Chapter VII: Summary and Conclusion-Will HIV/AIDS Triumph over Mankind in Darjeeling?

7.1 Summary of the Thesis

Ever since the first case of HIV/AIDS was detected in June 1981, in the United States of America, the disease has managed to grab headlines the world over. Having caught the public imagination, responses to it both at the national and international levels have been spontaneous. Especially when we compare it to other life threatening diseases like malaria, tuberculosis or even more ‘mundane’ issues like death due to hunger. There have been many programmes funded by the many institutions. Various international and national NGOs and even private foundations like the Bill and Melinda Gates Foundation have devoted time and poured huge amount of funds to fight this incurable disease. World leaders of the G8 nations have pledged unstinted support and initiatives like ‘Treat 3 Million by 2005’ have been implemented. So we see that there is no lack of will in combating HIV/AIDS. However, the question that remains unresolved is that in spite of all the efforts that seems to have been put in, why is there still a rise in the number of infections annually? The virus has long moved from being a “gay disease” and affecting those indulging in high risk behaviour to seemingly low risk groups. HIV/AIDS is making huge inroads from the vulnerable urban areas to fairly cocooned small towns and villages. Before the 5 PLWHA publicly disclosed their HIV sero positive status in May 2007, in a local daily the community members of Darjeeling hills had probably never in their wildest imagination conceived of the virus reaching Darjeeling hills. HIV/AIDS was and still is seen as a disease which is “somewhere out there” in the West or at the margins of society, far away from the average man and woman. So what has led to the rise in the number of HIV/AIDS infected individuals in Darjeeling? What factors have contributed to its spread? What have been the institutional responses? What are awareness levels among the community members, the at-risk groups such as FSWs, IDUs and bisexuals and the health personnel? What are the probable strategies to confront HIV/AIDS in Darjeeling? These and other related issues have been dealt with in this thesis.
The first case of HIV/AIDS in Darjeeling hills was detected in 2002 in an IDU after the only VCCTC was set up in Darjeeling District Hospital. As mentioned earlier this number rose to 141 by November 2007. However, it is important to note here that there is only one VCCTC for the entire Darjeeling hills which covers an area of 1421.54 sq. km (area of the study area). Bad of lack of roads, low levels of education, economic deprivation and low level of awareness about HIV/AIDS make the only VCCTC in the area inaccessible to the majority of the population who reside in remote villages and tea gardens. It can safely be stated that if the number of surveillance centers are increased then these numbers will also multiply.

A socio-political and economic overview of Darjeeling hills will make it evident as to why the area is so conducive to HIV/AIDS. Politically Darjeeling has been highly volatile for the last three decades. Demands for separation from West Bengal in the early 1980s, led to political unrest where many lost their lives in ‘police encounters’ and ‘custody.’ Finally in 1987 the Darjeeling Gorkha Hill Council was formed. The demand for the separation which centered on issues of identity, unemployment, lack of infrastructure and development were not resolved even under the DGHC. The funds that were granted by the state were misused by the political leaders. Economic opportunities remained low and frustration levels high. Casualisation of jobs led to the youth being further disgruntled. Drug abuse and alcohol consumption rose as a consequence.

Tea gardens and railways are the two major employers in Darjeeling hills. However, increasing lack of job in the railways has led to economic insecurities. Globally the expensive Darjeeling tea is facing stiff competition from Sri Lanka, China and Kenya forcing many tea gardens to close down. Even where the tea gardens are still functioning, the income levels of the workers remain low and many are not on the permanent payroll. Most are employed as casual labourers during the plucking season. There are harrowing instances where mothers give alcohol to infants to tide over hunger pangs (Sundas 2004).

The quality of education is very poor and economic levels are very low and this in turn is forcing many to migrate. As these migrants come from the lower strata of society they only find work in the informal sector. Devoid of any social network they indulge in
risk behaviours which subsequently intensify their vulnerability to HIV/AIDS. Most young women who migrate are employed as domestic help in the cities, where they are very vulnerable to various kinds of exploitation. Even if not exploited they seek companionship which may make them vulnerable to HIV/AIDS.

In the urban area many youth are attracted to the metros for jobs in the BPOs. Away from home and societal restrictions and the availability of disposable cash pushes many to involve in casual sex and other risk behaviours. Many are found to indulge in drugs and alcohol increasing their vulnerability to HIV/AIDS. When these migrants return home during vacations and festivals they create a bridge for transmitting the virus to their partners.

A number of people from the hills have been joining the army. HIV/AIDS cases have been detected among the army personnel as they avail the services of CSWs, so there is a possibility that when they visit home they can act as vectors.

Belief that condom use lowers sexual pleasure is the main reasons for the very low use of condom and thereby higher risks against STI/STD and HIV/AIDS. The FSWs, who are constantly engaged in sexual activities with a large number of clients also do not insist on condom use. Their social status and lack of any power within the relationship with the client also renders them powerless to negotiate condom use and safe sex practices. It has also been reported by both the FSWs and their clients that they consume alcohol before sex. In their inebriated state safe sex does not even cross their minds.

The reach of the FSWs is very wide, in terms of the spatial distribution of their clients as well as their movement. In such a circumstance they can act as a vector to a large number of people distributed across different regions. They are not just confined to the hills of Darjeeling but travel outside Darjeeling to conduct their business. This further aggravates the situation. As there is no brothel based sex industry in Darjeeling hills the identity of the FSWs remain hidden so targeted intervention among them remains a major challenge. There has been manifold increase in the business of FSWs with the introduction of mobile phones. Mobile phones are being successfully used to increase
their reach to clients. The anonymity which the phones provide makes it easier for the clients to avail their services too without the danger of being exposed in public. Earlier it would had been much more difficult to proposition a sex worker.

Other changes have also been noticed in the society. Attitudes of the youth towards sex are also changing very rapidly. This can be attributed to the changes that are taking place at the global level. The youth are indulging in casual premarital sex. Sex is no longer seen as a private act between married couples. The respondents have also shown indulgence in sex with multiple partners. Many married respondents have also reported to have indulged in extra marital sex which is against the traditional norms and values. None however, seems to see condom use as necessity. It was primarily seen as a device to prevent pregnancy. Multiple partners and unsafe sex can render one vulnerable to HIV/AIDS. Such irresponsible behaviour among the husbands have placed their wives at a risk of HIV/AIDS infection. It was also seen while conducting the research that married women had no say in condom use. Another important reason for not using condom has been the over emphasis on trust and love by the wives on their husbands.

Tourism is a major source of income generation in the Darjeeling hills. Not only Darjeeling but other towns like Mirik, Kalimpong and Kurseong have also grown as tourist spots. However, what is not being noticed is that sex tourism is on the rise. Domestic as well as foreign tourists come looking for sex in this beautiful region. To serve the rising demands of the tourists as well as the local population the number of FSWs have also increased. The FSWs who were interviewed reported never to have used condom and poses immense risk for the transmission of HIV/AIDS.

As noted earlier, the first case of HIV/AIDS in Darjeeling was detected in an IDU. Drug abuse has been prevalent in Darjeeling hills since the 1980s which coincided with the demand for a separate state. Punk culture also influenced many to do drugs which they saw as hip. Drug addiction is a grave problem in Darjeeling hills. Drugs are easily procured from either the porous Nepal border or from the North East states. However, there has not been any institutional response in dealing with this problem. As seen in the study carried out by the researcher awareness levels regarding HIV/AIDS is
vey low. Some were found to know about HIV/AIDS being transmitted through needle and syringe sharing but mostly saw them as being relatively safer. They also indulged in sex with other IDUs and FSWs which further aggravates the situation. In their desperation for a 'fix' the IDUs do not care much about safe injecting practices. Many of them are also married which places their spouses at risk.

Alcohol is an integral to the culture of the hills. However alcohol use has been on the rise and increasingly young high school boys and girls have started consuming alcohol. Alcohol consumption is related to risk behaviour. Also alcohol consumption has an adverse impact on the health of the people. It has been found that most of the people use alcohol to get rid of the inhibition they have regarding sex. Under the influence of alcohol it is difficult for them to practice safe sex thereby making both the partners vulnerable to STI/STD and HIV/AIDS.

Darjeeling has been identified as most vulnerable to HIV/AIDS by NACO and WBSAC&PS. As seen earlier factors conducive to the spread of HIV/AIDS places the community members at a great risk. Vis-à-vis HIV/AIDS the community members showed ignorance about the epidemic. It may be because of this that the PLWHAs do not want to disclose their status as they fear prejudice, stigma and discrimination from the public. What is grave is that even the hospital staff also exhibits such prejudices against the PLWHAs and do not show them any empathy. This has created a major hindrance among the PLWHAs to seek whatever little facilities the hospitals provide. They prefer to avail the services of the NGOs instead.

In Darjeeling the main actors involved in combating HIV/AIDS are the DACC, Shanker Foundation and a number of NGOs like the Sewa Karya, MANAS Bangla, HANDS etc. DACC provides the various organizations with the required funds, Shanker Foundation is the only network of positive people in Darjeeling hills and other NGOs are working in the field of HIV/AIDS and other related issues. Much needs to be done in terms of generating more funds and collaboration between various organizations. Shanker Foundation is doing enormous work among the PLWHAs but there is a paucity of funds as well as lack of human resources to carry out sustained advocacy. Most of the PLWHAs
have not disclosed their sero status so the work of the entire organization rests upon few shoulders.

Tea gardens and railways have shown utter lack of corporate responsibility towards the control and prevention of HIV/AIDS in Darjeeling hills. Political leaders view it as health concern so have washed their hands off it completely. The DGHC is functioning without any political participation since its dissolution in 2002. So no political pressure can be exerted and no one in the higher echelons of the administration seems to be concerned about this issue.

There is an immediate need to upgrade health facilities including surveillance centers, ART center and the availability of ARV and other facilities such as CD4 cell counting, hospice, care and treatment. Dissemination of information on safe sex has to be prioritized by the authorities.

### 7.2 Summary of the Findings

The primary mode of transmission of HIV/AIDS in the hills of Darjeeling is injecting drug use and heterosexual intercourse. The knowledge about HIV/AIDS among the sample population was very negligible. Though they knew that it could be transmitted during sexual intercourse they were not aware of the other modes of transmission. It was not just the community members who were lacking in the knowledge about the epidemic also many in the health sector did not know all the 4 modes of transmission of HIV/AIDS. The concept of ABC which has been successful in controlling and preventing the spread of HIV/AIDS was also not known to many.

Sexual behaviour of the sample population, whether at risk or not, was fraught will danger of getting infected. There is a widespread prevalence of premarital and extra marital sex among them. The use of condom is minimum among the MSM, IDU’s and FSWs do not use them. Young boys are buying sex to prove their masculinity or simply out of curiosity regarding sex. Alcohol consumption among the FSWs and their clients is high which also reduces the practice of safe sex. There are about 1200 registered IDUs in
the hills of Darjeeling. Apart from sharing needles the presence of multiple partners heightens the spread of HIV/AIDS in Darjeeling hills.

The mobility of the IDUs, FSWs and the behaviour of the community members when away from home also increases the risk of HIV/AIDS transmission. FSWs because of their mobility can spread the virus far and wide. The community members may be exposed to the virus while using the services of the commercial sex workers.

There are 141 cases of HIV/AIDS reported in the hills of Darjeeling and the number is presumed to be just a tip of an iceberg. The response to the epidemic was found to be lax. The DACC which is the most important institution for the control and prevention of HIV/AIDS in the hills is caught up in the bureaucratic protocol and has not been able to generate any political will to fight the dreaded virus. The NGOs are also not fully equipped to control and prevent the epidemic from further spreading. There is very little collaboration among the various NGOs working in the area of HIV/AIDS in Darjeeling. The dissemination of information among them was found to be negligible though efforts are being to improve networking. The involvement of railways and tea industry is also negligible though they have a large section of the population as its employees.

PLWHAs of the hills find themselves to be helpless whenever they have to visit NBMCH. Their experiences show that they have had bitter experiences at the hospitals and at the hands of the health care providers. They longed for the support of their partners at the times of distress and difficulties. They did not show any ill feelings towards the person who may have possibly infected them.

7.3 Summary of the Strategies

A broad but inclusive strategy is required to combat the disease. All members of the society, health personnel, police, NGOs, administration of all levels must be engaged in this task. Information dissemination is key to fighting this disease and public
participation is crucial to carry out a sustained campaign. Door to door campaign, free condom, information on safe sex is vital in this regard. Strategy at the district level is necessary for the control and prevention of the virus. The state government should also be active and not leave the onus of controlling HIV/AIDS in the district and not leave it as independent vertical programme. The control and prevention of HIV/AIDS should be made a part of the overall health programme. The DACC which is the nodal agency for controlling HIV/AIDS in the hills of Darjeeling should be made more accountable and proactive. It should make advocate with NBMCH for providing better facilities to the PLWHAs from the hills.

NGOs have to be more active in the rural areas as these areas are out of the ambit of control and prevention programmes. The focus of the NGOs should change from urban areas to tea gardens from where there are many youth migrating to other places. NGOs have to collaborate among themselves and share the information they have about HIV/AIDS in the hills. NGOs have to work hand in glove with the samaj as they can effectively help in the participation of larger number of people. Their reach is also greater and can directly or indirectly help the information and messages reach its members.

NGOs have to also engage the at risk groups and encourage them to participate in prevention programmes and in their targeted intervention campaigns. They should be encouraged to adopt safe sex practices. They should be empowered to negotiate safe sex and condom use with their clients. Incentives should be provided to all those at risk group people who participate in the programmes and also arrangements have to be made for them to undergo tests for STI/STD and HIV/AIDS.

The chemists should be sensitized to the dangers posed by selling drugs over the counter without the prescription of doctors. They should be made equal partners in the control of drug addictions which may also help in the reduction of new HIV/AIDS infection. The police department should also be made partners in the control of drug addiction. They should be sensitized about the behaviours of IDUs and other drug dependent persons. They should be asked to deal with the drug dependent persons with
empathy rather than implementing the laws which can be harsh. They should be made aware that these people are like any one of the community members and with proper care and handling can give up the habit of drug abuse.

Educational institutions should take the responsibility of educating its students regarding drug abuse, HIV/AIDS and dangers of abusing drugs. Teachers should be involved and schools and colleges should not rely too much on the NGOs for providing such information to the students. Parents and guardians of the students have to be made part of such programmes in the schools and colleges.

7.4 Conclusion: HIV/AIDS and Human Security in Darjeeling

The aspect of human security is very important while dealing with HIV/AIDS in Darjeeling. Though the impact of HIV/AIDS in Darjeeling has not been severe enough to warrant a study of human security but it will not take much time for such a study to be a necessity. People here in Darjeeling are facing insecurity in terms of decreasing agricultural land, rapidly decreasing job opportunities and lack of proper health infrastructure. HIV/AIDS has a severe impact on food security, affecting all of its dimensions: availability, stability, access, utilization. One of the most devastating impacts of the AIDS epidemic is the loss of human capital, as the disease robs households of adult labour and knowledge. The agricultural sector (including the tea industry) in Darjeeling will be under a particularly severe strain as the HIV/AIDS epidemic spreads, affecting and infecting more people. Given its effects on agricultural production and other livelihood strategies, HIV/AIDS will lead to a reduction of the amount of food available to individuals, households and communities. As the agricultural sector is a labour intensive sector the health of the youth is of paramount salience and their inability to work will impact the production which will directly and indirectly have an impact on the lives of thousand of individuals. This may lead to lower food intake, thus reducing both individual nutritional status and household food security.

The people of the hills are also insecure about their employment. As already mentioned in the earlier chapter, many people engaged in tea industry are employed as
casual labourers and some only during the plucking season they don’t have a steady source of income. There is a constant threat to their well being and consequently many migrate to other parts of the country and expose themselves to the risk of HIV/AIDS. Apart from the insecure nature of employment in the tea industry, jobs in other sectors have also witnessed rapid casualisation. After the formation of DGHC in 1989, the employment scenario has not improved but has in fact further deteriorated. The state government has virtually stopped recruiting people in the hills and people are recruitment is only on daily wage basis. This casualisation of labour in Darjeeling has made the people very insecure in terms of employment and their economic condition.

Prevalence of HIV/AIDS is determined by the policies and magnitude of development. Its severity is associated with various dimensions of poverty. Poverty not only increases the chances of HIV transmission, it also increases the sufferings of PLWHA. In the wake of globalisation the present model of development promotes rapid migration from rural to urban areas. Migration from Darjeeling is also facilitating the growth of HIV/AIDS cases in the hills. Many of the female PLWHAs reported to be infected by their husbands who were working in cities.

With the growing number of HIV/AIDS cases, safe sexual practices, safe injecting practices and responsible individual behaviour is important to check the transmission of HIV. Among the people of Darjeeling responsible behaviour, with their sexual partners, including FSWs is essential to control the spread of epidemic. Ensuring individual responsible behaviour is difficult if other spheres of the society do not reflect responsibility in their intent and content. Along with the individual social responsibilities, there is need for other domains also to show responsibility towards society. State should be responsible towards the wellbeing of the people. Health system should reflect concerns towards providing universal access and affordable healthcare services. Also doctors should show commitments towards the patients. Community should reflect on the socialisation processes and societal values, and also be responsible for its members (Ritu Priya 2003).
As stated in the hypothesis, poor socio-economic conditions and lack of infrastructure is pushing people towards risk behaviour and making them vulnerable to HIV/AIDS. This statement is seen to hold true for the hills of Darjeeling.

For the community to triumph over HIV/AIDS it becomes imperative for every body to be responsible towards each other. Being responsible reduces alienation, stigma and discrimination of those infected by the virus and thereby lessens the burden of the PLWHAs. Being responsible and involved reduces the fear of HIV/AIDS among the community members, which is responsible for stigma and discrimination.