CHAPTER - II

LITERATURE REVIEW

The social environment both internal and external determines the behaviour of a person in general and more particularly his sexual behaviour. The social environment includes the socio-demographic factors such as, place of residence, marital status, educational status, socio-economic factors such as occupation, influence of peers and friends, interaction in family before and after marriage and proximity of CSW centers. Most of these factors affect the sexual behaviour of a person leading to promiscuity. Some of the studies and papers published on these determinants are summarized below.

HIV infection has rapidly spread far beyond the centers where it was originally recognized in India. The epidemic is at different stages at various locations in the same state/Union territory. The infection is not only confined to high risk behaviour groups but is also spreading to the population at large.

Socio-demographic characteristics

The socio demographic factors such as, age, place of residence, marital status, occupation and religion have impact on the spread of HIV infection and AIDS. The most important characteristics of the Indian community are the moral values and codes of conduct. These norms may vary from one culture to the other. Misra Girishwar (1991) has examined the development of moral code, moral attribution, moral reasoning in the Indian context and has concluded that conceptualization of moral behaviour requires an indigenous
Every family imposes certain discipline on attending worships and participation in religious activities. Lack of attention by both the parents and children in such activities may result in undesirable performance of the children in later years. Sicard JM., Kanon S et al (1992), in their study on evaluation of sexual behaviours, have concluded that the place of residence and religion have an effect on the age of first sex experience.

Thornton A et al (1992) have studied about the effect of religiosity, cohabitation and marriage. They have concluded that religious affiliation was associated with many dimensions of family life including marriage, divorce, family size, pre-marital sex and child bearing. Bearden and James (1992) have found that among females, a need for close companionship is closely related to risky behaviour while frequency of religious service attendance is negatively related. A study on religious and cultural norms versus safe sex with school children in Tanzania reveals that if children are to be protected from HIV/AIDS infection adequate safe sex education must be included in the school curriculum as well as to propagate the change of absolute cultural/religious norms such as those which prohibit use of condom.

In the beginning of the study on HIV/AIDS, it was recognized that HIV/AIDS spreads among the city dwellers and urban areas. Sanders et al (1991) have concluded that urban migration causes family separation and extramarital sex. This is a definite factor influencing the spread of AIDS. John TJ, George Babu.P. et al (1993) in their study on epidemiology of AIDS in Vellore region, South India observed that HIV infection is also prevalent in rural areas. Anderson and Roy M (1992) have studied some aspects of sexual behaviour, age and the potential demographic impact of AIDS in developing
countries. They examined recent research on the influence of heterogeneity in sexual behaviour on the transmission dynamics of the human immunodeficiency virus (HIV), the etiological agent of AIDS. Attention was focused on the potential demographic impact of AIDS in developing countries and on how this was influenced by the structure of networks of sexual contacts (who mixes with whom), age-dependency in rates of sexual partner change and differences in the ages of female and male sexual partners. Analysis based on the construction of simple and complex mathematical models of the spread of HIV via heterosexual contact serves as a template for the interpretation of observed pattern and as a guide to the major aspects of sexual behaviour that govern the transmission dynamics of the virus. It is argued that much greater attention must be addressed to quantifying patterns of sexual behaviour in defined communities, despite many practical problems that surround data collection and interpretation.

Gilles et al (1993) have studied about the seasonal migration which may be a risk factor for HIV infection in rural Senegal. He found that migration between urban and rural areas appears to be an important factor in the development of the epidemic in rural areas. The occupation of the respondents also plays an important role in the contraction of HIV infection. Danziger R. (1994) studied the social impact of HIV/AIDS in developing countries. He has identified the following areas of impact namely economic, demographic, labour productivity, agricultural production, development, pressure on health sector, role of families, household and children.

Uitenbroek (1994) in his study has stated that the relationship between sexual behaviour and occupation is weak.
Banks, and Susan et al (1991) in their study on sexual behaviour and HIV infection in New York city concluded that infection was significantly associated with age. In India statistics reveal that the major group of infected people fall within the age group of 20-40. Uitenbroek DG (1994), who has studied the relationship between the sexual behaviour and healthy lifestyle, has reported that age and marital status are strongly related to sexual behaviour. He also stated that there is evidence of individuals engaging in risky behaviours in all ages and marital status groups.

SOCIO-CULTURAL CHARACTERISTICS

It is accepted that the behaviour of an individual is the product of the social and cultural values of one’s family and environment in which he/she is brought up in our society, there are various norms which have both scientific origin and otherwise. These norms also concern about sex and marriage. In the Indian context marriage and sex have been considered sacred and holy. But in reality we notice violations of the codes of conduct concerning sex.

Ramasamy, P. et al (1988) have discussed the relationship between promiscuity and family pathology. They have concluded that promiscuity is deeply ingrained in the personality of the individual and is a product of early life experiences. Thus the family and its impact on the individual is very vital in determining the activities of a person. Yung et al (1991) have reported in the study on the effect of family structure on the sexual behaviour of adolescents that there is a significant relationship between two parent/single parent family and the adolescent sexual behaviour such as age at first sex experience, frequency of intercourse and the level of sexual activity. It is
commonly noticed that the influence on the child by both the parents is greater and stronger when compared with that of a single parent.

In a study conducted in Uganda by Richard W. Goodgame, (1990) some important cultural factors are explained. Most of the Ugandan health workers do not think it is right to tell patients they have HIV or AIDS. This is sometimes due to a feeling that providing this information is cruel in the cultural context. Africans are averse to talk about death or dying. Another cause for concern about informing patients of their diagnosis is the fear of an adverse reaction such as suicide or a decision to spread the infection purposefully. Learning the truth about illness is like receiving a bad news and a discouraging prognosis is considered irrelevant. When doctors do tell patients the truth about their illness in a sensitive and compassionate way as possible, the frequent reply is "why are you telling me this? you must not be a real doctor!". Though such reactions are strange for some, yet the cultural context is very important in dealing with the social dimensions of any disease.

A study by K.S.Jacob et al (1987) have indicated the social causes which affect the life of the patient profoundly but also cause the serious problems for those with whom the patient has personal, intimate, familial and occupational ties. However the World Health Organization reports on the social aspects of AIDS (1988) stress that persons suspected or known to be HIV positive should remain integrated within the society and help to assume responsibility for preventing HIV transmission to others.

Foley M. et al (1994) have discussed in their paper on family support for heterosexual partners in HIV discordant couples (where only one of the
partners is HIV positive) that there is both encouraging and discouraging patterns of family awareness of HIV and support to sero-discordant partners.

In the socio-cultural context it is observed that the various habits formed during different stages of one’s life influence the total attitude of a person including his inclination to sex. Mc Ewan (1992) has investigated sexual behaviour under the influence of alcohol and the relationship between drinking habits and unsafe sex. Jemmolt et al (1993) have shown in their study that alcohol and drug users during sexual activity are predictors of the HIV risk related behaviours. Their study revealed that there is a significant relationship between alcohol and unprotected coitus and failure to use condoms.

It is commonly noticed that peer influence along with alcohol use has negatively affected a person’s behaviour. A number of studies have indicated that there is a significant association between alcohol consumption and ‘unsafe’ or ‘risky’ sexual behaviour. James Allan Neff and Sandra K. Burge (1995) in their study on alcohol use as a predictor of sexual behaviour have concluded that (1) alcohol consumption (drinking before sex) had a significant relationship to both number of partners and risky sexual behaviour (2) sexual liberalism was related to sexual behaviour (3) alcohol’s effect on sexuality was not significant and (4) the consistency of relationship between drinking before sex and sexual behaviour suggests that situational drinking rather than general drinking pattern is the more critical predictor of sexual risk behaviour. Rou.S.Gold et al (1992) have indicated that situational factors and thought processes are also associated with unprotected intercourse and have become a risk factor in contracting HIV.
The use of alcohol and drugs leads to unsafe sexual behaviour. A study was done of the gender difference in the use and influence of alcohol and drug use upon sexual behaviour in aboriginal population by Myers I et al (1994). While alcohol and drug use are often associated with various forms of risk taking in many aboriginal communities, this analysis suggests a gender difference response to substance use. Although males are more likely to use substances and that too in larger quantities, they are likely to become less sexually active when drunk. One must be cautious assessing the risk solely on this fact alone as one must consider that males initially have a higher level of risk while sober.

Another study on alcohol consumption and unsafe sexual behaviour demonstrates that, encounters with new partners are more likely to involve alcohol, but that the consumption of alcohol is not significantly associated with risky sexual activity.

James and Sandra (1995) have conducted a study on alcohol use as predictor of sexual behaviour. A number of studies have indicated significant association between alcohol consumption measures and ‘unsafe’ or ‘risky’ sexual behaviour. The study included the following specific measures. (a) Typical quantity of alcohol consumption and typical frequency of alcohol consumption (b) Frequency of alcohol use before sex (c) the perception that alcohol increases the individual’s desire or interest in sex and (d) the perception that alcohol increases the likelihood of participation in high risk behaviours. The findings of the study have brought out 1) alcohol consumption (before sex) remained significantly related to both number of partners and risky sexual behaviours 2) the expectation regarding alcohol effect upon
sexuality was not significantly associated with either number of partners or riskier sex and 3) consistency of relationships between drinking before sex suggests that situational drinking rather than general drinking patterns is the more critical predictor of sexual risk behaviour.

Joan M Herald et al (1992) have conducted a study to examine the sexual behaviour and contraceptive use of young adults in Chile. 35% of the females and 65% males had premarital intercourse, the median age at first sex experience being 18.4 years for women and 16.4 years for men. Only 20% of females and 19% of males used contraceptives at first premarital intercourse and 70% of first births were premaritally conceived. Among men the premarital experience were 47.6% of 15-19 year olds and 85.7% of 20-24 year old. A study conducted by Thomas T Kane et al (1993) in Bonjul, Gambia reveals that premarital sexual activity is common and it begins at an early age. However, 21% of young women and 7% of young men had practised contraception at the time of first intercourse.

It is well-known that the spread of the epidemic of human immunodeficiency virus (HIV) infection worldwide depends on the probability of transmission during sexual intercourse between men and women. Globally majority of cases of HIV infection are spread heterosexually and any intervention that reduces the risk of heterosexual transmission must be viewed as potentially life-saving. Consistent and appropriate use of condoms may reduce the risk of transmission.

A paper by Nancy Schepri-Hughes (1993) on the problem of AIDS in Cuba presents a different picture. Cuba is the only nation that has
incorporated elements of the classical public health tradition. Their programme enables partial social isolation of all infected individuals. The population of Cuba is over 10 million. As per 1993 statistics only 927 persons were reported HIV seropositive with only 187 cases of AIDS. Many factors have contributed to the control of AIDS in Cuba, apart from its controversial public health programme; the absence of intravenous drug use and a climate of sexual puritanism. However, the Cuban AIDS programme has been criticized for its violation of privacy and freedom of seropositive people. In 1986 a sanatorium was built to treat and observe the HIV infected people. They had 3 commandments in the sanatorium: (1) to have unprotected sex with an unknowing, uninfected individual is murder; (2) to have unsafe, but consensual sex, with an uninfected partner is criminal and (3) to have unprotected sex with another infected partner is a mutual suicide.

While concluding her paper the writer says that Cuba is the one country with the social infra-structure in which mass education alone might have been successful in containing AIDS. Individual liberty, privacy, free speech, and free choice are cherished values in any democratic society but they are sometimes invoked to obstruct social policies that favour universal health care, social welfare and equal opportunity. The paper insists that all people, women and children in particular, share equal rights in social and sexual citizenship so that the AIDS programme might represent the needs of all people.

In the Asian and African culture there are certain practices which have been identified as factors contributing contraction of HIV. Judith E. Brown et al (1993) have found various risk factors in both men and women in African culture. Both men and women in central Zaire like a dry and tight vagina
because it increases pleasure during sexual intercourse. In focus group interviews they described wiping and washing procedures as well as 30 different substances mostly leaves and powders, that women insert into the vagina to produce the desired effect. Women who use leaves said they crush and insert them for several hours, then remove them before intercourse. Women who insert powders leave them in place during intercourse. Individual interviews with 99 women (half of them unmarried and half of them married women) showed that over one-third of each group had used intravaginal drying or tightening at some time. Vaginal examination by physician revealed that several of the substances cause inflammatory lesions of the vagina and cervix. Furthermore some products cause extreme dryness that could foster epithelial trauma during coitus, both for the woman and for her sex partner. Breaks in the epithelium may promote the passage of the organisms that causes AIDS/STD. Thus the sexual practices of drying and tightening may increase the risk of infection.

A study was conducted in Uganda regarding the demographic and sociocultural factors influencing contraceptive use. The study showed that (1) contraceptive knowledge is widespread even among women with no education (2) the majority of the respondents have favourable attitude towards contraceptive use (3) the level of contraceptive use is low in comparison with knowledge and attitudes.

A study by Danziger R (1994) of the department of Public Health and Policy, London School of Hygiene and Tropical Medicine, England about the social impact of HIV/AIDS in developing countries has indicated the following areas of impact: economic and demographic, labour productivity, agricultural
production and development, pressure on the health sector, role of families and the households, children, women, HIV/AIDS discrimination and impact of HIV/AIDS on the individuals.

Many people harbor myths and misconceptions which make them deny that AIDS has any relevance to their own lives. In some parts of Africa it is believed that an infected man can rid of the virus through sexual intercourse with a virgin. Some people believe that it is because of Witchcraft. As Michael, the director of Global program on AIDS, WHO, says, HIV feeds on our weakness and thrives on cultural reluctance to discuss sexuality. Dorothy Nelkil et al (1992) have examined AIDS as a cultural phenomenon, a medically defined condition with the capacity to affect and reflect popular fears and anxieties about disease, sex and death. From their point of view AIDS has served both as a metaphor and as a means by which many aspects of society including interpersonal relations, cultural representations and institutional practices are being reshaped.

Even though the stigma of HIV/AIDS has a deep impact on society there should be support from the spouse, children, family members. A study was conducted by Foley et al (1994) about the family support for heterosexual partners in HIV infected couples. The results showed that awareness and support of family members were associated with gender of family member, HIV seropositivity and sex education.

Schriller NG et al (1994) have discussed about the use of the concept of culture to categorize high risk groups and risky behaviours. They are considered to be socially deviant or either abandoned by friends, and family or
community. Mc Grath JW et al (1993) have studied the cultural context of sexual behaviour among urban woman in Kampala, Uganda. The study was about cultural rules and norms for sexual behaviour and HIV specific risk behaviours. The study revealed that despite sexual norms prohibiting sex for women outside marriage subjects had reported that there are certain circumstances when a woman may take other partners for economic needs, for greater sexual satisfaction or revenge on husband with other partners.

Schriller NG et al (1994) in their article on cultural construction of AIDS further report that risk groups have explained why high risk groups continue and practise risky behaviours. Farmer P (1994) has even tried to develop a cultural model of AIDS. Hence AIDS has a number of cultural overtones besides being a medically profound subject.

Netting (1992) studied the sexuality in Youth Culture. He discussed about the sexual decision of adolescents in three ways-namely meaning of sexuality, process of male-female negotiation and adolescent's perception of danger. A study among college students in Columbia reveals that despite AIDS most students have not adopted careful sexual practices either in the number of sexual partners or in condom use. The conclusion of Netting was that adolescents have to balance their need for sex, love, freedom and self-preservation. Another important outcome of the study was that sexual expression was an important element of becoming an adult.

Yet another aspect of African culture is explained by M.Bulteryys et al (1994) in their paper on traditional mourning customs and the spread of HIV in rural Rwanda. In Rawanda during traditional mourning certain purification
rites are performed by which a widow or widower has a symbolic act or actual sexual intercourse with a partner who takes the contamination of death upon him/her. In the case of a widow the brother of the deceased and in the case of a widower some one outside the family. This study suggests that people at all levels need to be sensitized to the personal and collective dangers inherent in some cultural rules and values involving unprotected sexual intercourse. A culturally sensitive health education and an open discussion of sexual risk behaviour remain one of the effective weapons against further spread.

Simon Mansfield and Surinder Singh (1993) have studied as to who should fill the care gap in HIV disease. The main aim of primary care is the maintenance of good health, prevention of disease, diagnosis and treatment of disease, support for patient with acute and chronic diseases and support of caretakers. HIV disease has several important features that make it appropriate for care to be delivered in the community. HIV infection is preventable, it causes chronic illness with psychological & social morbidity and it requires a multi disciplinary approach.

The role of primary care team in HIV disease

* prevention of HIV infection
* Advice and support for those who perceive themselves at risk from HIV infection
* Maintenance of health symptoms free antibody positive individual.
* Diagnosis, treatment & support for symptomatic patients
* Terminal care for patients who will have to die at home
* Bereavement support for care givers.
Hence the phenomenon of AIDS introduces various aspects of the cultural outlook and enables us to understand the problem in a better way. Richard G Parker (1994) had talked about sexual cultures, HIV transmission and AIDS prevention. He had understood human sexuality as socially and culturally constructed. Sexual behaviour is seen as intentional yet its intentionality is always shaped within the context of socially and culturally structured interactions.

Bennet J F (1987) described AIDS as a social phenomenon. It was documented that the social issues such as the need for empowerment programmes aimed to encourage the development of negotiating and communicating skills of women to take control, to avoid unprotected vaginal and anal penetration and to insist that sexual activity be conditional on condom use are important. The other well-known social issue is that AIDS not only kills individuals but puts tremendous strain on relationships within families and on society in general. It affects young people who are productive members of the society and particularly women who are responsible for child bearing and child rearing. Thus AIDS concerns the following social issues such as family health, sexuality, contraception, child bearing, breast feeding, mental health and well-being. There is also social pressure such as stigma and ostracization which makes it difficult for families to continue support. Moreover the heterosexual promiscuous behaviour is brought to light through this disease. Eric A F Simeos (1987) brings out that the factors which contributed to the spread of infection in Africa namely heterosexual promiscuity, poverty and injection culture are also prevalent in India.
Social researchers have cautioned that the potential for HIV/AIDS spread should be perceived keeping in mind the general condition of human development and its interaction with socio-economic change.

WHO reports on the social aspects of AIDS stresses that persons suspected or known to be HIV positive should remain integrated within the society and help to assume responsibility for preventing HIV transmission to others. The social issue of AIDS has far reaching consequences. The impact of AIDS is that it not only affects men but also their spouses through them. Women have multiple roles in society. Health care providers, educators, wives, mothers, income generators. But they lack equal access or opportunity for education, information and services in health and social rights as to how to prevent from being HIV infected.

Again while discussing about the social impact of HIV infection Prema Ramachandran (1990) articulates that infected children may succumb to death in 5 years and all uninfected children whose parents are infected might become orphans. However Sandra Winn. and Robert.S. (1992) have recognized in their study on ‘HIV in the UK-problem of prevalence and sociological response’ that to date sociological work may not have made the most effective contribution in its support for intervention strategies against HIV/AIDS.

Sexual Practices & Risk factors

Heterosexual intercourse route is predominant in the spread of HIV infection in India. As per the Fact File of WHO (1995) it is projected that by the year 2000 the number of AIDS cases will be close to two million and HIV
infection will range between 8 and 10 million. In India the number of reported
AIDS cases are 3263. As heterosexual promiscuity is the main route of HIV
transmission, it is very vital that the information available about the sexual
practices is very important in this study. Literature survey on the aspect of
sexual practices and risk factors has shown that high risk sexual behaviours
significantly contribute to contracting HIV infection/AIDS.

A study conducted by James N J (1991) about the AIDS-related risk
perception and sexual behaviour has revealed that perception of risk has been
suggested as an important element of sexual behaviour change among people
who engage in behaviours which place them at risk of HIV infection. A study
of the relationship between perception of risk of HIV infection and risk-related
sexual behaviours was conducted in a genitourinary medicine clinic. The
sample comprised 767 patients attending over a 3 month period; data was
collected by self-completed questionnaire. A total of 574 questionnaires were
analyzed, representing a response rate of 75%. The majority of people in the
sample reported behaviours which increased their risk of HIV infection, but
only 19% (n=112) of the sample perceived themselves to be personally ‘at risk’,
deeply adequate knowledge of HIV transmission and methods of risk
reduction. Significant differences between social class groups were found for
knowledge scores, with highest scores among professionals and lowest among
unemployed subjects. Increasing age was significantly associated with better
knowledge; significantly more young people aged 16-20 years who did not
perceive themselves at risk (64%), had lower knowledge scores than older
people who did not perceive themselves at risk (41%). Among heterosexuals
who reported having sex with other people in addition to their regular partner,
79% did not perceive themselves as ‘at risk’ of HIV infection, and of these, 64% reported only infrequent condom use with casual sexual partners. Significantly more heterosexual men (67%) than women (44%) reported multiple sex partners. Schaw CR (1992) has estimated the following sexual behaviour parameters which will significantly explain the sexual practices of individuals. The parameters are number of sexual experiences, number of partners, frequency of intercourse, condom use and anal penetration. While the above being the broad based one, oral sex namely cunnilingus, fellatio; sexual intercourse with condoms both vaginal and anal, sexual intercourse without condoms both vaginal and anal are particularly important. In general there are three sites where exposure occurs genital, oral and rectal.

Isabella de Vincenzi et al (1994) have recognized heterosexual intercourse as the predominant mode of HIV transmission. It is very essential that we need to know the rate of transmission and risk factor for transmission.

A study conducted in India, by Simoes, Babu and John (1987) have concluded that HTLV-III is more likely to occur through heterosexually promiscuous individuals rather than through homosexuals.

Studies have been conducted to find the relationship between sexual behaviour and its social relevance. Sibthrope and Beverly (1992) have concluded that social construction of sexual relationships is a determinant of personal HIV risk perception and condom use. Hilary Standing (1992) has studied the conceptual and methodological issues in Sub-Saharan Africa. They stressed the importance of understanding the meaning attached to behaviour and the importance of contextualising social practice.
Michel Carael et al (1988) have conducted a study on HIV transmission among heterosexual couples in Central Africa. The findings indicate that the major risk factor for HIV infection was to wives and children due to the pre and extra marital sexual relations of their husbands. A study among employees and their spouses on heterosexual transmission at two large business centers at Zaire indicated that heterosexual promiscuity and the resultant increased risk of acquiring a sexually transmitted disease had played an important role in promoting HIV-1 transmission.

While considering heterosexual transmission, commercial sex workers play an important role. Prostitution is illegal in India but commercial sex work occurs in all parts of the country. In some of the major cities of India it occurs in well organized ‘Red light’ areas. In other places it is carried on illegally in centers like lodges, hotels, restaurants, residential areas along high ways catering to the transport workers. The work situation of truck drivers is such that they are away from families for a long period and they have sex with CSWs at different points.

HIV transmission also spreads from husbands to their spouses. The status of women in India and in some of the Asian countries is such that their roles are subordinate. They have to listen to their husbands in most of the decisions. Particularly in sex men decide for the women. Many women even after knowing that their husbands are promiscuous only talk in favour of the husbands. The cultural and social factors amplify vulnerability of women to HIV infection.
Sexually transmitted diseases are due to unprotected sexual intercourse. Factors such as migration, urbanization, changing social cultural attitudes, change in the outlook on marriage, the freedom that young people enjoy, knowledge of the cure for STDs and contraceptions influence the sexual behaviour of persons.

While looking at the vulnerability of adolescents and young adults, it is revealed that youth are often misled by lack of information and communication. Their level of knowledge of HIV, AIDS and STD is very hollow and they are misled. There is no scope in the educational system facilitating them to understand sex in the right perceptive. In fact even talking about of sex is taboo. At the same time the kind of ‘Adult movies’, obscene posters all along the roads and footpaths stimulate their sexual impulses and they are led astray most of the times. Use of alcohol and peer influence are yet another co-factors for their vulnerability. They have not been properly exposed and trained to practise religion. Worship has been ignored and religious values are forgotten. Neither parents nor teachers insist on such values in the present context of degradation of social values.

Rachel Mathai et al (1990) have studied the HIV seropositivity among patients with sexually transmitted disease in Vellore. They have identified women prostitutes as the risk group for HIV infection.

There is also risky sex even in stable relationships. Isabella de Zoysa, Michael D Sweat et al (1996) have published a paper on ‘Faithful but fearful’ for reducing HIV transmission in stable relationships. They have raised the question of how ‘risky is sex’ with a stable partner. They point out that stable
partners may be exposed to HIV infection in their stable relations and there is a possibility of the past record of such stable partners being exposed to HIV. The study stresses that mutual monogamy is the only option that is specific to persons in stable relationships. This is possible when both are faithful and also if both are uninfected at the start of their relationship. However many women do not believe that their husbands are faithful. They have concluded that containment of HIV pandemic will only be possible in the long run if there is commitment to social change which will modify the behaviour of individuals.

A study conducted by Susan Kippan et al (1994) on heterosexuality, masculinity and HIV have addressed the role of masculinity as a barrier to the use of strategies for reducing risk of heterosexual transmission. The aspect of masculinity that influences, power relations between men and women was studied. Two major issues have been identified. The first one was the masculine preference for controlling sexual initiative. The other concerning the assumptions of males about women’s sexual history. They concluded that heterosexual sex is dynamic and relational and that men and women negotiate these encounters from quite different positions of power.

However Geetha Sethi (1995) in her paper on sexual decision making for couples and HIV/AIDS epidemic focuses on key questions regarding how, by whom and what decisions are made. The importance of family, religion, school, media and traditions are discussed. The conclusion was that creation of an open environment that supports an acceptance of sexuality, a readiness to communicate about sex, promotion of gender equality will lead to health and happiness of both partners to have satisfying and pleasurable and mutually acceptable sexual relations.
Knowledge of HIV and High risk behaviour

Education to the public aimed at preventing behaviour that predisposes the spread of HIV infection, is supposed to be the main strategy for controlling AIDS. It is considered that HIV infection is transmitted mostly through behaviour patterns that are intimate and taboo. The knowledge and attitude towards AIDS and risk factors have been studied by different groups in various parts of the world.

Survey data from a convenience sample of 158 first year students in an urban college campus in Cleveland by MC Guire et al (1992) were drawn on to determine their sexual practices and their knowledge and attitude about AIDS. Among the 77 sexually active students many engaged in activities that could facilitate transmission of HIV. As many as 58% did not always use condom with a new partner. While 31% had 2 plus partners in the last year, 8% engaged in anonymous sex and 14% of women had anal intercourse. Although most of them said they would use condoms more or reduce the number of their sexual partners if they believed that these changes would reduce the risk of AIDS, and so a few had adopted these practices. Safer sexual practices were associated with heightened personal concerns about AIDS, but not with knowledge, which was at a high level. These findings demonstrate the need for preventive programs that overcome the gap between knowledge of safer sexual behaviours in this and similar groups of adolescents and suggest that programmes designed to heighten personal concerns may be most effective.
A comparative study conducted by Sonenstein, Frey et al (1989) in the US has indicated that there is a significant increase in the sexual activity reported by adolescent males with that reported in 1979, but also showed that the rate of reported condom use at last intercourse, had also increased. It is argued that improving condom use among all sexually active teenagers should be a national priority.

Griffore et al (1990) have studied the knowledge of students about AIDS and the effectiveness of use of condom in Michigan State University. In this explorative study it was observed that the condition and circumstances surrounding the use of condoms and the consistency and appropriateness with which they are used determine their effectiveness in preventing HIV transmission. A review of previous research indicates little evidence that knowledge of AIDS significantly influences condom use. Inclinations towards condom use can be inhibited by peer pressure, embarrassment, use of alcohol/drugs, the way in which condoms are packed and marketed, perceived acceptability of condoms, beliefs and information about AIDS and individual’s past history of risky sexual behaviour. It is concluded that college students must be given the opportunity to develop skills and strategies of behavioural self management directed towards appropriate use of condoms.

Sicard JM et al (1992) have studied the attitude, belief and practices among schools in Burkino Faso. The schools and colleges have been conducting various programs to educate the youth about HIV/AIDS. It was found in a study conducted among students that they perceived the AIDS epidemic as more severe than they did before the course, but they were more likely to believe that effective preventive measures were possible. They were also more
likely to believe that others in their peer group were taking action to prevent HIV infection. There was no significant increase in either the experimental or the control group in the students belief that they were personally vulnerable to AIDS, nor was there any statistically significant change in AIDS-related sexual or drug-abuse behaviours. A study was conducted to measure the perceived risk of AIDS among international travellers, to measure their knowledge of transmission and prevention of HIV and to identify some of the determinants of this knowledge. About 70% of the subjects believed in the efficacy of condoms when used with local people, as compared with 79% when used with other tourists.

While a study conducted in Germany among adults (n=2118) by Hahn Alois, et al (1992) showed that in some aspects, AIDS is viewed as a consequence of risk taking; however AIDS is also perceived as danger, with the threat of infection dependent on the behaviour of people other than oneself. Generally, poorly educated rural and traditionally religious respondents tend to view AIDS as a danger, while well educated, urban and more open minded respondents tend to view AIDS as a risk. Ironically the group that perceives AIDS as an external threat is characterized by a more conservative life style which reduces its level of risk taking behaviour.

Whereas a study conducted by Bearden and James (1992) among students of State University of New York on attitudes and knowledge about AIDS reveals that knowledge about AIDS and perceived HIV risk have had limited effect on college students' sexual behaviour. The results of 1991 students attending NY state college is reported, indicating that a measure of risky sexual behaviour is positively related to tobacco, alcohol and drug use
among both male and female respondents. Among females, feeling a need for a close companion is closely related to risky behaviour, while of religious service attendance is negatively related. Although knowledge about HIV and the levels of perceived risk are relatively high among the students, a substantial minority continue to have multiple sex partners and low rate of condom use.

Rao, AV. et al (1991) have studied the behaviour change in HIV infected subjects following health education in Vellore, India. Of the total of 85 HIV seropositive subjects among consecutive new registrants in the STD department were given health education measures directed to avoid high risk behaviours and also the events with a high potential for transmission of infection. The emphasis was on the use of condoms, discontinuing promiscuity, abstaining from homosexual acts and avoidance of pregnancy and advice against marriage for those contemplating it. The Health Education programme was delivered individually to each subject over two or three sessions, each lasting for 30 to 45 min. There was a good compliance on advice against marriage and pregnancy. Seven infants born during the follow up period were seronegative. The use of condom was not found to be acceptable. The prostitutes comprised the most resistant group to education. The study demonstrated the feasibility of health education at individual level in the clinical setting. A longer follow-up may indicate the sustainability of behaviour change in the subjects.

The use of condoms has been given high priority in promoting AIDS awareness and risk reduction activity. Ramachandran and Chandrasekar (1992) in their study among health workers on the perception about Nirodth (condom) have said nearly 70% of urban husbands and their spouses, 70% of
rural husbands and 76% of their spouses expressed satisfaction, the reasons being freedom from fear of conception, sexual pleasure being retained and the method being simple and easy. Among 30% who expressed dissatisfaction reduction in sexual pleasure, irritation and pain.

A study was conducted among the clients of female sex workers and unsafe sex by Elizabeth Plumridge et al (1994). The objective was to study the contexts and circumstances leading to unsafe sex practices. The results of the study showed that condoms were commonly used in commercial sex encounters, but relatively rarely in non-commercial sex. Clients approached condom use in a very passive manner, rarely carrying them nor initiating their use. With sex workers clients expected condoms to be provided as part of the service and this expectation carried over to non-commercial partners as well. The qualitative analysis explored the justification clients gave for their unsafe sex practices and the role of fantasy in sustaining unsafe sex. Clients of female sex workers may be at particular risk of transmitting HIV infection due to their passivity in condom use combined with frequent partner exchange. While their commercial partners may be protected by insistence on condom use, their non-commercial partners, including wives and permanent partners, may be at risk.

Rachel Mathai et al (1990) have concluded in their study in Vellore among patients with sexually transmitted disease about HIV seropositivity that the combination of low socio-economic and educational status, ignorance about the cause of AIDS and easy access to prostitutes are the possible factors which causes the STD patients susceptible to AIDS.
A study in Nepal regarding the sexual pattern reveal that 24.1% of male have pre and extra marital sex, 14.9% female had pre and extramarital sex, mean frequency of sexual contact was 3 per week in married couple, the earliest age of sex contact was 10 year for female and 13 year for males. Therefore early AIDS education is necessary in order to provide the right type of intervention.

A study about the perception and knowledge about AIDS among family planning clinic attenders in Johannesburg has revealed that while general knowledge about AIDS has increased, there was little change in behaviour. None used condoms and generally there was a negative feeling about the use of condoms. However a study conducted by the National center for HIV social research school of Behavioral sciences in Macquaric University Australia about the knowledge of safe sex practice concluded that accurate knowledge and safe sex are associated to some extent. There was strong evidence that change in practice needs to be understood as a function of socio-cultural change and not individual change. However a study on knowledge and attitude among University students at Lusaka has come to the conclusion that HIV counselling should be available and programs should be directed at improving attitudes to those who already have HIV and reducing the stigma in the society.

A study conducted with the social science students at the University of Bophuthatswana indicated that a majority of the respondents showed a general knowledge about AIDS in terms of common modes of transmission and the non availability of cure. Lack of enough knowledge was shown by their negative attitudes towards those who had already contracted the disease and the number of sexual partners they had. Despite the realization of the necessity
to use condom during sexual intercourse, majority of them did not use condoms. The findings call for the need to involve parents, schools and universities actively in the dissemination of information about AIDS.

Changes in the Finns knowledge of attitude to and behaviour in connection with HIV infection between 1986 and 1990 were studied. All subjects chosen for the study every year were interviewed at home or by telephone. Many Finns reported that there was change in the behaviour because of risk of HIV. 75% informed themselves about AIDS, 9% increased use of condoms, 6% tested themselves for HIV. In general there was overall change in the behaviour of the population.

**Sexual Practices**

It is widely recognized that heterosexual transmission of HIV is a more common than spread by homosexual contact. In the early stages of the HIV infection in 1987 in the US 4% of adult cases of AIDS have been classified due to heterosexual contact. Whereas in UK 3% of those cases were reported to be due to heterosexual. However the risk of male to female and female to male heterosexual transmission has been estimated from studies of stable heterosexual couples in United states and Europe.

There are certain barriers to the prevention of HIV transmission in stable relationships. Marriages are built on promises of trust. Many a times safety among the partner is assumed. But if the partner doesn’t adhere to his promises it involves risk even in stable relationships. Prevention messages
like, 'stick to your partner', 'love faithfully', 'live carefully' might help those deviate from loving, trusting and faithfulness.

A second barrier is the poor communication skill between males and females about sexual and reproductive health. Challenging men's control over sexuality may be harder in the context of marriage as majority of women in the developing world are socially and economically dependent on their spouses.

The third barrier being the meaning of safe sex. The social, structural and environmental factors play a major role in sexual networking pattern. Migration, industrialization can lead to separation or disruption of families dividing both men and women to seek partners other than their spouses. Condom use is rare in stable relationships. Even person who use condom in casual relationship do not use them in stable relationship.

The effectiveness of the use of condoms has been a debatable topic today. Among the high risk group such as truck drivers and sex workers one of the studies in Bangalore (1993) reveal that 89% said they never used condoms and that it is an obstacle to pleasure. It was considered that condoms are for family planning purpose only. One of the schools of thought on sex in the Indian culture is that women do not initiate sexual activity and generally do not take active role in condom use. Value of sexual abstinence is a dominant theme in Hindu religious scriptures. It is still deeply ingrained in some of the sections if not all in Indian society. Moni Nag argues that in the Indian cultural context it may be appropriate to emphasize abstinence from premarital and multiple sexual relationships rather than use of condoms.
However the early marriages in India seems to have acknowledged that young men and women have sexual needs and marriage was a way of channelling these urges safely. However recent studies have indicated extra marital and premarital sexual experience in the urban population.

The cultural constraints and inhibitions surrounding sex and sexuality suppressed the understanding of human interaction. The HIV/AIDS has made people to critically examine and understand what actually happens between sexual partners and how sex is viewed in a different perspective by some of the social researchers.

A study was conducted by Kline et al (1992) about minority women and sexual choice in the Age of AIDS. Attitudes and behaviours surrounding sexual decision making in minority communities are explored, drawing on focus group discussion data in NJ USA. The findings suggest that lack of control over sexual decision making is not a significant barrier to condom use for many females. More important factors include how females assess their risk with specific partners in specific situations and how they weigh this risk against their own expectations of potential physical discomfort or reduced sexual pleasure. Cultural factors function more often to facilitate, rather than prevent safer sexual practices. It is concluded that minority women often retain significant power with respect to sexual decision making.

Purnima et al (1994) have examined the extent to which sexual motivation by women in heterosexual relationship can be used to prevent HIV infection. They bring out an important fact that men & women rarely talk to each other about sexual matters. Sex is more often viewed as a private and
secret matters. But the study has brought to light that men talk of sex to CSW freely. There is also a fear among young women that talk of sex is greatly constrained by the strong cultural norms that emphasize the value of virginity. Young women fear that seeking information on HIV/AIDS or condoms will label them as sexually active.

In some cultures men would not like to have sex with the same partners. Boys want girls to be faithful to one boy. Some would like to maintain the tradition of his father by having more than one sexual partner. Men having more sexual partners are equated with being popular and important in the community. Some women involve in sex with other men to please their husbands. In some culture sex takes place in the midst of other men and are not conducive to eroticism.

They conclude that providing women with opportunities for group interaction to share personal experiences and model new behaviour is likely to build confidence in adopting preventive behaviours. The message of the use of condoms has initiated changes in some communities.

Uitenbroek and Mc Queen (1994) have reported in their study in multiple partner condom use that better educated respondents increased their use of condoms while less educated respondents showed a decrease in the proportion of multiple partners.

The plight of women however is in a state of concern. Marge Bever and Susananda Roy in their book on women and HIV/AIDS have said that women have always been sexually used and abused and deprived of sexual pleasure.
Women are now at the risk of HIV infection. They become infected at a younger age than men because men find it easy to have sex with younger women. Judy Sadgrove (1993) has indicated that consistent use of condoms is the only defence, but this presumes mutual desire, self assertiveness and willingness on the part of man.

The study conducted by Banks, Susan et al (1991) about sexual behaviour reveals that infection was significantly associated with age. Respondents reporting condom use and anal sex had lower infection rates, whereas it is higher in the case of oral sex and homosexuals and bisexuals. While discussing about masculinity and heterosexuality, this cannot be done in isolation without women.

De bruyn and Maria (1992) in their paper on women and AIDS in developing countries have pointed out the fact that women acquire AIDS because of (1) delayed diagnosis of infected women because of stereotypes relating AIDS with homosexuality and prostitution (2) increased risk due to poor access to information and prevalence of STD (3) greater social, economic and psychological burden on women to care for family members, (4) lack of knowledge regarding preventive behaviour due to low socio economic and educational status.

However a study on minority women and sexual choice conducted by Kline et al (1992) have concluded that minority women often retain substantial power versus their male partners in relation to sexual decision making.
Isomura S. and Mizogami M (1992) conducted a study in Japan to assess the sero-prevalence of HIV-1. A very low percentage of cases were found to be seropositive although the sero-prevalence of STD, including hepatitis B, syphilis, chlamydia etc were very high. There was a general decrease in the unsafe sexual practices.

Chetwynd (1992) conducted a study in New Zealand with 1000 New Zealanders aged 16-60. The study revealed significant differences in the reporting of sexual behaviour during the two year study period. The proportion of the sexually active reporting three or more sex partners in the previous year fell from 12% to 8%. The proportion reporting ‘always’ or ‘of-the’ using condoms rose from 13% to 18% and those reporting permanent changes in sexual behaviour because of AIDS rose from 16% to 26%. Changes towards safer sexual practices were more common amongst males, the young, the unmarried and those with multiple sex partners.

A study conducted in Mexico about the individual differences associated with high risk sexual behaviour implications for intervention programmes indicates that people with unrestricted socio sexual orientations have reported more casual sex encounters and multiple concurrent sexual partners. The study investigated the relationship of socio-sexuality to an impulsive personality profile characterized by impulsivity in decision making, general risk taking tendencies and greater responsiveness to situational cues. It was found that an unrestricted socio-sexual orientation was associated with greater impulsivity in decision making. The result of the study was that although unrestricted individuals had more knowledge about safe sex behavioral practices, they were more likely to engage in unprotected sexual intercourse.
Stanton B et al (1994) have studied the sexual practices and intentions among preadolescent and early adolescent low income American-Africans. The objective of the study was to assess the sexual practices and the social and interpersonal influences on sexual practices and intention which have an impact on the risk for AIDS. The median age was 11 years. About 35% of youths had sexual intercourse and 20% of virgins thought that they would become sexually active in the next six months. More than 60% of youth had used condoms during the last episode of coitus and 24% of boys and 35% of girls had anal intercourse. Rates of foreplay (non penetrative sex) were low even among sexually active youth. There was a strong relationship between social influence of parents, peers, and partners.

A survey conducted in 1990 among final year medical students in Singapore found that most respondents had a good knowledge about AIDS and its routes of transmission. Among the 13.7% of respondents that were sexually active, it was noted that only 35% had used condoms before and that only 20% had used it in the most recent occasion of sexual intercourse. It was noted that only 30% of the sexually active had intention of using the condom when they have the next sexual intercourse despite the fact that 40% of them were having sexual intercourse with casual partners. However having a high knowledge of AIDS, medical students at the National University of Singapore have a low use of condoms.

Three hundred and thirty seven truck drivers, in transit from Mombasa to destinations within east and central Africa were interviewed on their knowledge on AIDS and sex practices using a pre-defined questionnaire. Nearly all of them, 99% (317/321) had heard of AIDS through mass media and
from friends. When asked for a definition of AIDS, 87% (336/485 responses) described it as a sexually transmitted disease which causes body wasting and death. The majority were aware of the correct risk reducing behaviours; 76% (228/300) knew that use of condoms can prevent the transmission/acquisition of STDs but only 32% (90/295) had ever used them. This was in spite of the fact that 61% (226/309) admitted of visiting prostitutes. Various reasons were given for not using condoms. About 32% claimed that they did not sleep with prostitutes while 18% (34/188) did not see the need for using condoms. Condoms were unavailable to another 18% (34/188). The data obtained shows a clear lack of correlation between the correct knowledge of AIDS and application in the prevention of acquisition and transmission of STD.

The sexual practices of a person and the life style adopted have been related to each other. Uitenbroek (1994) of the University of Edinburgh, Scotland has studied the relationships between sexual behaviour and health life styles. The data was collected from 8817 respondents by telephone. The data showed that while age and marital status are strongly related to sexual behaviour, there is evidence of individuals engaging in risky behaviours in all age and marital status groups. The relationship between sexual behaviour and occupational status is weak; there is considerable and consistent difference between sexually more active and sexually less active respondents with regard to healthy life styles.

An article in the Lancet published in April 1993 carried a news item about ‘Arab Nations: Attitudes to AIDS’. There were a few reported cases of AIDS which doesn’t have official recognition. Arab nations also are under alert and are taking measures to curb the spread of HIV.
It is needless to say that both men and women have responsibility in making the sexual experience ‘wholesome’ in the true sense. The struggle for economic survival and personal autonomy have led many people to form relationships with new sexual partners particularly in African culture. This sexual relationship increases the HIV sero prevalence. Therefore both men and women share the burden of AIDS and the responsibility of prevention. But women find it difficult to control male sexual behaviour. HIV risk is the product of social, cultural, economic and interpersonal forces that determine the infinite complexities of human behaviour. The key to behaviour modification lies not with the individual but with the relationship and the delicate balance of decision making. The question regarding deeper understanding of sexual behaviour in relation to status, decision making and health should be looked into.

As illustrated by Balaji (1994) in his article on women and AIDS, the rate of infection is 2-3 times more in young women in their teens compared to young men of the same age group. It is also a cultural factor that status of girls and women are at the root of the AIDS problem. In India about 80-90% of infection results from heterosexual intercourse. Many young men tend to have unprotected sexual intercourse with multiple casual partners which increase the possibility of transmission to women, who in turn pass it on to the unborn children. The powerlessness of women and the likelihood of women getting infected early makes them more vulnerable.

In India and in some other parts of the world males choose younger females as spouses and also as casual sexual partners. Hence the younger women are more affected when compared with men of the same age. Initially
more number of men were reported to be positive in India but of late the number of women is going up steadily.

In India prohibitions against intercourse during menstrual period or abstinence of sex for a long time after giving birth contribute to male patterns to have multiple sex partners. Less access to proper health care system keeps them away from proper reproductive hygiene.

The promotion of condoms and its use as a barrier to avoid pregnancy and sexually transmitted diseases had a negative effect in a way. As Adrian Treloar and Anne-Marie Williams (1993) comment that the introduction of condoms has given a wrong message that any sex with anyone is OK provided a condom is used. The Church has never accepted conception before marriage and it is not a part of the Church's teaching. But the steady rise of teenage conception in the West is perhaps due to the increased provision of contraception.

Sascha and William (1993) in their study on procreation and HIV have found that 9 of 47 couples (HIV negative spouses and HIV infected males) had unprotected intercourse for the purpose of conception. Four of them did so before learning of the man's infection 12 to 50 times per month (median 26). The other 5 couples attempted pregnancy despite knowledge of the man's infection; four of them had 2 to 4 times per month (data of one more not available). They found that women who attempt to become pregnant may have high number of exposure to potentially infectious semen. Knowledge of HIV appeared to have motivated them to reduce their exposure. Failure to consider procreational as well as recreational sex limits the effectiveness of AIDS
prevention efforts. The best way for couples with a HIV infected partner to safe
parenting would be adoption, foster parenting and artificial insemination using
sperm from a healthy donor.

Dooley Worth (1989) has examined in her article the reasons for resistance to condom use among high risk women in New York city. This article bring out an important factor that sexual bargaining skills have been affected by the availability of safe, affordable abortion, which has reduced the need for risk taking women to negotiate barrier contraceptive use. While looking at the safe practices, abstinence seems to be 100% safe, but non penetrative sexual practices and barrier contraception in the form of condom use are not socially acceptable choices which weaken women’s sexual decision making power.

A study about the sexual Networking in Provincial Thailand was conducted by Napaporn Havanon et al (1993). Commercial sex has been widely practised in various provinces in Thailand. Many people patronize commercial sex workers. Visiting prostitutes has been considered normal for men.

The reasons stated by men who go to CSW are :

- If one doesn’t visit a prostitute - he can as well go into monkhood.
- The good thing about having sex with prostitutes is there is no risk of hassles - you climax, you pay, you split and that’s it.
- With girl friends we can’t have sex always; so go to CSW.
- Married men need a change.
The reason stated by men for non-use of condoms are:
- Men feel uncomfortable
- It's like having something blocking you
- It doesn't give natural feeling.

The reasons stated by women for non use of condom by their clients.
- The client has high education and should know how to protect himself.
- Boy friend knows what is good and bad.
- Sex partner doesn't like them.

WHO estimates that by the year 2000, 30 to 40 million people would have been infected worldwide. Of these 75% would occur in developing countries. 50% of this infection is likely to occur in Africa and 90% of this infection will be due to heterosexual activity. One of the major intervention programmes is promotion of condoms use. The major reasons for non-acceptance of condom are:

1. Condom still has a poor image; it is associated with prostitution.
2. Condom has been talked of as an ineffective and unreliable method of contraception.
3. Failures due to condom breakage and lack of knowledge about proper use weakens its image as a reliable method.
4. Condoms are associated with AIDS and STD.
5. Considered as inconvenience and embarrassment in personal relationships; men fear they may loose erection and women are powerless to insist on a condom.
6. The desire for occurrence of pregnancy often precedes marriage. Premarital pregnancy is an indication of fertility of a woman. Use of condom may signal an end to the relationships.

7. CSWs may be accused of having AIDS if they insist on condom use.

8. Alcohol intoxication interferes with condom use.