial sex. Women are increasingly faced with the burden of care for husbands or partners who are ill with AIDS. When they become widowed, women lack economic support, and in some cases their children are taken from them and cared for by the family of the husband's elder brother. In addition, evidence suggests that women's reproductive health is also affected by a heavy burden of sexually transmitted diseases and other illnesses including tuberculosis and liver complaints. This further affects the economic and social conditions in their daily lives.

The overall aim of the women's study was to use participatory rapid assessment techniques to gather preliminary descriptive information about the needs of women who have been affected by HIV/AIDS, and to document its social and economic impact on their lives. The specific objectives were to identify barriers encountered by women to harm reduction strategies relating to intravenous drug use and prostitution and through their sexual partners; to describe the range of STDs including HIV/AIDS that affect women's health in general and their reproductive health more specifically; to describe the range of health and social services available and used or not used by women in relation to STDs and HIV/AIDS; to describe the social and economic impact of HIV/AIDS on women's lives; and to develop and test with women participatory ethnographic techniques that they can use to document the economic, social and health impact of HIV/AIDS.

Study design and methods

As with the youth study, we used a qualitative design; however in the women's study we used a combination of participatory, rapid-assessment techniques which included participant observation, informal and formal group discussions and in-depth interviews. A peer approach guided the research with women as much as possible. A purposive sampling technique was used to target women and health care providers (Patton 1990). Two groups of women were sampled: women who themselves are affected by HIV or AIDS either directly through their own health or through the health of their husbands or partners; and women who are leaders and opinion makers. A third group of health care professionals who provide services directly to women was also sampled. This group was included so as to obtain information about the kinds of problem for which women seek care and advice, as well as the concerns among health providers in being able to meet the needs of women. The sample included in-depth interviews with 23 women affected by HIV/AIDS: seven were infected or at risk of HIV through personal risk factors including injecting drug use or prostitution, and 14 were affected through their partners or families. Two focus groups were held, one consisting of five women church leaders and one with five women social leaders. Seven in-depth interviews were held with health care providers or professionals. The interviews were recorded by taking notes during the interview and typing the notes up immediately after the interview; full summaries were then checked for accuracy.

Main findings

One of the overriding themes in the women's study was that HIV/AIDS affected women's lives in various gender-specific ways, depending on their roles as wives or sexual partners, as grandmothers, mothers and mothers-in-law. This became even more complicated for women who were themselves infected with HIV or AIDS.

For a woman with a husband or son-in-law infected with HIV or AIDS, the burden of caring for him significantly affected her ability to care for the rest of the family and especially to earn income outside the home. For example, women who had sick husbands spoke of the difficulties of juggling the daily burden of caring for both the husband and the children, having to earn an income outside the home to replace the husband's income, and not being able to meet the mother-in-law's expectations about housework and cooking.

Mothers-in-law told of the difficulties of keeping an extended household together when the sons were no longer able to work, and the expenses of caring for sons, grandchildren and daughters-in-law when other sons who were not infected might be spending family income and selling family property to support a drug habit. Women who were grandmothers

and mothers-in-law felt especially bitter as this was the time of life at which they had looked forward to being looked after.

When women themselves were infected with HIV, they said that they were often accused by their in-laws of wayward behaviour and of leading their husbands astray. While men in general were looked after by family, many of the women interviewed who were ill with AIDS, said they often had no one to look after them. As widows, when their husbands died, women faced a number of additional burdens. In the patrilineal kinship system of the area, women live in the household of the husband's elder brother. When a man dies, his children are expected to remain with his elder brother's family. Thus, widows spoke about their dilemmas: often they were no longer welcome in the husband's family and if they wished to return to their birth village, the children were not allowed to return with them.

Wives and mothers-in-law all told of the financial hardships they faced when sons in the extended family died. One woman told how her husband had pawned his widowed mother's house and land to the drug pedlar and so when he died, the women in the family were left not only with no home or economic base, but also with a debt that they could never hope to pay off. These big debts were a major concern to women and they pointed out how useless were many of the income-generating projects, such as sewing. Although they could assist in income for food, these schemes would never be able to help women to overcome their great debt. For some women, this cycle of debt leads them to work in the commercial sex industry.

Women also felt particularly helpless as mothers and grandmothers, and as parents of young adult children. While they said 'Our children are our lives', many of the older women felt that they lacked skills as parents. One woman said 'Our daughters are ashamed of us', because many of the older women had not learned to read and were not able to discuss current affairs. Thus, they felt they were outsiders in the lives of their daughters. Grandmothers told us that they were often the primary carers for their grandchildren yet could not even help the little ones to learn to read.

Finally, illnesses other than HIV/AIDS were identified as far more burdensome in the everyday life of women. Tuberculosis was of great concern and women indicated the children in the family who had a 'cough'. The women emphasized their concerns by showing us empty bottles of tuberculosis medication, which were never refilled because of cost.

Women put all of these problems within the context of the web of social obligations that they were expected to fulfil within the wider community. Funerals, weddings, births and church functions were some of the social activities that drew upon women's economic and social resources. When asked what could be done to ease their situation, many women told how they had been driven to putting sons in the local jail to keep them from selling all the family property. They also told how they were often forced to earn an income from activities such as prostitution, the lottery and for some, selling heroin. The last question we asked of all the women in our study was what their dreams were of the future. None of the women described happy dreams and an old grandmother summed this up by saying 'Our dreams have been turned upside down'.

In sum, for women, protecting themselves against HIV/AIDS and other STDs was not a priority compared to the many challenges they faced within their daily life.

Summary and discussion

In weaving the results of the two studies together, what emerges is the importance of the wider social context in relation to risk and protection for HIV/AIDS and other STDs. Especially in a context where the AIDS epidemic is highly visible, most people know a lot about prevention. Yet the social roles, expectations and the very impact of the epidemic itself,

create a situation where specific behaviour changes cannot be addressed in isolation from gender roles and expectations, social obligations and the high value that the young place on sexual relationships. While the social and political context of communities such as Churachandpur are far more complex than outlined in this chapter, it is important that the community itself is becoming increasingly critically self-reflective in gaining a better understanding of the problem of AIDS and the effective responses. For example, young people are quite clear about the need for access to condoms from easily accessible and less visible places. Our reports from service providers, parents and community leaders indicate that young people are having casual sex and there is a need to make safe sex easier. The immediate and felt needs of women must be addressed in order for them to be effective in behaviour which will also protect them personally from STDs including HIV. For example, the real needs of women who are ill and in need of care are currently being addressed by providing a women's home and a hospice program. The issues of debt have yet to be addressed. A number of women working in the commercial sex industry have become especially active as peer outreach workers with SHALOM in the needle exchange programs and with peer condom distribution programs. But perhaps most encouraging is the fact that community leaders, including members of the military, the police, doctors and elected members of the State government, have actively and publicly addressed the issues of care and prevention of HIV/AIDS. The two studies reported in this chapter illustrate a broader community willingness to make visible the complex nature of highly sensitive and previously taboo social issues, in order to bring about a situation where behaviour change can be initiated, supported and sustained. And it ultimately will be changes in the broader social context that will turn the dreams of the grandmothers 'right side up'.

References

- Bernard, R. 1988. Unstructured and semi-structured interviewing. Pp. 203-223 in *Research Methods in Cultural Anthropology*. Beverly Hills: Sage Publications.
- Dena, L. 1991. *History of Modern Manipur (1826-1949)*. New Delhi: Orbit Publishers.
- Eichler, A. D. 1996. IV drug use and HIV risks in Churachandpur, Manipur, India. New Haven: Yale University.
- Gifford, S. M. 1997. Fieldnotes.
- Gifford, S. M. 1998a. Ethnographic research. Pp. 504-510 in *A Handbook of Public Health Methods*, ed. C. Kerr, R. Taylor and G. Heard. Sydney: McGraw-Hill Book Co. Pty Ltd.
- Gifford, S. M. 1998b. Analysis of non-numerical data. Pp. 543-554 in *A Handbook of Public Health Methods*, ed. C. Kerr, R. Taylor and G. Heard. McGraw-Hill Book Co. Pty Ltd.
- Hangzo, C., A. Chatterjee, A. Sarkar, G.T. Zomi, B.C. Deb and A.S. Abdul-Quader. 1997. Reaching out beyond the hills: HIV prevention among injecting drug users in Manipur, India. *Addiction* 92, 7: 813-820.
- Hudelson, P. M. 1994. Introduction to qualitative research. Pp. 1-10 in *Qualitative Research for Health Programmes*. Geneva: World Health Organization.
- Jain, M. K., T. J. John, and C.T. Keusch. 1994. Epidemiology of HIV and AIDS in India. *AIDS* 8: S61-S75.
- Khai, K.S. 1995. *Zo People and Their Culture*. Khampu Hatzaw: New Lamka.
- Murphy, B., J. Cockburn and M. Murphy. 1992. Focus groups in health research. *Health Promotion Journal of Australia* 2, 2: 37-40.
- Narain, J. P., A. Jha, S. Lal and S. Salunke. 1994. Risk factors for HIV transmission in India. *AIDS* 8: S77-S82.

- Panda, S., G. Kamei, M. Pamei, S. Sarkar, K. Sarkar, N.D. Singh and B.C. Deb.. 1994. Clinical features of HIV infection in drug users of Manipur. *National Medical Journal of India* 7, 6: 267-269.
- Panda, S., S. Sarkar, B.K. Mandal, et al. 1994. Epidemic of herpes zoster following HIV epidemic in Manipur, India. *Journal of Infection* 28: 167-173.
- Patton, M. Q. 1990. Sampling and triangulation. Pp. 165-198 in *Qualitative Evaluation and Research Methods*. Newbury Park: Sage Publications.
- Sarkar, S., P. Mookerjee, A. Roy, et al. 1991. Descriptive epidemiology of intravenous heroin users- a new risk group for transmission of HIV in India. *Journal of Infection* 23: 201-207.
- Sarkar, S., N. Das, S. Panda, K. Sarkar, B.C. Singh, J.M. Ralte, S.M. Aier and S.P. Tripathy. 1993. Rapid spread of HIV among injecting drug users in north-eastern states of India. *Bulletin on Narcotics* 45, 1: 91-105.
- Sarker, S., S. Panda, K. Sarker, et al. 1995. A cross-sectional study on factors including HIV testing and counselling determining unsafe injecting practices among injecting drug users of Manipur. *Indian Journal of Public Health* 39, 3: 86-92.
- Sharma, V.P. 1992 *The Hmars of Manipur: An Anthropological Exploration*. New Delhi: Anmol Publications.
- Thomas, J. and M. Bandyopadhyay. 1999. Ethnic minorities and their vulnerability to AIDS in a border state of India. *AIDS Care* 11, 1: 45-60.