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Sexual behaviour in India with risk of HIV/AIDS transmission

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The estimate of cumulative HIV-positive persons in India by the end of 1994 ranges from 900,000 to 1.9 million. The corresponding figures projected for 2000 are 2.1 million to 6.7 million. The estimate of cumulative AIDS cases in India by 2000 ranges from 500,000 to 1.2 million. These figures indicate the magnitude of the problems India is going to face in the near future because of the AIDS pandemic.

Although at the initial stage of the spread of HIV/AIDS in the USA and a few other Western countries, male homosexual relations and sharing of equipment by intravenous drug users were the principal modes of HIV transmission, by now the predominant mode of transmission in all countries is heterosexual relations. In India this has always been the case. It is estimated that in India about three-fourths of HIV transmission occurs through heterosexual relations and the rest occurs mainly through transfusion of infected blood and sharing of infected equipment. The role of male heterosexual relations in HIV transmission in India cannot, however, be ruled out, although evidence of such transmission so far is rare.

The risk of transmission of HIV and other sexually transmitted diseases is higher in sexual relationships with multiple partners and without the use of condoms. Premarital sex often involves multiple partners, and extramarital sex, by definition, implies multi-partner relationships. The following categories of people are likely participants, voluntary or non-voluntary, in multi-partner sexual relationships: female prostitutes and their customers, male homosexuals, *hijras* and male prostitutes. Avoidance of multi-partner sexual relationships, use of condoms and sexual abstinence are usually advocated for prevention of spread of HIV and other sexually transmitted diseases. This paper provides salient findings from the empirical studies made so far in India along with the historical contexts of the topics mentioned above.

Premarital sex

Surveys of adult students of schools and colleges in contemporary India indicate that although premarital sexual experience among them is not as common as in Western countries, it is not as rare as perceived widely. For example, there is no evidence in India yet of premarital sexual experience among students as rampant as that found in the 1991 US National Survey of Family Growth: 76 per cent of young men and 66 per cent of young women in the USA had experienced sexual intercourse by their final year of high school (Laumen et al. 1994: 324). But the estimates of 25 per cent of male students in a Delhi school (Sehgal, Sharma and Bhattacharya 1992) and 28 per cent of male college students in Hyderabad (Goparaju 1994) reporting premarital sexual experience signal an urgent need for appropriate sex education in Indian schools and colleges.

There is very little information on the female sexual partners of unmarried male students. Neighbours, relatives, prostitutes, friends and fiancees have been mentioned as partners in a

few studies. There is an indication that the premarital sexual partner of a male student is often a married woman who may be a relative or neighbour. For example, one-half of all the first sexual partners of 72 college students in Hyderabad were married women older than themselves and a large majority of the partners were relatives. This is somewhat expected because of the higher value placed on the premarital chastity of Indian women than that of men and because most Indian girls are still married at an early age. Some findings indicate that a sizable proportion of unmarried students visit prostitutes. For example, a survey conducted in a red-light area of Calcutta found that eight per cent of the customers of prostitutes were students (Biswas 1994) and another survey in a Bombay red-light area found the corresponding figure as high as 30 per cent (Gilada 1994).

Findings from the responses of middle and upper class men and women to the questionnaires published in *Debonair* and *Savvy* — two expensive Indian magazines — indicate a very permissive attitude and behaviour regarding premarital sex among them, almost similar to that among their counterparts in Western countries (Savara and Sridhar 1992, 1993). But a methodologically more rigorous study among these classes in Calcutta, Delhi and Madras found a significantly less permissive attitude and behaviour (Basu 1994). In this 1993 study 17 per cent of male respondents aged 21 - 45 years and eight per cent of female respondents reported experience of premarital sex. However, these figures are also considerably higher than those commonly perceived.

Studies among the urban lower classes show a wide variation in premarital sexual experience. The percentages reporting such experience among 264 blue-collar workers, 258 migrant workers and 139 loom workers in four towns of Maharashtra were 25.4, 32.2 and 12.2 respectively (Savara and Sridhar 1994). The prevalence of premarital relations among sexually transmitted disease (STD) patients is high. In a study of 300 men in Lucknow diagnosed to have STDs, 81 per cent reported having had premarital sexual experience, most of them with prostitutes (Narayan 1984). A strong association of HIV infection with multipartner sexual relations is exemplified by the findings of a study of 115 professional blood donors in Delhi among whom 15 were HIV-positive (Chattopadhyay et al. 1991). All these 15 were unmarried and had multiple sexual partners, mostly prostitutes. Out of 100 HIV-negative donors only nine had multiple sex partners.

No quantitative estimate of the practice of premarital sex is available for any rural community of India, but casual reports indicate that it is not uncommon, particularly for unmarried men. An in-depth study of 72 male college students in Hyderabad revealed that among those who had a rural upbringing, the proportion having premarital sexual experience was higher (46%) than among those who had an urban upbringing (17%).

Anthropological studies in India have provided very little information on the sexual attitudes and behaviour of communities studied. Remarkable exceptions are those conducted by Elwin (1947, 1979) whose popular treatises on a few Indian tribes in central India during the 1930s and 1940s give detailed descriptions of sexual activity among them. For example, his description of institutionalized premarital relationships among the Muria Gonds indicate that almost all adolescent boys and girls of that tribe had premarital sexual relations in village dormitories known as *ghotul*, where all of them usually spent their nights. Elwin, however, observed the gradual erosion of the *ghotul* institution due to Hindu intrusion of the Muria territory. Another tribe known as the Santal living mostly in Bihar and Orissa, for whom reasonably good descriptions of premarital sex were recorded in the 1930s and 1940s, is also reported to have a permissive attitude towards premarital sex (Biswas 1956; Mukherjea 1962). But almost no information is available on the contemporary situation among any of the tribal groups.

Extramarital sex

The ideal for a Hindu woman to remain loyal to her husband under all circumstances — *patibrata* — has mostly retained its social force in contemporary India. As in the case of premarital sex, the violation of marital fidelity is more punishable for women than for men. Women often are bound by their helpless situation to accept their husbands' deviations from marital fidelity in order to stay in a married state. Despite these ideals and situational constraints, references to extramarital relationships are not uncommon in Indian literature but empirical studies regarding their prevalence and attitudes towards them are rare.

A study conducted among middle-class working women in Delhi metropolis in the 1950s and 1960s shows that attitudes towards extramarital relationships underwent identifiable changes towards permissiveness within a single decade, although different norms of sexual morality for married men and women were still maintained (Kapur 1973).

A few recent studies, varying considerably in quality, in various urban communities of India, show a wide variation in the practice of extramarital relationships. A study among the educated middle class in Calcutta, Delhi and Madras found that the proportion with experience of extramarital sex was nine per cent among men and less than three per cent among women (Basu 1994). Another study in four towns of Maharashtra found that the corresponding proportion was seven per cent in the middle-class group and varied from one to twelve per cent in the lower-class group (Savara and Sridhar 1994). No generalization is possible from these findings but they indicate not only that extramarital relationships are less frequent in India than in Western countries but also that these are not altogether absent as claimed by some staunch believers in the Indian tradition of strict marital fidelity.

Prostitutes

There is a widespread belief in India that prostitutes are primarily responsible for the origin and spread of AIDS and it can be mostly controlled by testing all of them for HIV and isolating those who are found positive. This belief is partly based on the highly publicized initial detection of HIV infection among a few prostitutes in Madras in 1986 and also on subsequent publicity about the phenomenal rise of HIV infection among prostitutes in the red-light areas of Bombay and other cities. It reflects a lack of knowledge about the complex nature of both prostitution and the spread of HIV infection in India.

History in India

Prostitution as a profession has a long history in India. A whole chapter is devoted to it in Kautilya's *Arthashastra* written *circa* 300 BC and Vatsayana's *Kama Sutra* written between the first and fourth centuries AD. The *devadasi* (handmaiden of god) system of dedicating unmarried young girls to gods in Hindu temples, which often made them objects of sexual pleasure of temple priests and pilgrims, was an established custom in India by 300 AD (Basham 1959). There are reasonably good records of prostitution in large Indian cities during the eighteenth and the first half of the nineteenth centuries of British rule; prostitution was not considered as degrading a profession in that period as it was from the second half of the nineteenth century. A Calcutta Corporation publication of 1806 reports that there were 2,540 women in 593 brothels in 82 streets of Calcutta and that tax-payers of about six per cent of Calcutta's property were prostitutes (Ghosh and Das 1990).

Current situation

Because of the clandestine nature of the sex industry and also because of the wide varieties and geographical distribution of prostitutes, it is impossible to have an accurate estimate of their number in contemporary India. Some guesses are, however, available. Gilada's (1985) estimates of 100,000 in Bombay, 100,000 in Calcutta, 40,000 in Delhi, 40,000 in Pune and 13,000 in Nagpur are considered overestimates by some critics and underestimates by others.

Empirical data on the way of life and sexual practices of prostitutes in contemporary India are scarce. The advent of AIDS has generated a few empirical studies along with intervention programs in red-light areas of a few large cities. The findings of these studies corroborate the common knowledge that prostitutes, in general, lead a poor standard of life in dilapidated and unhygienic environments (Gilada n.d.; Ghosh and Das 1994). A major portion of what their clients pay is shared by pimps, landlords, madams, financiers and policemen. They do not get nutritionally adequate food and they are exploited by local traders who sell them essential goods. Because of strong prejudice against them they cannot take advantage of the government health facilities and have to depend mostly on local quacks who charge them exorbitantly for treatment and medicines. A large proportion of them suffer intermittently from various kinds of STDs. Most of them are forced to enter this occupation because of adverse circumstances.

Many prostitutes send a part of their income to their families. A survey conducted in a red-light area of Calcutta in 1987 found that 59 per cent of prostitutes were abandoned by their husbands and that many of them originating in Murshidabad district, where young women in many poor families are expected to go into prostitution, remit a substantial amount of money (Rs 475 per month, on the average) to their families (Ghosh and Das 1990).

A few well-designed and well-executed intervention programs by non-government and government agencies in a few red-light areas have started showing signs of increased use of condoms and reduced prevalence of STDs among prostitutes (Jana et al. 1994). One key factor in these successes is the use of trained prostitutes living in the project areas as peer-group educators in raising AIDS awareness among prostitutes and motivating them to use condoms. Training was given to selected prostitutes without any charge and after the completion of training they were given some compensation and allowed to continue their occupation.

It has been reported that even when health education programs succeed in motivating the prostitutes to use condoms, their customers, who usually have higher bargaining power, are often reluctant to use condoms. The processes by which the prostitutes succeeded in making them use condoms in the above-mentioned programs are not well understood and deserve a high priority on the social research agenda in connection with AIDS.

Devadasi system

Studies of the *devadasi* system in contemporary India indicate that it still prevails as an institution in some Hindu temples, mostly in Karnataka and Andhra Pradesh. Its operations are, however, clandestine because laws against it have been passed in all states. Gilada and Thakur (1988) report that every year about 10,000 young girls of poor families are dedicated as *devadasis* to the goddess Yallama in a small temple of northern Karnataka. They speculate that most prostitutes in the border districts of Maharashtra and Karnataka are *devadasis.*

Call-girls

Prostitutes who are known as call-girls are usually more educated and attractive than those living in brothels and are often engaged in some other occupation. They earn higher incomes and have some freedom in choosing their clients who mostly belong to the middle and upper classes. In a study of 150 call-girls, 20 clients and ten madams in Delhi, Bombay and Calcutta in the 1970s, Kapur (1978) found that the earning of call-girls ranged from Rs. 50 to 100 per hour and Rs. 400 to 10,000 per night. Eighty per cent of their clients were married. Many of them had suffered from STDs at one time or other and had experience of induced abortion but in general, they tried to take good care of their health by visiting physicians whenever necessary. Many of them wanted their clients to use condoms but most clients did not comply. A high proportion of their clients preferred oral sex to vaginal intercourse. In a subsequent study of nine call-girls in Delhi in 1993 Kapur (1993) found that some of them belonging to the upper middle class were aware of AIDS and rejected clients who refused to use condoms.

Clients of prostitutes

A few hundred thousand men have sexual relations with prostitutes every day in India but very little is known about their socio-economic characteristics, ways of life and sexual preferences. It is not possible to implement effective intervention programs among them without such information. Insights derived by health practitioners and social workers from the experience of working in red-light areas suggest that the following categories of men are frequent visitors to prostitutes: low-level workers in the manufacturing and transport industries; other workers living away from their families for a length of time; traders and customers in transitory markets; visitors to fairs, festivals and pilgrim centres; defence personnel living away from families; students; pimps and others who have some control over prostitutes; traders and service providers in red-light areas; and professional blood donors.

As in many other countries, Indian truck drivers and their helpers who spend the major part of the year on or near highways are generally known to visit many prostitutes during their stopovers. In-depth interviews with 79 truck drivers and 21 helpers in a check-post near Calcutta in 1993 showed that a majority of them reported visits to between three and seven prostitutes in a week and that the number visited by each trucker ranged from 50 to 100 in a year (Rao et al. 1994). Also, most of them reported never having used any condoms. Blood tests in a sample of truckers in the same place in 1993-1994 showed that 5.6 per cent of them were already HIV-positive. These facts point to the urgent need for adequate intervention programs among truckers and other frequent clients of prostitutes.

Legal provisions

Legislation passed in India regarding prostitution in 1956 and 1986 did not have the objective of abolishing prostitutes and prostitution; the stated objectives of the legislation were 'suppression' and 'prevention' of prostitution. The 1956 Act (SITA) assumed that prostitution was a 'necessary evil' and prohibited a prostitute from soliciting clients in public places and forced her to work in certain areas known as red-light areas, thereby exposing her to exploitation by pimps and others. Though the SITA did not aim to punish prostitutes unless they solicited, it gave enough powers to police and other government agencies to terrorize, harass and financially exploit a prostitute. The 1986 Act (IPTA) provides marginal benefits to prostitutes by prohibiting male police officers from searching them unless accompanied by two female police officers; and also by seeking to draw women away from

prostitution through rehabilitation in Protective Homes. However, a recent review of the conditions in a well-known Protective Home in Delhi indicates little success in meaningful rehabilitation of its inmates (Agnes 1992).

Legislation regarding AIDS was introduced in the Rajya Sabha in 1989 which gave some government agencies sweeping powers to infringe the liberties of certain categories of people, but, owing to strong opposition by a few activist groups, it was withdrawn in 1992. A subcommittee of the National AIDS Control Organization is currently considering various issues related to HIV/AIDS with a view to making recommendations regarding its social, ethical and legal aspects.

Homosexuality

Problem of identification

Homosexuality can be described as the orientation and inclination of a person to have sexual relations with a person of his or her own sex. It is difficult, however, to identify a person as a homosexual, heterosexual or bisexual because the behavioural expression of the sexual inclination of a person may take a multitude of forms and may change in their life cycle. This is why in their analysis of sexual behaviour data of white males and females in the USA, Kinsey et al. (1948, 1953) developed a six-point scale to identify a person's position in the heterosexual-homosexual scale from his or her history of sexual behaviour. Because of the lack of any such behavioural survey data, such identification is not possible for the Indian population. In India people are commonly identified as homosexuals if they have experienced as adults any kind of explicit sexual act with any person of their own sex.

Male homosexuality and AIDS

The clustering of AIDS cases among male homosexuals in the initial phase of the HIV epidemic in the USA and a few other Western countries led to a misleading notion that the disease afflicted only 'reckless' male homosexuals and it was often referred to as the 'gay plague' or 'gay cancer', 'gay' being the current vogue word for homosexuals. Recent studies have shown that HIV is spreading everywhere more through heterosexual relations than through any other mode of transmission. It is, however, true that the risk of HIV infection is greater for persons who practise anal intercourse and this type of intercourse is more common between homosexual partners than between heterosexual partners.

Prevalence in Western countries

More surveys of sexual behaviour have been conducted in the USA than in any other country. The survey conducted by Kinsey et al. (1948, 1953) among 4275 white males (15-55 years) during 1938-1947 is perhaps more widely cited than any other in sexual literature. It found that four per cent had overt homosexual experience (to the point of orgasm) during their adult life, eight per cent were homosexual for at least three years during their adult life, and 37 per cent had at least one overt homosexual experience to orgasm as an adult. Surveys conducted in the USA in recent years with more sophisticated methodology show a lower prevalence of homosexual behaviour. For example, surveys conducted during 1970-1990 found that only five to seven per cent of males had had at least one overt homosexual experience as an adult (Rogers and Turner 1991). The prevalence of homosexual behaviour in France and Great Britain in 1990-1991 is somewhat similar to that in contemporary USA (ACSF 1992: Johnson et al. 1994).

Historical evidence in India

Vatsayana's *Kama Sutra* (written between the first and the fourth century AD) refers to the practice of eunuchs and male servants giving oral sex to their male patrons and masters respectively. Some erotic sculptures of mediaeval Hindu temples depict lesbian acts. The Muslim rulers in India are reported to have maintained harems of young boys. During the British rule sodomy (anal intercourse) was made illegal under section 377 of the Indian Penal Code enacted in 1861: this legislation is still in force. Indian homosexual activists think that because of this legal provision, male homosexuals are often subjected to undue harassment and blackmail (ABVA 1991).

Current situation in India

Very little is known about the practice of homosexuality in contemporary India. According to Ashok Row-Kavi (1993), a self-acclaimed homosexual activist, the number of exclusively or predominantly homosexual men in India may be over 50 million. His estimate is based, however, on the assumption that the prevalence of homosexual behaviour is not less than what Kinsey et al. found for white American males in 1938-1947. But recent surveys, as shown above, have shown that Kinsey et al. overestimated the number of homosexuals in the USA.

Since the advent of AIDS in India, homosexuality is often discussed in popular newspapers and magazines but information provided is almost always anecdotal. Only one survey of 1200 self-identified homosexual men of South Asian origin living in South Asian countries (mostly in India) and in Western countries (mostly in the UK), admittedly not a representative sample, provides some quantitative information on various aspects of the respondents' sexual behaviour (Khan 1994). A vast majority of them were married and living with their wives, reflecting the cultural situation in South Asian countries which obliges all men and women to marry members of the opposite sex, whatever may be their sexual orientation. Only five per cent of South Asian homosexuals living in their own countries reported that their family members accepted their sexual identity; 12 per cent of those living in Western countries did so. The most common locations of the first homosexual experience in both regions were parks and toilets. Relatives, mostly male cousins and uncles, were the second most common category of first homosexual partner, strangers being the most common category. Mutual masturbation was mentioned as the most common type of homosexual act.

Strong prejudices against homosexuality in India, enhanced by the popular misconception that it is at least partly responsible for the spread of HIV/AIDS in India, and the awareness among some Indian homosexual activists that the government should not continue to ignore homosexuals' needs in its AIDS prevention programs, prompted them to organize homosexuals in formal groups for social and political purposes. A few newsletters and magazines—*Bombay Dost* being one of the well-known newsletters—have been trying to establish local networks of such groups and provide information of special concern to homosexuals. *Bombay Dost* makes special efforts to popularize the use of condoms among homosexuals. The Government of India has already recognized the need for intervention programs among homosexuals and has taken the initiative to collect information necessary for the purpose.

Hijras and male prostitutes

A culturally identifiable group known by the Urdu term *hijra* in most parts of India and other terms in the southern states of India, deserves special attention in HIV/AIDS intervention programs because many members of this group are known to depend at least partly for their

livelihood on working as male prostitutes. Most *hijras* are castrated males and dress as females. A few are hermaphrodites, that is, born with ambiguously male-like genitals.

Ways of life

Traditionally, *hijras* earn their livelihood by receiving payment for their musical performance at homes on occasions of male childbirth, weddings and other festivals, as well as by begging. Because of their special identification with the Hindu god Shiva and the mother-goddess Bahuchara Mata, they are believed by many to have the power to confer prosperity and health on newborn babies and newlywed couples and also the power to do harm to them. With the erosion of such beliefs in contemporary India, *hijras* are reported to increasingly engage themselves as male prostitutes.

Hijras live in all parts of India but they concentrate more in north Indian cities where they have greater opportunities to earn their living by performing their traditional role as household performers on festive occasions. The total population of *hijras* in India is not known; in censuses many of them report themselves as female. The unofficial estimate of their population in India varies from 50,000 to 500,000.

Some anthropologists and other social scientists have made studies of the social, religious and sexual beliefs and behaviour of some *hijra* communities; the most recent and extensive ones are by the anthropologist Serena Nanda (1986, 1989). The usual working group of *hijras* is a household of five to 15 members organized as a commune. Members from all castes and religions can be initiated into the *hijra* community through a ceremony. After initiation they are expected to adopt the values and organizational principles of the *hijra* community, breach of which leads to punishments of varying degrees. The renunciation of male sexuality through castration is the heart of *hijra* social and religious identity. There are myths and folklore associating Bahuchara Mata, the major object of the *hijara* devotions, with transvestism and transsexuality. The castration operation is usually performed by a *hijra* called a *dai-ma* crudely and under insanitary conditions. It is legally punishable but reported to be performed secretly in large numbers.

Sexual practices

Anthropologists who have studied *hijra* communities in various parts of India agree that, in addition to earning their livelihood as performers, most *hijras* in contemporary India engage themselves in sexual activity with men for money or for satisfying their own homosexual desires, as long as they are physically attractive or capable of doing so. There are also nineteenth century reports of kidnapping of small boys by *hijras* for the purpose of sodomy or prostitution. Most *hijras* seem to engage in casual prostitution by offering sexual favours to men in exchange for money. Some others, particularly those with strong feminine identity, are involved in relatively long-term relationships with men who may be known as their 'husbands'. Having a 'husband' in an economically reciprocal and emotionally satisfying relationship is a preferred alternative for those *hijras* who openly engage themselves in sexual relations with men.

Upon formal initiation into the *hijra* community through the ritual of castration, a *hijra* is expected to abstain from sexual relations or to marry because sexual activity is offensive to Bahuchara Mata. According to sexually active *hijras*, many join the community mainly for sexual relations with other men although they are aware that such behaviour lowers their status in the society. Almost nothing is known about the sexual techniques *hijras* practise or are asked to practise when they perform the role of a prostitute. It is very likely that they are often passive partners in anal intercourse without the use of condoms, thus making themselves highly vulnerable to HIV and other STD infections.

Male prostitutes

In addition to a large section of the *hijra* community, there are many full-time or part-time male prostitutes in India. Some of them live in red-light areas of metropolitan cities; many seek male clients by offering massage services in parks, beaches, hotels and houses. Thousands of homeless and poor boys and young men employed in various establishments and firms are compelled to provide sexual services to their male bosses in return for their job security. Young men who work as helpers to highway truck drivers in their long trips provide such services.

Use of condoms

Although the condom was originally devised and used everywhere for protection against sexually transmitted diseases, it has been perceived and used in India during the last few decades mainly as a protective device against unwanted pregnancy. Its use as a method of contraception among reproductive-age couples in India (145 million in 1991) increased from three per cent in 1970 to over five per cent in 1991. The extent of the use of the condom as a contraceptive device varies considerably among states and union territories.

Use among prostitutes and their customers

There is a very low level of use of condoms among female prostitutes in India. Reports of rapid increase of prevalence of HIV-positive cases among prostitutes in red-light areas of Bombay and a few other Indian cities have persuaded non-government and government agencies to start intervention projects in pockets of those areas for motivating prostitutes to use condoms, and distributing condoms free or at subsidized prices. One such project in Calcutta (Jana et al. 1994) and two projects in Bombay (Gopalakrishnan 1992; Gilada 1994) are reported to have achieved reasonable success in increasing the use of condoms and reducing the prevalence of sexually transmitted diseases including HIV infection. As stated earlier, one common factor accounting for the success in these projects is the effective use of selected prostitutes as peer-group educators in project implementation.

The reports of the intervention projects indicate that with the proper approach it is not very difficult to convince the prostitutes of the need to use condoms for protecting themselves from HIV and other sexually transmitted infections. It is also not very difficult to impress upon the pimps, madams, landlords and others involved in the sex industry that keeping prostitutes free from diseases serves their own economic interests. The main problem lies in the persisting unwillingness of the customers to use condoms, and prostitutes' powerlessness to insist on their use or reject the customers. The literature regarding the increased use of the condom among small groups of prostitutes does not explain how the powerlessness of prostitutes in this respect was overcome, at least to a certain extent. This is an area which deserves high priority in behavioural research regarding HIV/AIDS.

Very little is known about the attitudes and behaviour regarding use of the condom among frequent customers of prostitutes. One such group about which a few small-scale surveys have been made is that of long-distance highway truck drivers and their helpers. The level of condom use in almost all the samples surveyed is reported to be low but there are indications that well-designed intervention programs involving both education and distribution of condoms can increase the use of condoms significantly among truck drivers and their helpers (Rao et al. 1994; ARFI 1994).

Constraints on condom use

Studies during the last few decades have identified a few reasons for limited use of the condom as a family planning device, although it does not have any side effects. The most common complaint of men against it is that it reduces the pleasure of sexual intercourse. People are also generally aware that the condom does not give full protection against pregnancy and sexually transmitted disease. The loss of its effectiveness in giving protection may be due to its inherent quality or its faulty use or storage. The powerlessness of women to make their sexual partners use condoms, if the latter are unwilling to do so, is also an important constraint on the use of the condom. The apparent link of the condom with the penis and sexual intercourse makes any reference to it culturally sensitive and often a forbidden topic for open discussion. Other constraints on the use of the condom are ethno-physiological misconceptions about it (e.g., it can remain hidden in women's body), its past association with prostitutes (for protection against STDs), and vaginal pain and irritation when prostitutes entertain too many customers in a short span of time.

The rapid spread of HIV/AIDS in India demands introduction of adequate programs to minimize the constraints on the use of condoms as far as possible. Some of them are: production of thin, robust and well-lubricated condoms in air-tight and attractive packages; distribution of condoms through channels which make them easily accessible to people vulnerable to sexually transmitted diseases including AIDS; enhancing men's motivation to use condoms through mass media, entertainment programs, group discussions, interpersonal communication and by emphasizing the pleasure aspect of using condoms; further experimentation in the distribution of condoms through vending machines installed in public places frequently visited by groups vulnerable to HIV/AIDS.

Sexual abstinence

One important way to avoid infection from sexually transmitted diseases including HIV/AIDS is to abstain partly or fully from sex. The biological drive for sex is almost universal in human beings but it is not necessary for the survival of a person, as food is.

Virtue in Hindu culture

In Hindu culture and religious scriptures abstinence from sex is considered a virtue. Although Hindu epics enjoin husbands and wives to have sexual intercourse for begetting children at specific periods of women's menstrual cycles, over-indulgence in sexual relations even between husband and wife is considered to be a sin and is believed to cause serious illness.

Sublimating sexuality into spirituality though sexual abstinence has always influenced Hindu thoughts and actions. Many people in contemporary India, both rural and urban, believe in the theory of sublimation in some form or other. In its most popular and simple version, semen is believed to be a source of physical and spiritual strength and should be conserved by men as far as possible. Food is supposed to be converted into semen by successive transformations through blood, fat, bone and marrow. Advocacy of the sublimation theory and virtue of sexual abstinence by Indian national leaders such as Mahatma Gandhi has reinforced the existing folk traditions and religious beliefs in this respect (Kakar 1989).

Implications for sex education

In some Western religions the virtue of abstinence from sex is recognized but Western psychologists and sexologists generally consider prolonged abstinence from sex as detrimental to mental and physical health (Robinson 1924; Biegel 1961). Freud (1924) thought of sexual abstinence as the source of various illnesses and at the same time, 'abstinence', he believed, was 'hardly thinkable for young artists because sexual experiences act as a stimulant to artistic activity'.

In contrast, Indian literature contains hardly any reference to the negative effect of sexual abstinence on the human body and mind. Despite the widespread intrusion of sexually explicitly scenes and themes in the Indian entertainment and advertisement industries, the virtue of sexual abstinence among both men and women and anxiety over loss of semen on the part of men still dominate Indian minds. So emphasizing abstinence from sex as a way of protection from AIDS and other sexually transmitted diseases in sex education programs is a more viable option in India than in Western countries.

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