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**A PATRIARCHAL LINK TO  
HIV/AIDS IN INDIA**

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# A PATRIARCHAL LINK TO HIV/AIDS IN INDIA

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## *Abstract*

In patriarchal societies a socio-cultural construction of a woman's body and sexuality is a general feature that considers a woman's body weak and docile. This often results in her powerlessness from several angles. Here, we have analyzed the extent to which woman's powerlessness has contributed to increasing her vulnerability towards HIV/AIDS. The result is drawn from the primary data analysis from Karnataka and West Bengal.

## **1. Introduction**

In most societies, especially patriarchal societies, a woman is perceived merely as a body. A female body having timid existence is considered as a sex object and gets little meaning as a person. Traditionally, a woman's body has been emphasized merely for production, to give pleasure to men and for reproduction. In the modern patriarchal society, though her stereotypical role has expanded, the approach of men towards women has hardly changed. Overtime, she has been used as a means to certain end. However, across time and place a stark difference could be observed between a man and a woman, in both natural and socio-cultural construction of their bodies. Such a socially constructed difference has become the focal point through which the dominant masculine body establishes its power over the so-called feeble feminine body. The dominant power establishes its hegemony through the construction of an ideal '*image*' or the *idea of a perfect woman*: an embodiment of body, sexuality and intellect, all of which are projected as historically correct and push women (in reality) to attain them. While building an 'idea-body' patriarchal society draws upon conducive myths in history, language<sup>1</sup>, false imagination and project the constructed 'idea-body' to be the ideal woman. Such an idea acts as the 'powerful woman' (image-woman) against all existing powerless women in reality. The imaginary woman

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body is considered as the normal existence whereby all 'other'<sup>ii</sup> women are forced to achieve such normalization. The masculine power has the ability to reward the ideal, while imposing deprivations or punishment upon the opposite.

For Foucault (1990) 'body is the focal point of the struggle over the shape of power'. By saying so he has affirmed the presence of the power, at decentralized institutional levels like school, hospital and family. However, he doesn't describe how the power over the body is being shaped or what is the process of power formation. He fails to project how female subjugation is normalized by the everyday male requirement, leading to vulnerabilities of femininity. Feminists like Susan Bordo (1993), Wollstonecraft (1988) and others have filled up the gap of understanding the power formation within western society, where women are trained to shape their body as per the cultural, masculine demand. While doing so they consciously or unconsciously engage themselves in the process of '*normalization*.' Susan Bordo (1993) points out to the instances of women in western society, with a view to achieving a perfect body opt for plastic surgeries. In the process, they attempt to conform to the masculine image of a 'beautiful body.'<sup>iii</sup> Through such beautification they enslave themselves to the power of masculinity. Of late, use of technology has contributed towards such normalization (Hogle 2005). However, it can be argued that the normalization as a process is not static, as the traditional body image of women is not the same as the modern body image.

Women in Indian society, historically as well as currently, are not an exception to the process of '*normalization*.' One may cite an example from the ancient text of *Manusamghita* in which a good woman, being a dependant woman, is projected largely in terms of the idea-body. With the change of time, Indian image of perfect woman altered while taking conglomerated ideas drawn from both modernity and tradition. Even Partha Chaterjee (1999) mentions this kind of a paradoxical situation of

Indian women, particularly, during Indian national movements. During this period and afterwards, Indian women were exposed to public sphere more as they were never before. Although, women were exposed to the modern world and performed some non-stereotypical work at one level, i.e, in public sphere, they maintained their traditional role at the other level of their private lives. In this process, women perhaps were unconscious of their suppression both in terms of the traditional and modern images of *perfect women*. Hardly questioning their dual subjugation, they repeatedly emulated the perfect role of a woman in both private and public spheres. Normalization at different times helps the woman's body to retain its expression of a desirable object. Even the capitalistic society looks at the women's body as an object. The hedonistic idea of availability of the body gets confirmed through such an objectification. Her body is never viewed objectively; and it is subjected to the tight gender rules and norms. Thus, the female body visualized and constructed in such a manner that 'heterosexual hegemony'<sup>iv</sup> is determined (Butler 1993). As per the requirement of the society, a woman's body is projected for performing some stereotypical roles and her powerless subjugation is confirmed in many aspect of her life. Patriarchal social norms, forces of economy and culture, play a major role in confining women's submission in both private and in the public life.

Patriarchy, while, shaping and asserting its power over women follows several roots. As is mentioned above, one root is the formulation of 'idea-body' and influence women to achieve the imaginary normalization. The other way of subjugation is through '*mystification*' of the existing female body, where the patriarchal force builds justification to prove women's existing body to be a fragile body. In the process of mystification, they consider woman's body, her physique, psychic, sexuality, and her intellect to be of lower quality as compared to male. While mystifying women's body, they take the help of science, language and governance. Thus, the misunderstood reality of women body is

built within the mainstream knowledge discourse that pushes subaltern knowledge aside. It often happens that women, in general, do not try to understand their own body and sexuality. They hardly question their subjugation because either they do not have any realization in the process of mystification or they themselves are not aware of their own subjugation to the process. Thus, they fail in resisting against either normalization or mystification. Moreover, women evade resistance due to the fear of punishment<sup>v</sup>, (such punishment may be physically violent by putting a jolt to women's survival). A concrete example of mystification is the pathological consideration of women's health that predicts women as morbid. Women's body is treated in such a way that it draws an impression of pathological inheritance to her body.

The hypothesis explored here is that the socio-cultural construction of body through normalization and mystification maintains the status of the masculine power, which could result in the powerlessness of women and such powerlessness can significantly lead to the violation of woman's rights leading to their vulnerability towards HIV/AIDS. In this paper, we have tried to understand as to what extent women were treated as sex objects, or were deprived of their rights and whether such situation of powerlessness has pushed them towards infection. We have also explored whether women have come to realize their subjugation and have resisted against it, after being infected with HIV. For the purpose, two states, i.e., Karnataka and West Bengal have been chosen on the basis of the difference in their prevalence rates. We have covered in all two hundred (100 from each state) HIV positive women. Since it is extremely difficult to interview HIV positive man or woman within the family, as the matter of confidentiality is attached with it, we have extracted our samples from institutions. We initially collected the list of hospitals i.e., public, private and NGO-led, that provide treatment to HIV positive people. Then, we selected three government hospitals having VCTCT, PPTCT or ART centres within it randomly (through lottery method). Similarly, we made

a list of some known private hospitals and civil society organizations led (Civil society organization) hospitals out of which, we selected two hospitals each. Later we interviewed hundred and odd samples in each state by using random technique. The detailed method of sampling is provided in Appendix 1.

## **2. The Socio-Economic Background of HIV Positive Women**

The socio-economic condition of the HIV positive women reveals their status and place in the society, which often provides us the overview of their probable position in the society that affects their power or otherwise. In our sample, married women constitute the major proportion of respondents, who have been infected with HIV. Majority among them, i.e, 70 per cent in both the states, fall under the age group of 22-35, i.e. at their reproductive period or young age. Interestingly, we have found that, in our sample, most of the married women were infected by their husbands, however, there is stark difference in the divorcee HIV positive women in one state where it is more (Karnataka) as against another state (West Bengal). Among the divorcees, a majority of the women are the ones who are discorded or are thrown out of their in-laws and husbands house as they were blamed for being the source of infection. More than half of the respondents in Karnataka belong to the urban area whereas in case of West Bengal it is slightly less than half. Not much difference could be observed in the status of rural origin among the sample. Though, overall, literacy is higher in both the states, in case of our sample, West Bengal has relatively less literate women as compared to Karnataka. Among the samples, around 40 to 50 per cent of the women in both the states were involved in either organized or unorganized work, out of which a majority of the women work in an unorganized sector and overall, more than 65% earned minimal monthly income, which was less than 2,000 rupees per month.

**Table 1: Socio-Economic Details of Women in Karnataka and West Bengal**

Variables	Indicators	Karnataka	West Bengal
Marriage	Percentage of respondents married	100.00	96.00
Age	Percentage of respondents falling within the age group of 22-35	76.00	75.00
Rural or Urban	Percentage of respondents from urban location	53.00	48.00
Economic Independence	Percentage of respondents Independent (Working)	55.00	52.00
Organized work	Percentage of respondents as Organized Labor	22.00	18.00
Literacy rate	Percentage of literate among the respondents	82.00	64.00

Source: Primary data

### **3. Powerlessness of Women and their Vulnerability towards HIV**

Power is the capacity of an individual to influence another individual(s) to behave in a particular way. In the process, it is possible that the other person may or may not be either conscious of this influence/ coercion on her/his behavior. However, in certain other conditions, despite consciousness and resistance, power is often exercised. In a patriarchy family, a male's power is synonymous to the subjection or powerlessness of women (it is a relative powerlessness of female body against men's power that creates situations not conducive to women's health). For analytical purposes powerlessness of women located in several situations: (i) lack of economic independence or fear of loss of economic security, (ii) lack of Political control, in terms of lack of knowledge of discourse on rights, limited chance of bargaining, (whereby, women either remain ignorant about their rights or become helpless to take any action to realize freedom and power), and (iii) the fear of loss associated with social status (from married to widow) and

'cultural constraint'<sup>vi</sup> that disallows or prevents women from enjoying rights and to have greater control over their own body. In the context of this present study, power basically means not only control over ones body but also the way to exercise rights. Such power can be achieved in several ways. For instance, within a family, it is through acquiring knowledge about rights (women's), initiatives to take decisions in household levels and also taking decisions on their reproductive as well as sexual life. It could also be achieved by taking initiatives to have control over their body (mind, sexuality and physique) or exercising rights. Here, we hypothesize that it is the powerlessness that results in loss of power to control one's own body and this make them highly susceptible to the health problems like STD and HIV.

The consent of women regarding the choice of bride groom as well as the age of their marriage are pivotal in explaining the freedom of choice, they exercise. Table 2 depicts that around 60 per cent out of the respondents in Karnataka as against 70 per cent in West Bengal got married below the age of 18. Most astonishingly, 20 per cent and 10 per cent of the girls in West Bengal and Karnataka respectively got married when they were below 13 years when they were even unaware about the concept of marriage. In terms of the relation between marital age and rate of infection, it is conceded that women who are exposed to physical relation at a younger age are biologically more vulnerable to HIV<sup>vii</sup> (Johnston, 2003, and UNAIDS, 2000). Furthermore, lack of choice relating marital age makes women susceptible to the HIV infection primarily due to unawareness as well as lack of consciousness. In a majority of the cases, from our sample, it is revealed that the consent/preference of women was not taken or asked for, regarding the choice of bridegroom, while arranging the marriages. Both these instances point to their significance in affecting the vulnerability of women towards HIV.

Table 2: Marital Age Group of Women in Karnataka and West Bengal

Age of marriage of women (in Years)	West Bengal	Karnataka
	Per cent	
0-13	20.83	10.0
14-18	53.13	51.0
19-35	26.04	37.0
36-55	-	2.0
Total	100.00	100.0

Source : Primary data.

Note : As sample size is 100 each percentages also would be the same number

In a patriarchal family, the degree of power exercised by men and women differs. In general, women are given less importance and are considered as less intelligent, less practical, and so on. While living with such powerlessness, women also lose their rights to bargain for a better control over their own body, where they also feel incompatible of questioning their husbands' errant behavior. Thus, their weak position in decision-making results in the inability to have control over their own bodies (how to control her body and how to use it). All such conditions increase their vulnerability to suppression and health hazards like HIV (Verma and Roy, 2002). Table 3 shows that around 32 per cent of women in West Bengal as against 22 per cent in Karnataka had received cooperation from their husbands in decision-making process at home. Cooperation is found higher in the high HIV prevailing state, however, at the same time, more than 30 per cent of the women in both the states had been subject to their husbands' dominant role (where wife's opinion was either not asked for or implemented). In several cases, irresponsible<sup>viii</sup> husbands not only neglected their demands but also did not give money for their household maintenance. The dominant, irresponsible, and unfaithful<sup>ix</sup> characteristics of husbands resulted in a greater powerlessness among women. Two women, Sarana Begam

from Karnataka and Astami (name changed) from West Bengal revealed that their husbands were alcoholic, unfaithful and violent and they used to beat them everyday. It had resulted in emergence of fear in their mind that created powerlessness within themselves. As a consequence, they neither dared to question their husbands' unfaithfulness nor resisted against violence. They considered it to be their destiny and felt helplessness against husband's dominance<sup>x</sup>. We also came across a few cases where respondents mentioned that their husbands were falling under more than one category like both cooperative<sup>xi</sup> but unfaithful. For instance, we found that in West Bengal, 13 stated that their husband's behavior was irresponsible and unfaithful, whereas in Karnataka it is 22, and 29 respectively. One male member was both cooperative as well as unfaithful in W.B. and in Karnataka, there were 2 male members who were unfaithful and cooperative. Such a conflicting situation also affects the vulnerability of women towards HIV/AIDS. For instance, when a husband was dominant and irresponsible then the position of the respondent used to be grimmer. In such case if the respondent decides or takes responsibility of managing the household affairs or decides to send her children to the school but her husband despite of his irresponsibility if changes the decision, she might feel the helplessness. In West Bengal, there were 19 cases where husbands were irresponsible and dominant.

**Table: 3: Behaviour of Husbands Towards Women in West Bengal and Karnataka**

Opinion	West Bengal	Karnataka
	Per cent	
Irresponsible	20.90	28.29
Unfaithful	12.69	17.11
Dominant	34.33	32.89
Cooperative	32.09	21.71
Total opinion	100.0	100.0

Source: Primary data.

The power of patriarchy can also be exercised either simply by the physical presence of the masculinity or established purely through a dual oppositional relationship of masculinity and femininity. It is complex in nature where physical presence of power is also substituted by ideology, norm, and values. Thus, the nature of the power in turn, makes women subject to the power even without them being aware of it. Such powerlessness in social, economic and political terms could make women more vulnerable towards HIV/AIDS. Due to powerlessness, women fail to realize that they have some rights<sup>xii</sup>. Even when women realize their power, often they fail to exercise it in terms of rights. Deciding on the contraceptive use is one of the examples of having rights to control over body (person who determines condom use had better rights or power). While deciding to control over their body women depend on men, particularly in the case of condom use. Kapil Sibal (2002) has argued that women's condom could be an important way of providing power to women to keep them safe. However, in India, inaccessibility, especially due to high price of female condom, has not resulted in improving the power of women. Table 4 shows women's power in deciding the contraceptive use (condom) that is essential in protecting them from infection. In both the states, among contraceptive users, only around 4.55 per cent and 2.04 per cent of women (in West Bengal and Karnataka respectively) had taken the decision of using contraceptive themselves other than condom, as they were not in a position in convincing their husbands to use them. Similarly, in both the states, a little more than 12 per cent of the women had taken decision regarding the use of contraceptive, along with their husbands. However, astonishingly, among such cases the practice of regular use of condoms was not followed. Majority of women didn't even know (before the infection) that regular use of the condom could have protected them from infection. In some cases, husbands turned down the plea of their wives when they asked for the use of condoms. It is found that around 51 per cent of the women in Karnataka and 56 per cent in West Bengal had never used condoms.

**Table 4: Identification of Decision Making Through Use of Contraceptive in West Bengal and Karnataka**

Decision taken	Karnataka	West Bengal
	Per cent	
Husbands	71.42	59.09
In-laws	2.04	9.09
Respondents	2.04	4.55
Doctors	12.24	13.64
Both husband and wife	12.24	13.64
Total	100.0	100.0

Source: Primary data.

While living with powerlessness, women could hardly exercise control over their bodies. Reproductive rights enhanced capability in realizing their own power in order to have control over their body (Cook, Dickens and Fathalla 2003). Here, we have considered the total number of pregnancy and delivery that a particular respondent has undergone in her life as the symbol of rights exercised by women. We have tried to see whether at each time they were pregnant, (while knowing or not knowing that they were HIV) women took the decision for the pregnancy, or somebody else decided. Moreover, if women had delivered babies after their detection of HIV/AIDS, it became important to see whether deliveries were made after the consent of a woman or not. Table 5 explains decision making of pregnancy for women during their life (till the interview date). In this context of realization of reproductive rights, two ideal decision-making situations might persist. Firstly, a situation when both men and women participate in taking decisions. Second, where women herself steers her choice relating to her own body. It is found that husbands in both the states have high authority to decide about the pregnancy as against the sole or shared right of respondents. However, husbands were involved less number of times in the decision making of pregnancy in

West Bengal (46.85 per cent) as compared to Karnataka 53.85 per cent. While deciding about the child, woman's opinion was generally not taken into account. In these cases, women were treated merely as a means to end. In West Bengal, around 23 per cent of the women had taken decision relating to pregnancy either solely or together with their husbands, whereas in Karnataka it was merely 11 per cent.

**Table 5: Identification of Reproductive Rights through Decision Making on Pregnancy in Karnataka and West Bengal**

Person decided	Karnataka	West Bengal
	Per cent	
Not Applicable	8.55	4.50
Husband decided	53.85	46.85
In-Laws decided	12.82	15.32
Respondent decided	5.13	5.41
Parents decided	1.71	0.90
Both Decided	5.98	17.12
Unplanned	11.97	9.91
Total	100.0	100.0

Source : Primary data.

Note : Both the husband and in-laws have taken the decision together is 13 times in Karnataka and 8 times in West Bengal.

Control over the body by female could ensure them good health and greater power. While looking at the emerging rights aimed at enabling women's capacity to decide over their bodies, we came to realize from our field experience that neither women had realized their capacity through the exercise of rights nor had they been able to control their body. This shows how reproductive activities were socially constructed (Petchesky and Judd 1998). Thus, they had remained less powerful in comparison with their male partners. While performing two major roles desired by men, i.e, production (labor rendered towards

household management) and reproduction, women were mostly abandoned in decision-making. They remained vulnerable and were treated merely as objects. In this context, there is a need to see how women's body had been used in the context of sexuality, and whether such construction of female body (sexuality) has also made them vulnerable towards HIV.

#### **4. Women's Sexuality and Vulnerability towards HIV**

An imaginary perfect woman was constructed socially and culturally to fulfill three major desirable roles. The 'desirable' was the imaginary determinant (as a measure) for calculating the extent of the role needs to be played by the real women. Men constructed this imaginary quantification of women's roles, where women's body was compelled to perform differently in diverse roles. As a labor (production function) she needed to be a strong body, as a reproductive body, she was required to be tolerant and caring and finally women's body was to perform sexuality, where it was necessary to be submissive and passive in the way that men's ego (as better performer) did not get hurt. Thus, the idea of desirable female sexuality was constructed in the societies in a way that it had made women's body susceptible for oppression, sexually transmitted infections and diseases. In addition to the image, the discourse of sexuality had been built, in the manner that it maintained the status quo of the female sexuality. The control of women's sexuality and reproduction was at the heart of gender relations, and was central to the denial of equality and self-determination to women (Sen et al, 2002).

Social construction of sexuality retains the structure of patriarchal power in tact. While drawing instances from the India, women's sexuality is imagined to be silent and submissive. A "culture of silence" surrounding sex in Indian society demands, "good women" to be ignorant about the sexuality discourse and to be passive in sexual interactions. This cultural determination makes it difficult for women to understand their own body and sexuality. It increases their helplessness to understand and inform others about any problem relating to sexuality like STD or

HIV/AIDS transmission ([www.unescap.org](http://www.unescap.org)). Women become more vulnerable when they become subject to oppressive sexuality of their partner in their family. Given the particular socio cultural context of patriarchy, it is essential to visualize as to who has the power in the arena of sexuality and who is subjugated. It is necessary to analyze particularly when such powerlessness and subjugation of female sexuality lead to serious health implications of HIV/AIDS. While bringing the issue of power imbalance between men and women on the basis of sexuality, we may argue against Foucault (1990). He stated "We must not look for who has power in order of sexuality (men, adults, doctors) and who is deprived of (women, adolescents, children, patients) who has right to know and who is forced to be ignorant...". Further, he mentioned that the law of sex operates in a binary term of 'illicit and licit', 'permitted and forbidden', and law provides legitimacy to licit as well as permitted sex. However, he has not gone beyond a limit to say how even within the 'permitted' space of sexuality, females are dictated by male sexuality. Sandra Bartky (1990) criticized Foucault for failing to notice that even disciplinary practices that regulate bodily movement, that were gendered, which also made women's body more docile. In a constant process, the power of the male sexuality was established over female even without proper resistance. Such a situation might be conducive in making women subject to bad social, mental and physical health. In a patriarchal society, it is mostly men's pleasure, which is materialized even at the cost of women's discontent. Thus, it is vital to analyze how the process of power relationship operates through sexuality, within the marital relationship.

Even in extreme cases within the aggressive sexuality women suffer a lot. In this context, it is difficult to agree with Foucault's interpretation that 'sex is pleasure seeking', as he has used it both as a goal and as an end. In a patriarchal society, sex is often used as a means by the powerful to seek pleasure and it is also used as a means to punish the second sex. During riots or even during wars, women usually have become victims of group repression (Kay 2002). During

these times, the powerful group gets pleasure by punishing women through sexual repression. Even within the permitted sphere of sexuality, women are subjugated or punished. The incidence of violent sex within marital relationship (marital rape) without the consent of women is nothing but punishment to her denial. Such repression uses women's body merely as a sex object and makes it susceptible to infection. When oppressive man's sexuality simultaneously operates within the marital relationship as well as outside it, the chance of sexual health hazards for women increases.

The discourse of sexuality is a hidden one where not only relationships but also the discourse (language, knowledge, action) are dealt with silence to such an extent that there is the projection of non-existence of it in the society (Foucault 1990). It has been a prohibited discourse for women than for men. When the state power enforces some sanction to the arena of sexuality and its discourse, it further drives women away from the discourse. By doing so, paradoxically, the state legitimizes the silence and the suppression that women face within the legitimate and illegitimate arena of sexuality. The patriarchal norms expect women to be ignorant about the discourse and it also projects a submissive picture of women's sexuality. So, a majority of the women remain ignorant of it, as it is believed that ignorant and submissive female sexuality is pure. The expected norm of virginity for unmarried women in many societies limits the ability of women to seek information on HIV/AIDS, for fear of being perceived as being sexually active ([www.unescap.org](http://www.unescap.org)). Therefore, women prefer to be ignorant about sexuality as well as the diseases associated with it.

#### **4.1 Women's Sexuality and HIV in Indian Society**

In Indian society, women's sexuality is legitimized under a married relationship. Her purity is determined by getting married to a man who, in turn, becomes the sole master of her body and protects her chastity (Ramasubban 1998). In such situations, women's sexuality is determined by her husband's desire and reproduction. Within the so-called legitimate relationship, when the man's behaviour becomes repressive and violent,

he is hardly questioned by anyone in the society. In such cases, the repressive man's sexuality is legitimized with the indifferent societal attitude to man's behaviour. The strong social norms do not allow women to look beyond their marital relationship. At the same time, the same culture maintains apathy towards men who engage in extra or pre-marital relationship. Even when some men maintain extra marital relationship, it is the sexuality of their wives, which is often blamed for not having the charm of keeping the relationship united. In such cases women hardly have any rights but are merely treated as sex objects.

Table 6 shows how respondent's husband treated and suppressed women in both the states. In Karnataka 49 per cent husbands had forceful and dominant relationship with their (respondent) spouses as against 45 per cent in West Bengal. Around 34 per cent of the cases in Karnataka and 41 per cent in West Bengal, behavior of husband was found to be cooperative. All other relationships were basically based on violent and physical coercion. In spite of such unhealthy relationships, no woman had reacted against it before the HIV detection. It is interesting to note that in West Bengal, women (respondent) had better marital relationship in terms of cooperation, less violence, and less forceful/dominance relationship as compared to Karnataka. The multiple responses depicted a much more violent relationship of the respondent with their husbands. For instance, a respondent who witnessed a forceful, dominant and violent husband faced much trouble than a respondent facing a forceful and dominant husband. In West Bengal, 2 husbands were forceful, dominant and violent whereas in Karnataka their number was 10. In addition, it was found that in West Bengal, 5 husbands were forceful and violent while in Karnataka they were more i.e, 8.

**Table 6: Sexual Behavior of Husbands Towards Women in West Bengal and Karnataka**

States	Karnataka	West Bengal
<b>Opinion</b>	<b>Percent</b>	
Force and Dominant	49.11	45.10
Violent	16.96	13.73
Cooperative	33.93	41.18
Total opinion	100.00	100.00

Source: Primary data.

There are groups of women who are considered as sex workers where they project themselves as sexual objects, but face problems in determining their right over their sexuality and body. After being infected with HIV, women face discrimination from many sides. In the context of HIV, as heterosexual caused diseases we hardly found any woman who was responsible for the spread HIV to her partners and outsiders. Violent and forceful sex in a marital relationship made women completely subjugated. It became extremely difficult for them to break the silence and complain against it in public. A case study of Taslima Banu (given below) shows how her husband forcefully and knowingly infected her with HIV.

**A Case Study of Taslima Banu, a 26-year-old Widow (name changed)**

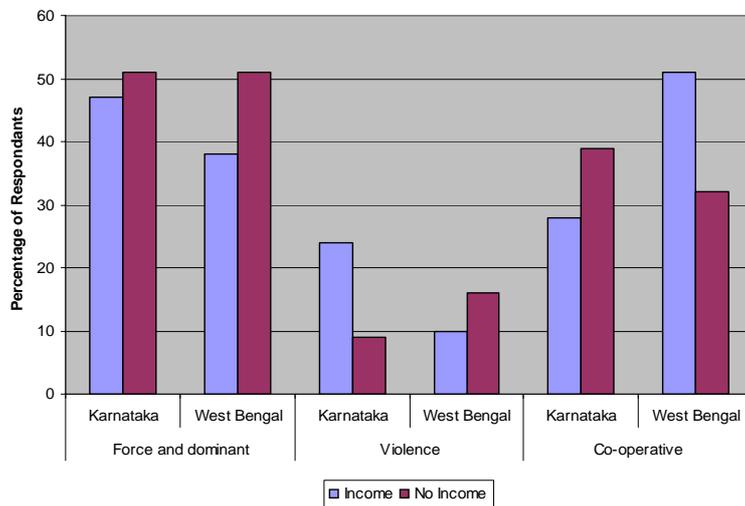
Taslima Banu is a 26-year-old widow whose husband died in 2006 due to AIDS. She has been staying in Kolkata, with her brother and sister-in-law. After her husband's death she started zari work, and is earning Rs 600 rupees per month. She stays in one room given by her brother-in-law. She has a 7 year old child, a daughter. She says Rs 600 per month is too inadequate to meet the basic amenities and to maintain the health of herself and her HIV negative daughter. She has no proper living and above all she is being discriminated by her sister-in-law, who does not even touch her and her daughter.

For all her drudgery, she blames her husband and she curses him, after his death. She said that her husband infected her consciously and forcefully. Her husband was a migrant labourer and used to do jewelry work in Mumbai for some years. During that period she was staying with her husband (she thinks that her husband had some extra-marital affair when they were in Mumbai). However, after staying for a few years both of them came back to Kolkata, to settle down in their native place. After coming from Mumbai, her husband underwent some check ups in the hospital. But he didn't disclose the kind of diseases diagnosed in the hospital. However, at that time Taslima didn't bother much but subsequently she got infected with STD and started having other problems. She requested her husband to use condom but her husband didn't bother about it. Rather, he used to beat her and used to do forceful and violent sex while saying "mein to marjaunga tu jeeke kya karegi." (If 'I will die what you will do after my death' which means that her husband considers Taslima's life as meaningless without him') She said it was very difficult for her to bear all the torture but she didn't know what to do. She thought that it was shameful to share these moments with her brother-in-law or sister-in-law. For so many months she could not reveal<sup>xiii</sup> her problem to anybody. But her husband's health deteriorated. The doctor revealed that he had HIV and instructed them to use condom. Afterward, she vehemently denied keeping any relationship with him, at least without condom. Her husband as usual didn't listen to her plea and raped her. This is an example of a powerless woman being bounded with cultural norms was forced that led to HIV infection, by her husband. She couldn't protect herself from infection, as initially she could not understand how to react against a forcible violence sexuality of her husband. She thought it was shameful to disclose such a private affair. She couldn't disclose this also because she was anticipating fear of getting the blame of being a bad wife. Moreover, she didn't know that she had the right to determine her sexuality. "Culture of silence" also stigmatizes women seeking treatment for sexually transmitted infections and HIV in some cases.

#### 4.2 Respondents' Income and Marital Relationship

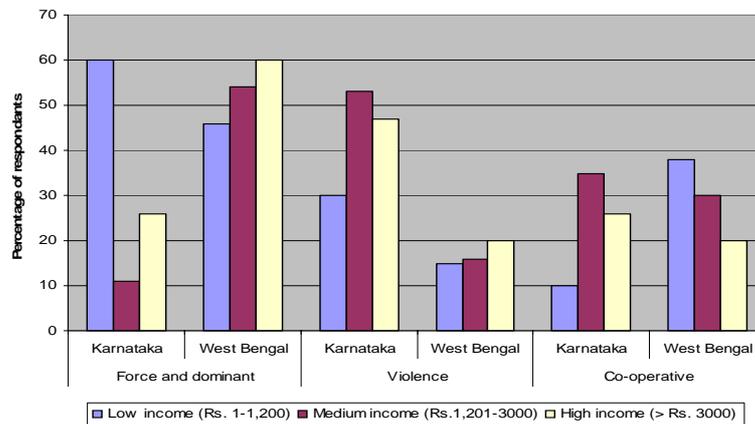
Economic condition is one of the most vital determinants of human relationship. It not only establishes the class factor but also decides the social status of the individual. It acts as an equalizer in providing economic independence to a woman on her path of progress. It is generally believed, even if it is not universally true that with the increase in the economic level, women's position or power improves. In literature one can find reference to enhancement of economic capability as the harbinger of women's empowerment. In our study, we have tried to see how far the economic condition has impacted on the life of women. We hypothesize that with the increase in economic power, women might get better bargaining power in the family and might face forceful and violent free marital relationship. More specifically, we want to see how far the status of economic empowerment of women constrains them in exercising rights towards decision-making or facilitate them in having control over their body

Figure 1: Economic Status and Marital Relationship of HIV positive women in Karnataka and West Bengal



In figure 1 we have classified the respondents on the basis of their income status, i.e., earning income and not earning income and in figure 2, we classified the income earning HIV positive women on the basis of their levels of income. In figure 2, it is quite visible that the change in the status of respondents in terms of income draws more cooperation in marital life in West Bengal (51%), whereas this is not the case in Karnataka, where women with no income are getting cooperation. The reason behind non-economic group facing cooperative sexuality might be that high societal importance attached to the submissive nature of women who address all the needs of husbands or home than earning income. Or else this might be due to their lack of knowledge about rights relating to sexuality as many women in this state have also disclosed that sex is husband's right. However, in contradiction to the general belief not much change has been noticed in terms of impact of higher earning with cooperative marital relationship in either state. Rather, it is the low-income group that gets higher cooperation in West Bengal. Many women in West Bengal, from low-income group, who might have better personality balance (personally women may be little reactive and prefer to question) and more knowledge about other rights that in turn have helped them to get cooperation.

**Figure 2: Levels of Income and Marital Relationship**



Note: Number of low-income women in Karnataka were 14 and 24 in WB, medium income women were 20 in Karnataka and 18 in WB, and high-income earning women in Karnataka were 8 and in WB 3 in number.

## **5. Resistance by HIV Positive Women against Patriarchy**

Whenever any individual becomes subjected to power, it is believed that they often resist in one-way or other. When women came to know that they have infected with HIV through their husbands (in a majority of the cases), it was generally believed that they might have raised their voice against husbands and in many cases they might have left them. Here, we have tried to see whether women after being infected with HIV had realized their own powerless condition in the family and if so had they resisted<sup>xiv</sup> against it. When husbands remain one of the major sources of infection for women (70%), it was surprising that only a few of them had shown any kind of resistance. There were several reasons to it. Some women came to know about their husband's HIV status in the last days of their husband's life so they forgave their husbands (who had infected her with the dreadful diseases). We also realized that some HIV positive wives are still committed and have forgiven their husband' and now they are much more committed to them as they now think of their husband's health as more important than their own health. One possible explanation for their non-resistant behavior is that they were not aware of their previous and current subjugation. At the same time, there were another group of women who didn't recognize that they were suppressed or mistreated. They still don't believe that their husbands were responsible for their ill health and drudgery. These groups of women didn't know how to react to an oppressive sexuality, if they had ever faced it. Table 7 shows women's opinion about sex, which also indicates their knowledge about their rights relating to sexuality. It is understood that women were subjugated due to lack of awareness, fear of loss of survival and social status, as they expressed their opinion that they didn't have any other option except for accepting a dominant and forceful husband. In Karnataka 39 per cent of women vis a vis 27 per cent in West Bengal straightway disclosed that sex is husband's right". In all these cases, women had been playing a submissive role so far as sexuality was concerned. They were and are still obedient to their husbands. They think that HIV is nothing but a misfortune. So they neither accuse their husband nor resisted them.

They were so engrossed with the socio-cultural construction of the sexuality that they could not think of an alternative to their position. These women also said (after getting counseling) that 'sex with husband lead to HIV'. This reflects their ignorance on the discourse on sexuality and 'diseases' was high. Most interestingly, when we asked women that how a woman should react to her coercive violent husbands' behaviour only a few stated that they should resist, protest and if necessary could move to court (5 in West Bengal and 3 in Karnataka).

**Table 7: Women's Opinion on Sex in West Bengal and Karnataka**

States	West Bengal	Karnataka
<b>Opinion on sex</b>	<b>Percent</b>	
Sex is husband's right	27.0	39.0
No way but to accept it	48.0	31.0
No force with consent	22.0	30.0
Not revealed	3.0	0.0
Total	100.0	100.0

Source: Primary data

In very few cases (5 cases in West Bengal and two cases in Karnataka) women had resisted vehemently and had left their husbands while retaining their property right with themselves. In a few cases, women had been empowered to understand their rights and power they were supposed to have. Thus, by retaining the rights, these women had started exercising their power in decision-making in their households, they might be a few in number but they had started bargaining with their husbands. Now a majority of women at different stages are surviving not to face death but to live a fulfilling life and meet up to the responsibilities. A majority of them surprisingly have the 'will to live' even after being infected with HIV. However, their life after HIV has not been easy to live when at many stages of their life they either compromise or resist to live.

## **6. Conclusions**

Control over the body by females provides them greater power, which in turn ensures them good health. While emerging rights aim at enabling women's capacity to decide over the body, we have come to realize from our field experience that a majority of the women neither had realized their capacity nor had exercised their rights. As a result, a majority of them had not been able to challenge the objectification of body while having control over their body. Thus, most of them had remained less powerful in comparison to their male partners. While performing two major roles desired by men i.e. production and reproduction, women were mostly excluded in decision-making. A majority of them remained vulnerable and were treated not less than desire mitigating objects or treated as a means to some end. As far sexuality was concerned, women's condition was much more dismal as a large chunk of women faced forceful and violent sex. But due to the socio cultural construction of sexuality, a majority of the women even didn't come to know that they were suppressed and needed to resist. Such powerlessness was generally conducive to making women, subject to bad social, mental and physical health. Moreover, cultures of silence and submissive women's sexuality had, in turn, made them vulnerable towards HIV/AIDS.

## **Appendix**

### **1. Method of Sampling**

The universe of HIV/AIDS is either taken as an estimated number or it is often referred as the detected case. When most men and women have not gone for HIV test, the universe of HIV/AIDS has remained a mystery to all. In such situation, detected cases can not clearly convey the generalization. Several factors limit the sample: the issue of confidentiality due to stigma attached to it, doctor's (mainly private) unwillingness to represent the HIV patients, and so on. Because of these factors, my study may reveal unexplored and in the process the study will only be limited. It may not be applicable to larger universe of

the HIV affected people, for there remain a lot more unknown factors and processes than the ones that have been made known through the study. Moreover, no one knows the full extent of the universe nor the varied social characteristics of such universe. The sample in this study can at best serve only as a broad indicator of the nature of relationship that are emerging in the context of women's health rights and the role of the state and civil society.

Since it is extremely difficult to interview HIV positive man or woman within the family, as the matter of confidentiality is attached with it, we have extracted our samples from institutions. We first identified all the Institutions and collected the list of hospitals i.e , government and non-government that provide treatment to HIV positive people. Using lottery method, we selected three government hospitals and two non-government institutions. Following which, the selection of the respondents was done randomly from these centers. We prepared list of women patients enrolled in the hospital out of which we selected every 10th patient. We have ensured at least 100 samples from each state that led to aggregate of more than 200 respondents.

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## End Notes

<sup>i</sup> Language plays an important role where it simply doesn't record the worldview but also provides a perspective to the world (Barry 2004).

<sup>ii</sup> Here, a woman in reality becomes the other and the imaginary woman is the prime body.

<sup>iii</sup> In the present capitalist society, Indian women are not lagging behind in imitating the western ideas of beautification of the body. What is peculiar about both the Western women and those elsewhere is the claim that they are exercising their rights of choice through beautification. However, when it concerns their household affairs, they are yet to exercise their choices of action. In other words, women seem to be much more prone to be 'modern' with their body looks than with their roles and agency. In either case, that is, with imitation in one dimension and refusing or slow to be imitating in another, they seem to be subjecting themselves to the masculine power.

<sup>iv</sup> Heterosexual hegemony was found in Butler's book on *Body that Matter*. Here, the word means that in a heterosexual relationship man is considered to be powerful as against the female.

<sup>v</sup> Foucault (1990) believes that where there is power, there has given rise to resistance against such power. He has used the concept of resistance in a different context (one can see *Discipline and Punish* and *The History of Sexuality*). Here, we meant, resistance as revolt or reaction against the masculine and patriarchal power.

<sup>vi</sup> Women's subordination is extended due to already existing structural inequalities (Waterberg 1990). Thus, the agency's consciousness without action operates as a false consciousness (not in the Marxian sense but about women who have never realized how even under the dominant patriarchal ideology, there is a possibility of change). However, it is not always necessary for power to operate without resistance, particularly, when the oppression is so intrinsic in a patriarchal society, where women who have internalize their subordination hardly realize that they are oppressed (Fraser, 1989).

<sup>vii</sup> It is estimated that over 35 per cent of all reported HIV infections in India occur among young people from the age group of 15-29 years age. For more details see (Santhya and Jejeebhoy 2007)

<sup>viii</sup> Irresponsible husbands neglected women's opinion, demand, and didn't give money regularly for their household maintenance. They remained worried about their own lives and enjoyment (most of them were alcoholic or addicted to bad habits).

<sup>ix</sup> An unfaithful husband often used to maintain a secret life without giving any hint about it to his wife. Sometimes these unfaithful partners (as per the respondent's opinion) were not accountable to their wives for many of their actions, for instance, they used to be away from home without any knowledge of women. However, these people often didn't respect women's desire, and wish.

<sup>x</sup> When a husband's general behaviour remains dominant, he increasingly takes the household decision and the women will have no say over any matter relating to the household.

<sup>xi</sup> A cooperative husband always respects his wife's opinion. In such situations, the woman gets freedom to express her opinion and she often gets opportunity to decide over the household affairs and other related matters

<sup>xii</sup> It is a common belief that when sex workers are commodifying their sexuality, they are free to decide the conditionality in terms of use of condom. But sex workers are not a united entity, depending upon the circumstances and their socio-economic condition one can see diversity among them, There are three possible situations determining sex workers' freedom to decide the use of condom: first, where sex workers are captive under pimps and treated as a bonded labour, in that cases sex worker do not have any rights of their own as they are subjected to the customer as well as pimps order. In another situation, sex worker are independent and have bargaining power and rights. Thirdly, where independent sex workers have their rights, they face physical repression or rape from local gundas, then they become helpless. In all these cases ultimately, use of condom depend on the knowledge of sex workers about their body, sexuality, health and whim that motivated them for safer sex negotiation.

<sup>xiii</sup> Taslima, a few months before her husband's death, disclosed her drudgery to her in laws but they advised her to avoid him and also assured her some help.

<sup>xvi</sup> After being infected they faced discriminations from in-laws and the community, also faced problems from state, thus, they had resisted against several stakeholders like family, community and state.