

KNOWLEDGE, BELIEFS, AWARENESS AND ATTITUDES OF HIV/AIDS AMONG DHURVA TRIBES OF BASTAR REGION, CHHATTISGARH

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ABSTRACT

HIV emerged later in India than it did in many other countries, but this has not limited its impact. Infection rates soared throughout the 1990s, and have increased further in recent years. The crisis continues to deepen, as it becomes clearer that the epidemic is affecting all sectors of Indian society, not just the groups – such as sex workers and truck drivers – that it was originally associated with. In a country where poverty, illiteracy and poor health are rife, the spread of HIV presents a daunting challenge. The object of the paper is to study the relevant epidemiological factors of HIV/AIDS of Bastar Region. Primary Data for the present study has been collected from randomly selected two village of Bastar District. Total of 110 samples were collected from Dhurva Tribe. Interview schedule, observation (semi participatory), focus group discussion are the tools to collect the data. The disease results in the additional burden of co infection and co morbidities, therefore, early recognition of the disease processes will not only prolong survival, but will also decrease the viral load and transmission. More research is needed to better define and understand the HIV/AIDS epidemic in terms of behavioral, laboratory, and medical science.

KEYWORDS: Beliefs, Attitudes, HIV/AIDS, Dhurva, Bastar, Chhattisgarh

In the early 1980s, the first recognized cases of the acquired immune deficiency syndrome (AIDS) occurred among homosexual men in the United States. By 1983, the etiological agent, the human immunodeficiency virus (HIV), had been identified. While some were initially resistant to acknowledge the connection (and indeed some remain so today), there is now clear evidence to prove that HIV causes AIDS. By the mid-1980, it became clear that the virus had spread, largely unnoticed, throughout most of the world, and since then, the global AIDS epidemic has become one of the greatest threats to human health and development.

HIV emerged later in India than it did in many other countries, but this has not limited its impact. Infection rates soared throughout the 1990s, and have increased further in recent years. The crisis continues to deepen, as it becomes clearer that the epidemic is affecting all sectors of Indian society, not just the groups – such as sex workers and truck drivers – that it was originally associated with. In a country where poverty, illiteracy and poor health are rife, the spread of HIV presents a daunting challenge.

HIV/AIDS was first identified in India in 1986, when serological testing found that of 102 female sex workers in Chennai were HIV positive. The initial response of the health authorities was slow primarily due to a common belief that AIDS would not become a problem in India due to the low levels of multi-partner sexual activity and other risky sexual behaviours among Indians (John et al., 1987). However, in the face of increasing numbers of people being identified with HIV,

the Government of India (GOI) initiated a systematic response by first establishing the National AIDS Committee (NAC) and then, in 1992, the National AIDS Control Organization (NACO) under the Ministry of Health and Family Welfare. Since then, comprehensive educational and awareness programmes have been implemented with mandates to increase prevention and control of HIV/AIDS in India. Under the National AIDS Control Programme (NACP), educational programmes have focused on enhancing people's knowledge about HIV/AIDS and building behavioural skills to enhance prevention practices (NACO, 2005). global AIDS epidemic has become one of the greatest threats to human health and development. At the same time, much has been learnt about the science of AIDS, as well as how to prevent and treat the disease.

HIV

HIV is the acronym for 'Human Immunodeficiency Virus'. This Virus is responsible for causing AIDS among human beings. HIV is a retro virus.

AIDS

AIDS is the acronym for 'Acquired Immuno Deficiency Syndrome'. AIDS is the stage of HIV infection when a person starts having symptoms and medical conditions caused in human beings after they have been infected by HIV. In 1984, scientists proved that HIV causes AIDS.

The Effects of AIDS on Humans

HIV harms the body's immune system by attacking certain kinds of cells, known as helper T cells or CD4 cells or simply white blood cells (WBCs), which are a part of the body's natural line of defense against illness. As time goes by, HIV destroys so many of these cells that the immune system becomes very weak and the body is no longer able to defend itself against certain cancers and other infections caused by viruses, bacteria, or parasites.

Frequent infections and illnesses plague affect a person who has developed AIDS. If the infections are left untreated it can be fatal for the person.

Prevent HIV Infection

There are three key things that can be done to help prevent all forms of HIV transmission. First among these is promoting widespread awareness of HIV and how it can be spread. Media campaigns and education in schools are among the best ways to do this.

Another essential part of a prevention programme is HIV counselling and testing. People living with HIV are less likely to transmit the virus to others if they know they are infected and if they have received counselling about safer behaviour. In particular, a pregnant woman who has HIV will not be able to benefit from interventions to protect her child unless her infection is diagnosed. Those who discover they are uninfected can also benefit, by receiving counselling on how to remain that way.

The third key factor is providing antiretroviral treatment. This treatment enables people living with HIV to enjoy longer, healthier lives, and as such it acts as an incentive for HIV testing. It also brings HIV-positive people into contact with health care workers who can deliver prevention messages and interventions. Studies suggest that HIV-positive people may be less likely to engage in risky behaviour if they are enrolled in treatment programmes. Nevertheless, it is also possible that widespread availability of treatment may make some members of the wider population less fearful of HIV infection, and hence less willing to take precautions.

Objective

The Present Study "Aptitude and Awareness of HIV/AIDS" was attempted with the following aims of objectives -

1. To study the relevant epidemiological factors of HIV/AIDS of Baster Region.
2. To study the knowledge Aptitude and Awareness of HIV/AIDS among the Dhrva tribe of Baster region.

MATERIAL AND METHEDS

The present work is an outcome of month long filed work conducted during May-June 2013. Primary Data for the present study has been collected from randomly selected two village i.e. Bodanpal, Machkot of Baster District. Total of 110 samples were collected from Dhrva Tribe. Interview schedule, observation (semi participatory), focus group discussion are the tools to collect the data.

STUDY AREA

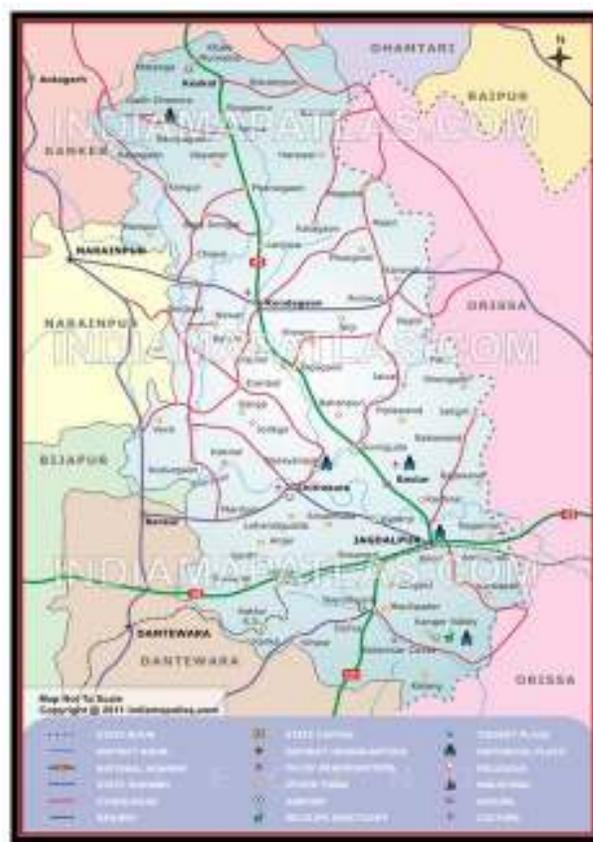


Figure 1



Figure 2

Bastar WAS formerly part of the princely state of Bastar. Earlier district, which had an area of 39,114 km², was one of the largest in India. In 1999, the district was divided into the present-day districts of Bastar, Dantewada, and Kanker, which constitute Bastar Division. I

The Land of Tribals and Natural Resources, is also enriched with natural beauty and pleasant

atmosphere. It is surrounded with dense forests, hilly mountains, streams, waterfalls, natural caves, natural parks etc. Bastar is located in the southern part of Chhattisgarh and situated at a height of 2000 ft above sea level .The borders of Bastar district are Kanker district in the north, Maharashtra State in the west, Dantewada district in the south and Orissa State in the east. The District head quarter Jagdalpur is situated approximately at a distance of 300 km from Raipur, which is the capital of Chhattisgarh state. Bastar district -the largest district of Chhattisgarh-covers an area of 17020 sq. km and lies between North latitudes 18°38'8.5" and 20°11'40.56" and East longitudes 80°39'47.12" to 82°14'51.29" with population of 1411644 as per 2011 census. Density of population in the region is 140 person per kilometer.Sex Ratio is1024/thousand male which is very high.The main flora available in Bastar are Teak, Sal, Mahua, tamarind, haldu, sheesham, Lendia, Tendu, Semal, Ber and Jamun. various medicinal plants etc. and Fauna are deer,Chital, Barking Deer, GaursBuffalos, Barasinghas, Tigers, Leopards, Gaurs (Indian Bison), The important MFPs available in Bastar district are Chironji, Shikakai, Ghot pal, Mango Kernal, Amchur, Vaybidding, Karanji, Tamarind, Peng Seeds, Karkatiya Seeds, Cashew, Kosa Cocoons, Nirmali Seeds, Chirayta, Mahua, Harra, Bamboo, Tora, Ambadi, Amla, Charota Seeds, Dhavai Phool, and Bhilwan Seeds etc (Figure 1 & 2).

Aids /HIV Status in study region Bastar

HIV Status of the Bastar region is as follows:

Table 1: ICTC AIDS DATA – BASTER DISTRICT 30.04.2013

S.N.	YEAR	COUNSLING	TESTING	M	F	HIV POSATIVE		HIV NEGATIVE		TOTAL POSSITIVE
						M	F	M	F	
1	2003	43	43	43	0	41	0	2	0	2
2	2004	65	65	61	4	58	2	3	2	5
3	2005	264	201	161	40	160	40	1	0	1
4	2006	685	629	275	354	254	334	21	20	41
5	2007	1485	1391	911	480	879	459	32	21	53
6	2008	1730	1703	1300	403	1261	377	39	26	65
7	2009	2149	2183	1419	719	1380	675	39	44	83
8	2010	2311	2293	1332	961	1238	913	94	48	142
9	2011	1956	1955	978	977	921	933	57	44	101
10	2012	3483	3480	1533	1586	1469	1519	76	67	143
11	2013	1081	1081	592	469	567	461	25	8	33
TOTAL		15252	14979	8605	5993	8228	5713	389	280	636

(Sources: ICTC Center Jagdalpur, c.g.)

Table 2: PPTCT AIDS DATA – BASTER DISTRICT 30.04.2013

S.N.	YEAR	COUNSLING	TESTING	ANC	L. ROOM	HIV NEGATIVE		HIV POSATIVE		TOTAL POSITIVE
						ANC	L.ROOM	ANC	L.ROOM	
1	2007	1073	1073	176	897	175	893	1	4	5
2	2008	2015	1920	1113	807	1108	804	5	3	8
3	2009	2254	2252	1113	1139	1110	1137	3	2	5
4	2010	1985	1936	1207	729	1197	727	10	2	12
5	2011	1358	1358	890	448	887	447	3	1	4
6	2012	1703	1703	971	732	964	732	6	0	6
7	2013	443	443	438	5	435	5	3	0	3
TOTAL		10831	10685	5908	4757	5877	4745	31	12	43

(Sources: ICTC Center Jagdalpur, c.g.)

Table 3: Village Information

S.N.	Description	Maachkot Village								Bodanpal village							
		ST		SC		OBC		GEN		ST		SC		OBC		GEN	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
2	Distance of District headquarter	28 K.M.								36 K.M.							
3	Police Station	Nagarnaar								Bhanpuri							
4	Market	Nagarnaar, Nangur								Bhanpuri, Devdaa							
5	Market day	Friday, Tuesday								Monday, Saturday							
6	School	Primary-1 Middle-1 High-0 Higher-0								Primary -2 Middle-1 High-1 Higher-0							
7	Source of water	Hand Pap -3 River-1 Well-2								Hand Pap -9 River-2 Well-3							
8	PHC/CHC	0								1							
9	Aganwadi	1								3							
10	Worship Place	Devgudies-1 Temple -1								Devgudies-2 Temple -1							
11.	Main Occupation	Agriculture/Labor								Agriculture/Labor							

1. Economics - Agriculture is the main livelihood activity that is practiced in the Study Village. They are also engaged in forest product collection as a secondary livelihood source of income. Forest collection, which most take villagers Sargi, Mahua, Imali, Kossa and other forest product. Villagers take only a single crop, which is generally of paddy, mixed with other millets and cereals like maize, jwar, arher, udad etc. because of low productivity of the land, there's not much of the marketable surplus left with the farmers.

2. Indigenous Systems - the village has its own indigenous system for addressing various health problems

of the villagers. these problems are cured using the local herbs and plants available in the forest. Mediums (siraghas), completely possessed by their detiies accompanied their clan - gods.

3. Housing - Villages have houses with the traditional Architecture having thatched roof and using bamboo, wood, stone and mud as the construction material.

4. Infrastructure - The village has quite some infrastructure, which would however need significant improvement, addition and most importantly the regular maintenance and management. Access road to village is in good condition. Even the interior village roads, made

up murum have been well maintained and extend good rustic and clean look to the village

DHURVA TRIBE

The Dhurva (also known as the Parji) are a sub-group of the Gond, the largest tribal group in India. Today, the Dhurva inhabit the central eastern portion of the Bastar district and overflow into parts of the Orissa district, especially south of the Indrawati River Duruwa (Devanagari) or Parji is a Central Dravidian language spoken by the Dhurva tribe, a scheduled tribe people of India, in the districts of Koraput and Bastar in Chhattisgarh state. Most of the Dhurva are farmers who use bulls to plow their fields of rice and other grains. Because they do not make their own farm equipment, the Dhurva are dependent on nearby villages for supplies like earthenware, iron tools, and carts. Such items can be obtained in the weekly markets. Dhurva society consists of *exogamous* clan units, which means that they do not marry within the same clan. There are two types of marriage: the *curca* and the *tika* (union). In a *curca* marriage, a bride-price is paid. A *tika* takes place when a divorced or widowed person is wed or when a Dhurva marries someone of a higher or lower ethnic group. The Dhurva live in small, windowless huts made with mud walls and thatched roofs. Some, though not all, of the villagers live together as extended family households. No one is allowed to settle in the village without first receiving permission from the leading clan. The Dhurva do not make their own clothes. Thus, all ornaments and items of dress are obtained from outside. Although the Dhurva are 100% Hindu, their beliefs vary from tribe to tribe. Many of their Hindu practices have been combined with *animism* (belief that non-human objects have spirits)

RESULTS & DISCUSSION

All the result show in table 4 to 9.

Socio Economic Information of Dhurva Family

Total population of the Dhurva tribes are of which 54.88% male and 45.11 % female.20.59 % of the total respondents belongs to age group of 26-30 while 0.74 % is above 50 age.89.09% of respondents has single family .Only 21.81% family resides in combine family rest in single family 78.18 % of the total women are unmarried . Most of the Dhurva tribes are 52.72 %cultivator.30.9 % working as labour and very few are work in govt. sector (9.09%) and 7.27 in other works.

Most of the Dhurva families (22) earn 11000-20000 Rs. Annually while 14. 5 are high income group population of the Dhurva families. Education status of the Dhurva families are as follows:

S.N.	Education	Number	Percent
1	Before	69	25.93
2	Primary	90	33.83
3	Medial	40	15.03
4	High School	35	13.15
5	Higher Secondary	22	8.27
6	Graduation	8	3
7	Master Degree	2	0.75
Total		266	99.9

It is evident from the table that the highest frequency shows primary education (41.94%), Before (29.96%), medial (14.23%), high school (9.73%), higher secondary (2.62%), master degree (1.12%) respectively. The lowest frequency shows in graduation (0.37%) Dhurva family.

AWARENESS OF HIV/AIDS INFORMATION

(96.36%) families had been Awareness Of HIV/AIDS and (3.69%) was not Awareness Of HIV/AIDS Dhurva family.

Table 4: Sources of Knowledge of HIV/ AIDS

S.N.	Sources Of Knowles	Number	Percent
1	Radio	6	10.9
2	T.V.	13	23.63
3	Newspaper	2	3.63
4	Teacher	10	18.18
5	Relative	4	7.27
6	Health worker	10	18.18
7	Anganwadi worker	5	9.09
8	Advertising	2	3.63
9	Other	3	5.45
Total		55	99.96

Sources Of Knowledge Hiv/ Aids table reveals that the 23.63% of respondents gain knowledge from T.V. while 7.27% known by relatives, 18.18% health worker, 10.9% radio,18.18 teacher also play an important

role to spread the Knowledge of Hiv/ Aids. 41.81% respondents . Aids is spread out by the infected blood while sexual relationship is answered by 61.81% respondents. 34 % respondents know about the spread of HIV through each other.

Table 5: Knowledge To Spread Aids

S.N.	Spread to Aids	Number	Percent
1	Injection	3	5.45
2	Infected Blood	13	23.63
3	Sexual relationship	34	61.81
4	Shake Hand	1	1.81
5	kissing	1	1.81
6	use cloth	1	1.81
7	Eating food	1	1.81
8	Other	1	1.81

74.54% families had not Aware about the Possibility Of transmitted disease while 25.45% are still unaware about the transmission of diseases. In the study region couples (52.72) make physical relationship monthly and 38.18% are weekly while very few are interested in daily. It is noted during survey that more than 56.36% of the people’s behave with HIV patient normally while 40% shows sympathy

Table 8: Response to Aids Patient

S.N.	Response to Aids Patient	Number	Percent
1	Normal Behavior	31	56.36
2	Sympathy	22	40
3	Detest	1	1.81
4	Untouched	1	1.81
5	Other	0	0
		55	99.98

Most of the respondents show faith in Modern health care facilities if the HIV is observed in the family and 89.09 % of the patient goes to health workers for treatment as he/she is the medical person available immediately to them

Table 6 : Advice For Aids Patient

S.N.	Advice For Aids Patient	Number	Percent
1	Consult doctor	33	60
2	Be Carefully	19	34.54
3	Other	3	5.45
	Total	55	99.9

Most of the respondents are attended the health camp but 54.4% feels that are not so beneficial to them.

In the study region 67.27 % females adopted various methods of family planning while 32.72 % not used any preventive measures. Following table shows the use of contraceptives by dhurva tribe:

Table 7: Precautions During Intercourse

S.N.	Precautions During Intercourse	Number	Percent
1	condom	19	34.54
2	copper T	1	1.81
3	Contraception Tablet	16	29.09
4	Indigenous drug	1	1.81
5	Other	18	32.72
	Total	55	99.97

76.36 % believes in safe relationship as per the HIV /AIDS are concerned followed by over all blood check up But they strongly believes that this diseases is incurable while 43 percentage of respondents shows ignorance.

Table 9: Prevention of Aids

S.N.	Prevention Of Aids	Number	Percent
1	Secure Physical Relevance	42	76.36
2	At first Overall blood checkup	9	16.36
3	use Infected Injection	3	5.45
4	Other	1	1.81
	Total	55	99.98

SUMMARY AND CONCLUSION

There was a high frequency of behavioral risk factors, together with unawareness, and very little health

infrastructure, thus creating an impending risk for the rapid spread of HIV/AIDS (acquired immunodeficiency syndrome).

HIV infection is one of the major infectious diseases in this part of India, and being chronic and lifelong in nature; its impact is huge compared to other diseases. People with high-risk behavior and spouses of affected patients need to be educated for primary and secondary prevention. The disease results in the additional burden of co infection and co morbidities, therefore, early recognition of the disease processes will not only prolong survival, but will also decrease the viral load and transmission.

Prevention is the best strategy for reducing the human and economic toll from HIV/AIDS. To have the largest impact on the HIV epidemic, a comprehensive approach is needed for HIV prevention. Comprehensive HIV prevention is a broad term that incorporates surveillance, research, prevention interventions, and evaluation. More research is needed to better define and understand the HIV/AIDS epidemic in terms of behavioral, laboratory, and medical science,

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