CICRED'S SEMINAR

Meeting unmet information needs on sexual health and safe sex through *dialogue*

R.S.Goyal

MEETING UNMET INFORMATION NEEDS ON SEXUAL HEALTH AND SAFE SEX THROUGH *DIALOGUE*

R.S.Goyal

Indian Institute of Health Management Research, Jaipur

Sexuality and sexual behaviour encompass a vast area of human nature and behaviour. However, in most societies, these issues are usually not a matter of overt discussions. Consequently, it has been found that many people have very little knowledge of issues related sexual health, sexuality etc., and whatever little they know (acquired through friends, relatives, peers, pornographic literature etc.) is often incomplete, full of myth and for removed from any scientific validation. The ambivalence and inhibition about sex is very large even in the mind of educated individuals (Ganguli 1988, Nag; 1994).

These behavioural attributes becomes significant in context of UNAIDS observation that ignorance (encompassing lack of access and inability to act on information) about safe sex is the largest contributing factor in the spread of HIV/AIDS in the world (UNAIDS: 2000). UNAIDS further notes that gender discrimination in the accesses n and/or ability to act on information has made women more vulnerable to HIV/AIDS in most societies, particularly in the traditional ones.

The behavioural change communication (BCC) initiatives envisage that to promote safe sex practices, the first logical step is to build an understanding of the issues related to sexual health and sexuality. This change can best be achieved by creating an enabling environment and opportunities for the people to freely deliberate, seek and validate information on these and related issues. Inter-personal interaction i.e, **dialogue** with in and between the sexes has been identified as an ideal strategy to initiate and/or facilities this process of learning. Technically (Webster's dictionary), dialogue has been defined as a *"conversation between two or more people*". In the context of sexual health, Family Health International (FHI) has defined it as follows*;*

dialogue is a human process through which individuals, families and communities begin to talk and exchange ideas in ways that result in mutually beneficial decision and creative situation for action.

Dialogue provides opportunities to people to talk freely with the people of same and/or opposite sex. It also enable men and women to seek and articulate information. These processes help in building an enabling environment for demystifying sex and sexuality. Dialogue is ideal for BCC initiatives to create awareness and educate people on various aspects of sexual health, STD, HIV/AIDS and to promote safe sex practices, including use of condom.

Dialogue is likely to be more effective in community setting because in these situations, s*ocial pressures for normative behaviour, behavioural change and adoption of safe sex practices (in case of risk behaviour) are more pronounced.*

OBJECTIVES

This paper presents the findings of an operations research project undertaken with the following objectives;

a) to assess the perception and behaviour of men and women towards sexuality and sexual health.
b) to identify Information needs of men and women in the context of sexuality, sexual health and safe sex, and
c) to meet these information needs through dialogue by creating an enabling environment, and
d) to empower men and women to adopt safe sex practices.

This project was funded by MacArthur Foundation, USA and carried out in selected rural and urban localities of Ajmer and Udaipur districts of Rajasthan (India).

METHODS

This project has two phases - research and intervention. In the research component of the project, 2000 married men and women (equal number) in sexually active age group of 20-50 years from 40 selected rural and urban localities in two districts were interviewed. From every district, 10 rural and 10 urban localities were selected for enumeration using a systematic random sampling procedure. In every locality, 25 men and an equal number of women were identified for interview, using a simple random sampling sampling procedure. A structured interview schedule (separate schedules for men and women) was used to collect requisite information.
In addition to quantitative data, a series of qualitative data were collected through focus group discussion (FGD) (#32), key informant interviews (#35) and case studies (#30).
The number of participants in FGDs, key informant interviews and case studies is as follows:

Type of Data	Men	Women
FGD	90	200
Key Informant Interview	15	20
Case Study	10	20

The intervention activities were designed on the basis of findings of baseline survey and carried out in 12 rural and urban localities in the two districts. Dialogue was the principal intervention tool as well as strategy to create an enabling environment,

bridge the knowledge gap and promote safe sex behaviours and practices. Dialogue was held in small groups of men and women (10 to 15 persons), meeting separately. Dialogue between opposite sex was also attempted, but could not succeed, because women were shy in talking about sex in the presence of men. Further, mother in-laws also disapproved of it. In every locality, 4 groups of women and 2 groups of men (men were less interested in dialogue pretending that they know everything about sexuality and sexual health). Every group met at least once a week for a period to 3-4 months. In every session, dialogue was held around a specific issue. During a cycle of three months, the subjects covered includes; human physiology, growing-up of men and women, sexuality, sex life, sexual health, reproductive tract infections (RTI), sexually transmitted infections (STI/ STD), human immuno-deficiency virus/ acquired immuno-deficiency syndrome (HIV/AIDS), promiscuous sex behaviour of men and women, violence against women, use of condom, safe sex etc. After completion one cycle of dialogues, another groups of men and women were formed, and the process was repeated. Interventions were carried out for a period of one year.

Dialogue sessions were facilitated by a team of professional counsellors (2 men and 4 women). Film and video shows, dramas/plays, on the spot painting, flip charts, talks etc. were used to impart new knowledge. For health promotion activities, individual, couple and group counselling, referral to medical care for treatment of RTI and STI and health check-up camps were organised. Men and women in need of medical investigations and care were referred to medical college hospitals in Ajmer and Udaipur. Wherever it was found that a large number of persons are in need of medical investigations and care, health check-up camps were organised in the village itself.

After completion of one cycle of interventions, its impact was assessed. Wherever found necessary, modification were introduced. After one year of interventions, an end of project evaluation was carried out. The evaluation tools included, weekly and monthly progress reports, quantitative and qualitative data particularly collected for the purpose of evaluation.

FINDINGS

A: Empirical Study

1. For men, the major sources of information on sex were, peers, books/magazines and films. Women learned about it from friends, relatives and spouses.
2. In response to question on perception about sex, two thirds of men and women observed that sex leads to weakness(table 1) .

Table 1: Men and Women's Perception about Sex

Perception	Male Respondent (Percent)	Female Respondents (Percent)
1. Sex is natural need of body	90	84
2. Sex leads to weakness	72	80
3. Women should not express desire for sex	61	65
4. Masturbation leads to weakens/impotency	81	51

Another important finding of the table 1 is the belief that, with in the married unions, sex is a male prerogative and, women should not express desire for sex. Importantly, a little less than two thirds of women have also agreed with this opinion. It reflect that socio-cultural dominance of men over women particularly in family setting is so overwhelming that most women themselves believe that *women's sexuality should be controlled by men.*

3. Inter-spouse communication on sex and related issues was frequent. Topics discussed are general bedroom talks and included, pleasure in sex, pornography in films, avenues to seek more information about sex and other related issues.
4. Enjoyment or satisfaction in sexual act was linked (by men) to mood (desire). premature ejaculation, ill health and impotency were negatively associated with sexual satisfaction. Women have also given more importance to mood and ill health in a positive and negative sense respectively (Table 2)

Table 2: Reasons for lack of Satisfaction In Sexual Act (Percent Distribution)

Reason	Men	Women
1. Physically ill	28	42
2. Not in mood	51	54
3. Lack of privacy	16	6
4. Drunken status of man	25	13
5. Impotency of men	41	1
6. Premature ejaculation	31	3
7. Suffering/fear of STDs	8	1

In the focus groups discussions, satisfaction in sexual act was linked to men's vigour, considered to be desired condition for pleasure in sexual act. Use of condom was however negatively associated with pleasure in sex. It was also observed that satisfaction in sexual act was not a consideration for most women. They treat it as a husband's domain. Over 60 per cent women observed that they do not draw any pleasure/satisfaction in sex. Wife beating and consumption of alcohol by husband (before the sexual act) were also associated with it.

5. One hundred sixty (16 per cent) men admitted that they have multi-partner sex relationships. (This question was not asked to women due to cultural reasons). This finding corroborate well with the data from Behavioural Surveillance Survey (BSS) (2001), which reports that 13.7 per cent men in Rajasthan had sex with a non-regular partner during 12 months preceding the survey. Over half of spouses (of these men) were aware of promiscuous sex behaviour of their husbands but tolerated it, due to their economic subordination to men, socio-cultural dominance of men in society and family. Promiscuous sex behaviour of men was not associated with religion, caste, socio-economic status etc. Further, in case of over 60 per cent of these men, the other partner (than spouse) was a commercial sex worker. Justification for promiscuous sex behaviour was found in vigour and large sexual power of men (one women cannot always satisfy a healthy man). It was also linked to pre-marital practices of having multi-partner sex relationships.
6. Only 25 (16 per cent) men maintaining multi-partner sex relationships were using condom (with other partner) as a protection against HIV/STI. Over 85 per cent of these men carried condom with them and used it every time. In the BSS (2001), consistent use of condom with a non-regular sex partner was somewhat higher (26.5 per cent).
7. With in married unions, 16 per cent men were using condoms. Only 5 per cent men having multi-partner sex relationships, were using condom while having sex with their spouse. Use of condom with in married unions was largely to space or limit the number of children.

   Though, 20 per cent women have suggested for use of condom (to their husbands), only 5 per cent could successfully negotiate for its use. In 11 per cent cases, condom was used on the initiative of men. Women's lack of ability to negotiate for the use of condom was associated more with their ignorance (about use of condom), than the socio-economic subordination to men.
8. Knowledge of STDs, its causes, symptoms and preventive measures was quite large (66 per cent) among men and women. However, many women were not able to differentiate between the symptoms of STIs and RTIs.
9. Several superstitions and beliefs were linked with STDs and their treatment. For example, STIs could be caused due to effect of evil eye, body heat, eating hot food etc. It was also believed that STIs could be cured by blessing of *holy* people, having sex with a **virgin** girl etc.
   Fifteen percent men and 29 per cent women reported a history of STI infection. Forty eight percent of these men have told their spouses about their infection . Sixteen percent of them continued to have sex relationship with spouses, in spite of infection. On the other hand, 93 percent of such women have told their husbands about their infection (they argued that this disease was communicated to them by their husbands). Sixty two percent of these women, however, maintained sex relationship with their husbands

during the period of the disease (according to them, they did not have any choice but to subject to their husbands' wishes).

Generally, indigenous treatment (or medicines from local unqualified doctors) was taken for STIs. Sixty nine percent men and 44 percent women took treatment for symptoms of STIs. But compliance with treatment, particularly among women was poor. Men resorted to treatment at an early stage. Women however, seem to have a tendency to delay the treatment till it becomes unavoidable. Following two case studies elaborate these behaviours.

Gomti (assumed name) *lives in Bhawta village (Ajmer). She is 35, married for 15 years and had 4 children (three daughters and one son). She is suffering from a STD (burning, itching and boils in the vagina). She got this infection from her husband. He has relationships with many women including commercial sex workers (CSW). She has shared her problem with her husband. But he has refused to take her for treatment. When her problem became severe, she took treatment from a local docto. But she has not been cured. The doctor says that her husband also needs treatment. But she cannot take her husband with her to the doctor. Now she is very weak; she cannot walk. Pain has also become unbearable.*

Devilal (assumed name*) is a truck driver. He is 26 years old, married and has one son and one daughter. He has 5 brothers. All of them are truck drivers.* He had multiple partner sex relationships (CSW) before marriage and continues to do so now also. He does not use condom because he does not enjoy sex with its use.

He has STD infection (boils, pain and burning while urinating). He took treatment from a local doctor but had only temporary relief. The problem continues. Now his wife is also infected. He has taken her for treatment. But he continues to visit CSWS.

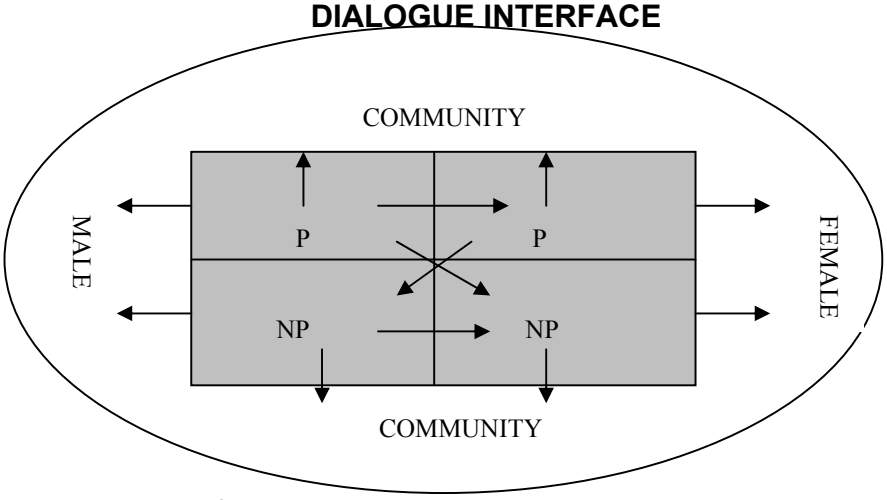
10. The level of awareness of AIDS was between 40-55 percent among men and 11-22 percent among women. In the Behavioural Surveillance Survey (2001) a higher proportion of men and women in Rajasthan (68.4 percent and 46 percent respectively) were reportedly aware that AIDS can be transmitted through sexual contact. It could be linked to an intensive campaign to build awareness for HIV/AIDS leading to improvement in its level during three years period between the two surveys.
11. AIDS was perceived as a deadly disease for which no treatment was available. It was believed that it is transmitted through multi- partner sex relationships (particularly with sex workers), use of infected blood for transfusion, and the use of infected needle for giving injection. Very few respondents knew about vertical (from mother to child) transmission of HIV.
12. Major sources of information about AIDS were; peers, posters, hording, TV, and pamphlets. Women learned about it from their husbands also.

13. Knowledge of preventive measures of AIDS, particularly use of condom was very limited. There were several misconceptions about the sources of the spread of AIDS.
14. There was a large desire to learn about AIDS and its preventive measures.

B: Impact of Intervention Programme (Dialogue)

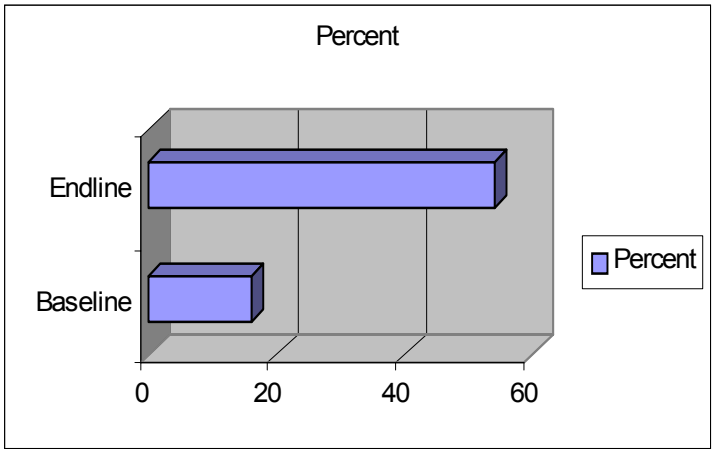
1. Four hundred and eighty men and women participated in the dialogue. Nearly 60 percent of them were women. Over 90 percent participants attended more than 3 dialogue sessions.
   The participants sustained their interest in dialogue.
2. Retention of knowledge acquired was large. More than three fourths of the participants could recall all the major topics discussed in the dialogue sessions. Further, retention of knowledge was almost equal among men and women.
3. Dialogue helped in building awareness, allaying fears and misconceptions and building a positive perception about sexual health. There was a large improvement in the appreciation for mutual sexual health by men and women.
4. Understanding of preventive measures of STDs has improved considerably. Importance of the use of the condom, treatment of both the partners in case of STI infection, avoiding multi-partner sex relationship, use of safe blood for transfusion and, use of the new/boiled syringe for giving injection were recalled by over 80 percent men and 85 percent women.
5. The dialogue helped in creating an enabling environment for free and open discussion on sex and related issues. It also helped in imparting new knowledge on sexual health.
6. Improvement in the knowledge of sexual health is believed to have contributed to an increase in satisfaction in sex.

There was impressive diffusion of knowledge in the community at large. Every participant in the dialogue talked on an average to 5 other persons.



P - Participant in Dialogue Session
NP- Non- Participant in Dialogue
→ Direction of Flow of Information

7. The counselling services were used by over 240 (50 per cent) men and women. Counselling was sought for the symptoms of RTIs, STIs, sexual discord (within married union) and abortion. More than three fourths of them were happy with the counselling provided.
8. Referral was taken for symptoms of RTIs, STIs and infertility by 40 percent women and 33 percent men (participants in project activities). Forty percent of them, however, were not satisfied with the services provided at the referral centres i.e., medical college hospitals. The main reasons for discomfort were lack of preferential attention and free medicines.
9. The use of condoms went up by more than 300 percent as a result of programmed interventions. Three fourths of the new users of condoms adopted the device as a protection against STDs and AIDS.



LESSIONS LEARNED AND RECOMMENDATIONS:

1. Common men and women in the community have poor understanding of and appreciation for sexual health, HIV/AIDS. They are at an equal risk of STD/HIV infection as `*high risk'* groups.
   High risk behaviour is not uncommon among common men.
2. Husbands have very little appreciation for wive's sexuality and sexual health. Wives accept this situation.
3. Dialogue (inter-personal interaction) is most appropriate strategy to create awareness and promote preventive measures against STD/HIV. It also helps in focusing attention on relevant media messages on TV and printed literature.
4. Dialogue is an effective inter-personal contact mode to build awareness and appreciation for sexual health and AIDS. It enabled participants to validate their knowledge. Dialogue builds capabilities, creates opportunities and environment for the use of information (such as appreciation and adoption of safe sex practices).
5. Dialogue is particularly effective in a community setting because of social pressure for normative behaviour.

6. Women show a greater motivation for new learning and acquiring new skills (particularly negotiation for safe sex practices within married unions). They have played a crucial role in the increased use of condoms (within married union) as a protection against STD/HIV.
7. Counselling (individual and couple) significantly contributes to reducing sexual discord within married unions and improvement in appropriate medical care for STDs.

There is a further need to consolidate these experiences for wider use by trying dialogue in different settings and environments.

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