This book is based on a pioneer study on the HIV/AIDS in Darjeeling which reveals a large number of paradoxes with which the Hill society is entwined. It shows that there is lack of sufficient awareness regarding HIV/AIDS among the people of the Darjeeling Hills, and on safety measures specially condom use among the people is very rare.

Lack of collaboration among the Non Governmental Organisations (NGO) working on HIV-AIDS in the Darjeeling Hills has resulted ill-bred health structure which is not sufficient to address the issue among the Hill population. It vividly portrays the realities in the Hills that are often hidden, ignored, neglected or unaccustomed to socio-cultural milieu of the Hills.
Binu Sundas, is an Assistant Professor in the Department of Social Systems and Anthropology, Sikkim University and is currently the Department Co-ordinator. He is the founding member of the department. He completed his Ph.D from Jawaharlal Nehru University, New Delhi. He is a native of Kurseong, District Darjeeling and is a Goethals’ Alumni. His area of research interest has been sociology of health. For his M.Phil dissertation he has worked on “Alcohol Consumption and Health of the People in Darjeeling Hills: An Analysis of Socio-Cultural and Development Factor.” He has done exclusive research in the hills of Darjeeling.

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Preface

Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) pose a great threat to the human population as has no other epidemics in the history of mankind. HIV/AIDS was identified only in the early 1980s in the USA. HIV/AIDS is affecting most of the regions in the world and is posing tremendous challenge to the civil society and Government. It has in a single stroke destroyed the developmental gains made in years. HIV/AIDS epidemic has continued to grow and this growth has been facilitated by the globalizing world, with faster means of communication and constant movement of the people. When sexual intercourse and sharing of needles among the intravenous drug users were recognized as the primary modes of transmission, it was observed that the high risk groups like the commercial sex workers, their clients and the intravenous drug users were more vulnerable and susceptible to infection. However, with time HIV/AIDS has made inroads into our social spaces and has rendered vulnerable each and every individual, ranging from the high risk groups to the housewives.

HIV/AIDS is not just a medical issue but it is rooted in the social, economic, political and cultural context and poverty, migration, gender inequality, access to health services all play a pertinent role in the spread of HIV/AIDS. In India a large proportion of the population are still in poverty and migrate from one part of the country to another in search of livelihood. In such cases they may engage themselves in activities which are conducive to the spread of HIV/AIDS. The patriarchal nature of the Indian society
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also facilitates the spread of HIV/AIDS. The women, especially the wives, do not have any say in the domestic life and regarding sexual matters they are at the mercy of their husbands which puts them in greater risk contracting HIV/AIDS. The absence of condom use among the consenting couples also poses a great threat to the women.

The first case of HIV infection in India was detected among the sex workers of Chennai and was subsequently reported from brothels from other parts of the country. In the North East India HIV infection was reported from among the intravenous drug users and their partners. The pattern of HIV infection in India is as diverse as the country itself. In a relatively short span of time the virus has spread to different parts of the country.

The first case of infection in Darjeeling was identified in the year 2002. In five years time the number of people infected had reached 141. The absence of a stable political situation and the lack of employment opportunities had forced many to migrate to other parts of the country and this has also facilitated the growth of HIV infection in the region. The absence of proper medical facilities and the lack of awareness among the people with regards to HIV/AIDS is also a cause of worry in the hills of Darjeeling. The lack of financial help to the NGOs is also a hindrance towards the prevention and control activities. Amidst the constraints Shanker Foundation has been able to help the PLWHAs to fight the stigma and discrimination associated with the disease.

Shanker Foundation is the most prominent among all the NGOs confronting the virus in the hills of Darjeeling. The Foundation works for the betterment of all the PLWHAs of the hills under enormous constraints and its single most important strength has been its ability to improve the quality of life of its members. However, there are other indicators that show success of a different kind. An important indicator has been the Foundation's ability to attract volunteers who do not have a direct stake in HIV/AIDS. For instance, in addition to the PLWHAs and their relatives, the Foundation has attracted the participation of a number of volunteers who are not sero positive and have no family members living with the virus. However, the work of Shanker Foundation has been handicapped by the lack of support from the civil society and the stigma and discrimination and most importantly the reluctance of members to disclose their positive status.

This book is developed from my Ph.D thesis titled 'HIV/AIDS in Darjeeling: An Analysis of Population Dynamics and Institutional Response' with few addition and deletion here and there. The introductory chapter highlights the crisis of HIV/AIDS and also focuses on the methodology. It also identifies the issues associated with HIV/AIDS with the help of a comprehensive review of literature on HIV/AIDS. The socio-political history of Darjeeling, in a brief manner is dealt with in the second chapter to substantiate the later arguments and also discusses the risk factors associated with HIV/AIDS and prevalence in the study area. Shanker Foundation is also discussed in the chapter.

The third chapter deals with the socio demographic conditions of the sample population and also analyses in detail each category of the groups of people that make up the sample population. The chapter profiles the PLWA and highlights their various experiences. The fourth chapter deals with mobility, sexual behaviour and trends among the people, risk groups, the knowledge and perception of HIV/AIDS among the people and also the stigma and discrimination associated with HIV/AIDS in the hills of Darjeeling. The fifth chapter gives a brief account of international response to HIV/AIDS and primarily focuses on the responses from various institutions in the hills of Darjeeling, to control and prevent the epidemic.

The sixth chapter discusses the spread of HIV/AIDS through porous mobility of technology, substance abuse, sexual behaviour, movies, television and the experiences of the infected and affected people. It also outlines some strategies to control the epidemic in Darjeeling hills. The conclusion chapter, written on the basis of the thesis is presented.
HIV and AIDS in Darjeeling

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The sixth chapter discusses the spread of HIV/AIDS through population mobility, use of technology, substance abuse, sexual behaviour, knowledge and experiences of the infected and affected persons. The chapter also illustrates the findings and proposes some strategies to address the epidemic in Darjeeling hills. The concluding chapter summarizes the thesis and on the basis of the thesis draws conclusions.
I take this opportunity to thank my mentor and supervisor during my M.Phil/Ph.D programme, Dr. Sanghmitra Acharya who always extended constant support and advice during the course of my dissertation and since my first year in M.Phil. She has been a constant source of inspiration to me as she epitomizes hard work and sincerity in all her efforts. More than being a good teacher she has been a person of high quality which has inspired me in my endeavour. She has shown immense patience with me all these years. The Center of Social Medicine & Community Health (JNU) deserves a special mention as it has played an important role in shaping up my perspective regarding the health of the people. Coming to this center for the M.Phil/Ph.D programme was an eye opener for me with regards to the understanding of health. I am also grateful to the teachers of the centre for all the support and encouragement they have had for me.

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them then this work would have never completed. I am very thankful to them and all the respondents who shared with me their opinions regarding HIV/AIDS as well as the 'Person Living With HIV/AIDS who were willing to share with me their experiences of being infected by the virus and all the ordeals they have to undergo.

I am also thankful to Bidhya didi, Bibu, Anu dada and Lokesh for their love and encouragement. I am also very grateful to the rest of my family members for their love and support. All my friends whose names if I write will fill more than a few pages have also been a constant source of encouragement to me and I am thankful to them.

I am forever indebted to my wife for all the help she has provided. She also read the first and second draft and made extensive comments, making many useful and constructive suggestions which I have tried to include as expansively as possible. She has been instrumental in the completion of this work.

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Chapter I
HIV/AIDS in Darjeeling: A Cause for Concern

Background

The HIV/AIDS epidemic is one of the greatest humanitarian crises of all times. It is destroying the lives and livelihoods of millions of people around the world. It causes death and untold misery, destroys families and communities. It breaks the social norms and values of the society (Nelkin et al. 1991) and it is a vicious cycle which affects directly or indirectly every individual in a society. It has had tremendous impact on the development gains of several years and in a single stroke has ruptured the social fabric of the society. It is a source of enormous psycho-social, mental and physical stress to individuals who are infected as well as affected by it. That is why it has become a salient component in the agenda of health personnel in the world, and has received unprecedented attention. In fact, there is no vaccine or drug to cure it and scholars like Tan (1998) think that even if a cure were to be found it would be too expensive to be universally available. In the case of vaccines and drugs to combat HIV/AIDS, the situation is far worse. The effectiveness of vaccines and drugs is placed in the hands of Unicef, WHO, World Bank and other international organizations. All these challenges resulting from the advent of HIV/AIDS have had a social, political, environmental and economic impact on millions of people both in developed as well as
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The origin of HIV/AIDS has puzzled scientists as well as
the public ever since the disease first came to light in the early 1980s. Since then it has been a subject of debates and a broad range of theories regarding its origin have emerged. These theories however do not converge to a common point but gives diverse perspective on the origin and spread of HIV/AIDS. It is unlikely that the truth regarding how, when and where HIV/AIDS actually originated will be known. A combination of many factors have attributed to the spread of the virus and undoubtedly certain features of the 20th century, like faster means of travel, communication and drug abuse etc. have played a major role in its global spread.

Regarding the origin of HIV/AIDS, there are three prevalent thoughts. One is that HIV was well established in all areas of the world but has only recently been recognized. However, this theory has not been well substantiated. A second proposition holds that HIV evolved through mutation of an older and non-pathogenic virus. Virologists however, have dismissed this explanation for HIV on the basis of specific characteristics of the virus and its relationship to other viruses. A third and widely discussed possible origin of HIV is zoonosis—the transmission of a non-human virus into human population. Zoonosis is the probable explanation for HIV because similar viruses exist in apes of Africa where HIV is endemic (Goudsmit 1997). However, the most widely held view is that a virus developed in humans in Central Africa and only recently spread to other regions of the world, primarily through global travel and transcontinental commerce has caused HIV to originate (Kalichman 1998). Epidemiological data provide the strongest support for this theory.

HIV/AIDS—The Global Scenario

In June 1981, the Centre for Disease Control in the United States of America reported the first clinical evidence of AIDS (Muthuswamy 2005). It was then an epidemic of the urban gay population and was called a ‘gay related immune disease’ (Lorber 1997). However, it has moved from being a ‘gay disease’ to affect individuals across regions, race, sex, ethnicities and is becoming ‘more complex every year’ (McKee et al. 2004).
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In the last two decades the epidemic has spread over the world. Countries in southern Africa have the highest prevalence ranging between 15-20 per cent. Nordic countries have prevalence below 1 per cent (Map 1.1). Globally over 33 million people were living with HIV/AIDS in 2007. The annual number of new HIV infections declined from 3.0 million in 2001 to 2.7 million in 2007 (UNAIDS 2008). This decrease in the number of PLWHAs is attributed to the improved methodology of estimation which was applied to a wide range of countries in the world (UNAIDS 2007). However, large numbers of new cases are reported from the developing countries, mainly in Sub-Sahara Africa, South-East Asia and South Asia. Sub-Saharan Africa is the most affected region in the world today. The sub-region alone accounts for 35 per cent of all PLWHAs and almost one-third of all new HIV infections and AIDS deaths globally in 2007. It also has the largest majority of women infected with HIV. In the east African countries the prevalence rate has stabilized. Uganda is one of the first countries to successfully control and prevent the spread of the epidemic.

In Asia the highest national prevalence of HIV is evident in South-East Asia. In countries like Thailand and Cambodia where HIV/AIDS became pandemic, there are signs of a declining prevalence rate. However, in Vietnam and Indonesia there are evidences of an increasing prevalence rate. Thailand and Cambodia implemented condom use among the risk group populations like the Commercial Sex Workers (CSWs), their clients and Intravenous Drug Users (IDUs) very seriously which helped them control the spread of HIV/AIDS. In Asia, there were an estimated 4.9 million PLWHAs in 2007, including the 4,40,000 persons infected in the past year. Approximately, there were 3,00,000 deaths due to AIDS-related illness in 2007 (Ibid.).

It is well recognized that HIV/AIDS is rooted in the social, economic, political and cultural context. The International community has come together to confront the disease. International organizations are making an endeavour to confront and stabilize the spread of the epidemic. Initiative like the 'Treat 3 Million by 2005,' though unsuccessful in meeting the target, was introduced. Now the G8 leaders have pledged a new goal of coming as close as possible to universal AIDS treatment access by 2010. Different governments have formulated different policies to combat the disease. However, the efficacy of such policies is determined by the degree of governance and a presence of a functional civil society. Good governance is the key to development and success of policies which are essential to address the HIV/AIDS epidemic. Political stability and the participation of civil society are prominent determinants for the effectiveness of governance. However, social stigma and discrimination associated with HIV/AIDS and inadequate public health systems severely impede the implementation of the policies like availability and delivery of effective interventions such as prevention, education, risk reduction counselling, condom distribution and needle exchange programmes.

HIV/AIDS in India

In India, HIV infection was first reported from among the sex workers in Chennai in 1986 and immediately thereafter it was found among the CSWs of Mumbai. Since then the virus has unprecedently spread to other parts of the country. In 1987, a National AIDS Control Programme was launched to coordinate national responses. Its activities covered surveillance, blood screening, and health education (NACO 2005). By the end of 1987, out of 52,907 who had been tested, around 135 people were found to be HIV positive and 14 had AIDS (Kakar and Kakar 2001). Most of these initial cases had occurred through heterosexual sex, but by the end of the 1980s, a rapid spread of HIV was observed among IDUs in Manipur, Mizoram and Nagaland—three north-eastern states of India bordering Myanmar (Panda 2002). Drugs from Myanmar come to these states as the border is not properly guarded and also because of insurgency. The drugs from these states are further trafficked to Siliguri, which can be reached within less than 48 hours. Once the drugs reach Siliguri it easily reaches Darjeeling. Today in India the number of PLWHAs is very high, representing a tremendous public health burden. The HIV affliction levels among High Risk Groups (HRGs) are being closely monitored all over the country. The proportion of population infected has crossed one per cent in six states. These states are Maharashtra, Karnataka, Tamil Nadu, Andhra Pradesh, Manipur and
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Nagaland and are termed as high prevalence states and account for 75 per cent of the country's estimated HIV/AIDS cases. Increase in numbers of HIV positive cases is being noticed in states of Rajasthan, West Bengal, Gujarat, Bihar and Madhya Pradesh. Although, the recent data has revealed that HIV prevalence has stabilized in Tamil Nadu, Andhra Pradesh, Karnataka, and Maharashtra, it is increasing in at-risk populations in other states such as West Bengal, Gujarat. In 2008, the figure was confirmed to be 2.5 million which equates to a prevalence of 0.3 per cent (UNAIDS 2008). While this rate may seem low, as India's total population is very high, this translates into a high volume of PLWHA. With a population of more than a billion, a mere 0.1 per cent increase in HIV prevalence would increase the estimated number of PLWHA by over half a million.

Based on the women attending Ante Natal Clinic (ANC) prevalence, the states and Union Territories are broadly divided into the high, moderate and low prevalence categories. There are inter-state and intra-state diversity, in the pattern of HIV transmission. There is a wide variance in HIV prevalence between districts and intra-districts as is evident from the sentinel surveillance data. Based on these data, the districts have also been categorized as A, B, C, D. The district which has been categorized as A indicates more than 1 per cent ANC/PPTCT (Prevention of Parent to Child Transmission) prevalence in district in any time in any of the site in the last 3 years. The district which has been categorized as B indicates less than 1 per cent ANC/PPTCT prevalence in all the sites during last 3 years associated with more than 5 per cent prevalence in any HRG group (CSW/MSM/IDU). The district which has been categorized as C indicates less than 1 per cent in ANC prevalence in all sites during last 3 years with less than 5 per cent in all STD clinic attendees or any HRG with known hot spots (Migrants, truckers, large aggregation of factory workers etc.). The district which has been categorized as D indicates less than 1 per cent ANC prevalence in all sites during last 3 years with less than 5 per cent in all STD attendees or any HRG or no or poor HIV data with no known hot spots/unknown (NACO 2006).

Map 1.2: The Worst Affected States in India
Source: http://www.avert.org/aidsindia.htm

In India, the majority of the HIV/AIDS cases are reported from few states. Although HIV/AIDS still is largely concentrated in at-risk populations, including Commercial Sex Workers (CSWs), Intravenous Drug Users (IDUs), and Men who have Sex with Men (MSM); the surveillance data suggests that the epidemic is moving beyond these groups into the general population; from urban to rural districts; and increasingly towards women and young people (NACO 2006). It is now estimated that many of the HIV cases in India were reported from among housewives with a single partner. The increasing
Nagaland and are termed as high prevalence states and account for 75 per cent of the country’s estimated HIV/AIDS cases. Increase in numbers of HIV positive cases is being noticed in states of Rajasthan, West Bengal, Gujarat, Bihar and Madhya Pradesh. Although, the recent data has revealed that HIV prevalence has stabilized in Tamil Nadu, Andhra Pradesh, Karnataka, and Maharashtra, it is increasing in at-risk populations in other states such as West Bengal, Gujarat. In 2008, the figure was confirmed to be 2.5 million which equates to a prevalence of 0.3 per cent (UNAIDS 2008). While this rate may seem low, as India’s total population is very high, this translates into a high volume of PLWHA. With a population of more than a billion, a mere 0.1 per cent increase in HIV prevalence would increase the estimated number of PLWHA by over half a million.

Based on the women attending Ante Natal Clinic (ANC) prevalence, the states and Union Territories are broadly divided into the high, moderate and low prevalence categories. There are inter-state and intra-state diversity, in the pattern of HIV transmission. There is a wide variance in HIV prevalence between districts and intra-districts as is evident from the sentinel surveillance data. Based on these data, the districts have also been categorized as A, B, C, D. The district which has been categorized as A indicates more than 1 per cent ANC/PPTCT (Prevention of Parent to Child Transmission) prevalence in any of the site in the last 3 years. The district which has been categorized as B indicates less than 1 per cent ANC/PPCTC prevalence in all the sites during last 3 years associated with more than 5 per cent prevalence in any HRG group (CSW/MSM/IDU). The district which in ANC categorized as C indicates less than 1 per cent prevalence in all sites during last 3 years with less than 5 per cent of known hotspots (Migrants, Truckers, large aggregation of factory workers etc.). The district which has been categorized as D indicates more than 1 per cent ANC prevalence in all sites during last 3 years with less than 5 per cent in all STD attendees or any HRG spots/unknown (NACO 2006).

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HIV and AIDS in Darjeeling

Table 1.1: Categories of States and Union Territories

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HIV prevalence among even the low-risk women is leading to the increase in mother to child transmission of HIV, and therefore infections among children.

The average HIV prevalence among women attending antenatal clinics in India is 0.48 per cent. Much higher rates are found among people attending STD clinics (3.6%), CSWs (5.1%), IDUs (7.2%) and MSM (7.4%) (www.avert.org).

Evolution of Concern for HIV/AIDS in India

The HIV/AIDS epidemic in India is now about 20 years old. However, the incidence of HIV continues to be a cause for concern as the virus continues to spread into new areas as well as into low risk population groups. India has seen a concerted effort to combat the epidemic, from the government, non-governmental as well as international agencies. India was among the first few countries to start sentinel surveillance and it was initiated under the aegis of ICMR in 1985 (NACO 2007). Surveillance data indicate that risk practices are getting diffused and infection rates are continuing to grow vertically among low risk groups like pregnant mothers. The considerable underreporting of HIV/AIDS cases also hides the fact that management and care of the infected and affected individuals will pose a grave challenge to the resources and capacity of the country.

The virus in India has taken different courses in different states since its first detection and has contributed to the heterogeneity of the epidemic within the country. This heterogeneity has been influenced by varied sexual and injecting behaviour patterns among network population groups such as the CSWs and the IDUs as well as bridge population such as the partner visiting the CSW or the IDU who is married or has a sexual partner thereby linking different networks.

Prevention of mother to child transmission is crucial for primary prevention, treatment and care and support for mothers, their children and families. Inadequate prenatal care services, family planning services, inadequate knowledge of HIV status among pregnant women and stigma and discrimination are obstacles to expanding prevention of mother to child transmission.

The HIV/AIDS epidemic is a serious public health problem. As HIV turns into full blown AIDS there will be a marked increase in the mortality and morbidity rates. Life expectancy will fall as has been witnessed in a number of African countries. Those who are the most infected by the HIV/AIDS are also the most sexually and professionally active groups that falls in the age group of 15-49 years. These people will witness a fall in their productivity rate and income and get trapped in a vicious circle of poverty. Individuals and households will find it difficult to cope with the economic hardships associated with increased treatment cost and reduced income due to illness and loss in productivity. At the micro household level, the financing issues include 3 aspects:

1. The expenses borne by households directly for the illness,
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HIV and AIDS in Darjeeling

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HIV/AIDS in Darjeeling: A Cause for Concern

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Table 1.2: Chronology of HIV/AIDS and State Response in India

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HIV/AIDS in Darjeeling: Historical Context and the Recent Past

Darjeeling is situated in a geographically strategic location. It shares international borders with Bhutan and Nepal. The
rapidly as a result of a hastily spreading epidemic (Gupta et al., 2003).

State Responses

Genesis and extent of response to the epidemic differed across states and played important roles in shaping the epidemic differently in different states. The Indian Government in an endeavour to curb the spread of the epidemic has responded by setting up the National AIDS Control Organization (NACO), to formulate and implement the National AIDS Control Programme (NACP). It is a centrally sponsored scheme, which comprises of Surveillance, Programme Management, Information, Education and Communication (IEC), Blood Safety, Condom Promotion, Control of STDs and Clinical Management. Initially, NACP was planned for a period of 7 years from 1992 to 1999 which was extended up to 2006. The first phase (1992-1999) of the project was financed by the GOI and a contributing $14.1 million and IDA credit of $84 million and WHO co-financing grant of $1.5 million (Action Aid 2006). In addition USAID and DFID are other two important sources and financing. The overall focus of NACP has been prevention of control and these two components receive the major share of care and the fund allocated followed by the two components of quasi-governmental support. Some government and quasi-governmental organizations have also joined hands with NACO in fighting HIV/AIDS in various capacities and forms. Important among them are Steel Authority of India Limited (SAIL), Indian Railways (IR) and the Defense Ministry. Indian Parliamentarians have also come forward to confront HIV/AIDS and the Parliamentarians Forum for HIV/AIDS was established which organized the first ever National Convention of Elected Representatives on HIV/AIDS in 2003. On December 1, 2003, the then Health Minister announced plans to provide free ARVs to all HIV positive new parents and children under 15 in six states with the highest rates of infection.

The first milestone in the evolution of the concern for HIV/AIDS was the initiation of sentinel surveillance in 1985. Five years later NACO was formed during 1990-1991. In the following year ICMR established its first AIDS research institute in Pune. NACO is also started in phases in the same year. About 10 years later VCCTC was established in Darjeeling District Hospital. In 2006, PPTCT and two years later ART centre was also started there (Table 1.2).

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HIV and AIDS in Darjeeling

borders of Bangladesh and China are also very close. In the year 1835, Darjeeling was ceded to the British East India Company by the Rajah of Sikkim (O’Malley 1989; Pinn 1990). Darjeeling as an urban centre came into existence with the entry of the British in this hill station due to their need for a sanatorium and a summer capital (Lama and Chakraborty 2007). The British developed Darjeeling for reasons of its strategic importance and its potential to become a major trading centre (Palit 2007). However, only with the introduction of tea and cinchona plantation did Darjeeling grow as an urban centre (Pinn 1990). With the plantation of tea and cinchona the population of Darjeeling gradually started to grow from 100 in 1835 to 10,000 in 1859 and a staggering 1,73,342 in the early twentieth century (O’Malley 1989). With the growth of Darjeeling as a summer resort, it soon started to attract the people of the plains with its ample business opportunities. Darjeeling was soon flooded with migrants and business was taken over by the people of the plains. The Bhisis and the Marwaris controlled the wholesale and retail business and the Gorkhas who were in majority were left to carry out petty business and manual work. This had a profuse impact on their being socio-economically underdeveloped vis-a-vis the business communities (Subba 1992). Darjeeling has today developed into a major tourist hot spot and has been connected with the larger global scenario. This exposure to the outside world has also had its negative fall outs. The youth are indulging in drug abuse and the past years have also witnessed large scale migration among them. Due to the lower socio-economic condition and a growing consumerist culture many are out to earn quick money by any means. Prostitution and drug abuse are on the rise. This situation has made Darjeeling highly vulnerable to HIV/AIDS.

Studies HIV/AIDS in Darjeeling

Darjeeling district has witnessed political unrest for many decades now. Unresolved issues concerning identity, political separation from West Bengal, underdevelopment and lack of willingness on the part of the Central and State Governments to resolve these issues has brought about social and economic crisis in the district and particularly in the hilly regions. The

Darjeeling Gorkha Hill Council (DGHC) was formed in 1988, after a long drawn out struggle for a separate state under the leadership of the Gorkha National Liberation Front (GNLF). However, the autonomous body was not given any real powers for development and employment generation. And there was misappropriation of any funds that came to the Council. This lack of vision and integrity on the part of the local leaderships has plunged the district into deeper crisis. In 2008, the GNLF was unceremoniously overthrown by Gorkha Jan Mukti Morcha (GJMM), which has again spearheaded the campaign for a separate state. The autonomous Hill Council has no elected leaders and was declared defunct. Recently it is being looked after by the District Magistrate of Jalpaiguri district, with no local political participation. Years of political instability and stepmotherly treatment from the Central and State Governments have had tremendous socio-economic repercussions in the hills of Darjeeling. Infrastructural development remains abysmally low. Health facilities, roads, potable drinking water, educational facilities are acutely inadequate to serve the rapidly growing population.

In the context of HIV/AIDS it is important to note that the only three important hospitals (Victoria, Eden and Planters) were established during the British period. In the past 62 years, the government has not deemed it important to establish any new hospitals there. A few private hospitals have recently come up but they cater to a richer clientele. The sub-divisional hospitals, PHCs and the sub-centre are ill-equipped to handle grave illnesses. During the fieldwork it was seen that among the hospital staff, there was not only a lack of correct awareness about HIV/AIDS, they also lacked empathy towards the positive people. This ill-behaviour may have stemmed from the prejudices arising out of inadequate knowledge about the illness.

As far as education is concerned, barring the schools run by the missionaries, the government run schools lack infrastructure to produce well-groomed students. There are also no good colleges in Darjeeling district so many students go to metros like Delhi, Kolkata, Bangaluru and Mumbai to study. There are no universities in the hilly regions of the district. The only university meant for the district is in Siliguri. The hill
HIV/AIDS in Darjeeling

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Studying HIV/AIDS in Darjeeling

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students therefore have to go elsewhere for higher studies. Being away from home at such a tender age, away from parental and societal control leads many to indulge in risk behaviours. So apart from those students whose parents can afford to send them outside Darjeeling to study, the rest have to make do with whatever is available. These youth are ill-equipped to compete at various levels. They also do not have any vocational training. This has contributed to higher levels of unemployment. This is leading the youth to frustration which in turn is leading to alcohol consumption and drug addiction. Under the intoxication of drugs and alcohol they are also indulging in risk behaviours. It is seen that even most of the students who have passed out from English medium schools have only managed to get employment in BPOs. BPOs with its glitzy lifestyle, in a metro provide one with anonymity to pursue risk habits.

As far as employment in the hills is concerned apart from the tea gardens which are facing closure due to an ever competitive global market, there are no other industries. The hills of Darjeeling are very fertile and produce a variety of fruits and vegetables and cash crops but it is seen that, the hills, like the colonies during colonial rule only serve to supply raw materials. There are no food processing factories in the hills which could be established if the governments desire.

The unpredictable situation of the tea gardens has exerted pressure on many to migrate in search for better livelihood. Many of these people who are unskilled labourers seek employment in the unorganized sectors and are very susceptible to diverse forms of exploitation. Many women come to the cities to work as domestic help. The nature of their jobs make these people financially insecure and long hours of work make it difficult for them to build social networks. In addition to such a financial position, the lack of social network so far away from home creates loneliness.

The youth who decides to stay at home becomes victims of frustration and depression. With no avenue to vent their anger these youth involve in the abuse of substances. Alcohol consumption and drug abuse among the youth of the hills of Darjeeling is common. At the time of fieldwork there were approximately 1200 youth enrolled at the different Indian Red Cross Society (IRCS) centres of the hills. In 2002, there were 114 alcohol related deaths in the Eden Hospital alone and in 2003 there were 815 enrolled on account of being alcohol dependent, at Kripa Foundation, a rehabilitation centre for drug and alcohol dependents. This indulgence of the youth is also facilitated by the exposure to the outside world. Both these factors are associated with the spread of HIV/AIDS. The sharing of needles among the IDUs and the engagement of these youth in risk behaviour in the intoxicated state makes them vulnerable to HIV/AIDS. The fact that a large number of PLWA in Darjeeling are former IDUs supports this fact. The location of the region, which shares international border with Nepal and is in close proximity with the North-East states, which are the recognized routes for drug trafficking, also makes it easy for accessing drugs and this also adds fuel to an already volatile situation.

The exposure to the outside world and the lack of employment opportunities has changed the behaviour pattern of the youth in Darjeeling. The changing value system and the dilution of the traditional lifestyle have removed the taboo against sex. Girls have become more open to sex and the lack of economic pursuits has forced many into prostitution. Sexual practices among the youth are changing at a rapid pace due to various influences on their lifestyle.

The region is also poor in terms of the enormous health infrastructure required for the prevention and control of HIV/AIDS. During the time of conducting the field work there were no ART centres, there was only one VCCTC, which unfortunately was not accessible to the rural populace, there were no CD4 cell counting centres and the health personnel were also ill-trained to provide care and support to the PLWA. The web of all these complex variables has today made Darjeeling very vulnerable and susceptible to the spread of HIV/AIDS.

**Rationale of the Study**

The HIV/AIDS epidemic puts the socio-economic, cultural and political condition and the public health crisis of the region into sharp focus. HIV/AIDS highlights the exploitation of
students therefore have to go elsewhere for higher studies. Being away from home at such a tender age, away from parental and societal control leads many to indulge in risk behaviours. So apart from those students whose parents can afford to send them outside Darjeeling to study, the rest have to make do with whatever is available. These youth are ill-equipped to compete at various levels. They also do not have any vocational training. This has contributed to higher levels of unemployment. This is leading the youth to frustration which in turn is leading to alcohol consumption and drug addiction. Under the intoxication of drugs and alcohol they are also indulging in risk behaviours. It is seen that even most of the students who have passed out from English medium schools have only managed to get employment in BPOs. BPOs with its glitzy lifestyle, in a metro provide one with anonymity to pursue risk habits.

As far as employment in the hills is concerned apart from the tea gardens which are facing closure due to an ever competitive global market, there are no other industries. The hills of Darjeeling are very fertile and produce a variety of fruits and vegetables and cash crops but it is seen that, the hills, like the colonies during colonial rule only serve to supply raw materials. There are no food processing factories in the hills which could be established if the governments desire.

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HIV/AIDS in Darjeeling: A Cause for Concern

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women, their low socio-economic status, the trafficking of young girls and it exposes the economic crisis and unemployment that pushes youth into drug addiction and it throws into sharp focus the explosive spread of intravenous drug use in the region (Panos 1999). So in order to implement the desired interventions, the epidemiology of HIV/AIDS in a particular region has to be understood especially with regards to various socio-demographic factors, level of awareness as well as patterns of risk behaviour of the population. The most effective approaches available for the prevention and control of the infection are awareness generation and lifestyle changes.

The area of study has been selected due to the rapid spread of HIV/AIDS in the recent past. Till 2005 about 65 people were detected with the killer disease. The number of cases doubled in the last two years. By November 2007, it had increased to 141. NACO categorizes Darjeeling as a district with increased presence of vulnerable population.

The study region has a large number of drug addicts due to its close proximity to Siliguri and the north-eastern states, which is one of the most important routes for drugs entering into other parts of India from Myanmar. The HIV prevalence among the IDUs was found to be 10-14 per cent in Darjeeling in a survey conducted by the government in 2003-04 which makes the region one with the highest prevalence of HIV among IDUs in the state of West Bengal (IRCS, Kurseong). Siliguri, a commercial centre, is a part of Darjeeling district and also the link between North-East, Sikkim, Bhutan, Nepal and rest of India, not only cater to the drug demands of Darjeeling alone but it also caters to the sexual demands of Darjeeling and its neighbouring places as it has a brothel based sex industry.

All these factors make Darjeeling very prone to HIV/AIDS. It is not just the brothel of Siliguri which acts as a vector for the transmission of the disease to the hills of Darjeeling but also the unorganized sex market available in the hills itself which is posing a great danger for the explosion of HIV/AIDS in the hills.

There is a serious shortage of employment opportunities in the hills of Darjeeling which is forcing the people to migrate.

As a result there is a large influx of people migrating from the hills in search of livelihoods to other parts of India, which also has a great potential for spreading HIV/AIDS in the hills. The political condition of the hills of Darjeeling is also conducive for the spread of HIV/AIDS. Health department comes under the jurisdiction of the DGHC but due to its dissolution, there is no one to take accountability for the intolerable condition of the health sector in the entire hills of Darjeeling. Though the health department is under its jurisdiction, DGHC has not been able to demand for the establishment of an ARV distribution centre in the district hospital. Apart from voluntary counselling and testing the district hospital does not perform any other functions associated with the prevention and control, care and treatment elements of HIV/AIDS.

The political unrest in the hills also favour the spread of HIV/AIDS. With the renewed demand for Gorkhaland strikes and ‘bandhs’ have become the norm of the day and these are in turn hampering the health seeking behaviour of the PLHWA, as they have to go to North Bengal Medical College and Hospital (NBMCH) at Siliguri, (80-90 kms from Darjeeling) for their check-ups and medicine. The infrastructure of health system is also not developed enough to tackle the rapid growth of HIV/AIDS in the hills of Darjeeling.

The awareness level among the people regarding HIV/AIDS is very low and a lot of misconceptions regarding HIV/AIDS exist among the people. The study area is also part of a district which is considered a high prevalence district in West Bengal. Thus drug addiction, alcoholism, unemployment and political instability is compounding the vulnerability of the area to HIV/AIDS. The area presents a major challenge to public health due to the debilitating effects of HIV/AIDS and the lack of infrastructure to combat the crisis.

Conceptual Framework

HIV/AIDS is rooted in the socio-economic and political conditions of a region and its people. The socio-economic condition of Darjeeling hills is very conducive to the spread of HIV/AIDS. The economy of Darjeeling is to a large extent dependent on tea industries. With the advent of cheaper tea
women, their low socio-economic status, the trafficking of young girls and it exposes the economic crisis and unemployment that pushes youth into drug addiction and it throws into sharp focus the explosive spread of intravenous drug use in the region (Panos 1999). So in order to implement the desired interventions, the epidemiology of HIV/AIDS in a particular region has to be understood especially with regards to various socio-demographic factors, level of awareness as well as patterns of risk behaviour of the population. The most effective approaches available for the prevention and control of the infection are awareness generation and lifestyle changes.

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There is a serious shortage of employment opportunities in the hills of Darjeeling which is forcing the people to migrate.
from other parts of the world, the exclusive Darjeeling tea lost a major portion of its market share due to its high price. This has led to the closure of many tea industries which could not compete in the world market. This had an enormous effect on the economic conditions of the people. Many people lost their livelihood and were rendered homeless and were pushed to poverty. These factors along with sex are recognized factors for HIV/AIDS (Collins and Rau 2000) and the people of Darjeeling hills have been affected by them. Many had to migrate in search of a livelihood. Living far away from home and outside the familiar social network may have forced many of them to engage in risk behaviours. In such a scenario there is a greater chance of them getting infected and transmitting the virus to their spouse at home.

Many young boys of the region join the armed forces. There are probabilities that they indulge in risky behaviour when away from home. Soldiers live far away from their home and families. They are under constant pressure and especially in stressful conditions and environment and are in search for recreation to relieve their stress and loneliness. Peer pressure also leads to risky behaviour and generally the military ethos tends to excuse risky behaviour (McKee et al. 2004). Thus, they are likely to be exposed to the HIV infection and in turn render their wives vulnerable to the infection.

The out migration from Darjeeling is largely caused by negligible employment opportunities. One of the recent trends in migration is of women migrating as domestic help, not just to other parts of India but also to foreign countries. This is a major cause of concern as these women do not have any negotiating power and may be exploited sexually which makes them vulnerable to HIV. Lack of employment opportunities can be frustrating, and many youths are attracted to drugs and alcohol. Drug addiction and alcoholism, which encourages risk behaviours is very prevalent in the hills. Drug addicts are shunned and looked down upon by the general population so they are confined to their groups and needle sharing among the intravenous drug users is high (Sundas 2004). This practice of needle sharing among them poses greater likelihood of HIV transmission. Female drug addicts, though far less in number than their male counterparts, are more susceptible to being infected by HIV as they face the double danger of being infected through needle sharing as well as sexual intercourse.

Tourism is also an important source of economy in Darjeeling. There is a large influx of tourists every year from around the world. There is a chance that the local population may get infected from the infected tourists in case of contact. There are a large number of sex workers who provide private services. They do not confine their work to Darjeeling town but also travel to nearby places and are likely to have among their clientele the tourists and the nouveau riche especially the contractors. According to a study conducted by NICED, the only brothel in the district is located in Siliguri and it poses immense risk of HIV/AIDS to the hills of Darjeeling as those who cannot afford the services of the Flying Sex Workers (FSWs) in Darjeeling avail the services of these CSWs. The sero-prevalence among the sex workers of this brothel was found to be highest (15.6%) in the whole of West Bengal. To compound the severity of the matter the sex workers also lack awareness and knowledge about methods of prevention of HIV transmission (NICED 2006).

The Voluntary Counselling and Confidential Testing Centre has started in Darjeeling. There is still a shortage of trained personnel. Also one VCCTC in Darjeeling will not suffice for the whole of the hills as it becomes very difficult for those residing in rural areas and in remote areas to access it. Blood safety measures also need upgradation in many of the rural as well as sub-divisional hospitals. As the health delivery systems falls far below the required standard, for the control and prevention of HIV/AIDS, the burden of treatment cost falls directly on the patients and their family. The travel cost is huge as they have to travel to Siliguri or Kolkata for better treatment and care.

The economic burden on those infected and affected by the disease is very huge as the cost of medicine (ARV) is high, beyond the reach of many in the hills and other related expenditures like travel, nutrition etc. also becomes high. The economic burden is much higher when it is compared with the economic conditions of those who are not affected, as the per capita income of the people in these areas is low. People in search of treatment will be in the danger of losing their life
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HIV/AIDS in Darjeeling

Analytical Framework

The analytical framework of the present study includes a discussion on research question and purpose of the study followed by the hypothesis and the research design.

Research Questions

The political situation of Darjeeling is volatile. The socio-economic conditions are rapidly changing. There is growing trend towards westernization. The above factors along with the present day dismal infrastructure of health system, educations etc. have grave implications on the health of the people. The dangers of HIV/AIDS are more pronounced in such situation. The following research questions are designed to arrive at a clear picture of the presence and threat of HIV/AIDS in the study area:

1. What are the main determinants of the spread of HIV/AIDS in Darjeeling hills?
2. Which sections of the society have been affected by HIV/AIDS?
3. What is the level of awareness of HIV/AIDS among the people and what programmes are implemented to raise awareness?
4. How do the community members perceive HIV/AIDS?
5. What are the important consequences of HIV/AIDS on the families of those infected?
6. What is the available infrastructure in terms of health clinics, treatment, care and counselling and testing centres?
7. What has been the state and institutional responses to confront the disease?

Encourage Spread of HIV/AIDS

Fig. 1.1: Conceptual Framework of Factors Associated with HIV/AIDS in Darjeeling Hills
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**Objectives**

Thus the main objectives of the study are—

- To study the provision, planning and management of HIV/AIDS services.
HIV/AIDS in Darjeeling

- To look at the implications of migration on the spread of HIV/AIDS in Darjeeling.
- To look at how the administrative structure of the region is responsible for the strategies and plans to address HIV/AIDS
  - What is the role of DGAHC?
  - What is the role of major employers such as the tea gardens and railways?
  - What is the role of other agencies (which are working and funding for the control and prevention of HIV/AIDS in the region)?
  - What is the level of success of the current modes of HIV/AIDS prevention and control adopted by the state and other concerned institutions?

Hypothesis

The poor socio-economic conditions of the people of Darjeeling hills since independence and the lack of infrastructure in terms of quality education, health facilities, employment avenues etc. has had an adverse effect on the society. This has pushed people towards risk behaviour, making the environment conducive to HIV/AIDS.

Research Design

Study Area

The study comprises of the three hill sub-divisions of Darjeeling district—Darjeeling, Kalimpong and Kurseong, which are situated in the northern part of the state of West Bengal. The study area was selected because it is part of Darjeeling district which has a high HIV prevalence among the IDUs and also among the women visiting antenatal care. The study area is labelled as Darjeeling hills for the purpose of the study.

Methodology

The present study incorporates review of literature and published data; and a field based data collection and analysis.
HIV and AIDS in Darjeeling

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HIV/AIDS in Darjeeling: A Cause for Concern

Literature on the global and Asian scenario of HIV/AIDS as well as that of India has been extensively reviewed. Relevant data from sources such as UNAIDS, UNDP, NACO and WBSAP&CS have been analyzed.

As part of the field study, data have been collected by employing qualitative as well as quantitative methods from the sample derived using purposive sampling and snowball techniques. The respondents comprises of community members, PLWHA, flying sex workers, intravenous drug users and bisexuals. The purposive sampling was used to identify the respondents from among the community members while snowball technique was used to draw sample from among FSWs, IDUs, PLWHA and bisexuals.

The methodology also included a case study of Shanker Foundation and other NGOs from the Darjeeling hills who were involved in the control and prevention of HIV/AIDS. NGOs were also visited for the conduct of in-depth interviews and observations of the implementation of the programmes. Participation in the programmes of the NGOs was also done to get a first hand knowledge of the way these NGOs functioned.

The data collection was undertaken from the month of July to December in 2007. Prior to the data collection, preliminary work was conducted on two field visits to the study area to establish relations with the key informants and the PLWHA. Before going to the field for data collection literature review was also done.

Tools and Techniques

Multiple methods were used for data collection, including non-participatory observation among the PLWHA and IDUs, in-depth interviews, informal conversations and focus group discussions.

Focus group discussion was also carried out among three groups. One group was those of FSWs and the other group was of the community members and the third group was of the IDUs. Unfortunately not many came for the discussion and there were no female participants among the community members and the IDUs. There were only 4 participants in the
focus group discussion conducted among the community members, 5 among the FSWs and 7 among the IDUs (Tables 1.3, 1.4 and 1.5). The focus group discussion for the community members was conducted in Kurseong, with the IDUs it was conducted in Darjeeling and with the FSWs it was also conducted in Kalimpong. The participants were educated, married, single and divorced. Still it provided an in-depth knowledge of important issues from the perspective of the participants. Guidelines for the discussion were prepared and used for the same to seek spontaneous responses from the participants.

Table 1.3: Characteristics of the Participants in the Focus Group Discussion (FSW)

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Age</th>
<th>Sex</th>
<th>Marital Status</th>
<th>Education</th>
<th>Income</th>
</tr>
</thead>
<tbody>
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<tr>
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<td>29</td>
<td>F</td>
<td>Single</td>
<td>12th</td>
<td>6000</td>
</tr>
<tr>
<td>5</td>
<td>25</td>
<td>F</td>
<td>Married</td>
<td>10th</td>
<td>5000</td>
</tr>
</tbody>
</table>

Source: Field Data.

Table 1.4: Characteristics of the Participants in the Focus Group Discussion (Community Members)

<table>
<thead>
<tr>
<th>Sl. No</th>
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<th>Sex</th>
<th>Marital Status</th>
<th>Education</th>
<th>Income</th>
</tr>
</thead>
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<td>Single</td>
<td>B.A.</td>
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</tr>
<tr>
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<td>2000</td>
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<tr>
<td>4</td>
<td>24</td>
<td>M</td>
<td>Single</td>
<td>12th</td>
<td>Nil</td>
</tr>
</tbody>
</table>

Source: Field Data.

Field notes were the salient method of data recording. Five groups of respondents formed the study population, the community members (public), ‘the flying sex workers (FSWs),’ the IDUs, PLWHA and the bisexuals. A semi-structured interview schedule was designed to collect primary data while a desk survey of relevant literature and organizational documents was done to collect secondary data.

HIV/AIDS in Darjeeling: A Cause for Concern

Table 1.5: Characteristics of the Participants in the Focus Group Discussion (IDUs)

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Age</th>
<th>Sex</th>
<th>Marital Status</th>
<th>Education</th>
<th>Income</th>
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<td>B.A.</td>
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<td>B.A.</td>
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<td>B.A.</td>
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</tr>
<tr>
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<td>Single</td>
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<td>2000</td>
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<td>Divorced</td>
<td>M.A.</td>
<td>9000</td>
</tr>
<tr>
<td>6</td>
<td>32</td>
<td>M</td>
<td>Married</td>
<td>7th</td>
<td>3000</td>
</tr>
<tr>
<td>7</td>
<td>26</td>
<td>M</td>
<td>Married</td>
<td>B.A.</td>
<td>8000</td>
</tr>
</tbody>
</table>

Source: Field Data.

A number of in-depth interviews were also carried out to acquire greater knowledge on the prevalence of HIV/AIDS, awareness and perception of the community members about HIV/AIDS, and stigma and discrimination faced by those infected and affected by the disease. Some data was collected through case studies done in all the 3 sub-divisions. Knowledgeable persons working in the area of HIV/AIDS were also interviewed as key informants and utmost care was taken to involve diverse sections of the society.

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The Interview Process

In order to ensure confidentiality and emphasize the voluntary nature of the interview all potential respondents were asked for prior appointments to ensure their convenience and were also given the choice of opting out of the interview. Moreover, even on the day of contact the researcher ensured that
Table 1.5: Characteristics of the Participants in the Focus Group Discussion (IDUs)

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Age</th>
<th>Sex</th>
<th>Marital Status</th>
<th>Education</th>
<th>Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>27</td>
<td>M</td>
<td>Single</td>
<td>B.A.</td>
<td>Nil</td>
</tr>
<tr>
<td>2</td>
<td>30</td>
<td>M</td>
<td>Married</td>
<td>B.A.</td>
<td>8000</td>
</tr>
<tr>
<td>3</td>
<td>29</td>
<td>M</td>
<td>Single</td>
<td>B.A.</td>
<td>Nil</td>
</tr>
<tr>
<td>4</td>
<td>25</td>
<td>M</td>
<td>Single</td>
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<td>2000</td>
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<td>M.A.</td>
<td>9000</td>
</tr>
<tr>
<td>6</td>
<td>32</td>
<td>M</td>
<td>Married</td>
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respondents could opt out, or negotiate a better time and place for the interview. The purpose of the interview was always explained and interviews lasted for 30-120 minutes.

Semi-structured schedule was used for interviewing. Most of the interviews were carried out in Nepali and only 10 interviews were carried out in English. It was designed to elicit spontaneous replies to open ended questions. The interview covered the subject’s views on how HIV/AIDS is transmitted, what are the ways to prevent it, who are the most vulnerable population, if they would like to talk, sit and communicate with the PLWHA. The interview also sought to find out the respondents’ view on the medical facilities for the welfare and treatment of those who were infected by the disease, and whether or not the PLWHA had to face any problems in accessing these facilities, if available. Importantly, from the key informants information on the political will to control the epidemic was sought.

The PLWHA were selected from Shanker Foundation, Darjeeling. As Shanker Foundation is the only network of positive people of the hill sub-divisions of Darjeeling the researcher was able to interact with PLWHA from different social settings and to generate diverse information on the experiences of the PLWHA. The location of the interview for the PLWHA was the Shanker Foundation office as this was the most convenient place for them to be interviewed without any disturbance and interruption. They were encouraged to seek clarification before the interview began and were also given the option to withdraw from the interview at any point of time. With their permission the interviews were noted down in details by the researcher. Depending on the context of the interview specific phrasing of the questions varied slightly across participants and some other open-ended questions were also asked during the interview process.

Choice of Shanker Foundation

Shanker Foundation was selected as it was the only place where the possibility of meeting all the PLWHA was overwhelmingly positive. Moreover, most of the PLWHA had not disclosed their positive status at the time of interview so there was a chance of at least interviewing those who had disclosed their sero status. All the PLWHA were not known to me except two with whom rapport was developed in the previous visit to Shanker Foundation. It was thought that to develop a good rapport it would be better to meet them in a place where they would be among the people they trusted. Shanker Foundation also helped me to meet all the PLWHA and approach them for interview and in case any one of them declined to be interviewed I had other interviewees.

The first PLWHA agreed to be interviewed only after I had made numerous forays at Shanker Foundation office at Darjeeling. Before the respondent agreed I had to talk with the members of the foundation and convince them that the purpose of the study was academic and was not for any profit making purpose. The members also tested my knowledge of HIV/AIDS and asked questions on discrimination and other aspects of the disease. The most important incident occurred when I had gone there the second day. The coordinator offered me tea and said that people think that the disease can also spread by having tea or for that matter from utensils used by people infected by the virus. To gain their confidence I had to narrate stories of meeting people infected with the virus from India and abroad. After hearing their stories about discrimination I also had to tell them about their rights and also how it was inhuman to discriminate only because somebody was infected by some virus. During this period I had to make sure that I did not hurt their sentiments in any way. After the co-ordinator of the foundation was satisfied, he allowed me to interview his colleagues. The first interview was of a female respondent and she was very honest. At the end of the interview she said that she felt very good talking to me as she could tell me everything she had inside her and so much wanted to share with somebody.

Among the community members almost everybody I interviewed suspected me of something or the other. The first interview I conducted was possible after many rejected the proposal. Many among the community members also inquired whether I was infected or not.
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Challenges of the Study

The study is subject to several important challenges. The findings reflect the behaviours and beliefs of a relatively small sample from one specific geographic area. The sample is small because many in the area refused to be interviewed and also many interviews could not be included here as there were inconsistencies and contradictions in the respondents' responses to the questions. Our understanding of knowledge and perception of HIV/AIDS are inferred from retrospective reports, rather than measured over time. More importantly, the large imbalance in the ratio between male and female respondents raises the possibility of selective bias for the male sample.

Some respondents were skeptical and suspicious regarding the motive and attitude of the researcher. Due to this reason many whom the researcher wanted to interview did not oblige. Many were too hesitant to talk about issues like sex, sexual behaviour and HIV/AIDS. The views of many people involved in the field of HIV/AIDS, like the secretary of DACC, the CMO of Kurseong Sub-Divisional Hospital could not be sought because of their time constraints and also as many did not want to give any interview. Only a few politicians were interviewed as they were either not available or denied talking about HIV/AIDS saying that it was not their concern and it came under the purview of the health department.

Only 11 PLWHA were interviewed as many had not disclosed their status and their identity was not known. Except one who was interviewed at Kalimpong, only those coming to Shanker Foundation and willing to give interview were interviewed. Out of the five PLWHA who had disclosed their status only two could be interviewed as one of them was in a rehabilitation centre in Sikkim and the other two were out of station, attending training programmes and official work of Shanker Foundation. The number of care givers is less in the sample as many of the PLWHA had not even disclosed their HIV sero positive status to their family. Due to some problem in bureaucratic protocol the report taken out by DACC for the area it covers was also not made available to the researcher. The interviews were desired to be one to one but some of the interviews had to be executed in the presence of someone or the other. Subjects may have underreported the number of persons with whom they had injected or had sex with as they did not want to mention knowing certain other drug injectors or sex partners. Since the subjects were recruited through purposive and snowballing sampling technique the data may also have limited representation. In spite of these challenges, the data has provided the opportunity to make a number of important inferences. It must also be borne in mind that the data are derived from self-report. Furthermore, all information is largely retrospective.

HIV/AIDS: Review of Literature

Under the aegis of ICMR in 1985, India was among the first few countries to initiate sentinel surveillance (NACO 2007). The impact of HIV/AIDS will be felt severely by the health sector and the government, with government health subsidies rising rapidly as a result of a hastily spreading epidemic the government will also feel the burden of the epidemic as it will have to subsidise health care immensely (Gupta et al. 2003). As per the UNAIDS report 2007 there are 2.31 million people currently infected by HIV. NACO Annual Report (2004) gives a comprehensive picture of the epidemic in India. It divides the states of India into high, moderate and low prevalence states and brings out a clear scenario of the disease in each of these states. The report ends that:

1. HIV/AIDS is increasingly affecting young people in the society, particularly the age group of 15-44 years.
2. The transmission of the HIV virus is mostly through sexual contact (85.7%), followed by mother to child transmission and transfusion of blood products. In the Hollingshead study the per cent of the infected who were in the married for 73.5 per cent. The risk of infection is maximum among those in the stage of premarriage.
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The study is subject to several important challenges. The findings reflect the behaviours and beliefs of a relatively small sample from one specific geographic area. The sample is small because many in the area refused to be interviewed and also many interviews could not be included here as there were inconsistencies and contradictions in the respondents' responses. Our understanding of knowledge and perception of HIV/AIDS are inferred from retrospective reports, rather than measured over time. More importantly, the large imbalance in the ratio between male and female respondents raises the possibility of selective bias for the male sample.

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HIV/AIDS in Darjeeling: A Cause for Concern

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The report finds that:

1. AIDS is increasingly affecting young people in the sexually active age group. The majority of the HIV infections (87.7%) are in the age group of 15-44 years.
2. The predominant mode of transmission of the HIV infection is through heterosexual contact (85.7%), followed by injecting drug use (2.2%), blood transfusion and blood product infusion (2.6%), perinatal transmission as 2.7 per cent and others as 6.8 per cent.
3. In the HIV sentinel surveillance 2003, males accounted for 73.5 per cent of AIDS cases and females 26.5 per cent. The ratio between male and female was approximately 3:1.
4. The predominant opportunistic infection among AIDS patients is tuberculosis, indicating a potential future spread of the HIV-TB co-infection.

There is an absence of vaccine or drug to cure the disease (Kalichman 1998) and this has led to further spread of the epidemic. Although HIV/AIDS is concentrated among the high risk groups there are evidences that it is moving beyond them and into the low risk population like the women and youth (NACO 2006).

The search for vaccines that could potentially impede the relentless increase in the number of the people infected by HIV cannot be accomplished without the involvement of large pharmaceutical companies. But these companies have hardly shown any interest in searching and producing AIDS vaccines as the countries severely suffering from the AIDS epidemic cannot afford to buy these vaccines in quantities enough for them to achieve minimum profit (Craddock 2007).

Determinants of HIV/AIDS

Poverty, sex work and migration are acknowledged socio-economic risk factors for HIV (Collins and Rau 2000). Poverty encourages the spread of HIV and quicker progression from HIV sero-positivity to full blown AIDS (Masanjala 2007). Poverty and inequality can drive those on the margin of destitution into risky livelihood and coping strategies that raise their likelihood of contracting HIV. AIDS overwhelmingly affects individuals living in underdeveloped countries, where poverty and lack of access to resources such as health care, ARVs continues to drive the epidemic. Although AIDS is not simply diseases of the poor, determinants of the epidemic go far beyond individual volition and that some dimensions of being poor increases risk and vulnerability to HIV (Dodoo et al. 2007; Masanjala 2007). Economic hardship is acknowledged to compound women's sexual vulnerability. Economic stresses associated with low wages, unemployment and poverty leads many women to use sex to generate income for basic needs provoking early initiation of sexual activity and high incidence of multiple sexual partners (Ulin 1992). These conditions also promote men to exploit women's economic vulnerability by paying very little for sex and subjecting women to domestic violence (Dodoo et al. 2007). Dodoo et al. further examines the relationship between economic circumstances and sexual outcomes across urban and rural Kenya. Although poverty is significantly associated with the sexual outcomes in all settings the urban poor are significantly more likely than their rural counterparts to have an early sexual debut and a greater incidence of multiple sexual partners. They compare the impact of socio-economic deprivation on risky sexual outcomes in rural and urban Kenya. The disadvantage of the urban poor is accentuated for married women and those in Nairobi's slums are at least three times as likely to have multiple partners as their rural counterparts. The determinants to vulnerability should be recognized as rooted in poverty, social disruption, underemployment, gender and access to resources (Social Science & Medicine 2007). For women vulnerabilities to HIV are exacerbated by widespread gender based social inequalities (Oppong 1998). HIV/AIDS highlights the exploitation encountered by women which is a fallout of their low socio-economic status (Panos 1999). Yet the dominant biomedical paradigm of AIDS research continues to centre upon individual behaviour rather than looking at the social and economic contexts (MacDonald 1996).

Condom has become an effective barrier against HIV/AIDS. However, its use is not very widespread among the people. Significant proportion of young people experience risky or unwanted sexual activity within the context of marriage and in premarital relationships and they do not receive prompt or appropriate care and experience adverse reproductive health outcomes including HIV/AIDS (Santhya et al. 2007). Married women constitute a group with distinct risk of HIV/AIDS and face a host of obstacles in making informed decisions in protecting themselves from infections. Findings from a number of studies conducted among HIV positive women also show that a substantial proportion of infected women were young women whose only HIV risk factor was sex with their spouse (NACO 2006). In societies where there is a prevalence of multiple sexual partners, where prostitution is a major
HIV and AIDS in Darjeeling

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HIV and AIDS in Darjeeling

component of sexual culture and where premarital sex is universal there is a likelihood of very rapid transmission of HIV/AIDS (Ford and Koetsawang 1991). Despite the increasing information on the risk of sexual relations without the protection of a condom people continue to be involved in this risk behaviour (Munoz-Silva et al. 2007).

Stigma and Discrimination

Wiess & Ramakrishna (2006) defines stigma as “a social process or related personal experience characterized by exclusion, rejection, blame or devaluation that results from experience of reasonable anticipation of an adverse social judgment about a person or group identified with a particular health problem.” Ever since the epidemic began PLWHA have been victims of stigmatization. The degree of stigma and discrimination associated with AIDS is the greatest compared to other infections (Crawford 1996). Discrimination related with HIV/AIDS is also compounded by the public’s negative attitude towards high risk groups such as CSWs (Peracca et al. 1998). General ignorance and misconceptions about HIV/AIDS have been the primary reasons for this discrimination (Zhou 2007). The negative responses and attitude towards PLWHA are related to the general levels of knowledge about HIV/AIDS and in particular to the causes of AIDS and the routes of HIV transmission (Bharat 2001). Within an environment where PLWHA are stigmatized and shunned, they conceal their status and if they do not disclose their sero status to their partners, friends and family they will not receive desirable help, care and support. Discrimination occurs when a person is treated unfairly and unjustly because he or she is perceived to be deviant from others or to belong to a particular group. Discrimination manifests in three major forms—overt, subtle and insidious, whereby stigmatized individuals realize that they have been labelled and have consequently lost their social status and also that stigma has both direct and indirect import on health (Link and Phelan 2006). The consequences of insidious discriminations include strained interactions, more restricted social networks and support, unemployment and loss of income (Deng et al. 2007). However, stigma and discrimination associated with HIV/AIDS stems from the underlying stigmatization of sex and intravenous drug use, both being the main paths of HIV transmission (UNAIDS 2003). There is a widespread discrimination towards PLWHA everywhere. Despite their knowledge and understanding about HIV/AIDS the perception of the PLWHA about and the response to HIV/AIDS is to a large extent influenced by their experiences of interactions with the others. The major implication of stigma and discrimination is that it creates a vicious cycle of social isolation, marginalization and thus addiction relapse (Deng et al. 2007). The prevention of HIV/AIDS should not be limited to the awareness of the infection but it should also focus on discrimination and stigma (Zhou 2007). Li et al. (2007) says that the Chinese professionals display more judgmental attitudes and less willingness to interact even casually with hypothetical patient with HIV/AIDS than with Hepatitis B. They further say that higher status medical professionals with more medical education and those occupying positions with more medical facilities showed more prejudice attitude towards PLWHA and less willingness to have social interaction with AIDS patients. Medical education in general and education about HIV/AIDS in particular will not necessarily reduce the stigma and discrimination attached with HIV/AIDS less it reduce specific fears of infection in the workplace. This to be achieved with access to necessary equipment and training so that health professionals can manage the infection appropriately (Deacon and Boule

HIV/AIDS in Darjeeling: A Cause for Concern

The report ‘Women Against AIDS in India’ (2004) conducted by the International Labour Office in Darjeeling and the support of ILO, the percentage of female elements were in the age group of 15-29. Most prominent among-group. This study found that the number of women and food increased. The report says that each person involved individually, and expenditure per event with each person had an adverse
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A study, ‘AIDS Discrimination in Asia’ (2004) conducted by the Positive People’s Network of India with the support of ILO, found that about 92 percent of the respondents were in the age-group 19–40 years, the most productive age-group. This study also shows that expenditure on medicines and food increased as a result of an infected person in the family, and expenditure on education and entertainment decreased, which had an adverse
HIV/AIDS in Darjeeling: A Cause for Concern

and well informed about HIV/AIDS and its treatment, especially those in the lower rungs of the hierarchy (www.avert.org). The growth rate has brought into action a variety of actors for its control and prevention. A variety of interventions have been implemented targeting diverse population. There has also been a wide spectrum of responses at the international, national and the local level. Yet the Indian public has not been well informed and active participants to confront the challenges posed by HIV/AIDS as there are very few sources of cogent information available about HIV/AIDS that people have access to (Ramasubban and Rathyasingra ed. 2005). ‘The Medecins Sans Frontiers’ expressed concern that access to affordable medicines for HIV/AIDS was becoming bleak (www.accessmed-msf.org 2005). In July 2005, the leaders of the G8 countries at the Gleneagles Summit committed to developing and implementing a package for HIV prevention, treatment and care with the aim of coming as close as possible to the goal of universal access to treatment by 2010 for all those who need it’ (UNAIDS 2006).

A Report by the Positive People’s Network of India (2004) states that serious and harmful discrimination against PLWHA prevails even in countries with progressive anti-discrimination legislation. Protecting the rights of PLWHA enables individual members of society to examine their vulnerability to HIV infection and that this is the most effective way to improve public health outcomes for all people.

Migration and HIV/AIDS

The fear that people coming from other countries and regions might bring dangerous contagious diseases into societies is deeply rooted among the people, ever since the Black Death (Knipe and Rector 2002). The epidemic seems to be more significant among the lower socio-economic groups mostly being migrants (Annual Report, WBSAP & CS, 2005-06). Mostly it is the young, often at the peak of their reproductive and sexual productivity, who are most readily displaced because of economic deprivation and the lure of the city. Their uprooting and movement to urban centers or other countries can involve a dramatic divorce from traditional values and the social control
impact on the quality of life of all the family members. Children were losing their parents due to AIDS which in turn put the responsibility of these children on the old grandparents who themselves were in need of support. This report documents a peer-led study on AIDS-related stigma and discrimination of people living with HIV and AIDS (PLWHA) in Asia. Findings show that over 80 per cent of respondents experienced some form of discrimination in the health sector, the community, the family and the workplace. Other findings included: lack of pre-test counselling, forced testing, treatment refusal and breaches of confidentiality. The report also highlights how women are significantly more likely than men to experience discrimination within the family and the community.

In India, as elsewhere, AIDS is perceived as a disease of ‘others’—of people living on the margins of society, whose lifestyles are considered perverted and deviant. Discrimination, stigmatization, and denial are the expected outcomes of such values, affecting life in families, communities, workplaces, schools, and health care settings (Bharat 2001). There exists no research in Darjeeling dealing with how PLWHA or those suspected of being HIV sero positive are perceived and treated because of their illness. However, it is quite evident from studies done in other parts of the globe that the PLWHA are not fairly treated and discriminated against because of their HIV/AIDS status (Aggleton 2000). PLWHA are stigmatized and discriminated against because their illness is primarily perceived to be contagious and threatening and not understood fully by the lay people. HIV/AIDS stigma and discrimination interfere with HIV/AIDS prevention, diagnosis and treatment and can become internalized by PLWHA (Simbayi et al. 2007). In India it is the women who are treated improperly than the men when found to be HIV positive. The women have to go through all the ordeals and are chased away from home, are not given the ancestral property (Bharat 2001). Stigma and discrimination may cause PLWHA to face social isolation, increased emotional distress and a loss of socio-economic support (FHI 2004). The PLWHA in the hills of Darjeeling are a hidden population as HIV/AIDS is the most ‘stigmatized medical condition in the world’ (Simbayi 2007; Kalichman 2007). The health officials in many parts of India are not well aware and well informed about HIV/AIDS and its treatment, especially those in the lower rungs of the hierarchy (www.aeveri.org). The growth rate has brought into action a variety of actors for its control and prevention. A variety of interventions have been implemented targeting diverse population. There has also been a wide spectrum of responses at the international, national and the local level. Yet the Indian public has not been well informed and active participants to confront the challenges posed by HIV/AIDS as there are very few sources of cogent information available about HIV/AIDS that people have access to (Ramasubban and Rashyasringa ed. 2005). ‘The Medecins Sans Frontieres’ expressed concern that access to affordable medicines for HIV/AIDS was becoming bleak (www.accessmed-msf.org 2005). In July 2005, the leaders of the G8 countries at the Gleneagles Summit committed to developing and implementing a package for HIV prevention, treatment and care with the aim of coming as close as possible to the goal of universal access to treatment by 2010 for all those who need it’ (UNAIDS 2006).

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which the family and the society structure exercise over their sexual behaviour (Carballo and Siem 2002). Migration in search of livelihood is conducive to the spread of HIV/AIDS as it places men and women in particular risk situation, in which institutions providing normal social support for stable family relations are absent (Collins and Rau 2001). Among the migrants, peer influences on risk behaviour have been documented among a number of groups (Imem and Suwannarat 2002).

The UNDP’s report on HIV and Migration (2004) examines the factors pertaining to HIV and migration in countries of South and North-East Asia. It highlights the increasing level of mobility and the context and conditions in which it occurs, which in turn affects the vulnerability of the migrants and their families to HIV. The report says that although all the seven countries have started to acknowledge that the HIV/AIDS epidemic poses a serious challenge, there are huge differences in the extent of commitment of each country and the resources available to tackle the epidemic. Further the absence of studies, data and information that explore issues concerning the vulnerabilities of specific sub-groups within migrant workers has contributed further to the lack of comprehensive responses directed at migrant workers and their communities. The inter-country migrants are more vulnerable than in-country migrants because of a host of reasons. Their vulnerability stems from language barriers feeling of alienation, distance and long periods of absence from home, limited access to information and services, limited rights to organize and negotiate for better services and fear of deportation upon testing positive for HIV.

The report says that countries like Bangladesh and Sri Lanka provide pre-departure training for outgoing migrants. However, these training either do not address HIV/AIDS or do so only minimally. The study found that there are very small number of models of good practice—which they do exists, they are limited in their scope and impact. The report says that unless Asian governments and international organizations respond quickly, the effect of the epidemic in the region could be devastating.

Human mobility is an overriding factor responsible for the spread of infectious diseases, particularly at the start of newly emerging or reemerging epidemics such as HIV/AIDS and SARS (Komatsu and Sawada 2007). The emergence of previously unknown infectious diseases, such as AIDS combined with the increased speed and volume of international trade and travel, have made countries conscious of their vulnerability to new and emerging infectious disease threats that can easily cross borders (Fidler 2004). All countries are vulnerable to the outbreaks either they emerge within national borders or present threats through international spread or decreased investment in public health has increased such vulnerability.

As the employment opportunities in the hills of Darjeeling are few there are many people migrating to other parts of the country as well to foreign countries in search of employment. Migration in search of livelihood is conducive to the spread of HIV/AIDS as it places men and women in particular risk situation, in which institutions providing normal social support for stable family relations are absent (Collins and Rau 2001). Migrants are more likely to be in high-risk situations since they are often poor, live away from their families and are more likely to engage in unprotected sex. Indeed, while there is no systematic information on this subject, government surveys indicate that most people who learn of their HIV status can trace their infection to a sexual encounter outside the state (Srinivasan and Sukumar 2006).

**Intravenous Drug Users and HIV/AIDS**

The association between injecting drugs and HIV transmission has been well established. However, this risk behaviour persists in most of the countries in the world and HIV infection associated with injecting drug in many of these countries has been found. The epidemic is sustained at high levels due to the dynamic interaction between high risk needle and syringe sharing, the high prevalence rate which increases the odds of sharing injecting equipment with an HIV positive partner, the high infectivity of new cases of infection and the extensive mobility and mixing between IDUs (Stimson 2005). Among the intravenous drug users, HIV infection is transmitted primarily through contaminated injection equipment, specifically needles and syringes. Drug paraphernalia is frequently shared by one or more individuals at
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the time drugs are injected. HIV infected IDUs can also transmit the virus to their sexual partners and wives, who may or may not themselves be IDUs (Rhodes and Malotte 1996).

Asia has seen the most rapid diffusion of HIV infection among IDUs. In Manipur the first HIV sero positive IDU was not detected until October 1989, within three months 9 per cent of the IDUs were found to be HIV sero positive, and in the next three months, the prevalence rate had increased to 56 per cent (Sarkar et al. 1994; Naik et al. 1991). By 1990 it was estimated that there were approximately 15,000 IDUs in Manipur and most were under the age of 25 and needle sharing was common among them (Sarkar et al. 1991). Due to this phenomenon high rate of HIV prevalence among the IDUs is found throughout the world. Extreme high prevalence was found among the IDUs of Ruili, China, at 82 per cent in 1992, in Chiang Rai, Thailand it was 61 per cent in 1989, in Myanmar rates of above 60 per cent have been reported from most of the testing sites since sentinel surveillance programme was introduced there in 1992 (Stimson 2005). Majority of the IDUs are males. Most are sexually active with their spouses, casual partners and with female commercial sex workers. Condom use among them is rare. There are evidences of rapid transmission of HIV to the spouses of IDUs sexually. In Manipur within one year of HIV spread among IDUs, 6 per cent of the wives who were tested were found to be HIV positive (ibid). The consistent use of condom among IDUs varies by the subject’s HIV sero status and by whether or not the partner in relationship is an IDU. Consequently, the individual may have consistent condom use with one partner but not with another (Friedman et al. 2005).

IDUs are also initiated into drug use under peer pressure and influence. It is this social aspect of injecting drugs which involves the sharing of needles and syringes that has given rise to the rapid increase in the rate of HIV transmission (Ford and Koetsawang 1991).

Women and HIV/AIDS

Women are found to be vulnerable to the onslaught of HIV/AIDS for a host of reasons. The salient reasons seem to the patriarchal nature of the society which restricts women from being aware or negotiate methods of safe sex. There are numerous obstacles posed by culture and traditions in the path of women to be self-reliant on issues of sex and sex education. Their initiatives to learn about safe sex are termed as unwanted and deviant and are socially ostracized if they intend to do that. Consequently, globally the number of women being infected by HIV is increasing. Women are thought to learn about sex after marriage and are thereby exposed to the dangers of being infected by their husbands after marriage. Even the sexual and reproductive health initiatives have focused only on the unmarried young couples assuming that the married couples practice safe sex and do not face any stigma that their unmarried counterparts experience in accessing sexual and reproductive health services. However, emerging evidences suggest that neither of these assumptions is tenable. They are of the opinion that the young married women are at a risk of HIV and face a host of obstacles in making informed sexual and reproductive health decisions (Santhy and Jejebhoy 2007) while leaving the married women who have neither the negotiating power nor the skill to safeguard their sexual health and are exploited within the institution of marriage. Early marriage also enhances young women’s HIV risk, however, presumably because married women have less negotiating power and more sexual exposure. They also experience pressure to bear a child, which increases the risk of unprotected sexual intercourse (Clarke 2004). The husband’s irresponsible behaviour is also responsible for the exposure of the women to sexual risks. They indulge in extra-marital sex which devoids the wife of sexual pleasure, emotional support from the husband and the economic security which a women looks for in marriage. Under such circumstances many women take to commercial sex to look for the economic security and at times for the emotional support. Some women have reported having multiple partners for attractive consumer goods and to revenge their husband’s infidelity (Tawfik and Watkins 2007). Migration of the husbands has also contributed to the risks of women. When women are left behind by the migrating husbands many a times the wives have to find their own means of survival and also provide for their children. Sex work has become a very common option and one of the few sources of employment left open to them (Carbolla and Siem 2002).
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Sexual Behaviour and HIV/AIDS

Till date, most of the studies of young people's HIV-related risk behaviours have focused on levels and determinants of condom use and sexual activity (Eaton et al. 2003) or on the social aspects of HIV/AIDS risk, such as unequal gender and power relations and sexual coercion (Wood et al. 1998). The advent of HIV/AIDS in the world has brought attention to sexual behaviour and partnership. Sexual relationships with multiple partners are associated with an increased risk of acquiring HIV/AIDS infection (Gregson et al. 2002). However, economic hardship may also motivate young women to employ their sexual resources to meet their economic demands.

Unequal power between the sexual partners often plays out in the arena of reproductive decision-making, causing women to be unable to control the timing of sex or to initiate safe sexual behaviour (Ankrah 1991). A woman's inability to refuse sex is closely related to her inability to avoid becoming infected with HIV/AIDS. A woman can refuse sex to multiple partners and can be monogamous. However, in the context of marriage she is over-powered by the desires and the wishes of her husband. Therefore, she cannot initiate safe sex or the timings of sex.

It needs to be borne in mind that the reporting of sexual behaviour is widely recognized to incorporate biases (Gregson et al. 2002) and are often rooted in gender considerations. Men are more likely to exaggerate the number of sexual partners and women are likely to underreport the number of sexual partners. Premarital sex is considered to be associated with risky behaviour which may result in increased prevalence of HIV/AIDS. The weakening of family and social control and the changing social, political and economic environment also has an impact on the sexual behaviour of the young people. The earlier the sexual debut of the young people there are more chances that they will indulge in risk behaviour and infection of HIV/AIDS. Men who are involved in substance abuse frequently indulge in risk behaviour.

The themes of study for understanding the dynamics of HIV/AIDS in different parts of the world are as diverse as the strains of HIV. The reasons for the dissemination of HIV/AIDS are also diverse. Taking this into consideration a lot of studies have been done using a perspective that would help to understand in greater details, the reasons for the spread of HIV/AIDS, the variables associated with it, the policy that need to be implemented for the control and prevention of it. However, not many studies have been done in the region of Darjeeling hills. The reasons for the spread of HIV/AIDS in the hills of Darjeeling are similar and pertinent as in other parts of the world. Unfortunately, till recent times the control and prevention of HIV/AIDS was neglected by the government in the hills of Darjeeling. This research is an endeavour to understand the dynamics of HIV/AIDS, the responses to control and prevent it, the care and support the PLWHA are receiving from different agencies and the understanding of HIV/AIDS epidemic by the community and society at large.

Design of the Study

The introductory chapter is designed to profile an overview of the crisis of HIV/AIDS in the world and also the responses it has elicited. It further discusses the methodology; tools and techniques of data collection; the reasons for selecting the study area and the ethical issues faced in conducting the research. The second section of the chapter is the review of literature on HIV/AIDS and different themes depicted in the large body of literature of HIV/AIDS in India. The chapter deals with the political history of HIV/AIDS awareness and an account of HIV/AIDS and prevention and the case of Darjeeling and the relationship of the study area with the rest of West Bengal.
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The second chapter gives a brief socio-political history of Darjeeling and also discusses the risk factors associated with HIV/AIDS and prevalence in the study area. It discusses the advent of HIV/AIDS in Darjeeling and highlights the profile of Shanker Foundation—a network of positive people in Darjeeling.

The third chapter titled ‘Socio-Demographic Profile of the Study Population’ deals with the socio-demographic conditions of the sample population and also analyses in detail each category of the groups of people that make up the sample population. The chapter profiles the PLWHA and highlights their various experiences.

The fourth chapter deals with mobility, sexual behaviour
and trends among the people, risk groups, the knowledge and perception of HIV/AIDS among the people and also the stigma and discrimination associated with HIV/AIDS in the hills of Darjeeling.

The fifth chapter gives a brief account of international response to HIV/AIDS and primarily focuses on the responses from various institutions in the hills of Darjeeling, to control and prevent the epidemic.

The sixth chapter discusses the spread of HIV/AIDS through population mobility, use of technology, substance abuse, sexual behaviour, knowledge and experiences of the infected and affected persons. The chapter also illustrates the findings and proposes some strategies to address the epidemic in Darjeeling hills. The concluding chapter deals with the summary of the study and based on these draws conclusions.

Notes and References

1. This ART Centre came into existence after the field-work was carried out.
2. They are called flying sex workers as they are not confined to any place and can carry out their business anywhere.
3. The sex workers in Darjeeling are called flying sex workers as they are very mobile and do not do their business from one place as their counterparts who are stationed at brothels.
4. Bisexuals are men who have sex with both men and women but their predominant partners are men.
5. In fact I did not come across any study done in the hills of Darjeeling particularly, apart from a few journalistic writings.