CHAPTER -1

INTRODUCTION

“Every human being is the author of his own health or disease”

Buddha

Human beings are affected by a number of diseases caused by germs, bacteria, viruses, fungi and parasites. But epidemic produced by bacteria and other viruses are controllable and preventable and we have controllable vaccines and medicines to safeguard the population from these epidemics. There is no discrimination or stigma with the diseases caused by bacteria, germs, virus and parasites. But as far as Human Immuno Deficiency Virus (HIV) and Acquired Immuno Deficiency Syndrome (AIDS) are concerned, it is entirely different from other diseases which society is faced today.

The first documented case of AIDS in the United States was identified in 1980s by a young immunologist, Dr. Michael S. Gottlieb at the University of California, Los Angeles. HIV-1 was identified in 1983 by Dr. Robert Gallo and other medical scientists at the National Cancer Institute in Bethesda, Maryland. At about the same time, Dr. Luc Montagnier of the Pasteur Institute in Paris isolated HIV-2 from AIDS patients (Arvind Singhal et al, 2003:46-49).

HIV/AIDS have a peculiar character of affecting the immune system of the body and make body susceptible to a number of infections leading to AIDS - a fatal stage of the body. Unlike other epidemics there is no vaccine for prevention and no medicine for the cure of the diseases. It affects the entire demographic and economic structure of the society by increasing mortality rate among the youth and children who are considered as the back bone of the development of any nation.

For AIDS, the transmission routes are clear and it is closely associated with individual behaviour. Therefore, it is hundred per cent preventable if the behaviour of individual is very much in line with societal expectations.
Certain behaviours like sex outside matrimonial life, homosexuality, drug addiction, prostitution are unapproved behaviours and these are stigmatized in the society. The spread of HIV has its route in these stigmatized behaviours. Therefore, those who got AIDS/HIV are socially neglected, economically isolated and psychologically deprived by the society in general and by their family members in particular. As a result of social discrimination many infected people are generally out of the mainstream of social life. The social stigma makes them to develop mental strain and stress and unbearable fear about their future.

In the beginning of the epidemic it was said that it is the disease of gay men or homosexuals and confined only to the western countries where these behaviours are not considered as abnormal behaviours. But now the disease is more and more identified with general population and it made us to feel that every one is under risk. The epidemic encircled the whole globe with out leaving any country with AIDS free status. The disease has no compromise with the people based on their caste, class, religion sex, age, power etc.

If there is no control on the rapid spread of the disease, it will threaten the entire survival of the society. Therefore, HIV/AIDS should be treated not only as major public health problem but also a social problem. Because, it has all the characteristics of social problems which affect larger sections of population to produce adverse impact on the society (Horton and Leslie 1970:4).

1.1. IMMUNE SYSTEM

The immune system is a complex assembly of organs, cells, and proteins that defend the body against potentially harmful foreign substances. The co-ordinate action of these components against such substances is called immune responses. The immune system is involved in various major activities within the body. It defends the body against invasion by pathogens, which are disease-causing micro organisms such as viruses, bacteria, fungi and parasites. It identifies and destroys abnormal or mutant cells and thus defends the body against the growth of cancerous tumor cells. It also eliminates worn out dead and damaged cells and rejects cells from other organisms.
The immune system accomplishes many of its activities by the action of white cells, which are technically called leukocytes. The leukocytes are divided into three sub groups called 'T' cells, 'B' cells and natural killer cells. Specific immunity is carried out by 'T' cells and 'B' cells. The 'V' cells also called CD4+ cells.

When HIV entered into the body it not only replicates at enormous speed but also cause the death of the host cells by selectively targeting CD4+ cells. The CD4+ cells become its virus factory. Although the body wagers a battle against HIV from the first day of infection replacing upto 1 billion T' cells killed by HIV very day. But over a period of years the immune system gradually wears out and loses its ability to regenerate immune system cells killed during battle. This leads to a steadily widening gab between the number of cells killed each day and the number replaced. Once the gap widens the point that immune function is compromised, an individual with HIV is open to the opportunistic infections and cancers characteristics of AIDS (Kimberly et al 1998:13).

1.2. HIV - A DESCRIPTION

Acquired immunodeficiency syndrome (AIDS) is a disorder caused by the human immunodeficiency virus (HIV), which like all viruses is a submicroscopic parasite that can only survive and reproduce inside the cells of a host organism. HIV is a particular type of virus, a retrovirus, and more specifically, a lentivirus. HIV is able to infect CD4+ cells, a component of the immune system. The losses of CD4+ cells largely devastate the immune system in individuals with AIDS. HIV’s sole activity is the production of new copies of itself. HIV infection persists for many years and attrition of the immune cells needed to fight infection gradually leads to an inability to generate new immune responses required to suppress HIV, and the replication rate of the virus increases to very high levels. The loss of CD4+ cells and a rise in the amount of HIV circulating in the blood stream (called the viral load) are the hall mark of AIDS (Harry W. Kestler et al, 1998:5).

1.3. DEFINITION OF AIDS

AIDS case definitions are established by the Centers for Disease Control and Prevention (CDC) in the United States. In 1981, after reports of Pneumocystis carinii pneumonia, kaposi’s sarcoma and other opportunistic infections in young gay men in San Francisco, New York and Los Angeles, the CDC began surveillance for a newly
recognized disease to be called AIDS. In 1982, CDC developed a surveillance case
definition for this syndrome focusing on the presence of opportunistic infections.
AIDS case definition was expanded in 1985 by including the total of 20 conditions.
Four of these conditions were cancers, kaposrs sarcoma and three distinct types of
lymphoma. The remaining conditions were opportunistic infections - those caused by
bacteria, fungi, protozoans and other infectious agents. The CDC has made another
revision in 1987 by including three additional conditions. One of the new conditions
was an opportunistic infection called tuberculosis (TB), but only the extra pulmonary
(outside the lungs) type. The other conditions were not opportunistic infections, but
rather conditions resulting from the direct effects of infection by HIV in the digestive
system (wasting syndrome) and the central nervous system. These conditions were
found among heterosexual African American and Latino individuals. These new
cases also included high number of injecting drug users. In 1992, the CDC has again
taken steps to expand the surveillance definition to address certain populations,
namely women, injecting drug users and communities of color. In November 1994,
the CDC announced that it was expanding the surveillance definition with effect from
January 1, 1993.

According to this definition any HIV - positive individual with a CD4+ cell
count of 200 or less or whose CD4+ cells represented less than 14 percent of all
lymphocytes are called AIDS patients. Two additional illnesses are also included in
the case definition that is AIDS - defining in children but not in adults. (Theresa et al

1.4. HISTORICITY OF HIV/AIDS

The sudden appearance of AIDS in early 1980s prompted studies of the origin
of this apparently new, fatal human disease. Ranee Sabatier (1988:34-35) has given
three explanation of the origin of the HIV virus. The first explanation is that it may
originate from an old human disease unknown to science for the long time. The
second assumption is that it has originated from species other than human beings like
apes, monkeys. The third explanation is that it may accidentally originated in
labouratories while conducting experiments.
The early theory believes that the virus has spread through homosexual contact of men. This syndrome therefore was initially called guy-related immunodeficiency or GRID (Parvi, 1992:2). The spread of the syndrome soon identified as contagious agent which transmitted through sexual contact, transfusions of contaminated blood, and use of contaminated hypodermic needles. A new retrovirus was identified in 1983 and was subsequently demonstrated to be the cause of AIDS. This virus was named human immuno deficiency virus, or HIV.

The cross species theory reveals that the virus was already existed in animals and transmitted to human beings (Ashok Sahmi 1993:2). The first evidence to support the cross over theory for HIV came in 1985, when an HIV - like virus was discovered in rhesus monkeys (macaques) that had developed Simian Acquired Immuno Deficiency Syndrome (SAIDS). The virus was named Simian Immunodeficiency Virus of macaques, or SIV mac. SIV mac was shown to be related to both HIV - 1 and HIV - 2 but was more closely related to HIV- 2. Since those first studies, the SIV family tree has expanded to five branches representing five different simian species, all from Africa. The SIVs have been detected in sooty mongabeys in West Africa; in African green monkeys in East, Central and West Africa; in the Sykes monkey in Kenya; in a mandrill colony in Gabon; and finally in chimpanzees, also from Gabon.

The sooty mongabeys were kept as household pets in West Africa and the Africans may be infected with SIV in the past through the contact with house hold pets or monkeys hunted for food. Inadequately sterilized needles or contaminated blood products may have played a role in spreading SIV among humans. Needles that could be reused were widely introduced into rural African clinics after world war second and this widespread needles use coincides with the emergence of HIV. Needle reuse may have resulted in SIV being rapidly transmitted from person to person, allowing SIV to adopt humans through mutation. SIV became HIV when it was able to cause disease in human beings and be sexually transmitted. Once SIV had adapted to humans and was capable of being spread by sexual contact, the virus spread worldwide through international travelers (Preston Mark 1998:17).
The virus HIV-1 and HIV-2 are believed to have had a common ancestor in Africa. Very recently new HIV, which is more dangerous than HIV-1 and HIV-2 is detected in New York in America among homosexual men. This new HIV is more susceptible to opportunistic infection very quickly than other two HIVs. Researches are going on to study further details about the virus (Sun News, 1.30 PM on 17.2.05).

The medical condition, which was later to be called AIDS, began to be noticed in the late 1970s and early 1980s in several widely spreaded locations, including Belgium, France, Haiti, the United States, Zaire and Zambia (Jon Tinker, 1988:33-35). The first medical reports of the syndrome were published in the United States in June 1981 (US Centre for Disease Control, 1981:250-252). For few years preceding these reports, a small but growing number of homosexual men and their physicians in New York city, Los Angeles and San Francisco were noticing rare or unusual disease symptom - pneumocystis pneumonia, kaposis’s sarcoma in young men. These ailments seemed to be related to inexplicable deterioration in the men’s immune systems (Randy Shills, 1987:630). Doctors began to suspect the existence of a new, sexually transmitted infection. Doctors at the US Centre for Disease Control (CDC) in Atlanta, Georgia, began to suspect that blood transmission could be a factor and similar symptoms were also recorded among intravenous drug users. By the end of 1981, doctors in Zairean capital of Kinshasa had also begun to documents dozens of cases where their patients multiple infections seemed to relate to a collapse of the body’s immune infection (Lamey. B, and Malemeka. N., 1982:507-11). It prompted the physicians to observe the similarity between the symptoms of Zambian patients and those which had broken out among American homosexual (Bayley. A.C., 1983:1318-1320).

During 1970s cases of AIDS had been seen by Belgian doctors in Africans. The first seems to have been a thirty four year old Zairian airline secretary (Vandepitte. J.l. et al, 1983:925-926). Late 1980s and early 1981 doctors at a Parisian clinic identified a case of pneumocystis pneumonia in a Portuguese man, in a Zairian women and in a French woman who came from Zaire (Offenstadl. G. et al, 1983:775). Of the two hundred patients affected by the new disease in Europe, fifty two were Africans (Biggar. R.J., et al, 1984:157-173). In Haiti, the combination of kaposis sarcoma and uncontrollable opportunistic infections has appeared in 1978-79 (Pape, J.W., et al, 1983:945-950). Haitian refugees with immunodeficiency disease were
seen in increasing numbers in New York City and Miami during 1980-81. By mid 1982, the CDC had documented thirty four such cases. By October 1982, researchers in Haiti had diagnosed sixty one cases (Morbidity and mortality Weekly Report, 1982:353-361). Since 1982 the similar symptoms of cases were reported from various parts of the world and HIV/AIDS became the global problem.

1.5. THE UNIQUE FEATURE OF HIV/AIDS

AIDS epidemic is vastly different from epidemics of yester-years for the following reasons:

• Primarily it is a sexually transmitted disease. Sexual activity is not something that can be banned morally, socially or legally.

• The new infection is rapidly increasing in every country. The moment the AIDS virus HIV enters a person’s blood stream he/she is capable of infecting the next person he/she has sex with.

• Social stigma is attached with the AIDS since it has its roots with sexual behaviours. Therefore infected people have lack of courage to face the reactions of the society.

• Majority of the people are ignorant about the spread of HIV and its preventive mechanism.

• Limited facilities for testing and lack of affordability increases the spread of HIV/AIDS even without the knowledge of the infected people.

• The causative organism of AIDS is a virus and these viruses are not affected by antibiotics at all. It is not easy to find a curative agent for AIDS. Vaccines are not yet available, treatments are limited and a cure is still a vision for the future.

Therefore AIDS will create severe damage to our society. The increasing trends of HIV infection and deaths due to AIDS would not only produce adverse impact on individual, households and communities but also on the benchmarks of human development like infant survival, life expectancy, per capita income, school enrolments, health, and loss of trained human resources and so on.
1.6. ROUTES OF HIV TRANSMISSION

HIV may be found in the cells, bodily fluids and secretions of infected persons and the presence of virus in the bodily fluids and secretions have different degrees of transmission risk. HIV can be easily isolated in semen, vaginal secretions and blood and breast milk. It is not easy to isolate the virus from tears, saliva, perspiration and urine. Therefore, it is currently accepted that the virus is transmitted to others only through blood, semen, vaginal secretions and breast milk (Digumarti Baskara Rao, 2000:6).

According to Gracious Thomas et al (1997:26) the HIV can pass on to an individual mainly through the following three routes:

1. **Sexual exposure**: It is most commonly transmitted through sexual contact:
   - from women to men, from men to women, between men seeking men.

2. **Contact with contaminated blood and blood products**: HIV is also transmitted through infected blood. People have become infected by blood transfusion, infected blood products including donated organs and by sharing of syringes and hypodermic needles. In many parts of the world, donated blood is now screened for antibodies to HIV, making this form of transmission is rare. However, in places where blood is not systematically tested and where many people are infected with the virus, transmission in this way may still be common. The virus has been also transmitted by recycling needles that have not been properly sterilized.

3. **From parent to child through pregnancy and birth**: This is known as pre-natal transmission. Before, birth it may be transmitted across the placenta to the developing foetus. During birth, the virus may be transmitted via the mother’s blood or bodily secretions. A small number of cases of transmission through breast milk have been recorded in some regions.

HIV can also be transmitted through some innocuous routes like ritual tonsuring of the head at religious places where mass ritual tonsuring is taking place, common razor used in hair-cutting saloons and by village barbers who shave customers without changing disinfecting blades and piercing the ears, tattooing and ritual circumcision, if done in group (Ashok Sahami, 1993:19).
1.7. THE GROUPS VULNERABLE TO HIV INFECTION

Though every one is under the risk of acquiring HIV infection, certain groups are more vulnerable to HIV based on their life on high risk situation. These groups are called high risk groups. The high risk groups identified by the UNAIDS are past and present intravenous drug users, prostitutes, devadasis and their sexual partners, homosexual and bisexual men, Eunuchs involved in sexual activities particularly with homosexual men, prison inmates involved in homosexuality, multi-sexual partners, drug addicts, street children involved in sex and drug abuse, truck drivers who involved in sexual activity in the highway. Defense personnel who are engaged in sex with prostitutes, children of HIV positive women, sexual partners of HIV infected people, thalassemia patients who often receive blood from the donors, migrants who are away from their home for a long time and are involved in extra marital sex, construction workers etc. (Gracious Thomas et al 1997:29).

1.8. IMPLICATIONS OF HIV/AIDS

The dreaded disease caused by HIV not only produces adverse impact on the individual but it also threatens existence of the basic social institutions of family and community and nation at larger level. HIV/AIDS is not only a health problem, but it is also a societal problem with important social, cultural and economic dimensions (Ram Ahuja, 1999:415).

a) Implication on the individuals: If the person is infected by HIV, immediately his/her character is assassinated by the public even without considering the mode of infection. The individual with HIV is subjected to criticism, boycott, segregation and dissociation, by their family members, friends, neighbours and feilowmen in the community.

Still the people have the fear that the virus can be transmitted even by touching or sharing of articles with the infected persons. The fear of death and the socially unapproved behaviours linked with the transmission of HIV resulted in stigmatization and discrimination towards the people infected with HIV positive.
The HIV positive people are looked down and they are isolated and rejected by the members of the society from the normal day to day life. In majority of the cases the individuals are blamed for their infection and they are treated like strangers who are involved in spreading HIV into general population. As a result they are denied proper care and support to lead a positive life with HIV positive status. The societal isolation creates psychological depression and mental stress and strain which affect the health of the people infected with HIV positive and invite the opportunistic infection without giving opportunity to prolong their life span. Loss of courage to face the society leads them to feel themselves as inefficient persons to continue or to take up work. Besides, the people with HIV positive also face lot of discrimination in their work places. In many cases they are thrown out of employment due to fear of contracting infection. Loss of hope on peaceful and dignified future questioned them about the meaning of life and resulted in alienation which forces them to end their life by committing suicide. The discrimination and stigmatization forced many people infected with HIV positive to get away from their own location to far away places where their infected identity can be hidden. And also the individuals who cannot cope up with their positive result normally get scared to face the friends and family members. These persons will try to hide their HIV status from the society in general and family members in particular.

b) Implication on the family: The whole family will get affected if any of its members is infected by HIV. The stigma associated with HIV not only affects the individual but also the entire family. If the infection is known to the public, the total family will be criticized and they may be excluded from the social activities of the society/community. In many cases the education, employment and marriage of the sibling is affected to a larger extent and force them to change their residence from their original place. The burden is heavy on the women. Because she has to bear the economical responsibility due to loss of employment and income of the infected persons. The early death of the economically productive youth leads to loss of income to the family. The expenditure incurred to treat the opportunistic infection forces them to lose all their resources and lead them towards indebtedness. The children are also affected for none of their faults. Significant percentage of children have been orphaned due to the loss of their parents.
c) Implication on Community: High prevalence of HIV infection in the community will lead to shortage of labour force which is highly essential for the development of any community. The increasing rate of women infection will definitely question the morality and ethics of particular community/society and it will strengthen the stigma associated with HIV/AIDS.

d) Implication at National level: The impact of the epidemic is visible in the demographic structure of the society. The morbidity and mortality rate is high among the youth-the most productive age groups. As a result children and old population will be found more in the region where the HIV and AIDS prevalence is high. South Africa is adversely affected by the increasing proportion of mortality and morbidity (Michel Caraël et al, 1998:S1). The large increase in adult mortality and moderate increase in child mortality lead to dramatic falls in life expectancy (Ties Boerma et al, 1998: S3). The infection is high among the women. Around 25% of the women infected with HIV positive in the world are at their reproductive age. The higher infection rate among the women of reproductive age will affect the fertility rate of country (John Stover and Peter Way, 1998: S29). Since there is no cure for AIDS, the epidemic produces adverse impact on the economic structure of the country. The loss of human resource and loss of labour forces due to sickness also create adverse impact on the growth of national income. The growth of per capita income depends on the growth rate of healthy labour and capital that can be invested by the country towards the development activities. Sub-Saharan Africa has the lowest levels of per capita income of any developing region and it has faced lot of economic problems since 1980 due to AIDS (Martga Ainsworth and Mead Over, 1994:232-233). The treatment for HIV/AIDS is very costly and the Government has to divert a major portion of its resources to distribute medicines either at subsidiary cost or free of cost like India. At national level the costs are incurred primarily through testing blood and blood products, improving treatment for sexually transmitted diseases, implementing precautions in health care settings, tracking the diseases and educating the public about the risk of the diseases. Besides, the medical researches require huge money to develop vaccine to prevent HIV/AIDS and drugs for the treatment of people infected with HIV/AIDS. At present the developed drugs are very expensive and beyond the reach of an average man (Ramamurthy, 2000:1-21.)
1.9. WOMEN’S VULNERABILITY TO HIV/AIDS

HIV/AIDS is projected as women’s epidemic. There is a common belief that the women in sex work are the major cause for spreading the virus in the society. The tendency of feminizing the disease is found among the general population in almost all countries without considering the real risk of women to acquire infection through their sexual partners. The disease becomes women specific by blaming the sex workers and women are perceived as virus carriers in many developing countries.

According to UNAIDS Global Epidemic 2004, majority of the women were infected through their single sexual partners especially in their marital life. Women usually have a faith that they will not get infection since they have sex with their single sexual partner/husband. Therefore, majority of the women will not be aware of their infection till their pregnancy or the death of her faithful partner. The negative attitudes towards HIV/AIDS by the society make her sexual partner to hide his HIV status with his family members. As a result, when men’s infection is known to their family members, they blame their innocent wives/sexual partners for transmitting infection. The women’s behaviours and character are questioned rather than analyzing real fact for men’s infection. Many infected women have been abandoned by their family members as a result of such baseless blame.

In reality women are particularly vulnerable to infection and increasing numbers of women are becoming infected. Among the people infected with HIV/AIDS 57% are women and in many countries women outnumbered men as in the case of Africa.

Women’s vulnerability to HIV/AIDS has different dimensions due to the following factors:

a) Social status of women in the society: Throughout the world irrespective of the development of the nations the women enjoy only secondary social status in the society. Globally around 60 per cent of women live below poverty line with illiterate status. They have inadequate access to property and other infrastructural facilities related to health care services (Usha, 2000:12). The lower status of women within the family and society is heightening by their economical dependence on males. This makes women to feel less power to control their reproductive health. The feeling of
powerlessness both in the personal relationship and in the society has resulted in keeping silent in sexual interaction and changing their traditional role by demanding the use of condom for safe sex. If a woman demands these she will be treated as of bad woman or thought to be inferring the infidelity of her husband and in the case of sex worker she has to face the risk of violence or lose clients and income if she advocates the use of condom (United Nations Commission on the Status of Women, 1998:3). Therefore the powerlessness as a result of lower social status increases the risk of getting HIV infections.

b) Economic subordination: Economic factors, such as poverty increases the risk of HIV for poor women mainly in two ways: 1. Poverty and lack of better resources lead many unmarried women to exchange sexual favors for economic survival. Struggle for economic survival coupled with personal autonomy may lead many to form relationships with many partners and consequently increase the risk of HIV infection. Significant proportions of unmarried women are driven to become sex-workers due to destitution. There is a growing trend among poor married women living along the busy interstate routes on national highways to take up prostitution as a means of coping with poverty. They mainly have truck drivers as their clients who now have emerged as the major high risk group. In the cross border areas of the nations, the poor women have engaged in sex work with professional groups like armymen and other security personnel who have very high incidence of HIV. (Usha, 2001). They will be less successful in negotiating protection, and it is less likely that they will leave a relationship where they perceive more risk. Malnutrition, uncontrolled fertility, complications of childbirth, poorly performed abortion, predisposes women to intrapartal hemorrhages. This directly increases the risk of HIV through unmonitored transfusion of blood. The groups of young women most vulnerable to HIV infection are those who are homeless or living in poverty. UNICEF estimates that over 40 million young people in the world are living on the streets. Many of those have left home because of sexual abuse or poverty (Digumarti Bhaskara Rao, 2000: 122).

c) Cultural and Traditional factors: Power imbalance is found in all societies and it is supported by socio-cultural system and controlled by men. As a result culture of silence is found around sex. It prevents the open discussion of sexual matters not only with men but also with women. The culture of silence dictates that the women should
be ignorant about sex and passive in sexual interactions. Therefore, it is very difficult to reach the women with the message of safe sex practices. Even when the women are informed about safe sex, it is very difficult for them to negotiate its practices with their sexual partners. (Carovano, 1992: 131-142), The traditional norm of virginity for women that exists in many societies increases the risk of infection for young women. Because, it creates fear and it restricts their ability to ask for information about sex. The concept of virginity also puts young girls at risk of rape and sexual coercion in high prevalence countries because of the erroneous belief that sex with a virgin can cleanse man’s infection. In addition, in cultures where virginity is highly valued, some young women practice alternative sexual behaviours, such as anal sex, in order to preserve their virginity, although these behaviours may place them at increased risk of HIV. (Weiss, et al 2000, 233-245). The strong norms of virginity and the culture of silence that surrounds sex prevent women to take treatment for sexually transmitted diseases which is highly stigmatized in the society (Weiss et al, 2000).

In the Indian context, sex is highly sensitive, confidential and purely related to the private life of the individual and it forces people not to discuss any aspects of sex in the public sphere. Therefore, culture itself acts as a stumbling block to access knowledge about sex and sexuality and its related issues including STD, HIV/AIDS etc.

d) Cultural practices: In many societies sex is considered as taboo, not for discussion. Women are ill-informed on sexual matters and their sexual desire and decision on sex is controlled by men. Women have no negotiating powers and the societies have double standards on the sexual behaviour of its members. It imposes rule of chastity on women but accept men’s multiple sexual partners. The use of contraceptive measures depend on the willingness of the male partners and women’s social status depends on bearing children and the uses of condom is opposed to the cultural tradition of having children. Males are expected to initiate relationships, and sexual assertiveness in women is often stigmatized or even punished. Age differences for sex is strictly maintained by culture of many societies like India. In such countries women usually have sex with older men who have been sexually active for longer period and have had more chances for sexually transmitted infection. Certain cultural practices of the regions increase the risk of HIV infection for women. In some parts
of the world, women use herbal and other agents in the vagina to cause dryness, heat and tightness. This practice is referred to as “dry sex” in which women feel like virgins and because they think that female secretions are unclean. The material used by women may include pieces of cloth, leaves, ground stone, herbs or western medications and their use has been reported in Nigeria, Zaire, Zamba, Malawi, Zimbabwe and South Africa (Luciano Sandala et al, 1995:S61-S68). The substances used can cause inflammation and erosion of the vaginal mucosa, making it easier for HIV to enter. Female genital mutilation (circumcision) is practiced in various African countries (Heidi Jones et al, 1999: 219). Infibulations leads to extensive tearing and bleeding when sexual intercourse is attempted. It may also cause couples to practice riskier anal sex. The procedure itself could be risk if unsterilized instruments are used for several patients in succession (UNAIDS 1998:11).

Early marriage of women is another important cultural practice which increases the risk of sexually transmitted infections for women. Most of developing countries like India, Pakistan, Sri Lanka, Bangladesh, etc are practicing both child marriage and early marriage. In these countries women are withdrawn from the school soon after they attained puberty. The girls are forced into marriage with men who are elder than her age. Most of these girls are entering into marriage without knowing anything about sex and sexuality and reproductive health. Along with other social norms their age at marriage becomes a barrier for them to discuss or to learn the matters related to sex. In this context, they accept the domination of their husbands on their body as well as on their day to day life. Poor knowledge on reproductive health increases the risk of HIV infection. The knowledge on reproductive health is either poor or lacking among the age groups of 15-40 years. At these ages both men and women are sexually active and many a time their unsafe sexual activity increases the chances of infection. There are lots of discussions throughout the world about reproductive health, but the message has not reached the vulnerable group of 15-40 years and the women become innocent victims in the context of HIV/AIDS.

In recent years, in various parts of the globe male circumcision is getting more popular since the people believe that circumcision may reduce the risk of HIV infection (Kim Best, 2001). There is evidence that male circumcision protects against HIV infection in Africa and the uncircumcised men in Africa are twice as likely to be infected as circumcised men (Arvind Singhal, 2003:48).
Male circumcision is considered as a ritual practice by many communities especially Muslims. It is also a traditional ritual practice for the Christians in the continent of Africa. Similarly, circumcision is the common cultural and traditional practice in North America. The rate of infection identified here is only less than 1 percent. But in South Africa, the rate of infection ranges from 15 to 25% where less percentage of men have undergone circumcision (Halperin, 1999). Male circumcision provides significant protection against HIV infection and other sexually transmitted diseases such as syphilis and gonorrhea. The circumcised males are two to eight times less likely to become infected with HIV (AIDS Update, 2000). The specific cell called Langerhans cells are found in the foreskin of the male. These cells are the major receptors of HIV primary infection (Kim best, 2001). Therefore, the removal of specialized cells in the penis reduces the risk of HIV infection (Rosbert Szobo, 2000). But if it performed in an unsterilized situation it will increases the risk of all HIV. Lack of male circumcision is found in many countries like India. Many women are getting infected through their faithful male partners. If men had undergone circumcision, they may not get infected with HIV and in turn the women may not get infected with the dreaded diseases.

In many developing countries including India, sons are preferred over daughters. The concept of son preference is the principal determinant of high fertility in most regions. In the regions where son is given more importance, the women never come forward to use condom as safe sex to prevent them the STDs. Their attitude towards giving birth to male child may increase the risk of HIV infection in their marital life.

e) Female Biological Vulnerability to HIV: Women are biologically more vulnerable than men to HIV infection and other sexually transmitted diseases. The major factors responsible for differential transmission are the larger mucosal surface areas exposed to virus in women and the semen having high concentration of virus compared with vaginal secretions. Young girls are particularly vulnerable. Their immature cervix and relatively low vaginal mucus production presents less of barrier to HIV, making them biologically more vulnerable to infection than older pre-menopausal women (Digumarti Bhaskara Rao, 2000:281).
Many women get HIV infections by a single sexual contact. The chances of a woman being infected by one act of sexual intercourse with an HIV positive man are about one in 100. The chance of a man being infected by one act of sexual intercourse with an HIV positive woman are about one in 1000, but this probability may increase considerably if one of them has STD (Moses et al, 1991:407-11)

Women are disproportionately the recipients of blood transfusions and other blood products (eg. for anemia or child birth complications). In the absence of adequate blood screening, women’s vulnerability to blood-borne HIV transmission increases.

I) Marriage increases the women’s vulnerability to HIV: Marriage may be viewed as a social and economic commitment between individuals and families. Sexual access, procreation, child rearing and other services are universal to social expectation of marriage. Because of this and as well as lower social status and economic dependence, married women may be unable to challenge their husband’s extra-marital affairs or insist on condom use for themselves. The magnitude of HIV transmission in stable/monogamy relationship in the event of disloyalty is high inspite of vigorous and purposive intervention programmes. The infection among women in monogamy relationships are current problem in all regions of the world in general and India and Thailand in particular. In these regions the men who visit sex workers also have wives or other stable partners (Isabella de Zoysa et al, 1996:S 197-S203). Marriage provides no protection against HIV. Across the world millions of women infected through heterosexual sex were infected by their husbands. Double standard of culture with regard to virginity keeps silence when men have multi sexual partners or engage sex with sex workers. If the men are infected through their behaviours of multisexual contact, they will pass the infection to their wives or stable partners. The women in monogamy relationship never emphasized the need of using condom with the faith that they will not get infected through their husbands or stable partners. The married women have higher rate of infection than their unmarried, sexually active peer (Isabella de Zoysa et al, 1996:S 197-S203).
Most of the men who got infections are highly ignorant about their infections. Because they never realised the need for taking HIV test before getting married or whenever they had sex with sex workers. Some men will get married with the ignorance of their own infections and they will pass the infections to their wives. On the other hand some men are hiding their infections from others and transmit the virus to their wives. Therefore, many women are not aware of the risk of getting infection from their male partners. They are also not aware that their husbands have HIV/AIDS (Gladys Baingana et al 1995: S21-S30).

It is very difficult to implement HIV prevention among the married women. The factors which act as barriers to the prevention of HIV transmission in the stable relationships are: First, there is a widespread belief that sex with a stable partner carries few risks. Second, communication between stable partners about protective behaviours is compromised by prevailing norms about partner and gender relations. Third, condom use and other risk-reducing behaviours are problematic in long-term unions, because it prevents procreation. Many seem unable or unwilling to recognize that they may be exposed to HIV infection in their stable relationship, even when they are aware of their partner’s past or current risk behaviours. Most people believe that the “normal” sex with a stable partner is safe and sex “outside” the marriage and with “promiscuous” partners is risky. Many preventive messages, such as “stick to your partner”, “love faithfully”, or “love carefully” reinforce the notion that HIV infection only strikes “others” who deviate from the norm of loving, being faithful and having trusting relationships. Thus, monogamy is somehow constructed as a protection against HIV (Isabelle de Zoysa et al, 1996, S197-S203).

g) **Sexually transmitted diseases and HIV/AIDS to women:** Sexually transmitted diseases have challenged the control measures even in the most developed countries. It acts as a co-factor in HIV transmission by increasing susceptibility to HIV. The diseases are multi dimensional and their prevalence in any community depends on various socio-economic factors (Nair et al 1973:1967). The presence of sexually transmitted diseases (STDs), particularly ulcerative conditions, increases the likelihood of infection in both men and women. STDs are common amongst young women, particularly in Africa, the Caribbean and Latin America and Asia. They are not easy to detect in women and so most women remain unaware of their presence.
World Health Organisation estimates that about 330 million cases of treatable STDs exist worldwide at any time and 50-80% of STDs in women are asymptomatic or go unnoticed because they are internal (UNAIDS, 2000:11).

STDs—especially those, such as chancroid and syphilis, which cause ulcerative lesions—greatly facilitate both the acquisition and transmission of HIV. However, women with STDs are often asymptomatic and fail to recognize any infections. As a result, women are more vulnerable to HIV infection because they are more likely to have untreated STDs. Often their vulnerability to STDs is the result of their partners’ behaviour rather than their own.

Preventing and curing the STDs may reduce the incidence of HIV infection. But the women, who know their infection, tend to avoid STD clinics for fear of being recognized and stigmatized. Women normally used to visit primary health centers and family planning and maternal and child health clinics to seek medical services. But unfortunately, the facilities to treat STD are often less equipped to diagnose and treat STDs. Further, women’s inaccessibility to STD clinics, economic dependency and house hold responsibilities, negative attitudes of health workers towards the women with STD prevent them from getting treatment. Lack of sex education also increases the risk of STD among youth. Biological and psychological changes associated with marked desire for sexual adventures during adolescence have put the teenagers in the “high risk” group. Urbanization and industrialization have not only broken down the established class structure but also shattered the social and religious constraints which prevented promiscuous sexual behaviour (Dutta, P.K, 1998:16). The prevalence of STD is higher among the women involved in prostitution.

Innocent women never discuss any STD due to cultural constrains and the infection is tolerated by the women.

h) Female sterilization increases the risk of women’s infection on HIV/AIDS: In many countries young women and adolescent girls were very much conscious about preventing pregnancy rather than getting infected from sexually transmitted infections. The women who involved in pre marital sex are often familiar with oral pills rather than condoms (Ann K, Blanc and Ann A. Way, 1998:114). The magnitude of condom use is found to be less among the women at younger age. In a thickly populated country like India, Family Planning is an official policy. In these
countries both men and women are motivated to undergo terminal methods of male and female sterilizations. Once any one of the spouses has undergone sterilization they never think about safe sex to avoid sexually transmitted infections (Ann. E. Biddlecom et al, 1997: 108). In a country like India more and more women are enthusiastic about female sterilizations and their number is increasing by leaps and bounds. As a result of permanent method of birth control, these women were liberalized from procreation rather than sexually transmitted infection through their male sexual partners. The permanent family planning methods act as a barrier for both men and women to use condom for safe sex and increases the risk towards HIV and other sexually transmitted infections.

i) Lack of awareness on reproductive health enhances the vulnerability to HIV/AIDS

Many women have poor understanding over their own bodies, mechanisms of HIV/STD transmission and their level of risk in unprotected sex. Many men also have inadequate information about their own bodies and women’s reproductive health. A time of growing sexuality and identity consolidation, adolescence is also at greatest risk of contracting sexually transmitted diseases (STDs) and the HIV virus. The women in general and adolescent girls in particular are ignorant about their reproductive health. The culture of silence prevents them from gaining information with regard to the problems associated with their reproductive health. In many developing countries women’s education is compromised with the tradition and culture. Therefore, the illiteracy or poor education has not allowed them to acquire knowledge on their reproductive health and the information related to their own risk of getting sexually transmitted infection and HIV/AIDS. The women’s inaccessibility to the reproductive health education has resulted in adolescent childbearing in developing countries. The proportion of birth to unmarried adolescents is increasing in the countries of North Africa, Asia, Latin America and Sub-Saharan Africa (Susheela Singh, 1998:117). The increasing pattern of high pre marital pregnancy appears to reflect a low incidence of contraceptive use, especially condom (Michel Garenne et al, 2000:47). The exposure to media and the influence of modernization and peer pressure has made many girls from the educated community to get involved in non-marital sexual activity without insisting on condom use for intercourse. Their
Involvement in unprotected sex is based on their insufficient knowledge and distorted judgments of the risks of becoming pregnant and acquiring sexually transmitted infections (Anastasia J. Gage, 1998:154).

Ineffective health programmes implemented by the government on the reproductive health is one of the major causes in Sub-Saharan Africa for the exposure of young girls into risky sexual behaviours (Laurie Schewab Zabin and Karungari Kiragu, 1998:210). The regions of Ghana and the regions of Western Countries have open social environment. Such free social environment influences boys and girls to experiment with sex without giving much importance to the implication of reproductive health and the diseases associated with the risky behaviours (Barabara S. Mensch et al., 1999:95). The adolescent unproductive sexual behaviours increase the vulnerability to HIV infections both in rural and urban areas.

j) **Attitude towards parenthood increases women’s vulnerability to HIV infection**

In most societies, women’s primary role is to bear and nurture children. The status of women in the society is directly related to her capacity to become a mother. The childless women are looked down by the society and they are sidelined in all social and cultural ceremonial celebrations. Number of children given birth by the women is the rating scale to perceive the women’s position is the family as well as in the society. The norms related to parenthood have two broad implications on women in relation to HIV/AIDS and STDs. One is that women are expected to concentrate more on their reproductive role rather than productive role as earning members to the family. The second consequence is that the childless woman used to try to become pregnant with unprotected sex without getting treatment for her/his infertility. In such cases if men are infected, the woman will also get infection without her knowledge.

k) **Violence against women and HIV infection**

Violence against women is an important factor which increases the risk of women's vulnerability to HIV infection. Rape is high risk factor which is inadequately recognized or addressed. In developing countries many poor and underprivileged women are subjected to sexual harassment like rape, molestation, and kidnapping and abduction either by the members known to their family or by the members of affluent community in work place. Drunken behaviour of the youth is reported as a major cause for the sexual harassment of women in the developing
countries like India (Sangmeswaran. K.T, 2004). Sexual harassment is a crime against women which increases the risk of HIV infection. Marital violence is more tolerated by the society than the violence outside the marriage. The rape within the marriage is not recognized as offence in many parts of the world and it is the privilege given to the men in the male dominated patriarchal society. Physical and sexual violence against women are intensified during wars and armed conflicts. Sexual violence can also occur against children, homosexuals, and transgendersed people. The myth prevailing everywhere among the men in the society is that the sex with the children or young girls may cure or prevent all sexually transmitted infection including HIV/AIDS. As a result of this myth many girl children are trafficked and forced into prostitution. The sex under the condition of force or violence never think to use condom and it increases the risk of HIV and STDs infection to women.

1) Migration of male increases women’s vulnerability to HIV infection

Male migrants are away from their home for a longer period. For example, transport workers, military and armed force workers, traders, seasonal agricultural labourers, are highly mobile and they have to leave their spouses and families for longer periods. Sex impulsion, separation from spouses, and stress and strain owing to their work influence male migrants to seek sex with sex workers and to use drugs with their peer groups in order to get relief from their personal problems. Thus poor migrants are not in a position to value one’s own life or to take steps to protect one’s own health. Generally, the migrants are not much aware of the use of condom. The lack of or poor usage of condom increases the risk of HIV infection. These migrants were not coming forward to test their HIV status though they know their risk behaviours. As a result, they were unaware of their infection. If the men are infected due their risky behaviours, they well pass the infection to their wives or other sexual partners when they returned home. The impact of prevailing power imbalance and its associated gender inequality and women’s faith on their male sexual partners do not permit the women even to suggest safe sex. The risky behaviour of men and their ignorance of their HIV infection increases women’s vulnerability to HIV infection.

in) Migration of women increases their vulnerability to HIV

Generally the migrant women have least power to protect themselves from sexual exploitation. Many women migrants have ended up in prostitution to earn
more money to improve the standard of living of their family members. Geographic mobility to young girls would lead to increased risk. Migration among the young girls under the age of 15 is predominant in rural areas in many Latin American Countries, in some African countries such as Ghana and Morocco and in Asian countries like Bangladesh, India, Indonesia and the Philippines. They migrate to urban areas for seeking schooling and employment. A large proportion of the young women migrating to European countries from Asia and Africa end up in prostitution. Many sex workers move from place to place either voluntarily or involuntarily. For example, women from Cambodia, Laos, Myanmar and Vietnam work in brothels in Thailand. Sex workers from Thailand and Philippines work in Japan. Thai women became sex workers in Singapore and Nepalese women work in India. Sex workers may spread HIV from cities to rural areas when they returned home (UNDP, 2004:1).

The process of increasing feminization of migration is found throughout the world. It is estimated that roughly 48% of all migrants in the world are women (UNDP, 2004:5). Women migrants from Asia constituted the largest number of unskilled workers in labour receiving countries. Rampant gender inequalities, low social status and lack of understanding of their sexuality and reproductive health and lack of access to information and service make migrant women especially vulnerable to HIV/AIDS. Large number of migrants face an acute risk of exploitation, physical violence, sexual abuse and socio-political marginalization. Sexual abuse and sexual exploitation will also increase women migrant’s vulnerability to HIV infections (UNDP, 2004:6).

1.10. PARENT TO CHILD TRANSMISSION OF HIV

Parent-to-child transmission (also called PTCT, or “vertical transmission”) is common today, resulting in millions of pediatric AIDS cases. The chances of a baby born to an HIV positive mother being infected are 40 percent (Arvind Singhal et al, 2003:49).

Throughout the world hundreds of babies are born with HIV positive every day and there is no sign of decreasing trend in the world. Such increasing trend is mainly because of the failure of recognizing child’s rights which is guaranteed under the United Nations Conventions of the Child Rights.
The HIV infected mother can pass virus to her baby in the womb itself or during pregnancy, labour, delivery or after birth through breast feeding. The vertical or prenatal transmission is the major cause for the infant to get infection. The risk of transmission from mother to child is around 15-30% if the mother does not breast feed the child. But it can rise as high as 30-45% with prolonged breast feeding (Pushpa Khurana, 1998:103). Therefore, WHO has recommended bottle feeding for the children of HIV infected mothers (Gracious Thomas et al, 1997:42). In developing countries, the infection rate is increasing among the women at child bearing age. The increasing rate of infection among the women will increases the infection rate in infants (UN AIDS Briefing paper, 1997). The viral load of the mother is an important factor which influences the prenatal transmission. If the viral load is high, the risk of infection is also high (UNAIDS, July, 2004).

In 2004, around 640,000 children under 15 became infected with HIV mainly through mother to child transmission and 90% of these children are living in developing countries (UNAIDS, 2004). It is estimated that by the year 2010, if the spread of HIV is not controlled, around 75% of the infant mortality and under-five child mortality in the world will be due to AIDS (UNAIDS Briefing paper, 1997).

Since the beginning of the pandemic, over 5 million infants have been infected with HIV. Among them 90% were born in Africa and the worst affected region is Sub-Saharan Africa. In this region, the HIV infection rates of 10-30% are common among the pregnant women. At the same time the number of cases also increasing in Eastern Europe, India, and South East Asia (UNAIDS, 2002:1-8). In these regions the infection rate among pregnant women ranges from 1% to 5% and it increases the vulnerability to infant infection (Gangakhedkar, R.R., 1999:125-136)

HIV infection is a major contributing factor to childhood diseases and mortality in developing countries. It will threaten the survival of the child. The risk of transmission can be reduced upto 50% with the administration of anti retroviral drugs to mother and baby at the time of delivery, in conjunction with replacement of breast feeding (UNAIDS, 2002:1).
In 1994, French and American researchers found that a two-month course of the antiviral drug AZT (Zidovudine) administered to HIV positive women in pregnancy during labour and delivery and after birth to their newborns reduced the rate of mother-to-child transmission by two-thirds in the absence of breast feeding. This preventive regimen is impossible to apply in many developing countries. Because, AZT is a very expensive drug and it is only available for the wealthy (UNAIDS Briefing Paper 1997). In Western countries the mother to child infection is found to be less due to effective voluntary testing and counseling, access to anti retroviral therapy, safe delivery practices and the widespread availability and safe use of breast milk substitutes (UNAIDS, August, 2001).

Poverty is the key reason for increasing pediatric transmission in developing countries. The women who are infected by HIV in developing countries are identified as poor and they are not in a position to avail anti retro viral drugs to prevent mother-to-child transmission. Besides, breast feeding is the common norm in most of the developing countries. Lack of awareness on supplementary feedings and lack of financial sources to avail such supplementary feeding force the women to depend only on breast feeding to their child. Therefore, the nursing mother has an increased risk of transmitting the virus to her infants.

The important factor which is responsible for mother to child transmission is lack of awareness and ignorance about the status of HIV infection. Most of the people are not interested to take up voluntary testing to know their HIV status owing to their risk behaviour. Therefore, many pregnant women are ignorant about their own infection and the need of taking anti retroviral drug to prevent their babies from infection.

1.11. STIGMA AND DISCRIMINATION ASSOCIATED WITH HIV/AIDS

Erving Goffman (1963:3) described stigma as “an attribute that is deeply discrediting within a particular social interaction”. His explanation on stigma focuses on the public attitude toward a person who possesses an attribute that falls short of social expectations.

“Stigma” is a powerful tool of social control used to marginalize people. It can exclude people and can have great power over their lives with regard to social interaction. Generally, the public have a belief that they can get HIV by any kind of
physical contact with the people infected with HIV positive. They also have a belief that the promiscuous individual alone can get HIV. The negative conception on HIV forces the public to treat the people infected with HIV very badly and indifferently. This problem of stigmatization is found all over the world. When people with HIV are treated as outcasts or as morally bad people, it is discrimination (PFA, 2004:1).

HIV related stigma refers to all unfavorable attitudes, beliefs, and policies directed towards people perceived to have HIV/AIDS as well as towards their significant others and loved ones, close associates, social groups and communities. Patterns of prejudice, which include devaluing, discounting, discrediting and discriminating against these groups of people will strengthen the existing inequalities related to gender, sexuality and race.

1.11.1 CAUSES FOR HIV RELATED STIGMA

According to Goffman, diseases associated with the highest degree of stigma share following common attributes:

1. The person with the disease is seen as responsible for having the illness.
2. The disease is progressive and incurable
3. The disease is not well understood among the public
4. The symptoms cannot be concealed.

HIV infection has all these common attributes and attracts high level of stigmatization. First, people infected with HIV are often blamed for their life style and many people believe that HIV could be avoided if individuals made better moral decisions. The behaviours associated with HIV, for example, sex outside the marriage, sex between men, injecting drug use, and prostitution are already stigmatized in the society. Therefore, people infected with HIV positive are often thought of as responsible for infection. Second, although HIV is treatable, it is a progressive and incurable and life threatening disease. Third, HIV transmission is poorly understood by some people in general population. As a result of the poor knowledge and misconception, they scared of contracting HIV by accepting the presence of the people infected with HIV positive. Finally, although asymptomatic HIV infection can often be concealed, the symptoms of HIV related illness cannot be concealed. HIV related symptoms may be considered by the people as repulsive, ugly and disruptive to social interaction (Herek, 1999).
1.11.2. IMPACT OF STIGMA ON THE PEOPLE INFECTED WITH HIV POSITIVE

The stigma associated with HIV/AIDS prevents the high risk groups from taking up HIV test voluntarily. The delay in testing further increases the transmission of HIV. The discrimination and social stigma has made many people to be ignorant about their disease. The ignorance on the status of HIV leads to the spread of virus into the general population. Early detection of HIV infection is important. Knowledge of one’s own HIV seropositivity can lead to earlier treatment and improved outcomes. Knowledge of seropositivity can also lead to changes in risk behaviours that can reduce or eliminate the risk of HIV transmission.

The nature of stigma also prevents the infected people by disclosing their HIV status in the society. Even after testing HIV positive, many people have denied their seropositivity and many have not accepted their seropositivity status. The denial and hiding of the disease from others again aggravates the situations by spreading the disease to their sexual and needle injecting partners.

Delay in testing, denial and non-disclosure of the infection are major causes for the increasing rate of infection in the general populations.

1.11.3. IMPACT OF STIGMA ON WOMEN

Women’s social and economic vulnerability and gender inequality make women to find difficulties in coping with the stigma and discrimination associated with HIV infection. HIV positive women bear a double burden: they are infected and they are women. HIV testing is a critical ingredient for receiving treatment or for accessing drugs to prevent the transmission of HIV from a woman to her child. But the woman is ostracized, marginalized and even killed as consequences of exposing her HIV status (Hindu, July 18, 2003). Since women are sexually, economically and biologically vulnerable to HIV/AIDS and other STDs, they are often stigmatized and blamed for “causing” HIV/AIDS and other STDs. Women are frequently identified as “reservoirs of infection” or as “vectors for transmission” to their male partners and their offspring. This inaccurate view on women by the public will neglect the focus on men's equal responsibility in preventing HIV/AIDS. It will also prevent the development of programmes to meet the needs of women to protect themselves from all sexually transmitted diseases including HIV/AIDS.
Generally, the people assume that if a woman has HIV infection, she has engaged with multiple sexual partners or engaged in prostitution. As a result, the infected woman’s character is under the threat of assassination and such women are treated as “bad women”. Many of such infected women have been dismissed from their jobs or not hired for jobs, evicted from their homes, abandoned by their husbands or other long-term partners, and denied the custody of their children, denied shelter and share of household property, refused access to treatment and care and often blamed for their husbands’ HIV diagnosis. In addition, women perceived to be at risk of HIV infection have been denied health insurance.

Some countries have implemented mandatory testing schemes targeting women. Women who test positive or who are suspected of being infected suffer from increased discrimination, random and institutional violence, arrest, incarceration and deportation. Most often such testing is without the woman’s informed consent, and without appropriate pretest and post test counseling (Digumarti Bhaskara Rao, 2000:284).

In all regions women are expected to assume care giving responsibilities to the children and other family members who are sick. In the case of HIV/AIDS also women are expected to take care of their infected partners and it gives more stress and strain. Owing to sickness, loss of employment of the male partner forces her to take up employment outside the home to cope with loss of income of the male partners. When she becomes ill she will not get any one support to take care of herself.

Often women are blamed for husbands’ HIV status. If the man is diagnosed HIV first, automatically the woman’s fidelity is questioned by the husband and by her in-laws (Shalini Bharat, 2001). In case where the man has admitted his relationship with the sex workers, the burden of blame still falls on the wife for failing to “satisfy” her husband’s sexual impulsions. These women were often isolated, shunned by family and friends, and become the target of abuse or gossip. Therefore, women infected with HIV positive tend to be more stigmatized than men due to social expectations of moral integrity. As a result, many women infected with HIV positive are experiencing violence in the homes (Sathiamoorthy and Suniti Solomon, 1997).
1.12. THEORETICAL FRAME FOR THE STUDY

I. A. Structural Functional Theory: Social structure refers to the recurrent and patterned relationship that exists among the components of social system. The social structures have interrelated and interdependent parts in the form of institutions. Each institution or parts serves the function to maintain stability and equilibrium in the society at larger level for the existence of society and its members. The consequences which permit the adoption or adjustment of a system is called functions (James W. Vander Zanden, 1990:29).

The social structure consists of invisible rules and institutional arrangements like family, religion, education, etc, to guide the behaviours of the individuals. The major assumption behind structural functionalism is to maintain stability, harmony in the society and to adopt changes according to new needs and demands through evolution. If any institution or parts of structure fails to perform its function, it will result in imbalance or disequilibrium in the society.

The social structure has two basic components - status and roles. Status refers to the individual’s position and power in the society. It may be achieved or ascribed status. A status carries with it a set of culturally defined rights and duties. It is called roles. The norms of the structure specify the appropriate and inappropriate behaviour for the occupant of particular status.

According to functionalist perspectives, unequal distribution of social rewards is necessary to get the essential task of the society from its member to maintain harmony and equilibrium. Kingsley Davis and Wilbert Moore argued that social stratification is both universal and necessary, and hence no society is ever totally classless. In their view, all societies require stratification to fill all the statuses composing the social structure and motivate people to perform the duties associated with these positions (James W. Vander Zanden, 1990:242).

For a functionalist, society is system, a combination of things or part that forms a larger whole. All the parts of the society are related to one another. Institutions such as family, religion, the economy, the state, education are among the crucial parts of any society. Changes in one institution have implication for other institution and for the society as a whole.
Robert K. Merton argues that the institutions and other parts of the society can contribute to the maintenance of the social system. But at the same time they can also do the opposite to other parts of the social system. The consequences that lessen the adoption or adjustment of the system are termed by him as dysfunctions. Merton also distinguishes between manifest and latent functions. Manifest functions are consequences that are intended and usually recognized by the participants in a system. Latent functions are consequences that are unintended and often not recognized (Jonathan H Turner, 2002:87-97).

Durkheim argues that the social structure is made up of norms and values. It regulate the behaviour of the people which is considered as appropriate and worthy in different settings. According to him the individual can learn the normative behaviours through socialization. Socialization is a process which makes individuals become the members of society and makes social life possible. For Durkheim social solidarity is ensured by socialization. Durkheim’s conceptualization of social systems in terms of “normal” and “pathological” states exclusively depends on the adoption and practices of culturally expected norms and values (functional needs) by the individual in the society (Pip Jones, 2005:37-40).

Talcott Parsons defined “social structure as a stable system of social interaction”. Parsons takes “action” as the building block of the system. The term action refers to the behaviour of the individual. For Parsons, the cultural institutions of the society consist of cognitive beliefs, systems of expressive symbols and private moral obligations. The main function of the cultural system is the legitimation of the society’s normative order. Cultural value patterns provide the most direct link between the social and cultural systems in legitimizing the normative order of society. They define what is appropriate and what is not, not necessarily in a moral sense but in accordance with the institutionalized order (Francis Abraham. M. 1982:63). According to him the social system has the following characteristics (Jonathan H Turner, 2002:58-65): -

1. It involves a process of interaction between two or more individual

2. Each one of the individuals influences the another individual
3. Their interaction is mainly based on collective goal orientation or common value and of a consensus of normative and cognitive expectations.

4. The actor is confronted with a variety of situational conditions as societal environment and ecological constrains

5. The actors’ orientation to the situation is both motivational and value oriented.

It is evident from the structural functionalist perspectives, that members of society are expected to do their duties according to the norms and cultural values of the society.

For Weber, the society is existed because of social action. People do things because they decide to do so in order to achieve ends they desire. Having selected their goals, and taken account of the circumstances they find themselves in, they choose to act. Social structure is the outcome of such action; ways of living are the product of motivated choice. Existing action created social circumstances exercise constraint as structural forces but action is nonetheless still mental in origin - chosen in the light of the actor’s perception of these structural constraints (Pipe Jones, 2003:82)

B. Application of Structural functionalist theory to the present study

The individual has to act according to the norms and rules of the various institutions of the society. To fit in as a member of the society, the individual is learning all the culturally expected norms, values and rules from the childhood through various institutions like family, school, religious institutions, government etc. The individual is socialized in such a way as to act according to the norms and values of the society. The individual should not think of deviating from the laid norms and values of the society.

Indian society is highly a culture-bound society. The individual behaviours are encircled by the rigid norms, values, rules, moral codes, mores and traditions of the society. The Indian culture and traditions have a belief that the adoption of culturally expected norms and values alone help to maintain harmony and equilibrium in the society. It also has a fear that if the individual is allowed to act according to his own choice without giving importance to values of the culture, the Indian society will lose its credibility, reliability and integrity.
Family, marriage, religion and community are the important institutions which serve to socialize the individual in accordance with the cultural expectations of the society. Gender related behaviours status and roles and sex and sexuality are learned by the individual due to the influence of these institutions. The society’s norms regulate sexual behaviour by specifying who may engage in sexual behaviour with whom and under what circumstances. The Indian society is very rigid in regulating the sexual activities of the individual with the cover of silence around the sex. Discussing sexual matter is considered as taboo in India. The people are not allowed to discuss sex and sexuality with any one including spouse. As a result, fear is created among the people to learn or collect information related to sex and sexuality.

In India, family and marriage are highly valued. The individuals are expected to engage in sex only after marriage. Sex outside wedlock is highly devalued in the society. The pre marital and the extra marital sexual relationship will entirely damage the life of the people who engage in such activities. If such relationship is known to others, the particular individual has to face stigma and discrimination in the society. Murders due to extra or pre marital relationship are frequently reported in the local newspapers and magazines of India.

Indian society is patriarchal. Men are the dominant figures in the family. The women are expected to have the character of ideal wifehood. It means the husband must be considered as God and the wife should be faithful to him even if the husband has deviant behaviour and seek pleasure outside the marriage. The good wife must never do anything that would displease her husband. According to Manu - the Hindu code maker-“Women must particularly be guarded against evil inclinations. If they are not guarded, they will bring sorrow on both the families” (Kapadia, K.M, 1966:254). Manu therefore wants woman to be under the surveillance of her father in her childhood, her husband in her youth and her sons on the death of her husband. “A woman should never think of independence from the father, the husband or the sons because by so doing she will make both the families contemptible”. Her status is determined only through her reproductive capacity. She is expected to bear children, that too male children. As per social norms male has to take decision with regard to family matters. The male has to decide the contraception to control the birth.
But normally, the safe sex is not a rule in family among the spouses. Therefore, in the era of HIV/AIDS infection, women are subjected to the infection as a result of unsafe sexual behaviour.

With regard to marriage, age difference between bride and bridegroom is strictly maintained in the society. The bride must be younger than the bridegroom. This age gap further strengthens the inequality and low status of women. As a result of younger age, the woman can not raise her voice against her husband’s sexual domination on her body. The hidden aspect of sex and sexuality which is deep rooted in the culture prevents the woman to gain knowledge on her reproductive health. According to the traditional norms of good woman, she cannot practice it in her life if she knows little knowledge about reproductive health.

Even the friendship between male and female is not encouraged in the society. The girl must be away from the boy. As far as sex is concerned, men are also not encouraged to involve or experience sex outside wedlock. As per religion and culture it is immoral. Sex is related to morality in India. If any one deviates from this norm he will be treated as an immoral person. Therefore, the secret behind sex influence the weak minded men as a result of poor socialization to experience it with the sex workers. The same secrecy prevents men to use condom to safeguard from sexually transmitted diseases. Once he is infected he will take the virus to his innocent wife and children through his wife.

In Indian society irrespective of regions, cultural taboo is associated with sex and it is not a open topic for discussion in the family and society. Religion also promotes the culture of silence around sex and it imposes virginity on women rather than men. Such kind of cultural notion and peer pressure encourages men to have an experience with sex outside their marital bond. Besides in every society the individual have certain status and accordingly roles. The society is expected value-oriented action or use of value rationality to satisfy their sexual urge. The individuals’ irrational action is responsible for acquiring HIV infection for both men and women who have sex outside marriage. The infection among the spouse and children affect the institution of the family. It will question the socialization of the individual in the family with regard to morality and moral values of the stability of the family. If the institution of family is affected it will bring adverse changes in the
institution of economy, government, politics, education etc. In turn it affects the social health and social fabric of whole society by bringing imbalance and disequilibrium among the different parts of the social structure.

Therefore, the structural functional aspects of society are responsible for acquiring as well as spread of HIV infection in India.

II. A. Theories of anomie and alienation

According to Durkheim, the mechanical solidarity is achieved in the traditional society where the simple division of labour and the feeling of togetherness exist. But in modern society there are so many different roles to be played and so many different ways are possible. Durkheim believed that human beings are not naturally consensual. He believed that if it is left to our own devices, we are anti-social. He pointed out that during time of rapid social change people become unsure of what is expected of them, and they find it difficult to fashion their actions in terms of conventional norms. Old norms do not seem relevant to current conditions and emerging norms are too ambiguous and poorly formulated to provide effective and meaningful guidelines for behaviours. Under these circumstances, Durkheim believed, an upsurge in deviant behaviour could be expected. The individual has unlimited desires and it can be regulated by a moral force. The moral power is superior to the individual and he must accept the social and moral expectation to maintain social solidarity. But any abrupt transition such as economic disorder, industrial crisis or sudden prosperity can cause a deregulation of a normative structure. As a result the mechanism of solidarity breaks down and normlessness ensures. Durkheim called this situation as anomie.

For Merton, social structure consists of culturally approved goals and institutionalized means to achieve the goals. Merton defined anomie as the disjunction between cultural goal and institutionalized means. The process where by exaltation of the end generates a literal demoralization and de-institutionalization (Francis Abraham, M, 1981:181). Merton identified the following five responses to the end-means dilemma and the violation of which culturally adopted means leads to anomie (James W. Vander Zonden 1990:210-211).
1. Conformity: It exists when people accept both the cultural goals and the culturally approved means to achieve the goal. Such behaviour is the bedrock of stable society.

2. Innovation: The individual accepts the cultural goals but rejects the approved means.

3. Ritualism: It involves the abandoning or scaling down of the lofty cultural goals but accept the cultural means.

4. Retreatism: Rejection of both cultural goals and cultural means and without substituting new norms for them.

5. Rebellion: Rejection of both cultural goals and cultural means and substitute new norms for them.

According to Merton anomie refers to a property of a social system, not to the state of mind of this or that individual within the system.

The concept of alienation was first used by Karl Marx. For Marx, the history of mankind is not only a history of class struggle but also the increasing alienation of man. In the capitalist society, the estranged or alienated labour involves four aspects: the worker's alienation from the object he produces, from the process of production, from himself and from community of his fellow men. Marx felt that when the labours are devalued and sink to the level of commodity, he/she will get alienated. Marx has identified two "hostile power" which render labour and its product alien. One is the capitalist who commands production and the other is the economic system which governs the behaviour of capital and the process of production (Karl Marx, 1964:124).

Treating alienation from the personal standpoint of the actor Melvin Seeman found five basic ways in which the concept of alienation has been used: 1. Powerlessness, 2. Meaninglessness, 3. Normlessness, 4. Loneliness and 5. Self-estrangement (Francis Abraham, 1982:199).

Scnacht argued that the individual may get alienated due to loneliness, exclusion from social and cultural participation, lack of identification with other’s views, interests and tastes, dissatisfaction in social relations, lack of job satisfaction, feeling of powerlessness, dissociation from popular culture, dissociation from societal values, rejection of societal behavioural norms and incomprehensibility of events (Francis Abraham, 1982:199).
B. Application of theory of anomie and alienation to the present study

The contemporary society is a highly complex society. Unlike traditional society the individuals are expected to perform different roles to meet the challenges of life. As a result of urbanization, industrialization, modernization and globalization, the present society is witnessing frequent changes. The rapid changes taking place in the society increase the inequality with unequal distribution of wealth and means to meet the ends. It has the characteristics of materialism, consumerism, exploitation and dehumanization. Modernity eroded the faith in ethics. It has given farewell to God and its related religious faith and moral values and norms. The society became fit for the person who knows the tactics of extracting the benefit without evaluating its morality.

The people, especially the migrants, illiterates, marginalized groups including women and poor, unemployed, and the rich who always have the intention of enjoying all worldly affairs find very difficult to satisfy their needs by using conventional norms. For them, the old norms are unsuitable to earn for their livelihood and/or to satisfy their needs. The emerging new norms are too confusing and it has not helped them for their empowerment and modifies their behaviour. As a result of normlessness the individual gives more importance to fulfill his desires rather than societal expectations.

HIV/AIDS emerged and spread nook and corner of the world as a result of the risk behaviour of individual. These individuals have not given importance to culturally accepted norms in the society. Poverty and other economical crises forced some women to fulfill their goal of survival by violating culturally approved means of earning and taken prostitution as a means for survival. Their sexual involvement with different customers increases the chances of getting HIV infection.

For sex, marriage is the only means which is approved by the society. Sex outside the marriage is considered as deviant behaviour. But the migrants and the others who have sexual impulsion find prostitution as an easily available source to satisfy their sexual urge. It increases the chances of getting and spreading HIV infection. The prevailing normlessness in the society created number of deviants including drug addicts and criminals. They find lot of confusion to match their life with the new norms emerging as a result of modernization.
The survival strategy makes them frustrated and to become addicts either by using heroin or using injecting drugs. They have a false hope that it will help to forget their problems to some extent in subconscious mind. As a result of frustration, the injecting drug users often seek sex with sex workers without realizing their risk and the need for safe sex. Their unsafe sexual behaviour increases the risk of getting HIV infection not only for them but also for the sex workers. If the infected people have other sexual partner/wives or if they get married they will infect the innocent women.

The individual is not the only person responsible for the spread of HIV infections in the world. The society is responsible for individual’s risk behaviour. Because the rapidly changing society has increased the gap between rich and poor and it has not distributed the resources equally to all people. The people who have more resources and who have the capacity to control the flow of resources are more powerful and they try to exploit the powerless by devaluing their rights. The present economic system also favors only to the growth and benefit of economically, socially, politically and intellectually wealthy people. The sense of powerlessness, meaninglessness, normlessness, isolation and self-estrangement of the individual causes alienation not only from himself but also from his goal, means and community and the world to a larger extent. The conflict with the present situation forces alienated individual to take another option as means to survival. The poor, poverty stricken and under privileged women who are alienated as a result of their economic suppression and domination of economically powerful people and have chosen prostitution as a alternative means for their survival. Similarly are the exploited, low skilled, unskilled and unemployed people who are involved in migration as a result of the alienation due to their devolution in the local areas. Their separation from the spouses influences them to satisfy their sexual urge through sex workers and get infection.

The infected individuals are isolated from the society. They will not get support and care from their primary relationship and they are excluded from social and cultural participation. They lose their identity with others. The infected individuals also normally develop the feelings of powerlessness and inability to influence others to get support and help. They develop the sense of feeling that their rights are denied and their life is made meaningless by the non infected and so called
conservative people in the society. Their disassociation from the normal social network as a result of their infection make them to get alienated and forces them even to the extent of committing suicide.

The stigma and discrimination affects different segments of population in different ways. The revelation is based on the nature of infection. The women who got infection through their husbands will easily reveal their status to their family members rather than sex workers and who got infection through their promiscuous relationship and pre marital sex. Though the discrimination have no bond, the house wives may get little support from their parents and sympathy from their relatives, friends and neighbours.

The spread effect is more in India due to the severity of anomie among the infected individual and non-revelation of HIV status in the society.

III. A. Jurgen Habermas Neo-Conflict theories or Critical theories

Habermas argued that expecting revolution from the proletariat class in the contemporary society is meaningless. They are now a pampered class of people within the trap of the capitalist class. In such situation, Habermas puts his critical theory of communication and domination. According to Habermas, we must talk to each other in order to find common ground and establish a consensus with the others over meaning. It is because we are capable of being rational and reasonable to co-exist with others in our every day social encounters. So long as the parties to a communicative exchange have an equal opportunity to state their views, so long as they treat each other as equals and honest, the agreement on the issues can be easily obtained. In other words, so long as an encounter is approached rationally with reason, the differences can be overcome (Pip Jones, 2005:171).

In order to solve the problem of domination, Hebermas suggests the construction of an ideal speech community. His main point is that purposive rationality penetrates every day practices, especially every day communications. His ideal speech community has the features of (i) all individuals capable of speech can participate in the debate, (ii) all individuals have equal right to give their reasons for their stated position and (iii) no individual can be denied the right to participate in the debate (Doshi, S.C., 2003:475-76).
B. Application of Habermas Neo-conflict theories/critical theories in the present study

Women are the marginalized segments in the institution of family under the domination of patriarchal culture. The domination of male over the female is also supported by the religion and the commercial economic system of the country. The women are not given much opportunity to express their opinion related to the issues which affect them adversely. As far as sexual relationship is concerned, they are denied the rights of communication with their sexual partners. The lack of communication is the major factor for the spread of infection among the women in India. The communication/information disseminated through various print and visual media has created sufficient knowledge and awareness about AIDS and its implication on the society. No doubt, the women and men have some knowledge about AIDS and its prevention. The communication between spouses or between sexual partners with regard to safe sex is essential to prevent the infection between them. Women should be given equal opportunities to state their views with regard to sex and sexuality. If male partner treat the women as equal and honest they can easily arrive consensus with regard to the use of condom as preventive method for all sexually transmitted infections.

The stigma based hidden status of HIV infection affects not only the infected individual but also their family. The infected individual undergoes traumatic experiences due to non-communication of their feelings and inflectional status either to their marital partners or to their family members. The implication of non-communication with regard to HIV infection at level of individual, family and community may bring adverse impact in the spread of infection to the larger society.

Therefore, communication at all level is the urgent need to prevent and control the rate of HIV infection in all societies.

1.13. SIGNIFICANCE OF PRESENT STUDY

Women become the epicenter of HIV/AIDS epidemic in India and in almost all parts of the country, the epidemic is feminized without realizing the circumstances leading to infection. The infected women are subjected to discrimination, abuse and violence. The stigma and discrimination may affect their social interaction in the
social system. The present study is undertaken to fulfill the research gap by identifying the circumstances leading to HIV/AIDS, socio-economic conditions of women infected with HIV positive, circumstances leading to prostitution, sexual behaviour after infection, changes taken place in the social interaction of the women infected with HIV positive and attitude of infected women towards pregnancy and child birth.

1.14. CHAPTERISATION

The present study is comprised of seven chapters arranged in systematic sequence. The First chapter presents an introduction of women infected with HIV positive with a brief account of causes and consequences of HIV on women. The Second chapter presents review of literature related to the study. A comprehensive view on the global scenario of HIV/AIDS is presented in the Third chapter. The Fourth chapter deals with the methodology adopted to conduct the present study, which includes objectives, operational definition of the concept, sampling procedure and sample size, tools of data collection and method of analysis. The Fifth chapter analyses the primary data with a view to derive findings based on the objectives designed for the study. The Sixth chapter contains major findings, suggestions and conclusion of the study. The implication of research in the form of Action Plan towards prevention and control of HIV/AIDS, care and support and relief and rehabilitation of HIV/AIDS affected people with the goal of creating AIDS free society is presented in the Seventh chapter.