
Chapter 1

THE PRESENT STUDY: An overview

The existence of the well-known treatise, *Kama Sutra*, erotic sculptures carved elegantly on the stone walls of *Khajuraho* built in medieval India, indicates a state of extraordinary openness in sexual matters in certain periods of Indian history - almost unthinkable in contemporary India as well as during the Muslim and British reigns. But there is lamentable lack of empirical knowledge about sexual attitudes and behaviours of men and women belonging to the varieties of ethnic, cultural, religious and socio-economic groups in India. The dearth of empirically derived knowledge about sexual behaviour has given rise to a host of myths and unfounded stereotypes about it.

The advent of AIDS and the rapid increase in the prevalence of HIV in India is an undeniable impending doom to her existence, as the myths and stereotypes about sex are largely propagated even through popular media. Most people in India might have heard about AIDS as life-threatening disease and are vaguely aware that its principal mode of transmission is sexual intercourse. Biased and distorted beliefs about sexual behaviour along with misconceptions about transmission of HIV often lead to either ominous complacency or undue panic regarding HIV/AIDS.

AIDS stands for Acquired Immune Deficiency Syndrome, a medically defined condition first identified in the early 1980s among young gay men resident in New York and San Francisco. It has subsequently been diagnosed in a wide range of other settings. In Europe, North and South America, Asia and Australasia, those particularly affected at present time include gay and bisexual men, haemophiliacs, injecting drug users, prostitutes and the recipients of blood transfusions and blood products. In some parts of sub-Saharan Africa AIDS has been more generally diagnosed and roughly equal numbers of women and men have been affected.

HIV/AIDS infection has in the last 15 years had a profound impact on medicine, science and society. Few diseases in history have had been intense interest in the problem, not only among the medical and scientific communities, but also in the general public, largely through coverage by the news media. As a result, ideas about the subject have been translated to a wider audience often before they have been subjected to critical assessment in the way normally applied to other areas of scientific inquiry. In principle, this degree of public awareness is highly desirable for the purpose of rapid dissemination of scientific information and for the containment of the infection within the community.

The epidemic has emerged so rapidly that political responses and planning strategies already inevitably lag behind the need. Even the most affected communities have only appreciated the significance of AIDS when cases were emerging in their midst, by which time the spread of HIV was already well advanced - this is well illustrated by the fact that the HIV seroprevalence amongst San Francisco homosexuals was already over 25% by the time the first AIDS cases were diagnosed.

More importantly, because AIDS is the most severe consequence of HIV infection, and because there is a long 'incubation period' between HIV infection and the development of AIDS, counting AIDS cases continually underestimates the scale of the HIV epidemic. In the absence of widespread screening for HIV antibodies, which is unlikely to be either practicable or acceptable, the HIV epidemic itself can only be estimated from a knowledge of the ratio between diagnosed AIDS cases and HIV infected persons in small studies. Extrapolation from these can only give a crude estimate of the full extent of HIV infection.

AIDS represents the last stage of HIV infection. Most people infected with HIV are asymptomatic for long periods of time and may not know that they are infected. However, they can transmit the virus to others by sexual intercourse or donating blood; by donating semen, organs or tissues; by sharing contaminated needles or syringes, as well as during pregnancy or delivery by mother-to-foetus/infant transmission. Persons

with HIV infection are presumed to be infectious for life and since there is presently no cure, most of them, if not all, will eventually develop AIDS.

Clinical signs and symptoms of HIV infection are caused by diseases that occur because of impairment of the immune system and by the virus itself. A few weeks after the initial infection, some people may experience symptoms such as fever, enlarged lymph glands, skin rash and cough. These symptoms, when they are present, develop at about the time antibodies produced by the body against HIV can first be detected. An asymptomatic period that lasts a few months to many years follows the initial response to infection. During the asymptomatic period HIV usually causes progressive deterioration of the immune system until the person eventually develops signs and symptoms of wasting syndrome, opportunistic infections and cancers and the diagnosis of AIDS is made. HIV infection can be confirmed only with a blood test, and the diagnosis of AIDS requires a comprehensive clinical assessment. The fatality rate of AIDS, within 2-5 years of diagnosis, is very high-close to 100%.

Human immunodeficiency virus (HIV) was first isolated and identified as the cause of AIDS in 1984. In 1986, a second virus, similar to HIV, was also found to cause AIDS. To avoid confusion, the original virus was named HIV-1 and the new virus, HIV-2. Except in West Africa almost all of the cases of AIDS in the world have been obtained by studying patients infected by HIV-1. HIV-2 infection seems generally to cause the same clinical signs and symptoms as HIV-1 infection, including AIDS. Although HIV-2 is still limited to certain geographical areas and caused relatively few cases of AIDS, it could spread throughout the world in the near future and possibly cause large number of AIDS cases.

One of the particular problems about the development of ideas about AIDS and HIV has been the fact that most of the work has been done in developed countries; perceptions arising from these observations have been carried over, sometimes inappropriately, to the interpretation of emerging problem in the developing world. There are many differences in the impact of AIDS and HIV infection in the developing countries.

HIV/AIDS is the millennial catastrophe that looms over India. The National AIDS Control Organisation (NACO) figures explicate that 51,000 of the 30 lakh people screened national are found to be HIV carriers, which totals to and alarming 17.8 per thousand in seropositivity rate. One percent of all adult Indian population is feared to be HIV hit, heralding the possibility of thousands succumbing to the virus each day. What enhances the tragedy is the fact they will be in their prime and the number of children infected will be sizable. AIDS is becoming the great leveler, transcending age, caste, class.

The relentless march of the HIV is poised to convert India into the AIDS-capital of the world, and Kerala the HIV hub of India. Sordid tragedies enacted by the HIV infected is beginning to be a routine media diet, along with rape, accidents or murders. HIV is crafting a new genre of untouchables in the Indian communities (India today, 1997).

HIV/AIDS is primarily a heterosexually transmitted disease. It is, contrary to popular belief, not confined to the high risk groups like commercial sex workers, truck drivers, intravenous drug users or even homosexuals. At this time, HIV is catching like a wild-fire among people in all walks of life like trusting wives, innocent children, students, professionals, casual labourers and middle class executives.

Worldwide, about 75 percent of all HIV infections occur through unprotected sexual intercourse between man and woman (heterosexual) or between men (homosexual) when one or other partner has HIV. There are no documented cases of sexual transmission between women. The risk of HIV is greatly increased when other sexually transmitted diseases (STDs) are present. Women are physically more vulnerable than men to STDs, including HIV/AIDS.

HIV is also spread through blood, blood products, and donated organs or semen. The use of blood contaminated with HIV for transfusions carries a very high risk (almost

100%) of spreading the virus. HIV can also be passed on from a mother to her child during pregnancy, at the time of delivery through breastfeeding. However, in countries with high infant mortality where bottle feeding carries a high risk of disease and death, WHO and UNICEF recommend that mothers with HIV should still be encouraged to breastfeed their babies.

Aim of the present study

The present study has been conducted to design and implement a strategic HIV/AIDS prevention intervention and stress inoculation approach in the present developing context of Kerala.

Significance of the study

Impact of AIDS has been felt in every continent, and Asia in particular has recently observed an increasing trend in the number of cases reported. The main reason HIV/AIDS poses so great a threat is that its extremely long incubation period makes it hard to detect: infected people often end up spreading the virus for several years before realising they have it themselves. In Asia, this pattern has been especially devastating. Many Asian countries have thriving sex industries, and young adults often have multiple sex partners. In addition, rapid economic transformations in much of Asia have created huge populations of internal migrants, whose unstable lives makes them particularly vulnerable to infection.

HIV/AIDS is also destabilising on a broad scale because it claims mainly the most economically productive members of society. HIV/AIDS is much more than a medical issue; its consequences are not confined to health, but are felt in the socio-economic spheres as well. In a short span of about seven years HIV infection has reached practically every state in India. Population groups practising behaviours such as multi-

partner, or sharing injecting equipment served as entry points for the epidemic in many states. Infection has been building up in these specific groups, following the pattern which was observed in Africa in the mid-1980s. From these groups infection has started to percolate to the general population. Rising trends are now seen in ante-natal clinic attendees, as per reports available from various sites in different states of the country.

Distribution of HIV/AIDS infection is not uniform, and depends upon a number of factors such as industrial development, urbanisation, trade and so on. Available data from the major cities of countries shows that the disease Tuberculosis is forming an "epidemic within an epidemic" amongst HIV positive people, and there is concern that once it is established in this group, it may spread further into the general population. Poor access to sexually transmitted disease (STD) treatment, because of its attached stigma and inadequate supply of drugs and other equipment, remains an important problem. New evidence confirms the importance of controlling STDs to contain the spread of HIV/AIDS.

As the epidemic ages in some parts of the world, a large number of young people becoming sexually active will replenish the pool of susceptible people, especially in developing countries where the base of the age pyramid is quite broad. Evidence of high incidence in young age populations as compared with older cohorts is already emerging for various countries. As many as two-thirds of all new HIV infections are expected to occur in the age group of 13 - 21 year olds'.

In Vancouver, at the International AIDS Conference 1996, UNAIDS, AIDSCAP and Harvard School of Public-health declared that the estimated number of HIV carriers in India is between twenty and fifty lakhs. This means that, India stands first in the world having highest number of HIV infections.

Yet India remains cocooned in its placid denial, smug in its hypocritical moral posture. All facets of the Indian social life is beginning to be affected by the advancing pandemic. So is the case of the literate progressive Kerala, which still remains indifferent

to the advance of the pandemic. Marooned in their conservatism and prudery the Malayali refuses to confront reality. Basic sex education is still taboo in most schools, though pornography is rampant. In Kerala children learn about sex through peers or pornography. It is the husband who teaches the wife about sex (India today, 1997).

The only way that the uninfected majority of this country can hope to stop the spread of AIDS is by becoming sufficiently educated about the disease. Through imparting authentic knowledge, populace will come to understand the necessity of maintaining an appropriate balance between the right of uninfected members of society to be provided proper protection from AIDS and its related infections, and the necessity to provide humane care and treatment for those with HIV disease.

It has been understood that a change in sexual behaviour of people can reduce the transmission of the sexually transmitted diseases, HIV/AIDS in particular, to a considerable extent. Panic and ignorance or misinformation should be substituted with awareness, informed choices and curbs on reckless sexual behaviour.

Competition in the field of education and employment; increasing number of broken families; poor coping skills; acculturation resulting from information explosion; decreased social relatedness; accessibility of drugs, alcohol, and pornography entice the younger generation to unhealthy way of life. It is high time for India, particularly Kerala, to wake up to the advancing health threat, devise measures to counter it and prepare in population to face and control it.

Current multi-drug anti-drug anti-retro-viral therapy against HIV/AIDS costs around Rs. 2 lakhs a month. None of the typical Indian patient will be able to afford to undergo the treatment. The only recourse in the Indian context against HIV/AIDS is thus containment and prevention through sex education.

Most of the problems related to sexuality, which ultimately lead to the infection of HIV/STDs are rooted in the sexual identity issues. This originate most often in the period

of adolescence, when a positive knowledge and attitude have to be developed, but denied unfortunately. Restlessness among youth is more in Kerala's cultural context. Majority of Keralites undergo University education, but they do not have the exposure to tackle interpersonal conflicts, identity crisis and other stress related problems like alcohol, smoking, drug abuse etc. Many of these problems lead to indulgence in unhealthy sexual behaviour. Hence a skill development approach involving the college students, in order to make them capable of identifying the problems concerned to youth and helping to resolve it, along with educational efforts to prevent HIV/AIDS/STD transmission is intended in this study.

The need for primary education strategies, as the battle against HIV/AIDS pandemic and stress related problems, focusing on educational efforts to influence social, cultural and behavioural factors among young people in developing context of Kerala is undeniable. "Anticipatory Crisis Management", the strategic HIV/AIDS prevention intervention and stress inoculation approach is a prudish attempt in this regard.