CHAPTER I

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1.1 Incidence of Sexually Transmitted Diseases

Sexually transmitted diseases (STDs) are found to be one of the most common causes of illness throughout the world and have been ranked among the top five diseases in developing countries for which adults seek health care services (WHO, 2007; Dyck et al, 1999; Buve et al, 1993). Sexually transmitted diseases are major public health problems, not only because of their severe complications and sequel but also because they increase the risk for transmission of the human immunodeficiency virus (HIV) and AIDS, which are the major concerns to health care providers, all over the world. The annual incidence of sexually transmitted infections (STIs) was estimated around five percent of the adult population, with three to four percent of rural population being suspected to be infected with STD at any particular time. On an average, about 40 million new STI cases were occurring annually in India (Khanna, 2003; NACO, 1998, 2000, Ramasubban, 1999). This was possibly a conservative estimate of the actual number of cases as it was based on surveillance data from public sector STD clinics, which were mainly located in urban areas and utilized by only 5-10 percent of patients with STIs (NACO, 1998). As such, sexually transmitted diseases form an enormous public health burden and responsible for a large number of undocumented complications. Keeping these factors in mind governments of many developed and developing countries are trying to control STDs. Therefore, managing STDs and altering the behaviour that leads to it are the essential elements of any HIV/AIDS prevention and control programme (Olasode, 2007).

Sexually transmitted diseases are epidemics of tremendous health consequences spread all over the world. There are four serious health consequences of sexually transmitted diseases. These are a) blockage of the fallopian tubes which can lead to infertility and ectopic pregnancy, b) pregnancy loss and increased newborn deaths caused by transmission of the infection to the infant during pregnancy and
childbirth, c) genital cancers for males and females, and d) enhanced transmission of HIV/AIDS. Besides, the psychological impact of having a sexually transmitted disease can be severe. Some persons become depressed or anxious. They fear recurrent outbreaks, transmission to sex partners, and encounter difficulties in developing new relationships.

Globally, more than 340 million new cases are being reported every year related to STD. Of these, over 80 percent are believed to occur in the developing countries (Khanna, 2002). According to the national estimates for 1996, more than 15 million new STD cases occur each year in United States (Cates W et al., 1999). However, the annual STD incidence among young Americans is not known, even though 15-24 year olds represent 25 percent of the sexually experienced population aged 15-44 (Sonenstein FL et al., 1998; Abma et al, 1997).

Sexually transmitted disease is a major health problem among youth in much of Asia, according to the studies commissioned by UNESCO. For example, in Bangladesh two third of all reported STDs occur among people under 25 years of age and incidence is much higher among women aged 15-19 than among men of the same age (Uddin, 1999). Half of the HIV/AIDS infected persons in Viet Nam were adolescents and youth (Nga, 2000). In China, 8.7 percent of the HIV carriers and AIDS patients belong to the age group 16-19 (Sun, 2000).

In the era of HIV/AIDS, despite of having awareness about HIV/AIDS, the number of sexual partners has been increasing over a period of time among youth, which is considered as risk taking behaviour (Reddy, 1993). Currently, India is the country with largest HIV epidemic in the region (Reid et al, 2002; MAP, 2001; UNAIDS and WHO, 2001; UNAIDS 2001). In the beginning of the millennium, an estimated 3.7 million adults and children were living with HIV in India. At the end of 1999, an estimated 1.3 million Indian women were living with HIV (UNESCO, 2001). HIV prevalence estimates were derived primarily from sentinel surveillance among pregnant women attending government antenatal clinics and patients attending STD clinics. National Family Health Survey-3 (NFHS-3), conducted during 2005-06 is the first national survey in India to include HIV testing. Results from NFHS-3
indicate that 0.28 percent of adults age 15-49 are infected with HIV. This estimates into 1.707 million HIV positive persons age 15-49 in India in 2006 (IIPS, 2007).

Though South and Southeast Asia are very different from each other with regard to many aspects of sexual and reproductive health of youth, there are also important issues which are common in nature. Most young people throughout the region have little and accurate information about their bodies and their sexual and reproductive health (Bott et al., 2003). South Asian society, which is mainly patriarchal in nature and where gender defines the social roles and power relationship in the family, is characterized by stronger social control on female sexuality than on males (Khan et al., 2002).

1.2 Review of Literature

This section presents the review of available literatures related to sexually transmitted diseases and the sexual behaviour of the youth with reference to knowledge and attitude towards sexual aspects. For a smooth interpretation purpose the studies have been broadly grouped into two major sections i.e. studies on general population and studies on tribal population. Further the studies have been presented in nine sub heads. These are as follows.

1. Sexuality and sexual behaviour in Indian context
2. Knowledge on sex and sexuality among youth
3. Attitude towards sex and related aspects
4. Sexual behaviour and sexually transmitted diseases
5. Determinants of knowledge, attitudes and behaviour related to sex
   a) Familial factors
   b) Individual factors
6. Tribes and health and behavioural aspects related to sex
7. Youth dormitory system and customs related to marriage and sex among tribes
8. Contact with outsiders and Consequent Health Hazards among Tribal/Indigenous people
9. Sexually transmitted diseases and youth
1.2.1 Sexuality and Sexual Behaviour in Indian Context

Many researchers had done work on human sexuality in the present day context. Sexuality is simply defined and understood as the mode of expression of sexual desire (Verma and Lhungdim, 2004; Sprecher and McKinney, 1993; Hawkes G, 1996), which is reflected through sexual behaviour of the individual.

Ancient Hindu literature is rich in sexual symbolism and eroticism. Vatsyayana’s Kamasutra (a practical discourse on aspects of sexuality), erotic sculptures carved on the stone walls of the holy shrines of Khajuraho, Konark and many other Hindu temples of the medieval era, beautifully depict the various techniques of sexual acts, probably practiced during those times. Certain indications towards polygynous and polyandrous relationships from the famous Indian mythological scriptures indicate a state of extraordinary openness in the sexual matters in certain period of Indian history, contrary to the period of Muslim and British reigns and contemporary India (Tripathi et al, 2003; Nag 1995).

By and large, Indian society is still rooted in traditions and people’s attitude towards sex is influenced by values, which are peculiar to the traditional belief systems. Marriage is a norm in India. Since the last few decades, the age at marriage for both sexes has been rising by about a year per decade. As a result, a substantial proportion of boys and girls in contemporary India have to pass through a long period of heightened sexual desire (Nag, 1996).

Although unmarried men have more opportunity for sexual adventures (often with married women/female sex workers) than unmarried women, there is no mainstream society in India that actually encourages men to have pre-marital sex (Chandiramani et al, 2001). As in case of pre-marital sex, sanctions against extra-marital affairs and sex are severer against women. The Hindu concept of ‘pativrata’- the ideal for a woman to remain loyal to her husband under all circumstances, has no counterpart.
for men (Nag, 1996). Thus unmarried women for the fear of being called promiscuous find themselves unable to seek reproductive health services. However, women are now getting greater attention towards the emancipation of their sexuality. Sexual activity among unmarried adolescent women has been steadily increasing and so is the vulnerability towards STD including HIV (Tripathi et al, 2003).

Gender relations in marriage are dynamic and continually negotiated. Women tend to use access to sex as a resource, a bargaining chip to reward/punish their husbands (George, 1998). Sexual coercion occurs frequently in marriage (Khanna et al, 2000; Martin et al, 1999). However, women and men tend to differ in their perception of the nature of sexual coercion. The women consider sex to be coerced if the sexual relations with their husbands are against their wish. The men in contrast feel that they have a right to demand sex in marriage and have right to access to their wives’ body (George, 1998).

Social and attitudinal changes and socio-economic developments during the post-independence period have lead to emergence of industrialist society and development of western oriented life styles. Western influence is evident in daily living, particularly in the urban areas amongst youth. Pubs, late night parties and discotheques are often frequented by young in metropolitan cities, exposing this vulnerable population to risky behaviours. Recent years have seen developments in electronic media and sex entertainment is available through video, X-rated films and internet.

Indian society presents a contrasting picture of notions about sexuality, attitudes and sexual behaviour. The society can neither be regarded as rigid, nor permissive with regard to the area of sexuality, making generalisation difficult. The behaviour pattern varies across regions and states, gender, sub-population, tribal and religious groups (Tripathi et al, 2003).
1.2.2 Knowledge on Sex and Sexuality among Youth

Studies on sexuality knowledge among youth have basically explored the youth’s knowledge in the area of puberty, menstruation, and reproduction. A number of earlier Indian studies assessing young people's knowledge basically in the areas of puberty, menstruation and reproduction view that the knowledge level is not adequate (IIPS and PC, 2007; Ram et al., 2006; Patnaik, 2003; Todankar, 2001; Ahuja and Tiwari, 1995; Sharma and Sharma, 1995; Verma et al., 1995; Bhende, 1994; Murthy, 1993; Watsa, 1990; Awasti et al., 1980; Gupta et al., 1979 and Rasheed et al., 1978).

The study conducted by Awasti et al., (1980) revealed that gender, age, discipline of study and socio-economic status have a significant effect on sex knowledge. However, overall knowledge level was found to be very poor. Recent literature also shows that the same trend persists regarding knowledge. A study among the newly married men and women in Gujarat finds half of the women being ignorant about the sexual life after marriage (Khan et al., 2004).

There are few other studies conducted among school and college going adolescents about their knowledge of sexuality, contraception, sexually transmitted disease and HIV/AIDS. A qualitative study of adolescents in the slums of Mumbai reported that more than two third (67 percent) of girls and less than half of the boys knew nothing about married life and its sexual aspects (Bhende, 1993). Knowledge about reproduction was also reportedly poor among adolescents. Only 16 percent of girls and 54 percent of boys answered correctly regarding how a girl becomes pregnant. Nevertheless, the author suspected, on the basis of observation of body language and non-verbal responses that awareness levels among adolescents were higher than reported.

Some other studies conducted in different socio-cultural contexts have also confirmed the conservatism in the attitude towards sex (Patnaik, 2003; Bhende, 1994 and Goparaju, 1993). Moreover, societies that dictate different attitudes towards males and females with respect to youth sexuality and where talking about
sex with young people continues to be a stigma, may further contribute to the permissive behaviour (Hardee et al., 2004 and Miller and Whitaker, 2001).

In an evaluation study of the AIDS prevention programme in Maharashtra, a series of focus group discussions with boys and girls of age group 14-16 years revealed a low level of knowledge on sexuality. It was evident during the Focus Group Discussion (FGD) that students, particularly those from the 11 standard, were curious about sex and a majority of the students felt that they need to know more about their sexual health and problems related to physiological changes. Girls from 9th standard articulated the need for sex education even at younger ages. According to them, ‘several girls start maturing when they are in 7th standard, therefore they need to know about these changes and the ways of managing them at that age (Verma et al, 1995).

Beside the factors mentioned above, it was also found that the knowledge on sexuality and sexually transmitted diseases is relatively poor among the NGO personnel working in the field of health and STD. In a study on impact of training on knowledge regarding modes of transmission and prevention of sexually transmitted infections including HIV/AIDS of functionaries of non-governmental organisations it was found that the knowledge was poor regarding the complications of STDs like repeated abortion and sterility and importance of partner treatment in STDs. About one fifth (17 percent) continued to believe that having sex with virgin female could cure sexually transmitted infections (Paul and Gopalakrishnan, 2003).

1.2.3 Attitude towards Sex and Related Aspects

Sexual attitudes have been studied primarily in areas related to pre-marital sex and nature and extent of friendship with opposite sex. In fact, studies on sexual attitudes are not of recent origin. One of the studies conducted in 1966 by Fonseca, among 1354 students and 148 non-students in Mumbai, showed that around two third of the students and non-students disapproved the pre-marital sexual relationship. Disapproval was voiced more by women than men. Up to the last decade, the sexual attitude did not change substantially as it was evident from the number of studies. But during the last decade the attitude towards sex is found changing. While
working on reproductive health among men in Nepal, Hollerbach and Rogers (2005) have opined that due to the changing values, group norms and increasing independence, young people are more vulnerable to STIs than the general population. The tendencies to break with a traditional way of life and changes in behaviour are particularly marked among young people and are encouraged by trends in contemporary thought. Earlier physical maturity also makes young people aspire to sexual satisfaction sooner in life (WHO, 1977). The Demographic and Health Survey (2006) also shows that early sexual activity exposes young women and men to diseases such as syphilis and gonorrhoea, which in turn make them more vulnerable to HIV.

1.2.4 Sexual Behaviour and Sexually Transmitted Diseases

Anthropological literature on the tribal societies of India refers to the wide prevalence of pre-marital sex in many of them (Elwin, 1939, 1947), but the practice of pre-marital sex among the mainstream population is rare. In contrast to this, few studies also indicate that the practice is not that uncommon in both educated and uneducated and in both rural and urban population (Nag, 1996). Furthermore, studies also indicate that transmission of HIV is no longer confined to high-risk urban population, but is spreading across rural settings as well (Maniar, 2000). Another study conducted by NACO in 2002 states that STD and HIV infection are no longer restricted to the high risk groups, but have spilled over to affect the general population as well.

Though pre-marital and extra-marital sex is considered as a taboo, teenagers and young adults have always experimented with it. The last two decades have perhaps seen an increasing trend towards greater experimentation by more individuals at a younger age with more partners in India (Nag, 1996; Jain, 1994; Jejeebhoy, 1994; Watsa, 1994; Ramasubban, 1992; Sehgal, 1992).

United Nations (2005) reveals that pre-marital sex appears to be increasing among youth and HIV/AIDS is the first cause of mortality of youth in the world. Lear (1997) has found approximately 60 percent of the youth in Canada, USA and Australia have already experienced sexual intercourse, usually without condoms or
knowledge of each other's HIV status by the time they turn 17 years. Another study in Sri Lanka by Silva and Schensul (2003) has shown that low income and less educated young people are somewhat more likely than University students to approve pre-marital sexual activity. Further, it has been found that the youth, who have dropped out of school in the United States, are more likely to initiate sex at an earlier age (Brewster et al., 1998).

Although there is scarcity of large-scale studies showing the picture at the national level, many small-scale studies on young people have agreed upon the prevalence of pre-marital sex (Longkumer, 2003; Todankar, 2001; Abraham and Kumar 1999; Jejeebhoy, 1998; Nag, 1996; Kaur et al., 1996; Sharma and Sharma, 1995; Bhende, 1994; Jain, 1994; Watsa, 1993; Goparaju, 1993; Rakesh, 1992). Collumbien et al. (2001) have found that 22 percent of single men in Orissa have reported at least one sexual partner and 17 percent of the students included in their study have experienced pre-marital sexual intercourse.

Like pre-marital sex, the review of literatures on extra-marital relationships in different parts of the world indicates that such relationship is not alien among young people (Smith, 2007 and Kongnyuy and Wiysonge, 2007). The extra-marital relations are there in Indian society and have been found in some of the past studies exploring sexual behaviour of the people. Mishra (2002) in his study among the migrant males in Delhi has revealed that 29 percent and 59 percent of those migrants respectively staying with and without family, have been found involved in extra-marital relations. Again, Swain (2002) is of the view that one-fifth of the migrant males in Bhubaneswar (Orissa) slums have extra-marital relation. Exploring the extra-marital sex among young people, a recent study reveals that four percent, three percent and two percent of the married men aged 15-29 years respectively in the states of Tamil Nadu, Maharashtra and Jharkhand have experienced extra-marital sex (IIPS and PC, 2007).

A study conducted in the early 1980s among male and female students aged 14-28 years of few colleges in Madras city regarding sexual behaviour and attitude is quite revealing (Reddy et al, 1983). Out of the total responses about three fifth of the male and half of the female students stated that they had their first sexual experience
before they attained 25 years. Since 96 percent of the male students and 93 percent of the female students were unmarried, it could be presumed that the majority of male and a substantial number of female students had already experienced pre-marital sex. Another study conducted among boys by Sehgal et al. (1992), in Delhi, showed that 25 percent of respondents had admitted having sexual intercourse.

Findings from the responses of middle and upper class men and women to the questionnaires published in ‘Debonair’ and ‘Savvy’ indicate a very permissive attitude and behaviour regarding pre-marital sex among them, almost similar to that among their counterparts in western countries (Savara and Sridhar, 1992, 1993). But a methodologically more rigorous study among these classes in Calcutta (now Kolkata), Delhi and Madras (now Chennai) found a significantly less permissive attitude and behaviour (Basu, 1994).

The 1993 study of Savara and Sridhar shows that 17 percent of the male respondents aged 21-45 years and eight percent of female respondents have reported experience of pre-marital sex. The findings suggested that sexual initiation among male frequently had occurred during their adolescence phase. Of the 1158 who reported sexual activity, the average age at sexual initiation was around 21 years, but about 41 percent reported that they had their first sexual experience during their adolescent years. Among those reporting pre-marital sexual activity, 28 percent reported sex with a friend and 13 percent with a relative. However, commenting on the findings of this study Nag (1995) had opined that these figures were also considerable higher than those commonly perceived.

Studies among the urban lower class people show a wide variation in pre-marital sexual experience. The percentages reporting such experience among 264 blue-collar workers, 258 migrant workers and 139 loom workers in four towns of Maharashtra are 25.4, 32.2 and 12.2 respectively (Savara and Sridhar, 1994). The prevalence of pre-marital relations among sexually transmitted disease (STD) patients is high. In a study of 300 men in Lucknow have been diagnosed to have STDs, 81 percent have reported having pre-marital sexual experience, most of them with prostitutes (Narayan, 1984). Unlike urban areas, no quantitative estimates of practice of pre-marital sex is available for any rural community of India, but casual
reports indicate that it is not uncommon, particularly for unmarried men (Nag, 1995).

Reddy’s studies (1980 and 1993) in Madras conducted through mailed questionnaire among youth indicated that at least half of the male respondents had their first pre-marital sexual experience between the age 15-24 years.

A study conducted by Jain (1994) among students at an elite secondary school in New Delhi reported about 60 percent of the male students were involved in sexual activities with commercial sex workers or older women in their neighbourhoods. Girls were also observed to be sexually active. Although a larger number of boys compared to girls were aware of the use of condoms as safe sex, very few of them actually used them.

Sexual involvement of young people with older women in the neighbourhood has also been found in some other studies (Collumbien et al., 2003; AIMS, 1998 and Goparaju, 1994). Another recent study in Maharashtra finds that 18 percent of the married men aged 15-29 years and three percent of the married women aged 15-24 years have experienced pre-marital sex while the figure for the same is 15 percent and three percent respectively among the unmarried men and women (IIPS and PC, 2007). The same study has further revealed urban-rural disparity in the prevalence of pre-marital sex.

Adolescents are more vulnerable than adults to unplanned pregnancies, sexually transmitted diseases and HIV/AIDS. It has been observed that when adolescents become sexually active, they tend to have multiple partners and use condoms and other contraceptives inconsistently (Ashford 2001). A study conducted on STDs in Delhi showed that out of 302 respondents only 8 respondents reported using condom consistently and another 43 percent used condoms irregularly. However, majority of them used it for prevention of pregnancy and not for protection from STDs (Gupta et al, 2005).

In another all India study covering a total of 4709 educated youth, both males and females, it was found that 28 percent of all unmarried males and six percent of all
unmarried females admitted to having sexual contact, which included penetrative sex as well as other activities such as hugging, caressing and so on (Watsa, 1993). Of all those males who reported pre-marital sexual intercourse, two third (66 percent) reported sexual activity with a female friend, neighbour or finance. Another ten percent had sexual activity with a male friend and 19 percent with a sex worker. Of the few females reporting pre-marital sexual contacts, over three quarter (78 percent) reported a male friend, acquaintance or relative as their partner.

On the basis of focus group discussions with 91 students in Hydrabad, Goparaju (1993) found that 80 students reported sexual activity. The earliest age at initiation to sexual activity was reported to be 15 years. About one fifth of the sexual contacts occurred with females aged 15 years or lower, while another one fifth occurred with considerably older women and remaining among adolescents of their own age. The majority of the partners were neighbours (45 percent), followed by friends (30 percent), relatives (15 percent) and fiancées (10 percent). Almost half of the first contacts were reported to be with a married woman (45 percent). As far as sexual histories are concerned, two in three respondents reported multiple partners and the average number of partners was as high as four. About one quarter of all respondents admitted to having sex with a commercial sex worker. A review of over 45 studies of cross-generational and transactional sexual relations in sub-Saharan Africa reports that engaging in sexual relations with older partners is the norm among adolescent girls in some settings (Luke, 2003; Luke et al, 2002).

Further, the partner’s alcohol use and subsequent involvement in sex outside marital union put the women at the risk of STD/HIV (Lindan et al., 2004). Some other studies attempting to explore the sexual behaviour of young people within marital union, report the practice of multiple sex partnerships in urban and rural areas, of married women with unmarried adolescents (Verma et al., 2003; Abraham, 1999 and Savara and Sridhar, 1994). Although human risk-taking behaviour plays a role in determining the prevalence and incidence of most diseases, peoples’ risky choices more directly and immediately affect the incidence of sexually transmitted infections (STIs) than for most other diseases (Over and Aral, 2006).
The thing that needs to be clarified here is that the studies conducted on sexual behaviour in India, have either concentrated on specific groups of people or have been done mostly without rigorous sampling design. This is an important reason for inconsistencies in the findings on pre-marital and extra-marital sex. Again, it is almost accepted that adolescent males are much more likely to report that they have engaged in sexual intercourse as compared to adolescent females (Dixon-Muller, 2007 and Herold et al., 1992). Further, the social desirability leads to bias response i.e. the self-reports might be biased because people's tendencies to appear in a positive light in the society cannot be totally ignored (Wiederman, 2002).

1.2.5 Determinants of Knowledge, Attitudes and Behaviour related to Sex

Many research works have identified a number of factors which may influence knowledge about sex, sex attitudes and sexual behaviour particularly the heterosexual activity of youth. The influence of various factors on sexuality and sexual behaviour among youth can be divided into two major groups, namely, familial level factors and individual level factors. In addition, environmental factors have also been considered important in their influence over sexual behaviour.

a) Familial Factors

Families are the first context in which young people are socialised into gender roles including sexuality, masculinity and ethnicity (Harter, 1999) and research clearly supports the impact of the family on young people’s sexual behaviour (Rose et al., 2005; Sieverding et al., 2005; DiLorio et al., 2004; Borawski et al., 2003; Ellis et al., 2003; Pradhan, 2003; Davis and Friel, 2001; Miller et al., 2001; Upchurch et al., 1999; Gage, 1998 and Miller, 1998). In addition to this, greater parental warmth and acceptance (Markham et al., 2003), more frequent parent-adolescent discussion about sex and sexual risk-taking (Hutchinson et al., 2003 and Miller et al., 2000), parental control (Small and Luster, 1994; Miller et al., 1986; Hogan and Kitagawa, 1985 and Jessor and Jessor, 1975) and parental education (Cubbin et al., 2005) predicts young people's decision to delay sexual initiation, greater use of contraceptives and fewer sexual partners. Some other studies are of the opinion that young people who are staying alone or with a single parent are more likely to
indulge in sexual intercourse (Pradhan, 2003; Miller et al., 2001 and Lema, 1990). Mother's employment outside home has also been found as an important factor affecting youth sexual behaviour (Urdy and Billy, 1987).

Additionally, an Indian study is of the view that gender differences are most significant in the differential opportunities that boys and girls have in terms of access to information and in the exploration of their sexuality (Abraham, 2004). The same study reveals that gender socialisation in the context of a patriarchal sexual culture manifest in the development of male sexuality as aggressive and in the cultivation of sexual passivity in females, which in turn reflects in their attitude and behaviour.

b) Individual Factors

In addition to the familial factors, a host of individual characteristics has been assumed and established as important determinants of youth sexual behaviour. Age, gender, migration status, occupation, self religiosity, alcohol consumption, drug abuse and social net working and sexual permissiveness have been studied extensively for their effect on the sexual attitude and risk behaviour pattern among youth.

Young age of the individual has been found as one of the most important factors affecting sexual behaviour of the youth (Dixon-Mueller, 2007; Abraham, 1999; Radford et al., 1989; King et al., 1988 and Faulkenberry et al., 1987). Sarkar (1998), after a thorough review of studies conducted during 1975 to 1997 on young people in India, is of the opinion that the level of education is the most important factor influencing an individual's sexual and contraceptive behaviour. Dixon-Mueller (2007) also has the same opinion. Mishra (2002) reveals type of occupation of the young migrants as an important determinant of involvement in pre-marital and extra-marital sex. Migration removes people from the cultural restrictions of sexuality and puts into a set-up where there is a possibility of enhancing sexual fulfilment, putting people at both ends of migration at risk (Puri and Busza, 2004 and Wolfers et al., 2002).
Mahendra et al., (2006) in their study among truckers in India, have found that long absence from their family leads them to engage in MSM (Male having Sex with Male) activities. Personal income (Abraham, 1999) and lifestyle of the young people (Stueve and O'Donnell, 2005; Singh et al., 2004; Rashad and Kaestner, 2004 and Graves and Leigh, 1995) have also emerged as significant factors associated with greater likelihood of sexual encounters outside wedlock. Researchers all over the world, in the past have tried to see the association of peer pressure/influence with young people’s sexual behaviour and mostly have found it positively influencing the sexual involvement outside marriage (Babalola, 2004; Pradhan, 2003; Whitaker and Miller, 2000; Bearman and Bruckner, 1999; Rangaiyan, 1996; Walter and Vaughn, 1993 and Walter et al., 1992).

Individual attributes like depression and low self-esteem (Longmore et al., 2004) and stress and trauma (Kaufman et al., 2004) have been proved to have some influence on youth sexual behaviour.

The role of mass media is undoubtedly a factor that affects the attitude towards sex and subsequent sexual behaviour of the individual. Studies have found that young people with unsupervised access to television are more likely to engage in sexual activities (Gruber et al., 2005) and young people who view television with more sexual content are more likely to initiate intercourse in early age (Collins et al., 2004). Some other studies have also revealed the high exposure of sex in mass media and pornographic literatures, as predisposing factors to pre-marital sex (Rangaiyan, 1996; Rakesh, 1992 and Hein, 1980). On the other hand, the individual level factors that have been identified as preventing factors to sexual behaviour of young people outside the marital union, include, being involved in sports or youth groups, having strong religious belief (Whitehead et al., 2001 and Kiragu and Zabin, 1993), self-efficacy for abstinence (DiLorio et al., 2004), and sexual attitude as well as knowledge (O'Donnell et al., 2003 and Rosengard et al., 2001).

Besides the above discussed socio-demographic factors, the individual's own knowledge about sexual matters considerably contributes to his/her behaviour (Tiwari and Kumar, 2004). Anderson (1990) and Ku et al (1992) found that teenagers are less likely to have multiple partners if they are more knowledgeable.
about AIDS. Whereas, a study conducted by Winslow et al (1992) among undergraduate college students with an average age of 20 found that knowledge regarding AIDS was unrelated to either resistance to behaviour change or type of sexual partners. By supporting this, Miller and Moore (1993) presented evidence of peer influence on individual sexual behaviour and observed that high peer involvement not only worked against parental efforts, but many times overrode them.

In addition to this, studies have also found various environmental variables like place of residence and location of college influence sexual behaviour of the youth (Cleveland and Gilson, 2004; Ku et al., 1993; Kiragu and Zabin, 1993 and Rakesh, 1992). Cultural and traditional setting in which individual is born and brought up is also known to influence his or her sexual and contraceptive behaviour (Zafar et al., 1995).

1.2.6 Tribes and Health and Behavioural aspects related to Sex

Despite remarkable worldwide progress in the field of diagnostics, curative and preventive aspects of health, still there are people living in relative isolation, in natural surroundings, maintaining a socio-cultural distance from others. Owing to their unique traditional life ways, the concept of health and well being of tribal people also differs from the rest of the population in many ways. The World Health Organisation defines health as, “a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity” (WHO, 1971).

However, the concept of health, disease, treatment, life and death among the tribes is as varied as their cultures. Tribal society is guided by traditionally laid down customs to which every member is expected to conform (Kumar K.A. 2007; Basu, 1994). One of the recent articles on health status of tribes reveals that the common beliefs, customs, practices and taboos of the tribal communities are connected with their health and disease and also related to the treatment of diseases that affect the morbidity and mortality (Rath, 2004). Further tribals consider themselves healthy, so long as they have not lost appetite and are able to work. Minor ailments are ignored and are considered as normal (Raina, 1990).
One of the recent article shows, tribal world of belief and practices has been constructed and surrounded by their parochial perception and action of natural and supernatural entity. They find themselves closely knit with the web of these two entities in every sphere of life (Sonowal and Praharaj, 2007).

**PRIMITIVE TRIBAL GROUPS IN INDIA**

India is a homeland of a large number of tribal population. According to the general census of India 2001, the tribals constitute eight percent (84 million) of the total population. Komaraiah (2001) had opined that the tribals are the most backward ethnic group in India in relation to the main indicators of development, health, nutrition, literacy and income. Because of their extreme backwardness, the tribals become a national concern.

Among the schedule tribes, there are certain communities, which live more or less in isolation having a life style very much different from non-tribal as well as many other tribal populations. They are known as primitive tribal groups (PTGs). Anthropologist Franz Boas (1938) defined the primitive people as, those people whose activities are little diversified, whose forms of life are simple and uniform and the contents and forms of whose culture are meagre and intellectually inconsistent. Their inventions, social order, intellectual and emotional life should all be poorly developed.

The criteria generally followed in identification of primitive tribal groups are (a) pre-agricultural level of technology, following a hunting gathering way of life, (b) extremely low level of literacy, and (c) small, stagnant or diminishing population (Misra P.K., 2005; Behura and Panigrahi, 2005; 28th report of commissioner for SC & ST, 1986-87). There are total 75 primitive tribal groups (PTGs) identified by the Government of India in 17 states and one union territory. Among these states and union territory Orissa was found to be possessed the maximum number of primitive tribal groups (13), followed by Andhra Pradesh with 12 (GOI, 2002).

There is a common consensual agreement that the health status of the tribal population is very poor and worst among the primitive tribes because of their
isolation, remoteness and being largely unaffected by the developmental process going on in the country (ICMR, 2003). The common beliefs, customs, practices related to health and diseases in turn influence the health seeking behaviour of the community (ICMR, 1998).

Literatures clearly state that the culture of the community determines the health seeking behaviour of the community in general and individual member in particular. The health seeking behaviour of an individual is closely linked to the way he or she perceives various health problems along with access to various health care facilities. Primitive tribal groups in India have special health problem and genetic abnormalities like sickle cell anaemia, G-6-PD red cell enzyme deficiency and sexually transmitted diseases. Poor sanitary condition, ignorance, lack of personal hygiene and health education are the main factors responsible for a majority of health problems (Paliwal, 2004; ICMR, 2003).

Sexual behaviour has the bearing of the risk of unwanted pregnancy and contracting sexually transmitted diseases, particularly gonorrhoea, syphilis, chancroid and AIDS. The alarming growth of STD poses an invisible threat to our country (Saha and Chatterjee, 1998). Indian society generally permits marriage as involving just one man and one woman at a time (monogamy). But a lot of tribal societies have allowed a man/woman to be married to more than one women/men which is known as polygyny and polyandry respectively (Mair, 1972; Majumdar and Madan, 1961). Some of the tribal societies also prefer group marriages, in which more than one man/woman marries to more than one woman/man at a time. In India dormitories, bi-sexual as well as mono-sexual, are found across the country where tribal people have their inhabitation (Majumdar and Madan, 1961). Some of the examples of tribes with youth dormitory system are the Konyak Naga of Assam, Bhotia of Uttar Pradesh, Munnda, Ho of Orissa, and Oraon of Bihar, etc. Besides these, traditionally the tribal women are accustomed to move and behave freely among the men folk from their tribe/village. The pre-marital attitude towards sex is liberal within most of the tribal groups, though the norms of behaviour for a married woman is are very strict (Deogaonkar S.G., 1990).
Another study conducted among tribal communities of southern region of Karnataka on emerging high risk groups for HIV/AIDS clearly says that there is a high prevalence of behavioural risk factors, coupled with ignorance and inadequate health infrastructure thus creating potential risk for rapid spread of HIV/AIDS as well as other sexually transmitted diseases (Naik et al, 2005).

Increasing sexual activities have been shown not only among the main stream population but in tribal population as well. A study conducted in the rural and tribal belts have also revealed the existence of a very high level of sexual activity among youth. On the basis of physical examinations for assessing the reproductive tract infection (RTI), a study conducted by Bang et al, (1989), showed that nearly half of all unmarried girls had already experienced sexual activity. Although it has been often explained in the context of tribal culture which is usually permissive, the findings of the Bang’s study emphasises the existence of risk behaviour in a society which may not have the means to protect itself from silent sexually transmitted infections.

1.2.7 Youth Dormitory System and Customs related to Marriage and Sex among Tribes

The dormitory is generally housed in a specially built building. It is often built outside the village, in the heart of the jungle. But it may also be near the cornfields as among the Naga, or right inside the village as is the case with many Oraon villages. It serves as council-chamber, as a guesthouse for strangers and as sleeping resorts for the young boys and girls. The boys and girls spend night in these dormitories and enjoy liberty to know each other more and more intimately.

In some instances these institutions seem to have lost their original purpose, which was to provide security to unmarried girls as well as to the other villagers, group work including hunting, teaching of art and craft and traditional norms and values to the young members. As all the young boys stay together in dormitories, they used to do their work collectively. Among some tribes these dormitories used to serve as the center of the puberty initiation ceremonies. But with the development of the secret societies, it replaces the earlier puberty institutions to secret lodge (Haywood, 1998).
Among the Kikuyu, the young sleep in mixed sex dormitories, where the practice of sex without penetration is permitted, (Worthman 1986). The sexual aspect plays a fairly dominant part in dormitory life. Among the Murias of central India, senior girls often train younger boys in the sexual act, and no permission is needed from the leaders for sexual intercourse (Majumdar and Madan, 1961). Among the Adis of Arunachal Pradesh it was found that the most vital role of the dormitory life was to channeling the sexual life and the art of love making in an effective way among the youth (Sonowal, 1997). Besides this, the adolescent Muria also elects husbands and wives peculiar to their ghotul (Dormitory) lives, different from their betrothed. Interestingly, they claim to avoid pregnancy by changing partners frequently (Elwin 1968).

Commenting on sexual life of Santhals, Mukherjea (1962) and Biswas (1956) found that among Santhals unmarried men had free access to have intercourse with unmarried girls, if the partner did not belong to the clan, which was customarily forbidden to intermarry. Unmarried women, widows, widowers and divorcees enjoyed the similar freedom. But almost no information is available on the contemporary situation among any of the tribal groups.

1.2.8 Contact with outsiders and Consequent Health Hazards among Tribal/Indigenous people

Contact with alien people may have detrimental effect on health. Such contact exposes the tribal people to new strain or species of disease creators to whom the tribal people have no immunity. This is more so in case of tribal people because of their long standing exclusion from heterogeneous physical environment. This may happen when tribal migrate to non-traditional domain due to displacement or in search of jobs etc. Moreover, tribal areas always experience immigration of non-tribal alien fortune seekers. In both the situations the tribal or the indigenous people experience or likely to experience the effect of diseases alien to them. There are ample instances of such widespread health problems in the forms of epidemics leading to wipe out of tribal people or depopulation, especially in new world due to contact with old-world diseases.
In the first fifty years of European occupation of Australia, there were at least two major epidemics of smallpox among the aboriginal population. The first epidemic was occurred by the year 1789 witnessed by the members of the First Fleet around Sydney. The second in the years between 1829 and 1831 coincided with the beginning of a dramatic expansion of the pastoral frontier into the lands of the Wiradjuri, the Kamilaroi and other peoples of the South western interior of New South Wales (Campbell J, 2002; 1985; 1983; Frost A, 1994; Butlin N G, 1984; 1983). It was said to be consequence of contact with “Macassan” visitors of the North Coast of Australia (Macknight and Campbell C, 1976; Cleland J B 1950). The smallpox epidemic initiated a period of intense cultural disorientation for the native people of New South Wales during which the direct impact of the disease was compounded by the effects of European colonization, military action, and losses from other introduced diseases, especially influenza (Reece R. H. W., 1974).

Due to colonization, depopulation of aborigines occurred in Australia. For example, the New South Wales was colonized with convicts and soldiers, then increasingly with larger number of pastoralists and other settlers, so that by 1841 there were 131,000 European living in an area previously occupied by less than 100,000 aborigines (Ward 1966; Jones 1970; Smith 1976; cf. Dianne Kirkby: 1984). The impact of colonization was such that within seventy years of first contact the aboriginal population of the whole Australia reduced, and many tribes on the east coast had disappeared altogether. It has been estimated that the original New South Wales population declined by seventy five percent (Foxcroft E.J.B., 1942).

Henry F. Dobyns (1993) has extensively reviewed anthropological and other literatures in his article “Disease Transfer at Contact” published in Annual Review of Anthropology. His review opens up the extensive nature of spread of diseases among native population of colonized world and consequent depopulation or even wipe out of native population. His review shows that old-world diseases like smallpox, measles, typhus, plague, influenza etc were wrought havoc among the Native Americans and natives of Islands in and around the New World at different times in history.
After first contacts with Europeans and Africans, some believe that the death of 90–95 percent of the native population of the New World was caused by Old World diseases (Diamond: 1997). It is suspected that smallpox was the chief culprit and responsible for killing nearly all of the native inhabitants of the Americas. In 1519 Hernán Cortés landed on the shores of what is now Mexico and was then the Aztec empire. In 1520 another group of Spanish arrived in Mexico from Hispaniola, bringing with them the smallpox which had already been ravaging that island for two years. After the Aztecs battled the Cortés and his men, the Aztecs contracted the virus from the invaders' bodies. It killed most of the Aztec army and 25 percent of the overall population. The effects of smallpox on Tahuantinsuyu (or the Inca Empire) were even more devastating. Beginning in Colombia, smallpox spread rapidly before the Spanish invaders first arrived in the empire. Within months, the disease had killed the Sapa Inca Huayna Capac, his successor, and most of the other leaders. Within a few years smallpox claimed between 60 percent and 90 percent of the Inca population (cf. Elizabeth Orlow: web source), with other waves of European disease weakening them further. In 1561, smallpox reached Chile by sea, when a ship carrying the new governor Francisco de Villagra landed at La Serena. It ravaged the Chilean native population and the natives lost between twenty and twenty five percent of their population. In 1633 in Plymouth, Massachusetts, the Native Americans were struck by the virus. As it had done elsewhere, the virus wiped out entire population groups of Native Americans. It reached Mohawks in 1634 (Canadian encyclopaedia: web source), the Lake Ontario in 1636, and the lands of the Iroquois by 1679. During the 1770s, smallpox killed at least 30 percent of the West Coast Native Americans (Greg Lange: 2003; Houston and Houston: 2000). The smallpox epidemic of 1780–1782 brought devastation and drastic depopulation among the Plains Indians (Rich and Johnson: 1952). This epidemic is a classic instance of European immunity and non-European vulnerability. A particularly virulent sequence of smallpox outbreaks took place in Boston, Massachusetts. From 1636 to 1698, Boston endured six epidemics. In 1721, the most severe epidemic occurred. The entire population fled the city, bringing the virus to the rest of the Thirteen Colonies.
In the late 1770s, during the American Revolutionary War, smallpox returned once more and killed an estimated 125,000 people (Pearson, J. Diane: 2003). Peter Kalm in his *Travels in North America* described how in that period, the dying Indian villages became overrun with wolves feasting on the corpses and weakened survivors (Peter kalm: 1987).

In certain Indian situation tribal women are more prone to victimisation. A tribal woman has a cultural background due to which she mixes freely with the men, particularly before marriage. But outsiders, which includes officials, roving merchant’s/traders, truck drivers, contractors and their labourers brought from outside misinterpret the women’s behaviour and tries to take undue advantage of their simplicity. At times the poverty or her curiosity is also exploited for the satisfaction of carnal desire (Deogaonkar S.G., 1990).

It was also found that the tribal groups were caught between an apathy and neglect by the government on the one hand and the exploitation and invasion by the traders and contractors on the other. This situation led to an indiscriminate exposure of tribal life to alien factors which led to their socio cultural as well as ecological degradation. Many tribal cultures and social systems are collapsed under this pressure (Kulkarni and Gurjar, 2000).

The review of available literature also reveals that in the 19th century, with the advancement of the British rule in the southern hill stations, the *Toda* women were sexually sought after by the foreigners, who transmitted a variety of diseases. By 1927, according to anthropologist Anthony Walker, “forty nine percent of the *Toda* population was suffering from venereal diseases”. This was also found to be the reason for *Toda’s* low fertility rates (Walker, 2003). Another study conducted by Ashford (2001) revealed that younger women are more vulnerable to forced sex and sex in exchange for gifts and money, with increased risk of contracting sexually transmitted diseases including HIV/AIDS.

It is evident from the available literatures that many times tribals are exploited by the non-tribal persons or by the people from outside their tribal world, which hampers their own traditional culture, norms and values of life. Sexual exploitation
is one of the major forms of exploitation faced by the tribal women. Ultimately these sexual exploitation results in transmitting and introducing different type of sexually transmitted infection and diseases to the tribal community and the people. As youth are more sexually active as compared to the other age groups, they become the victim of such infections and diseases.

1.2.9 Sexually Transmitted Diseases and Youth

The present generation youth are more urbanised and better educated. However, transitions to adulthood are often marked by abrupt and premature exit from school, entry into the labour force and strongly held gender norms (Jejeebhoy and Sebastian, 2003). Further, young peoples’ vulnerability caused by their young age coupled with lack of and/or poor knowledge on matters related to sexuality and their inability or unwillingness to use family planning and health services puts them at a significant risk of experiencing negative consequences (Jejeebhoy and Sebastian, 2003; Mamdani, 1999 and Singh, 1997). Again, there is a strong relationship between socio-demographic problems like infertility, unwanted pregnancy, sexual abuse and sexually transmitted infections including HIV/AIDS, with youth sexual behaviour (Varga, 1999 and Radhakrishna et al., 1997).

It has been calculated that four times every second, somebody in the world is contracting one of the major sexual infections. The flighty butterfly- the polygamous male in the age group 16-25 years is a more frequent victim than his female counterpart (Dastur, 1989). In a study in Mumbai slums, Bhende (1993) observed that awareness of sexually transmitted diseases was poor among the adolescent boys and girls. Only ten percent of boys and girls had some knowledge about STDs. Out of these ten percent most of the boys could name at least one STD, while not a single girl could name STD. In another study it was observed that awareness of sexually transmitted diseases including HIV/AIDS is not universal. About the mode of transmission, misconception was wide spread and also among those who were aware there was little awareness that it was a fatal disease (Jejeebhoy, 1994).

Another study among the youth in Maharashtra reveals that merely 21 percent married men and 14 percent married women have heard of RTI/STI (IIPS and PC,
2007). At the national level, it is 48 percent and 41 percent respectively among the married men and women aged 15-24 years (IIPS, 2006).

The level of awareness, concern and skill of family welfare staff regarding the control of RTI/STDs is low. In addition, attention to protecting the privacy and confidentiality of clients is usually scanty in the health sectors (Parivar Seva Sansthan, 1995). The lack of doctors, the stigma associated with genital complaints and the lack of privacy and confidentiality is commonly found in many cases of non-utilisation of health care services. In many countries self-treatment is common because it is less expensive and convenient or may be because people are feeling uncomfortable to visit local clinics, particularly when the illness is an STD (Field Mary Lyn, 1996).

Public health officials and educators have a long standing interest in adolescent and youth sexual behaviour and risk prevention which is an interest intensified by the spread of HIV. In few studies conducted among Nigerian men, the authors found that more than 15 million new cases of STDs are diagnosed every year and approximately 65 percent of these cases are diagnosed in people under age of 24 years (Godin et al, 1993; Institute of Medicine, 1997).

Several studies have confirmed that adolescents and youths are more vulnerable to get sexually transmitted diseases. The situation is more critical in the under developed or less developed countries. Many authors opined that sexually transmitted diseases have always been a significant health problem in India. The epidemic of HIV/AIDS has increased the significance of sexually transmitted infections (STIs) in public health settings as it increases the risk of HIV infection 2 to 10 folds (Anonymous, 1997; Thomas K et al, 2002).

Early sexual debut places young people at increased risk of acquiring STDs. This vulnerability to STDs is because of biological and behavioural factors (Olasode, 2007). Young people who begin sexual activity early, appears more likely to have sex with high-risk partners or multiple partners and are less likely to use condom (WHO, 2000).
Adolescents often do not have access to sufficient and correct information. Cognitive distortions and sense of non-susceptibility lead to uninformed decisions, which may result in unwanted pregnancies and STDs. The notion that they are “too young to be pregnant” and “unprotected intercourse just once could not lead to conception or transmission of any sexually transmitted disease” are prevalent among teenagers (UN, 2001)

The influence of peer pressure is increasing in the context of the erosion of traditional parental control over pre-marital sexual behaviour and the declining role of family members, especially grandmother, in providing adolescent girls with pre-marital instruction and advice on appropriate sexual and marital behaviour (Gage, 1998). A study on sexual experience of rural Thai youth found that peers influence was one of the main motivations for engaging in first pre-marital intercourse (Isarabhakdi, 2000). Young people are increasingly vulnerable to sexually transmitted infections (STIs) due to changing values, group norms and increasing independence. For this reason both the incidence and prevalence of STIs are higher among young people that in general population (Hollerbach and Rogers, 2005).

Linking the young men with their migration status, Puri in 2001 stated that young and mobile men who tend to be away from home for periods ranging from a few months to a few years were more likely to be involved in casual sex with non-regular partners, including sex workers. Another study conducted in Nepal revealed that employment oriented seasonal and short-term migration of Nepalese youth and young adult men to cities in Nepal, India and other countries was emerging as a major factor in driving the HIV epidemic in Nepal (Furber et al, 2002).

In another study conducted among men by Gupta et al (2005) showed that sexually transmitted diseases (STDs) among men not only jeopardised their own health but also increased sexual morbidity among spouses. Sexually transmitted diseases are primarily attributed to high risk sexual behaviour. Sexual promiscuity, unsafe sex etc., are the primary causes of transmission of STDs and HIV infection.
1.2.10 Sexually Transmitted Diseases and Tribes

There are very few studies conducted among Indian tribes especially on their sexual health related aspects. Some of these studies are discussed below. Sexually transmitted diseases were the most prevalent diseases in the tribal areas. These infections were often untreated as they were difficult to diagnose and would even lead to infertility as was found by Basu (1993).

A study conducted among the 400 currently married males in the age group 15-40 years belonging to primitive Baiga tribe of Baigachak area of Dindori district of Madhya Pradesh revealed that about 18 percent men were aware of RTI, while awareness for STD was 21.5 percent. Only 10 percent had heard about HIV/AIDS and most of them had no knowledge of its transmission and prevention (Saha, 2005). The study also estimated the mean age at first intercourse and first marriage to be 17.8 and 18.0 respectively, suggesting prevalence of pre-marital sexual relationship among Baigas. Further, about five percent of the respondents strongly favoured extra-marital sex.

In a targeted intervention research to improve STD programme, Mary Lyn Field (1996) found that in South Africa, men used to drink a herbal beverage before having sex because they believed it would protect them from any attack of evil, including sexually transmitted diseases. Basu (1994) opines that sexually transmitted diseases are generally the result of contacts of tribals with non-tribals. These sexually transmitted diseases are present in various tribal groups, for example the Andamanese, Toda of Nilgiri hills, Khasaa of Jaunsar-Bawar (Uttar Pradesh), Kondha of Orissa, tribal groups of Madhya Pradesh, Rajasthan, Mysore, Laccadiva and Minicoy islands.

VDRL, a very sensitive test to diagnose the person suffering from syphilis, was found to be positive in 17.12 percent cases of polyandrous Jaunsaries of Chakrata tehsil of Dehradun district. Moreover among the sufferers 9.92 percent were male and 7.19 percent were females (Basu et al., 1993). In another study among the Santhals of Mayurbhanj district, Orissa, 9.92 percent were found to be positive in syphilis testing (Basu et al., 1993). While conducting morbidity study among the
*Kondh* tribe of Phulbani district, Orissa, Swain et al. (1990) found syphilis (10 percent) in *Desia Kondhs*, whereas it was not diagnosed among the primitive *Kutia Kondh* tribal group.

One of the most recent literatures also supports the fact of existence of sexually transmitted diseases among primitive tribal groups. While working on the health status of the Porja tribe, Subramanyam (2007) found that the institutions like family and marriages were very loosely organised among Porja. In their society pre-marital and extra-marital relationships were acceptable. As a result of the loose social organizations and acceptance of pre-marital and extra-marital relationships, more numbers of STD and RTI cases were found among the Porja. Similarly he has also worked on the health status of the Khond tribe. He has opined that alcoholism is too much among Khond. Both pre-marital and extra-marital relationships are acceptable in the community which culminates for the high incidence of STD and RTI cases in the community.

Another study conducted on health status of tribal women found that the incidences of sexually transmitted diseases among tribal women folk were on the increase. Occupational migration, prodigious urbanization and fast industrialisation were identified as the causal factors for the same (Chatterjee, 1993).

Prasad et al (2001) undertook a study to determine the nature and extent of gynaecological morbidity including RTI among married women. In an attempt to estimate the need for health care in the group they conducted a study in 13 villages of Vellore district of Tamil Nadu. Out of the 451 samples, forty eight percent had RTI’s. About seventy three percent of women did not use any contraceptives and six percent used abortion for spacing. It was also found among the *Santhal’s* of Mayurbhanj district, Orissa, that very few people were using condom because of the poor economic condition.\(^1\) And also because of the belief on traditional medicine system, the utilization of the public health services (Modern medicine systems) was found to be less (Praharaj, 2003).

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\(^1\) The condoms available at Govt PHCs/Subcentres are not of good quality and the santhals themselves are not in a position (both economically and psychologically) to purchase condom from open market.
In an important study conducted by Indian Council of Medical Research on health status of primitive tribes, it was found that widespread poverty, illiteracy, malnutrition, absence of safe drinking water and sanitary conditions, poor reproductive health services, ineffective coverage of national health and nutritional services etc., were the possible contributing factors of dismal health condition prevailing among the primitive tribal communities of the country (ICMR, 2003).

All the above literatures describe that in tribal societies the system of youth dormitories, multiple sex partners and unprotected sex are in existence. These in turn, create the favourable conditions for spread of sexually transmitted diseases among the tribals. Lack of female doctors, the stigma associated with genital complaints and the lack of privacy and confidentiality catalyses the situation as very few RTI/STD patients make use of public health care services due to such inhibitions.

1.2.11 Importance of Traditional Health Care System And Treatment Seeking Behaviour of Tribes

Every community tries to view health or illness from its own cultural perspective and they decide as to what ought to be considered a disease, who should be contacted for the treatment of the sick person. In the early fifties the famous anthropologist Kroeber thus has opined that disease in some form is one of the fundamental problems facing by every society and every known society has developed methods for coping with disease and thus created a medicine. There are certain beliefs, practices, customs, and traditions, which are found among tribal population. Tribal societies have their indigenous methods and practices for the cure of illness and diseases, mostly based on the psycho-therapeutic qualities (Sharma and Malik, 1993). The tribes have been in interaction with the natural surroundings and obtain the cure of common ailments by the plants and herbs collected from the forest (Sonowal and Praharaj, 2007; Praharaj, 2003; Sharma and Malik, 1993). Another author working on tribal medicine system has also opined that nature has created plants in the world for every ailment and there is a cure for every diseases, man has to find out it (Pal and Jain, 1998).
The tribal mythology indicates that there are separate and separable, indigenous health care system among our tribal population and the health care system are managed by two kinds of practitioners. One is the common every day type which is known by most of the people. The others are religious and medical practitioners, who specifically practice certain kind of medical healing (Ghosh A. 2005).

From the available literatures, there appears to be different opinions among scholars about the ways of treatment among the tribals. Basu (1994) opines that the tribals by and large are reluctant to use modern medical health care system as they have firm faith in their traditional system of treatment, which is based on belief in supernatural powers. Another study conducted among Khairwars of Sidhi district, Madhya Pradesh have shown that due to economic constraints, illiteracy and lack of faith in modern medicine, they do not avail the available health care facilities (Pandey et al., 1996).

Swami, however, suggests that treatment of diseases among tribes may not resemble with the modern scientific method as prevalent in the western medicines, but it will be wrong to assume that it has no science. It rather moves in a way which covers not only a scientific principle, but also involves the society at large to overcome the catastrophe (as referred by Burman, 2003). Swain (1994) writes treatment naturally would be influenced by cause of sickness perceived by the group. It has been observed that however primitive a group is, it has some scientific knowledge which is gathered/learnt through trial and error method. But this knowledge does not exist in isolation, rather is a part of their entire socio-cultural and religious system. Besides these, magic is also a part of tribal religion.

Bhupinder Singh argues that though most of the tribe depends on faith healing, it cannot be trivialised; it is also part of a treatment. He states that even in the western medicines, confidence and rapport building are a part of the total approach.

Many studies have pointed out that religious belief plays an important role in case of health seeking behaviour of tribes. As per these belief systems diseases and death are caused by certain spirits or supernatural powers (Sonowal and Praharaj, 2007; Praharaj, 2003). This belief system leads to a separate kind of treatment procedure,
where herbal medicines are administered along with prayers and performance of different rituals. Jain and Agrawal’s (2005) study shows that the Bhills in Udaipur, Rajasthan, attribute disease to the act of deities and spirits of various kind and by appeasing them, they believe, disease may be cured. Pramukh and Palkumar’s (2006) study shows that the tribal groups namely, the Savaras, Bogatha, Konda Dora, Valmiki, Koya, Kond Reddi etc., believe in the power of prayers and rituals that enables some herbs to act as medicines to heal diseases among them. They attribute diseases to certain deviant acts of self and others towards elders, nature, and divine rules. Thus, their first priority is to get spiritual cure in a traditional way. It is claimed by this type of view point that each and every tribe has its own method of diagnosis and treatment, which is if not completely self sufficient but close enough to be treated as such (Ghosh 2005).

Working on the traditional tribal medicinal practices of Bhutias and Lepchas of Sikkim, Burman (1993) found that the tribal people very rarely do depend exclusively on allopathic medicines. People generally take up the allopathic system as a last resort, only when they fail with the traditional medicine.

There are, however, cases when the patients revert back to the traditional healers even after consulting the doctors. This is more so with the accident cases or chronic and serious cases. At times in such cases sometimes they are found to go both to the doctor as well as the Shamans (Traditional healers).

Veena Vhasin (1997) states that it is mainly due to the lack of medical infrastructure and facilities along with lack of education that the tribal people in Sikkim are stuck to the traditional medicines (as referred by Burman, 2003).

1.3 Summary of Literature Review

In the foregoing paragraphs we have discussed, to some details, the various aspects of STDs/STIs among different population groups. Now, for operational purpose the foregoing discussion can be summarised as follows:

i) STD/STIs are found almost in all population groups across the world. It has been one of the major health concerns in world population.
ii) The socio-cultural connotation of Indian society on sexual act and sexuality plays an important role in determining, reporting and treatment of STD/STI, across the population.

iii) Knowledge about sex and sexual health etc. are found to be poor among Indian youth due to socio-cultural traditions and inhibitions. Poor knowledge in one hand and exposure to STD/STIs on the other hand, has made Indian youth more vulnerable to health hazards.

iv) There is marked change in attitudes and actions over a period of two decades among the Indian youth towards sex and other related aspects.

v) Sexual behaviour has direct and compounding relation with STDs. Premarital sexual behaviour of youth has been changing over a period of time de-limiting its pre-existing traditional codes and conducts that used to control it. Thus, where such sexual acts are attached with ignorance and poor knowledge about proper sexual health there is maximum probability of contacting STD and HIV/AIDS etc. Likewise, extramarital sexual relation have also been broken its traditional barrier in Indian society posing a greater risk factor.

vi) The age at first involvement with sexual activities is also important in terms of STD and HIV/AIDS etc. The age factor is also compounded with level of education, economic condition and social environment.

vii) There are certain factors which influence the knowledge about sex, attitudes towards sex and sexual behaviour, especially on heterosexual activities of youth.

a) Inculcation of gender identity, and other aspects related to the act of gender differentiation including attitude, behaviour and expectation, is developed in a person’s perception within its family and culture at large. Moreover, parental or elder’s nature and extent of interaction with growing ups may determine the knowledge, attitude and activities related to sex.

b) At individual level both dependent and independent factors like age, gender, migration, status of occupation, alcohol consumption, exposure to alien culture, mass media etc.,
have great influence in building process of knowledge, activity and behaviour towards sexual aspects.

viii) There is a categorical difference between health among tribal people and non-tribal counterparts. Beliefs in supernatural power as cause of disease and illness, rule of customs and traditions and taboos in determining the nature of disease and treatment etc makes tribal health affairs a concern for modern health care providers as well the welfare agencies.

ix) Genetic diseases as well as STD/STIs etc are prevalent among the PTGs in India. Social institutions regulating or channelling sexual behaviour, especially pre-marital sex, are present in some tribal societies in the form of youth dormitory etc.

x) Youth Dormitory serves the role of enculturation in tribal society. Along with other aspects of life, it prepares its members for healthy married life through traditional way of knowledge giving about the act of love making.

xi) Tribal or indigenous people worldwide have been affected by the intrusion of non-tribal people in to their virgin land. They suffer physically, culturally, economically and morally too. The widespread elimination or depopulation of native Americans and Aborigines of Australia due to old-world disease as a result of immigration of Europeans now a known history to the world. STDs and other infectious diseases have the history of contact in Indian tribal lands like the Todas of Nilgiris. Displacement, deprivation and consequent migration of tribal people to alien land also attracted certain health hazards to them.

xii) Adolescent and the youth are the population highly vulnerable to STD and HIV/AIDS etc. This population in underdeveloped and developing countries are yet another major concern in particular due to poor knowledge level, low economic condition, low level of literacy and awareness etc.

xiii) Studies on sexual health among tribal India are particularly scanty. Available studies show that STDs were prevalent among tribal groups as a result of contact with non-tribals. Such contacts have been increasing due to occupational migration, urbanisation and industrialisation etc. The
studies also reveal that awareness and knowledge level about STDs/RTIs etc was very low among tribal groups.

xiv) Health care system and treatment seeking behaviour of tribal people attract special attention in terms of disease prevention, diagnosis and treatment etc. This is basically due to the following facts:

a. Tribal people have their traditional beliefs and practices regarding disease and treatment.

b. Tribes attribute most of the incidence to natural and supernatural entities that complements their belief system and consequent practices.

c. Reluctant to accept modern (non-traditional) health care facilities among tribes may be due to:

   i) lack of accessibility,

   ii) monetary constraints,

   iii) lack of required spiritual security in modern health care system which is, otherwise, provided by traditional system to tribal people as it is based on their culture and belief system.

   iv) inability to relate cause-effect-remedial relationship by the tribal people in modern health care system.

1.4 Rationale of the Study

The idea of conducting a study among the PTGs on sexually transmitted diseases emerged, at the first instance, from the finding of a previous study conducted by the researcher himself among the Santhals of Mayurbhanj district of Orissa. Further deliberation on the issue resulted into a proposed field study for Ph. D work.

The rationale of the study can be forwarded on the basis of the literature reviewed in the foregoing paragraphs. These can be stated as follows:

   i) STD is one of the major health concerns among different population groups. As the tribal people are also affected by STDs and there is
shortage of such studies among the tribes, the present study might get priority.

ii) Sex related issues are culturally coded and/or controlled in India. Being rich in cultural tradition, the tribal groups must have their own code of conduct on sexual behaviour and related aspects which need to be explored, especially in terms of STDs.

iii) The studies suggest that the knowledge base of a society about sex related aspects play important role in terms of spread and treatment of STDs. Thus, it would be interesting to explore as to how far and in what way richness in traditional knowledge and lack of modern knowledge about sexual health etc., affect the health status of tribal people.

iv) Sexual behaviour of tribal people is somewhat different from other communities. In many cases tribal societies have institutionally trained, culturally defined and customarily approved pre-marital sex-relation (channelised through youth dormitory and other such social institutions). Thus, it will be fruitful to explore the effect of such system on sexual health of tribal people.

v) Tribal societies are culturally bound and enculturation occur through family as well as other social institutions. It would be interesting to note how and to what extent tribal culture influences the most individualistic act – the sexual activities and its individual determinants like age, sex, gender etc.

vi) When the problem setting is the same (prevalence of STD) the differential treatment seeking behaviour of tribal people must have some unique effects on sexual health status of its population. This would be interesting to explore how far the traditional practices are able to protect its population from the effect of STDs, what are the factors influencing the nature and extent of acceptance of modern health care system etc by the tribal people and what are its consequences.

vii) It would also be interesting to trace the genesis of STDs among the selected PTGs and also the nature and extent of health hazards created by contact with non-tribal others over a period of time.
vii) Finally, a systematic and scientific study on the issue discussed above would bring out some inferences which will enrich the knowledgebase in terms of health care practices for the welfare of the PTGs, which is, otherwise, very scanty till date.

On the basis of these aforesaid rationales it was proposed to conduct the study as a partial fulfilment for the degree of Doctor of Philosophy.

1.5 Objectives

The broad objective of the study is to find out the nature, extent and the determinants of sexually transmitted diseases and health seeking behaviour of the male youth of primitive tribal groups. Considering the fact that tribal societies have their own indigenous beliefs and also have a distinct socio-cultural setting, which influences their life ways and practices in health seeking behaviour, following lines of investigations have been adopted to conduct the study among the selected population.

1. To study the nature and extent of prevalence of sexually transmitted diseases, knowledge and awareness among male tribal youth.
2. To study the factors responsible for the prevalence of sexually transmitted diseases among male tribal youth.
3. To study the nature and extent of available health care services and the nature of health seeking behaviour among tribal youth.

1.6 Hypotheses

On the basis of the above mentioned objectives and the available literatures, the following hypotheses have been formulated.

1. The tribal youth under study have a definite system of acquiring knowledge about sex and STIs/STDs. Exposure to media etc might have some affect on traditional arrangement of knowledge transfer in terms of sex education and related aspects.
2. Presence or absence of institutionalised pre-marital sex relation might have influence on sexual habit of tribal youth and also on beliefs and mental framework of tribal youth in terms of contact of disease and unwanted pregnancy and consequent dignified social acceptance of children born out of such acts.

3. Nature and extent of pre-marital sex relations and multiple sexual partners may be attributed to the presence or absence of now disappeared institutionalised system of social approval to such act (like youth Dormitory).

4. Tribal people have acquired STD on contact with non-tribal people alien to them. This might have happened by:
   a. Sexual exploitation of PTG women by non-tribal alien people who intruded in to tribal domain.
   b. Exposure to urban locality as wage labourers through seasonal migration and indulging in the act of sexual activities with unknown persons.
   c. The prevalence of social approval of pre-marital sex and unprotected multiple partner sexual habit helped in spread of STDs among them.

5. As in the cases of many other diseases occurred among them, the tribal people might have attributed STDs to any act of crime or sin committed by the victim. Tribal people closely guard such occurrence due to such notions affecting their treatment and healing.

6. Higher the level of attachment to traditional belief regarding any disease, higher the incidence of acceptance of traditional healing system by the youth.

7. Higher the level of exposure to non-traditional and urban elements, higher the level of acceptance of non-traditional health care facilities.

8. Higher the acceptance of modern health care facilities, lower the instances of STDs among the tribes.
1.7 Conceptual Framework

On the basis of the literature reviewed and the hypotheses formulated, the conceptual framework for the study has been prepared. The entire framework has been divided into two vertical segments, namely, the description of problem setting and the levels of investigation.

The community characters as tribal groups, religion and cultural beliefs and practices, norms etc., are observed in general in the first level of investigation termed as the “Level of general observation” along with the family and individual characters of the selected population. This level of observation leads us to the second level of investigation.

The second level of investigation gives us an idea about the traditional domain of the selected primitive tribal groups along with their life-ways and socio-cultural beliefs and practices. This level of investigation is termed as the “Level of general Abstraction.”

On having such abstract ideas we may inquire in to the ethno-history of the tribal group to draw a relationship between past and present situation which is the next level of investigation.

The next level of investigation on the problem setting is the “Level of Historical retrospective and/or hypothetical interaction” where it is tried to relate the contact of non-traditional alien culture/population with the selected tribal groups and probable physical contact or sexual exploitation of the tribal people. As there is scanty information available on such events it has been termed as the “Level of historical retrospective and/or hypothetical interaction”.

By summarising the outcomes from these levels we may derive at certain conclusion tentatively (or hypothetically) which builds up the next level, the “level of hypothetical abstraction” where health status, including sexual health of the selected population is described. This derived problem setting at hypothetical observation level can be arranged or conceptualised through the “level of observable interactions” that contain exposure to urban environment, media and campaign,
migration (in and out) activities in youth dormitories and the act of multiple sex relationship etc.

In the next level we can empirically examine the observable interactions. This observation derives at an "empirical observation level" where one can see the empirically analysed cause-effect relationship of STDs and the related aspects in terms of the culture or the life-ways of the people under study.

In the next level "Level of empirical abstraction", an abstract picture of the population can be drawn on their present health status including sexual health, health seeking behaviour and the factors effecting health status of the selected population.

Thus at the end an empirically analysed data base on health and well-being and health seeking behaviour pattern will be available to depict a tribal group(s). It is expected that this will have a good deal of implication on policy planning in health sector among the tribal people.
CONCEPTUAL FRAMEWORK

DESCRIPTION OF PROBLEM SETTING

TRIBAL GROUPS
Religious and cultural beliefs and practices related to sex and marriage

THE FAMILY
Types and size of family, parents’ education, economic condition

INDIVIDUALS
Age, sex, marital status, occupation, education

LEVEL OF GENERAL OBSERVATION

TRIBAL GROUPS
Religious and cultural beliefs and practices related to sex and marriage, youth dormitory activity etc

THE FAMILY
Types and size of family, parents’ education, economic condition

INDIVIDUALS
Age and sex, marital status, occupation, education, migration, exposure etc

LEVEL OF GENERAL ABSTRACTION

TRIBAL GROUPS HAVING EMPIRICAL DATA BASE ON HEALTH STATUS, HEALTH CARE AND CAUSES OF STD AND RTI ETC.

LEVEL OF HISTORICAL RETROSPECTIVE/HYPOTHETICAL INTERACTION

LEVEL OF HYPOTHETICAL ABSTRACTION

LEVEL OF OBSERVABLE INTERACTIONS

LEVEL OF EMPIRICAL OBSERVATION

LEVEL OF EMPIRICAL ABSTRACTION
1.8 Over View of Chapters

The thesis has eight chapters including summary and conclusions. The data collected for the study are analysed and presented in these chapters. The present chapter i.e. Chapter I gives introduction about the study. It also presents the review of literatures, need for the study, objectives, hypothesis and conceptual framework of the study.

Chapter II presents the methodology used in the survey, sample size and response rate, tools of data collection and the data collection procedure adopted during the field work. Besides this it also provides the operational definitions used in the present thesis to define different aspects, information on the study area and data processing and analysis.

Chapter III deals with profile of the study villages, description of the socio-cultural life of the study population with special reference to Census 2001, demographic and socio-economic characteristics of the study population, and profile of the male youth of selected primitive tribal groups. It also provides information on intensity of interaction of the male youth with their friends and village environment for couples.

Chapter IV presents the level of knowledge about sex, reproduction, sexually transmitted infections (STIs)/ sexually transmitted infections diseases (STDs) among male youth of selected primitive tribal groups. It also highlights the knowledge of the youth on HIV/AIDS and its transmission.

Chapter V deals with the sexual life of the youth of primitive tribal groups. It presents the information related to marital union, description of sexual life, pre-marital sexual relationship, extra-marital sexual relationship and the first physical contact of the unmarried youth. The chapters also discuss the factors responsible for the sexual behaviour of the male youth. Besides these, the chapter also presents the impact of culture and migration on the sexual life of youth.
Chapter VI presents the findings on the prevalence of sexually transmitted disease among the male youth of primitive tribal groups. It also highlights the differentials and determinants with regard to prevalence of sexually transmitted diseases. It also highlights the other non STD sexual health problems prevailing among the youth.

Chapter VII deals with the findings on health and treatment seeking behaviour of the youth of primitive tribal groups. It also presents the differentials and determinants of health seeking behaviour of youth.

Chapter VIII is the last chapter and provides summary and conclusions of the findings. It also presents the policy implications of the study.