SEXUAL BEHAVIOUR PATTERNS IN THE CONTEXT OF HIV/AIDS IN INDIA: A REVIEW

A DISSERTATION SUBMITTED TO THE
JAWAHARLAL NEHRU UNIVERSITY
IN PARTIAL FULFILMENTOF THE
REQUIREMENTSFOR THE AWARD OF
THE DEGREE OF

MASTER OF PHILOSOPHY

VISHWA DEEPAK

ENTRE FOR SOCIAL MEDICINE AND COMMUNITY HEALTH
SCHOOL OF SOCIAL SCIENCES
JAWAHARLAL NEHRU UNIVERSITY
NEW DELHI – 110067
INDIA
1998

CENTRE OF SOCIAL MEDICINE & COMMUNITY HEALTH
SCHOOL OF SOCIAL SCIENCES
JAWAHARLAL NEHRU UNIVERSITY

New Delhi-110067

CERTIFICATE

21ST July, 1998

Certified that the dissertation entitled, "*Sexual Behaviour Patterns in the Context of HIV/AIDS in India: A Review*" submitted by *Mr. Vishwa Deepak Singh* is in partial fulfillment for the award of the degree of *Master of Philosophy* of this University.

This dissertation has not been submitted for any other degree of this University and it is his own work.

We recommend that this dissertation to be placed before the examiners for evaluation.

Dr. Mohan Rao
Chairperson

Dr. Ritu Priya Mehrotra
Supervisor

Tel. : (011) 6107676, 6167557/2420, 2472 Gram : JAYENU Fax : 91 (011) 6165886, 6198234

ACKNOWLEDGEMENTS

The present study would have never been possible without the constant support and encouragement from people around me. I like to convey my sincere heartfelt gratitude and thankfulness to all those wonderful people who were with me in all my endeavours that lead to the completion of the present work.

With kind regards and respect, I would like to express my sincere gratitude to my guide Dr. Ritu Priya for shaping my understanding on the subject and providing guidance for the research.

I owe a special debt of gratitude to the faculty members of CSMCH, who had helped in developing my conception on the subject of public health.

I take this opportunity to express my sincere indebetedness to Mr. Narsh Kumar Vaid (Director, VAID's ICS) who helped me in multiple ways whenever I needed.

I would like to express my thankfulness to all the researchers, activists and victims of HIV/AIDS, whose endless efforts in stemming the spread of HIV encouraged me to accomplish the present work. I also would like to thank various Institutes and Libraries which had provided me with all the reference material that was needed for the present study.

Words fall less in expressing my profound thanks to my friends Michael, Suresh, Venkatesh, Dr. Chinkholal, Akhilesh for all their timely help and support. I must also thank Arup, Aseem, Dhruba, Srinivas and Lima who helped in shaping my dissertation to the present form.

Vishwa Deepak

CONTENTS

ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
CSW	Commercial Sex Worker
GPA	Global Programme on AIDS
HIV	Human Immunodeficiency Syndrom
ICMR	Indian Council of Medical Research
IEC	Information, Education and Communication
IMF	International Monetary Fund
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
SAP	Structural Adjustment Programme
STD	Sexually Transmitted Disease
WB	World Bank
WHO	World Health Organisation

INTRODUCTION

It was in Madras (now known as Chennai) in 1986 that HIV was detected for the first time in India. It was seen in those engaged in commercial sex work in the lower socio-economic group (Swaminathan, 1993). This was five years after, Michael Gottlieb from Los Angeles (USA) reported the first case of immunodeficiency in the year 1981.

HIV is a very clever virus. Instead of infecting any old cell in the body, it simply attacks and finishes off the body's central defence system itself, i.e., the immune system. Here too, it goes straight for the cell, which is at the hub of important functions of the immune system: the CD4+ T_{helper} lymphocytes. HIV slowly but progressively damages the CD4+ cells, thus steadily making the body susceptible and vulnerable to attack by all microbes present in the environment, i.e., the opportunist which produce opportunistic infections. In persons with a normal immune system these opportunist are of no consequences. They get destroyed before they do any harm. In a person with HIV infection on the other hand, these opportunistic infections steadily keep destroying the defenceless body of the victim until one finally succumbs to the diseases and dies. (Malaviya, 1992).

The simplest and the least confusing way to understand HIV infection is to see it as infection which proceeds along three stages. These are the prolonged asymptomatic stage; the early clinical stage; and the late clinical stage. This late clinical stage is generally referred to as AIDS (Malaviya, 1992).

HIV infection spreads through body fluids- blood, semen, vaginal/ cervical secretion (including menstrual fluid) and breast milk. Since the other body fluids or products (saliva, tears, perspiration, urine, and faeces) are completely or nearly completely free of live cells (although they may contain non-human cells, such as bacteria), HIV can not spread through them (Fan et al., 1994).

The major routes of HIV infection are blood transfusion, sexual intercourse and from the infected mother to her new born child. Sexual intercourse includes anal as well as vaginal intercourse. For blood transfusion there are more than one route. First, direct blood transfusion in case of operation, accident, pregnancy etc., second through a needle or any other operational instrument, which has once been used on someone and is again used without

disinfecting, and third, through direct contact of open wounds of two individuals. In all these cases one will contract HIV infection only when the other partner is infected.

Worldwide, sexual intercourse appears to be the major route of HIV transmission and India is no exception. Till now about 75 percent of reported AIDS cases in India have contracted HIV infection through heterosexual intercourse. So far as the magnitude of the problem of AIDS is concerned, there has been an ongoing debate and the views expressed reflect three perspectives. According to the first viewpoint AIDS in India would wreak havoc. In 1987, WHO stated that it is very difficult to predict how many people may become infected with HIV in the next five years, but the figures may be as high as 50-100 millions. Two major areas of uncertainty are Asia and South America; if AIDS epidemic should occur in Asia, an even larger number of infected persons and cases could be expected (WHO, 1987). Subscribing to the same view, the then Director-General of Indian Council of Medical Research (ICMR), Dr. A.S.Paintal, stated that "in the future the situation is certain to be extremely grave. Indeed, if we in India do what the Western countries have done so far with regard to controlling the spread of AIDS, then one can say that in due course of time (say 20 years) India will face the sort of situation that certain African countries are facing, i.e., the danger of actual extinction of the indigenous population. The masses may vanish and only the cream of society might remain" (ICMR, 1989). The World Health Organisation's (WHO) Global Programme on AIDS (GPA) had estimated that by 1991 there would be between a quarter and one million HIV-infected cases in India (NACO, 1991). Accepting to this view the former Director of ICMR Ramlingaswami called AIDS problem in India as a 'disaster' (Ramlingaswami, 1992). T.J. John, a doctor who detected the first case of HIV infection in India estimated even higher figures and declared the WHO projections as 'highly conservative' (John, 1992). This view was also subscribed by NACO (Lal et al, 1993; Lal et al, 1994 and Lal, 1994). In 1995 it was stated that India is beginning to experience a striking and disastrous increase in HIV infection (Bayer, 1995). By the turn of the century most new HIV infection in the world will probably occur in Asia and the epidemic in Asia is eventually expected to surpass that already devastating sub-Saharan Africa. India will probably have the largest number of infected persons of any single country with an estimated 5 million people (Bollinger et al, 1995). UNAIDS and WHO's combined report on the global HIV/AIDS epidemic, 1997 states that India is the country with the largest number of the HIV-infected people in the world (UNAIDS and WHO,1997). The supporters of the first view are thus, looking at the numbers of HIV-infected people in India in relation to that in other countries and not at rates. The purpose of these numbers put forward by the first

view is to generate an awakening in the minds of policy makers about the seriousness of the threat of AIDS and to impress upon them the need to take urgent action to control it. This first view about the magnitude of the AIDS problem in India was actually followed by a second view point held by minority which was soon abandoned. In 1986 at International AIDS Conference in Montreal, a higher official from ICMR declared that 'AIDS can not, will not be a problem in India because we are a traditional society, because we are unlike the decadent West, where the pill brought about a sexual revolution with promiscuity and homosexuality' (Savara, 1992).

According to a third view HIV/AIDS is a public health problem (Banerjee, 1992) in India but not to the extent to which the first view has been propagating and not a problem to be panic stricken about (Ritu Priya, 1994). As Chin (1990) has stated that the efforts made thus far by organisations like WHO and the Centre of Disease Control (USA) in estimating the size of the problem of AIDS in different countries of the world have not only been less than satisfactory, but much more ominously, sometimes questionable assumptions have been adopted to give a highly exaggerated or distorted picture of the size of the problem of AIDS (Chin,1990). Chin and Mann (1989) find it difficult to predict the long range (>10 years) dimensions of this pandemic for the reason that our knowledge of the behaviours associated with transmission of this virus, as well as the number of persons engaging in such behaviours, is incomplete and their investigation is difficult. Banerjee (1992) finds AIDS as a major challenge to the country, however he says, 'the 'estimates' flung by WHO about the future trends of the problem of AIDS in Asia, in general and India and Thailand in particular, are particularly deplorable.' AIDS is a disease that is here in India to stay, a disease likely to reach peak incidence of cases within the next few years and then to stabilise at lower levels, finally persisting as a low grade endemic in general population, with some high endemicity pockets. Even during its period of maximum incidence, the number of cases and the mortality will be similar to that of many other health problems and less than many others (Ritu Priya, 1996). Taking in account the rate of HIV spread in India the third view does not find the magnitude of the AIDS problem in India to be of the extent posed by the first view and urges to see the whole issue in the Indian context of prevailing morbidity and mortality.

Whatever the view on magnitude of the problem, all are agreed that steps must be taken to control spread of HIV. Since, according to available data about 75% of AIDS cases have contracted HIV infection through sexual transmission, it is necessary to explore the sexual behaviour patterns of the Indian population. The analysis of sexual behaviour pattern in India will help in understanding the present and future situation of the AIDS epidemic and in

devising AIDS prevention and control strategies in India.

In India, ancient Hindu literature, in Sanskrit religious texts (epics, novels and dramas) is a storehouse of sexual symbolism and eroticism. The well-known literature *Kama-Sutra*, composed by Vatsyayana over 1500 years ago, is a practical discourse on some aspects of sexuality. Erotic sculptures carved beautifully on the stone walls of Khajuraho and many other Hindu temples built in medieval India attract a large number of national and international tourists. The existence of these relics indicates a state of extraordinary openness in sexual matter, unthinkable in contemporary India as well as during the Muslim and British reigns. However, there is a lamentable lack of empirical knowledge about sexual attitudes and behaviour of men and women belonging to the variety of ethnic, cultural, religious and socio-economic groups in India both past and present (Nag,1996).

Till recently the study of sexual behaviour was an untouchable subject. The sensitivity of the subject and difficulties in data collecting discouraged most social scientist from exploring this area of human behaviour. The advent of AIDS and its spread in India has changed the scenario. Today the study of sexual behaviour is an important subject and both national and international agencies, as part of the AIDS control programme, are encouraging research on the subject (Khan et al, 1996). For AIDS control, the main activities, which have been undertaken by National AIDS Control Programme (NACP) of India are: surveillance, blood safety, condom promotion, STD treatment and IEC activity to raise awareness among people about HIV transmission and to promote behavioural change and safer sexual practices. The major focus of NACP is on the promotion of safer sexual behaviour and condom promotion through IEC activity, as HIV spreads mainly through sexual intercourse. In relation to AIDS epidemic, modification of sexual behaviour requires a deep understanding of how and why people behave the way they do. Only then can feasible and specific interventions be designed for demographically, culturally and socially diverse groups. However, obtaining accurate information about a sensitive, private and personal experience is a strong challenge (George, 1996). Given the highly conservative attitude towards sexual behaviour in India few studies have attempted to elicit information on sexual behaviour, whether outside or within marriage (Jejeebhoy,1996). While survey and other means of getting easily quantifiable data provide useful information on the prevalence of attitudes and practices of interest, they could reduce a complex social process to one dimension, namely coitus. But it is necessary to analyse the socio-cultural and economic contexts of a society's sexual behaviour pattern; otherwise it would be very difficult to say, why sexual behaviour pattern of one society is different

from the other. There are studies to reveal that there were socio-cultural and economic forces that led the people to adopt such sexual behaviour that placed them at high risk for HIV infection. It is, therefore, necessary to analyse a society's sexual behaviour pattern in the context of its socio-cultural and economic structures for planning any intervention to change sexual behaviours.

Are the strategies adopted by NACP of India enough to save people from contracting HIV infection? Does it really help in changing people's sexual behaviour? If not, what more is needed? Parker (1996), d'Cruz-Grote (1996), Decosas (1996) and Lurie et al,(1995) suggest that apart from above activities, we have to induce changes in those forces which are shaping a society's behavioural pattern, particularly sexual. It is thus, necessary to study such forces in Indian context, so that an effective policy to prevent HIV/AIDS can be framed.

It is with this general objective of reviewing studies on the sexual behaviour patterns in India in relation to the HIV/AIDS epidemic and of identifying the social basis of sexual behaviour, the following study has been undertaken.

Specific Objectives of the Study

1. To analyse the sexual behaviour patterns in India based on review of the available studies.
2. To explore the determinant factors of sexual behaviour patterns.
3. To study the implications of the Indian sexual behaviour patterns and their determinants for projecting and assessing HIV/AIDS prevalence in India.
4. To identify possible effective interventions to stem the spread of HIV infection through sexual route in light of the sexual behaviour pattern and its determinants.

Methodology Used in the Study

The following is essentially a review of literature. The source material for the first chapter on sexual behaviour patterns has been derived from the published and unpublished studies on sexual behaviour of various sections of Indian society. The second chapter on determinants of sexual behaviour and comparison of sexual behaviour of Indians with that of other countries is based on material collected from published sociological studies across the world regarding the socio-cultural and economic context of sexual behaviour and/or AIDS. The material for the later section of the same chapter was derived from published studies and reports on sexual behaviour patterns and HIV/AIDS preva-

lence in different countries. The understanding of sexual behaviour patterns developed in the previous two chapters and experiences of prevention methods for HIV/AIDS in various countries constitute the source material for the third chapter dealing with intervention methods.

Papers from conferences and workshops as well as participation of the researcher in a national workshop (Vishwa Deepak, 1997) also helped to carry out the study on the basis of the specified objectives. The studies cited in books and published articles have also served the purpose.

Chapterisation

The first Chapter reviews the studies on sexual behaviour of various sections of Indian population. The methodological limitations of these studies have been discussed in the first section of this chapter. In the later section the findings of these studies have been brought together. Basing on this an attempt has been made to sketch a broad picture of the studied populations' sexual behaviour patterns.

In the second chapter an attempt has been made to analyse different factors that determine sexual behaviour patterns in a society. In the later part of this chapter sexual behaviour patterns and HIV/AIDS prevalence rates of India have been compared with those of the industrialised western and African countries and also with those of Thailand.

In the third chapter the possible intervention methods to stem the spread of HIV through sexual route in India have been discussed. This chapter is based on the discussions undertaken in previous two chapters as well as on AIDS prevention experiences gained across various countries and by various institutions.

CHAPTER I
SEXUAL BEHAVIOUR PATTERNS: A Review of Indian Studies

Soon after the advent of HIV/AIDS in India, a need to know Indian populations' sexual behaviour pattern was felt by those who were involved in the field of public health. The major efforts in this direction were made mostly after 1990. Now, as a result of efforts made in this direction, there are studies available on the sexual behaviour pattern of various sections of Indian society. Some of these studies have been conducted by researchers from educational institutions while some of them have been conducted by governmental and non-governmental institutions involved in the control and prevention of HIV/AIDS.

Though there are studies covering various regions of the country, we can not generalise their findings due to a number of methodological reasons. At the same time there are smaller studies too, which have been conducted among specific groups of population at specific places. At state level also, this kind of studies have been undertaken. By bringing together the results of all these studies, it is possible to generate a probable picture of the sexual behaviour patterns of these sections of Indian population, comprising of the educated, upper and middle socio-economic strata, since most of these studies deal with these sections only.

An attempt has been made here to chalk out a probable picture of sexual behaviour pattern of Indian population by bringing together thirty-four studies. Out of these thirty-four studies, twenty deal with the sexual behaviour of general population and the remaining fourteen provide information regarding STD clinic attenders in different regions of the country. Thirty-one studies have directly been taken from journals and magazines in which they were published or from the reports of the institutions concerned, while the remaining three studies have been taken from Moni Nag's book (1996)- "Sexual Behaviour and Aids in India"and Shireen J. Jejeebhoy's book (1996)- "Adolescent Sexual and Reproductive Behaviour: A Review of Evidences from India."

Out of twenty studies on general population's sexual behaviour, nine studies

deal with the sexual behaviour patterns among school and college students. Two of these nine studies deal with the senior secondary school students of Delhi (Sharma et al., 1997 and Sehgal et al., 1994), while rest of the seven deal with the college and University Students. Among these nine studies, only two (Sharma and Sharma, 1994 and Goparaju, 1994) have included rural students in their sample, while the remaining six were exclusively based on urban institutions.

Other than students there is only one study which have been conducted among the youths aged between 15 and 29 years by FPAI-SECRT (1993). This study has also taken educated urban youths from 15 cities of India, but not restricted only within educational institutions.

Five out of twenty studies on general population, deal with the sexual behaviour pattern among upper and middle class of the English educated urban society. Three of these are based on magazine surveys (Savara and Sridhar, 1992; Savara and Sridhar, 1993 and Tejpal, 1994). One of these is a study to compare two methodologies for questionnaire based surveys- in one part of the survey, typed questionnaires were answered by the respondents in their houses while in another part respondents answered questionnaire in a hall, where they had been asked to gather by the researcher.

One of the twenty studies deals with the sexual behaviour of different occupational groups in three districts of Maharashtra (Savara and Sridhar, 1994). The occupational groups were students, blue-collar, white-collar, migrant and loom workers.

Two studies deal with the population of two States namely, Manipur (Sehgal and Singh, 1992) and Tamil Nadu (Sehgal and Arnold, 1994). Both these studies have included urban as well as rural populations from almost all walks of life.

Four studies deal with the sexual behaviour of truckers. One of these studies has taken only adolescent truck cleaners as its subject (Bansal, 1992), while rest of the three deal with truck drivers. This study has been done in Indore. Another study in Indore was done by the same author (Bansal, 1995) but among truck drivers. A study conducted by Rao et al, (1994) deals with 100, truck drivers, crossing Uluberia check post in West Bengal. Fourth study done by Sachar et al, (1997) does not provide any information regarding the site of their study.

Out of the fourteen studies which have been conducted among STD clinic attenders, eleven studies were conducted on those who visited STD clinic at governmental hospital and/or medical college situated in urban areas.

One study by Kaur et al, (1992) have taken those as sample who visited a reputed doctor's private STD clinic for treatment. Another study by Kanbargi and Kanbargi (1996) has taken private as well as governmental STD clinic attenders in Banglore city. Four of these studies (Jaiswal and Bhushan, 1994; Murugan et al, 1993; Parasuraman et al, 1994; and Narayan, 1984) on STD clinic attenders have taken only male STD patients into account.

In this way, since all these available studies on STD clinic attenders are institution based, they represent only that part of population, which can avail these services. A large part of population which did not visit or unable to visit these institutions for several reasons, has remained untouched.

The basic idea behind including studies on STD clinic attenders, while reviewing studies on sexual behaviour of Indian population to explore: (a) What is most probable source of STD infections, and (b) What type of behaviour these STD clinic attenders are possessing.

As it was stated earlier, that the study of sexual behaviour in India is a recent phenomenon and is in its infancy, therefore any conclusion on the basis of these studies has to be drawn very carefully. There are number of problems inherent in the conceptualisation and methodologies of these studies. These problems and, thus limitations, have to be considered before analysing and using the data provided by them.

Methodological Limitations of the Studies

The limitations of these available studies arise at various steps including:

(i) Conceptualisation of the problem,

(ii) Sampling,

(iii) Tools used for data collection, and

(iv) Analysis of data gathered.

(i) Conceptualisation of the Problem

Most of the studies on sexual behaviour of any segment of Indian population have been conducted with a specific intervention strategy in mind to prevent STD/HIV infection, i.e., behavioural change for safer sexual practices through IEC activity. With this mindset most of the studies have set their objective and methodology to be used. None of these studies attempted to understand sexual behaviour per se and then to see what intervention will be best suited to prevent STD and HIV infection.

All of these studies, with an exception of Rakesh's study (1980) provide

information only about that percentage of population, engaging in pre-marital sex, extra-marital sex, homosexuality, sex with CSWs etc. The target of intervention to prevent HIV infections was those engaging in risky sexual behaviour, therefore identifying such persons and groups became the purpose of these studies. A preliminary exploration of the nature of risky behaviours being practiced was another purpose.

None of these available studies has set its objective as generating knowledge to understand sexual behaviour of any section of a society as a whole (as if those engaged in risky sexual behaviour are isolated) and its various determinants, so that the best possible intervention strategy to prevent HIV infection may be devised.

Attempt to identify patterns of risky behaviour in terms of age at sexual initiation and also the nature and number of partners in pre- and extra-marital sexual relations had rarely been made by researchers in this sensitive field. The number of new sexual partners per year (partner frequency) is a key factor in the spread of sexually transmitted diseases. Correlates of high partner frequency were being single, young and male having an early sexual debut (Stigum et al., 1997). It is therefore, important to know the age at which maximum number of boys and girls, either willingly or coercively, initiate their sexual life. At the same time, it is also necessary to know the nature of partner, especially when we are talking in the context of HIV/AIDS. If both the partners are steady and not involved in sexual relations with anybody else or if both are virgin, then there is no chance of contracting HIV infection, no matter even if it is pre-marital sexual relation. But if the partner is a CSW or involving in sexual relations with more than one man or woman then there is a potential risk of contracting STD/HIV infection. It is therefore, equally important to know who are the most probable partners in pre- and/or extra-marital sexual relations. Very few studies, however, attempted to explore these two sensitive issues.

Another equally significant issue that has been neglected by almost all studies is of the conditions or factors, which lead a male or female to get involved in pre- and extra-marital sexual relations or in unsafe sex. These all has seldom become the subject of studies on the sexual behaviour patterns in the Indian population.

(ii) Sampling

Generalisability and applicability of the findings of a population based study largely depends upon the sampling method used in it. If the samples are not representative of the population, a study's findings cannot be true for that population. For being representative, the first necessity is proportionate repre-

sentation of all sections of society in the sample taken for study. However, this fact has hitherto been neglected in almost all of these studies. This is a major problem with the studies claiming to represent the sexual behaviour pattern even among a particular group of a society.

The studies conducted in Manipur (Sehgal and Singh, 1992) and in Tamil Nadu (Seghal and Arnold, 1994) have taken their samples from almost all sections of the society. But, the proportions of different sections in the sample are not representative of society at large.

Most of the studies have been conducted among educated urban upper and middle class population. Some studies, which have taken rural population, have not taken a proportionate sample and do not provide information regarding their sexual behaviour, separately. These studies have mixed it with that of the urban samples.

Though, most of the studies have been conducted among urban population, they cannot even be called representative of urban populations' sexual behaviour. Since all these studies have used self-administered questionnaire in English language, only that part of population has participated which could read, write and understand English language. This particular English educated part always constitute upper and middle class of the Indian society and represent a small section. FPAI-SECRT (1993) in their study, have translated the questionnaire into regional languages also, to make their study more representative. But as their samples are not random, the study remains unrepresentative. The respondents of this study were the youths of college campus, youth group meetings and at workshop/seminars and were contacted on the basis of their availability and the willingness to respond. A study conducted by Basu (1994) with an aim to find out appropriate methodologies for studying sexual behaviour in India, has also got this problem of unrepresentativeness, as its samples were from upper and middle-class urban English educated group and who were willing to participate.

The studies on STD patients are urban-clinic based, therefore they are not representative of all STD patients of India. In all these studies the number of female sample is very less and in none of these, has gone beyond 13 % (with an exception of a study by Chopra et al., 1990). In fact, a very small proportion of Indian society approaches governmental STD clinics. There are many reasons behind it, some of these reasons are: (a) Asymptomatic nature of many STD's, specially in females because of which patient does not seek treatment (Kanbargi and Kanbargi, 1994) (b) Social stigma attached to STD's, prevent many people to visit STD clinics. Since a person with STD is considered promiscuous, most of the people actually do not go to the clinics specially meant for it or where

they are not 'safe'. (c) The lowered rapport of Governmental health services itself is also responsible for preventing a large section of population to visit them, and (d) The accessibility and affordability of STD clinics for a significant part of population is another major barrier which keep them away from it, even if they seek treatment. Thus, the studies that have been conducted among STD clinic attenders are representative of only very small section of STD patients, mainly living in and around urban centres and who can avail facilities provided at Governmental and/or private institutions.

Overall, even for the particular sections that have been studied, the samples (that have been taken by all these studies) are not representative, as they have not been selected on any systematic basis in most of the studies.

(iii) Tools used for data Collection

It is the appropriateness and sensitivity of tools and their mode of application, which determine the reliability, and validity of data gathered. Sex even in general is an intensely personal matter about which people do not speak readily. The situation becomes more difficult when an individual's personal life is under question. Societal pressure largely determines individual behaviour and value system. But it was found that intensity varied with the social class. The Victorian closed mind attitude to sex seems to affect the educated middle class the most. The middle class, especially the women from this class, suffers from sense of guilt and therefore may be expected to understate their sexual behaviour. One must also add that in this class, sexual freedom as in the western model is absent and therefore the fear of disclosure becomes a strong deterrent for discussing the issue freely and frankly. On the other hand, lack of sexual opportunity induces a 'deprivation syndrome' which many a time, leads to sexual fantasy and over statement of sexual experience (Basu, 1994). We, therefore, need very sensitive and sophisticated tools for data collection regarding sexual behaviour of people, which can maximise the reliability of gathered data.

Most of the studies (reviewed here) have used self-administered questionnaires for collecting data, which confines them only among educated class. Since, most of the studies have used questionnaires in English they did not cover all educated people but only English educated. Even a study conducted by Basu (1994), that claims to have devised appropriate methodology for studying sexual behaviour has the same limitation. It is also based on self-administered questionnaire in English. It is clear that self-administered questionnaire method generates a very biased sample and therefore the result too. Though this method provides greater level of confidentiality to the respondents, possibility of overstatement and/or understatement can not be ruled out.

The confidentiality and privacy desired by the respondents is provided by self-administered questionnaire even though the response rate in most of these studies is considerably low. Savara and Sridhar's study (1992) had only 1424 respondents, 1665 in Tejpal's study (1996) and 383 in Savara and Sridhar's (1993) study. These three studies are based on surveys conducted through widely circulated magazines and news-papers. Similarly the studies conducted by Reddy et al.(1983) in Madras, FPAI-SECRT (1993) in 15 cities of India etc., also show considerably low response rate. On one hand the low response rate shows the conservative and closed mind attitude towards sex among public while on the other hand it raise a question about who the respondents are. According to a psychologist Lewis Terman, the male respondents who took part in Kinsey's survey on sexual behaviour (1948) were anywhere from two to four times more active sexually than the people who did not volunteer (Wildovsky, 1997). Same may not be completely true in India but one have to accept that people who volunteered for magazine survey or participate in direct surveys have had more permissive sexual attitude and behaviour. As these people do not represent the whole population, the problem of overrepresentation of those engaging in risky behaviour occurs.

Another problem with self-administered questionnaire method (especially when used in direct surveys) is that the respondent has to answer all the questions within a given time. So, there is every possibility that respondent may leave some questions unanswered, specially those which need information regarding past life or those which need answers for cross checking. None of the available studies reveal the fact regarding how many respondents actually answered all the questions and/or what type of questions remained unanswered. Moreover, peer influence while answering self-administered questionnaire can also be not ruled out.

Next problem is that with the language of the questionnaire used, either as self-administered or as interview schedule. There is every possibility that a respondent may understand some (or all) terminology in a sense entirely different from which the researcher had used them. None of the available studies explain how valid the responses are which they have collected, in this regard. For example, in FPAI-SECRT (1993) study, it was reported that 33.7% males and 11.8% females have experienced 'sexual contact'. Further, when the question regarding the nature of sexual contact had been put forth, it was found that only 18.9% males and 5.8% females actually have had 'sexual intercourse'. As its a usual practice that there are code languages used by a group or section, to communicate sexual matter it is very much possible that the terms used by a researcher, may be taken in some other sense by the respond-

ents. This will definitely affect the findings of a study. This problem is more serious since a code language used among one group may differ from other group of the same society. No study other than FPAI-SECRT (1993) says that whether they have explained the terms in their questionnaires to the respondents or not. This fact poses a major limitation on the finding of these studies.

Another approach for data collection, i.e., face to face interview method was also used by three studies, which are Sehgal and Singh (1992), Sehgal and Arnold (1994) and Savara and Sridhar (1994). Some of the problems with self-administered questionnaire method are more evident here. The first and major problem is the representativeness of the respondents themselves. Of course, the people who have answered the questions orally are more permissive in their sexual attitude and behaviour, even more than those who answered self-administered questionnaires. Since in face to face interview the people's confidentiality and anonymity are more in danger, they seek an interviewer upon whom they can trust. This definitely needs a well-reputed interviewer. It is no doubt a time taking process. How these three studies made it possible, have not been explained. Apart from these two above, the problem of different meaning of terms derived by respondents, becomes more difficult in face to face interview method. In questionnaire method there was at least a scope to explain each and every term in written but in the interview method, the chances to explain the meaning of terms used, are very less as well as embarrassing.

Overall, the tools used in the available studies for data collection have a number of inherent problems, which can be avoided by taking necessary precautions. But none of the available studies talk about these problems, which pose a major limitation on the finding of these studies.

(iv) Analysis of Data

Analysis of data is a crucial part of any scientific study, since it directs the conclusion of the study. Further, it also affects the recommendation (if any) made on the basis of the findings of the study. The way in which a researcher analyses the data collected, is largely influenced by the conceptualisation of the problem. As it has been discussed in an earlier section, most of the studies focussed attention on the percentage and section of population practising risky sexual behaviour. None of these studies have given any importance to the methodological problems outlined above, in the analysis part of their study. No study have discussed the reliability of the data collected or their generalisability. Sometimes they have exaggerated the facts and given a conclusion that can not be drawn, on the basis of responses to the questions posed from the respondents. For instance, a study by Sengupta et al,(1996) among school and college

students in Delhi have asked the following questions:

(a) Is AIDS threat real in India?

(b) What is the most common route of HIV transmission?

(c) Do you think sexual activity among the college students is common/ uncommon/rare?

(d) Do you think homosexual activity is common among college going adolescents?

(e) Do you think the sexual involvement between two people is knowing each other/physical expression of love/just a biological need/not related to love/part of fun of student life.

(f) Do you think increased sexual activity among the college students is a progressive young generation/a cultural revolution/deteriorating social values/a broad minded society/freedom of thought and action/westernisation.

(g) Is there anything common between STDs and AIDS?

Based on the answers of above questions the conclusion drawn by the authors were (a) A noteworthy percentage of school/college going youth is sexually active and is thus at a potential risk of contracting STD and HIV infection. (b) Suitable strategies need to be evolved to assess STD prevalence rate among the adolescent youth. (c) Suitable strategies need to be evolved to make STD detection and treatment facilities accessible to them under assured confidentiality.

Another study done by Savara and Sridhar (1994) among different occupational groups in three districts of Maharashtra have used two different methods for data collection. For those who can read and write, the self-administered questionnaire was used while for illiterate the interview method was used. Since these two methods can generate different kinds of data, it is necessary to explain these differences at first. But this study has mixed both data without explaining the differences between them and analysed. As discussed above, two different methods generate different kind of samples and therefore responses (data) too. Here from itself rise two different categories, one literate and another illiterate whose responses can not be mixed, since they form two different sections of a society. Moreover, its a matter of separate analysis. Further, this study does not provide any information if it has taken any measure to maintain the similarity in the responses collected from the two methods. Neither it gives any reason for mixing the data gathered from two different methods.

A study by Sehgal and Arnold (1994) in Tamilnadu is an example of another

kind of error. First, this study has taken disproportionate sample and moreover it is written in its report itself that "as such this study is not strictly population based survey, for, the target number is definitely known and the high risk groups are a mobile population without any permanent known habitation. As such the only way was to select a convenient or purposive sample of the size appropriate according to available time and resources in hand." But while talking about intervention strategies, the same report says that "the KABP (Knowledge, Attitude, Behaviour and Practices) Study shows that all risk behaviour which promote spread of HIV are present in the study area of Tamil Nadu. The study showed prevalence of high promiscuity and extremely low condom usage." And on this basis the study have recommended multipronged prevention programme for Tamil Nadu. Here, it seem that the authors of this study have forgotten while drawing the conclusion, the limitations posed by the quality and proportion of samples.

In spite of all these limitations, due to the following facts, these studies on sexual behaviour of general population and on STD clinic attenders have been reviewed here:

1. Though these studies do not provide an in-depth view of sexual behaviour of Indian population, some of them essentially inform us about various kinds of sexual practices existing in our society.
2. These studies provide us information regarding the rough, probable proportion of population engaging, either willingly or forcibly in different kind of pre-marital and/or extra-marital sexual relations.
3. Some of these studies also provide us information regarding the nature of sexual partner, which help us to analyse how risky the sexual practices are, of those identified as engaging in sexual relations outside marriage setting.
4. Studies on STD clinic attenders provide us information regarding the kind of people approaching various STD clinics for treatment and about their socio-economic background. These studies also provide information regarding the most probable sources of STD infections (at least in people who visit STD clinics). This may be helpful in explaining the most probable routes of STD and HIV infection in general population.
5. With all their serious methodological problems, these studies provide at least a starting point for further studies on this subject, especially epidemiological and sociological studies on related aspect of sex.

There are many investigations that show the relationship between promiscuity and venereal diseases (Sutherland, 1950). In India also, we have a long

history of venereal diseases. In the duration of five years (from 1986 to 1990) total 6,405,102 patients of STDs have been seen in governmental hospitals (Min.H.F.W, 1994), which is actually a tip of the iceberg. This figure is enough to reveal the existence of 'promiscuity' in India. In Indian context, promiscuity may be defined as any sexual relationship outside marriage setting, since in most sections of the Indian population sexual relations are supposed to occur only within marriage setting. It is, therefore, easier to find out the level of 'promiscuity' in India in terms of pre- and extra-marital sexual relations. These relations also play a major role in carrying HIV infection to the monogamous population. It would, therefore, be better to understand the level of sexual relationships outside marriage setting among different groups of population. Table-1.1 gives us an overview of the studies that have been reviewed. The analysis has been discussed under the following headings: (1) Pre-marital sex, (2) Extra-marital sex, (3) Sex with commercial sex workers (CSW), and (4) Homosexuality. Under above headings the behaviour of different sections of Indian population has been discussed.

Pre-marital sex

The average age of marriage for both women and men in India has been rising by about one year per decade since last few decades. In 1981, it was nearly 20 years for women and over 24 years for men. The averages are, however, lower for rural than urban areas. In urban areas, the average at present is about 21 for women and 26 for men; in rural areas it is about 19 for women and 24 for men (Nag, 1996). In most of the Indian societies, strong emphasis is placed on 'purity' and chastity before marriage which has been sanctioned by family elders. But there is always been some laxity in favour of men. Women's virginity until marriage is still greatly valued (Jejeebhoy, 1996 and Nag, 1996). As average age at marriage is increasing in India, a substantial proportion of youth is going through the long period in which sexual attraction towards the opposite sex grows. As many researchers have noted, this is also the age, when most of the adolescents, are likely to experiment sexually (Lier, 1997). Admission records from hospitals and clinics suggest that adolescent pregnancy outside marriage is increasing, particularly in urban areas (Jejeebhoy, 1996). Beside these considerable attendance of unmarried youths at STD clinics corroborate above view of sexual experimentation. Fifteen of the studies reviewed here provided either direct or indirect information about pre-marital sexual relationship among various groups.

Table - 1: An overview of the studies reviewed.

Sl. No.	Reference	Year	Place	Sample size M	F	Total	Methodology	Category of the respondents
1	Sehgal et al.	1992	Delhi	na			S.A.Q.	Adolescent school students
2	Sharma et al.	1997	Delhi	368	332	700	S.A.Q.	"
3	Rakesh	1980	Delhi		300		S.A.Q.	College girls
4	Reddy et al.	1983	Madras	634	486	1120	S.A.Q.	College students
5	Savara & Sridhar	1994	Nashik & Thane (Maharashtra)	1025			S.A.Q. & interview	College students, White & Blue Collar, Migrant and Loom workers
6	Sharma & Sharma	1995	Kheda(Gujrat)	nm			Interview	College and rural youths
7	Goparaju	1993	Hyderabad	72			S.A.Q.	College students
8	Sachdev	1997	Delhi	206	681	887	S.A.Q.	College students
9	CCM-AIIMS		Delhi	681	668	1349	S.A.Q.	College students
10	FPAI-SECRT	1993	15 major cities	1974	2735	4709	S.A.Q.	Educated youths
11	Basu	1994	3 metro cities	242	206	448	S.A.Q. in home	Urban upper/ middle educated class
				240	220	460	S.A.Q. in hall	
12	Savara & Sridhar	1992	Major cities	1424			Magazine survey	Urban upper/ middle class educated
13	Savara & Sridhar	1993	Major cities		383		"	"
14	Tejpal	1996	Major cities			1665	"	"
15	Sehgal & Singh	1992	Manipur	853	167	1020	Interview	General and high risk behaviour population
16	Sehgal & Arnold	1994	Tamil Nadu	1027	520	1547	"	"
17	Bansal	1992	Indore	210			"	Adolescent truck cleaners
18	Bansal	1995	Indore	420			"	Truck drivers
19	Sachar et al.	1997	nm	281			"	Jr.& Sr.. truck drivers
20	Rao et al.	1994	West Bengal	100			"	Truck drivers
21	Narayan	1984	Lucknow	300			"	STD clinic attenders
22	Kanbargi & Kanbargi	1996	Banglore	264	22	286	"	"
23	Bhargava et al.	1975	Delhi	878	122	1000	"	"
24	Singh et al.	1990	Allahabad	1832	90	1922	"	"
25	Siddappa et al.	1990	Davangere	393	57	450	"	"
26	Chopra et al.	1990	Patiala	350	150	500	"	"
27	Jaiswal & Bhushan	1994	Tezpur	720			"	"
28	Nigam & Mukhija	1986	Gorakhpur	652	78	730	"	"
29	Gupta et al.	1997	Rohtak	522	72	594	"	"
30	Vora et al.	1994	Ahmedabad	924	47	971	"	"
31	Chaudhari et al.	1988	Rohtak	665	29	694	"	"
32	Kaur et al.	1992	Varanasi	54	6	60	"	"
33	Murugan et al.	1993	Tirunelveli	3624			"	"
34	Parasuraman et al.	1992	Madras	2293			"	"

nm - not mentioned
S.A.Q. - self administered questionnaire

Among *school and college students and other youths*, nine studies on sexual behaviour have been conducted. A brief idea about these studies can be had from table 1.2. There were only two studies available regarding the sexual behaviour pattern among school students, aged between 15 and 19 years. Since both these studies are from Delhi only and are having limitations, nothing much can be said about the sexual behaviour patterns among school students.

Table - 1.2: Sexually experienced students and other youths.

Sl. No.	Reference	Location	Sample size M	Sample size F	Experienced sex (%) M	Experienced sex (%) F	Methodology
School students							
1	Sehgal et al, 1992	Urban	na		25		S.A.Q.
2	Sharma et al, 1997	Periurban	368	332	23.4	15.1	S.A.Q.
College students							
3	Rakesh, 1980	Urban		300		6	S.A.Q.
4	Reddy et al, 1983	Urban	634	486	61	48	S.A.Q.
5	Goparaju, 1993	Urban	72		28		S.A.Q.
6	Savara & Sridhar, 1994	Urban	129		18.9		S.A.Q.
7	Sharma & Sharma, 1995	Urban	nm		9		Interview in Gujrati
8	Sachdev, 1997	Urban	206	681	39.3	20.4	S.A.Q.
9	CCM-AIIMS	Urban	681	668	28.6	4.8	S.A.Q
Other youths							
10	FPAI-SECRT	Urban	1974	2735	18.9	5.8	S.A.Q.
11	Sharma & Sharma, 1995	Rural	nm		16		Interview in Gujrati

na - not available
nm - not mentioned
S.A.Q. - self administered questionnaire

Sehgal et al's study (1992) has been taken from Nag's (1996) and Jejeebhoy's (1996) books. In both these books, the sample size and socio-economic class of students have not been mentioned. In Sharma et al's study (1997), samples have been taken from four schools of a peri-urban area of Delhi. Two of these schools were under Municipal Corporation of Delhi (MCD), the third was Model school and the fourth was a Central school. The students were from 10 to 12th standard. Lower middle class students mostly attend MCD schools because of their low fee requirements, while central and model schools were mostly attended by middle-middle class students. Due to their differential educational standards beside socio-economic class, the samples taken from these schools cannot be matched with each other. In this condition, using questionnaire in English and then, analysing data together, poses a major limitation for this study. The authors have neglected this fact. Moreover, nature of sexual experience and partner(s), age at first experience, number and fre-

quency of sexual experiences etc. have not been mentioned. According to these two studies, about 25% of school boys are experiencing sex in various ways (as the nature of sex is not mentioned). Since there is only one study about school girls' sexual experience (Sharma et al, 1997) nothing can be said about them. Since these studies indicate that adolescents in schools are claiming sexual experiences, methodologically more sound studies are needed among them. As early sexual debut has directly been related to the frequency of sexual experiences and number of partners (Anderson, 1992), the study among adolescents in schools can be of help in finding out the contemporary conditions in which they are experiencing sex.

There were seven studies available regarding College goers, aged mostly between 17 and 25 years. Three of these studies are from Delhi. In two of these three studies the socio-economic background of students have not been mentioned (Sachdev, 1997; CCM-AIIMS). Rakesh's study (1980) is more detailed which have taken only female samples. Out of remaining four studies one each have been conducted in Kheda (Sharma and Sharma, 1995), Hyderabad (Goparaju, 1993), Madras (Reddy et al, 1983) and Nasik and Thane (Savara and Shridhar, 1994).

Out of these seven, four studies provide data regarding the proportion of female samples experiencing pre-marital sex. In Rakesh's study (1980) about 6% (19 out of 300) of female samples have experienced sexual intercourse before marriage, at least once. Most of these 6% females had it with only one male. In Sachdev's study (1997) 20.4 percent of females and in CCM-AIIMS's study 4.8 percent of girls reported having sexual experience. In both these later studies average age at sexual debut and the frequency of sexual experience have not been reported.

Another study of Reddy et al, (1984) among college girls in Madras reported that 48% of 486 have experienced sex. As 7 percent of the female samples of these studies were married, it can be assumed that a substantial minority of the female students had already experienced pre-marital sex. Since the response rate of this study was very low (about 12%) (Nag, 1996), deriving anything from this study is very difficult. The problem of low response rate besides disproportionate and non-random sampling is also attached with Sachdev's study (1997), reporting higher percentages.

Among above, considering Rakesh's (1980) and CCM-AIIMS's studies comparatively more near to the actuality (since their questionnaires were more detailed and response rate was over 80 percent) it can be said that about 5 to 6 percent of urban college going girls in Delhi who are mostly belonging to upper

and middle-middle classes of society, are experiencing sex before marriage. Since, the nature of partner and frequency of sexual experiences has not been mentioned in any of these studies, nothing can be said about the risk of HIV infection carried by these minor percentage of sexually experienced unmarried girls.

It is very interesting to note that the percentage of female college students who are sexually experienced reported by Rakesh (1980) and CCM-AIIMS (6 and 4.8 percent respectively) in Delhi is far less than that, reported for senior secondary school girls of Delhi (15.4%) by Sharma et al,(1997). To understand this large difference we have to see the basic differences in the methodologies, that is the language of questionnaires used in these studies. Though for both the groups it was in English, the standard of education was not similar for these two groups. It was more difficult for school going girls who participated in the study, than their college counterparts. So, the possibility of misreporting by school girls can not be ruled out. Apart from these, the socio-economic differences of these two categories of girls also seem to play a major role. The school going girls were from peri-urban areas and lower middle and lower class whereas college girls were from upper and middle class of the society. These differences may be also because of changing sexual trends in society. However, to ascertain the causes of the differences we need more studies of these kinds. The percentage (5.8%) of female respondents who reported having experienced sex in FPAI-SCERT's study (1993), corroborates the findings of Rakesh (1980) and CCM-AIIMS's studies in Delhi. These may be explained as similar status of women in upper and middle, middle classes of urban societies of India.

About the sexual behaviour patterns among college going male students, there are six studies. These students were aged between 17 and 25 years of age. Two of these studies report about the college students of Delhi, who mostly belong to the upper and middle-middle class of urban society. According to CCM-AIIMS' study 28.6%, while according to Sachdev's (1997) 39.3% male students in Delhi were sexually experienced. One study (Goparaju, 1993) reports about the male students of Hyderabad. The sample size of this study was very small (72). Here, 28% students reported having sexual experience. A study among college students of Madras (Reddy et al, 1984) reported that 61% of the males were sexually experienced. The response rate of this study was about 12%. Another study in Nasik and Thane district of Maharashtra (Savara and Sridhar, 1994), reported 18.9% sexually experienced male college students. One more study among similar samples in Kheda district of Gujarat reported 9% of sexually experienced males. Out of these, only two studies (Goparaju, 1993 and Savara and Sridhar, 1994) have reported some details regarding

sexual experiences. In Savara and Sridhar's study (1994), the average age of sexual debut was 16.6 years and almost similar was reported by Goparaju (1993). In Savara and Sridhar's study (1994) the partners were friends (12.6%), relatives (3.1%) and others (0.8%). In Goparaju's study (1993), 45% of the sample have had their sexual experience with a women in neighbourhood, 30% with their friends, 15% with their relatives and 10% with their fiancées. None of the respondents in this study reported having visited CSWs and other than fiancée, no other partner was steady and sometimes relationship ended after one or two encounters. Often the encounters were intermittent and depended upon availability of place and privacy (Nag, 1996).

Leaving apart Reddy et al's study (1984) because of its very low response rate, from rest of the studies a trend can be made out. In big cities like Delhi (CCM-AIIMS) and Hyderabad (Goparaju, 1993), more college students (about 28%) are experiencing pre-marital sex than their counterpart in relatively smaller cities like Thane and Nasik (about 19%) and Kheda (9%). The large difference between Nasik and Thane, and Kheda can be attributed to the basic differences in methodologies. Study in Kheda is based on face to face interview method, while in Nasik and Thane, self-administered questionnaire was used. Further, the difference in data from big and smaller cities can also be attributed to the exposure of students to various channels of mass-media and modernised life-styles in big cities. This is directly related to the socio-economic factors. Moreover, in big cities colleges are also attended by large number of students from farther areas, who are comparatively enjoying more societal freedom than their counterparts, living with their families in the same city. As it was also reported by Goparaju (1993), among sexually experienced college students of Hyderabad the number of rural students was higher (Jejeebhoy, 1996). Societal freedom gives them more opportunities for sexual experiences (Savara, 1992).

There is a significant difference between percentage reported by CCM-AIIMS and Sachdev (1997). A possible explanation may be that, the CCM-AIIMS' study have taken only college students who were in graduation, while Sachdev's study's (1997) have also included University students. The college students being younger than University students, it may be inferred that with increasing age, more male students are experiencing pre-marital sex.

The category of other youths deal with those studies, that have taken samples without any restriction of educational institution. There were two studies available on other youths: FPAI-SECRT (1993) and Sharma and Sharma (1995). The FPAI-SECRT's study (1993) which is methodologically more dependable, reports that 18.9% of male and 5.8% of female respondents (15-19 year old educated youths from 15 cities) have experienced sex. Sharma and Sharma's

study (1995) which was conducted among rural, illiterate or less educated male youth reports that 16% have experienced pre-marital sex. Both studies are reporting almost similar percentage of male youths experiencing pre-marital sex eventhough their methodologies as well as samples are different from each other.

Overall it seems that, about 19 percent males and 5 percent females are experiencing sex before marriage, though the result of studies are varying from 9 to 61 percent for males and 4.8 to 20.4 percent for females.

There were five studies available regarding pre-marital sexual experiences among *urban upper and middle-class males* and females. A detail of these studies is presented in table-1.3. As it can be observed from the table-1.3, that Savara and Sridhar(1994) and Basu (1994) have used two kinds of samples and also presented findings separately (married and unmarried in Savara and Sridhar, 1994 and 'in -home' and 'in-hall' samples in Basu, 1994), so there are actually seven studies available regarding pre-marital sexual behaviour of urban upper and middle-middle class educated people.

Table - 1.3: Pre-marital sexual behaviour of educated urban upper/middle class.

Sl.	Reference	Location	Sample size			Experienced pms(%)		
			M	F	M&F	M	F	M&F
1	Savara & Sridhar, 1992	Urban	1424			65		
2	Savara & Sridhar, 1993	Urban	66			65.2		
3	Savara & Sridhar, 1994	Urban	125(married)			26.4		
			130(unmarried)			26.2		
4	Basu, 1994	Urban	242	206		23	10	
			240	220		17	8	
5	Tejpal, 1996	Urban			1665			33

pms - pre-marital sex
S.A.Q. - self administered questionnaire

Out of these, three studies have used magazine survey to collect data. Sava and Sridhar (1992) and Savara and Sridhar (1993) have used 'Debonair' ai 'Savvy' magazines to distribute their questionnaires to respondents. Tejpal (199 has used more than one magazine and newspaper to reach respondents. Sin all these studies had used English magazines and newspapers, which we mostly read by upper and middle class educated urban people, the respon ents of these survey were only from these sections. Moreover, the samples these studies were self-selected, as the surveys were completely depend upon respondents' will. Further, in a magazine survey there is enough sco for respondent to even express their sexual fantasies. Another problem of the studies was that their sample size was very small as compared to the circul tion of the magazine. For example the 'Debonair' has a circulation of 8500

while the respondents of the survey (Savara and Sridhar, 1992) were 1424. Due to all these problems, the findings of magazine surveys are questionable and cannot be used here.

Another study conducted by Basu (1992) had used two methodologies for administering questionnaires. One group had answered questionnaires in English at their homes while another group had answered it in a hall, where they had been called upon by the author. This study was conducted in Delhi, Calcutta and Madras. The response rate of this study was about 60 percent. The first part of this study (in-home survey) reports that 23 percent (of 242) males and 10 percent (of 206) females have experienced pre-marital sex. In the second part of the survey (in-hall), out of 240 males, 17 percent and 8 percent of (out of 220) females reported having been sexually experienced before marriage. There is a gap of 6 percent between the two groups of males reporting pre-marital sexual experience, while between the two female groups this gap is around 2 percent. These deviations in the findings may be attributed to the different settings of the studies itself. In the first part of the study in which responses were collected in-home, respondents may have found it more confidential and comfortable to answer. At the same time, the possibility of fantasisation, because of respondents' own setting, cannot be completely ruled out. Whereas, in-hall setting, respondents were called at a place chosen by the author, where they had to answer questionnaire along with other respondents sitting nearby. In such a setting as that of the second part of the study, understatement of facts by respondents, cannot be ruled out.

A study conducted by Savara and Sridhar(1994) among white collar workers in Nashik and Thane district of Maharashtra also gives two types of data, one on unmarried samples and the other on married samples. Among 130 unmarried samples, 26.2% have experienced pre-marital sex, and among married samples (125), this percentage was 26.4 percent, which is almost similar to the former one.

Since, there is a considerable difference between the percentages reported by Basu (1994) and Savara and Sridhar (1994), nothing specific can be said about the actual situation among urban educated upper and middle class males. It is however, clear that at least about 17 percent (Basu, 1994) males of this class are engaging in sexual activity before marriage.

About the females of urban educated upper and middle class, there are five studies. Two of these studies have been conducted by Basu (1994) while remaining three are magazine surveys. The data of magazine surveys are not dependable as was discussed in earlier section, thus bearing only two relatively reliable studies, reported by Basu(1994). In the first part, in-home, 10

percent of 206 females have reported having experienced pre-marital sex, while in the second part, in-hall, 8 percent of 220 females have reported the same. The difference between these two findings may again be attributed to the different settings of the studies as was discussed earlier.

Since there were no other studies available regarding sexual behaviour patterns among urban educated upper and middle class females, to compare with above studies, nothing specific can be said. Here, what may be inferred is that, a small section of women in this strata of society is experiencing pre-marital sex. This finding is in the range of what had been reported about urban college female students. Here, the increased percentage, than that for urban college female students (about 6%) may be influenced by the increasing age factor. In this above study, all respondents were married who may be older than their college counterparts.

Though the proportion of urban educated upper and middle class males involving in pre-marital sex ranges from 17 to 65 percent, about 24 percent appear to be the most reliable. For females of this stratum the results of 3 studies are ranging from 8 to 65 percent.

There is only one study, which deals with the pre-marital sexual experiences among *lower middle and lower class* males. Savara and Sridhar (1994) in Nashik and Thane conducted this study. A brief description of this study is presented in table-1.4. There is only one study about this group of urban population, which also has many limitations (discussed earlier) in its methodology. What this study shows, within its limitations is that a significant proportion of this class is engaging in pre-marital sexual relations. What significant is that, the percentage of married and unmarried blue collar workers and married migrant workers are almost in the similar range reported for white collar workers, by the same study (mentioned earlier). But these are different for unmarried migrant workers (high 39.9%) and for loom workers (low 14.3 and 10.4). See table-1.4. Moreover, considerable difference can be observed (table-1.4) between the percentage reported for married and unmarried blue-collar workers and between married and unmarried migrant workers and also between married and unmarried loom workers.

Table - 1.4: Sexually experienced percentage of urban lower middle class and lower class males

Sl.	Reference	Location	Sample size	Experienced pms(%)
1.	Savara & Sridhar, 1994	Nashik & Thane (Maharashtra)	127(a)	24.6
			137(b)	29.9
			132(c)	26.7
			126(d)	34.9
			72(e)	14.3
			67(f)	10.4

(a)-Married blue collar workers; (b)-Unmarried blue collar workers; (c)-Married migrant workers; (d)-Unmarried migrant workers; (e)- Married loom workers; (f)- Unmarried loom workers

The similarities and differences between the percentages of different classes, having experienced pre-marital sex can be attributed to their socio-economic class and aspirations. This would be discussed in the next chapter, under the determinants of sexual behaviour. Now, so far as the differences between the unmarried and married respondents of the same class are concerned, this may be attributed to a kind of fear among married ones. There is a possibility that respondents may be having some doubts about the confidentiality of their responses and therefore a kind of fear regarding their marital relations. Influence of this factor may have generated understatement among married respondents. Less societal responsibilities, less fear, adulthood and economic independency may be attributed for fantasisation and overstatement by unmarried respondents in this study. At the same time, there is a possibility that unmarried ones have not properly understood the terms regarding sexual acts while married respondents, because of their sexual experiences within marriage also, have shown better understanding of the terms. There is also a possibility, that, the results are almost true and report the actual difference. In this case the difference may be attributed to migration of unmarried males leading to higher pre-marital sex.

There are two studies reporting about sexual behaviour patterns among the *populations of two states*, Manipur (Sehgal and Singh, 1992) and Tamil Nadu (Sehgal and Arnold,1994). Both these studies have considered mixed samples, but in disproportionate manner. There are other methodological limitations of these studies too, as was discussed earlier. The findings of these studies are presented in Table-1.5.

Table - 1.5: Findings of the State level studies

Sl.	Reference	State	Sample Size M	Sample Size F	Experienced pms(%) M	Experienced pms(%) F	Methodology
1	Sehgal & Singh, 1992	Manipur	632 (unmarried)	133	27.8	11.3	Interview
			221 (married)	34	44.3	32.4	Interview
2	Sehgal & Arnold, 1994	Tamil Nadu	322 (unmarried)	207	50.9	37.2	Interview
			705 (married)	313	59.6	45.4	Interview

pms - pre-marital sex

It can be observed from table-1.5 that 27.8% unmarried males and 11.3% of their female counterparts have experienced pre-marital sex in Manipur. These percentages have gone high upto 50.9% in unmarried males and 37.2% in unmarried females of Tamil Nadu. For married males and females in both the states, the percentages are much higher than that for unmarried ones, (see table- 1.5). Because of their serious methodological flaws, the findings of both these studies are not even applicable to the corresponding states' population.

Two studies, Narayan (1984) and Kanbargi and Kanbargi (1996) have reported the percentage of pre-marital sexually experienced STD clinic attenders (table-1.6).

Table -1.6: Findings of two studies on STD clinic attenders.

Sl.	Reference	Place	Sample size		Experienced pms(%)			Methodology
			M	F	M	F	Total	
1	Narayan, 1984	Lucknow	300		81			Interview
2	Kanbargi & Kanbargi, 1996	Banglore	264	22			78.5	Interview

pms - pre-marital sex

The first study conducted by Narayan (1984), among 300 male STD patients at Lucknow (U.P.) reports that 81% of male attenders have experienced pre-marital sex. In Kanbargi and Kanbargi's study (1996) at Bangalore, 78.5% of male and female STD clinic attenders are reported to have had pre-marital sex. In the study at Bangalore, the number of females were less than even 10 percent of males and moreover there is no separate data regarding pre-marital sexual experience among males and females, therefore this study also, to a large extent, represents male STD clinic attenders. Since these two studies are from two distant places, situated in different regions and show almost equal percentages of STD clinic attenders having experienced pre-marital sex, it may be inferred that over three-fourths of the male STD patients, who attend STD clinics, would have experienced pre-marital sex.

Though remaining studies on STD clinic attenders does not provide specific data on the prevalence of pre-marital sex among total attenders, the percentage of unmarried male and female patients, reported in 7 studies certainly show the prevalence of pre-marital sex among them. See Table-1.7.

Table - 1.7: Proportion of unmarried STD clinic attenders.

Sl.	Reference	Place	Sample size		Unmarried (%)	
		M	F	M	F	
1	Bhargava et al, 1975	Delhi	878	122	56.6	21.3
2	Singh et al, 1990	Allahabad	1832	90	38.7	11.1
3	Siddappa, 1990	Davangere	393	57	43.7	24.6
4	Chopra et al, 1990	Patiala	350	150	40.3	6
5	Jaiswal & Bhushan, 1994	Tezpur	720		30	
6	Nigam & Mukhija, 1986	Gorakhpur	652	78	46.6	30.8
7	Gupta et al, 1997	Rohtak	522	72	38.5	27.8

As it can be observed from table 1.7, the proportion of unmarried male STD clinic attenders at different places varies between one-third and half of male STD clinic attenders. For unmarried females this proportion is ranging from 6 to 30 percent. It may be also because that, unmarried girls are likely to have

Average Age at First Sexual Experience

It has been documented that there has been a gradual decline in the age at onset of puberty. At the same time, the average age at marriage for both men and women is rising, as was discussed in the earlier section. Consequently, children are now experiencing a longer period of adolescence (Sharma and Sahrma, 1995) and heightened sexual desires (Nag, 1996). If the same trend (lowering age of puberty attainment and increasing age at marriage) continues, this long period of adolescence and of heightened sexual desire is also bound to increase. The age at which an average male and female is becoming sexually active and experiencing sex for the first time, outside marriage varies according to studies.

Since Sehgal et al, (1992) and Sharma and Sharma's (1994) study among school goers (aged between 15 and 18) reported sexually experienced male and female students, it appears that in urban areas a small section of adolescents start their sexual activity between the age of 15 and 18 years. This fact is supported by other studies also. FPAI-SECRT's study (1993) reported that on an average, the males were about two years younger than the females when they had first sexual experience. It was 16 years among males and 18 years among females. Sharma and Sharma (1995) have reported the average age of 17.9 years at first sexual experience for adolescent males in Kheda district of Gujarat. In Goparaju's study (1993) 55% of respondents have reported that they were between 17 and 18 years at the time of first sexual experience. Savara and Sridhar's study (1994) among the males of Nashik and Thane also corroborated this finding. Age at sexual debut in this study ranged from 16.6 years among the sexually active college-aged sample to between 17 and 19 years among unmarred migrant, blue and white-collar workers.

The above discussion is true only for a rough probable section of urban adolescents who are experiencing sex before marriage. So far as urban girls are concerned, a very small section of them is experiencing sex before marriage. Only Rakesh's study (1980) among available ones provides information about average age at sexual debut among girls outside marriage, i.e., 17 years. For a large part of Indian girls, sexual activity commences within marriage. Since early marriage continues to be the norm despite the existing laws on child marriage (Jejeebhoy, 1996) a large number of girls are experiencing sexual intercourse even before attaining the age of 18 years. Thirty six percent of married female adolescents aged 13-16 and 64 percent of those aged 17-19 are already mothers or are pregnant with their first child (Jejeebhoy, 1996).This corresponds to 17 percent of all adolescent females aged 13-19 (ICRW, 1997).

Finally, sexual debut occurs at the average age of about 16 for a rough probable section of urban males who have experienced pre-marital sex. This would mean that there is a long gap between their first sexual experiences and marriage. This has significant implication for HIV infections, since early sexual debut is related to higher frequency of partner change. However, no study provides specific information, which is immensely needed to assess the risk of HIV infection among Indian adolescents.

Partner(s) in Pre-marital Sex

A study conducted by Tata Institute of Social Sciences, Mumbai, among urban college students of Mumbai reports that, their sexual activity centred around visit to sex workers. Boys also quoted having carried on sexual activity within time pass relationship with a girl of the same age, or with a rich "auntie" (older women whose husbands reportedly do not satisfied them), and in true love (ICRW, 1997). Goparaju's study (1993) suggests that partners appear to be largely the same age as the respondents (55 percent), although for as many as 20 percent, the first partner was a girl under 15, and for another 20 percent, a considerably older women. In fact, the majority of partners were married women from the neighbourhood (45 percent), friends (30 percent), relatives (15per-cent), and fiancée (10 percent) (Jejeebhoy, 1996).

In the Manipur study, (Sehgal and Singh, 1992) 19.1% unmarried males (of sexually experienced) had sex with CSWs. This would constitute 5.4% of all unmarried males. 17.4% and 3.8% of unmarried males and females (of sexually experienced) respectively have had more than one sexual partner. In Tamil Nadu study (Sehgal and Arnold, 1994) 42% and 29% of unmarried males and females respectively have had more than one sexual partners. 25.8% of unmar-ried males had sex with CSWs. About the sexually experienced unmarried respondents, the same study reports that 43.9% of males have had their first sexual encounter with a friend, 29.3% with a CSW, 20.1% with a relative, 1.2% with fiancée, 0.6% with their official boss, 3.0% with their worker and 1.8% with other unspecified partner. Among sexually experienced unmarried females, 46.8% have had first sexual experience with a friend, 27.3% with a relative, 9.1% with their fiancé, 10.4% with their worker, 2.6% with their official boss and 3.9% with other unspecified partners.

In the first part of Basu's study (1994), i.e., 'in-home' survey, respondents who reported pre-marital sex, 62% of them quoted their fiancé or fiancée as a partner. 34%, 10% and 19% of the same quoted friends, relatives and other unspecified person respectively as their partner. In the later part of the same study, i.e. 'in-hall', 60%, 28% and 7% of the sexually experienced respondents

quoted fiancé/fiancée, friends and relatives respectively as a partner in pre-marital sex. 18% of these respondents quoted an unspecified person as their partner in pre-marital sex. In Savara and Sridhar's study (1994) in Maharashtra among married respondents, 16.7% blue collar workers, 19.8% migrant workers, 14.4% of white collar workers and 12.9% of loom workers (out of total sample) quoted a friend as a partner in their first sexual experience. 4% blue-collar workers, 6.1% migrant workers, 10.4% white-collar workers and 1.4% loom workers quoted a CSW with whom they had first sexual experience. A relative was quoted as first sexual partner by 3.2% blue-collar workers, 1.5% migrant workers and 1.4% loom workers. Among all unmarried male samples, 12.6% students, 23.6% blue-collar workers, 26.1% migrant workers, 16.9% white-collar workers and 1.5% loom workers quoted a friend with whom they have initiated sex. A relative was quoted as first sexual partner by 3.1% students and 1.5% blue collar workers, 1.6% migrant workers, 0.8% white collar workers and 1.5% loom workers. 1.6% students, 4.7% blue collar workers, 7.9% migrant workers, 14.6% white collar workers and 3% loom workers visited a CSW for their first sexual experience.

These studies suggest that friends are widely preferred in pre-marital sex. Only in Basu's study (1994) friends appear to be at the second place, fiancé/fiancée being first. In most of the Indian societies, having sex with a relative is a taboo and there are also strong sanctions against it. However, the studies show that a considerable proportion of males and females are experiencing pre-marital sex with a relative. A considerable percentage of men had also visited a CSW for pre-marital sexual experience. Although the percentage of males visiting to CSW varies from one to another study, in almost all studies, CSWs stand at third or later in order of preference.

Extra-marital Sex

In most of the Indian societies, after marriage a woman is supposed to consider her husband as God and should remain loyal to him, even after his death. Similar rules are there for males also. A married man is not supposed to see a woman other than his wife with 'wrong intentions' and he is also expected to remain loyal to his wife. But as it has previously been stated, there was always some laxity in favour of men. A wife cannot force or ask her husband to behave 'wisely' but it is not the same for her. This is because of women's socio-cultural and economic dependency on men and patriarchal system of societal inheritance. Even if a man is known to have extra-marital sex, it is his wife who would be blamed for being "incapable". For a long period of time, in absence of any empirical study, it had become difficult to speak about the

occurrence of extra-marital affairs among various groups of Indian society. Though, prevalence of STDs among married individuals has clearly shown the existence of extra-marital affairs, since all STD patients do not consult STD clinics, the prevalence of extra-marital sexual affairs was not known. After the advent of AIDS in India, studies regarding this aspect of some sections of Indian society have been conducted. There are seven studies available in this context. See table-1.8.

Table - 1.8: Extra-marital sex.

Sl.	Reference	Location	Sample size		Experienced ems(%)		
			M	F	M	F	Total
1	Basu, 1994	Urban	nm (in-home)	nm	11	3	
			nm (in- hall)	nm	9	3	
2	Sachdev, 1997	Urban	nm	nm	23.1	9.5	
3	Sehgal & Singh, 1992	Manipur	221	34	30.3	29.4	
4	Sehgal & Arnold, 1994	Tamil Nadu	705	313	57.4	47.3	
5	Savara & Sridhar, 1992	Metro cities	686		55.5		
6	Savara & Sridhar, 1993	Metro cities		296		25	
	STD clinic atteders						
7	Narayan, 1984	Urban	300		74		
8	Kanbargi & Kanbargi, 1996	Urban	107	19			79.4

ems - extra-marital sex

nm - not mentioned

Out of these seven studies, one among upper/middle class (of Calcutta, Madras and Delhi) (Basu, 1994), one each among state population of Manipur (Sehgal and Singh,1992) and Tamil Nadu (Sehgal and Arnold,1994), one each among upper and middle class males (Savara and Sridhar, 1992) and females (Savara and Sridhar,1993), and one each among STD clinic attenders at Lucknow (Naryan,1984) and Bangalore (Kanbargi and Kanbargi, 1996) have been conducted. A study among different occupational groups in Maharashtra has given the type of partners quoted by the percentage of respondents, but it does not provide information regarding the total proportion of respondents involved in extra-marital sex. It is a major flaw of this study because of which it has not been included here.

In Sachdev's study (1997) among married college and University Students in Delhi, 23.1% male and 9.5% females reported having experienced extra-marital sex. The number of married sample has not been revealed. According to other details of this study, the students mostly belong to upper and middle-middle class of urban society. A study by Basu (1994) among upper and middle class of urban society have been done in two parts, in its first part (in-home survey) 11% of married males and 3% of married females reported having experienced extra-marital sex. In the second part (in-hall survey) out of 332 males, 9%

reported having experienced extra-marital sex while among 312 females 3% reported the same.

In Manipur study (Sehgal and Singh, 1992), 30.3 % (of 221) males and 29.4% (of 34) females reported having experienced extra-marital sex. In Tamil Nadu study (Sehgal and Arnold, 1994) 57.4% (of 705) males and 47.3% (of 313) females have reported experienced extra-marital sex. Samples of both these studies were from general as well as high-risk behaviour population.

One study among upper and upper-middle class urban males (Savara and Sridhar, 1992) and another among females of the same class (Savara and Sridhar, 1993) have used magazine survey. Study among 686 males (Savara and Sridhar, 1992) reported that, 55.5% of the respondents have had extra-marital sex. Further 25% of 296 self-selected female samples have reported having had extra-marital sex (Savara and Sridhar, 1993).

Kanbargi and Kanbargi's study (1996) among STD clinic attenders in Bangalore found that 79.4% of males and females have had extra-marital sex. This finding largely represents males, as their number was about 6 time greater than that of females (107 males and 19 females). Narayan's study (1984) among male STD clinic attenders reported that 74% of them have experienced extra-marital sex.

There are a number of limitations of these studies, which have already been discussed under earlier sections. The data provided by magazine surveys (Savara and Sridhar, 1992 and Savara and Sridhar, 1993) cannot be used for any discussion for their serious methodological limitations. The same with that of studies in Manipur (Sehgal and Singh, 1992), Tamil Nadu (Sehgal and Arnold, 1994) and among college and University students in Delhi (Sachdev, 1997) also. Though Basu's study (1994) also has limitations, they are less as compare to other studies.

It is however, evident that males and females of upper and middle urban educated class are experiencing extra-marital sex. The percentage of males (10%) is about 3 to 4 times greater than that of females (3%) (Basu, 1994). Since there was no other study available to be compared with Basu's study (1994), it is difficult to find out the actual percentage of males and females of this group, engaging in extra-marital sex.

Now, so far as extra-marital sex among STD clinic attenders is concerned, Narayan (1984) and Kanbargi and Kanbargi's study (1996) report almost equal prevalence of extra-marital sex. The little greater number in Kanbargi and Kanbargi's study (1996) can be attributed to the time and regional differences. On the basis of almost equal percentages reported from two distant regions of

the country, it may be inferred that about three-fourths of male STD clinic attenders are engaging in extra-marital sex. Considering non-acknowledgement of extra-marital sexual relations by patients and also their sexual experiences before marriage, it may also be inferred, that some percentage of males are contracting STD infections from their wives. This would simply mean, involvement of females in extra-marital sexual relations. The number of married male STD clinic attenders reported by other studies also reveal their involvement in extra-marital affairs. The same can not be inferred about female STD clinic attenders as a large proportion of them are contracting infections from their promiscuous husbands. Among STD clinic attenders, 43.4% in New Delhi, (Bhargava et al, 1975), 61.3% in Allahabad (Singh et al, 1990), 56.3% in Davangere (Siddappa, 1990), 59.7% in Patiala (Chopra et al, 1990), 70% in Tezpur (Jaiswal and Bhushan, 1994), 53.4% in Gorakhpur (Nigam and Mukhija, 1986) and 61.5% in Rohtak (Gupta et al, 1997), were married males.

So far as partners in extra-marital sexual relationship is concerned, a magazine survey has provided some information. According to the magazine survey among males (Savara and Sridhar, 1992), 53% quoted a friend as a partner in extra-marital sexual relationship. 26% males quoted casual acquaintances, 26% a relative and 18% a colleague as a partner. But as it has been discussed earlier that this study has many limitations, its findings are not dependable.

In a study on reproductive health of adolescents in a rural area near to Vellore (Tamil Nadu), the informants have given reasons for engaging in extra-marital sexual relations. According to the informants, the reasons men have extra-marital affairs are: they are used to their pre-marital relationships and so continue them; they are rich and can pay for extra-marital sex; their wives are pregnant, hence not available or attractive for sex; and there are women available to entertain them in exchange for money. The reasons given for extra-marital affairs, on the other hand by females are: they are impoverished and need money; or they are not sexually satisfied by or happy with their husbands (ICRW, 1997). Vora et al's study (1994) in Ahmedabad among STD clinic attenders found that most of the STD patients were married and staying away from their native places and occasionally visited their native place.

Finally, since there is no study among rural population, which constitute 74% of India's total population, nothing can be inferred about the prevalence of extra-marital sexual relations in general Indian population. However, 10% and 3% appears to be the most reliable figures, denoting the number of males and females respectively, having extra-marital sexual relations. But findings ranging from 23 to 55 percent for males and 9.5 to 47 percent for females have also been given by different studies.

Sex with commercial sex workers

A Commercial Sex Worker can be defined as a woman who is having sex with more than one partner to earn livelihood, either on part time or full time basis. CSWs or prostitutes are found, and prostitution practised in almost all states and every type of society (Mathur and Gupta, 1965).

As CSW's gratify more than one partner's sexual desire over a time, they are at a higher risk of contracting STD and HIV infection and thus play a major role in the spread of HIV/AIDS. The first HIV positive case in India was reported among CSWs of the South. As in the other countries, CSWs have been singled out for special attention in the context of AIDS, due to their multiplicity of sexual relations and high STD rates. Unfortunately, this has led to a situation where they are viewed as transmitters of HIV, rather than recipients of the virus (Mane and Maitra, 1992). The size of population of CSWs in India is not known, as it is not a licensed occupation. However it is estimated that in Bombay alone, in a locale which is clearly recognised as a red light district, there are about one lakh CSWs (Mane and Maitra, 1992). Gilada (1985), provides estimates for the following cities: Bombay (100,000), Calcutta (100,000), Delhi (40,000), and Nagpur (13,000). These figures are under-estimates compared to those made by Bhartiya Patita Uddhar Sabha (BPUS), a voluntary agency dedicated to the welfare of female sex worker (Nag, 1996). According to the BPUS, there are 8.7 million female sex workers, living in 87000 Kothas (brothels) in addition to 7.5 million call-girls in India (Telegraph, 1992).

It is, however, clear from the above discussion that a large number of women are catering to the sexual needs of men as CSWs. The number of men who visit CSWs is around 2 to 4 times more than the total number of CSWs themselves.[1] Basing on these rough statistics, we can say that a considerably large number of Indian population, involved in sex trade (either willingly or forcibly) as a client or a CSW are under the threat of contracting STD and HIV infection. Both the clients and the CSWs serve as transmitters of STD and HIV infection among the general population.

Though a study on the sexual practices among CSWs and their customers, besides their number and socio-economic background is immensely needed, for their crucial role in the transmission of STDs and AIDS, there are unfortunately only a few studies mostly dealing with the social, cultural and work environment in which prostitution occurs (Bhattacharya and Senapati, 1994). Out of the studies available, only a few of them indicate the percentage of

1. It is based on information provided by CSWs about the average number of clients per night in studies conducted by Sehgal and Arnold (1994) and Mathur and Gupta (1965).

males visiting CSWs or quoting them as a source of STD infection. There are two studies (Sehgal and Singh, 1992 and Sehgal and Arnold, 1994) that have taken CSWs also as samples while studying sexual behaviour of general population. This may help in the construction of actual sexual behaviour in a population, as comparable data would be available then. Though there are methodological limitations of these studies too, they are at least a good initiative in this direction. Brief descriptions of the percentages provided by various studies have been shown in table -1.9.

Table 1.9: Proportion of males visiting to CSWs.

Sl.	Category	Place	Methodology	Sample size	Visiting (%)	Reference
1	Unmarried	Manipur	Interview	632	5.4	Sehgal & Singh, 1992
2	Married	Manipur	Interview	221	10	Sehgal & Singh, 1992
3	Unmarried	Tamil Nadu	Interview	322	5	Sehgal & Arnold, 1994
4	Married	Tamil Nadu	Interview	705	25	Sehgal & Arnold, 1994
5	Truck cleaners (15-19 year old)	Indore	Interview	210	25.2	Bansal, 1992
6	Truck drivers	nm	Interview	281	48	Sachar et al, 1997
7	Truck drivers	West Bengal	Interview	100	97	Rao et al, 1994
8	Rural youth	Gujrat	Interview	nm	12.4	Sharma & Sharma, 1995
9	Upper/middle class	Metro cities	S.A.Q.	240	8	Basu, 1994
10	College students	Hyderabad	S.A.Q.	72	5	Goparaju, 1993
11	Educated youth	15 cities	S.A.Q.	1974	6.4	FPAI-SECRT, 1993
12	Blue collar workers	Urban	Interview & S.A.Q.	126	5.6	Savara & Sridhar, 1994
13	Migrant Worker	Urban	Interview & S.A.Q.	131	6.9	Savara & Sridhar, 1994
14	White collar workers	Urban	Interview & S.A.Q.	125	3.2	Savara & Sridhar, 1994
15	Upper/middle class	Urban	Magazine survey	1158	30.1	Savara & Sridhar, 1992
16	Upper/middle class	Urban	Magazine survey	nm	13	Tejpal, 1996
STD clinic attenders						
17	Not specified	Urban	Interview	878	42.4	Bhargava et al, 1975
18	married	Urban	Interview	1070	80.6	Singh et al, 1990
19	Unmarried	Urban	Interview	762	96.4	Singh et al, 1990
20	Not specified	Urban	Interview	350	51.4	Chopra et al, 1990
21	Industrial workers	Urban	Interview	924	73.9	Vora et al, 1994
22	Not specified	Urban	Interview	720	92	Jaiswal & Bhushan, 1994
23	Not specified	Urban	Interview	54	40.7	Kaur et al, 1992
24	Not specified	Urban	Interview	652	47.5	Nigam & Mukhija, 1986
25	55%-Urban 45%-Rural	Urban	Interview	665	67.1	Chaudhary et al, 1988
26	Not specified	Urban	Interview	107	59.8	Kanbargi & Kanbargi, 1996

nm - not mentioned

It can be observed from table-1.9 that the three studies about truckers report higher percentage of CSW visitors, than other categories. As shown by these studies, the percentage of truckers who had visited CSWs increased with the age. Study among adolescent truck cleaners (Bansal, 1992) who are aged between 15 and 19 years, reports that only 25.2% had visited CSWs. Another study which had included both junior and senior truckers had found this percentage as 48.0 (Sachar et al, 1997). A third study in this connection in which senior drivers (79) and their helpers (21) have been taken as sample, reports that 97% of sample have visited CSWs (Rao et al, 1994). Here the increase in percentage can be attributed to the dominating numbers of drivers

over their helpers. Senior drivers are in most cases, older than helpers. Or, this increase could also be due to methodological flaws of the study itself.

Studies with less limitations (Sharma and Sharma, 1995; Basu, 1994; Goparaju, 1993; FPAI-SECRT, 1993 and Savara and Sridhar,1994) report that 3 to 12 percent of males of different categories are visiting CSWs. The maximum percent (12) was reported for rural youths of Gujarat (Sharma and Sharma, 1995), while the least, that is 3.2 percent was reported for married white-collar workers in two districts of Maharashtra (Savara and Sridhar, 1994). For the same group of respondents from three cities, the percentage reported by Basu (1994) was high, i.e., 8.0%. Percentage of those who had visited CSWs among college students in Hyderabad (Goparaju, 1993), among married blue-collar workers and migrant workers (Savara and Sridhar, 1994) are almost similar to each other, which is about 6 percent. Percentage of youth from 15 cities of India who visited CSWs (6.4%) reported by FPAI-SECRT (1993) also falls in this range. The percentage of unmarried males in Manipur and Tamil Nadu, (ie.5.4% and 5.0% respectively) may also be placed in the above range, but the limitations of these studies can not be neglected. Higher percentage reported by magazine surveys (Savara and Sridhar,1992 and Tejpal,1996) may be the result of their methodological flaws.

So far as STD clinic attenders are concerned, from about half to three-fourth of them have reported having contracted infection from a CSW. This would mean that a large number of STD clinic attenders are CSW visitors and also that sex with a CSW possesses higher risk of STD and HIV infection. Since truck drivers and migrant workers (as compared to their other counterparts in the same study) are the categories in which higher percentage of CSW visitors were reported, it can be inferred that males who are away from their families are more likely to visit CSWs. Vora et al.(1994) have reported that about 74% of STD clinic attenders in their study were CSW visitors and most of the respondents were staying away from their native places. These males occasionally visited their native places.

Homosexuality

It is widely assumed that "gay" (homosexuality) is a phenomenon new to India. However, it can not be assumed that because homosexual behaviour has been proscribed or considered undesireable, it does not occur or that homosexuality exists only in hidden, guilty ways. The story of homosexuality in India is certainly not an unrelenting tale of repression and woe. Numerous gay men and lesbians reveal that varied, often rich forms of gay life have long existed, and continue to flourish in this country. It is easy to find the existence of the

entire gamut of same sex intimacies in India: intense friendship, romance and companionship between people of the same sex; sexual interactions not perceived by the partners as a basis for defying their identity in terns of sexual-orientation; and homosexual sex and emotional involvement self-consciously recognised as a gay identity (ABVA, 1991). While discussing homosexuality in his book "Sexual Behaviour and Aids in India" Moni Nag (1996) states that 'it is not easy to define homosexuality and identify a person as a homosexual. In a simplistic sense, a homosexual male or female is one who engages in a sexual act with a person of the same sex. But what kind of act should be considered as sexual'. Though there are some studies available reporting about the percentage of a rough probable section of urban educated population experiencing homosexuality, they do not provide answer to the above question. It is necessary to define homosexuality before collecting data on it. There is a possibility that the respondent may understand homosexuality as any kind of close relationship with a partner of the same sex. There are only two studies available, which have actually defined the type of sexual practices under homosexuality (Savara and Sridhar, 1994 and Sachar et al, 1997). Other studies seem to have neglected this aspect, specially studies among students (CCM-AIIMS and Reddy et al, 1984) and two magazine surveys (Savara and Sridhar, 1992), since the percentage reported (26.7% and 11% respectively) by these studies are about two to six times greater than those reported by other studies. See table-1.10. Proportion of urban educated upper and middle class males involving in homosexuality was 5.0% as reported by Basu (1994). Savara and Sridhar (1994) reports that 6.4% for married and 3.1% for unmarried males of the same class have experienced homosexuality. This difference between married and unmarried males of lower class (blue-collar and migrant workers) can also be noticed (see table-10) in the same study. The same study found that 1.5% unmarried loom workers reported having experienced homosexuality but none of their married counterparts have reported homosexual experience. 2.4% college students have reported homosexuality in this study. 3.3% unmarried males in Manipur (Sehgal and Singh, 1992) and 6.8% unmarried males in Tamil Nadu (Sehgal and Arnold, 1994) have had homosexual experience. The percentage of truckers experiencing homosexuality is not much different from that for other sections of population (Sachar et al, 1997), that is 6.8%.

Now, so far as studies among STD clinic attenders are concerned, most of them support the lower incidence (about 5 to 6%) of homosexuality, though the samples of these studies are not representative as discussed earlier (see table-1.10).

ıle- 1.10: Proportion of males reporting homosexual experience

Category	Place	Methodology	Sample size	Reporting HS(%)	Reference
Upper/middle class	3 metros	S.A.Q.	240	5	Basu, 1994
Married white collar workers	Urban	S.A.Q.& interview	125	6.4	Savara & Sridhar, 1994
Unmarried white collar workers	Urban	S.A.Q.& interview	130	3.1	Savara & Sridhar, 1994
College Students	Urban	S.A.Q.& interview	127	2.4	Savara & Sridhar, 1994
College Students	Urban	S.A.Q.	681	26.7	CCM-AIIMS
College Students	Urban	S.A.Q.	464	11	Reddy et al, 1984
Married blue collar workers	Urban	S.A.Q.& interview	126	2.4	Savara & Sridhar, 1994
Unmarried blue collar workers	Urban	S.A.Q.& interview	127	3.1	Savara & Sridhar, 1994
Married migrant workers	Urban	S.A.Q.& interview	131	3.1	Savara & Sridhar, 1994
Unmarried migrant workers	Urban	S.A.Q.& interview	126	1.6	Savara & Sridhar, 1994
Unmarried loom workers	Urban	S.A.Q.& interview	67	1.5	Savara & Sridhar, 1994
Unmarried	Manipur	Interview	632	3.3	Sehgal & Singh, 1992
Unmarried	Tamil Nadu	Interview	322	6.8	Sehgal & Arnold, 1994
Upper/middle class	Urban	Magazine survey	1424	36.6	Savara & Sridhar, 1992
Truckers	nm	Interview	281	6.8	Sachar et al, 1997
clinic attenders					
At Banglore		Interview	264	3.2	Kanbargi & Kanbargi, 1996
At Rohtak		Interview	665	7.8	Chaudhary et al, 1988
At Gorakhpur		Interview	652	19.7	Nigam & Mukhija, 1986
At Tirunelveli		Interview	3624	1.9	Murugan et al, 1993
At Patiala		Interview	350	17.1	Chopra et al, 1990
At Delhi		Interview	878	1.1	Bhargava et al, 1975
At Madras		Interview	2293	3	Parasuraman et al, 1992
At Lucknow		Interview	300	2	Narayan, 1984

not mentioned

lere, it is necessary to discuss about male commercial sex workers, (MCSWs). SWs exist in large numbers in India and they provide sex services to male nts at different places in various forms such as room service boys in hotels, ıasseur on beaches and parks on highways, in red light areas etc. (Nag, 96). These MCSWs are eunuchs as well as normal males. The normal men in profession do not consider themselves as homosexuals (Nag, 1996) since y are also participating in heterosexual relations with their wives and girl nds. Moreover, it is also because they have adopted this profession for ıetary gains only.

verall, about 2 to 6 percent of a rough probable section of urban males are aging in homosexual relationships. Though a few studies report it as high about 37%, the actual percentage of them is not known for a variety of sons. A major reason is the definition of homosexuality itself. In the context AIDS, only penetrative sex is considered as homosexuality, which exists ong male homosexuals. This is also why female homosexuality has not been ussed here. As STD clinic attenders are quoting homosexuality as a source heir infection, though their percentage is low, it also appears to be the rce of HIV infection. Moreover, it confirms the existence of penetrative ıosexuality in Indian population. There is an immense need of studies on ıosexual practices and the proportion of population involving in it, which ıld be addressed to urgently.

CHAPTER II
DETERMINANTS OF SEXUAL BEHAVIOUR PATTERNS: IMPLICATIONS FOR THE AIDS EPIDEMIC

Although the basis for sexual motivation is physiological there is no known society in which the frequency or the forms of human sexual behaviour is determined solely by physiological factors (Berelson and Steiner, 1964). From their earliest years men and women are taught either directly or indirectly about sex. What is even more significant is that the teachings differ from society to society. Sexual practices considered taboo by some cultures are highly acceptable to others. The result of this is that an adult's view of what is proper and normal in sexual matters depends entirely on the society in which he was reared. According to Fromme (1955), our sexual behaviour is essentially the result of our attitude towards sex; and this attitude, in turn is a product of how we have been brought up (McCary, 1967).

In different societies and cultures sexuality can be variously perceived- as a necessity for procreation, as an expression of caring, sharing and bonding between two individuals as a means of deriving emotional and physical pleasure from transient relationships, as a means of displaying power, punishing adversaries and so on. All view points i.e., those giving primacy to one or the other view, exist in all societies at all times but the relative proportion of persons subscribing to different views, changes with variation in societal values and social conditions. Social control, self-restraint and the degree, to which society value these, determine the dominant pattern of sexual behaviour in a society (Ritu Priya, 1996). For instance, even today Maria, Muria and Hulba tribes in Bastar district of Madhya Pradesh allows their adolescent boys and girls to live together during night hours, before marriage under their 'Ghotul' system. There they are free to have sex, provided girl should not become pregnant. If a girl becomes pregnant then she has to marry only that boy who made her pregnant. It can be considered as a rule to bring unwed pregnancy under the institution of marriage. In this way, in these societies virginity and pre-marital chastity are not very important. But at the same time in many other societies pre-marital chastity and virginity are greatly valued. In these societies any sexual activity outside marriage setting is considered as immoral.

There are also societies where polygamy (having more than one wife) is a general practice, while some societies give liberty to their women to have more than one husband at a time (polyandry). There are also societies in which group marriage (polygynandry) is a well accepted tradition, for example, among Jounsar Bavar tribes in Western Himalayan range. However, in general monogamy is widely practiced phenomenon. This is how different societies have institutionalised and regulated the sexual activities of their members. Similarly, every society has some rules and norms regarding remarriage after divorce or in case of widowhood, so that an individual's sexual activities can be satiated and confined within institutions.

Almost all societies of the world are having an institution of marriage of which sexual activity is a crucial part. Whether an individual can have sex outside marriage setting, largely depends upon the attitude of that society towards such activity. However, in all societies there are always some who break the dominant rules and norms. Social norms are, in fact, not stationary and change with context. May be some practices of few people in a society constitute a breach of social rules today, but there is every possibility that this 'breach' itself may become a dominant norm in future and after sometime it may become the rule to replace the older one. This actually depends upon the proportion of people and their position in the society, which are involved in the process. As the change in practice spreads to larger numbers, the norms and rules themselves change. In societies undergoing rapid changes, an individual's behaviour will depend upon how one value the existing norms and culture of the society to which one belongs, and also how one looks upon oneself in relation to that society and culture. Both these factors are shaped for an individual and therefore for a social group, by the socio-economic and cultural environment in which one had been reared up and is living. This is again provided to an individual by the society only. It is in fact, a kind of cycle in which all factors are interrelated either directly or through other factors.

Factors which play major role in the shaping of sexual attitudes and behaviours include: (1) Socio-economic status, (2) Culture, (3) Religion, (4) Educational level and life options, (5) Mass media and Modernisation, and (6) Peer group.

1. Socio-economic Status

Socio-economic status and occupation of people determine the condition of their life, which has major role in shaping their attitude and behaviour in general and sexual behaviour in particular. Change in socio-economic structure of a society brings changes in the behaviour of its members, as will be discussed.

As it has been observed in the last chapter that the percentage of males who ever visited CSWs decreases with the increase in socio-economic status. In Savara and Sridhar's study (1994) it was reported that the number of white-collar workers who visited CSWs was less than that of blue-collar workers and migrant workers. Migrant workers were at the top of the list of these three. Similarly in Sharma and Sharma's study (1995) among Gujarati youths in Kheda district, it was found that the number of rural youths who visited CSWs was higher then that of urban youths. Goparaju (1993) also noted similar differences.

However, the occurrence of pre-marital sex, extra-marital sex, visit to CSWs etc. have no socio-economic boundaries, but the percentage of people involved, varies according to their socio-economic status. At higher socio-economic status people are having better life conditions, better job opportunities, access to various and better kind of facilities etc. At higher socio-economic status in India, people aspire to western life style and therefore changing themselves accordingly. This change manifests through changes in their attitude and behaviour, particularly sexual. Most of the people of this class are having much freer attitude and behaviour regarding sexual relationship outside marriage setting. Because of their relatively freer attitude and behaviour than middle and lower class, they have access to other members of their class, therefore, their need to visit CSWs is lesser.

In middle class a considerably large section of people perceive the need for all those facilities and luxuries which are availed of by the upper class. The economic constraints of middle class act as a major barrier in achieving upper class life style. Due to this barrier middle class tries to develop other attitudinal and behavioural similarities with upper class. Using their physique to earn (as models. etc.,) so as to gain access to the upper class life style, girls of this class may end up as sex workers. In fact, it is one of the major factors which forces many middle class girls to become call girls (Kapur, 1978).

At lower socio-economic stratum of society the causes are different. In this class it is people's economic need, which force them to involve in risky sexual behaviour. In Rajasthan, Uttar Pradesh, Madhya Pradesh and also in some other parts of India there are some scheduled castes and tribal groups who provide their adolescent females with prostitution as an option beside marriage. In five bordering districts of Maharashtra and Karnataka every year thousands of minor girls are initiating as 'Devadasis'. These girls are dedicated by their parents mostly because of economic reasons. Beside this thousands of minor girls, mostly in rural areas, who being sold by their parents to the 'agents', invariably end up their lives in sex trade.

It is poor socio-economic status of rural people for which they migrate from rural to urban areas, mostly alone, in search of employment. However, due to occupational needs also many people migrate even if they belong to upper class. It has been observed that migrating people are more involved in 'risk behaviour'. Separation of people from their home and natural neighbourhood unit reduces the restraint that a community exercises upon one's behaviour in the sexual field, as also in other matters. They are also deprived of the social activities from which they had formerly derived satisfaction and security, and there is a break in their established human relations. There is, therefore, an urgent need to establish new and intimate associations: relations based on sex offers an easy, quick and exciting way of doing so (Sutherland, 1950). Hence, it is the socio-economic status, and working conditions together, which influence them to behave in a way, they do. Catering to such needs, the sex industry develops and then acquires a vested interest in promoting demand supply point for sex workers along the centres, outside red light areas.

As Berelson and Steiner (1964) have argued, differences in sexual behaviour related to socio-economic status seem to be correlated with the social position eventually acquired, rather than actual social position held at the time. In general, it is seen that the sexual history of the individuals accord with the pattern of the social group into which they ultimately move, rather than with the pattern of the social group to which their parents belong and in which they were placed when they lived in the parental home (Yerkes and Yelder, 1936). An individual generally used to imitate the attitude and behaviour of the social group into which he wanted to move and this process begins soon after he starts realising the differences between various socio-economic strata. For instance, truckers reported a fairly common scary feeling on the eve of their first visit to CSW. But feelings varied once the visit was over (Rao et al, 1994). It may also happen that to remain part of and to retain acquired position in a societal group, people used to behave even if they do not possess the attitude similar to that group.

In case of women, especially from middle and lower strata of society, socio-economic status acts more intensely. A large number of women from middle and lower class, specially in developing countries entering into the sex trade. It was reported, that in Madurai (an urban area in Tamil Nadu) around two to three hundred women age between 25 and 40 years, who are working at clerical posts or as nurse in various governmental and private institutions also working on part time basis as CSW. These women have cited two major reasons for doing so; first, on account of the poverty due to insufficient income to run their families and second to have sophisticated luxurious and comfortable

life with extra income (Parthasarathy, 1997). In Bombay poor widowed, divorced or abandoned women reported having sex with slum landlords in return for access to resources or guarantees of physical security (Rao Gupta, 1993). There are many more examples (not only from India but also from other developing countries) available which show how poor socio-economic conditions act as a major factor in women's submission to sexual relationship outside marriage.

Studies from many parts of the world are showing that the problem of HIV/AIDS is exacerbated by lopsided developmental policies, which have brought abrupt changes in traditional socio-economic structure of the societies. These abrupt changes have actually ingested the traditional economies mostly based on natural resources, which have provided the base for other societal factors, since long. For instance, in Thailand, in the name of faster economic growth of the country, the rich forest resource was exploited for wood-export. Due to rapid deforestation, a large part of population, which was living in rural areas, has lost its source of economic support. Many of these people's livelihood was based on forest produce and agriculture. Deforestation has led to change in weather cycle as well as soil erosion, which damaged agriculture. In this way the people whose lives were based on natural resources have lost their livelihood. At the same time the advent of consumerism and invasion of various status symbols has added fuel to the fire. Young people started migrating towards urban centres, where they were forced to work in low pay jobs due to their low level of education. Since their aspirations were high, males entered in more profiting drug industry while women in sex trade. Young women find sex trade in various forms (bar-maids, masseurs, dancers etc.) one of the best available options with less competition and more money. Remittances in various forms made by these women to their homes in rural areas turns more and more girls to urban areas and finally into prostitution (Usher, 1993).

Similar phenomenon was also reported from Ghana. Here also in the name of faster economic development government took up a project to develop Akosombo hydroelectric dam in 1960. Under this multipurpose project, one of the largest men made lakes- Volta-lake was created in the Agomanya area. With the beginning of the project around 80,000 people in the area, predominantly agriculturists were displaced. Since these people have lost their traditional livelihood and societal structure, males started working as labourers in the project and some as fisherman. Females, who were till now supporting home economy by helping in agricultural works, had no employment, but their homes were still in need of support. With this purpose these females started taking jobs in hotels, bars and clubs, where from sex trade was at very short distance. This is how these women entered into sex trade.

With the end of construction work after five years, a major workforce went back. The local males and females of the area again lost their livelihood. Subsequently the males of the community migrated to other areas in search of employment as unskilled labourers. The females took their business to other cities and also to other countries. Because of the poor economic conditions the next generation of this migrated population had to remain in the similar conditions. Moreover, because of patriarchal inheritance in this society, a child who does not know his or her father has no chance of ever inheriting. There were few opportunities for economic survival for the many illegitimate children born during the construction boom. The situation was especially difficult for the first cohort of girls born to young women who were just learning to survive by selling sex to construction workers. Today, the HIV prevalence among birth cohorts of pregnant women in Agomanya is highest. This is an indication of the contribution of returned sex workers to the HIV prevalence in their native area. The largest contribution is in the older age groups, which is to be expected because primarily older women returned to their home. An alternate explanation, however, is that there are fewer prostitutes in the younger cohorts. The infection rates are highest in the 1956-1965 birth cohorts among women born at the height of construction activities. Many of them are the daughters of construction workers for whom there were no other economic choices but to follow their mother into sex trade (Decosas, 1996).

In case of males, however, the situation is not very different. Reducing employment opportunities in rural areas due to the degradation of traditional resources and natural calamities, both are equally responsible for male migration in developing countries, which again contribute effectively in increasing HIV prevalence. For instance, populations in West Africa are highly mobile. Fishermen follow the Southern coast from Cameroon to Liberia in pursuit of the seasonal migration of fish stocks, traders ply the coastal routes from Senegal to Nigeria, and farmers of the Sahel migrate to the plantations in the coastal countries to survive the dry season. Today, the main destination of migrants is Cote d'Ivoire. Among its population of 12 million, one quarter is migrants from neighbouring countries. In the capital, Abidjan, this proportion is as high as 40 percent. Cote d'Ivoire also has the highest HIV prevalence rates in West Africa. The country has the largest concentration of mobile populations. It is, therefore, the place to observe the factors that make migrants vulnerable to HIV infection (Decosas et al, 1995). A large agricultural enterprise in Cote d'Ivoire may have camps of as many as 2000 young male migrant workers. In these camps, the tight external (societal) control on sexual behaviour at their original place is temporarily replaced by a culture of male-

ness. On the weekend after pay day, a convoy of 30 to 40 female commercial sex workers may arrive at the plantation, often brought from the town by the employer, and service a mean of 25 workers each over a period of two nights. The incredible burst of sharing of genital microflora is a powerful motor for the spread of HIV infection. It is this pattern of mixing, and not the actual number of partners, which is responsible for the extensive spread of HIV among migrant workers (Decosas et al, 1995).

A study among STD clinic attenders at Ahmedabad (Gujarat) report that most of the infected male patients were migrants and their families were living in native places (Vora et al, 1994). There are also studies among truckers in India which report that truckers usually stay away from their homes for about a month continuously; in some cases they visit their families once or twice in a year (Bansal, 1995 and Rao et al,1994). In these cases, where nature of employment is such buying of sex is not surprising. Moreover, the easy availability of commercial sex near around makes situation more vulnerable.

During last decade the rate of urbanisation has increased and urban population has become about 26percent in 1991 as compared to 24percent in 1981. This growth in urban population is because the agriculture has become non-profitable business in India for middle and low class farmers. Continuous loss in agriculture and increasing debt on these middle and low class farmers creating frustration among them. Recent news about the suicide by many farmers in Uttar Pradesh, Punjab and Andhra Pradesh are extreme examples to show the problems faced by the farmers. To overcome such problems most of these people are migrating to urban centres in search of employment in various industries. In urban centres these people live in slums where they come in touch of various kinds of activities- drug abuse, alcoholism and illegitimate sexual relationships are few of them. Poor income does not allow them to visit their families frequently. To satisfy their sexual urge these people may go for illegitimate and paid sex. Further, the women in rural areas remain dependent on their male partners for financial support, decreasing the women's ability to negotiate for safe sex when the men return, and fostering the spread of HIV from cities to rural areas. Women who remain in rural areas for protracted periods without their male partners may also take other partners, increasing their HIV risk(Lurie et al, 1995). Overall, socio-economic conditions are not only making commercial sex widely available but also generating clients for it. In this way, the socio-economic conditions are having major role in spreading HIV infection.

During the period of last two decades Structural Adjustment Programme(SAP) of the World Bank(WB) and the International Monetary Fund(IMF) have exacer-

bated the pre-existing socio-economic circumstances. Under this programme developing countries were forced to enter into agreement to meet specified macro-economic targets- first With the IMF and later with the WB, if they need loan. The measures taken under SAP, seek to stimulate the growth of the private and export sectors in developing countries, thus making their economy competitive on the international market. From the internationalised perspectives, they enhance the security of loans, benefiting international lenders and others involved in trade with developing countries (Lurie et al, 1995).

The major impact of SAP on the socio-economic conditions includes (i)declining sustainability of the rural subsistence economy due to the shift to the large scale export agriculture, logging and mining which displaces rural subsistence producers,(ii) rural to urban migration, and (iii) increasing poverty and the widening gap between poor and rich. First and second impacts are closely interrelated and discussed. So far as the third is concerned, data show that in India the proportion of poor households declined from 39.3 percent in 1987-88 to 34.3 percent in 1989-90 and then rose to 40.7 percent in 1992-93. In absolute terms, there were 310 million persons living below the poverty line in 1987-88. By 1992-93 the number of poor had risen to 355 million (Swaminathan and Ramachandran, 1995).

2. Culture

In any society, prevailing attitudes and behaviours regarding sex are part of its culture. Culture is internalised through a process of socialisation, which begins from the moment of birth and does not cease until death. It determines, how the sexual behaviour in a given society will be controlled. For this purpose, in most of the societies there is an institution of marriage. But, again it is the culture, which determine how sexual activity within and outside the institution of marriage is viewed. In some cultures both men and women are considered equal and so are their sexual activities, while in most of the cultures it is a man who enjoys more freedom in the matters of sex than a woman. There are also cultures in which, under certain circumstances men and women are legitimately allowed to have sex outside marriage.

Sexual behaviour, however, not only varies in the term of gender, but also in terms of caste, class, religion, region etc. For instance, an Indian upper class, mostly comprised of upper castes and living in urban areas, has different attitude regarding sex as compared to the lower class, generally belonging to lower castes and living in urban slums and rural areas. Even then, in every part of the world, a dominant culture exists which encapsulates its various forms in different societies living in that part of the world. The dominant

culture of the middle classes in India today influences that of a majority of population groups. In this context nature of the institution of marriage, age at marriage, gender relations and commercial sex are some important dimensions of a culture.

In India, marriage is considered as a lifelong partnership. It is the rock on which the family is built, and which in turn, is the foundation of society. Basically, marriage is a social and legal contract. Frequently, traditions, culture, religion, caste and community pressure all play an important part in the institution of marriage and the family (FPAI-SECRT, 1990). Even after the decades of number of changes in Indian society, arranged marriage is still preferred by most over love marriage. And, this is mainly because of strong familial bondage and responsibilities besides societal pressure. Overall, in most of the Indian societies marriage is not just union of two individuals but of two families in which community involvement is considered as necessary for societal approval of marriage. Age of effective marriage (age at which a girl starts cohabiting with her husband) is a major determinant of sexual behaviour pattern of an average Indian girl. In most of the Indian cultural settings, women have no say in the matter of their marriage, but they have to follow their parental choice. As it has been observed and discussed in earlier chapter that only a small (about 5 to 6 percent) proportion of Indian urban educated females have experienced pre-marital sex and almost similar percentage, extra-marital sex. This means, that most of Indian women's sexual activity remain within marriage itself, which also commences for half of the girls in their teen age. As it can be observed from table-2.1 that median age at effective marriage in 1993 was 19.6 years for Indian girls, which mean that half of Indian girls' sexual life commence before this age (19.6 years).

Table - 2.1: Median age at effective marriage (female); India and major States

Sl.	India/Major States	Combined	Rural	Urban
	India	19.6	19.4	20.5
1	Andhra Pradesh	17.8	17.6	18.9
2	Assam	20.9	20.5	23.2
3	Bihar	18.9	18.9	19.4
4	Gujrat	19.9	19.8	20.6
5	Haryana	18.9	18.5	20.7
6	Karnataka	19.4	19.1	20.5
7	Kerala	22	22.1	21.8
8	Madhya Pradesh	18.8	18.6	20.6
9	Maharashtra	18.8	18.3	20.1
10	Orissa	20	20	23.3
11	Punjab	20.6	20.5	20.8
12	Rajasthan	18.4	18.4	18.6
13	Tamil Nadu	20.1	19.8	20.8
14	Uttar Pradesh	19.3	19.2	20.1
15	West Bengal	19.4	19.2	21.5

Source: Registrar General, India SRS - 1993

Moreover, Indian women are forced to accept sexually whatever their husbands want. They are not supposed to express and enjoy their sexual desires and feelings as males do. Since marriage is a very stable institution in India and there are very few cases of divorce (this will be discussed in subsequent section) most of the women's sexual behaviour patterns are shaped by their husbands. Indian women's economic dependency and a culturally inferior view of their gender (especially if they are divorced or separated) make this situation worse. In all sexual matters women have to tolerate their men's desires to keep them happy.

In most of the Indian societies virginity is greatly valued and under the institution of marriage marital chastity is very important and it is expected that one should not have sexual relations outside marriage. But these social rules are stronger for women and men have always enjoyed liberty. A woman who has had sexual relations outside marriage setting is considered a fallen woman and is invariably punished severely- no matter in what conditions she had it. But the same can not be inferred about a male. Consequently, as has been observed in the previous chapter, the proportion of males experiencing sex outside marital union is around 3 to 4 times more than that of females.

Sexual activity among Indian females outside marriage is related to a number of factors. As Rakesh's study (1980) reported that, the sexually experienced unmarried girls associated their experiences with fear of pregnancy, venereal diseases, and feelings of disgust and guilt. Though we need more studies on this aspect, the above study at least provides an indication that in general, a woman's sexual experience before marriage occurs under their partner's pressure. In case of pregnancy or venereal diseases before marriages a woman will be noticed by society which will definitely bring stigma for her and family. In fact, this fear is so strong that very few girls actually dare to have sex before marriage even with a person whom they plan to marry. But the same is not true for the majority of the Indian males. Their sexual activity outside marriage though considered condemnable is not as punitive as women's. Moreover, after marriage if a man is having sex with a woman other than his wife, it would be his wife who will be blamed for being incapable of satisfying her husband's sexual needs (Bang and Bang, 1991).

Some studies, however, have reported that there exists a small segment of Indian women experiencing extra-marital sex. These women have told variety of reasons for it. (Savara, 1992; George, 1997; Kapur, 1973 and Balse, 1976). Women engages in sex outside marriage for the reasons like economic and social security, brutal physical and sexual experience with their husbands, need to be loved and need to express their sexual desires and feelings. The

major reason behind suppressed sexual life of females and liberties to Indian men in the same regard lies in culturally inferior view of the female gender. Female infanticide, more malnourished girl than boy children, dowry deaths etc. are some examples to reveal women's position in Indian society. In majority of Indian societies a woman has no independent life. Since their birth they have to live under their father's control till the age of effective marriage. After marriage they have to follow their husband's choice and after his death sons will take their care. In most of the Indian societies, however, women have no property rights, and economically they are dependent on their male partners.

The situation in urban areas is, however, changing with the growth in socio-economic conditions and education. Western culture is also influencing this cultural change mainly in upper class Indian urban society, which have easy access not only to better education, luxuries and facilities but also to the requirements for western life style. Armed with all these women of the upper strata have become more assertive and more aware of their legal rights. Moreover, like most of the western societies sexual activity for both men and women of this stratum has become freer and an avenue for pleasure seeking. Expression of sexual feelings and desires in public is no longer a taboo.

The higher levels of education and access, though limited, to some luxuries and facilities have introduced cultural changes in the life of middle class. To a greater extent the life style of upper class also influences changes in middle class behaviour. Middle class tries to adopt the norms and cultural values of upper class in which its economic limitations and cultural values act as major barrier. So, the middle class is hanging between its own and the aspired culture due to economic and social limitations as well as cultural barriers. It is actually one of the major causes for majority of call girls, mostly belonging to middle class, to enter in this profession. They find it as an easiest way to mingle with upper class and to achieve higher status.

In the context of HIV/AIDS prevention, it is necessary to see what is meant by the term prostitution in a particular socio-cultural setting and how a male member's visit to a CSW is seen by the society. As it has been discussed, even today there are some societies in which a girl have entry into sex trade as an option. These societies celebrate the occasion when an adolescent girl of their community enters into the flesh trade. Likewise, there is a long tradition of *Devdasi* especially in Orissa and Southern States. Under this system a girl is devoted to the Goddess Yellamma by her parents for many reasons, but the reason which has been highlighted is spiritual gain. These *Devdasis* also known as Jogatis are supposed to perform the duties of a wife for the God. She is also supposed to sing and dance before 'her' God. But the rights of her body used to

be reserved for the priest of the temple. A *Devdasi* used to have sexual relations with the priest and with those devotees, who were recommended by the priest. The sexual relations with all these devotees, in fact, a *Devdasi* used to have against money, which actually goes to temple, but this has been given spiritual form, which is socio-culturally accepted. In Orissa however, *Devdasi* is an employee of the temple who is supposed to perform singing, dancing etc. for the God, and she is not bounded to have sex with priest or any devotee as a part of culture. Situation of *Devdasis* varies in various regions of the country. In Karnataka, *Devdasis* are well accepted in the society and they have been invited home by the people on different occasions. The daughters of these *Devdasis* and also newly initiated ones have now shifted to various red light areas of the country. Here, though they are working as any other CSW, consider themselves of higher status than the common CSWs.

Finally, however, culture is not stationary but keep on changing with aspirations and values of society, which are mediated by the mass-media, economic conditions, education etc. With cultural changes outlook and understanding of society towards any act of its members also changes, thus sexual attitudes and behaviour are modified.

3. Religion

Almost every religion of the world sanctions a kind of sexual behaviour for its followers. For instance, in Hinduism, if there is a whole book on sexuality and sex education, i.e. Kamasutra, then there are also many other pieces of literature which describe what is good and what is bad sexual behaviour. Virginity of the unmarried girl and marital chastity is greatly valued both in Islam and Hinduism. There are punishments described for men and women who go against the religious sanctions.

The extent to which religious sanctions affect a person's attitude and behaviour depends upon that individual's attitude towards religion itself. It largely depends upon the environment he receives at home and partially in his education and environment outside the home. According to Berelson and Steiner (1964), at least in the United States, the more devout people, both men and women but especially the later, begin sexual activities at a later age and engage in them less frequently and more conservatively; but once sexual activity is begun, the differences are small. Kinsey et al.(1948) in their study found that the differences between religiously devout persons and religiously inactive persons of the same faith are much greater then the differences between two equally devout groups of different faiths. In regard to total sexual outlet the religiously inactive groups may have frequencies that are 25 to 75 percent

higher than the frequencies of the religiously devout groups (Kinsey et al, 1948). Kraft's study (1991) among Norwegian adolescents report that the higher median age at first sexual experience of intercourse was observed for those boys and girls who and whose parents also were religiously more committed (Kraft, 1991).

There is, however, no study of this content in Indian context but studies in other parts of the world reveal the relationship between religion and sexual activity. To understand the extent to which religiosity of people influences their sexual behaviour in India this issue has to be included in the studies on sexual behaviour patterns.

4. Educational level and life options

An individual's educational level is directly related to life options available for him. Both these factors together and separately, in either way, influence people's sexual attitude and behaviour. Educational level includes the years of schooling as well as the quality and type of education. The life options deal with the real opportunities available for self-actualisation to any social group. An individual with higher level of education will be having more life options as compared to an individual with lower level of education. Education is, however, also one component of life options. People with lower level of education and with fewer life options may easily fall prey to lonesomeness, especially when the people around them are more educated and at comparatively higher positions. In this condition it is very natural that they will seek emotional and societal support by developing intimate associations. In their search for support and intimate association they find developing sexual relationships as one of the easier ways available.

People with higher education would be having more professions available, basing on their capabilities, which in turn may aspire them to achieve more. This aspiration works as a major factor in shaping of people's sexual behaviour, as it has been discussed earlier that people's sexual behaviour accords with the social group into which they ultimately wanted to move. Studies have also shown clear variations in sexual behaviour of educated and uneducated or less educated people. For men, sexual activities decreases with the increasing level of education while for women the reverse trend have been reported (Sharma and Sharma, 1995; Rakesh, 1980; Kinsey et al, 1948; Berelson and Steiner, 1964).

In a study amongst Gujarati youths it was reported that less educated (till fifth standard or less) and illiterates were more involved in sexual activities as compared to their higher educated counterparts. They were also more likely to

visit CSWs (Sharma and Sharma, 1995). This findings are similar to that for American youths, reported by Kinsey. Kinsey et al.(1948) reported that amongst U.S. men the highest total sexual outlet (marital or otherwise) occurs among those who have only some high school education and are in semiskilled occupations. They found that the mean frequency per week was less for those males who had 13 or more years of schooling than that for men who had 12 or less years of schooling. As against men, for U.S. women, there is a slightly higher outlet for those with high school education and beyond (Berelson and Steiner, 1964). Rakesh (1980) has also reported the same trend among college girls of Delhi. The study reports that the proportion of girls with higher levels of education was more among those who have experienced pre-marital sex and have liberal attitude towards it.

A possible explanation for reverse trend in women as compared to men may be that with higher education, women become more assertive and aware of their rights. Which may be responsible for their freer attitude and behaviour in relation to their less educated counterparts. Whereas in case of men with higher level of education, they become more serious and ambitious about their career and may find less time to involve in sexual relationships. The same may also be true for women that with higher level of education they become serious and ambitious about their career but due to social perceptions of women's role and also because of the domination of men in the world of professions they find less options in the field. Men with lower levels of education will be having fewer and less diversified employment opportunities. At the same time, opportunities for non-economic self-satisfying activities will be less for these people. As against less educated men, less educated or illiterate women may be having limited societal interactions and more familial limitations and are therefore under more pressure of socio-cultural rules and norms. It is, however, not certain. We need to have more studies in this connection, so that actual factors responsible for this trend can be explored.

In fact, educational level of people depends upon their socio-economic status. As has been discussed earlier, the sexual history of people accords with the patterns of the social group into which they ultimately move. Here, therefore, it is again people's socio-economic status which determines their educational level which subsequently shapes their sexual behaviour. However, this may not entirely hold true for people with higher socio-economic status where educational level may not play an important role in shaping their sexual behaviour. Similarly among the lower socio-economic classes due their economic backwardness and lack of access to better education their sexual behaviour is not much influenced by educational levels. So, it is mainly among the middle

classes, that socio-economic status and educational levels have a direct bearing on sexual behaviour.

5. Mass-media and modernisation

Modernisation stands for the changes brought about in people's life styles under the influence of western culture which is invading through various channels, mainly through mass-media (which includes electronic and print media) and direct cultural contacts. At any given point of time, mass-media actually reflects the prevalent attitudes, views and cultural norms amongst that group of contemporary society which virtually controls it. In turn mass-media acts as a major catalyst for cultural change. Though mass-media reflects the viewpoint of particular group of society, it carries its messages to all sections.

In India it is mainly the upper class, which controls major part of the mass-media. The main interest of this class is to create demand for various commercial products among the general public. This is achieved through widespread advertising. Most of the advertisements actually depict lifestyles of the western society and the richer Indian class. Further, various programmes aired over the television and radio and various lifestyle articles that appears in the newspapers have a distinct touch of the west influenced Indian upper class. Exposure of the general public to all such influences would lead to growth of consumerism and subsequently to a change in attitude and behaviour.

It has been established that media creates impressions, images and identities. What emerges from this creation is a reflection of the upper class society and a picture of an imagined future. As social norms have become more permissive among upper class (whose life-style is well westernised), media (especially television) has become increasingly explicit in its portrayal of sexual behaviour (Bearinger, 1990). Studies of the effect of this content, while scarce, suggest that adolescents who rely heavily on media for information about sexuality will have high standards of female beauty and will believe that pre- and extra-marital intercourse with multiple partners is acceptable. They are unlikely to learn about the need of contraceptives as a form of protection against pregnancy or disease (Brown et al, 1990) as responsible sexual behaviour is rarely communicated.

With growing consumerism, the advertising industry increasingly started to indulge in a not very subtle use of the erotic and sensual to sell their products. The society is becoming increasingly sensualized, with lips, breasts, cleavages and skin spilling out of every paper, magazine and TV programmes. All these factors point to a situation where there is a growing tendency towards freer

social relationships outside of immediate family, village or caste control. With the increasing independence of women, one would expect a larger number of affairs contracted, not on the basis of force or money, but for mutual satisfaction (Savara, 1992). Effects of all these above discussed, which can also be termed as modernisation of society and culture, is more visible in cities (specially among higher class), where people's accessibility to mass-media and vice-versa is easier than in rural areas. This is also because of their inherent differences in purchasing power and developmental disparities.

In a study in which modernisation was defined as liberal attitude of family towards dating and friendship with boys, freer access to media and exposure to eroticism, it was found that the girls reporting higher degree of modernisation were more permissive in their sexual attitude and behaviours than girls reporting lesser degrees of modernisation (Rakesh, 1980).

In USA, both girls and boys are initiating sexual intercourse earlier than ever before, and girls are getting pregnant at greater rates than in other industrialised countries in the world. In 1971, only one among every seven fifteen year old girls in the United states had sexual intercourse (Kanter and Zelnik, 1972). By 1986 the ratio had increased to more than one in four. About one quarter of college women in USA reported having been raped or sexually assaulted since they were 14 year old (Koss et al, 1985). Moreover, one in ten teenage girls became pregnant each year (Jones et al, 1987). This rapid change in adolescent sexual activity in USA is greatly influenced by television, as Brown et al (1990) has found it after reviewing studies of this content.

Another example of this content is provided by FPAI-SECRT's study (1993) in 15 big cities of India, among 15 to 29 year age group. 47 percent of male and 38 percent of female respondents of this study have quoted mass-media as their source of most useful information about sex. As according to the same study, the knowledge among its respondents regarding sex was not good and was even less about contraception. It can well be observed that mass-media is playing a major role in providing (mis)information regarding sex to a large number of males and females. Other sources of information about sex quoted by the respondents of the same study in decreasing order were friends (51.5percent males and 32.2 percent females) teachers (16.2 percent males and 20.3 percent females), and parents (3.2 percent males and 13.2 percent females).

Overall, media has very important role in shaping people's ideas regarding their appearance, needs and priorities in life and ultimately their attitudes and behaviour in general. On the other hand, through advertising media is accelerating the growth of consumerism and creating demand for varieties of things.

Further, advertising create status symbols out of commodities and depicts them as basic amenities for a 'good-life'. Consequently, it is creating an aspiration among people for all those facilities. With increasing aspiration, most of the people, especially of middle class, are trying to be seen as modern as media is projecting and also as they are finding in their surroundings. In turn, where it leads them to, has already been discussed.

Thus media to a large extent is responsible for rapidly changing attitudes and behaviour and also for (mis)information regarding sex in the society. And it is in two ways: first, by showing various kinds of programmes through which it creates images of desired body shape, modern attitudes and behaviour etc., and second, by advertising the kind of facilities through, which it creates the symbols of higher status. In fact, the later is feeding the needs created by the former. Therefore mass-media is playing major role in shaping people's attitude and behaviour related to sex in dual ways.

6. Peer group

One's peer group influences an individual's attitude and behaviour especially towards sex. Friends or peers are an important influence on adolescents. Adolescence being a stressful period of growth, it is natural that the youth experience a sense of security in being with a group undergoing similar stress and subscribe to the norms of this group. It is not unusual to see students making choices on matters concerning pursuit of further education, choice of subject, college, extra-curricular activities, even matter of personal appearance, food habits and so on, on the basis of choice(s) made by their peers. While friends are an important influence (Hans, 1994) they too are products of societal factors discussed previously.

Within a peer group, people feel more comfortable to talk and exchange their views regarding sexual matters rather than with anybody else (parents, teachers etc.). It is more relevant in the Indian context, as there are very few families, in which talks about sex between parents and children are appreciated. Most of the parents do not like to talk about sexual matters with their children. Moreover, an individual behaves as per norms of his peer group to remain a part of it and also to receive his friends' greater acceptance, at least for the duration he lives amongst them.

It has been found in a number of studies that a significant proportion of respondents quoted their friends as source of their knowledge about sex (Rakesh, 1980; FPAI-SCERT, 1990 & 1993; Sehgal and Singh, 1992; Sehgal and Arnold, 1994; Francis et al, 1994; CCM-AIIMS; Sharma and Sharma, 1995 and Sachdev, 1997). Moreover, there are studies reporting that among those who have expe-

rienced sex with CSWs, a significant proportion have done it under the influence of their friends (Bansal, 1992; Bansal, 1995; Rao et al, 1994; Kanbargi and Kanbargi, 1996). A study in Norway found that there is a significant correlation between decreased age at first experience of intercourse among both boys and girls who reported having visited discotheques more than 5 to 7 times a month and whose frequency of alcohol consumption were more than 5 to 7 times a month. Both these groups have reported maximum peer affiliation as one of the significant predictors of age at first experience of intercourse (Kraft,1991).

Comparison of Indian's sexual behaviour pattern with that of other countries

As it has been discussed under previous section that there are certain factors which mainly determine that what type of sexual attitude and behaviour will exist in a society at any given point of time, it is very natural that with changes in these factors, the sexual behaviour and attitude will also change. The variations in sexual behaviour and attitude are thus, very natural across societies and countries due to variations in their socio-economic structures, cultural institutions, norms etc. Here, a careful note needs to be taken regarding the fact that none of these determinant factors works in isolation. They all are needed and in varying combinations their effect also varies. So, there is every possibility that two societies at equal socio-economic status will be having large differences in their sexual behaviour and attitude due to the variations in other factors. Similarly for all other factors too.

For instance, as it has been discussed in the last section that half of Indian girls are effectively being married by the age of 19.6 years, among whom, again a major proportion is experiencing sex at lower ages. It has also been discussed in previous chapter that only about 5 to 10 percent of women are experiencing sex outside marriage setting (Rakesh, 1980; Basu, 1994 and CCM-AIIMS). A large proportion of Indian women are experiencing sex at early ages and their sexual activity remains within marriage itself. In Norway and France the median age at first sexual experience for girls are 17.3 (Kraft, 1991) and 18 years (ACSF, 1992). This means that in these countries the girls are experiencing sexual intercourse at even younger ages than in India and that too largely outside marriage. In Sweden also 58 percent of 18 year old girls are coitally active before marriage (Herlitz, 1993). Moreover, in these industrialised western countries, since girls are equally free as boys, more than one sexual partner in their lifetime is very much possible. In Sweden 47 percent of 18-19 year old sexually active girls have reported that they were single with no

regular partner. This proportion raised up to 62 percent for 16-17 year old coitally active girls (Herlitz, 1993). It is contrary to the Indian setting, where strong societal rules and norms, especially against women's involvement in sex outside marriage, restrict their sexual activity to marriage setting and reduce multiple partners.

Overall, India has many differences in terms of socio-economic, cultural and other institutions with industrialised western countries. These differences in accumulation are actually responsible for the variations in sexual behaviour patterns in these countries. In a different way, these reasons lead to differences in sexual behaviour pattern of Indians from that of the many Latin Americans, Africans and Thais. Though all these are low-income regions, the differences in their sexual behaviour patterns can be explained on the basis of cultural differences between them, which are further supported by socio-economic and other factors. For instance the conceptual framework of marriage in most of the African societies is entirely different from that in India. Social concern with pre-marital or extra-marital sexual relations endangering marriage is unlikely to be strong if marriage does not establish the basic unit of society. This is in fact, the case with the African descent lineage. Fortes (1949) argued of West Africa that the real bonds are within the lineage, and not across marriage lines. Bleek (1987) wrote of Ghana: 'whatever people say about their preference for stable marriage, in practice lineage stability comes before marriage stability. Security is found in the lineage rather than in marriage, and it would be foolish to invest much in marriage, Jack Goody (1973) reported that the lineage of the Lo Willi of Ghana often wanted children so much that they encouraged their girls to have them before marriage so that the lineage could keep them. In most of the African societies virtue is related more to success in reproduction than to limiting profligacy; and in many societies the initiation ceremonies allowing sexual activity to commence are ritually more important than the celebration of marriage. The marriage bond is typically weak, with spouses retaining strong lineage links, and with a marked spousal separation of economic activities and responsibilities; the marriage payment takes the form of bridewealth paid to the wife's family from the husband's rather than to the couple themselves and never included land. In many of these societies, polygamy exists on a scale not found in the Eurasian system, and consequently the basic family unit is a mother and her children. Divorce is fairly common. Among most ethnic groups and women, at least in the past, abstained from sexual relations after giving birth for a period that might extend to years. (Caldwell et al, 1994). McGrath et al. (1993) have found no significant institutional constraints on marital separation among the Baganda ethnic group in Uganda, so that high rates of marital dissolution are not unexpected.

As it has been discussed earlier that in Indian context the importance given to marital union makes it much stronger and stable. Marriage is considered as basic unit of most of the Indian societies. This is reverse to the situation in most of the African societies, where marital union has almost nothing to do with the regulation and institutionalisation of sexual activities. Because of socio-cultural reasons most of the African males and females are free to have sex as per their choice. Since marital unions are not strong and stable, it is very much possible for a women also to have more than one sexual partner even under the institution of marriage (serial monogamy). Whereas, it is almost unthinkable for an average Indian women because of socio-cultural rules and norms.

In above discussed and similar kind of other situations where entering into and coming out of the institution of marriage has no strict regulation and remarriage is a norm, it is very difficult to define non-regular sexual partners. In most of the Indian societies it is not like that and marital sex predominantly occur only with one partner and since the process of divorce is very difficult and it has not yet received social sanctions in general, it is easy to define one's non-regular sexual partner. According to the Ministry of Health and Family Welfare of India's Year Book, 1993-94, there were only 0.23 percent males and 0.42 percent females living as divorced or separated. The socio-cultural norms against divorce or separated individuals seem to have much influence on people's lives, in India. But in African and Western societies serial monogamy (remarriage after divorce) is not uncommon due to their socio-cultural beliefs, rules and norms. In due course of development in all the ways, in Western industrialised societies most of its social institutions have lost their importance in an individual's life; especially personal life in which sex is included. Community pressure on individual's sexual behaviour is almost negligible. Now, with more developments, couples have started cohabiting even without marrying. Moreover, successive reforms in the law, which have gradually extended the facilities for divorce to a wider population (Hart, 1976) have also influenced the serial monogamy. Since, after various reforms in the law a marriage can be ended on the grounds that it just does not work; and there is no necessity to allocate blame and retribution between the two partners (Hart, 1976), the process of getting divorce became much easier in countries like U.K.

Overall, in industrialised Western and African countries defining marriage itself is a problem. To overcome this problem GPA (Global Programme on AIDS) surveys have used a broad definition of marriage such as to include any sexual relationship that had lasted for one or more year, or if more recent but expected to continue for at least this period of time (Carael et al, 1995).

Moreover, in most of the industrialised Western countries consumerism has reached at almost peak whereas in India it is a recent phenomenon. Under the process of consumerism almost every aspect of human life which can be bought and enjoyed has been commodified. Commodification of sex is a part of it that can be enjoyed by providing enjoyment (kind of payment) to a partner or also it can be bought against cash. Community has nothing or very little to say in it. Though, consumerism has taken few steps in India and succeeding in its aim too, it is mainly located in metro cities and specially among higher classes. The process of its filtration from upper to lower classes of society is also taking place even then it is not affecting to a greater part of the population due to their deeply rooted social values and institutions and to some extent also due to unfavourable socio-economic conditions.

In Sub-Saharan African countries, predominantly in cities, with the increasing dissolution of the traditional family system, many women have become the providers of income for themselves and family members and many are forced by poverty into some form of prostitution (McGrath, 1991). It is also a phenomenon in the Indian context. Studies from Thailand also suggest the same thing. In fact, almost in every part of the world, the main reason for a woman to enter into sex trade is economic. Social conditions act as a 'pull' and 'push' factors in the process. For instance, in Thailand, Phongpachit has traced the historical origin of prostitution to a culture of male dominance in which polygamy and concubinage played a significant role. She finds two reasons for the establishment of prostitution on a large scale. Firstly in response to the predominance of young males in the migration streams attendant to Thailand's urban growth in the late nineteenth century and second, that prostitution is a by-product of the double standards for males and females pertaining to pre- and extra-marital sex inherent to traditional Asian sexual cultures (Ford and Koetsawang, 1991). The reasons for the present rapid growth of sex-industry have been analysed by Usher (1993). She finds that it is a result of lopsided developmental policies accompanied with the introduction of consumerism in Thailand. This has been discussed in detail under an earlier section. In this regard situations are more or less similar in India and also in many African countries. In this regions also it is mainly economic factor, which pushes a girl in sex-trade. However, the differences lie in socio-cultural context of sex-trade in these countries.

In India, it is not a woman as individual who takes decision to enter into the profession of commercial sex, even due to the poverty. Leaving aside those caste-groups in which sex-trade is traditionally accepted, in other Indian societies, a girl once entered in the sex-trade is considered dead for the family.

Besides poverty other social factors like inferior look at girl child, dowry, higher expenses in a girl's marriage and other problems in upbringing a girl child, force poor parents to send their young daughters with 'agents' to the urban areas to work as maids in houses. Sometimes parents also sell their young daughters to meet their immediate financial needs. Many of these girls end up in the sex-trade in urban areas. So, in India it is actually man who takes the advantage of his superior socio-cultural position over a women and makes profit out of their bodies. A more relevant example in this regard is initiation of thousands of minor girls in prostitution through socio-culturally approved 'Devadasi' system, which has been discussed earlier.

In contrast to Indian situation, in African countries and in Thailand, as studies show, its actually a woman who takes employment in sex trade. If, in African societies more or less free sexual culture is responsible for it then in Thailand, there are evidences that the very scale of the numbers involved in sex industry and importance of remittances returned have combined to greatly reduce social stigmatisation and social sanctions against sex-profession in some communities, especially in the Northern region. It has been suggested that links with the commercial sex industry have become so common in some villages in the Northern Thailand that when a daughter is born her parents celebrate with lavish meal, parents are seeing their daughters as commodities that will soon bring the family wealth (Rattanawannatip, 1990). Money earned through prostitution is often used to build new houses for the families. Rather than being stigmatized, a young women who has acquired some wealth from working as a CSW may become an attractive marriage prospect in her home area. It should be noted however, that community attitude to daughters' involvement in the commercial sex industry are different in other regions of Thailand. In the North-East it may be reluctantly tolerated as a means of coping with the family's deep poverty, whilst in the (slightly more prosperous) South negative sanctions are fairly strong. Indeed, many CSWs in Bangkok from regions other than the North strive to keep their occupation a secret from their families and home community. The importance of the social and community dimensions of involvement in the commercial sex industry is further evidenced in that girls often (at least initially) take employment in establishments where siblings, relatives or friends, already work. The procurers of CSWs in a village are often female members of the community who have experience of prostitution themselves(Ford and Koetsawang,1991).

These are, however, not the only differences between these three regions, the socio-cultural context, in which a male visits CSW, is also different in India from that in African countries and Thailand. In African countries, due to less

importance given to marriage the visit of a male to CSW in most of the societies, is not stigmatised. Moreover, a male is expected to visit CSWs in these societies. Postpartum abstinence in some African societies used to be observed for at least 40 days which may continue in some societies even for a year. During this period of time a man is free to have sex with his other wives or visit CSW. There appears no strong socio-cultural sanctions against a male's visit to CSWs. Though, in Indian societies man is enjoying superior position, his visit to CSW have never been encouraged and it invariably brings a social stigma for him as well as for his family. Most of the Indian men's visit to CSW are usually a secret from their families and community. As it has also been observed in the last chapter that about 10 percent of studied male groups have visited CSWs. In Thailand, however, the situation in this regard is different from Indian and African region. In Thailand also, the recourse taken to CSW by single and married Thai males is certainly not 'socially acceptable', it nevertheless continues to be a significant component within the overall sexual culture. A survey of the sexual experience of Bangkok students(from universities, teachers, colleges and commercial colleges) aged twenty or over, revealed that nearly two-thirds of the males admitted to having engaged in sexual intercourse (Koetsawang, 1987), which is around two to three times more than that for Indian urban males. Furthermore, two-thirds of the Thai male non-virgins admitted having engaged in sexual intercourse with prostitutes (Koetsawang, 1987). This is also more than that of sexually experienced educated urban males in India. In Thai societies, as Niramol Phrvethatorn, a senior member of the (Thai) Friends of Women Group has commented "people always say that a man who 'mai thiew' (a man who does not frequent prostitutes) is not a real man" (Rattanawannatip, 1990). In this way, a Thai man's visit to CSW is seen as the sign of virility or of real manhood at least among his peer group which exert a pressure on him to visit CSW. As a result of these differences in the socio-cultural context of sexual behaviour patterns in India are not as risky for the spread of HIV/AIDS as in Thailand, most of the industrialised Western and African countries. This fact is evident by the studies on sexual behaviour patterns in some of this countries and also by the reported rate of AIDS cases (AIDS cases per one hundred thousand population) and the modes of transmission.

Carael et al, (1995) has surveyed 18 developing countries to study the sexual behaviour patterns in these countries. For this purpose they have defined marriage so as to include any sexual relationship that had lasted for one or more than one year or if more recent but expected to continue for at least this period of time. All relationships lasting less than 12 months were classified as non-regular. Using this definition they found that in studied African countries 8 to 47 percent of males and 2 to 19 percent of females reported non-regular

sexual partners in the last twelve months. By going through earlier discussion in this section about the institution of marriage and sex-culture in many African societies, it can be observed that the definition of marriage used here has many limitations. Comparing the Indian situation with other countries using this definition will mean that the percentage of Indian population involving in sexual relationships outside marriage setting will definitely go down from what available studies have reported. As it is sexual behaviour outside marriage is already much less than in many of the other countries (about 15 to 20 percent for urban educated males and about 6 to 8 percent for females). It will decrease because of following two reasons:

(i) The studies in India have defined no specific time limit but recorded if the individual had any pre-marital or extra-marital sexual contact in his/her life-time.

(ii) A significant proportion of those males and females who have reported sexual contact before marriage have had it with their fiancé/fiancée which in general, expected to continue for the rest of their life time. This percentage of males and females will have to be deduced from the total sexual activity outside marriage setting if we use the definition given by GPA.

Thus, where 14% males and 5% females in Central African Republic; 47% men and 13% women in Cote d'Ivoire; 38% men and 19% women in Guinea Bissau; 20% men and 5% women in Uganda; 28% men and 12% women in Kenya; 45% men and 10% women in Rio de Janeiro and 28% men and 2% women in Thailand reported to have multiple sexual partners in the previous year the figure would be much less for India. The comparison of AIDS case rates and percentage of heterosexual transmission in these countries also support this. See table 2.2.

Table - 2.2: Comparison between magnitude of the problem of AIDS in India and in other countries.

Sl	Countries/ Region	AIDS case rate	Heterosexual transmission (% of cases)	Heterosexual transmission rate @	Heterosexual transmission rate as multiple of Indian rate $
1	India	0.09	73	0.065	1
2	Thailand	30.2	89	26.878	409
Europe					
3	Denmark	2.99	17	0.508	8
4	France	6.33	19	1.202	18
5	Germany	1.43	8	0.114	2
6	Norway	1.15	20	0.23	4
7	Spain	14.31	11	1.574	24
8	U. K.	2.08	15	0.312	5

contd...

contd..

Americas					
9	U.S.A.	13.81	13	1.795	27
10	Mexico	4.42	34	1.503	23
11	Canada	2.68	13	0.348	5
12	Brazil	10.02	34	3.406	52
Africas					
13	Angola	1	59	0.59	9
14	Botswana	98.69	94	92.769	1412
15	Chad	18.98	98	18.6	283
16	Ethiopia	1.47	97	1.426	22
17	Mozambique	12.61	84	10.592	161
18	Niger	6.89	99	6.821	104
19	Zimbabwe	79.28	86	68.181	1038
20	Togo	35.77	91	32.551	495

Source: Report on the Global HIV/AIDS epidemic, December, 1997, UNAIDS and WHO.

@, $] estimated based on source

$@ = \frac{\text{AIDS case rate}}{\text{heterosexual transmission (\% of cases)}}$

$\$ = \frac{\text{heterosexual transmission rate in a country}}{\text{heterosexual transmission rate in India}}$

In table 2.2, situation in India, Thailand and in major Western and African countries has been shown. In the third column, the AIDS cases per 100,000 population has been given, which shows that India is lagging behind as compared to other denoted countries. Taking heterosexual transmission into account it can be observed that the percentage is high for those AIDS cases in India who have contracted HIV infection through heterosexual mode of transmission. The rate of heterosexual cases per 100,000 population is still lower in India than Thailand and other major countries in Europe, American and African continents, (see fifth column of table 2.2). The last column of the table indicates the rate of heterosexual transmission in the mentioned countries as a multiple of the Indian rate. While it can be argued that under-reporting of cases in India account for the low rate of AIDS cases and its heterosexual transmission, the difference in rates is so large that this can not be the full explanation. Further, under-reporting is as likely in many of the other regions too.

Thus, sex related attitude and behaviour of people, is determined by various interrelated factors. None of these factors work in isolation and we cannot explain people's sexual behaviour on the basis of only one factor, though their importance varies in relation to each other. Sometimes for some group of people socio-economic status appears to have major impression on their sexual life and other factors namely, culture, education, religion, mass–media and peer groups seem to have less importance. But for some other group of the same society, it is very much possible that other factors may become major determinants of their sexual life. Thus, the role of these various factors influ-

encing people's sexual life, varies for different groups in a society. Further, it also varies from one region to another and from country to country.

However, there is sufficient multiple partner sexual behaviour to make the spread of HIV a public health problem. Now so far, spread of HIV infection is concerned, it seem that in India its spread through heterosexual relationships route is many times less than that in other mentioned regions. It can, therefore, be expected that the HIV infection may not go to the extent it has reached in those regions.

As it has been discussed, that in India itself, sexual attitude and behaviour varies from one group to another. If at upper class of Indian society, their aspiration to westernisation mainly shapes their sexual attitude and behaviour than at lower class it is their economic condition which mainly influences sexual behaviour. At middle class of Indian society, these both (higher class aspiration and economic conditions) factors seem to act together. Other discussed factors also play their role in shaping of sexual behaviour in various ways for mainly these three strata of Indian society. It is clear that the factors influencing these three strata and their sexual behaviour are tending to increase unsafe and multi-partner sex. Unless something is done seriously to address those factors, the behaviours leading to spread can only increase.

CHAPTER III
PREVENTION AND CONTROL OF HIV/AIDS IN INDIA.

The Global AIDS prevention strategy consists primarily of three interrelated strategies: (1) Encouraging people to reduce their number of sexual partners, (2) Promoting the widespread use of condoms, and (3) Treating concurrent STDs in population at risk of HIV. The current global strategy is inadequate for meeting the protection needs of people in the context of previous two chapters.

In the context of discussion taken into previous chapters, for the prevention and control of HIV/AIDS in India through sexual route, the possible strategies can be categorised under following headings:

1. Socio-economic development.
2. Women's empowerment.
3. Strengthening of national health services.
4. Short term interventions.

1. Socio-economic development

As it has been discussed in previous chapter that socio-economic status of people play a major role in shaping of their sexual behaviour. It acts through various ways. Migration and poor economic conditions are mainly predisposing people to risk of HIV infection. Lopsided developmental policies are exacerbating the condition. In this context to reduce HIV transmission substantially modifications in developmental policies are needed. In policy making due attention has to be given to the overall development of poor people. Lurie et al, (1995) have suggested the elements of an alternative development strategy which are as follows:

(a) The satisfaction of basic human needs such as food, housing education and transport must become primary goal; this can be accomplished in large part by reducing spending on military and luxury commodities. A relatively inexpensive example of this would be altering long distance truck drivers' work schedule so that they spend less time away from

home, potentially decreasing the frequency of sexual contact with casual partners.

(b) To answer regional self-sufficiency, emphasis should shift from the production of small number of primary commodities for export to the diversification of agricultural production. This may help in stopping rural to urban migration through the development of agriculture.

(c) Marginal producers and subsistence farmers must be supported. Thus, large infrastructure project that are often environmentally destructive and socially disruptive, must be de-emphasised and more attention paid to smaller scale projects using appropriate technology. This may help in reducing the growth of urbanisation due to rural to urban migration, beside stopping trafficking of poor rural girls for sex trade in urban areas.

(d) Because the economic value added in the production process results largely from the technological innovations that occur in industrialised countries, greater emphasis must be placed on human resource development in developing countries, which may help in reducing the number of unemployed youths and also in increasing better income opportunities.

(e) The kind of paternalistic 'top-down' approach adopted by governments in many developing countries and favoured by the IMF and the WB must make way for a truly co-operative development policy, in which the desires of developing country citizens can be heard.

Eventhough, these above suggested solutions are nowhere directly related to the HIV/AIDS problem, they may be affective in reducing the pressure of factors pushing an individual at the risk of HIV/AIDS.

2. Women's empowerment

Due to their biological structure of genital organ and inferior position then men in every aspect, women are at more risk of HIV infection than men. A decade ago women seemed to be on the periphery of the epidemic. Today they are at the centre of concern (WHO-UNDP-UNDAW). As it was discussed in the previous chapter, the women's condition is so, that the three pronged strategy (mention above) of AIDS control and prevention programmes can not meet the protection need of many of the world's women (Heiss and Elias,1995).

So far as first and second methods of AIDS prevention (encouraging to reduce multi-partner sex and condom promotion) are concerned there are number of realities in women's lives that limit the utility of this prevention advises. First, for most women in need of prevention are not sex workers but women with one partner, their husband. For them monogamy is an irrelevant

strategy. Studies indicate that 50-80% of all infected women in Africa have only one sexual partner and at 1991 infection rates on estimated 1500 monogamous women were being infected each day. In India, 30-50% of HIV seropositive person are women, most of whom have been infected via heterosexual transmission and many of whom do not belong to high risk group (d'Cruz-Grote,1996). It is the sexual and drug using behaviour of these women's sexual partners that put them at risk. Second, for a significant portion of those women, who are not monogamous, having multiple partners is not a pleasure seeking strategy, but a way to gain access to resources that only men control. These women can not easily reduce the number of their sexual partners; multiple partners are their key to survival (Heiss and Elias,1995). With few marketable skills, women may have to use sex as a means of earning a living for themselves and their children. And, that partner reduction and condom promotion messages assume that women are always in control of when they have sex and with whom, while it is not like that. There is enough literature to show that not only sex workers but housewives too, are unable to force man to use condom and in taking control over their own sexuality. On one hand if this is related to the question of bread earning and securing place in brothel for sex workers then on the other, it is related to the question of social security for housewives. As has been discussed in previous chapter that Indian women have almost no control over their own sexuality for various reasons, the strategy of partner reduction and condom promotion is irrelevant for them. Further, as data on rape and coercive sexuality indicate, the above strategies are far from the case in many sexual encounters. Now as far as the third method to prevent HIV spread (i.e., STD treatment) is concerned, there are again number of constraints for a women, which prevent her to visit STD clinic. The first constraint in this regards is the asymptomatic nature of STDs in women itself (Bang and Bang,1989). This makes women's much more vulnerable to HIV infection. The second constraint is related to the social meaning of the disease. In most of the Indian societies STDs are seen as manifestation of promiscuous behaviour. Since, women are already in inferior position, they may face grave consequences if their STD surfaces. If a women contracts STD infection, society first doubts her chastity and then her husband's relations with other women. Even if husband's relations with other women become known, its his wife who will be blamed for being incapable of satisfying her husband's sexual needs. Therefore, most of the women, even after manifestation of the disease, do not go STD clinic. Overall, social stigma attached to STD clinics prevent many women to go there even if they need treatment badly.

In all the ways, the methods available to prevent HIV infection are under the direct control of men and for discussed reason women can not force them to

follow or to use these methods. At the same time there is no alternative method available to which a woman can use without letting her male partner know about it.

There is, therefore, an urgent need for women's socio-economic empowerment so that they can choose, when and with whom they should have sex and also they can ask their partner(s) to use condom. For women's empowerment, first we need overall socio-economic development programmes, discussed before, under which issues related to women should be emphasised. It is also because any kinds of socio- economic problem first affect a woman. Invariably in most of the Indian houses its a woman whose health, education and specially appetite suffer in case of any economic problem in the family. Again, its a girl who may be sold out by her parents to meet urgent economic needs. Therefore, overall socio-economic development will lay down the foundation for women's empowerment.

For women's development, the first need is their health. Girl child's birth in general, is not welcome in a family and they are never considered as a member of the family because they will go off after marriage. So less attention has been given to a girl child's rearing up process. Consequently, they develop bad health that affects their education also, if they are admitted in a school. So first attention would be given to their health and nutrition.

The second need is women's education. It has been noticed that when education opportunity for women improve it influence their life in many ways. The increasing level of women's education is directly related with the increase in age at their marriage and it decreases the age difference between sexual partners (Decosas, 1996). Apart from providing women, better opportunities for higher education, creation of avenues for employment or entrepreneurship are also necessary. This may at least reduce their complete economic dependency on men, which would, in due course of time also influence their socio-cultural position. Even in case of CSWs also they may be provided with other economic opportunities without asking them to leave their occupation, so that they can exercise control over their clients. They may be persuaded through this approach to leave sex trade also. Overall, provisions of supportive kind of economic opportunities would empower women to exercise better control over own body. For example, in Zambia women fish traders are frequently forced to provide sex in addition to cash to buy fish from fishermen. As a way to protect hem from this kind of sexual exploitation the National AIDS Programmes, in collaboration with a women's group and the Zambian Co-operative Federation, have formed an economic co-operative that conducts collective bargaining for ish as well as giving credit to woman fish traders (Rao Gupta,1995). Experi-

ence gained in empowering women to exercise control over their lives in other areas, e.g.,family planning can have implications for HIV/AIDS prevention. In Bangladesh, though the credit programmes of the Grameen Bank, rural women have become economically empowered to exercise greater control over their sexual behaviour as indicated by their increased contraceptive use (d'Cruz-Grote, 1996).

These are, however, long term solutions. There would be little progress in improving the economic status of women and in promoting gender equality unless policy revision are undertaken to enable access to education, skills training and employment opportunities for women. Simultaneously, the sexual vulnerability of women must be addressed. There is growing concern about the link between sexual violence and HIV transmission. Sexual abuse of girls and forced sexual intercourse has never been addressed adequately. The culture of silence surrounding incest, sexual abuse and sexual coercion must be broken. Communities may question cultural and traditional practices that put girls at risk and that sanctions double standards which allow men multiple partners and prevent women from protecting themselves.

For the treatment of STDs among women STD services need to be integrated with other health services, because women are seldom willing to endure the stigma attached to attending STD clinic (Heiss and Elias,1995).

3. Strengthening of Primary Health care Services

We need better STD clinical services condom distribution centres and effective surveillance system besides AIDS awareness campaigns. Since sex and related matters, (including diseases) are taboo in India, expecting that all people would visit especially made clinics for it is nothing but at large the waste of resources. It is more true in case of females. Moreover, as it has been experienced in the case of other vertical programmes, the costs of specific interventions, carried out through these programmes far exceeds the costs of providing the same intervention when integrated, because in the later case the costs of logistics, training and supervision can be shared. Further, in order to carry out their disease control or health promotion activities vertical programmes rely heavily on the very infrastructure, they contribute to weakening (Matomora et al, 1991).

In above given situations to reach everybody in a huge country like India with AIDS prevention messages and STD treatment facilities, we need to have an extensive network of primary health centres with effective services. Though till now lot have been done to provide health services to every citizen of the country but due to centralised structure of the system and top-down ap-

proach, effective implementation of the policies is lacking. In addition to this, similar policies have been drafted for socio-culturally and economically diversified areas and regions of the country, which also hampered the utilisation of health services. Moreover, in long course of number of vertical disease control programmes, the network of primary health centres and sub centres have become the providers of services related to few specific diseases, which again restricted the utilisation of primary health centres (PHCs) and sub centres (SCs) by people in general.

It is, therefore, necessary to improve the quality of primary health care services at PHCs and SCs level and referral services, so that more and more people may utilise it. It would be easier for women to visit SC or PHC for their sexual problem, rather than going to special STD clinics provided STD services would be available there. STD services can be a part of antenatal, postnatal and family planning services, available at SC level. For making it effective there should be effective referral system, which should be within the reach of rural people. Since sex and related matters are taboo there should be a female physician at referral centres so that female patients can easily avail the services.

Now, so far AIDS prevention messages and condom promotion is concerned these can be the part of basic health education and family planning activities. Primary health centres can also serve the purpose of AIDS surveillance centres, if trained worker and equipments are provided there. In this way most of the HIV sero-positive cases can be detected and more lives could be saved.

4. Short Term Control and Prevention

The above discussed three methods are essentially long term interventions. But it does not mean that we should wait till the time these methods will be implemented. The short term methods, like raising awareness, pre and post HIV test counselling, guarantee of basic human rights of HIV positive and AIDS patients, in fact, are very necessary. Apart from these introduction of sex education in schools and popularising responsible and safer sexual practices through various kind of programmes on mass-media may also be helpful in this regard. But all these short term steps should be taken in such a way that later on they can become the part of long term interventions and may sustain.

To raise awareness about HIV/AIDS among people the messages related to it would be framed in cultural specific ways. As it has been discussed earlier that rules and norms regarding sexual attitude and behaviour varies from one to another culture , the messages related to AIDS awareness and sexual practices should also vary. It would only be possible in effective way when the

approach will be bottom - up as against existing top down. When the messages will be formed at local levels with appropriate assistance from of centre, they may be more effective in creating awareness and also in preventing the spread of HIV infection, since they will be taking various local socio-cultural aspects related to AIDS into account. As has been discussed in previous chapter that adolescents are heavily relying on mass-media for information related to sex and sexuality. The media, in this way may be helpful in informing adolescents about responsible sexual behaviours and safer sexual practices. Media beside transmitting AIDS related messages as advertisement, may also raise AIDS awareness through its various programmes.

To prevent coercive sex legal provisions and their implementation institutions should be strengthened and confidentiality of victim. Specially women, would be assured. At the same moment the time taken in jurisdiction procedure should be shortened to prevent the harassment of victims. This may help many women to raise their voice against coercive sex and also help in breaking the culture of silence.

To ensure that majority of people will come forwards voluntarily HIV testing, it is necessary to address the issues of confidentiality of their seropositive status and violation of basic human rights. To address these issues appropriately, proper training of medical workers should be the first step in this direction, so that no HIV positive individual would be denied of treatment and his/her HIV status would remain confidential. Apart from these strict laws should be there against termination of HIV positive people from their respective employment and they should be allowed to work till they need and like to work. There are example (ABVA,1990) when people have been terminated by their employers. Beside this, before and after HIV testing an individual should receive proper counselling. Under this counselling one may be informed of all health consequences and also about the care she/he may take. This may help positive individual in building himself/herself psychologically strong.

Overall, under short term needs of AIDS prevention beside creating awareness among public, through various means developed at local level we also need socio psychologically supportive environment for HIV positive people. This is only possible through government interventions in which non governmental organisation experiences (in the prevention of HIV/AIDS) may be helpful.

Thus, interventions to control HIV/AIDS in India will have to address the factors influencing sexual behaviours, through long-term and short-term meas-

ures. These long-term programmes of appropriate socio-economic development, women's empowerment and strengthening of primary health services may serve as a background for short-term strategies like locally developed AIDS awareness and prevention messages, sex education in schools, ensuring basic human rights of HIV positive individuals, HIV-testing facilities pre- and post-HIV test counselling.

SUMMARY AND CONCLUSION

This study has been undertaken in the light of the debate about the magnitude of the AIDS problem in India and the strategies for its control. Since HIV virus mainly spreads through sexual route, study of the sexual behaviour patterns would help in constructing risk of HIV infection for Indian population. There is only preliminary empirical data on this subject.

The available studies on sexual behaviour patterns of Indian population have been reviewed with the above objective. There are inherent problems in the methodologies of these studies. The available studies are predominantly representing urban educated upper and middle class. The samples of these studies are not representative. The studies among STD patients are institution based and also not representative. Yet these studies provide a good starting point for future studies and informing us about at least some aspects of Indian sexual behaviour patterns. Based on the review of these studies it can be said that about 15 to 20 percent of males and around 6-9 percent females of urban educated upper and middle class are experiencing sex outside marriage setting. Among adolescents of this class who are engaging in pre-marital sex, males are starting their sexual activity between 16 and 18 years while females about 18 years. According to available studies the most preferred partners in sexual activity outside marriage are friends and around 6 percent of males are visiting CSWs. Now so far as homosexuality is concerned there are many problems with the studies on general population. Studies among STD clinic attenders are suggesting that around 3 percent of them have contracted infection through penetrative homosexuality, which is in fact only carrying risk of HIV infection.

Though we can not generalise the results of this review for Indian population it can be inferred that a considerable section of Indian men and women in urban areas are engaging in sexual activities outside marriage setting as against rules and norms in most of the Indian societies. However, their risk of contracting HIV infecetion cannot be constructed on the basis of available studies on sexual behaviour. Studies on STD clinic attenders are suggesting that at least the number of STD patients visiting clinics are at risk of HIV infection. The number of STD clinic attenders at governmental institution are increasing

among this group of population at least. The determinant factors of sexual behaviour are having varying effect for different sections of population. Major of these factors are socio-economic status, culture and gender bias and mass-media, which act not only directly but also through other factors like education, and peer groups. At upper strata of Indian society the aspiration to Western life-style mainly influences their attitude and behaviour towards sex. Through the mass-media and direct socio-cultural contacts the upper-class status. Socio-cultural and economic constraints do not permit the lower middle-class to achieve upper-class life-styles, but it adopt certain values, attitudes and behaviours of the upper-class. At upper-class their aspirations lead them to 'freer' bbehaviour whereas aspirations of the middle-class lead them to 'promiscuity'. Difficult socio-economic conditions at lower strata of Indian society also lead them to 'promiscuity' without freedom.

Due to the determinants and their differing context, the sexual behaviour of Indian population is different from the populations of countries such as Thailand, Industrialised Western and African countries. Studies in these countries indicate that sexual activity outside marriage, number of sexual partners in an individual's life and men's visit to CSWs are more than among Indian population. Therefore it can be inferred that people in India are at lower risk of contracting HIV than in the mentioned regions. Data on AIDS rate and proportion of heterosexual transmission of HIV are manifold that in India, which also corroborates the above inference.

However, HIV/AIDS still is a public health problem in India, for the prevention and control of which we need appropriate socio-economic developmental as well as women's empowerment programmes to decrease people's vulnerability to HIV infection. To reach everybody in the country effectively with AIDS prevention messages and activities, the development and strengthning of primary health care services are necessary. Apart from these long term solutions we need short term solutions also. To make these short term solutions (such as, AIDS awareness, condom promotion, sex education etc.) effective, interventions should be planned in such a way that they can be supportive to the long term programmes and not go counter to them. In this way, they may become more sustainable too.

However, we need methodologically more sound studies on sexual behaviour patterns among various groups of the Indian population. This is not only necessary to construct the risk of HIV/AIDS in India but also needed to explore the roots and determinants of sexual behaviour pattern among various groups of Indian society. This may further help in the development of more effective interventions to stem the spread of HIV through the sexual route.

REFERENCES

ABVA (1990): Women and AIDS: Denial and Blame, A Citizen's Report. AIDS BHEDBHAV VIRODHI ANDOLAN, New Delhi, India.

ABVA (1991): Less than Gay: A Citizens' Report on the Status of Homosexuality in India. AIDS BHEDBHAV VIRODHI ANDOLAN, New Delhi, India.

ACFE Investigators (1992): AIDS and Sexual Behaviour in France. *Nature*, 360, pp. 407-9.

Anderson,RM (1992): Some Aspects of Sexual Behaviour and the Potential Demographic Impact of AIDS in Developing Countries. *Soc. Sci. Med.*, 34(3), pp.271-280.

Anderson,RM and May,RM (1988): Epidemiological Parameters of HIV Transmission. *Nature*, 333, pp.514-19.

Balse,M (1976): The Indian Female: Attitude Towards Sex. Chetana Publications, New Delhi.

Banerjee,D (1992): Combating AIDS as a Public Health Problem in India. Voluntary Health Association of India and Nucleus for Health Policies & Programmes, New Delhi.

Bang,RA and Bang,A (1991): Why Women Hide Them: Rural Women's Viewpoints on Reproductive Tract Infections. *Manushi*, 69, pp. 27-30.

Bansal,RK (1992): Sexual Behaviour and Substance Use Patterns among Adolescent Truck Cleaners and Risk of HIV/AIDS. *Indian Journal of Maternal and Child Health*, 3(4), pp.108-110.

Bansal,RK (1995): Truck Drivers and Risk of STDs including HIV. *Indian Journal of Community Medicine*, XX(1-4), pp.28-30.

Basu,DP (1994): Appropriate Methodologies for Studying Sexual Behaviour in India. *The Indian Journal of Social Work*, LV(4), pp.573-588.

Bayer(1995) - see page -81

Bearinger,LH (1990): Study Group Report on the Impact of Television on Adolescent Views of Sexuality. *Journal of Adolescent Health Care*, 11, pp.71-75.

Berelson,B and Steiner,GA (1964): Human Behaviour: An Inventory of Scientific Findings. Harcourt, Brace and World, New York.

Bhargava,NC, Singh,OP and Lal,N (1975): Analytical Study of 1000 Cases of Venereal Diseases. *Indian Journal of Dermatology and Venereology*, 41(2), pp.70-73.

Bhattacharya,S and Senapati,SK (1994): Sexual Practices of the Sex Workers in a Red Light Area of Calcutta. *The Indian Journal of Social Work*, LV(4), pp.547-556.

Bleek,W (1987): Family and Family Planning in Southern Ghana, as quoted in Caldwell et al, 1994.

Bollinger et al(1995) - see page -81

Brown,JD, Childers,KW, and Waszak,CS (1990): Television and Adolescent Sexuality. *Journal of Adolescent Health Care*, 11, pp.62-70.

Caldwell,JC, Caldwell,P and Quiggin,P (1989): The Social Context of AIDS in Sub-Saharan Africa. *Population and Development Review*, 15(2), pp.185-234.

Carael,M, Cleland,J, Deheneffe,JC, Ferry,B and Ingham,R (1995): Sexual Behaviour in Developing Countries: Implications for HIV Control. *AIDS*, 9, pp.1171-1175.

CCM-AIIMS (undated): A Survey of Knowledge Attitude and Beliefs about AIDS among Undergraduate College Students. Centre for Community Medicine, All India Institute of Medical Sciences, New Delhi. (Unpublished).

Chaudhari,SD, Bhatia,KK, Bansal,RK and Jain,VK (1988): Pattern of Sexually Transmitted Diseases in Rohtak. *Indian Journal of Sexually Transmitted Diseases*, 9(1), pp.4-7.

Chin,J and Mann,J (1989) : Global Surveillance and Forecasting of AIDS. *Bulletin of The world Health Organization*, 67 (1), pp.1-7.

Chin,J (1990): Epidemiology: Current and Future Dimensions of the HIV/AIDS Pandemic in Women and Children. *Lancet*, 336, pp.221-224.

Chopra,A, Mittal,RR, Singh,PP and Sharma, P (1990): Pattern of Sexually Transmitted Diseases at Patiala. *Indian Journal of Sexually Transmitted Diseases*, 11(2); pp.43-45.

Dasgupta,PR (1994): Strategies for Prevention and Control of HIV Infection/AIDS in the Country. *Journal of the Indian Medical Association*, 92(1), pp.5-7.

d'Cruz-Grote,D (1996): Prevention of HIV Infection in Developing Countries. *Lancet*, 348, pp.1071-74.

Decosas,J (1996): HIV and development. *AIDS*, 10(suppl.3), pp.s69-s74.

Decosas,J, Kane,F, Ararfi,JK, Sodji,KDR and Wayner,HV (1995) : Migration and AIDS. *Lancet*, 346, pp.826-28.

Fan,H, Conner,RF and Villarreal,LP (1994): The Biology of AIDS. Jones and Bartlett Publication, Boston, USA.

Ford,N and Koetsawang,S (1991): The Socio-Cultural context of the Transmission of HIV in Thailand. *Soc. Sci. Med.*, 33(4), pp.405-414.

Fortes,M (1994): The Web of Kinship Among the Tallensi: The Second Part of Trans-Volta Tribe. Oxford: Oxford University Press.

FPAI-SCERT (1990): Attitudes and Perception of Educated Urban Youth to Marriage and Sex. Family Planning Association of India, Bombay.

FPAI-SCERT (1994): Youth Sexuality: A Study of Knowledge, Attitudes, Beliefs and Practices Among Urban Educated Indian Youth, 1993-94. Family Planning Association of India, Bombay.

George,A (1996): Understanding Sexuality, *Seminar*, 447, pp.26-28.

George,A (1997): Sexual Behaviour and Sexual Negotiation among Poor Women and men in Mumbai: An Exploratory Study. SAHAJ Society for Health Alternatives, Baroda (Gujarat).

Gilada,IS (1985): Women in Prostitution in Urban Centres: Study perspectives and Positional Problems for Social Interventions, *as quoted in* Nag,M. (1996).

Goody,JR (1973): Bridewealth and Dowry in Africa and Eurasia, *as quoted in* Caldwell et al (1989).

Goparaju,L (1993): Unplanned, Unsafe: Male Students' Sexual Behaviour. Paper Presented at the Workshop on Sexual Aspect of AIDS/STD Prevention in India, Bombay, 1993, *as quoted in* Jejeebhoy,SJ (1996).

Gupta,SK, Jain,VK and Aggarwal,K (1997): Trends of Sexually Transmitted Diseases at Rohtak. *Indian Journal of Sexually Transmitted Diseases*, 18(1), pp.2-3.

Hans,G (1994): Lifestyle Education for Student Youth: Need and Strategy. *The Indian Journal of Social Work*, LV(1), pp.225-239.

Hart,N (1976): When Marriage Ends: A Study in Status Passage. Tavistock Publications, London, p.IX.

Heiss,LL and Elias,C (1995): Transforming AIDS Prevention to Meet Women's Needs: A Focus on Developing Countries. *Soc. Sci. Med.*, 40, pp. 931-43.

Herlitz,C (1993): Sexual Behaviour in the General Population of Sweden. *Soc. Sci. Med.*, 36(12), pp.1535-1540.

ICMR (1989): Dr.A.S.Paintal, Director-General ICMR at the Seminar at the Campus Law Centre, University of Delhi, Delhi on 3 December, 1988. *ICMR Bulletin*, 19(1), pp.3-4.

ICRW (1997): Adolescent Sexuality and Fertility in India: Preliminary Findings. *ICRW Information Bulletin*, International Centre for Research on Women, Washington DC. (January, 1997),

Jaiswal,AK and Bhushan,B (1994): Pattern of Sexually Transmitted Diseases in North-Eastern India. *Indian Journal of Sexually Transmitted Diseases*, 15, pp.19-20.

Jejeebhoy,SJ (1996): Adolescent Sexual and Reproductive Behaviour: A Review of the Evidence from India. ICRW Working Paper, No.3, ICRW, Washington DC, USA.

Jejeebhoy,SJ (1996): Adolescent Sexuality and Fertility. *Seminar*, 447, pp.16-23.

John, TJ (1992): The Epidemiology of AIDS in Vellore, in Proceedings of the Second International Conference on AIDS in Asia and the Pacific, New Delhi, Directorate of Health Services,Government of India, *as quoted in* Ritu Priya, 1994a.

Jones,E et al. (1987): Teenage Pregnancies in Industrialised Countries, *as quoted in* Brown et al. (1990).

Kanbargi,R and Kanbargi,S (1996): Sexually Transmitted Diseases in Banglore City: Some Findings from an Exploratory Study. *The Journal of Family Welfare*, 42(1), pp.30-37.

Kanter,JF and Zelnik,M (1972): Sexual Experience of Young Unmarried Women in the United States. *Family Planning Perspective*, 4, pp.9-18.

Kapur,P (1973): Love, Marriage and Sex. Vikas Publishing House, New Delhi.

Kapur,P (1978): The Life and World of Call Girls in India. Vikas Publishing House, New Delhi.

Kaur,V, Kaur,P and Singh,S (1992): Sexual and Treatment Behaviour of STD Patients. *Indian Journal of Sexually Transmitted Diseases*, 13(2), pp.83-86.

Khan,ME, Townsend,JW, Sinha,R and Lakhanpal,S (1996): Sexual Violence Within Marriage. *Seminar*, 447, pp.32-35.

Kinsey,AC, Pomeray,WB, Martin,CE (1948): Sexual Behaviour in the Human Male. W.B.Saunders Company, Philadelphia, U.S.A.

Koetsawang,S (1987): Siriraj Adolescent Counseling Programme, 1983-85 Report. Theera Press, Bangkok, as quoted in Ford and Koetsawang (1991).

Koss,MP, Gidycza,CA, and Wisniewski,N (1985): The Scope of Rape: Incidence and Prevalence of Sexual Aggression and Victimization in a National Sample of Higher Education Students. J Consult Clin Psychol, 55, pp.162-70, as quoted in Brown et al. (1990).

Kraft,P (1991): Age at First Experience of Intercourse Among Norwegian Adolescents: A Lifestyle Perspective, *Soc. Sci. Med.*, 33(2), pp.207-213.

Lal,S (1994): Current Status of AIDS and HIV Infection in India. *Journal of the Indian Medical Association*, 92(1): pp.3-4.

Lal,S, Khodakevich,L and Sengupta,D (1994): AIDS Case Surveillance. *Journal of the Indian Medical Association*, 92(1), pp.29-30.

Lal,S, Salil,P and Thakur,BB (1993): HIV Testing Policy and Surveillance. *Journal of the Indian Medical Association*, 91(12), pp.330-331.

Lear,D (1997): Sex and Sexuality: Risk and Relationships in the Age of AIDS. Sage Publication, New Delhi, India.

Lurie,P, Hintzen,P and Lowe,RA (1995): Socio-economic Obstacles to HIV Prevention and Treatment in Developing Countries: The Role of the International Monetary Fund and The World Bank. *AIDS*, 9, pp.539-546.

Malaviya,AN (1992): Some facts. *Seminar*, 396, pp.16-20.

Mane,P (1994): Exploration of Some Determinants of Lifestyles. *The Indian Journal of Social Work*, LV (1), pp.213-214.

Mane,P and Maitra,SA (1992): AIDS Prevention: The Socio-cultural Context in India. Tata Institute of Social Sciences, Bombay.

Mann,J (1990): Gobal AIDS into the 1990s. *Journal of Acquired Immune Deficiency Syndromes*, 3, pp.438-442.

Mann,J (1990) Women and AIDS: The Unprotected Sex. *Women's Health Journal*, 18, pp.26-51.

Mathur,AS and Gupta,BL (1965): Prostitutes and Prostitution, Ram Prasad and Sons, Agra.

Matomora,KSM, Lanboray,JL and Laing,R (1991): Integration of AIDS Programme Activities into National Health Systems. *AIDS*, 5 (Suppl.1), pp.s193-s196.

McCary,JL (1967): Human Sexuality: Physiological and Psychological Factors of Sexual Behaviour. Van Nostrand Reinhold Co, New York.

McGrath,JW, Rwabukwali,CB, Schumann,DA, Mark,JP, Nakayiwa,S, Namande,B, Nakyobe,L and Mukasa,R (1993): Anthropology and AIDS: The Cultural Context of Sexual Risk Behaviour Among Urban Baganda Women in Kampala, Uganda, *Soc. Sci. Med.*, 36(4),pp.429-439.

Min.H.F.W. (1994): Family Welfare Programme in India: Year Book 1993-1994. Department of Family Welfare, Ministry of Health and Family Welfare, Government of India, New Delhi.

Min.H.F.W. (1994): Health Information of India, 1994. Ministry of Health and Family Welfare, Government of India, pp.151-152.

Mukherjee,KK (1989): Flesh Trade - A Report. Gram Niyojan Kendra, Ghaziabad, U.P., India.

Murugan,S, Srinivasan,G, Kaleellulah,MCA, and Krishnamoorthy (1993): Deviated Sex Behaviour Among Male STD Clinic Patients. *Indian Journal of Sexually Transmitted Diseases*, 14, pp.67-68.

NACO (1991): India: Country Scenario, An Update. National AIDS Control Organisation, Ministry of Health and Family Welfare, Government of India.

NACO (1996): India: Country Scenario, An Update, National AIDS Control Organisation, Ministry of Health and Family Welfare, Government of India.

Nag,M (1996): Sexual Behaviour and AIDS in India. Vikas Publishing House, New Delhi.

Narayan,V (1984): Venereal Diseases: A Social Dilemma. New Delhi, Cosmo, *as quoted in* Nag, M (1996).

Nigam,P and Mukherjee,RD (1986): Pattern of Sexually Transmitted Diseases at Gorakhpur. Indian Journal of Sexually Transmitted Diseases, 7(2), pp.70-73.

Pachauri,S (1992): The Problem. *Seminar*, 396, pp.12-15.

Pachauri,S (1996): The Problem. *Seminar*, 447, pp.12-15.

Parasuraman,R et al. (1992): STD and AIDS in Homosexuals. Abstract Published In the 2nd International Congress on AIDS in Asia and the Pacific, Randwick, Australia: AIDS Society of Asia and The Pacific, p.200, *as quoted in* Nag,M(1996).

Parker,RG (1994): Sexual Cultures, HIV Transmission and AIDS Prevention. *AIDS*, 8(Suppl. 1), s309-s314.

Parker,RG (1996): Empowerment, Community Mobilisation and Social Change in the Face of HIV/AIDS. *AIDS*, 10 (Suppl.3), pp.s27-s31.

Parthasarathy,S (1997): Sex Business of Working Women is Growing Practice in Madurai. Paper presented at the Workshop on HIV/AIDS, 7-9 November, 1997 at Pondicherry, India.

Rakesh,A (1992): Pre-marital Sexual Attitude and Behaviour among Adolescent Girls. Ph.D. Thesis Submitted to Delhi University, Delhi.

Ramlingaswami,V (1992): India: National Plan for AIDS Control. *Lancet*, 339(8802), pp.1162-3.

Rao,A, Nag,M, Mishra,K and Dey,A (1994): Sexual Behaviour Pattern of Truck Drivers and their Helpers in Relation to Female Sex Workers. *The Indian Journal of Social Work*, LV(4): 603-616.

Rao Gupta,G and Weiss,E (1993): Women and AIDS: Developing a New Strategy. ICRW Policy Series, No.1, ICRW,Washington DC.

Rao Gupta,G (1995): Gender and Sexuality: Implications for HIV prevention. Third USAID HIV/AIDS Prevention Conference, August 7-9,1995, *as quoted in* d'Cruz-Grote (1996).

Rattanawannatip,M (1990): Prostitution: Necessity or Naked Greed. Friends Women Newsletter, 1, 21, *as quoted in* Ford and Koetsawang, 1991.

Reddy,DN, Eswar,P and Sreedharan,AK (1983): A Report on Urban (Madras) College Students' Attitudes Towards Sex. *Antiseptic*, September: 1-5, *as quoted in* Nag,M (1996).

Ritu Priya (1994a): AIDS, Public Health and Panic Reaction (Part-I). *The Natiuonal Medical Journal of India*, 7(5), pp.235-240.

Ritu Priya (1994): Issues of Women and AIDS in India. Paper Presented at NGO Forum at the International Conference on Population and Development, Cairo.

Ritu Priya (1996): Women and AIDS: Possible Consequences of Packaging with Reproductive Health. Paper Presented at the Workshop on Reproductive Health, Jawaharlal Nehru University, New Delhi.

Sachar,RK, Soni,RK, Kaushik,PV, Singh,WP and Kumar,V (1997): A Study of the Sexual Behaviour of Long Distance Truck Drivers: Implications for HIV Transmission. *Indian Journal of Preventive Social Medicine*, 28(1-2), pp.18-22.

Sachdev,P (1997): University Students in Delhi, India: Their Sexual Knowledge, Attitudes and Behaviour. *The Journal of Family Welfare*, 43(1), pp.1-12.

Sadhana Mohan (1996): The AIDS Scare: Is it Aid Induced? *The Times of India*, New Delhi, 13 September.

Savara,M (1992): Sexuality. *Seminar*, 396, pp.26-30.

Savara,M and Sridhar,CR (1992): Sexual Behaviour of Urban Educated Men: Results of a Survey. *The Journal of Family Welfare*, 38(1), pp.30-43.

Savara,M and Sridhar,CR (1993): Sexual Behaviour of Urban Educated Indian Women: Results of a Survey. Bombay: Shakti (Revised Version of "Sex Life of Indian Women" in Savvy, October, 1991.

Savara,M and Sridhar,CR (1994): Sexual Behaviour Amongst Different Occupational Groups in Maharashtra, India, and the Implications for AIDS Education. *The Indian Journal of Social Work*, LV(4), pp.617-632.

Sehgal,PN and Arnold,S (1994): Knowledge, Attitude, Beliefs and Practices (KABP) Study Related to AIDS in Tamil Nadu State, India and Intervention Strategies. Voluntary Health Association of India, New Delhi.

Sehgal,PN and Singh,K (1992): Knowledge, Attitude, Beliefs and Practices (KABP) Study Related to AIDS in Manipur State, India and Intervention Strategies. Voluntary Health Association of India, New Delhi.

Sehgal,VN, Sharma,AK and Bhattacharya,SN (1992): K.A.B.P. Study on AIDS among School Boys. Abstract published in the 2nd International Congress on AIDS in Asia and the Pacific. Randwick, Australia, 1992, *as quoted in*, Nag,M (1996).

Sengupta,S, Chaturvedi,P and Shastri,S (Undated): Adolescent Indian Youth, Sexuality and Need to Enhance STD Related Information in AIDS Prevention Programmes. Drishtikon, New Delhi.

Sharma,AK, Sehgal,VN, Kant,S, Choubey,D and Bhardwaj (1997): Knowledge, Attitude, Belief and Practice (KABP) Study on AIDS Among Senior Secondary Students. *Indian Journal of Community Medicine*, XXII (4), pp.168-171.

Sharma,V and Sharma,A (1995): The Letter Box Approach-A Model for Sex Education in an Orthodox Society. *The Journal of Family Welfare*, 41(4), pp.31-33.

Siddappa,K, Kumar,VJ and Ravindra,K (1990): Pattern of STD at Davangere. *Indian Journal of Sexually Transmitted Diseases*, 11(2), pp.39-42.

Singh,KG, Joshi,MK and Bajaj,AK (1990): Pattern of Sexually Transmitted Diseases in Allahabad. *Indian Journal of Sexually Transmitted Diseases*, 11(1), pp.6-8.

Stigum,H, Magnus,P, Harris,JR, Samuelson,SD and Bakketeig,LS (1997): Frequency of Sexual Partner Change in a Norwegian Population: Data Distribution and Covariates. *American Journal of Epidemiology*, 145(7), pp.636-643.

Sutherland,R (1950): Some Individual and Social Factors in Venereal Diseases. *British Journal of Venereal Diseases*, XXVI (1), pp. 1-12.

Swaminathan,M and Ramachandran,VK (1995): Structural Adjustment, Poverty and Unemployment: A Note. *Vikalp*, IV(1), pp. 13-20.

Swaminathan,S (1993): AIDS Prevention among Individuals with High Risk Behaviour: The Madras Experience in Senanayake,P and Kleinamn,RL (eds.) Family Planning: Meeting Challenges, Promoting Choices. Proceedings of the IPPF Family Planning Congress. 1992 October, New Delhi. New York. Parthenon Publication, pp.339-345.

Tejpal,TJ (1996): Sex in the '90s: Uneasy Revolution. *Outlook*, 11(37), (September,11), pp.68-88.

Telegraph (1992), *as quoted in* Nag,M (1996).

Training Orientation and Research Centre (1994): Stop AIDS: Trainer's Training, Report of the Regional Workshop of NSS Key Functionaries. Department of Social Work, University of Delhi, Delhi.

UNAIDS and WHO (1997): Report on the Global HIV/AIDS Epidemic. December, 1997. UNAIDS Information Centre. Geneva.

Usher,AD (1993): After the Forest: AIDS as Ecological Collapse in Thailand, in Minding Our Lives, Women from the South and North Reconnect Ecology and Health, (ed.) Vandana Shiva, New Delhi, Kali for Women.

Vishwa Deepak (1997): NGO and AIDS Action: Relating to the Social Context. Paper presented at the Workshop on HIV/AIDS, 7-9 November, 1997 at Pondicherry, India.

Vora,NS, Dave,JN, Mukhopadhyay,AK, Patel,N, Roy,K and Ghosh,A (1994): A Profile of Sexually Transmitted Diseases at Apex ESIS Hospital, Ahmedabad. *Indian Journal of Sexually Transmitted Diseases*, 15, pp.36-38.

WHO (1987): AIDS- A Public Health Challenge of Historic Dimensions. *World Health Forum*, 8(1), p.113.

WHO (1992): AIDS in South-East Asia: No Time for Complacency. World Health Organization, Regional Office for South-East Asia. New Delhi, p.3.

WHO-UNDP-UNDAW: Women and AIDS: Agenda for Action. World Health Organization, Geneva. (undated).

Wildavsky, R (1997) Sex, Lies and Kinsey Reports. *Reader's Digest*, 151 (904), pp.55-59.

Yerkes, RM and Elder, JH (1936): Oestrus, Receptivity, and mating in Chimpanzee. *Comp. Psychol. Monogr.*, 13(5), *as quoted in* Berelson and Steiner (1964).

Bayer,R (1995): Ethical Issues Posed by HIV Testing and Screening. *Current Science*, 69(10), pp.861-864.

Bollinger,R, Tripathy, S and Quinn, T (1995): The Human Immunodeficiency Virus Epidemic in India. *Medicine*, 74, pp.97-106.