AIDS Awareness Campaigns, Sex Education Programmes and Pornography
The Shaping of Sexuality Awareness among College Students

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This article attempts to explore what constitutes awareness of sexuality and sexual health among urban, unmarried, college-going young men and women from low income families. It shows that sexuality awareness among the youth is limited and the sources that address young peoples' needs are few. The article discusses campaigns to enhance awareness on sexuality and AIDS among youth and explores the reasons for the failure of these campaigns. It is argued that the sex education programmes currently available in colleges are silent on the discourse on sexual pleasure and desire by adopting a medicalised approach to sexuality that has an authorised, 'scientific' voice. Erotic and pornographic sources gain legitimacy in this scenario as they address some of the needs and concerns of young people.

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INTRODUCTION

The AIDS awareness campaigns in India, which began in the 1990s, are possibly unmatched by any other public health campaigns in recent times in the country in terms of the volume of funds, the variety of communication strategies employed, and the number of agencies involved. The medical and social crises that the HIV unleashed in the United States, the phobia generated by a lack of understanding of ways to deal with the spread of infection, and the projection by international agencies of the devastation that the infection is capable of causing in the poor countries of Africa and Asia, provided the rationale for AIDS policies and programmes in India. International pressure, combined with funds and technical support, was instrumental in producing such an overwhelming response to AIDS in India. The AIDS work in India has focused chiefly on preventive measures using 'information, education and communication' strategies, with youth being targeted as a group vulnerable to the HIV infection. Using this approach, a variety of awareness campaigns organised by government agencies, non-governmental organisations (NGOs), educational institutions, the media, medical professionals, and citizen's groups are currently underway.

These campaigns have had several far-reaching outcomes. First, the campaigns based on the epidemiology of HIV brought into public discourse previously unmentionable sexual acts and sexual relationships. Second, the focus on the sexual modes of transmission of the virus meant that some degree of sex education accompany the AIDS awareness campaigns if they were aimed at young people. Thus, riding on the AIDS campaigns, sex education programmes for the youth, which were earlier vehemently opposed by parents, school authorities and government agencies, gained some legitimacy.[1] Third, by now, there are several manuals and modules available for providing sex/AIDS education to different youth groups.

As a result of these efforts one would assume that some information on sexuality and AIDS would have reached a vast population, at least in the cities and towns. However, studies conducted in different parts of the country show that while some information on AIDS is widespread among the youth, adolescents and young adults, even the educated among them 'lack information' on sexuality and sexual health despite being exposed to the campaigns mentioned above (Bott, Jejeebhoy, Shah and Puri, 2003; Jejeebhoy, 2004; Khanna, Gurbaxani and Sengupta, 2002; National AIDS Control Organisation [NACO] and UNICEF, 2002; Verma, Pelto, Schensul and Joshi, 2004). More significant is the finding that information on HIV/AIDS and protective measures did not lead to the use of this information in people's lives. It was found that knowledge of condoms and their safety value did not induce 'safe sex' practices, even among those who engaged in 'risky' sexual behaviour. These observations draw our attention to several issues. What do young people learn from these campaigns? How do they make sense of the various, and often, conflicting messages provided by different agencies (advertisements versus public health messages)? What is meant by 'lack of information'? What are the sources that they access for information and how do their class and gender positions influence all of the above?

The data used in this paper to address some of these questions are drawn from a study on youth sexuality conducted among low income college students from the city of Mumbai in India during 1996-1998. Data were gathered from students of higher secondary class (XI Standard) and third and final year (TY) undergraduate course covering the Arts, Science and Commerce streams from four colleges that largely catered to low income students. The respondents were in the age group of 16-22 years.[2] Data were gathered in two phases: qualitative data in the first phase using focus group discussions (FGDs) (75 students in 10 groups) and interviews (87 students), followed by a survey of 966 students (625 boys and 341 girls) in the second phase.

Respondents were either self-recruited (as in the FGDs) or recruited by the research team (as in the interviews). The respondents for the

survey were drawn from a representative sample of boys and girls from all the various streams based on the proportional distribution of students in the college. The FGDs explored the students' social interaction, views on marriage, partners and premarital sex, sexual experiences, and sources of information. The interviews explored, in detail, the individual views and experiences. The survey explored specific areas of knowledge, beliefs and experiences related to sexuality.[3] Data from all these sources are used in order to understand what constitutes sexuality awareness among these youth.

Specifically, sexuality awareness refers to a person's understanding of sexual identities, sexual beliefs, norms and practices. It includes an understanding of how all of these are structured and shaped by societal arrangements and cultural practices. It allows individuals to understand themselves as sexual persons and also the underlying meanings as well as the consequences of their sexual practices. It includes sexual health awareness, a broad category of critical information that may enable young people to control pregnancies and prevent sexually transmitted infections (STIs). While people's perceptions are shaped largely by the normative and discursive practices, they also reconstitute their perceptions based on information and experiences. Awareness of sexuality and sexual health is important, not just for their instrumental value in limiting teenage pregnancies and spread of diseases, but because of their capacity to enhance self-understanding and sexual well-being, especially among young men and women. Further, we see this awareness as being critical to the agency of the youth in questioning the social structures and cultural arrangements that control their sexualities through a patriarchal sexual ideology that defines sexualities in unequal and oppressive terms.

The article shows that sexuality awareness among the youth is limited and the sources that address young peoples' needs are few as well. Sexuality awareness among the boys[4] is mediated primarily through peers, pornography and various erotic materials, to which they have relatively freer access. Girls, in contrast, face normative and material constraints in accessing information on sex. The normative prescriptions restrain them from seeking information on sex as such behaviour is seen as transgressing the notions of femininity. The article argues that by curtailing access to information, silencing the discourse on sexual pleasure and desire, and medicalising sexuality through the authorised, 'scientific' voice of the sex education programmes, erotic and pornographic sources gain legitimacy as they address some of the needs and concerns of young people. The uncritical consumption of these sources perpetuates oppressive patriarchal constructions and distorts young men's perception and experience of their sexuality. Enhancing sexuality awareness among the youth cannot be achieved through a discourse of diseases that ignores sexual desire and pleasure — concerns that young people grapple with.

FINDINGS

Young people's understanding of sexuality and sexual health awareness is generally tested against medical knowledge so that much of what constitutes their understanding is generally dismissed as 'myths and misconceptions'. In this study we used a combination of approaches wherein medical knowledge was tested along with an attempt to understand cultural meanings that underlie the interpretation of such knowledge on topics as diverse as male and female bodies, pubertal changes, sex, pregnancy, contraception and HIV/AIDS. The following discussion gives insights into young people's social, sexual, and cultural interpretations in the light of new measures of sex education and awareness.

Body and Pubertal Changes

Even though it is generally held that youth are obsessed with their body, the study showed that knowledge of genitals or the 'private parts' is limited, especially among girls. For instance, the presence of clitoris is not known to them and some of the younger girls could not clearly say whether the urinary, vaginal and anal passages are separate. Many girls thought that the urinary and vaginal passages are common. Knowing the external genitals is a taboo for girls[5] even when lack of awareness may compromise sexual health. It cultivates a 'culture of silence' around 'woman's problems' such as white discharges, discomforts and a range of minor or major infections throughout their lives (Oomman, 2000). Boys are generally more aware of their own body and are more informed about a woman's body as well. The discussions and interviews show that boys gain this knowledge through self-exploration, peer discussions, and erotic and pornographic materials, especially movies. Their understanding of the female body and sexuality is derived largely from pornographic sources.

> If I had not seen blue films then what is female body is not understood.... only curiosity increases *(Standard XI Boy, FGD).*

How do we explain this lack of knowledge about one's body in the face of sex education classes that seek to teach about the male and the female body?

The current sex education discourse in India (and elsewhere too) reduces the discussion on 'body' to a set of 'reproductive organs' and to the reproductive process.[6] It is conducted in an abstract manner, speaking of 'a body' or 'the body' and relies on terminologies drawn from biology and medicine. The medicalising and depersonalising strategies produce a discourse that objectifies bodies and ignores the fact that bodies are sites of sexual pleasure and pain, sexual assertion and subordination and freedom and social control, and distances participants from the fact that the discussion is about themselves and their bodies.[7] It is understandable then that in the discussion of

women's bodies, virginity assumes importance even when hymen and clitoris remain unknown. The girls moreover understand the concept of virginity as being 'pure' and being 'untouched'. Girls are not familiar with either the English terms 'virginity' and 'hymen' or the Hindi equivalent, *purda.* The lack of vocabulary or the knowledge of the existence of hymen does not come in the way of girls internalising the cultural meaning of virginity as being 'pure and untouched'. The notion of virginity is asserted through several terms that girls use such as 'pure', *paripakwa,* untouched, and *kaumaryata.*

While girls may be ignorant about hymen, boys have fairly detailed knowledge of its existence and its link with virginity. Some of the boys know the English term virginity, but they use words such as *purda,* 'seal' or 'seal pack', more frequently, to refer to hymen.

(TYBoy)

R: To ladies — blood comes, it is painful. First time pains to married women.
I: Why does this happen?
R: Because the "seal" breaks.
I: What is it?
R: It is a curtain *(purda)* on the vagina. It tears while doing intercourse ...
I: Where have you heard this?
R: It is shown in Hindi movies, it pains even to "gents". The "penis" pains while breaking the "seal".[8]

The link between virginity and hymen, preserving female virginity until marriage, and the act of penetration are part of boys' awareness of sexuality. While the topic of virginity generated much discussion among both the boys and girls, it was exclusively on female virginity. According to boys, there cannot be male virginity because boys have no *purda.* The cultural significance of girls' virginity, for both boys and girls, is evident from the response of an overwhelming majority of girls and boys who said that a girl's virginity was her 'most valuable possession'. Some of the boys knew of the fact that the hymen could be ruptured through 'cycling and other vigorous exercises' and 'sports'; yet, this knowledge did not alter the cultural notion *of purda* as the signifier of virginity and purity.[9]

While there are a few studies on menstruation, the experience of pubertal changes and how young people negotiate these changes are not studied in the Indian context. The studies on menstruation show that girls are not prepared to deal with menstruation prior to its onset. Girls suffer embarrassment, fear, shame and anxiety besides physical pain and discomfort. The data from our survey show that the situation is not different among the urban educated girls. Of all the girls (341), 44 per cent were not told anything about menstruation prior to its onset,

Of the remaining girls, only half were informed about 'why it occurs' and others were told about the normative restrictions with respect to food, worship, domestic work, and play. All the girls were cautioned against interacting with older boys and men.

Many boys have heard about menstruation ("MC" or *"masic palli")* but do not know why it happens, when it happens, and for how long. For instance, some of the boys believe that menstruation occurs only once in six months or once a year and some others think that it occurs once in two or three months. According to some, bleeding during each cycle lasts for 15 days. Girls and boys believe that menstruation is dispelling of 'impure blood', 'bad or dirty blood' or 'waste' from the body and some of the girls saw themselves as polluting. Except for a few older girls, both boys and girls viewed menstruation as an event independent of conception and pregnancy. Some of the girls knew that women stopped menstruating during pregnancy and wondered why. The cultural socialisation that surrounds menstruation not only withholds information from the girls, but produces two important consequences for them: girls develop a sense of shame attached to their body, and they begin to see sex as something dirty (Abraham, 2001). Both, in turn, have consequences for women's denial and suppression of their sexuality.

For information on menstruation, girls rely on two main external sources — family (especially mothers and older sisters), and teachers or educational programmes. Boys depend mainly on friends. There is virtually no exchange of information between boys and girls. While girls are not informed about how and why menstruation occurs, they themselves do not make efforts to learn about it. The efforts made were often silenced by responses such as, 'it happens to all women', 'it is part of being a woman', and 'now you are young, you will come to know when you grow up' — given to them by mothers or other women in the family. Considering the way women are socialised in India combined with their low income and educational status, the mothers themselves may not be knowledgeable enough to help their daughters.

Not much has been written about the pubertal experiences of boys in the social science literature on youth in India. A number of boys in our study talked about their experiences of 'nightfall' or 'wet dreams', especially the first time it occurred. They saw parallels between nightfall and menstruation, as indicating the onset of puberty. Both these events were landmarks in the evolving masculine and feminine sexual identities. Some of them stated, Tike MC in girls, boys have *swapnadosh',* 'like MC comes in girls, in boys, liquid comes out at night' (TY Boys, FGD). The first experience of nightfall caused anxiety and, in some cases, embarrassment. Most of the boys did not know what was happening to them. They never consulted their families (though older brothers were approached by a few), but friends older in age were

approached for advice.[10] Friends reassured them that 'it is only normal' (TY Boys, FGD).

> It started from llth-12th std. I was shocked. Then friends told it happens in one-two weeks. Don't know why it happens ... Felt that once it happens, won't get any disease na; asked friends, they said, won't happen. I don't feel anything now. Other friends also tell. Came to know from them. *(TYBoy)*

Boys' peer socialisation is conceptualised generally in terms of its negative outcomes such as drug and alcohol use, skipping school, and so on. However, this study shows how peer support is an important aspect of boys' sexual socialisation and the formation of identity. It was most evident among boys while sorting out their sexual anxieties. Boys' rich vocabulary and metaphors help them in peer communication and to reduce sexual anxieties. Nightfall is expressed as 'heavy rain', *swapnadosh, botli futli* (bottle broke), leaking, *shivai geli* (ink leaked out), and so on. The voices of reassurance that boys reported to have received are absent in the girls' narratives of their experiences of menstruation. Boys' pubertal experiences may be seen as more liberating as they are not constrained by cultural and ideological inscriptions that restrict girls' experiences. These early pubertal experiences shape the constructions of masculinity and femininity differently for boys and girls. Both knowledge and peer support contribute to the distinct cultural constructions.

In the Indian context, a recurring theme in male sexuality is the anxiety about semen loss. Culturally, semen preservation is valued through practices of celibacy and abstinence. Anxiety about the intense sexual feelings and frequent penile erections were more evident among younger boys (Standard XI), while that of semen loss and 'body building' were stronger among the older boys (TY). Masturbation was said to be common, especially among older boys. Despite its wide prevalence, some of the boys reported feeling guilt and physical weakness.

> Don't feel anything before doing it, but when "sperms" come out, feel guilty, dirty. *(TYBoy)*

There seems to be some fear that frequent masturbation leads to weakness and this may affect the normal growth of their body. One sure way to deal with the perceived negative consequences, according to them, is to 'build the body'. The cultural anxiety of semen loss as causing physical weakness and loss of virility is compensated by 'building one's body'. As some of the boys stated during the FGDs, 'body *ek dum acha hona chahiye'.*

However, for some, the fear of losing one's 'body' overrules the possibility of such autoerotic pleasures. Some boys consider masturbation as the safest way of dealing with sexual desires until they are married. As adolescent male sexuality is particularly concerned with physical growth and physical strength, the perceived loss of

virility and physical strength is addressed either by adopting a preventive posture of abstinence from masturbation or by adopting a curative approach of health and body enhancing practices.

(TYBoy)

R: Some say that they get pleasure, but what pleasure I don't know. I don't do, feel afraid. If something happens, then?
I: What will happen with masturbation?
R: Swelling, or there will be problem going to toilet, or it will affect the body.
I: From whom did you hear this?
R: No, only felt. Friends told it affects the body. Friends told only this much that if the body is good then the person does not become weak.

(TYBoy)

R: In the 10th std., a school-friend told me (about masturbation). He was from NCC Camp. It was cold there. Everyday he used to do.
I: How do you feel?
R: Don't feel anything for the first time. Got satisfaction when did 2-3 times. When it is going on, one feels good, but later, very bad. Hand starts paining, thighs start paining, body aches, and feel weak.
I: What do you think, is this good or bad?
R: It affects health, but if diet is good, then the semen that goes is filled up and nothing happens.

Though the English term 'masturbation' is known to boys, they use a variety of terms, including the commonly used terms *halwayache* or 'hand practice'. In striking contrast, girls had not heard the English term or the words that boys used. They did not know the meaning of masturbation either. When it was explained in the local language, girls were surprised, showed disbelief and thought of such practices as something 'bad' or 'dirty'. Only two older girls said that they had heard about it from a friend. Girls are not aware of the fact that masturbation is common among boys. It is the differential gender socialisation of boys and girls and the gendered constructions of femininity and masculinity that produce conditions which allow relatively better access to information and possibilities for autoerotic experiences for boys. For them, the cultural anxiety associated with autoerotic practices does not act as a major deterrent but is constructively overcome by focusing on improving one's health.[11]

Sex and Pregnancy

School- and college-based sexuality education in India do not conceptualise sexuality beyond the narrow focus of marriage and procreation. It is most evident in the manner in which it is often

packaged as 'family life education' or as part of 'life skills education'. The official sexuality education is silent on themes of sexual pleasure or sexual exploitation, and shies away from discussing topics such as sexual intercourse. In the current medicalised, procreative discourse, sexual intercourse is described as a biological act leading to procreation and all other associated experiences of pleasure, companionship, emotional bonding, or even violence and aggression do not find any space. Such a discourse depersonalises sex and denies the embodiment of the self. It shifts the focus away from the embodied experiences to a set of outcomes — pregnancies and diseases. Sexual intercourse, *per se*, is generally glossed over as 'male organ (or penis) enters the woman's body (or vagina) and the sperms are released'. From there onwards there are detailed descriptions about what happens if sperms enter the egg and if they don't. There is information about normal pregnancy, 'ectopic' (tubal) pregnancy, safe period for abortion, foetal growth during various 'trimesters', and finally childbirth. Use of technical terms such as fallopian tubes, fertilisation, zygote, MTP, XX and XY chromosomes, vas deferens — are part of the school- /college-based sex education.[12] The reluctance to discuss sex in the school-based sex education programmes is linked to issues of morality, on the one hand, and power relations between teachers and students, on the other hand (Abraham, 2002b; Lupton and Tulloch, 1996). Teachers defend their reluctance to discuss the topic of sex with their students by posturing that it is not necessary because people know about sex, they learn as they grow.[13]

As young men's experiences and narratives show, they have to rely on their own or others' experiences or pornographic sources to learn about sex. Except for a few younger boys, others had fairly detailed knowledge about various sexual acts, while many girls were not aware of the act of penetration. Perhaps it is this lack of information that turns many young women's first experience of sexual intercourse into a painful nightmare (George, 2003) shattering the romantic build up towards marriage. Both the medicalised sex education (with all the technical information it carries) and the highly eroticised Hindi movies (with the intense romance between the hero and the heroine, and the elaborate marriage preparations) do not give girls the basic idea of penetration. Like 'hymen', 'penetration' remains hidden from girls.

(Std. XI Girl)

After marriage, honeymoon is there. Then child is born... "Intercourse" means "delivery".

(TYGirl)

I: How are children born?
R: By doing "inter-sex", children are conceived.

I: "Inter-sex" means what?
R: When the sex organs of a boy and a girl "touch", children are conceived.

While boys may know more about sexual intercourse, their information on pregnancy is as confused as that of girls.

(TYBoy)

Our sperm, *shukratantu* [he was not very sure of the term] goes into uterus of lady and "reacts". How much it "reacts" depends upon our *"shukratantuchya* power", and then the child is conceived.

(TYBoy)

Boy puts his "pelvis" [penis?] in to girl's *"khaddyat"* and then the *"chik"* [liquid] comes out. Because of this the girl gets pregnant... *"gunasutra"*, which are there of man and woman come together and unite then child is conceived. If it is XX then boy and if it is XY then girl is conceived.

(TY Girl who was knowledgeable about sex)

Friend had told me in detail that "sexual parts" of husband enter into our sex organs and then X and Y cells meet and then we get a baby.

Girls rely mostly on Hindi movies and married friends for information on sex. Accessing blue films and other erotic materials and in a few cases, a visit to a commercial sex worker (CSW) were pedagogical strategies used by boys to gain knowledge about sex. The experiences and the 'knowledge' thus gathered are then circulated among peers, often in an exaggerated manner (given the status of sexually experienced boys among peers as 'hero', or *bade kamgar* — great worker). All these attempts are fraught with many difficulties such as fear of being caught, guilt, self-doubt, economic costs, insults, embarrassment, and so on. Risking these difficulties and breaking the general norms are important for boys in order to establish their sexuality and identity. Some of these behaviours, along with rash driving and new dressing styles, could be seen as the emerging individual rites of passage that are becoming widespread in modern societies (Le Breton, 2004). The outcomes of these risks are buffered by the liberal societal attitudes to male sexuality and by the boys' peer support networks.

For boys, the mass media is overwhelmingly the major source of information on the topics of pregnancy and abortion followed by friends, medical staff and sex education programmes. Some of the girls who participated in the FGDs and some who were interviewed said that they gathered information from the health workers who visited their

homes as part of the birth control campaigns. These findings were also corroborated by the survey data (Table 4).

Contraception: Who 'Takes' What and When?

Some information on contraception has been disseminated as part of the population control programmes since the 1970s and as part of the AIDS awareness campaigns since the 1990s. There has been a steady rise in media messages on contraceptive methods with a focus on condoms for men and pills for women, while the government intervention programmes focus on the terminal method of tubectomy. Contraceptive messages are aired by the industry, and by the various governmental and non-governmental agencies promoting population control and AIDS prevention.

The growth and expansion of television as a major mass medium of communication along with radio, posters and hoardings have extended the coverage of these messages across society. It was assumed at the time of the study that the extensive social and commercial marketing and awareness campaigns would have made contraceptive information fairly widespread among young people as they are a major consumer of the mass media. However, recent studies show that contraceptive information remains low and uneven across the country (NACO and UNICEF, 2002). The present study's findings show that information on contraception is more widespread among boys than among girls. The interview data, however, show that the information is partial and often disjointed. Many girls were keen to learn about contraception from the research team, while some of the boys were eager to cross check what they already knew.

More boys than girls, irrespective of their age, are better informed about various contraceptive methods. As the survey data show, nearly 82 per cent of boys know what a condom or *Nirodh* is (Table 1) and almost the same number know that condoms could be procured from chemists or from some of the *paan* shops. Knowledge of condoms among younger girls is extremely low (12 per cent) compared to older girls (40.6 per cent) or boys of their age group (76 per cent).

The interviews and group discussions reveal that boys not only know what a condom is and from where to access it, they can rattle off the names and costs of various brands of condoms — both Indian and foreign. Barring some of the younger boys, others have seen condoms and are able to describe how to use them. How are these stark gender differences in the knowledge of condoms produced in a context where condom use is promoted by the population and AIDS control campaigns? Further, why would girls lag so far behind boys with whom they share the same socioeconomic and educational status? Girls' narratives show that many of them are quite clueless about what a condom is, what it looks like, how to use it, who should use it, and when to use it.

(Std. XI Girl)

I: Have you heard the word 'condom', *Nirodh?*
R: The packet is shown on the TV but what is inside it that I don't know.

(Std. XI Girl)

I: Have you heard of *Nirodh?*
R: Yes.
I: What is it?
R: They are pills not, taken by men.

(TYGirl)

I: You just now mentioned condom, what is it?
R: They are pills, boys take.
I: From where did you get this information about condoms?
R: Advertisements that come on the TV. Read in the magazine and some information I got from friends.
I: And how it is to be used?
R: It is written over the packet of pills.
I: Why it is used?
R: To avoid pregnancy.
I: Any other use?
R: No.

(Std. XI Girl)

I: Do you know anything about condom?
R: Yes.
I: Who uses it?
R: Women only use them.
I: Have you ever seen a condom?
R: No.

(TYGirl)

R: [I] Have heard about *Nirodh.*
I: What is it?
R: I don't know, something like a ring.

(TYGirl)

R: I have heard about *Nirodh.*
I: What is it?
R: I don't know. But it is not a tablet that much I know — it is something else.
I: Have you heard about condom?
R: Yes, I have heard, what is shown on TV about AIDS and on the walls of (railway) station something was written. ...

I: Who uses them?
R: Men and women both.

Girls' narratives on condoms continue in this mariner. The contraceptive awareness of girls is, thus, alarming. How can condoms make any sense if girls have no way of knowing about sexual intercourse? If girls cannot visualise what condoms are, how are they to understand their use? It can be tedious to figure out how a 'ring' (condom) prevents pregnancy or AIDS. Some of the girls know of condoms, not as male contraceptive, but only as a preventive measure against AIDS.

(Std. XI Girl)

I: Have you heard about condom?....*Nirodh?*
R: Have heard the name.
I: Why is it used?
R: To prevent AIDS.
I: Who uses?
R: That I don't know.

(TYGirl)

R: Pills, and something needle type is shown on TV, don't remember the name. Condoms are used.
I: For what?
R: To prevent AIDS.
I: If you don't want a child, then is condom used?
R: No, only for AIDS.... I don't know, [confused]

(TYGirl)

I: Do you know about 'contraceptives'?
R: Means condoms, no?
I: For what are they used?
R: To avoid AIDS.
I: Any other use?
R: No.
I: Any other 'contraceptives' do you know?
R: No.
I: What is used to prevent pregnancy — what do you call that?
R: Pills, tablets, Mala-D, Choice...
I: And condoms? Is it used for this purpose?
R: *Maine* condom *ka naam* to AIDS *he saath hi suna hai.* [I have heard the name condom only with AIDS.]
I: Not for anything else?
R: No.
I: Where did you get all this information?
R: About condoms and pills, my friend told me. Also my neighbour told me.

I: What did they tell you?
R: This only. What is condom, how is it, who uses it.
I: Who uses it? [pause] Boy or girl?
R: Both have to use it.
I: Do you know any brands?
R: *Kamasutra.*
I: Any other?
R: Know only this one.

Boys' information on contraceptives is not limited to condoms, but included pills and intra uterine devices (IUDs) such as 'Copper T'. A few of them had also heard about female condoms and 'creams' (spermicides). Although girls' knowledge of condoms is limited, they were more familiar with contraceptive pills and IUDs *("tambi",* "Copper T").

(Std. XI girl)

I: Have you heard about condom?
R: No.
I: *Nirodh?*
R: Haven't heard.
I: Mala-D.
R: Have heard this.
I: What is it?
R: *"Garbhanirodhak" tablets.*
I: Who uses?
R: Women.
I: For what?
R: Don't know.
I: Just now you said that it is *'garbhanirodhak'* pills, so *'garbhanirodhak'* means?
R: [Pause] It is used to prevent more than one child.

(TY Girl)

I: What do you know about contraceptives?
R: Mala-D tablets are taken, and also pills — *"Saheli",* also "operation" is done. It is called *"NasbandF* (vasectomy), *"Kamasutra",* "condoms", *"Nirodh"* are used.
I: From where did you get all this information?
R: From TV, advertisements.
I: Who uses the tablets?
R: Girls.
I: Condoms?
R: Don't know.

Girls' information on pills is mainly from television and from a married sister, relative or friend and on the *tambi* from a married woman or a health worker who visited their homes. For girls, along with

pills, other methods of preventing pregnancy include 'abortion' and 'operation' (tubectomy), the two methods that are commonly resorted to by most women, especially from lower income households. The narratives also show that girls are discussing preventing pregnancy within the context of marriage and they cited examples of their married sisters, friends, neighbours or relatives and sometimes their mother.

(Std.XIGirl)

I: To prevent pregnancy what is done?
R: Do operation.
I: When is operation done?
R: When the baby is expected then... or after one baby when a second one is not wanted.
I: What else is used, besides doing operation?
R: Pills.
I: Which ones?
R: Don't know
I: Who takes?
R: Girl takes.
I: When?
R: Means, soon after physical relation [looks unsure].

(Std. XI Girl)

I: What is done to prevent pregnancy?
R: Operation or else stitch the mouth of the uterus with "wire", or else fix the "stopper".
I: All this how did you come to know?
R: My cousin sister she has fixed "stopper". That is how I came to know. She told me everything. My mother has done operation for not having the child.
I: What else is done?
R: Girls take pills.

Girls' contraceptive information is more complex. Some of them also made distinctions between contraceptives for premarital and marital sex. For instance, condoms may be used to avoid pregnancy or prevent AIDS in premarital sex, while pills and IUDs are for marital sex.[14]

(TY Girl)

I: Is condom used in sex with all types of partners?
R: While having sex with wife, condom may not be used, only with prostitutes and girlfriends it is used.
I: Why?
R: To avoid pregnancy.

Even if some girls appear to have a lot of information on contraception, it is grossly inadequate. For instance, a more confident

and 'knowledgeable' girl is also unsure about 'who' uses 'what' contraceptives and 'why'.

(TY Girl)

I: Do you know about 'contraception'?
R: Yes.
I: What do you know about it?
R: Means condom *na?*
I: Yes, and what else do you know?
R: And *"Tambi"* or "Copper T", "Mala-D", "Kamasutra", *"Nas-bandi"* [Vasectomy].
I: Who uses all these?
R: Boys.
I: From where did you get this information?
R: From TV, a friend told me about condoms, he was doing a NSS project, and other information I got from books.
I: Which books?
R: I had read one Standard XII psychology text, my friends' sister's (book).
I: Do you know different brands of condoms?
R: "Kohinoor", "Nirodh", "Choice", "Kamasutra".
I: Why are they used?
R: To avoid pregnancy.
I: Who uses it?
R: Boys....girls...no...[seems unsure]

Except for a senior girl, other girls did not know what a vasectomy was, but most of the boys had some knowledge of it. The discussion with girls about contraceptives centred around pills, IUDs and tubectomy. Their understanding of contraception is limited to female methods and, that too, mainly terminal methods. This is not only an outcome of their immediate circumstances where women control their fertility through terminal methods, but also reflect women's general inability to negotiate temporary methods especially through the use of male condoms.

Many girls believe that condoms are used by both men and women, pills are to be consumed either by men or by both men and women, and that condoms are a synonym for pills and, therefore, are to be consumed by either men or both men and women. There is much confusion about contraception, about 'who' uses 'what', 'when' and 'how'. Some of the boys feared that condoms may "get lost' inside a woman's body and some of the younger boys attributed several qualities to condoms — 'place the condom on the tip of the penis, it will automatically stretch and cover the penis', 'condom increases heat in the body', 'they are made of plastic', 'Indian condoms always break' (although he has no experience), 'condom pains the girl' and that condoms 'must be blown

and put on'. These confusions are too complex and subtle to be resolved through the 'one time' sex education generally followed.

Instead of demystifying sex, AIDS/sex education mystifies it further.

For both boys and girls, the main source of information on contraceptives, especially on condoms, is the mass media (Table 5). While boys mentioned other sources of information such as friends and sex education programmes, girls mainly depend on the mass media. The inference that condoms are pills is made from TV visuals, which do not show a condom but show only the sealed packet carrying pictures of a man and a woman.[15] The media messages on contraception are projected in a manner which assume that the viewer has information on intercourse, penetration, conception, and so on. The only clear message the advertisements on condoms communicate is that they should be used for birth control or to prevent AIDS. These two messages are, however, seldom combined. Among girls, those who have heard of condoms thought that the main use of condoms is prevention of AIDS, while pills and *tambi* are for preventing pregnancies. Although these are not viewed as mutually exclusive options, the distinction made is quite significant.

In the girls' awareness of contraception, the English words, 'contraceptives' and 'condoms' are synonyms and are associated with AIDS, while pills and *garbanirodhak* are clubbed together, making a clear distinction between the male and the female domains of sexuality.

It is evident from our study that only the girls who have some idea of penetrative sexual intercourse and how it may lead to pregnancy know about the use of condom and they are a small minority. The agenda of sex education cannot be just providing factual information, but to ensure that girls do not learn about sex through a shocking experience of their first intercourse. As neither the TV visuals nor the educative posters (which are the main sources of their information) show how a condom looks, how to use it, or state clearly who should use it, girls will have a tiring time in accessing something which the educators view as 'basic' information.

The general conceptions and the inadequacy of knowledge are the outcomes of their social and gender locations and a deep-rooted patriarchal ideology that defines male and female sexual roles and sexualities asymmetrically rather than being a situation of mere 'lack of information'.[16] The gendered nature of awareness is misconstrued as lack of information and studies on sex/contraceptive/AIDS awareness continue to emphasise 'more information' (Jejeebhoy and Sebastian 2003; several studies reviewed in Khanna and others, 2002; Sachdev 1997; Verma and others, 2004). A critical interrogation of gender ideologies and asymmetries, as argued by Baber and Murray (2001) and others, is required if the teaching of human sexuality is to have any relevance in the lives of young people, especially girls.

Sexually Transmitted Infections and AIDS

Although the abbreviation of STD is widely used for sexually transmitted disease in sex education messages, a majority of the boys (81.2 per cent) and girls (85.6 per cent) from the survey do not have this information (Table 2). About 6.1 per cent of the boys thought that it was the name of a medical test to detect AIDS. However, 24.3 per cent of boys and 13.5 per cent of girls knew how STDs are spread. From the FGDs and interviews, it was amply clear that STD, the abbreviation for sexually transmitted diseases, was confused for STD, the popularly used abbreviation for subscriber trunk (g, a telephone facility for long-distance calls!

The interviews and discussions show that both boys and girls do not have much information on sexually transmitted infections (STIs). Some of the boys, however, are familiar with the terms 'VD' (venereal disease) and *guptarog*, but do not know that they refer to STIs. The only STI that they know is AIDS. Similar findings are reported in other studies too (Bott and others, 2003; NACO and UNICEF, 2002). As these studies show, the knowledge situation has not improved significantly over the years.

The survey data of the present study shows that some basic information about AIDS is near universal among the boys, although half of the younger girls do not know that condoms prevent HIV infection (Table 3). From the survey data it may seem that AIDS awareness is high at least among the boys, the individual interviews and group discussions provide better insights into students' 'AIDS awareness'.

Just as sex education assumes that young people know about penetrative sex, AIDS education assumes that young people have some knowledge of STIs and condoms.

(Std.XI Girl)

I: What should be done to prevent AIDS?
R: Should use condoms.
I: Who should use?
R: That I don't know.
I: Have you seen it?
R: No.
I: Do you know about STDs?
R: No.
I: Are there any other diseases that can be contracted through sex?
R: Only know about AIDS.

(Std. XI Girl)

I: Have you heard of AIDS?
R: Have seen the ad on the TV, but cannot understand only.

I: What is AIDS?
R: [Pauses and then says hesitantly] It is some type of disease. It happens due to man-woman relations, and to pregnant woman if she is given an injection.
I: Do you know about any other diseases contracted through sex (relations)?
R: No.
I: Could there be any such diseases?
R: AIDS happens, but not any other disease.

(TY Girl)

I: Do you know about AIDS?
R: AIDS means disease that can only be known at the last stage and then there is no cure for it....Those who do sex with more than one person and also don't use condom those people get it....
I: What should be done to prevent AIDS?
R: Condom should be used.
I: Who should use condom?
R: Who should use that I don't know.

The causes and consequences of the infection are also confusing to some of them.

AIDS happens only due to blood-contact, only that much I know. By kissing also AIDS can happen, on TV I have seen such advertisements. *(TY Boy)*

Due to keeping relations with many women, cannot happen by itself, happens from blood, from saliva and also by kissing. *(Std. XI Boy)*

It is caused during blood transfusion, it is shown in a TV serial that one person donates blood very frequently, so he gets it, and in that serial there is a small girl she also gets it but how she got it that I don't know. *(Std. XI Girt)*

(TYGirl)

I: By donating blood means?
R: Suppose blood of A-group person is given to B-group person, then he gets AIDS.
I: And by doing sex means what?
R: I know only this much that it happens due to sex.
I: What should be done to prevent AIDS?
R: While donating blood, the blood group should be checked. Other person's injection should not be used, and condom should be used while having sex.
I: Why should condom be used while doing sex, means even with wife condom should be used?
R: Yes, I don't know properly, only seen an advertisement on the station. It said — 'condom should be used while doing sex'. I don't

know about it in detail. You tell *na* — whatever I told you is correct or wrong.

The AIDS information received along with other media messages reinforce gender stereotypes and the double standards in sexuality. There is a tendency among boys, especially the younger boys, to associate AIDS only with CSWs. Some of the students believe that *anaitik* (immoral) relations with women cause AIDS.

If *"anaitik"* relations are kept with women, then it [AIDS] happens. *{TYBoy)*

I have very little information (on AIDS). It is announced on FM radio channel that by keeping illegitimate relationship this disease is caused. *(Std.XIGirl)*

It happens if immoral relations are kept. *(TY boy)*

If a man keeps relation with more than one woman then AIDS can happen. AIDS does not spread by air. *(TY Girl)*

Some of them have altered the slogan of 'safe sex' to suit their perceptions and for some others any contraceptive method may be useful in preventing AIDS.

(TYBoy)

R: (to prevent AIDS) Like using condom, "Do sex with safe person".
I: How can you know whether the person is safe or unsafe?
R: Should make a guess.

(Std. XI Boy)

I: How can you prevent AIDS?
R: Should use condom while doing intercourse, girls should use pills, Mala-D and "Nasbandi" (operation).

Some of the students provided symptoms of AIDS and appearance of persons affected with AIDS.

(TYBoy)

R: *"Pulya"* (boils) erupt on the body.
I: And?
R: On the penis of the man also *"phoda"* (boils) erupt.
I: And in women?
R: In her also *"phode"* (boils) comes.

(TYGirl)

R: Fever comes, eyes go inside, if that person is sleeping on the bed you cannot even see — that thin he becomes. On his body there are wounds.
I: From where did you get information about AIDS?

R: On the TV Shabana Azmi's advertisement is shown and in the neighbourhood one man had AIDS that time everyone at home used to talk.

We found that most of the students could also list the various non-sexual modes of transmission of HIV, that is through HIV-infected blood, from an HIV-infected mother to her children, and through an infected needle ('through injection' as they reported). Although needle sharing is associated with mixing of blood, it was mentioned as a separate mode of transmission. Students' awareness of AIDS may be described as rote knowledge constituting the expansion of the acronym, modes of transmission of the virus, that condoms prevent AIDS (mainly among the boys), and that there is no cure for AIDS. These are the 'facts' about AIDS that are stressed in the campaigns in India and, as Pigg (1998) points out, elsewhere in South Asia too. As others have also observed, those who know 'the facts' about AIDS have not done much more with those facts than to memorise them word for word. Rote memorised information[17] and creatively interpreted 'AIDS facts', constitute the repertoire of AIDS awareness of students. Some of them stated during the discussions that it was tedious to remember the expansion of the acronym AIDS and felt it was irrelevant and therefore changed it to 'All India in a Dangerous Situation', a message that the education programmes in any case intended to convey to young people. AIDS information is, thus, fragmented and ambiguous.

As the survey data show, sex education programmes have been of little help to students for information on STIs (Table 6). It also shows that for information on AIDS, boys have relied on mass media than the sex education programmes (Table 7), while many girls stated that their information on AIDS is from sex education programmes. The fragmented nature of the awareness campaigns and the exclusive emphasis on the epidemiology of HIV have resulted in the superficial nature of AIDS knowledge. As Altman (1994) and others have argued, it is the social and cultural dimensions of AIDS that need to be emphasised rather than the medical and the technical. If the young people's responses are any indication, then the campaigns lend themselves to the criticism that they are strategies of social control by the state and various international agencies (Brown, 2000; Lupton, 1993).

'RISK PERCEPTION' IN A HIERARCHY OF RISKS

Several studies in India referred to earlier point out that 'perception of risk' to STI/HIV infection is low among young people and this is also true of individuals who engage in multi-partner, unprotected sex ('risky sex'). Studies have also shown that while exposure to educational interventions removed some of the 'misconceptions' regarding these infections, they failed to translate into an increased sense of personal vulnerability (Awasthi, Nichter and Pande, 2000). Drawing a distinction

between 'risk' and 'vulnerability', the former as a population-based concept and the latter as an individual's perception of danger, which is context specific, they argue that participants perceived their environment and social networks as not rendering them vulnerable. As a result 'risk perception' continued to be low among the youth who were exposed to the STD prevention intervention programme. In the present study too, the young people did not find themselves particularly at risk of infection; however, they did perceive the risk of pregnancy in premarital sex and those who engaged in it made efforts to reduce these risks. Boys used condoms more often in sex with girls of their age than with older women or prostitutes (Abraham, 2003).

The use of condoms, however, was inconsistent even among the few who engaged in multi-partner sex, including commercial sex. Contextual factors such as unplanned sex, non-availability of condoms, several apprehensions about condom use, and perception of 'low risks' associated with different partners were some of the reasons for not using condoms. There was greater concern about their image, issues of privacy and performance, and some anxiety about violating a social taboo. Risk of infection was, thus, low in a context of several other risks. The contexts of risks may differ for different youth groups. As a study on street children by Ramakrishna, Karott, Murthy, Chandran and Pelto (2004) shows, risks associated with survival on the streets outweighed the perception of risk of infection among street boys. As a result, condom use was inconsistent among them even though they were aware of their protective function. Studies have shown that women have very little power in protecting themselves from infection as their ability to refuse sex or to negotiate condoms within and outside marriage are minimal (George, 1998; Khanna and others, 2002; Ramasubban and Jejeebhoy, 2000). The risk of immediate violence outweighs the risk of infection, the effects of which may only appear in the future.

The girls' reluctance to engage in premarital sex noted in **our** study was to preserve their virginity for their husband as a strategy to ensure marital peace. The threat of violence employed in order to suppress and to subordinate women's sexuality before and after marriage may limit, to a great extent, their ability to both perceive the risk of infection and, even if perceived, to act upon it. Further, attempts to induce 'risk perception' and enhance the sense of personal vulnerability in a context where there is low level of sexual activity, as reported among the unmarried youth, and the fact that they have neither experienced an STI nor seen persons suffering from STIs or AIDS may be a difficult task. AIDS continues to be an imaginary disease for most youth.

Moreover, the youth are likely to be highly suspicious of adults' (educators, representatives of the State and welfare organisations) concerns about their vulnerability to infection when the same persons or agencies are unwilling to trust them or recognise their real concerns of dealing with their identity, sexual desires, and so on.[18] If sex

continues to be treated as a taboo subject, not open for discussion, and the patronising attitudes towards youth do not change, and if sexual desires and sexual pleasures do not get foregrounded in sex/AIDS education, the aim of health promotion through educational programmes may not succeed in engaging the youth.

PORNOGRAPHY AS PEDAGOGY

This study shows that boys are more informed about sex than girls and the chief source of their information is pornographic materials. The gendered sexual socialisation of boys and girls by the family and society is evident in the way boys are encouraged to be the repository of information on male and female bodies, sex and sexuality before marriage, while girls' learning is mediated through the institution of marriage and childbirth. Boys, from early adolescence, access pornographic sources freely in order to acquire this information. For them pornography becomes first pedagogy and then practice; answering curiosity first and satiating desires later. Both may also happen simultaneously.

Several studies show that pornographic consumption is quite high among the youth (Aggarwal, Sharma and Chhabra, 2000; Apte, 2004; Rangaiyan and Verma, 1999). These studies also show that pornography is the most common source of information on sex and is a recreational activity for young people. The study by Aggarwal and others (2000) found that for information on sex even medical students relied on pornographic films, books and magazines. Our findings also show that pornography is one of the main sources of information on sex, accessed quite freely by boys. Being an important aspect of peer socialisation, and especially sexual socialisation of boys, there are extensive peer support systems that initiate and promote pornographic consumption among them. These support systems manage the necessary finances and other resources, and more importantly, aid in overcoming any guilt attached to viewing materials considered taboo. Boys' narratives show that such materials are freely available and at costs that are within the reach of even the low income students. They are more inclined to see films and to look at photographs or pictures that show erotic expression of sex, rather than to read written materials. In fact, very few boys have read books although they have access to inexpensive erotic and pornographic literature. They seem to prefer pornographic films and magazines in foreign languages, and think that the messages that they carry are more reliable than the vernacular sources.

> Initially, when I was in 7th, 8th, that time we used to discuss only among friends, and then in 9th when we saw movies, means blue films, that time I came to know what is intercourse, and how to insert sex organ, etc. — that time only I came to know... *(TYBoy)*

(TYBoy)

I: From where did you get information about sex?

R: By watching BP, by going through some books.
I: Which books have you read?
R: I haven't read any but have definitely seen some.
I: Which ones?
R: *Karamchand, Dapha 302, Debonair, Health* and *Femina.*
I: Which films have you seen?
R: BP.
I: What do they show in that?
R: They show sex, sometime they show "jungle" sex with one female one is doing intercourse from front and one from back ...
I: And from where else do you get information?
R: From friends.

(TYBoy)

R: There was no problem, I had one friend in school that time, he used to take me to his home. That time we were in KX School, and he was the son of a businessman. He was very rich. There used to be no one at his home, only we used to be there. That time, we used to secretly see movies.
I: And, were there any other sources from where you got information?
R: When I was in S.S.C., before that, I had told you *na* that I had read that book, means Nancy Friday.
I: What is there in this book?
R: Mainly there are sexual fantasies in this book, and about women's fantasies are explained.
I: Besides this?
R: *Gurpantory, Galaxy, Playboy,* etc. There was information about sex in these magazines.
I: Are all this information correct?
R: I think that about 75% of the information in this is correct. Yes, I think this information is correct...
I: Do you discuss such topics (on sexual experiences) in your friends circle?
R: Yes, we do discuss such information with each other.
I: For you, there were magazines brought by your brother, but what sources did your friends use to get information?
R: Other friends are there na, then mostly from *Debonair, Ecstasy, Fantasy* and in Marathi there is *Dafa 302.*
I: Those (magazines), which are in Marathi, is there information in them?
R: Yes, that information is not correct. In these Marathi magazines, mostly the stress is on sexual activity.

The same boy had received information on pregnancy and childbirth from text books, but for information on sexual intercourse his source was movies.

(TYBoy)

R: The male genital organ enters the female (genital) organ. Then "semen" comes out of the male organ. This semen then fuses with the girl's egg, and then a "zygote" is formed from this union. This "zygote" stays in the girl's womb, and it develops there only. And then either a boy or a girl is born.

I: From where did you get all this information?

R: Most of the information I got from books and some information I got from foundation course. There is a topic on this subject in the FC [Foundation Course].

I: Have you heard any experiences of your friends, about intercourse, sex?

R: No there are no experiences of friends, but most of the information on sex I have got from movies.

The pornographic materials, especially BPs (blue pictures or blue films), are not merely consumed for information and recreation, but serve as occasions for discussions that generate 'knowledge' and 'understanding', thus reinforcing its pedagogical role. A few boys (6) who were interviewed also stated that frequent viewing of pornography eventually led to seeking commercial sex.

(TY Boy)

R: For the first time when I was in 8th (class) and that time I got it through my friends in school. About sperm, intercourse, that time the sperms were called "mani". We thought "mani" means, money — currency. At the same time came to know about masturbation and also came to know that if we get the desire for sex then we should do masturbation. Then in 9th there was an older friend who used to go out (commercial sex), then he used to go with the call girls, for him it was like a status that I have gone there (had commercial sex).

I: And what did he tell?

R: About intercourse, different positions, sex, kissing and also on rest of the topics.

I: That means in 9th (class) you came to know about all these things?

R: No. I came to know clearly in 10th Std. when I saw an adult film at the new theatre.

I: What was shown in that?

R: They showed intercourse. Then after seeing the film we friends used to do discussion on that...

Boys' narratives carry graphic descriptions of what they have seen in BPs and much less about what they have seen in magazines or books. There is a sense of having graduated when they watch BPs; that is when they gain a 'clear' understanding of what sexual intercourse is 'really' all about.

(BP shows) different-different types of sex, *"shots kase lawle jatat te"* (how to do different types of intercourse) is there in detail. "Animal BP" is also there, "Homo type" is also shown. *(TY Boy)*

(TY Boy)

R: At first, did not have any information. Had got some information only from friends. When saw BP — understood what intercourse "originally" (actually) is.

I: What is shown in BP?

R: In BP, how intercourse is done is shown. Different types of intercourse, different positions, "dog-shot"... "Original intercourse", "dog-shot" from rear-side, taking in mouth.

I: Do you get any information from those stories that you had read?

R: No — they only arouse/stimulate mentally... No specific information, they are to be read only for satisfaction.

They see pornography as the only source that explicitly provides information on all aspects of sex. Pornography becomes a legitimate source for them because it combines pleasure with information, it deals with their feelings and what they want to learn. These sources fill a major void in the form of sexuality education and act as an important agent of sexual socialisation of boys and in the construction of masculinity. The absence of alternate sources that address their questions and worries and an uncritical consumption of such materials may reinforce the gendered norms and ideals of sexuality. It reinforces the legitimacy of pornography as pedagogy.

While there are some studies on how Hindi films and 'film going' in India are integral to the construction of masculinity (Derne, 1999 and 2002), little is known about how pornographic and erotic materials and messages construct notions of masculinity in the metropolitan Indian context. Some of the studies on adolescent/youth sexual behaviour show coercion and violence as integral to male sexual behaviour (Sharma, Sharma and Dave, 1996; Sodhi, 2000). Boys' narratives of sex in our study consist mainly of graphic descriptions of varieties and the mechanics of sex. The masculine images that emerge from the boys' views as well as their experiences are that of aggression, of the all encompassing decision-maker and the one who knows about sex. Their narratives are devoid of feelings of emotion. Girls, however, have no easy access to the pornographic world of 'information' or 'recreation'. Very few girls have seen a BP. The girls' sources of information on sex are Hindi films, television (serials and advertisements), married friends and magazines.

While pornography is a crucial player in the construction of masculinity, as analysed and theorised in the feminist scholarship, our findings show how knowledge is implicated in this process whereby young people legitimise pornography as an important source of information, on what is important to them as sexual beings, which are

tabooed and controlled by society. However, sexuality awareness is more than information; rather it involves a 'deconstructing' of or a critical analysis of the constructions of which the information is only a part (Baber and Murray, 2001). The deconstruction of sexualities and identities becomes even more important when they are built on pornographic sources. As feminists have pointed out,

Pornography is a means through which sexuality is socially constructed, [it is] a site of construction, a domain of exercise. It constructs women as things for sexual use and constructs its consumers to desperately want women to desperately want possession and cruelty and dehumanization. (MacKinnon, 1989: 139). Further, pornography is not just a harmless fantasy or a misrepresentation or distortion of otherwise healthy sex, but it makes gender inequality both sexual as well as socially real (Dworkin, 1981). Pornography reveals that 'male pleasure is inextricably tied to victimizing, hurting, exploiting' (Dworkin, 1981: 69).

Making men bearers of sexual knowledge and decision-makers in sexual relationships; foreclosing opportunities for freer sexual socialisation between sexes through sexual segregation and restrictions on girls' mobility; and restricting communication on the topics of sex are ways through which patriarchal sexual ideology establishes the norm of heterosexuality and constructs masculinity as powerful and aggressive and femininity as subordinate and passive.

CONCLUSION

To conclude, the AIDS discourse has certainly aided in bringing sex into public discussions in India, but it has done so by narrowly focusing on diseases and by suppressing the discourse on desires. By postulating AIDS as a public health issue, the discourse is insulated from issues related to pornography, sexual violence, prostitution and the increasing commercialisation of sexuality—forces of modernity that are deepening vulnerabilities of individuals and groups to the infection.

Yet, dealing with sexual desires constitutes an important part of the construction of masculinity that cannot be ignored. To this end, the sexuality readers and the sex/AIDS education materials produced by the state and the educators seem a pale substitute to the colourful pornographic materials offered by the market. Perhaps, because they are authored by medical professionals or educationists, sexuality readers appear like medical textbooks of anatomy and physiology. The chapters that discuss sexual intercourse and male and female body are titled 'reproduction' and 'reproductive organs' and carry full page visuals of cross sections of the 'organs' with complete technical terms such as 'vas deferens' and 'seminal vesicles'. These readers shy away from the use of common vocabulary and essentialise sexuality as a biological state of being. The central focus of such resource books and educational programmes has been the dissemination of what is considered 'objective, scientific' information, with the assumption that

the information will 'empower' people to make rational choices and behavioural changes that will then prevent infections and unwanted pregnancies. Sexuality, as a cultural construction, has yet to inform the writing of such readers. Only when sexuality is seen as culturally rooted can such readers address it in terms of the meanings that people attach to their sexual bodies and sexual relationships.

As the study shows, young people's sexuality awareness is distorted and their perceptions of 'risks' and protective measures are limited and are influenced by a host of cultural and contextual factors over which they have little control. As the article argues, though information and education are crucial, by themselves are insufficient resources in the struggle against STIs, including HIV. It is time that the sex education programmes in colleges move beyond the narrow agenda of the AIDS/sex awareness campaigns as there are obvious shortcomings of these programmes.

The AIDS/sex awareness campaigns are based on the rational choice theory of human behaviour: they resort to biological essentialism to explain sexuality and rely on biomedical knowledge to deal with sexual health problems. One of the common assumptions of these campaigns is that individuals given 'objective' (scientific) information, will respond by making rational choices that will lead to behavioural changes that reduce 'risk' of infection or undesired pregnancies. Information is believed to influence 'risk perception', which will alter attitudes and behaviours. The same assumptions also guide research studies, which are generally aimed at exposing the lack of knowledge among people and which advocate providing 'scientific information' to reduce the above risks. Both the campaigns as well as the research (although the former, in most instances, has emerged independent of the latter) equate objective information with biomedical knowledge on sex and HIV. These assumptions about human behaviour and the faith in the power of scientific/medical knowledge are not shaken even when research shows knowledge as failing to induce the desired or expected behavioural outcomes. For instance, the failure by people to use condoms in 'risky sex', despite possessing the relevant knowledge, is not seen as a limitation of such theorising, but is rather interpreted as indicating the need for a larger 'dose' of knowledge. The remedy recommended is the spread of more information. Such an approach ignores the understanding that 'risk' is unequally distributed among different social groups and the very perception of risks and people's responses to these risks are culturally constructed and are often constrained by their specific structural locations (Herdt and Lindenbaum, 1992). Under such circumstances, information has a limited role in raising the levels of risk perception especially in case of young people.

Moreover, there is adequate understanding that knowledge is not as neutral as it is made out to be and it produces discursive practices that

create differences and legitimise hierarchies (Harding, 1991; Lupton, 1994). Awareness campaigns apparently built on universal, objective biomedical knowledge, may carry with it layers of messages that in effect are aimed at political and social control (Brown, 2000). Through an analysis of the United Kingdom government's response to AIDS and the language used in the educational campaigns by various public health organisations, Brown (2000: 1273) shows that the knowledge of AIDS produced through these institutions construct discursive boundaries between the idea of 'normal' and 'abnormal' behavioural practices. He argues that it is through the production, articulation and normalisation of 'at risk' groups that society is fragmented and, hence, subject to the governance strategies of late modern liberal economies.

While information on HIV/AIDS and health promotion may be desirable, the political and ideological content of these awareness campaigns is problematic. They strengthen the authority of the state as moral guardians and expand the power of medical ideology in regimenting and regulating sexualities. As argued by Foucault (1976, 1977), in modern societies, sexuality becomes a fundamental arena for the exercise of power through a web of disciplinary technologies and apparatuses of surveillance. By medicalising that which is predominantly a social concern, these campaigns divert attention from local inequalities and the global economic and political forces that generate AIDS scare and distribute AIDS care. Thus, through redefining the meaning of 'risk' and creating 'high risk' groups and classifying 'risky behaviours', these campaigns segregate and stigmatise individuals and groups (Brown, 2000; Kane and Mason 1992;. Further, they posit the responsibility for contracting the infection upon the individual and then blame the victim in the event of infection for putting others (through infection) and the state (for the economic loss) at risk (Lupton, 1993). The concept of risk, thus, becomes a new ideological tool in the control and management of groups and populations, not of AIDS (Douglas, 1990). As Douglas points out, professionals now prefer to use the term 'risk' in place of danger because 'plain danger does not have the aura of science or afford the pretension of a possible precise calculation' (1990: 4)

The choice of language for communicating 'about AIDS and sex shows that internationally established truths about sex do not convert into local languages as readily as the referential concept of language presumes' as this process of 'cultural translation' is 'inevitably enmeshed in conditions of power' (Pigg, 2001: 4). The transnational flow of terminologies not only obfuscates the complexity of social relationships, but imposes certain identities and categories where they do not exist. The imposition of such categories on the one hand and the assumption that people have no knowledge or constructing their knowledge as 'myths and misconceptions' on the other hand are both problematic. For example, in non-Western societies, men who engage in same sex relationships cannot be perceived as constituting homosexual

identity.[19] We have to acknowledge that people's sexuality 'knowledge' is not a simple set of ideas but is constituted by sites, processes and discourses that run parallel to the biomedical discourses of sexuality through the traditional cultural practices, alternate medical systems, the modern sex clinics, and the footpath pornography in Indian languages (Srivastava, 2001).

Yet another problem with these campaigns is that there is a tendency in these campaigns to see sexuality as a purely (or largely) biological (or natural) phenomenon characterised by fixed sexual drives that are essentially different for men and women, rather than seeing sexuality as a construct. The sexual experiences and the associated health outcomes cannot be conceptualised without considering the diverse constructions of sexuality. Besides sexual drives, sexuality includes sexual identities, sexual norms, sexual practices and behaviours, and also the subjective dimensions of the experience of sex. Sexuality is socially constructed through complex processes of scripting, influenced by various historical and cultural factors (Gagnon and Simon, 1973). Conceptualising sexuality as a construct does not deny the physiology of sexuality but holds that the meanings attached to desire and objects of desire and how individuals interpret their sexual experiences are not just determined by personal experiences, but largely by culture (Dworkin, 1987; MacKinnon, 1987 and 1989). The cultural constructions are shaped by and also reflect the unequal power relations in society. They not only reflect unequal gender relations, but are the key elements in the gendering of inequality (Holland, Ramazonoglu, Sharpe and Thomson, 1992; MacKinnon, 1989). The meanings and forms of sexuality differ across communities, societies and groups and also differ across age groups (West, 1999), social classes (Wight, 1994) and ethnic groups (Vance, 1984). The diversity and multiplicity of meanings demonstrate that sexuality is not a monolithic concept and it may, therefore, be more appropriate to speak of sexualities rather than 'sexuality'.

While AIDS awareness campaigns have erred in promoting a limited definition of sexuality, it is not unrealistic or idealistic to desire that sex education programmes in colleges need to focus on more liberatory processes of sexuality that challenge and redefine unequal gender relations and make room for diverse constructions of sexuality. If the sex education programmes recognise sexuality as a cultural construction and young men as bearers and transmitters of sexual knowledge schooled in pornography, the first lessons in sex education would be to challenge these constructions. Educational programmes that aim towards sexual health promotion among the youth need to develop a framework that recognises sexual pleasure, desire and erotic experiences as being central to youth sexuality.

The findings show that the official attempts to 'empower' individuals and groups through objective information run parallel to young people's

efforts to understand and cope with their sexualities by navigating through a barrage of discrete 'scientific' information, cultural practices, pornography, and media images and messages. The youth struggle with diverse discourses interspersed with technical medical terms, cultural connotations and political messages. These struggles are largely futile as they do not liberate them, but rather reinforce patriarchal constructions and enhance personal vulnerabilities to infections and undesired pregnancies.

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NOTES

1. Although by now there is some consensus about providing sex education for young people, a lingering apprehension continues among the guardians about its potential for increasing sexual experimentation or promiscuity among their wards. There is always doubt about how much to tell, who should tell, what is the best age to start giving information, and so on. Yet, it is difficult to argue against sex education in schools and colleges.

2. The students belonged to the lower socioeconomic strata of Mumbai, which is reflected in the type and location of their residence (single room *chawls* and slums), monthly family income (Rupees 5,000 [US$ 120] or less), parental education and occupation. A majority of the students' fathers had completed schooling only up to the secondary level, while the mothers had hardly studied beyond the primary level. There were also first generation learners with illiterate parents. The fathers were employed as mill workers, taxi drivers, watchmen, police constables, clerks, peons, and so on. A few self-employed fathers were engaged in small businesses or trade. Except for a few, the mothers did not work for an income. Students belonged to different religions (mainly Buddhists, Hindus and Muslims) and caste groups (mainly Dalits). Students from middle class and upper caste families were a minority in all the four colleges.

   The family's poor income status forced some of the students to take up employment along with their studies. More boys and seniors worked for an income. Working students are underrepresented in this study as they are more frequently absent from college on account of their jobs. Their jobs included giving tuition, secretarial jobs, and sales, while a few were employed in small-scale manufacturing units. Except for a few working students, others had very little personal money. For more than one-third of the boys and girls, the monthly personal income did not exceed Rupees 100 (US$ 2.5).

3. Survey is a limited research tool to study awareness, especially about sexuality. The information on awareness gathered from the survey is summarised in the Appendix which contains Tables 1-7. The survey data on other themes have been reported in detail in Abraham and Anil Kumar (1999).

4. The use of the terms 'boys' and 'girls' in this article should not be seen as being paternalistic. Their usage should be seen strictly in the Indian context where young men and women are addressed as 'boys' and 'girls' until they are married or cross the marriageable age. With marriage, they attain the social status of man and woman. Hence, the usage of 'girl' and 'boy' throughout the article, although our respondents, the college students, were in their late adolescence or early adulthood.

5. Understanding of own sexual body is taboo for women, while they may explore 'every inch of their body to identify the extra hair growth, blemishes and subject themselves to a whole range of invasive painful and harmful cosmetic procedures' (Chandita Mukherjee, during a discussion on a sexuality reader at the Comet Media Foundation in February 2002). Self-exploration of genitals by girls is perceived as a threat to the notions of femininity, while such exploration by boys is seen as normal.

6. There are some source materials prepared by community-based organisations and women's groups that address sexuality in a broader context. These are exceptions.

7. As Pigg (1998) points out, at a superficial level, this distancing allows a public discussion of a taboo subject such as sex. The comfort in the abstract discussion comes from the fact that it does not disturb the power relations between the educator (often a teacher) and those being educated.

8. Words placed within double quotes in the interview excerpts are words used by the respondents.

9. Gender differences, sexual ideology and double standards in the constructions of youth sexuality are discussed in Abraham (2001).

10. A few boys learnt about nightfall from a male teacher (reported in boys' school) who talked about it in class and reassured them that it was part of growing up.

11. Any perceived 'loss' of male sexuality (semen loss, virility) can be compensated. Not merely compensated, but can be transformed into a 'gain' (body building through diet and exercises). But not so in the case of female sexuality. Perceived loss of virginity outside marriage is an irredeemable loss and sets off a series of 'losses' (honour, status, peace, and so on) for her and her family. Only within marriage it is rewarded.

12. These observations are based on the sex education classes held in two colleges included in the study, from the source materials prepared for this purpose, and also from the training modules used by teachers. See Panthaki (1997).

13. Some of the general retorts from teachers included 'animals do not go for sex education, 'how come our poor country has such a huge population', 'have all these poor people learnt about sex through sex education', and so on.

14. The campaigns do not clarify or address specific issues of 'AIDS prevention' within marriage. For instance, questions such as 'how can women have children if they have to insist on condoms because their husbands engage in premarital/extramarital sex?' are ignored.

15. Students drew attention to the specific Nirodh and Kohinoor (brands of condoms) advertisements quite common at the time of data collection.

16. The campaigns reflect patriarchal messages. The birth control or population control campaigns target women, especially poor women, through controlling their sexuality and by vesting the responsibility on them. The AIDS control campaigns exhort men to use condoms so that they do not 'catch' the infection. Male sexual freedom is not curbed. As one campaign message targeted at men said, 'when you mix business with pleasure, do not forget to carry condoms'.

17. Studies reported in Khanna and others (2002), Bott and others (2003), and Parker (1992).
18. For instance, one of the colleges from where data was collected had separate stairs for girls and boys. In another college, respondents reported that a girl who was pregnant was asked to leave the college.
19. The Kothis, Panthis, Hijras, and so on, in the Indian context. Similarly, the complex categories of heterosexual partnerships *(bhai-behen,* 'true love', 'time-pass' relationships) among youth cannot be merged into a simplified notion of 'boyfriend - girlfriend' relationship (Abraham, 2002a).

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APPENDIX

TABLE 1: Knowledge of Condoms

A Condom is...	*Boys*			*Girls*		
	Std. XI	*TY*	*Total*	*Std. XI*	*TY*	*Total*
	N = 351	*274*	*625*	*149*	*192*	*341*
A tablet taken before sex	13 (3.7)	4 (1.5)	17 (2.7)	16 (10.7)	19 (9.9)	35 (10.3)
Thin rubber shield to cover penis during sex	267 (76.0)	244 (89.0)	511 (81.8)	18 (12.1)	78 (40.6)	96 (28.1)
T-shaped device inserted inside the vagina	3 (0.9)	10 (3.6)	13 (2.1)	3 (2.0)	10 (5.2)	13 (3.8)
Thin rubber kept inside the stomach	3 (0.9)	1 (0.4)	4 (0.6)	1 (0.7)	0 (0.0)	1 (0.3)
Do not know	65 (18.5)	14 (5.1)	79 (12.6)	109 (73.2)	83 (43.2)	192 (56.3)
No Response	0 (0.0)	1 (0.4)	1 (0.2)	2 (1.3)	2 (1.1)	4 (1.2)

Note: Figures in parentheses denote the percentages.

TABLE 2: Knowledge of STDs among Students

Knowledge items	*Boys*			*Girls*		
	Std. XI	*TY*	*Total*	*Std. XI*	*TY*	*Total*
	N = 351	*274*	*625*	*149*	*192*	*341*
STD refers to:						
Diseases transmitted through sexual contacts	51 (14.5)	63 (23.0)	114 (18.2)	10 (6.7)	37 (19.3)	47 (13.8)
Name of a contraceptive device	7 (2.0)	4 (1.5)	11 (1.8)	2 (1.3)	0 (0.0)	2 (0.6)
Medical test to detect AIDS	23 (6.6)	15 (5.5)	38 (6.1)	4 (2.7)	3 (1.6)	7 (2.0)
Infertility	5 (1.4)	5 (1.8)	10 (1.6)	3 (2.0)	1 (0.5)	4 (1.2)
Do not know	263 (74.9)	185 (67.5)	448 (71.7)	129 (86.6)	150 (78.1)	279 (81.8)
No response	2 (0.6)	2 (0.7)	4 (0.6)	1 (0.7)	1 (0.5)	2 (0.6)
One can get STD by:						
Sharing cups/ utensils	2 (0.6)	1 (0.4)	3 (0.5)	0 (0.0)	0 (0.0)	0 (0.0)
Dirty toilet seats, door handle, bed sheets or clothes	2 (0.6)	3 (1.1)	5 (0.8)	1 (0.7)	0 (0.0)	1 (0.3)
Eating unhygienic food	8 (2.3)	4 (1.4)	12 (1.9)	6 (4.0)	2 (1.1)	8 (2.3)
Direct skin to skin contact through sex	70 (19.9)	82 (29.9)	152 (24.3)	16 (10.7)	30 (15.6)	46 (13.5)
Don't know	267 (76.0)	183 (66.8)	450 (72.0)	124 (83.2)	159 (82.8)	283 (83.0)
No response	2 (0.6)	1 (0.4)	3 (0.5)	2 (1.4)	1 (0.5)	3 (0.9)

Note: Figures in parentheses denote the percentages.

TABLE 3: Knowledge of AIDS among Students

Knowledge items	*Boys*			*Girls*		
	Std. XI	*TY*	*Total*	*Std. XI*	*TY*	*Total*
	N = 351	*274*	*625*	*149*	*192*	*341*
AIDS is caused by						
Prostitutes	33 (9.4)	26 (9.4)	59 (9.4)	7 (4.7)	10 (5.2)	17 (5.0)
Hand to hand touch	2 (0.6)	1 (0.4)	3 (0.5)	0 (0.0)	0 (0.0)	0 (0.0)
HIV virus	284 (80.9)	237 (86.5)	521 (83.4)	118 (79.2)	173 (90.1)	291 (85.3)
Bacteria	8 (2.3)	0 (0.0)	8 (1.3)	3 (2.0)	1 (0.5)	4 (1.2)
Do not know	22 (6.2)	7 (2.6)	29 (4.6)	19 (12.8)	8 (4.2)	27 (7.9)
No Response	2 (0.6)	3 (1.10)	5 (0.8)	2 (1.3)	0 (0.0)	2 (0.6)
One can reduce the risk of AIDS by						
Washing sex organs before or after sexual intercourse	3 (0.9)	3 (1.1)	6 (1.0)	5 (3.4)	5 (2.6)	10 (2.9)
Taking contraceptive tablets	5 (1.4)	6 (2.2)	11 (1.8)	7 (4.7)	3 (1.5)	10 (2.9)
Using condoms	304 (86.6)	255 (93.1)	559 (89.4)	76 (51.0)	138 (71.9)	214 (62.8)
Having sex with different partners	3 (0.9)	4 (1.4)	7 (1.1)	3 (2.0)	1 (0.5)	4 (1.2)
Don't know	36 (10.2)	5 (1.8)	41 (6.5)	58 (38.9)	42 (21.9)	100 (29.3)
No Response	0 (0.0)	1 (0.4)	1 (0.2)	0 (0.0)	3 (1.6)	3 (0.9)
AIDS can be transmitted from an infected person by						
Kissing, hugging, petting	39 (11.1)	16 (5.9)	55 (8.8)	11 (7.4)	1 (0.5)	12 (3.5)
Sharing toilets and clothes	3 (0.8)	3 (1.1)	6 (1.0)	2 (1.3)	1 (0.5)	3 (0.9)
Unprotected sexual intercourse	272 (77.5)	248 (90.5)	520 (83.2)	110 (73.8)	174 (90.6)	284 (83.3)
Bed bugs/ mosquitoes	1 (0.3)	0 (0.0)	1 (0.1)	0 (0.0)	0 (0.0)	0 (0.0)
Don't know	35 (10.0)	5 (1.8)	40 (6.4)	25 (16.8)	16 (8.4)	41 (12.0)
No Response	1 (0.3)	2 (0.7)	3 (0.5)	1 (0.7)	0 (0.0)	1 (0.3)

Note: Figures in parentheses denote the percentages.

TABLE 4: Sources **of Information about** Pregnancy **and Abortion**

Source	*Boys (n) N=62S*	*Girls (n) N=341*
Doctors/nurses	133	127
Friends	133	58
Teachers	35	34
Movies/ blue films	61	5
Parents/relatives	16	46
Sex education Programmes	84	52
Mass media	236	118
Own experience	20	1
Don't know	137	31
Total	855	472
No response	11	6

Note: The 'n' includes multiple responses.

TABLE 5: Sources of Information about Contraception

Source	*Boys (n) N=625*	*Girls (n) N=341*
Doctors and nurses	90	36
Friends	**151**	36
Mass media	**329**	169
Sex education programmes	**136**	41
Teachers	37	15
Movies/ Blue films	30	2
Parents/Relatives	10	23
Own experience	18	1
Don't know	0	0
Others	42	51
Total	**843**	374
No response	4	7

Note : The 'n' includes multiple responses.

TABLE 6: Sources of Information about STIs

Sources of information	*Boys (n) N=62S*	*Girls (n) N=341*
Mass media	177	**80**
Friends	**97**	**26**
Sex education programmes	**86**	**25**
Doctors/nurses	**69**	**21**
Teachers	**25**	13
Movies/ Blue films	**29**	**2**
Parents/ Relatives	**20**	11
Own experience	**17**	**2**
Don't know	**213**	167
Others	**4**	**0**
Total	**737**	**347**
No response	**19**	**20**

***Note:* The 'n' includes multiple responses.**

TABLE 7: Sources of Information about AIDS

Sources of Information	*Boys (n) N=625*	*Girls (n) N=341*
Sex education programmes	171	**221**
Mass media	381	**25**
Doctors/Nurses	97	**26**
Friends	100	**22**
Teachers	52	**25**
Movies/ Blue films	38	**0**
Parents/ Relatives	13	**14**
Others	33	**31**
Don't know	0	**0**
Total	885	**364**
No response	3	6

Note: The 'n' includes multiple responses.