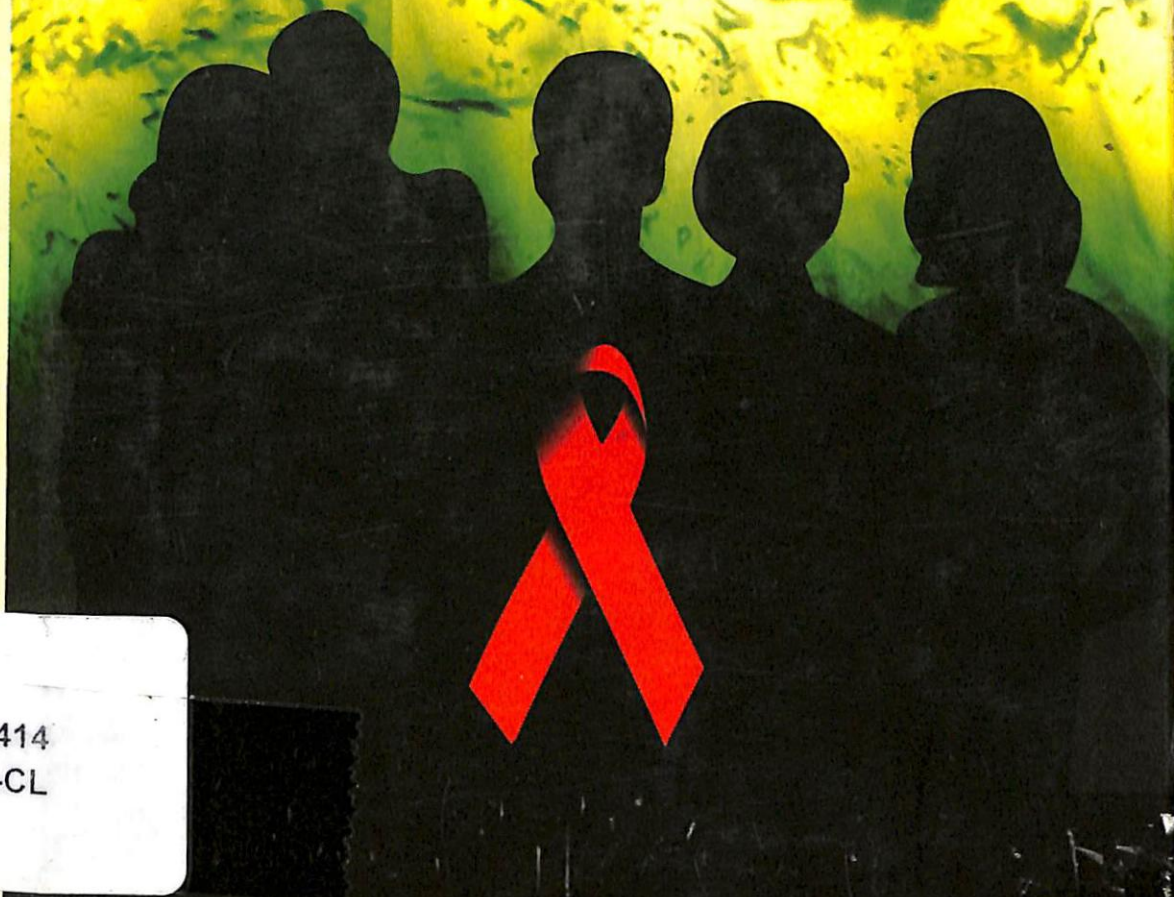
HIV and AIDS in Darjeeling

Emerging Socio-Political Challenge

Binu Sundas



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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 house wives.

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

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 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 indictor 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 arguements 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 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 summarizes the thesis and on the basis of the thesis draws conclusions.

Acknowledgements

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.

I take this opportunity to show my gratitude to my parents. They have been the best possible parents. They have been very selfless in supporting me. They have always installed in me the value of education. I hope this work reflects the inspiration I got from them.

There have been many people who have provided me with the opportunity think about HIV/AIDS and I am indebted to all of them. Hari and Polsen from the Shanker Foundation had been very kind to help me establish contacts with all the people concerned with HIV/AIDS in Darjeeling hills. If it were not for

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.

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Binu Sundas

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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 personnels across the world, and has received unprecedented attention. At present, there is no vaccine or drug to cure it and scholars like Kalichman (1998) think that even if a cure were to be found it will be so expensive that it would not be universally accessible. In the absence of vaccines and drugs to combat HIV/AIDS, a greater responsibility has been placed in the hands of human service professionals caring for People Living with HIV/AIDS (PLWHA) who has to confront many challenges resulting from HIV/AIDS infection—social, economic, lack of knowledge and shortage of trained medical staff.

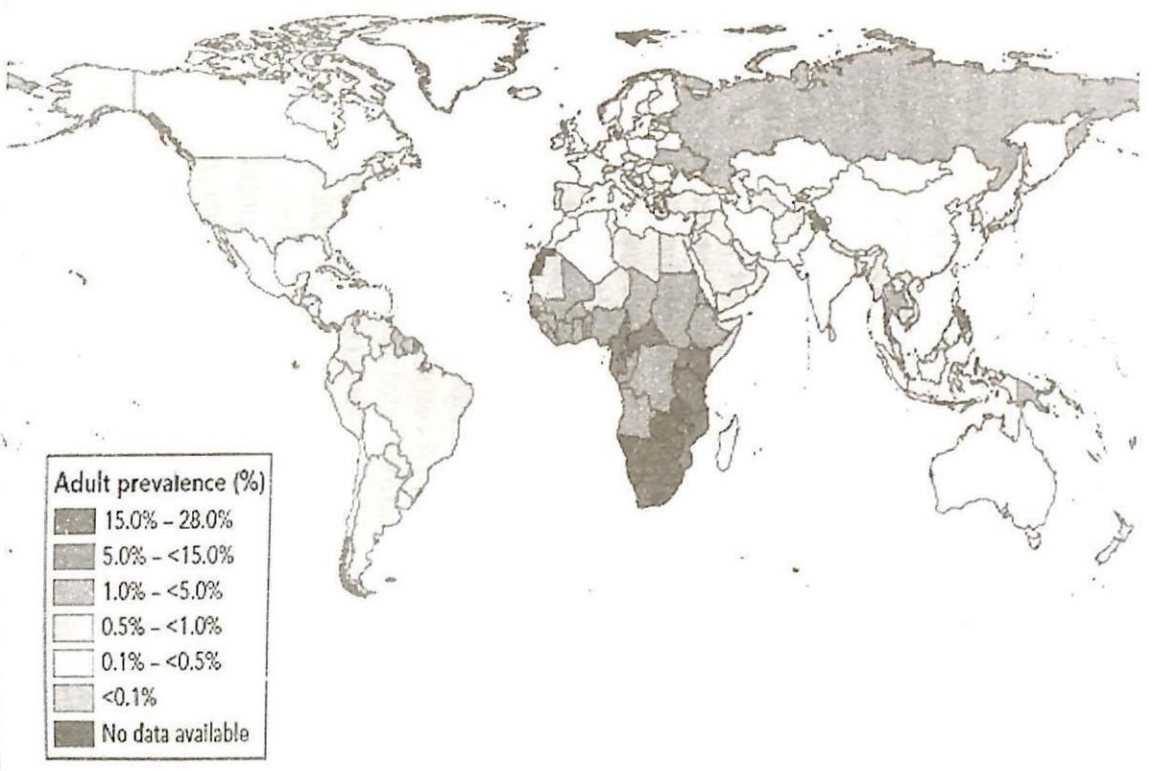
The origin of HIV/AIDS has puzzled scientists as well as

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).



Map 1.1: Prevalence of HIV/AIDS among Adults in Different Countries, 2007

Source: 2008 Report on the Global AIDS Epidemic.

In the last two decades the epidemic has spread all-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 PLWHA 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 PLWHA 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 population 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 PLWHA 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

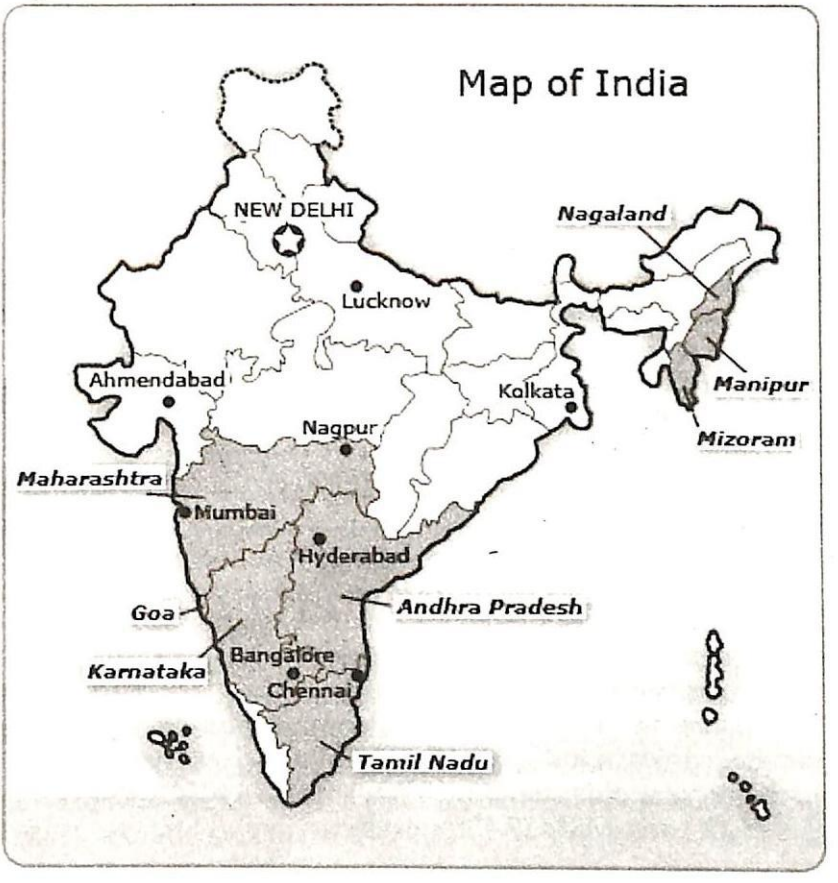
formulated different policies to combat the disease. However, the efficacy of such policies is determined by the degree of governance and a presence of a functional civil society. Good governance is the key to development and success of policies which are essential to address the HIV/AIDS epidemic. Political 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 impedes 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 unprecedentedly spread to other parts of the country. In 1987, a National AIDS Control Programme was launched to co-ordinate 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 PLWHA 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

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/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 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

Table 1.1: Categories of States and Union Territories

High Prevalence	*Moderate Prevalence*	*Low Prevalence*	
		Highly Vulnerable	*Vulnerable*
Tamil Nadu	Gujarat	Assam	Arunachal Pradesh
Andhra Pradesh	Goa	Bihar	Haryana
Maharashtra	Pondicherry	Delhi	J&K
Karnataka		Himachal Pradesh	Meghalaya
Nagaland		Kerala	Mizoram
Manipur		Madhya Pradesh	Sikkim
		Punjab	Tripura
		Rajasthan	A & N Islands
		Uttar Pradesh	Chandigarh
		West Bengal	D & N Haveli
		Chhattisgarh	Daman & Diu
		Orissa	Lakshadweep
		Uttaranchal	

Source: NACO, 2006.

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-government 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,
2. The associated coping cost for the family members, and
3. The direct income loss due to illness.

Impact would also be felt severely by the health sector and the government, with government health subsidies rising

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, contributing $14.1 million and IDA credit of $84 million and a WHO co-financing grant of $1.5 million (Action Aid 2006). In addition USAID and DFID are other two important sources of financing. The overall focus of NACP has been prevention and control and these two components receive the major share of the fund allocated followed by the two components of care and support. Some government and quasi-government organizations have also joined hands with NACO in fighting HIV/AIDS in various capacities and forms. Important among these organizations are Steel Authority of India Limited (SAIL), Indian Railways (IR) and the Defense Ministry. 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. NACP 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).

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

Year	*State's Response*
1985	Sentinel Surveillance activity in blood donors and STD patients under the aegis of ICMR
1986	First Case of HIV infection found among the CSWs of Chennai National AIDS Committee was formed
1986-1992	Denial of the Threat of HIV
1989	HIV infection reported among the IDUs in Manipur
1990-91	National AIDS Control Organization was established
1990-92	Medium term Plan for prevention and raising awareness
1992	ICMR establishes National AIDS Research Institute in Pune
1992-99	National AIDS Control Programme Phase I is started
1999	HIV testing of all blood bottles becomes mandatory under Supreme Court judgment.
1999-2006	National AIDS Control Programme Phase II
1998-2001	Focus on Targeted Intervention
2000-01	NACO starts feasibility studies for prevention of parent to child transmission of HIV with zidovudine and nevirapine
2002	VCCTC at the Darjeeling District Hospital Established on April 1st
2002	National AIDS Prevention and Control Policy
2002-2003	Tripartite agreement between NACO, ICMR and International AIDS Vaccine Initiative signed to facilitate HIV vaccine development and testing in India
2003	Central Government announces the policy to provide highly active anti-retroviral therapy to those who suffer from AIDS
2005	First AIDS Vaccine trial was initiated
2006	PPTCT started at the Darjeeling District Hospital on March 18th
2007-2012	National AIDS Control Programme Phase III
2008[1]	ART Centre inaugurated at Darjeeling District Hospital on December 1st

Source: NACO, 2006., Kishore, 2005., Panda *et al.* 2002, Godbole & Mehendale. 2005, Field notes.

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

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 Biharis 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-à-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.

Studying 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 Mukhti 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

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 PLWHA 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 PLWHA. 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

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 PLWHA, 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

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 lead 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 risk 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 risk 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)[2] 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

long savings and other assets but all will be in vain as there is no therapeutic treatment for HIV/AIDS till date.

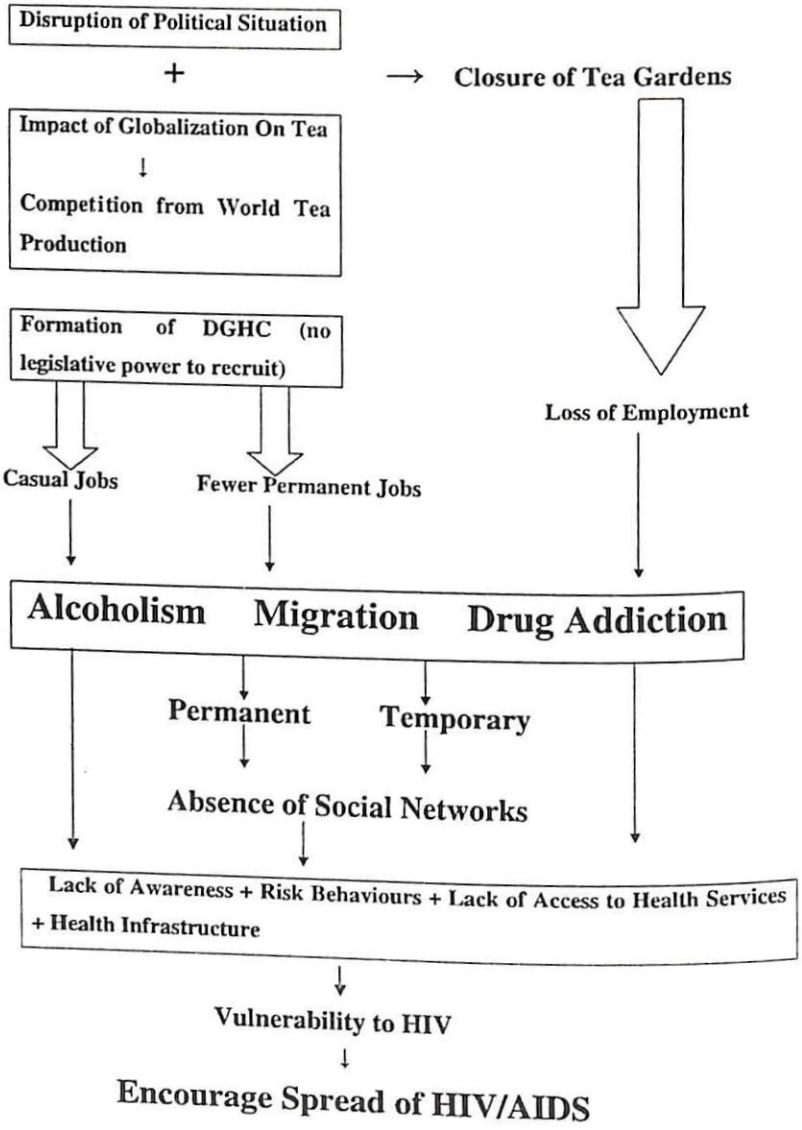


Fig. 1.1: Conceptual Framework of Factors Associated with HIV/AIDS in Darjeeling Hills

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?

Objectives

Thus the main objectives of the study are—

— To study the provision, planning and management of HIV/AIDS services.

- 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.

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[3], intravenous drug users and bisexuals.[4] 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)

Sl. No	Age	Sex	Marital Status	Education	Income
1	30	F	Married	12th	2500
2	26	F	Married	7th	3500
3	23	F	Single	12th	5000-6000
4	29	F	Single	12th	6000
5	25	F	Married	10th	5000

Source: Field Data.

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

Sl. No	Age	Sex	Marital Status	Education	Income
1	25	M	Single	B.A.	3500
2	32	M	Married	B.A.	12,000
3	25	M	Single	12th	2000
4	24	M	Single	12th	Nil

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.

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

Sl. No	*Age*	*Sex*	*Marital Status*	*Education*	*Income*
1	27	M	Single	B.A.	Nil
2	30	M	Married	B.A.	8000
3	29	M	Single	B.A.	Nil
4	25	M	Single	12th	2000
5	33	M	Divorced	M.A.	9000
6	32	M	Married	7th	3000
7	26	M	Married	B.A.	8000

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.

Choice of Language

The choice of language was Nepali and English. Nepali was chosen, as this is the *lingua franca* of the region, so it made the communication with the respondents easier. Speaking in the local language also helped to establish a cordial relationship thereby making the interview process easier. The choice of language was left to the respondents. English was also chosen as many were conversant in it.

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

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.

Other Books of Interest

BINOD C. AGRAWAL (Ed.)
Media for Health: Planning Programme & Practice

ARCHANA R. SINGH
Mass Communication in Prevention and Control of AIDS: Mass Media Strategies in India

ASOK SARKAR
NGOs: The New Lexicon of Health Care

M. RAJAMANICKAM
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Psychological Perspectives on Stress and Health

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