CHAPTER - I

INTRODUCTION

The Acquired Immunodeficiency Syndrome (AIDS) first came to light in 1981 in USA. AIDS is caused by a virus called Human Immunodeficiency Virus (HIV). In 1983 at the Institute of Pasteur of Paris, HIV was first identified. The first name given to the virus was Lymphadenopathy Associated virus (LAV). In 1984 at the National Cancer Institute at Bethesda, USA, it was confirmed that LAV causes AIDS. In 1986 the US National Expert Committee introduced the term ‘Human Immunodeficiency Virus’ (HIV). Later another virus was identified in Western Africa and it was named HIV-2 and presently one more virus was identified namely HIV-3 (George Babu P et al. 1993).

In 1981 AIDS was found spreading among homosexuals in USA. (ICMR Vol.20. 1990). The same mode of spread was identified in UK and Australia. In 1986 medical scientists in India have found that AIDS also spreads among heterosexuals also. The Western countries have initially resisted to accept this as a mode of transmission. However the scientific evidence have proved that HIV also spreads through heterosexual route. Later it was found that drug addicts and intravenous drug users were found to be infected with HIV.

How does HIV affect human beings?

When a person is infected with HIV, the immune system produces antibodies to neutralize the virus. These anti-bodies do not inactivate the (HIV) virus. On the other hand, HIV attacks the key cells in the immune system.
This causes a gradual breakdown in the total immune system of the body. Hence the body cannot protect itself against any infection and becomes susceptible to any kind of infection.

HIV is a slow acting virus. The uniqueness of the HIV infection is that the infected persons look normal and they can still transmit the virus to others. The end stage of HIV infection is AIDS. It is characterized by a cluster or syndrome of illnesses like intense fatigue, persistent cough, fever, sweating in the nights, diarrhoea, dramatic weight loss, skin lashes, mouth ulcers, oral thrush, white warts on the inside of the tongue and cheek etc. It also causes neurological and psychiatric problems.

**The three fold routes of HIV transmission (ICMR Vol.20, 1990) are as follows :**

1) **Sexual intercourse**: Unprotected peno-vaginal intercourse either from an infected male to a female or vice versa causes the transmission of HIV. In the case of homosexual acts, the partner who receives the sperms are at a high risk of being infected. Oral sex also causes HIV transmission.

   The risk of transmission increases with multiple sex partners. It is also found that inflammatory genital diseases increase the risk of transmission. Risk of transmission is greater if there are aberrations of the skin or mucous membrane. The risk becomes greater when a woman is menstruating.

2) **Blood and blood products**: Use of blood donated by an infected person causes transmission. Syringes and needles shared among intravenous drug addicts cause transmission. Use of infected needles and tattooing
equipment to pierce the skin can cause transmission. There is also a risk of infection from contaminated razor blades.

3) **Perinatal**: HIV may be passed on from an infected mother to foetus. Infection may also occur at the time of child birth or breast feeding.

**GLOBAL VIEW OF HIV/AIDS TRANSMISSION**

The transmission of HIV follows a particular pattern in different regions. Depending on the major mode of spread, countries in the world have been divided into three patterns (Prema Ramachandran 1990).

Pattern I includes North America, Western Europe, some parts in South America, Australia and New Zealand. The major mode of spread is through homosexuals and intravenous drug users. Perinatal transmission is high among drug using women and sex partners of intravenous drug using men. Heterosexual transmission accounts for a relatively small number.

Pattern II includes parts of Africa and the Caribbean. Heterosexual transmission is predominant in these countries. Perinatal transmission is substantial because of heterosexual intercourse.

Pattern III includes Asia, most of the Pacific, Middle East and Eastern Europe. The predominant route of HIV transmission is through heterosexual contact. Receipt of unscreened blood and blood products also accounts for HIV transmission. Perinatal transmission is also quite high because of heterosexual involvement. Intravenous drug use and homosexuality account for a small proportion.
HIV/AIDS detection in INDIA

The statistics on HIV infection published by the National AIDS Control Organization, New Delhi, reveal that there are 50984 HIV infected and 3263 (2491 males + 772 females) AIDS cases as on 28 Feb. 1997 (from 1986 to Feb.1997) in the various states and the Union territories in India. Of these 19403 (38.1%) were infected because of heterosexual promiscuity. While 188 (0.4%) were homosexuals, 4111 (8.1%) blood donors, 252 (0.5%) dialysis patients, 464 (0.9%) antenatal mothers, 863 (17%) recipient of blood; 9018 (17.6%) suspected AIDS, 2499 (4.9%) intravenous drug users, and 14186 (27.8%) others unspecified. Of the 3263 AIDS cases, Maharashtra tops the list (1578), then comes Tamil Nadu (571).

The first case of HIV in India was detected in Aug 1984 in a blood donor who had acquired infection by visiting a commercial sex worker. Following this in Feb 1986 first case of HIV among commercial sex worker (CSW) was identified in Madras (Lalit Kant, 1992). In May 1986 the first AIDS patient was detected in Bombay, who was reported to be a recipient of unscreened blood in the USA. In Dec 1986 the first seropositive man was detected at a sexually transmitted disease (STD) clinic in Tamilnudu. During 1987 the first spouse to spouse transmission was recorded. In Oct 1987 the first seropositive infant was detected. In Jan 1989 evidence of the presence of HIV antibody in an indigenously produced blood product was found. In Jan 1990 cluster of seropositive among intravenous drug users in North East India was detected. In Jan 1991 first HIV-2 case was reported in Bombay (Manoj K Jain, 1994).
In Indian culture family plays an important role in fulfilling continuity and stability. The institution of marriage consecrates a new family. In the Indian context a family fulfills three fold aims: namely, "dharma" (fulfilment of obligations that undergird life), "praja" (progeny) and "rati" (enjoyment). Indian culture does not subscribe either to the idea of autonomy of pleasure or to the abandonment of sexuality. In other words human sexuality is seen as an integral part of family life. However Indian Culture recommends sexual restraint for sexual fulfilment. People have been advocated to guard themselves from the power of passion from women. Moreover from the overall socio-cultural context in India, sexual drives are meant for replenishment of kinship group and perpetuation of a family.

In the Indian Culture, total obedience and loyalty are expected from children. The father is the head of the family. The authority of the husband supersedes that of the wife in most of the families. However wife is consulted in most matters of familial decisions. An Indian wife is called ‘pativirata’- she is obliged to follow her husband in all matters. However a traditional wife takes pride and finds fulfilment in it. In some cultures in India it is acceptable for men to have more than one sex partner; women mostly hide their husband’s extra marital sex for the sake of the ‘reputation’ of the family in the society. In some cultures the status of a woman is based on fertility. A woman gets more rights in her husband’s family because of attaining the dignity of motherhood. Therefore they are unable to impose conditions on their husband’s sexual practices. At the same time women who would like their
husbands to practise safe sex methods, are being looked down and might create mistrust between husband and wife.

Another custom in Indian culture is the tradition that most women go to their mother's house at the time of first confinement. Most of them take leave of their husbands in the 7th month of their pregnancy and return home say after the 3rd or 5th month after delivery. This means her spouse (the young man) has to go without sex for a substantial period of time.

**Need for the study**

In India as well as in other parts of the world, HIV/AIDS affects adults in the age group (20-40 years) and infants/young children (John T.J et al. 1993). A number of researches are in progress about the management of patients with HIV/AIDS with a view to providing comprehensive health care. But not much has been achieved in social research namely identifying the socio-cultural determinants that foster heterosexual promiscuous behaviour.

It is very important to recognize that the behaviour of a person is deeply ingrained in the personality of an individual and is a product of experiences of a person in the school age, during teens and as an adult (Ramasamy et al. 1988). The various influencing factors may be studied in terms of parental control, peer influence, value system, the social environment, moral and religious values. It is also essential to understand the influencing factors before and after marriage of a person which promotes risky sexual behaviour resulting in HIV infection. It may be very helpful to examine and reassess the cultural values in order to redefine or modify them to be acceptable for all of
us in the era of AIDS. Thus the socio cultural context decides an individual’s sexual behaviour and the sanctions against promiscuity (Ramasamy et al. 1988).

**Experiences during early life (school age <13 years)**

Basically the relationship between parents and children are vital factors which influence the behaviour of a young child. Most of the quarrelling and alcoholic parents are unable to discipline their children. Such experiences in a child in the early life may affect the personality of the child. For example a child who comes late from school regularly needs personal and continued supervision. If the child at this stage is not corrected then the probability of the child becoming indisciplined is quite high. The child may acquire negative characteristics.

In most of the families children are entrusted with certain chores. It is the responsibility of the parents and elders to ensure that the child completes the task given to him/her. If the parents do not have proper follow-up then the child might not realize the responsibility.

In most of the families if not in all, parents have meals along with children. However some families do not have this practice as parents are employed outside. It is an important factor that parents need to realize that fellowship at the time of food will certainly help the child to learn caring and sharing.

Family worship is yet another important activity in a family. Children need to be encouraged to join the parents and other members to have corporate
worship. ‘Fear of God is the beginning of wisdom’ (Bible). Every religion emphasizes the need to pray and worship God, the creator of all beings. If children are brought up in such faith then it might yield fruit at the right time in creating positive values in the individual and to be useful members of the society.

Hence a child which grows in such a positive climate of nurture and care develops a responsible personality as he grows into teenage and in the later stages of life.

Experiences during Teenage and Premarital Period

Further, habits, behaviours, beliefs and attitudes are developed during the teenager. The type of friends one chooses determines the personal habits such as smoking and drinking in most of the individuals. The influence of peers plays an important role in shaping the personality and character of a person. The experiences in schools and educational institutions have an indelible impact on the character and conduct of a person. The training obtained in religious and moral values plays a significant part in the total life of a person.

The traditional Indian culture does not give emphasis to sex education to male children during their adolescence period. What is observed commonly among teenage boys is the tendency for ‘sex gossiping’. They join as a group to go for sex movies. They begin to read sex literature clandestinely. Just as blind leading the blind, teenagers are misled. Sometimes they may go for sex for the
sake of fun. They may continue to go in order to give company to friends. Sometimes they may even be forced by their girl friends to have sex.

In schools, talk of sex is considered a ‘taboo’. No one talks of sex openly. It is also generally considered that students may be prompted to go for sex if teachers talk about sex. At the same time many teachers feel that it is an overloaded topic. Some students are shy to talk about it while some others find it difficult to listen.

‘Movies’ play yet another important place in the life of a person, particularly sex movies. Young people often go in groups and try to imitate what they have observed in movies. Some teenagers, having been sexually aroused, may go for sex with prostitutes without knowing the implications. They may also develop the habit of consuming alcohol.

Picnics/outing is yet another social activity which may also affect teenagers, if they go unguided. Alcohol forms a part of picnic enjoyment. In some cases sex becomes a part of the picnic.

With the advancement of Science and Technology, electronic media causes considerable impact on the life style of youth. They go for "XXX" rated or "Blue"movies (pornographic) and sometimes screen them in their own houses when parents are away.

During the premarital period some young people may be away from home on business, profession and studies. If the location of their place of stay is in proximity to commercial sex centers it might influence their sexual urge.
As the individual begins to earn and manage his funds in the absence of monitoring by parents, young people tend to spend the money as they like. Such an attitude clubbed with peer influence may result in smoking, drinking and sex.

Many young people do not have the knowledge of safe sex practices. Granting that some may have, there is no guarantee that they may practise this knowledge. It is also possible that use of condoms by males is teased by women. If some woman partner insists on men using condoms, the male partner disagrees and finally women have to yield to the whims and fancies of the males (Peter Lampley 1991).

**Experiences during Marital Period**

Marriage is supposed to help the young person to become more responsible towards himself and to his wife and family. He begins to build a family of his own not necessarily in terms of nuclear family but in terms of establishing new relationships based on mutual love and trust. In an Indian family man is normally considered as the bread winner and wife the care-giver. In modern context a new equilibrium is seen between bread winner and care giver when both husband and wife are employed.

As the husband and wife begin a new family life, it is but natural for the wife to expect her spouse to return from work promptly and be available to help in family matters. He is expected to join the wife and children to have food as a family and also to participate in the family worship. He is also expected to spend more time with children. However, men who have been used
to practices such as drinking neglect the family. Some men may go for extra marital sex. One can observe quarrels in such families, unhappiness, and misunderstanding.

In the area of sex, some men are not aware of the sexual needs of the partner. They are not faithful to their wives. On occasions of overnight stay on business etc they have extra marital sex. When the wife is away from home either due to sickness or has gone for confinement they are unable to control their sexual urge. Some women who are not sexually satisfied offer sex to other men.

The knowledge of HIV/AIDS

In general, both the educated and the uneducated have not fully understood what is HIV and AIDS. Many people consider HIV as AIDS. The depth of the knowledge about HIV/AIDS is absent. Many of them mistake STD for HIV/AIDS. As there is no external symptoms for the presence of HIV, it is not possible for men and women to know if they are infected or not. Some men as well as women do not know that they will transmit this virus to their sex partners (spouses). Some hold the notion that if they spend good amount of money for sex, in a big hotel/Lodge, then they are free from infection and that they are healthy. Some people are not serious about infection as they are not aware of the consequences.

Even today people think that condoms are used only to prevent pregnancy. People still have aversion to use condoms. Either they are ashamed to buy or it is uncomfortable to use. There is also a notion that non-use of
condoms avoids mutual doubts about the partner’s health. Use of condoms may involve unsatisfactory sex and hence some people dislike it.

Sexual Practices and the spread of HIV

In the study of HIV spread among heterosexuals, it is very essential to know the frequency of intercourse and the number of sex partners they visit. The type of sex practised either vaginal sex, oral sex or anal sex is important in the study. The other important factor is the knowledge of the sex partner whether she is a commercial sex worker (CSW) known to the male partner or friends, in order to understand the risk involved. This will also help us to understand the spread of the epidemic.

The ‘place of sex’ is also important in this study. While sex with a prostitute is considered as ‘a masturbatory gratification’ it is of great value to note how sex is very poorly understood and practised in an undignified manner in Indian society. The possible places for sex are CSW centers, hotels, lodges, hostels and partners’ houses. It is also practised under the bushes, fields and in roadside corners. They merely have a penetrative act for a very brief period of time. Sex which has been considered as an act of mutual experience of emotional well-being between man and a woman has gone to such a low state in Indian society.

Sexuality and Spirituality

Sexuality is at the heart of the family. The character of a family depends on its sexual culture. Sexual health is vital to the family health. At the same time the principal route of HIV transmission is also sexual. In the Indian
culture, sex is considered as 'sacred' and 'holy'. In Bible we read 'So God created man in His own image; in the image of God he created him; male and female he created them' (Bible Gen 1:27).

The Jewish religion understood the sacredness of sex as cooperation with God in creating human beings. Every Hebrew child carried a mark on the body to mark his identity as a member of God's chosen race and he carried it on his sex organ. Therefore it was considered that procreation was one of the most sacred activities (T. Jacob John 1995).

In the Hindu religion, the basic concepts of creation, preservation and destruction are represented by Brahma, Vishnu and Shiva. They are always coupled with Saraswaty, Lakshmi and Parvathy respectively. In Shiva the linga represents the phallus and the platform called 'yoni' represents the vagina (T.Jacob John, 1995).

In most of the temples in India there exist beautiful carvings in stone and wood - both males and females in nudity. In Indian culture sex was cultivated as a fine art and as a science; and it was in India the famous sex literature, Kamasutra, was written.

Interestingly the practice of marrying girls to gods resulted in the famous institution of the Devadasi system in India. These girls later became temple prostitutes who cohabited with priests and visitors. Devadasis were supposed to be incarnations of Urvashi, the celestial dancer. These Devadasis were decent girls, who were compelled by poverty or other considerations, have taken to this profession (Nagendra Kumar Singh, 1997).
Thus, the Indian culture, its social customs and its mores, aim at taming and domesticating human sexuality. A young husband’s personal conjugal interest in no way interferes with his duties to parents. The emphasis on the procreative aspect exerts a controlling influence on human sexuality. Marriage is a fellowship between a man and a woman who seek to live creatively for the pursuit of Dharma (righteousness), Artha (material advancement), Kama (sexual fulfilment) and Moksha (liberation) (Valson Thambu, 1995).

Marriage has heterosexual intent; he says marriage is more than a union; it is a kind of reunion (Stott John). It is not a union of aliens but union of two persons who were originally one, then separated from each other, and now in the sexual encounters of marriage have come together again.

The Divine sexuality involves dynamic mutuality (Valson Thampu 1995). This involves both God and man. Wherever healthy relationship exists, mutuality is operative. It is because of the imbalance in mutuality and lack of understanding of the sacredness of sex, that people have premarital and extramarital sex. This promiscuous behaviour has been recognised as one of the major causes for transmission of HIV.

Hence, responsibility for not properly training an individual for orderly heterosexual life lies on the whole society, right from parents, kith and kin, teachers, friends, coworkers and the society at large. It is in this context a need for social research has significance. The study on socio-cultural factors that influence promiscuity in heterosexual males infected with HIV is a significant one for diagnosing and curing negative sexual behaviour.
Significance of the study

Heterosexual promiscuity is due to the influence of a number of socio-cultural factors. These factors have been very rarely investigated and reported. This study focuses on identification of these factors. It is hoped that the data and the findings of the study would enlarge scientific knowledge and bring new light on the unexplored field of social aspects of human behaviour linked with promiscuity.

The findings will be translated into intervention strategies which will help to initiate attempts which might be focused to bring in changes in the behaviour of an individual.

In the absence of any allopathic curative drugs only social intervention strategies might help to prevent the spreading of AIDS. Though it is very difficult for adults to impose certain changes in the behaviour yet attempts can always be made to initiate such changes. This study tries to find out the various stages at which attempts need to be made to effect positive changes in sexual attitude. In the present context education on health and sex is the primary means to control and prevent HIV epidemic. Hence this study would indicate specific social intervention and other strategies based on the findings.
The thesis has VI chapters.

Chapter I deals with the background of the study, need for the study.

Chapter II deals with the review of literature. It is summarised under the headings of Socio-Demographic characteristics, Socio-Cultural Characteristics, Sexual practices and risk factors, knowledge of HIV and high risk behaviour.

Chapter III deals with Research Methodology. Objectives of the study, study design, population and setting, sample selection, pilot study, data collection and limitations.

Chapter IV deals with Data Analysis which is collected from the sexual experiences of person in early life (school age), teenage, premarital and marital periods and its influence on promiscuous behaviour.

Chapter V provides Discussion of Results of the various socio-cultural factors influencing heterosexual promiscuity.

Chapter VI offers Summary & Conclusions. The whole study is summarised and important conclusions are arrived at and possible suggestions are made for intervention strategies.