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HIV/AIDS Awareness among the Tribals of West Bengal and Consequent Challenges

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HIV & AIDS around the world

The overwhelming majority of people with HIV, some 95% of the global total, live in the developing world. The proportion is set to grow even further as infection rates continue to rise in countries where poverty, poor health care systems and limited resources for prevention and care fuel the spread of the virus.

Table 1: Estimates of the global HIV & AIDS epidemic at the end of 2005

	Estimate	Range
People living with HIV/AIDS in 2005	38.6 million	33.4-46.0 million
Adults living with HIV/AIDS in 2005	36.3 million	31.4-43.4 million
Women living with HIV/AIDS in 2005	17.3 million	14.8-20.6 million
Children living with HIV/AIDS in 2005	2.3 million	1.7-3.5 million
People newly infected with HIV in 2005	4.1 million	3.4-6.2 million
AIDS deaths in 2005	2.8 million	2.4-3.3 million

Source; published by UNAIDS/WHO in May 2006, and refer to the end of 2005

HIV/AIDS epidemic

UNAIDS, WHO and other organizations now speak about feminization of the HIV/AIDS pandemic, because an increasing proportion of people affected by HIV/AIDS around the world are females. They include adolescent girls, women of reproductive age and post-menopausal women, although most of the new infections are occurring in young adults.

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Asia and the most of the Pacific (excluding Australia and New Zealand) have been classified as a 'pattern III' region by the WHO in relation to the HIV/AIDS pandemic. HIV was introduced into these areas in the early to mid-eighties. Although there was indigenous spread of the virus in most of these countries, the prevalence of both AIDS and HIV infection was low at the end of the 1980s, with no clearly dominant pattern of HIV transmission. However, the situation is changing rapidly in a few countries. During the late 1980s, the prevalence of HIV infections has greatly increased among intravenous drug users in South East Asia, especially Thailand, where the prevalence is now nearly 50 percent; focal increases (up to 50 percent) have been recorded among female prostitutes in several cities in Thailand and India.

The percentages of infected women are substantially lower than the percentages of men in some regions, such as Eastern Europe and much of Latin America. This has led advocates working on behalf of men who have sex with men (MSM) to take issue with claims that the HIV/AIDS epidemic is becoming more feminized. They argue for more nuanced portrayals of how HIV is spreading so that programs and interventions focused on MSM do not lose attention, momentum and funding. Their point is well taken: interventions to reduce HIV infection and deal with its effects among MSM — and heterosexual men — must certainly continue and receive funding that is proportionate to the numbers of men being infected in certain areas. That said, however, a focus on women and girls remains warranted because women everywhere are highly vulnerable because of sex- and gender-based factors that are strikingly similar across most regions.

Whilst the number of officially reported cases of HIV/AIDS across most of South and South East Asia is low relative to other regions of the world, the epidemic has probably reached 'take off point' in Thailand and is already well established in many other countries. But the inadequacy of the data available on HIV/AIDS in many countries in the region means that it is difficult to know with any certainty what the level of infection really is. The HIV/AIDS epidemic in South East Asia and the Pacific has not yet reached the dramatic proportions of some other regions (notably Sub-Saharan Africa and the Caribbean) but this merely points to the importance of making early interventions which might limit further spread of the disease.

According to one recent UN report, India has 3rd-highest number of HIV-infected people. The estimated number of people living with HIV was 2.1 million at the end of 2013 behind South Africa (6.3 million) and Nigeria.

The first case of HIV infection in India was diagnosed among commercial sex workers in Chennai, Tamil Nadu in 1986. Soon after, a number of screening centres were established throughout the country. Initially, the focus was on screening foreigners, especially foreign

students. Gradually, the focus moved on to screening blood banks. By early 1987, efforts were made to set up a national network of HIV screening centres in major urban areas.
India has had a sharp increase in the estimated number of HIV infections, from a few thousands in the early 1990s to a working estimate of between 3.8-4.6 million children and adults living with HIV/AIDS in 2002. With a population of over one billion, the HIV epidemics in India will have a major impact on the overall spread of HIV in Asia and the Pacific and worldwide. The spread of HIV within the country is as diverse as the societal patterns in between its different regions, states and metropolitan areas. India has a large population and population density, low literacy levels and consequently low levels of awareness, and HIV/AIDS is one of the most challenging public health problems ever faced by the country.

Table 2: HIV prevalence, 1998-2005, India

Year	HIV cases	Increase from the previous year/s	Prevalence rate in adult population
1998	3.50	--	0.70
1999	3.70	+0.20	0.70
2000	3.86	+0.16	0.75
2001	3.97	+0.11	0.75
2002	4.58	+0.61	0.85
2003	5.10	+0.52	0.93
2004	5.13	+0.03	0.92
2005	5.21	+0.08	0.91

Source: Compiled from various reports of NACO

Several factors put India in danger of experiencing a rapid spread if effective prevention and control measures are not scaled up and expanded throughout the country.

HIV/AIDS and the Tribals

The tribal population in the country has poor health generally due to, among other factors, their poverty and social vulnerability. Tribal people are known to have sexual practices that differ from those of mainstream culture, and a high chance of sexually transmitted infection. Less or nothing is known about the prevalence of STI/HIV/AIDS among the tribal people in India, except perhaps in some of tribal states of North East India as these have high prevalence of drug use. The tribal population in the country is high and their

sheer number makes it imperative for the Government to bring them in the fold of National AIDS Control Programme. To be able to do so, it is essential to understand the behaviours, practices that drive the vulnerability and risk among the tribal people. This would help guiding evidence-based design of HIV/AIDS prevention, diagnosis, treatment and care programmes oriented towards tribal population.

Tribal culture particularly youth dormitory gives scope to the youth for choosing his/her mate. So the sexual debut takes place a little early among the tribals. It is in this youth dormitory the STI infected women or men comes closer and increases the chance of getting infected with HIV/AIDS. If such indiscriminate mating takes place there will be risk of HIV/AIDS infection. Outsiders mainly contractors visit the tribal area and sometimes to have fun tribal girls are lured away by them. The simple minded tribals thus become risk prone and vulnerable. So there is chance of HIV/AIDS infection among the tribals who also can not escape from this menace. Some of the cultural practices can also be mentioned. Among a tribal community in Uttarakhand, there is the practice of bride price. Interestingly, the high the bride price, the higher is the status. Because of the poverty, the family often takes loan to pay the bride price. It has been reported that after marriage, to repay the loan, the newly married bride is sent to the nearby towns of U.P. to earn as prostitute. Naturally the concerned families become vulnerable.

In West Bengal prevalence of HIV/AIDS has not taken an alarming stage as in Mumbai. According to NACO, the state has performed well so far as the prevention of HIV/AIDS is concerned. Spread of HIV/AIDS takes place through many routes but if poor health tribals are affected by it there will be serious problem in the state. It was reported that 574 tribal people have already been affected with HIV/AIDS in West Bengal and 244 people were under treatment.

Scope, Objective and Methodology

The National AIDS Control Programme (NACP) in India has made commendable efforts to formulate its strategies based on continuous research and evidences among general population and high-risk groups. While there is focus on extensive awareness creation among the masses, for effective prevention, the NACP has initiated targeted interventions among the high risk populations. Now NACP aims at going beyond the high-risk groups and extend the interventions to populations that are vulnerable to HIV such as tribal people and those socially disadvantaged in both rural and urban areas. The tribal population in the country has poor health generally due to poverty and social vulnerability. Less or practically nothing is known about the prevalence of HIV/AIDS among tribal people in India except in the predominantly tribal states in India as these states have high prevalence of drug use. The tribals in India constitute a sizeable percentage of India's population and

it is imperative on the government to bring them in the fold of the national programmes. To be able to do so, it is essential to understand the practices which may increase vulnerability and risk among the tribal people and also to study their awareness to formulate the appropriate strategy to address this problem. For intervening HIV/AIDS in tribal areas a Tribal Action Plan has been formulated by the Ministry of Tribal Affairs, Government of India on the basis of the report submitted by the Social Assessment Study commissioned for the NACP-III. The report suggests that the tribal people are vulnerable to HIV/AIDS because of their awareness and lack of availability of health services in general and HIV/AIDS related services in particular. The study also found out that tourism, mining, displacement and other external influences increasingly lured tribal women/girls into commercial sex work/ trafficking. In order to enhance National AIDS control programme (NACP-III) activities, tribal research institutes are entrusted to carry out an assessment on the prevalence and awareness of HIV/AIDS among the tribal population in the concerned state. It has been observed that NACP-III services are deficient in tribal areas because of remoteness, deficiency of health infrastructure and their operations. Besides, the tribal people do not feel at home while assessing the mainstream institutions due to their traditional customs and practices and strengthening linkages among the tribal, health and HIV/AIDS sectors,a more forceful response to HIV/AIDS have been suggested for better HIV/AIDS prevention, treatment and control among the tribal population in India.

A study was conducted in 2012-13 on HIV/AIDS awareness and prevalence among the tribal population in West Bengal in six selected districts in the background of health and related facilities. The six suggested districts were Bankura, Birbhum, Jalpaiguri, Purulia, North Dinajpur and West Midnapur covering 300-400 tribal families in each district. As it was a quick pilot survey, all tribal groups could not be covered. Besides, rural urban variations could not be studied though data from both rural and close to urban areas were collected. Due to shortage of time, separate treatment of rural urban data could not be made. Again, variations could be there in the same district or for the same community in different districts. Separate treatment could not be made in this context also, variation within a community living in different districts and variation among communities in a particular district.

Study Sample: The present study was conducted in 6 districts, covering 24 Blocks, 53 villages, 2315 families and 10522 individuals. Apart from studying the socio-economic profile and migration history of the studied population, their awareness about different common diseases in tribal areas including HIV/AIDS were noted along with the health facilities and treatment in the studied areas. In the meetings held at CRI to plan this study,

it was repeatedly suggested not to focus only on HIV/AIDS considering the general attitude towards this illness. Apart from collecting secondary data, primary data were collected with help of a schedule, observation and case studies. The collected quantitative data were coded and data-entry was done with the help of computer and with the help of SPSS, the data were analysed and different tables were made. Information about studied population, district, block, village and community, family and male female population is given in Tables 3 & 4,

Table 3: District Wise Studied Population

District	Block	Villages	No. of Communities	No. of Family	Male	Female	Total
Paschim Midnapur	4	8	5	418	901	867	1768
Bankura	4	9	2	341	694	671	1365
Purulia	8	15	8	416	904	880	1784
Jalpaiguri	2	6	7	392	924	960	1884
North Dinajpur	3	12	6	408	971	1016	1987
Birbhum	3	3	2	340	878	856	1734

Table 4: District and Community –wise Studied Population

District	Communities	No. of .Villages	No. of Family
Paschim Midnapur	Santal	4	128
	Lodha	2	182
	Bhumij	2	75
	Mahali	1	12
	Munda	1	21
Bankura	Santal	9	306
	Mahalia	1	35
	Bhumij	2	54

Purulia	Mahali	2	35
	Santal	2	47
	Munda	1	29
	Savar	1	33
	Bedia	1	16
	Kora	1	20
	Kheria	6	182
Jalpaiguri	Oraon	4	110
	Munda	3	77
	Kharia	1	30
	Santal	3	99
	Mech	1	38
	Mahali	1	13
	Rabha	1	25
North Dinajpur	Oraon	6	195
	Chik Baraik	1	14
	Santal	6	108
	Nagesia	1	25
	Munda	1	40
	Mech	1	26
Birbhum	Santal	3	224
	Kora	1	116

With the help of a schedule, socio-economic data of all the families covering land ownership, occupation, birth place and migration history, civil condition, education, place of work and nature of addiction, if any, of all family members were noted. Migration history was noted including job related migration as it increases the vulnerability of an individual, the more the migration, the more is the exposure and the more is the vulnerability. Their awareness of different diseases including HIV/AIDS was ascertained and nature of treatment during illness was also noted. The case of transfusion of blood was also ascertained and the use of syringe was noted. The transfer of blood and multiple use of syringe increase the vulnerability. Data were also collected on the nature of contact with health centres as more contact may increase awareness and better health facilities. Nature of treatment was also studied with reference to western health facilities, traditional medicine men and quacks. The use of condom and nature of pre or extra marital relations were also specifically noted as they are considered as potent factors for the prevention and transmission of HIV/AIDS.

A few points may be added here regarding the areas and studied districts. There are four important tourist areas in Bankura, Birbhum, Jalpaiguri and Purulia Districts. This is to be considered in the context of vulnerability as the tribals are likely to be more exposed even though the districts are predominantly rural. Again, in north Bengal, in the districts of North Dinajpur and Jalpaiguri, the tea gardens are located and tribals mostly work there and have more interaction with outside. In Birbhum and West Midnapur Districts, tribal villages very close to urban areas were studied. However, no separate data analysis could be made due to shortage of time, but some case studies were made and added to explain the situation.
Now some of the major findings of this study may be stated.

***Economy*:** Agriculture is the main occupation in the districts of Bankura, Purulia and West Midnapur accounting for more than 1/3 of the working force. Majority of the people live below poverty line, which is as high as 99.27 % in North Dinajpur and lowest in Purulia (88%).Interestingly, illiteracy was the lowest in North Dinajpur (31.2%) and highest in West Midnapur (60.07%). Again, below Rs.2000/- monthly income was the highest in North Dinajpur (89.24%) and lowest in West Midnapur (21.5%).

***Migration*:** Family migration was very low in all the districts suggesting that most of the families were born and brought up in the area and job related migration was less in Jalpaiguri and North Dinajpur (tea garden area) and more in Bankura, Purulia and West Midnapur, predominantly the agricultural areas. Even in this context, these three districts recorded the highest individual migration making the population more vulnerable.

***Addiction*:** Addiction was the lowest in Bankura District (32.6%) and the highest in Birbhum District (57.35%). Not many have taken injection and use of syringe only once is generally common, but the alarming point is many reported that they were not aware whether the syringe was used only once or more. They were not concerned about it and understood the implications.
The same thing applies in the context of donation or receiving of blood. Thus the population becomes vulnerable. The studied population in Jalpaiguri were more concerned about it, 37.95% reported that it was used only once, while in case of Bankura it was as low as 0.59% and quite low in North Dinajpur (2.2%) and in West Midnapur (2.39 %). Again, attendance of Medical Camps was the highest in Jalpaiguri (27.95%) and the lowest in Purulia (1.92), making one group more aware and the other more vulnerable. Contact with PHC was the highest in Birbhum (61.76%), next Jalpaiguri (59.74%) and the

lowest in West Midnapur (19.4%). There is no doubt that it helps in the awareness of different diseases.

HIV/AIDS Awareness: Except in Purulia (44%), majority of the respondents (more than 50%) have heard the name of HIV/AIDS, Bankura (73.61%), Birbhum (63.53%), North Dinajpur (57.95%)Jalpaiguri (56.92%), and West Midnapur (55.5%), but the alarming point is they do not have much idea how one is likely to be affected and what are the implications of blood, syringe or use of condom. This awareness level was as low as 3.1% in Purulia, 5.91% in North Dinajpur, 6.16 % in Bankura. It high in Birbhum (16.18%) may be because of the fact that the sample covered villages within Bolpur- Sriniketan and the villagers were more aware. This awareness no doubt can influence in the reduction HIV/AIDS attack.

Family Planning: Adoption of family planning was common in Jalpaiguri and North Dinajpur may be due to the programmes of tea industry. It is known that use of condom is suggested to address the spread of HIV/AIDS. The use was the lowest in West Midnapur (3.3%), very low in Purulia (3.8%) and the highest in Birbhum (39.71%) followed by Jalpaiguri (33.3%). In general, pre or extra marital relations was less reported, but still it was there., the highest in Jalpaiguri(7.44%), and the lowest in North Dinajpur (3.18%). This, no doubt, increases or decreases the vulnerability of a population.

India is the second most populous country in the world and has changing socio-political and demographic characteristics. These changes along with high population growth have created a number of health challenges. Since 1986 when the first case of HIV was reported, it has become imperative to include AIDS in the context of emerging public health issues. According to UNAIDS by 2003, more than 5.1 million persons were affected by AIDS in India and the most alarming issue is it is no longer confined to urban areas or high risk population, but spreading to rural areas and other categories of population which may seriously affect the socio-economic development of the country in the long run. To address this problem, it is very important to have knowledge about the socio-cultural and economic factors that may contribute in the spread of the disease. It is very important to know how much people are aware about this disease, how it is transmitted and what are the preventive measures.

Now a few cases are given below to reflect the reality as noted in different studied districts.

> Mr. Sama Sabar, of Kheria tribe, aged 20, female of Purulia District pointed out, “We do not know about the disease HIV/AIDS. If HIV occurs we shall have fun of it at first. HIV does not occur in our area. Please make me understand about the disease HIV/AIDS. In our area there are doctors and nurses or health workers who give us

condom to use for protection from this HIV/AIDS. But our males do not want to use it."

Mr. Mangal Sardar, a Kheria, aged 45 years of Purulia District commented, "I have no idea about the HIV/AIDS. I do not know what disease is this? Here nobody has been affected by it. You please make me understand about the disease. In our society no one sleeps with female other than his wife. In our area "X" tribe goes to fair or market or see rural drama (Yatra) and often takes female of his choice to any direction and enjoy."

Hem Marandi was a 65 years old man lived at the village Kaogaph of Moynaguri block under Jalpaiguri district. He is illiterate. He lived in this village since his birth. He is married and lived with his wife and married children. He knew the name of the six diseases but he never heard the name of Thalasemia and HIV/AIDS. So, he did not have any idea regarding these two diseases.

Jate Rabha a 28 years old young man living in the village Tuklimari, block Dhupguri under Jalpaiguri block. He lived in this village. He lived here with his family since his birth. He worked as a tea garden labourer. He used condoms at the time of intercourse. He knew that AIDS transmitted sexually and he has a little concept of prevention

Kotim Mahali 50 years of age lived in Khutimari village of Dhupguri block in Jalpaiguri district. He lived here since birth and with his wife and two children. He has heard the term HIV/AIDs but he did not know its effect in human body. According to him disease is natural and it results a wrath of God. Some malevolent power can harm the human body due to some bad work.

Sanka Munda was a 50 years aged man living in Jadavpur Tea Garden village at Moynaguri block of Jalpaiguri district. He resided here with his wife and four children. According to him no one of the villagers was affected by HIV/AIDs of thalasemia. This two disease were out of their knowledge and unnatural in nature. Public health centre provided condom for safe sexual life; they knew it but not used it because of the Supreme God wrath.

Sam Murmu was a 28 years aged married man resided in Panjipara village of Goalpokhor-I block, North Dinajpur.. He attended a health awareness camp of Malaria disease in his locality. He used both traditional method and western method of family planning system. According to him no one was affected by HIV/AIDs or Thalasemia in his village, as per his knowledge Marang Buru protects them from those foreign diseases. These diseases were common among urban and non tribal people but the Santals were never affected by those kinds of diseases. If one is affected it means he or she had done something wrong.

Sanka Munda was a 50 years old man of Chopra Block, North Dinajpur. He knew two languages. He informed that his newly married son used some western method of family planning and used condoms during intercourse. He or his sons never had a pre or post marital relations with others. According to him no one was affected by HIV/AIDs or Thalasemia in his village; as per his knowledge the Supreme God protects his family members from those foreign diseases.

Areas of Concern

A. ***Poverty and educational backwardness*****:** As we all know, education is a crucial factor that can make people aware. The tribals in all the six districts are educationally very backward and illiteracy in one district was as high as 60.07%. Besides, the level of literacy was such that it could not really help them in the context of any type of awareness by going through papers or leaflets or posters. All the families in the six districts were very poor; in one district, 99.27% families belonged to below poverty line and in the best situation it was 88%; in another district, it was 89.49% and in all other districts it was much above 90%. This educational backwardness and poverty have a number of other implications which can make a population more vulnerable to HIV/AIDS.

B. ***Migration*****:** Even though majority of the families are not recent-migrant families, because of poverty, job related migration was quite high, as high as 90.14% in Purulia, followed by West Midnapur, 82.9% and Bankura 74.78%, the three relatively agriculturally backward districts. Less job related migration was noted in Jalpaiguri, (37.44%) as the tribals were working in the tea gardens. In many cases, people migrated alone and in many cases, the total family migrated. Both have risks and vulnerability. When one moves alone, mainly the males may look for a new partner, and thus exposed and bring the disease. When moving in a group, the women are likely to be sexually exploited. It was also reported that women often carried roots and tubers to prevent pregnancy. This can prevent pregnancy but cannot ensure prevention from HIV/AIDS.

C. ***Addiction*****:** Addiction was quite high among the studied population and atleast in three districts it was more than 50%. Though it was mostly liquor, the risk factor is there as the addicts may start other types. Drinking of their traditional drink is a part of their culture and both men and women enjoy it.

D. ***Injection and blood transfer*****:** It was well-known that affected needle and blood are the main carriers through which HIV/AIDS virus can be transmitted or spread. So adequate protection is always suggested when it comes to transfer of blood or taking injection. It is always suggested that the needle should be used only once to

avoid the risk. The percentage of taking injection was the highest in Purulia (74.52%), then Bankura (66.28%), next West Midnapur (66%) and the lowest was in North Dinajpur (25.43%). Thus the chance of getting infection was there which could be prevented if proper care was taken. It was tried to ascertain whether the respondents were aware about the use of the syringe, only once or many times thereby increasing the vulnerability of the studied population. In case of Purulia District, where the percentage of population taking injection was the highest, it was reported that in case of 69.7%, the syringe was used only once, but an alarming percentage, 30.3% reported that it was used many times making the population very vulnerable and the risk of spreading HID/AIDS very fast. Though lesser percentage of population took injection in Birbhum, only 44% reported that it was used only once, 12% reported many times and an alarming 44% were not aware. In case of Midnapur District, 94.3% people who had taken injection reported that the syringe was used many times. In case of North Dinajpur, where the lowest percentage of people took injection, an alarming 35.6% people who took injection reported that the syringe was used many times while 39.4% people were not aware about it. It implies that the people were not aware about the risk involved in the context of multi use or using an infected syringe and that to prevent HIV/AIDS the syringe should be used only once. Atleast that would reduce the risk. In such a situation, it is good that not many people donated or received blood. Donation of blood was the highest in Jalpaiguri District and lowest in Bankura, next West Midnapur and Purulia. The syringe was used only once more in Jalpaiguri and least in Bankura, then North Dinajpur, West Midnapur and Purulia. An alarming 88.6% people in North Dinajpur were not aware about it. HIV/AIDS was not reported anywhere among the studied population in the six districts, but considering the above facts, the risk of HIV/AIDS epidemic is always there.

E. ***Participation in Medical Camp and contact with PHC:*** An attempt was made to know the nature of participation in the medical camp and contact with PHC as this may help to increase the level of awareness of different diseases including HIV/AIDS and adopt preventive measures. Participation in medical camp was quite low among the respondents, the lowest being only 1.4% in West Midnapur District, next Purulia 1.92%. The highest was in Jalpaiguri, 27.95%. So it is quite natural that the chance of increasing the awareness level was extremely low among the respondents atleast in two districts. The contact with PHC was also not very encouraging. The lowest was again recorded from West Midnapur District (19.4%) and the highest in Bibhum (61.76%) followed by Jalpaiguri (59.74%). Now let us examine the nature of awareness of the respondents with reference to HIV/AIDS.

F. ***Awareness and Knowledge of HIV/AIDS:*** The respondents were asked whether they have heard the names of different diseases including HIV/AIDS'. Here we are analysing their responses only with reference to HIV/AIDS. Except Purulia, in all other districts, more than 50% of the respondents have heard the name of this disease. Our next question was whether they were aware how one might be infected and how it is transmitted, what precautions one should take to prevent the disease. The level of awareness was as low as 3.1%, 5.91% or 6.16% and the highest being 19.4% only. Even in the context of the district where the level of awareness was the highest, the use of syringe only once was as low as 2.39%. **Thus the limited level of awareness did not have any reflection in the context of practice**. It may not be out of context to narrate a few cases here. Mr. Dilip Sarpa Bediya, age 48, belonging to Bediya tribe of Purulia District observed, "In our area HIV/AIDS has not occurred as yet. Is this disease a new phenomenon? You, Babu, have let us know the name of it but actually we don't know what it is and how it affects?" Mr. Niranjan Mahali, aged 55, belonging to Mahali tribe of Bankura District observed," You see ! Disease HIV/AIDS you are talking about has not happened to any one. In our area nobody has been affected by HIV/AIDS. Even we have not heard the names of HIV/AIDS. Is the disease similar to Leprosy? Perhaps the HIV/AIDs is a new disease. What we have to do if HIV/AIDs happen to us?" This only reflects the alarming situation in the studied areas to far the awareness of HIV/AIDS is concerned.

G. ***Pre and Extra Marital relations and use of Condom****:* It is known that HIV/AIDS is transmitted through sexual intercourse and naturally the practice of pre or extra marital relations and use of condom can increase or decrease the risk factor. Data were collected from the respondents about these two issues. The highest pre or extra marital relations were reported from Bankura (14.99%), but the lowest use of condom was reported from the same district (3.23%) making the population highly vulnerable. The lowest pre or extra marital relations was reported from North Dinajpur (3.18%). Again, the use of condom was the highest in Bibhum (39.71%) followed by Jalpaiguri (33.3%). It was quite low in West Midnapur (3.3%) andPurulia (3.8%), the two tribal dominated districts. The observation of Dharam Hembram, a Santal male, aged 54 years of Bankura District may be mentioned here. He commented, "We have heard the name of HIV and to be free from this disease we have to use condom". But the low use of condom makes the population very vulnerable.

H. ***Social practices, socio-cultural traditions and HIV/AIDS****:* It is very pertinent to examine here some of the typical tribal socio-cultural practices or behaviour pattern

that may promote the spread of HIV/AIDS or protect the people from HIV/AIDS. It is to be seen whether the tribals are more vulnerable than the other communities living in the same situation due to certain behaviour pattern or socio-cultural practices. In this context one can examine their marriage pattern, status and position of women including freedom of women compared to non tribals, and certain social institutions and their belief pattern. The tribals practise endogamy or marriage within the group. Inspite of migration, exposure to outside influence, the different tribal communities were noted to follow it in all the districts. This no doubt, helps in the prevention of spread of HIV/AIDS till no body is affected within the community. But once it is there, HIV/AIDS may spread very fast. Even though we have not noted among the studied population the presence of any institution like youth dormitory present elsewhere, where free mixing is often allowed and permissible according to the tradition of the society, polygyny is present. Again, pre or extra marital relations were also reported and the general attitude of the community is tolerance towards such behaviour. These are the potent factors for the spread of HIV/AIDS and once it is there, it is likely to spread very fast within such communities. It may not be out of context to discuss about the status and position of women in tribal societies as noted and the freedom women enjoy. There is no doubt that compared to non-tirbal women; tribal females enjoy more freedom in decision-making process and in their movement. Women also enjoy more freedom in the context of selection of mates and can change partners which one may not find in non tribal societies. In all the studied districts, we have noted more separated/divorced women living without much social stigma. Women also work outside independently and earn. But this increases the risk of sexual exploitation and consequent more vulnerability of the population. It has already been pointed out that women often carry herbal medicine to stop unwanted pregnancy as sexual exploitation of tribal girls is not uncommon. This can stop pregnancy but does not prevent the spread of HIV/AIDS. It increases the vulnerability of the population. Religious belief pattern often prevented in the use of condom during sexual intercourse.

It is evident from the study that in the context of the tribals of West Bengal, the following problems were identified with reference to HIV/AIDS:

1. Limited access to health care and general health seeking behaviours
2. Lack of awareness of HIV/AIDS, its mode of transmission and prevention
3. Risk involved during injection as proper care is not taken
4. Risk involved during blood transfer as proper protection is not taken
5. Migration in search of job due to poverty

6. Prevalence of pre or extra marital relations and limited use of condom

At present, virtually no resources are available towards the treatment of those infected with HIV/AIDS. Proper education and preventive measures to control the spread of the disease seem to be the most practical and cost effective strategy in a country like India and particularly in the context of the tribal people. It is very important to address the health concerns raised in our study in order to formulate effective, culture-sensitive and appropriate intervention programmes to avoid HIV/AIDS epidemic among the tribal population. Illiteracy, high level of poverty, inadequate health facilities, ignorance and lack of proper awareness among the tribal communities has made the population vulnerable and highly susceptible for rapid spread of HIV/AIDS.

- This paper is based on a larger study conducted on Health Situation and HIV/AIDS Awareness among the Tribals in West Bengal conducted during 2012-13.

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