

Social Representations of HIV /AIDS: A Study of Adolescents and Young Adults in Lalitpur District of UP

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Social representations are ideas, thoughts, images, and knowledge which belong to society and which shape individual consciousness. The social representation framework explores how a representation is anchored and objectified in a given social structure. This paper explores the social representations of HIV/AIDS among the adolescents and young adults in Lalitpur district of UP.

What are social representations?

Social representations are ideas, thoughts, images, and knowledge which belong to society and which shape individual consciousness (Augoustinos, 1995). For Durkheim who is the pioneer in this field the advantage of sociology that explores the connection between collective representations and individual consciousness was to construct typologies of individual action and look for social ways to minimize risks (Durkheim, 1951). Durkheim (1953) said:

It is in the whole as it is by the whole. In this sense it is exterior to the individuals. No doubt each individual contains a part, but the whole is found in no one. In order to understand it as it is one must take the aggregate in its totality into consideration.

To follow Durkheim, study of social representations is important because the beliefs are structured on knowledge categories which are socially produced and reproduced (Mike, 2003). When a new issue like HIV comes up, people use the pre-existing thought categories to make sense of it, i.e., the new ideas are anchored in what is already known. Somehow in studies of HIV which have been conducted from the policy perspective due importance has not been given to the social and community dimension and major emphasis has been placed on studying knowledge as such. As a result of that social scientists have studied the knowledge and misconceptions about HIV as an objective researcher: people's own

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perspectives remain hidden behind them. The issue is: what do people understand by what beliefs and opinions they express and how does that affect their behaviour and society? The focus of the researchers has been on high risk groups such as truck drivers, female sex workers, etc. while the general population too is now at risk and cases of ordinary men and women, including women in monogamous marriages are coming to light. Therefore, it is of utmost importance to explore the ideas of HIV/AIDS, risk and coping among the lay persons so that people can be educated to protect themselves and those already affected can be rehabilitated in the community where stigma against AIDS is very strong.

Review of literature

The ideas of HIV/AIDS vary across societies. Many people living in remote places or those estranged from society have no idea of HIV/AIDS at all. They have not yet heard about HIV. But there are a large number of people who have heard about HIV but who do not understand the causes and consequences of HIV in the same perspective as the experts. As a matter of fact, following Parker (2001), it may be said that in each culture people attach 'emic' meanings to terms like sex work, prostitution, diseases of the sexual organs, morality etc. which are different from the 'etic' concepts used by planners, activists and experts. Therefore, in place of asking whether they have knowledge or not it is more appropriate to ask what the content of their knowledge is. Moreover, whatever knowledge they have it is mixed with social, cultural and political beliefs and valuations. For example, in one of the important studies on the subject Kaler (2004) showed how in Malawi people's concepts of state and family planning have made them skeptical about use of condoms.

People's knowledge categories are rooted in their social context and representations, i.e., 'discourses concerning condoms, involving aesthetics, religion, and social stigma' (Kaler, 2004), are the most important source of the individual's consciousness and action, even if absurd or irrational from the perspective of modern science. As a matter of fact even the scientific representations (when they reach lay people through change agents or media) are re-represented in the context of their collective representations. In other words the new concepts are anchored (i.e., named and classified into intelligible categories) and objectified (the process by which unfamiliar and abstract notions, ideas and images are transformed into 'concrete and objective common-sense realities') (Augoustinos, 1995) through personification and ontologization. No wonder the Malawi people find a sinister design of powerful countries in promotion of condoms in the country. It has been established that

consistent with social representations theory and previous research, images of AIDS continue to be anchored to concepts of the “other” (i.e., ‘not-me’), death, victimization and culpability. Despite attempts to the contrary, textbooks also inadvertently present AIDS as a disease of homosexuals and as associated with mental disorders (Schoeneman, 2002).

What is true about Malawi is not necessarily true about other societies. Others’ knowledge categories are rooted in their own social context and representations as is the case. For example, Indians People’s, i.e., discourses concerning risk behaviour, condoms and social stigma are part of Indian discourse on aesthetics, religion, etc.

Thus it is important to examine how the representations of HIV/AIDS enter society, where do they get sustenance from and what is their place in society, different networks, mobility and flows. Durkheim assumed that the most formidable task in studying the social facts is to proceed from causes to effects, i.e., to begin with the type of representations and then only look for patterns as facts. Thus in exploring representations of HIV/AIDS one may begin with the types of representations and only subsequently study variations in the incidence of HIV or safe sex practices. Moscovici begins with the similar position.

To quote Moscovici (1998):

The ideas and beliefs which enable people to live are incarnated in specific structures (clans, churches, social movements, families, clubs, etc.) and adopted by the individuals who are part of them. The meaning which they communicate and the obligations which they recognize are profoundly incorporated in their actions and exercise a constraint which extends to all the members of the community.

However, for Moscovici the representations are fluid and mobile. They move between experts and laypersons and between different categories of people.

Table 1 summarizes the various pre-existing ideas in which concepts of safe and unsafe sex are anchored. Some major concepts useful to explore social representations of HIV/AIDS are: relationship of dependence; ideas about love, trust, confidence in the partner; lack of understanding; association of condom with loose moral character; lack of communication with the partner; and strong faith in religion/God.

TABLE 1: ANCHORING OF IDEAS OF SAFE AND UNSAFE SEX

Pre-existing ideas	Ideas related to condoms/safe sex	Action
Males have a strong sexual urge; husband as a protector, superior and a source of support	Husbands understand whether to use condom or not	One has to keep husband satisfied who may abandon or torture wife if she does not satisfy his desire
God has made woman to bear and rear children	Desire to become pregnant	Unsafe sex till one has achieved the desired family size
Trust	Men and women in loving relationships are of good moral character and, therefore, safe partners	One does not have to use condoms with lovers/spouses
Love and sacrifice	True love demands sharing pleasures and pains, including infection	If the partner has infection, one can show his true love by forcing him/her to have sex (without condom) and catching the infection
Confidence in the partner	Spouses/partners are trustworthy. If they have problem they will let them know	One does not have to use condoms with lovers/spouses
Expression of love	Condoms prevent free expression of love	Condom should not disturb the free expression of love
Husband is the bread earner; he can't sit ideal at home	No time to discuss about sexual matters and condoms	Unstructured decisions
Sex is a human weakness, one has sex only in moments of weaknesses; sex is most private	Condom being associated with sex, it is embarrassing or shameful to procure condoms	Cannot use condoms though the person may like to use them
Sex is a natural desire	Misconceptions about condom which are artificial and promoted by some interests <ul style="list-style-type: none"> • May come off the male and sucked into uterus or cause cancer, genital sore, or other diseases • Government people are promoting them in their own interest 	From people's perspective, for safety and health condom should be avoided
People with loose moral character hide their relationships and pregnancy	Keeping condom, use of condom or asking or condom use may imply "cheating"	One has to avoid condom for maintaining a good image
Happiness and sorrow depend on what God wishes for us	Beliefs and statements as: "Many persons without condom use are healthy and many people who used condom died of HIV/AIDS"	No need to worry about diseases
For every disease there is a treatment	Science has found solutions to diseases of sexual/reproductive systems	Since there are medicines one can enjoy life freely

In all post-horticultural societies family has been a hierarchical organization in which women played a subordinate role. Even though in post-industrial context their position has improved considerably a large proportion of them are housewives and dependent on husband. They may agree to accept unsafe practices because they cannot or do not want to resist husband without whom they would not survive (Simmons, 1996). It has been observed that at certain stages, such as among newly married girls there is a pressure to become pregnant and thus accept unsafe practices even if inadvisable in a given context. Although Clark (2004) documented this in the context of Sub-Saharan Africa such ideas are common to all settings in which reproduction is one most important role of women. Religion, economic circumstances, community relationships, concepts of love and lack of control in sexual decisions (Smith, 2004; Varga, 2003; Blanc, 2001; Worth, 1989; Gorgen, 1993) affect safe sex practices. Commenting on HIV in the context of Kenya Du Lou (2005) says: "It is difficult for some couples to discuss, because the only place they ever discuss is in the bedroom. The husband just wants to have sex and not discuss family planning." This observation not only highlights the importance of place and timings of communication between spouses and how they might affect the sexual communication and practices but also establishes the supremacy of husband.

Further, sexual norms create demarcation between the feminine sphere and the masculine sphere and the notions of love and altruism. In a recent paper on emotions and reproductive health Basu (2006) has distinguished between two meanings of unsafe practices: (a) when love and romance mean "not worrying about one's partner's sexual past or present" and "not even worrying about an unwanted pregnancy"; and (b) "when the unsafe sex is a part of the quest for love". Buckwalter has reported similar experiences from Mumbai in which some persons forced the infected partner to have unprotected sex so that they themselves can also catch the infection. Catching infection, for them, was the proof of their love for the partner. From another perspective, people may be told that HIV tests are not simply ways to obtain information but are also tests of love and loyalty of a partner (Obermeyer, 2005).

Some studies have shown how beliefs such as the belief that someone who has HIV/AIDS can be recognized and, therefore, that a partner's lack of visible symptoms means that he/she is not infected or that certain categories of sex workers such as message-parlor workers can lead to unsafe practices (Havnon et al., 1993). Beliefs regarding interference in pleasure or side effects of condoms have also prevented many men and women from using

them. Individual and social understandings of risks affect use of condoms (Castle, 2003). In one extreme case a wide spread belief exists in West Africa that condoms may come off the male and be sucked into the female's womb, causing sterility, infection, and even death (Orubuloye et al., 1991). It was found that in New York city women believed that in oral sex there is no risk which is not medically true (Worth, 1989).

People also make a distinction between natural, moral and medical. In case of health and illness, health may be associated with natural, illness and disturbances with outside interference. Studies show that the diffusion of biomedical knowledge is often incorporated into local systems and held alongside pre-existing information (Obermeyer, 2005). Very high beliefs in efficacy of modern science (such as modern medicine can cure any form of disease) or traditional medicine system may adversely affect the safe sex practices (Orubuloye et al., 1991). Disbelief in modern medicine and practices too can have the same results. Lastly, from the point of view of voluntary testing, disclosure is another issue. One may argue that disclosure is not a binary, yes-no event but a complex process involving concealment, hints, rejection, and admission (Obermeyer, 2005).

Objectives of the paper

The objective of this paper is to identify social representations of HIV/AIDS among the common adolescents and young adults.

Methodology

The data used in this paper is drawn from *District Situation Analysis-Lalitpur*, a comprehensive study of district's vulnerability to HIV/AIDS for UNICEF. This study enjoyed the triangulation of quantitative and qualitative methods. Both secondary and primary data are collected. The purpose of the secondary data is to understand the general socio-economic situation and cultural milieu in the district against which the results of the findings of the survey can be interpreted. The primary data is collected, covering the whole district on sample basis, including men and women in the age group 10 – 24 years, and employing quantitative and qualitative methods such as survey, structured interview schedules, interviews with key informants, and focus group discussions.

In each of the six blocks of the district, five villages were selected keeping in view the general socio-economic condition in consultation with the NGOs working in the area so that all types of villages are represented and the results are least affected by selection bias. Thus the selection of the villages was done based on the vulnerability related information collected through secondary data sources, brainstorming sessions with NGOs and in-depth interviews of key informants. Besides the villages, the town area of Talbehat and Lalitpur were also surveyed. It was also decided that in Mahrauni one village is replaced by Mahrauni proper.

For the survey, in each of the villages and urban units, primary data were collected using quota sampling. The quotas for age and sex groups were fixed as follows:

- i. 10 young girls/women (age 10 – 24 years)
- ii. 10 teenage boys/men (age 10 – 24 years)

MAP 1: LOCATION OF THE SURVEY VILLAGES AND TOWNS



The key informants for in-depth interviews included doctors posted at district hospital, CHC and PHC, development officials, health workers at CHC, PHC, and sub-centre level, village workers, school teachers, village Sarpanchs, police officials, members of high risk groups, and activist and volunteers associate with local NGOs.

In all the selected villages, four FGDs were planned separately with parents and boys and girls belonging to two age groups, 15-19 years and 20-24 years. Checklists were prepared for carrying out the FGDs with each of the identified group. Informal discussions were carried out with very young girls (less than 15 years) and boys. This study also benefited from meeting with all prominent NGOs of the district. Discussions were held on their assessment of the situation of adolescents in the district, the status of health, culture and practices that may have a bearing on this study. Based on this discussion, villages in each of the six blocks were identified. Later on also, as the study progressed, several brainstorming session were held with NGOs.

Sample

Finally, the primary data were collected from 639 respondents – 326 men and 313 women.

Interviews with men and women were conducted at home with the oral consent of the respondents and, in case of children, with the consent of the parents or other elderly members of the family, whoever was available. Truck drivers were interviewed at the village/urban ward to which they belong, and check posts where they stop for quite some time. FSWs, IVDUs and MSMs were contacted through local NGOs. Some FSWs were contacted independently also in the villages and urban wards in Laltipur and Talbehat towns where they reside. Doctors were interviewed at the district hospital, CHCs and PHCs. The most difficult person to contact was ANM. First of all, all the sample villages did not have a sub centre. Secondly, ANMs lived in Lalitpur and reportedly, made only monthly or bi-monthly visits to their field. The district level officers were contacted in their offices.

The young men and women who were interviewed represented different age groups. 42.64 percent of the male respondents and 39.29 percent of female respondents were in the age group ‘up to 18 years’. The rest were in the age group 19 – 24.

The survey has adequate representation of all castes and economic classes. Generally, the team started the survey in a village by meeting the Sarpanch, to get an overall understanding of the profile of people, and various habitations of the village. It was ensured that all habitations and communities are represented in the survey. It is clear that the sample is by and large representative of the general situation in the district except that it has proportionately more number of cases of SCs and STs. This is because researchers showed special interest in interviewing vulnerable sections of society from lower classes such as the poor, migrant workers, mining workers and the dancing girls.

Social representations of HIV/AIDS

To understand social representations of HIV/AIDS the following questions were explored:

- Have the respondents heard about RTI/STI and HIV/AIDS?
- Can HIV/AIDS be treated?
- In their opinion, how does HIV spread?
- What can be done to prevent HIV?
- Can a woman refuse sex to her husband?
- How should the people living with HIV be treated?

Knowledge about HIV

Table 1 exhibits the distribution of respondents according to sex and awareness of RTI/STI and HIV/AIDS. The table shows that in the sample a majority of respondents have heard about both RTI/STI (72.14 percent) and HIV/AIDS (67.76 percent). However, when the data are examined separately for men and women, it is found less than half of the women respondents only know about HIV (49.20 percent). It is also found that relatively more men have heard about HIV and RTI/STI than women. The proportion of women knowing about RTI is a little higher (63.58 percent) than the percentage knowing HIV/AIDS (49.20 percent). The fact that among women the awareness of RTI/STI is better than of HIV/AIDS is easy to explain. As compared to common RTI/STI, HIV is a new disease and women respondents have not been exposed to HIV communication, nor have they known about actual cases of HIV. Moreover, in the village milieu due to poverty, malnutrition, unhygienic conditions a majority of women suffer from RTI. The women respondents are either facing RTI/STI or have heard about women suffering from some special problems of women from the older family members and relatives. In local parlance RTI is known as *Prasut Rog* (diseases related

to reproduction) or women’s problem. Ironically, among men RTI/STI is known as *Gupt Rog*, i.e. a secret disease and is not revealed to anyone, other than one in which somebody can confide, not even to general physician, yet more than eighty percent male respondents that they have heard about it. This may be due to the fact that the men are more exposed to media and they are also freer to talk about sexual and personal problems than women.

TABLE 1: PERCENTAGE OF RESPONDENTS BY THEIR AWARENESS ABOUT RTI/STI & HIV/AIDS

Sl. No.	Category		Men		Women		Total	
			Number	Percent	Number	Percent	Number	Percent
1	RTI/STI	Aware	262	80.37	199	63.58	461	72.14
		Not aware	64	19.63	114	36.42	178	27.86
2	HIV/AIDS	Aware	279	85.58	154	49.20	433	67.76
		Not aware	47	14.42	159	50.80	206	32.24

It has to be stressed that there are several respondents who say that they have heard about HIV but they lack the ‘correct’ understanding of it. Anyway hearing something does not imply that one has the ‘correct’ knowledge. There are respondents who have heard the term HIV but cannot tell exactly what it means, how it spreads or whether it can be cured or not. Table 2 shows that 43.19 percent respondents (25.77 percent men and 61.34 percent women) are not able to report even one way of transmission of HIV. 21.44 percent respondents (35.28 percent men and 7.03 percent women) are able to report only one method. Thus there are more than sixty percent men and women who have either no knowledge of HIV transmission or know only one mode of the transmission of infection. This shows that the level of knowledge about HIV is very poor. There is a need to inform people about the nature of HIV and how it spreads.

TABLE 2: DO PEOPLE KNOW FOUR METHODS THROUGH WHICH HIV/AIDS SPREAD							
Sl. No.	No. of methods known	Men		Women		Total	
		Number	Percent	Number	Percent	Number	Percent
1	Four	8	2.45	49	15.65	57	8.92
2	Three	45	13.80	17	5.43	62	9.70
3	Two	74	22.70	33	10.54	107	16.75
4	One	115	35.28	22	7.03	137	21.44
5	None	84	25.77	192	61.34	276	43.19
	Total	326	100.00	313	100.00	639	100.00

There are several misconceptions about HIV/AIDS. They are shown in Box 1.

Can HIV be treated?

Table 3 shows the knowledge of respondents regarding whether HIV/AIDS can be treated or not. It shows that 29.73 percent respondents (32.52 percent men and 23.64 percent women) said that HIV cannot be treated. Others were either ignorant or thought that it can be treated. It was observed that some of the government people too are giving wrong information. In the district hospital one responsible person involved in HIV programme said that when the people learn about their HIV positive status they are shocked. To save them from this shock they tell them that HIV is a disease like other diseases and it can be cured. Similarly the homeopathic doctors tell that HIV too can be cured if they take medicine from the hospital. One homeopathic doctor claimed that homeopathic treatment is symptomatic and he has treated 182 cases of RTI/STI among both men and women during 2005 – 06.

BOX 1: MISCONCEPTIONS ABOUT HIV/AIDS

- **HIV/AIDS is caused when people have sex during menstruation**
- **Children do not get HIV/AIDS**
- **HIV spreads through mosquitoes and bug bites**
- **HIV spreads if infected person touches you**
- **When people do not keep their body clean, they get infected by HIV/AIDS**
- **HIV/AIDS is so contagious that one should never bring mouth close to the infected person (spreads through air)**
- **Those who do not eat well may catch HIV/AIDS (poor diet)**
- **Consumption of dirty water leads to HIV/AIDS**
- **Consumption of stale food causes HIV/AIDS**
- **People with nervous temperament get infected by HIV/AIDS**
- **It is caused by masturbation among males**
- **Sharing of soap with infected person can spread HIV/AIDS**
- **Sharing of garments with infected person can spread HIV/AIDS**
- **Sharing of food and eating with infected person from same utensils can spread HIV/AIDS**
- **Handshaking and physical touch will spread HIV/AIDS**
- **When a person jumps over someone's urine, it causes HIV/AIDS**
- **RTI/STI, if untreated, develops into HIV/AIDS**

TABLE 3: RESPONSES TO CAN HIV BE TREATED							
Sl. No.	HIV/AIDS	Men		Women		Total	
		Number	Percent	Number	Percent	Number	Percent
1	Can be treated	137	42.02	53	16.93	190	29.73
2	Can not be treated	106	32.52	74	23.64	180	28.17
3	Can not say	83	25.46	186	59.42	269	42.1
	Total	326	100.00	313	100.00	639	100.00

Respondents have several misconceptions about treatment of HIV too. Box 2 shows some.

BOX 2: MISCONCEPTIONS ABOUT TREATMENT
<ul style="list-style-type: none"> • HIV/AIDS can be cured if the person is taken to doctor in time • If a HIV positive woman is given proper medication during pregnancy (as suggested by PHC doctor/health worker to pregnant mothers), her child is protected from getting HIV/AIDS • There are homeopathic medicines that successfully cure HIV/AIDS • HIV/AIDS can be cured by having sex with donkeys • Medicines of HIV/AIDS are available at the district hospitals • HIV/AIDS can be cured if one takes cow urine continuously for eleven days • HIV/AIDS can be cured if one has sex with a much younger person of the opposite sex than his/her age

Gram Pradhans and other elderly people in the village are less knowledgeable about HIV/AIDS. They connect HIV with extramarital affairs and bad practices. Assuming that he is the custodian of village morality, in one interview on HIV a Gram Pradhan responded that “there is no such thing here, we have good control of the situation and all people are decent.” In the same village it was found that there are several seasonal migrants who indulged in sex at the destination, commercial sex workers who had clients in the village as well as outside,

and children who watched blue films and had sex before marriage. Outside world is so demonized and untrustworthy for the villagers that even their own men can misguide them. At the time of the survey many people expressed the fear that if they tell their name to outsiders (registration for National Rural Employment Guarantee (NREG) scheme was going on at that time), they would be sent to Iraq. Later on it was found that this rumor was successfully spread by the labor contractors, their own men, to prevent people taking part in the scheme. The fear is spread throughout the district. At several places the survey team encountered resistance among people, who would even refuse to give their names to the survey team.

Knowledge about how HIV/AIDS spreads

Table 4-A shows the distribution of respondents according to their understanding of how HIV/AIDS spreads. In general a majority of people possess the right understanding of the following sources: intercourse with infected person, heterosexual relationships-multiple partners, and blood transfusion. More than half of the respondents know that HIV would not spread through shaking hands with infected person, hugging, sharing clothes, sharing utensils and sharing of urine pots. However, it may be noted that for each source a significant percentage of respondents are either unaware or carry an incorrect understanding of the matter. Homosexual relationship is one source about which more than half of the respondents are just unaware. There is a particular need to educate people about the risk of HIV/AIDS involved in homosexual relationships, mother to child infection, use of public toilet, kissing, mosquito/flea or bed bug, and sharing blade with infected person.

The major source of information on matters related to sex and HIV are TV and radio. To some extent respondents also received information in friends' circle. The levels of literacy and income being very low newspapers and magazines are not read. However, the adolescents can easily get CDs and watch blue films on their television sets. This explains why the respondents lack clear knowledge about HIV and their ideas of HIV are anchored in their ideas of other epidemics though a large number of them see some connection between illegal sex, bad blood and HIV.

TABLE 4-A: DISTRIBUTION OF RESPONDENTS BY KNOWLEDGE OF HOW HIV/AIDS SPREADS									
Sl No.		Yes		No		Don't know		Total	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
1	Intercourse with HIV/ AIDS	338	52.90	24	3.76	277	43.35	639	100.00
2	Homosexual relationships	181	28.33	111	17.37	347	54.30	639	100.00
3	Heterosexual relationships- multiple partners	369	57.75	15	2.35	255	39.91	639	100.00
4	Lack of personal hygiene	147	23.00	226	35.37	266	41.63	639	100.00
5	Use of HIV/AIDS infected needles	362	56.65	20	3.13	257	40.22	639	100.00
6	From HIV/AIDS infected mother to her child	302	47.26	37	5.79	300	46.95	639	100.00
6	Transfusion of HIV/AIDS infected blood	363	56.81	14	2.19	262	41.00	639	100.00
7	Use of public toilet	78	12.21	282	44.13	279	43.66	639	100.00
8	Sex with FSWs	370	57.90	22	3.44	247	38.65	639	100.00
9	Shaking hands with HIV/AIDS infected person	34	5.32	357	55.87	248	38.81	639	100.00
10	Hugging a HIV/AIDS infected	36	5.63	355	55.56	248	38.81	639	100.00
11	Kissing on mouth or lips of HIV/AIDS infected person	84	13.15	303	47.42	252	39.44	639	100.00
12	Sharing cloths with HIV/AIDS infected person	44	6.89	343	53.68	252	39.44	639	100.00
13	Sharing utensils/ eating with HIV/AIDS infected person	70	10.95	325	50.86	244	38.18	639	100.00
14	Sharing of urine pot with HIV/AIDS infected person	43	6.73	331	51.80	265	41.47	639	100.00
15	Mosquito/flea or bed bug	119	18.62	250	39.12	270	42.25	639	100.00
16	Sharing blade with HIV/AIDS infected person	300	46.95	68	10.64	271	42.41	639	100.00

Table 4-B shows the distribution of respondents according to their understanding of how HIV spreads and sex. The seven main responses among men, given by more than half of the respondents are:

- heterosexual relationships (77.91 percent)
- sex with female sex workers (76.99 percent)
- transfusion of HIV/AIDS infected blood (75.15 percent)
- use of HIV/AIDS infected needles/blades (74.54 percent)
- intercourse with HIV/AIDS infected person (70.86 percent)
- sharing blade with HIV/AIDS infected person (64.42 percent)

- from HIV/AIDS infected mother to her child (57.06 percent)

Among women no response is given by more than 39 percent respondents. The six main categories among women, given by more than one-third of the respondents are:

- use of HIV/AIDS infected needles/blades (38.02 percent)
- sex with female sex workers (38.02 percent)
- transfusion of HIV/AIDS infected blood (37.70 percent)
- from HIV/AIDS infected mother to her child (37.06 percent)
- heterosexual relationships (36.74 percent)
- intercourse with HIV/AIDS infected person (34.19 percent)

These results too show that the respondents, both men and women, have very poor knowledge of how HIV/AIDS spreads. The men respondents have fairly good idea of how HIV/AIDS spreads. Most of them can tell that it spreads through sexual relationships and blood transfusion. However, they need to be educated that it can also spread through homosexual relationships and parenthood. FGDs show that in the rural areas homosexuality is rare and this may be one reason why the respondents cannot connect HIV to homosexuality. The study identified a network of MSMs in Lalitpur city and found that there are some people from all classes who are married but engage in MSM activities due to the *myth that it cures pile*. It appears that MSM activities are more common among the auto rickshaw drivers. Further, many respondents associate HIV with personal hygiene.

Thus as mentioned above, the idea of HIV is anchored in the ideas of infectious diseases, objectified by a higher chance of infection among truck drivers, who cannot maintain personal hygiene due to long journeys and who commonly engage in sex with ‘dirty women’. The implication of this fact is that the sense of personal risk is low.

TABLE 4-B: DISTRIBUTION OF RESPONDENTS BY KNOWLEDGE OF HOW HIV/AIDS SPREADS AND SEX													
Sl. No.	Method of spreading HIV/AIDS	Men						Women					
		Yes		No		Don't Know		Yes		No		Don't Know	
		No.	Per.	No.	Per.	No.	Per.	No.	Per.	No.	Per.	No.	Per.
1	Intercourse with HIV/AIDS infected person	231	70.86	17	5.21	78	23.93	107	34.19	7	2.24	19	63.58
2	Homosexual relationships	109	33.44	99	30.37	118	36.20	72	23.00	12	3.83	22	73.16
3	Heterosexual relationships-multiple partners	254	77.91	10	3.07	62	19.02	115	36.74	5	1.60	19	61.66
4	Lack of personal hygiene	115	35.28	138	42.33	73	22.39	32	10.22	88	28.12	19	61.66
5	Use of HIV/AIDS infected needles	243	74.54	10	3.07	73	22.39	119	38.02	10	3.19	18	58.79
6	From HIV/AIDS infected mother to her child	186	57.06	29	8.90	111	34.05	116	37.06	8	2.56	18	60.38
7	Transfusion of HIV/AIDS infected blood	245	75.15	7	2.15	74	22.70	118	37.70	7	2.24	18	60.06
8	Use of public toilet	48	14.72	198	60.74	80	24.54	30	9.58	84	26.84	19	63.58
9	Sex with FSWs	251	76.99	16	4.91	59	18.10	119	38.02	6	1.92	18	60.06
10	Shaking hands with HIV/AIDS infected person	23	7.06	242	74.23	61	18.71	11	3.51	115	36.74	18	59.74
11	Hugging a HIV/AIDS infected person	25	7.67	241	73.93	60	18.40	11	3.51	114	36.42	18	60.06
12	Kissing in mouth or lips of HIV/AIDS infected person	68	20.86	194	59.51	64	19.63	16	5.11	109	34.82	18	60.06
13	Sharing clothes with HIV/AIDS infected person	31	9.51	232	71.17	63	19.33	13	4.15	111	35.46	18	60.38
14	Sharing utensils/ eating with HIV/AIDS infected person	51	15.64	217	66.56	58	17.79	19	6.07	108	34.50	18	59.42
15	Sharing of urine pot with HIV/AIDS infected person	24	7.36	235	72.09	67	20.55	19	6.07	96	30.67	19	63.26
16	Mosquito/flea or bed bug	90	27.61	160	49.08	76	23.31	29	9.27	90	28.75	19	61.98
17	Sharing blade with HIV/AIDS infected person	210	64.42	42	12.88	74	22.70	90	28.75	26	8.31	19	62.94
	Total	326	100.0	326	100.0	326	100.00	313	100.0	313	100.00	31	100.0

Knowledge of how HIV can be prevented

The responses to the question on how HIV/AIDS can be prevented, is similar to that to the question regarding how to prevent RTI/STI (Table 5-A and 5-B). However, in case of HIV a higher percentage of respondents mention about preventing action related to blood contact and pregnancy.

TABLE 5-A: DISTRIBUTION OF RESPONDENTS BY THEIR KNOWLEDGE OF PREVENTION OF HIV/AIDS

Sl. No	Method of prevention of HIV/AIDS	Yes		No		Don't know		Total	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
1	Sex with only one partner	388	60.72	14	2.19	237	37.09	639	100.00
2	Using condom correctly during each sexual	366	57.28	9	1.41	264	41.31	639	100.00
3	Checking blood prior to transfusion	381	59.62	7	1.10	251	39.28	639	100.00
4	Sterilizing needless on syringes for injection	379	59.31	8	1.25	252	39.44	639	100.00
5	Avoiding pregnancy by those having HIV/AIDS	331	51.80	17	2.66	291	45.54	639	100.00
6	Avoiding sex with FSWs	393	61.50	3	0.47	243	38.03	639	100.00
7	Abstaining from sexual intercourse	313	48.98	53	8.29	273	42.72	639	100.00

Table 5-B shows the distribution of respondents by knowledge of how HIV can be prevented and sex of the respondents.

TABLE 5-B : DISTRIBUTION OF RESPONDENTS BY THEIR KNOWLEDGE OF PREVENTION OF HIV/AIDS AND SEX														
Sl. No.	Method of preventing HIV/AIDS	Men						Women						
		Yes			Don't Know			Yes			No		Don't Know	
		Number	Percent	No	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
1	Sex with only one partner	268	82.21	7	2.15	51	15.64	120	38.34	7	2.24	186	59.42	
2	Using condom correctly during each sexual intercourse	257	78.83	6	1.84	63	19.33	109	34.82	3	0.96	201	64.22	
3	Checking blood prior to transfusion	257	78.83	5	1.53	64	19.63	124	39.62	2	0.64	187	59.74	
4	Sterilizing on needless syringes for injection	257	78.83	5	1.53	64	19.63	122	38.98	3	0.96	188	60.06	
5	Avoiding pregnancy by those having HIV/AIDS	220	67.48	11	3.37	95	29.14	111	35.46	6	1.92	196	62.62	
6	Avoiding sex with FSWs	269	82.52	2	0.61	55	16.87	124	39.62	1	0.32	188	60.06	
7	Abstaining from sexual intercourse	207	63.50	46	14.11	73	22.39	106	33.87	7	2.24	200	63.90	
	Total	326	100.00	326	100.00	326	100.00	313	100.00	313	100.00	313	100.00	

Can a woman refuse to have sex with husband?

The role of gender is explicit in statements on husband's right to have sex even when the wife is unwilling. Table 6 shows the distribution of respondents according to belief of respondents regarding men's right to have sex even when the wife is unwilling. Traditionally, it was considered a man's right to have sex with wife even when she is unwilling. Even in law in India forced sex by husband is not defined as rape. This explains why 53 percent of the married women were forced by their husbands to have sex even they were not willing (data not tabulated here). But it is only surprising that 31.46 percent respondents (29.14 percent men and 33.87 percent women) agree with the man's right over wife. 19.25 percent respondents (12.58 percent men and 26.20 percent women) somewhat agree with this. 48.04 percent respondents (57.06 percent men and 38.66 percent women) do not agree. It is interesting that more men disagree with husband's right than women. These data indicate that either there is a general change in husband-wife relationship or the women's report is more reflective of their experiences: while husbands are giving a socially desirable answer and wives are expressing the reality. On the basis of qualitative feedback it may be said that a lower percentage of the agreement among men seems to arise more from desire to look equal than from greater sensitivity towards wives. Similarly a higher percentage of the agreement among women seems to arise from the subservient role in the matter rather than acceptance of "any way man needs sex" or desired to keep husband happy.

Further, it may be stressed that the above beliefs are reflected not only in marriage but also in premarital and extramarital relationships in which men believe that they can initiate sex even when the partner does not show explicit interest in this or they perceive a slight provocation.

TABLE 6: BELIEFS OF RESPONDENTS ABOUT MEN'S RIGHT TO HAVE SEX EVEN WHEN PARTNER IS UNWILLING							
Sl. No.	Response	Men		Women		Total	
		Number	Percent	Number	Percent	Number	Percent
1	Agree	95	29.14	106	33.87	201	31.46
2	Some what agree	41	12.58	82	26.20	123	19.25
3	Do not agree	186	57.06	121	38.66	307	48.04
4	Non response	4	1.23	4	1.28	8	1.25
	Total	326	100.00	313	100.00	639	100.00

What happens when wife is unwilling and refuses to have sex? The data showed that refusals commonly result in physical (44.51 percent) and mental abuse (14.45 percent) (data not tabulated here). Anita lives in Dhangaul village. She is married and has four year old son. She says her husband consumes liquor every day. After that he wants sex, and if she refuses, he beats her up without any mercy. This is not an isolated case. Most women think they cannot refuse sex to their husbands because it is their right to have sex whenever they want.

No wonder only 38.18 percent women reported that they can refuse sex (data not tabulated here). Women have no option if the husband wants to have sex. If a man wants to have sex woman should silently lie down, said many respondents. A large number of women respondents said “*aurat to kamjor hai aur admi jo chahe kare* (woman is weak and cannot resist him)”. In most parts of Lalitpur, position of women is still defined by the traditional social norms. However, it is not merely weaker position of woman that results in such a situation. *It may be noted that the romantic idea of love is essentially urban. In rural areas love means sex. Whether between married couples or between partners outside wedlock love means sex. It is natural for men to express sexual intention. Moreover, in marriage commitment, love, loyalty etc. are expressed in acceptance of sexual orientation on the part of women. Sex between a man and woman is natural and a source of happiness. The control of sex is essentially the control of inheritance.*

Attitudes towards PLHA

Table 7-A shows the distribution of respondents according to stigma associated with HIV/AIDS. The table shows that majority of people seem to be against exiling those living with HIV. They also want special health care for such people and they favor permitting them to visit public places. However, in general, the respondents are against permitting HIV infected persons to marry or produce a baby. This is because of the knowledge that the HIV spreads through sexual route. Yet, it has to be noted that for each category of stigma close to 30 percent respondents expressed their ignorance about the matter.

Sl. No.		Yes		No		Don't know		Total	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
1	Should be exiled	91	14.24	351	54.93	197	30.83	639	100.00
2	Keep is isolation	197	30.83	245	38.34	197	30.83	639	100.00
3	Should be supported by village	389	60.88	50	7.82	200	31.30	639	100.00
4	Should be treated with other patients in hospital	281	43.97	158	24.73	200	31.30	639	100.00
5	Should be provided special care by health care facilities	436	68.23	6	0.94	197	30.83	639	100.00
6	Should be allowed to	109	17.06	319	49.92	211	33.02	639	100.00
7	Should be allowed to be a parent	68	10.64	359	56.18	212	33.18	639	100.00
8	Should be allowed to mix with others	306	47.89	135	21.13	198	30.99	639	100.00
9	Should be allowed to visit public places	330	51.64	111	17.37	198	30.99	639	100.00
10	Has got HIV as deserved	215	33.65	220	34.43	204	31.92	639	100.00

Table 7-B presents responses to questions regarding how to deal with PLHA and sex. The responses are found to vary according to sex. In general men are of the view that the PLHA should not be exiled (68.71 percent) and should be supported by the village (80.67

percent). An overwhelming majority of men are also of the view that they should be provided special care by health care facilities (90.49 percent). A majority of men respondents say that they should be allowed to mix with people (60.43 percent) and should also be allowed to visit public places (68.71 percent). Thus the respondents are not against helping PLHA. 59.20 percent of them say that they may be treated along with other patients. However, they are afraid that if the PLHA stay with others the virus may spread to others. Consequently, the opinion on whether they should be kept in isolation is divided. Thus the number of those who say that PLHA should be isolated and those who disagree with this are almost equal. 46.32 percent of the men respondents say that the PLHA should be kept in isolation. In other words the dominant opinion among men is that the PLHA should be provided all support but while living closely with them extra precaution may be required so that the virus does not spread to others. People are also of the view that the PLHA should not marry and should not be allowed to produce children. These data lends a partial support to the stigma theory. *The source of the stigma is that many respondents compare it with other types of deadly viruses which are contagious in nature.*

Women who are less knowledgeable about the nature of the virus are more uncertain about how to respond to HIV positive persons. Yet they also say that the PLHA should not be exiled (40.58 percent), they should be supported by the village (40.26 percent), and should be provided special care by health care facilities (45.05 percent). Proportionately more women are in favor of not isolating PHLA (31.31 percent) than in favor of isolating them (14.70 percent). However, more than half of them are uncertain which makes their response less effective. Interestingly, lesser percentage of women (14.06) than men (52.45) say that an HIV infected person got what he/she deserved. This may be partly due to the reason that among men HIV is associated with moral violation – caused mostly by desire to seek pleasure, and among women with compelling economic circumstances.

TABLE 7-B : DISTRIBUTION OF RESPONDENTS BY STIGMA ASSOCIATED WITH HIV/AIDS AND SEX													
Sl. No.	Suggested treatment to be given to HIV positive person	Men						Women					
		Yes		No		Uncertain		Yes		No		Uncertain	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
1	Should be exiled	73	22.39	224	68.71	29	8.90	18	5.75	127	40.58	168	53.67
2	Keep is isolation	151	46.32	147	45.09	28	8.59	46	14.70	98	31.31	169	53.99
3	Should be supported by village	263	80.67	33	10.12	30	9.20	126	40.26	17	5.43	170	54.31
4	Should be treated with other patients in hospital	193	59.20	105	32.21	28	8.59	88	28.12	53	16.93	172	54.95
5	Should be provided special care by health care facilities	295	90.49	3	0.92	28	8.59	141	45.05	3	0.96	169	53.99
6	Should be allowed to marry	82	25.15	208	63.80	36	11.04	27	8.63	111	35.46	175	55.91
7	Should be allowed to be a parent	50	15.34	237	72.70	39	11.96	18	5.75	122	38.98	173	55.27
8	Should be allowed to mix with others	197	60.43	100	30.67	29	8.90	109	34.82	35	11.18	169	53.99
9	Should be allowed to visit public places	224	68.71	73	22.39	29	8.90	106	33.87	38	12.14	169	53.99
10	Has got HIV as deserved it	171	52.45	123	37.73	32	9.82	44	14.06	97	30.99	172	54.95
	Total	326	100.00	326	100.00	326	100.00	313	100.00	313	100.00	313	100.00

Conclusion

This paper shows that the level of knowledge about RTI/STI and HIV/AIDS among adolescents and young adults in Lalitpur district of UP is poor, particularly among women. Although a large percentage of them have heard about HIV/AIDS, mainly through radio and TV, there are gaps in their knowledge and there are also several misconceptions. Only about 28 percent respondents think that HIV cannot be treated. The most important sources of information for the people have so far been radio and TV which obviously are not good for providing detailed and correct information about safe practices. The work done by mass media has to be supported through special campaigns and interpersonal communication. The nature and strategies of interpersonal communication need to be designed according to the social context. Women cannot refuse sex to husband. It is seen to be husband's right. Refusal on the part of women can lead to physical and mental violence. One good thing is that the dominant opinion among men is favor of providing all support to PLHA. Less than one-fourth men and less than 6 percent women want them to be exiled. Since they equate HIV with deadly, contagious diseases they say that while living closely with them extra precaution may be required so that the virus does not spread to others.

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