Condoms and Viagra: An exploration of processes and forces that shape notions of sexuality and policies

Jayashree Ramakrishna

Introduction

Examination of the development, propagation, acceptance and use of condoms and Viagra provides a keen heuristic device for exploring contexts, processes and factors that shape sexuality and policies related to sexuality. Juxtaposing condoms and Viagra affords sharp contrasts, which focus attention on cultural and societal norms, religious injunctions, and perceptions of femininity and masculinity, in the context of nationalism and the neoliberal economy. This understanding might help to improve ways of identifying and influencing these processes.

One such process, medicalization, has been a major intellectual trend of the 20th and 21st centuries. Increasingly, medical and biomedical modes of thought dominate the discourse on sexuality, and the expansion of medical authority over many domains that were hitherto considered social conditions or life experience is unquestioned. For instance, life processes such as birthing, going through menopause (Gunson, 2010), aging and dying (Seymour, 1999), conditions such as shyness (Scott, 2006), obesity, infertility (Becker & Nachtigall, 1992), sexual behavior (Hart & Wellings, 2002) and domestic violence, as well as "risk factors", have come under the purview of medicine. This medicalization of society, Conrad (2007) notes, has resulted in transformation of the human condition into treatable disorders. Recasting social conditions as disease in the biomedical framework has drawn attention away from the social, cultural, economic and political causes that influence

these "diseases". Such formulations make it feasible to retain the status quo and offer biomedical solutions. Thus, medicalization can be conceptualized as a form of social control (Zola, 1972; Lock, 2003) that aids in the perpetuation of social norms (including gender and sexual norms); and as a means for biomedicine to acquire power and authority (Friedson, 1970). Medicalization is not solely due to medical professionals. The pharmaceutical industry, biotechnology (Clarke et al., 2010) the development of consumerism, direct advertisement to consumers (Conrad & Leiter, 2008) as well as insurance and government policies play a significant role (Busfield, 2010). The neoliberal economy, the push towards a free market, and deregulation have served to reinforce the dominance of biomedicine, technological interventions and the pharmaceutical industry.

Reframing conditions as illness or as conditions amenable to cure or management has served to remove the stigma and self-blame and, to a certain extent, to alleviate suffering. However, medicine, rooted in the values of the dominant society, tends to reinforce its norms, especially as they pertain to gender, sexual orientation and behavior. Medicalization privileges a narrow concept of "normal" and values conformity to it. It is largely not tolerant of divergence and shies away from accepting a wider range of normality. Anything outside the bounds of this strict definition of normal is defined as pathological, a disorder, as exemplified by the case of erectile dysfunctions. Some, though, challenge such an understanding of sexual dysfunction, believing erectile dysfunction (ED) to be part of the natural aging process, with which one learns to live (Potts et al., 2006) (very much the traditional Indian view). The medical profession seems to show some sign of partially endorsing this view: of late, two prestigious medical journals, the *British Journal of Medicine* (2002) and *Lancet* (2007), have brought out issues with a focus on medicalization and resurrected the views of Illich (1975).[50] Some others hold that advertising has created a sense of inadequacy in older men. On the other hand, medicalization of unpleasant or unpalatable conditions such as impotence makes

50 Lancet, 369(9562), February 24, 2007, includes Essay Focus: Medicalisation in the 21st Century; British Medical Journal, 324, April 13, 2002. Retrieved from http://www.bmj.com/archive/online/2002/04-08.

them more acceptable.

Centering on the Indian experience, this paper teases out the cultural, social and economic processes and factors (including vacillations in international policies) that have inhibited the acceptance of condoms, the persistence of the 'culture of silence' with regard to sexuality, and the increasing intolerance of diversity. While condoms and sexual education have been part of public health and cultural discourse, Viagra has, essentially, remained confined to the medical arena. Nevertheless, in a short time, the process being eased by the neoliberal economy, Viagra has become accessible and gained acceptance. The juxtaposition of condoms and Viagra in the Indian milieu also highlights the tension between preventative and curative aspects of biomedicine, and the privileging of the latter over the former. The differing standards used for approval of female condoms, and research (to be discussed later in the paper) pointing to the utility of Viagra for treating sexual dysfunction in women on antidepressants is telling. The paper ends with a brief discussion of innovative responses to the disregard and violation of sexual rights, and the effective use of media and community mobilization (both traditional and Internet-based) to bring the issue to the forefront of national attention.

The concept of the condom – a device to encase a man's erect penis as a physical block to the entry of ejaculated semen into the body of a sexual partner – has been known for a long time. Historically, 'condoms' were made from various substances ranging from horn or animal skin to oiled silk (Collier, 2007). Modern condoms, used as a contraceptive to prevent pregnancy and/or the spread of sexually transmitted illnesses, are usually made of latex or polyurethane. This is presently the most commonly used barrier-method of contraception. The efficacy of condoms in preventing conception is well documented, and the failure rate among those who use them correctly and consistently is very low.

The active ingredient in Viagra is sildenafil citrate, an enzyme that regulates blood flow to the penis. This drug was being tested for treating angina pectoris, a symptom of ischemic heart disease. While

it was found that the drug has little effect in angina, it was observed to induce penile erections. This fortuitous discovery led to the patenting of this molecule in 1996, and in record time, in 1998, the US Food and Drug Administration approved it as the first oral medicine for erectile dysfunction (inability to sustain a satisfactory erection to complete intercourse).

Sildenafil citrate also relaxes the arterial wall. It is effective in a rare disease, pulmonary arterial hypertension (PAH), and ameliorates symptoms of heart failure. After seven years Pfizer submitted to the FDA an additional registration for sildenafil use for this indication. Sold under the brand name Revatio, the 20 milligram tablets are white and round to differentiate them from the distinctive blue Viagra, which are informally known as 'bolt from the blue'.

Taking sildenafil with medications or other substances that contain nitrate causes a serious decrease in blood pressure and results in fainting, stroke or heart attack. Nitrates are also found in recreational drugs such as amyl nitrate poppers. Sildenafil is contraindicated for persons who have heart disease, diabetes, high blood pressure or high cholesterol. Alpha beta blockers, azole antifungal medicines, and rifampicin are inadvisable. There is also an adverse reaction with antiretrovirals prescribed to those who have HIV infection. Some report possible negative effects in those who smoke or use alcohol or are over 50 years of age. However, these interactions and contraindications are not highlighted, many of them coming to public notice only after users have complained about problems.

The rest of the paper demonstrates how cultural notions as well as larger macro-processes affect the construction of sexuality and the course of action taken. The play of power is crucial to understanding these dynamics, be it between the genders, the majority and the minority, the state and the individual, global and local/regional economies, or overarching global processes.

Concepts of masculinity, manhood and fertility in India

As in most patriarchal cultures, in India sexual prowess is associated with manhood, masculinity, strength, vigor and procreativity. Ayurvedic tradition (Indian system of medicine) sees semen as one of the most important of the seven vital fluids of the body; harmony of all these fluids produces good health. Semen is precious; it takes 40 days for 40 drops of food to be converted into one drop of blood, 40 drops of blood are needed to make up one drop of bone marrow and 40 drops of bone marrow to make one drop of semen. Thus it is understandable that men want to conserve this precious fluid, and put it to its right use, i.e. for procreation.

Fertility in women is valued, and motherhood is hallowed. Marriage is almost universal. The most sacred duty of parents is to arrange the marriage of their children, especially that of their daughters, to free them from the confines of maidenhood. A woman's status in society is affirmed when she has a child, particularly a son. Traditionally, couples are expected to have children soon after marriage. Elders do not advise delaying pregnancy, and young married women say that their doctors do not advise them to use contraceptives till after they have had their first child. Stories abound of couples who postponed pregnancy, only to find that they could not conceive when they wanted to.

Men's life stages are well laid out. Childhood and youth (till 21 years of age) are for learning and developing. During this time, excessive interest in sex is thought to be detrimental. Celibacy is advocated, and conserving sexual energy is thought to increase physical strength and vigor as well as intellectual acumen and spiritual quotient. For instance, wrestlers are followers of Hanuman and remain celibate to maximize their physical strength. Similarly, men in the pursuit of knowledge or God do the same. The next stage, a period of another 21 years, is that of the householder, the time for having children, raising a family and fulfilling worldly duties. After that, during the hermitage and sanyasi stages, men are supposed to be essentially celibate.

Alongside these views, there is an opposing notion that sexual release is important, as without it, the body heats up and a man loses mental balance. Concern about nocturnal emissions and premature ejaculation and anxiety about sexual performance are widespread. One of the most common complaints in men is "weakness" (Verma & Schensul, 2004). "Quacks" and various types of sexual specialists, from those who operate out of roadside shacks to sexologists in modern clinics, cater to men who have these conditions.

Pleasure underlies all sexual discourse; it is seen as a potent force that can overtake all other concerns and therefore needs to be regulated. Any form of interaction or even the social intermingling of young men and women is frowned upon. Sexual attraction and desire are thought to be irresistible and the norm of early marriage is a tacit acknowledgment of the sexual needs of both young men and women. Concern about not "keeping" a marriageable girl at home is great and seen as a great responsibility and burden, for something untoward may happen. It is well acknowledged that men are easily aroused and find it difficult to control their desire, but there is some ambivalence about the sexual nature of women. It swings between the notions of women as devi who are put on a pedestal and viewed as essentially asexual, embodying the virtues of motherhood, devotion, goodness, nobility and sacrifice for the larger good, and the idea of women as temptresses with insatiable desire, who entice "helpless" men.

Condoms are seen as inhibiting sexual activity by restricting intimacy and skin-to-skin contact and interfering with spontaneity. Moreover, the use of condoms, which are seldom seen as contraceptives, is perceived as a sign of distrust of the partner. This is especially true in a country where most women who have had two or three children opt for permanent tubal ligation/tubectomy and there is no need for contraception. Couples in India, especially in crowded urban low-income areas, have little privacy and time for sexual intercourse let alone using condoms. Purchasing condoms is embarrassing, and disposing of used condoms is a challenge. Further, in many cases sex takes place in the context of alcohol use and violence, in which situations the woman has little power to negotiate condom use.

Sex and sexual issues are not part of the cultural or general discourse, and the culture of silence pervades. For one, there is no commonly understood language. Medical/health professionals are comfortable talking in terms of sexual anatomy, physiology and disorders. Literary language in the area is well-developed but the local languages offer very little that is not euphemistic and vague or vulgar and crude. Moreover, as a female participant in one of my early research projects who happened to be a sex worker noted: "Good women do not talk about sex. We may have sex but we do not talk about it". This idea is widely prevalent even in the health sector. This, coupled with the middle-class reticence about all matter sexual, means that there is little discussion.

Population control programming

A brief discussion of the Indian National Family Planning Programme will provide a historical perspective opening an understanding of current attitudes towards condoms. The program, seen as crucial to development, was one of the first programs to be instituted after Independence in 1947.[51] It received funding and technical support from USAID and technical assistance from donors such as the Ford Foundation.

Essentially, it was a top down program. Indian policymakers prioritized controlling population growth. This, however, was not the priority of the common man or woman, who valued fertility and procreation. Agrarian families with many children could better meet high labor needs. Children were also social insurance and male children were especially valued (Mamdani, 1972). Initially, the program was a clinic-based approach following the traditional notion that contraception is a woman's responsibility (Harkavy & Roy, 2007). Intrauterine devices were preferred, as a semi-permanent method, controlled by physicians who inserted the IUD and removed it. Healthcare

51 See Harkavy and Roy (2007) for detailed discussion of the evolution of the Indian National Family Planning Programme.

workers minimized the complications and side effects – infection, pain, and bleeding or general malaise. Women complained about such effects but saw no other option. Condoms generally carried the negative connotations of being associated with prevention of sexually transmitted diseases and sex with casual partners, "illicit relationships" and sex outside marriage.

When this method was found to be ineffective in reducing the population growth, the emphasis shifted to vasectomies. This was the first time a male-centered method was used and it was approached with much apprehension: both men and women felt that it would weaken the man and men saw it as an assault on their manhood. However, because relatively high incentives were provided in cash and kind, men, especially the rural poor, participated. Healthcare workers who had to meet targets persuaded or coerced men into having vasectomies.

In 1975, the court declared the prime minister's election illegal. In response, the government declared a national internal emergency. Democratic civil rights, including reproductive rights, were suspended. The Indian administration had been confronted with high population growth and a stagnant economy since the 1950s and accorded priority to population control in the national five-year plans. In 1976, the emergency enabled the National Population Policy, which could institute legislation to make family planning compulsory: if the state so desired, citizens were to stop child-bearing after three children. A constitutional amendment was also introduced to freeze parliamentary representation for states at 1971 levels until 2001, thus removing any incentive for states to increase their population size. Quotas for vasectomies were allocated to government functionaries, who, fearing punishment, recruited poor, marginalized and old men as "subjects".

Vasectomy camps (often in none too hygienic conditions) were opened from 1975 to 1977, carrying out 8.26 million vasectomies. Other measures such as "slum clearance" accompanied this tactic. Coercive policies of this kind had a serious backlash when democracy was restored in April 1977, and the government was soundly defeated in the elections. New administrations were apprehensive,

and family planning took a back-seat. The Family Planning Programme was renamed the Family Welfare Programme, targets for sterilization were changed, and education and motivation became the key strategies. One wonders whether a government would so rapidly be toppled because of a female-oriented family planning program.

Condoms in the Indian context

The threat of AIDS reemphasized the usefulness of condoms. In the early days, when there were no drugs for HIV treatment, the focus was firmly on prevention, and the condom was the method of choice. With the encouragement of donor agencies, condoms were promoted aggressively to a diverse audience and often with little sensitivity to or recognition of cultural mores. Voices that spoke of the need for more culturally appropriate options and a wider array of choices, such as delayed sexual debut, were not heeded. For the first time there was public advertisement of condoms and some political figures endorsed condoms, winning the approval of visiting donor representatives. Meetings, at first organized by the World Health Organization (WHO) and then by the National AIDS Control Organisation (NACO) highlighted the Thai experience with condoms, lauding the skills of Thai sex workers in motivating and convincing men to use condoms. Little attention was paid to differences between conditions of sex work in India, where it is hidden and unorganized, and in Thailand, where it is relatively organized and open, or to the commitment of the Indian government to bring about similar changes. In addition to the advertisements, the government program for the first time had counselors who could promote condoms to individuals, and condom demonstration became a part of the HIV counselors' responsibilities. Unfortunately, even though the condom was to be used by the man, it became women's responsibility to motivate, cajole and entice men to use the condom. Responsibility was given to the partner with the lesser power and the lesser ability to respond.

International agencies, using estimates suggesting that India would have a larger number of people

with HIV than South Africa, urged the Indian government to take swift and decisive action. The National AIDS Control Organisation protested that these numbers were inflated, but was disregarded. Re-estimation a couple of years later, however, using different, more accurate parameters, showed actual figures that were closer to NACO's estimations, lower than what had been predicted.

In the ensuing years three events occurred that again turned the focus away from condoms. The US Bush administration strongly advocated abstinence only, or the ABC strategy – Abstinence, Be Faithful and Condom method – in which the emphasis was on the first two options and condoms would be a mere third option. Organizations that received funds from the President's Emergency Plan for AIDS Relief (PEPFAR) were required to sign a pledge that they did not support prostitution or abortion services. They were also requested to report how many people they had counseled on abstinence and faithfulness. Those who had been championing a wider range of options felt vindicated. This proposition also resonated with the conservative elements of all the religions, and condoms were again marginalized. Decisions taken by powerful countries do not remain confined to their 'home' programs but soon find their way into other international and national programs. NACO too subscribed to this ideology and included this language in its policy and program documents. As this decision was in accordance with the thinking of the larger society, there was little protest except from civil society organizations working in such areas as HIV and gender issues.

The advent of antiretroviral therapy (ART) for HIV, especially of HAART, shifted practice to providing treatment along with care. Understandably, those who were infected wanted access to these drugs. The WHO set up an ambitious program, and made a concerted effort to make affordable generic drugs available. This brought HIV firmly back into the biomedical domain. Increasingly, the focus shifted to testing, treatment and counseling, and prevention services for the general population were again de-emphasized.

Condoms have been part of the Indian population control arsenal from the beginning of the family

planning program in the 1950s. In the early days, condoms were purchased from the United States as a part of USAID programs and then condom manufacturing began in India. Condoms have been associated with sex outside marriage, for prevention of sexually transmitted diseases. Condoms that were initially available in the government system were not of good quality. Instances of breakage and damage were reported. Early condoms were not lubricated. The new lubricated condoms did not have enough lubrication or were too oily. Storage of latex condoms in a hot and humid climate is also a challenge. This, coupled with a widespread disdain of all things provided for free by government, gave condoms a poor image.

Considering the high demand for condoms, the Indian government set up public sector unit, Hindustan Latex Limited (HLL), over 30 years ago. This company aims to make good quality contraceptives available at affordable prices at 'an arm's length of desire'. It is the largest condom manufacturer in the world, producing more than 1.316 million pieces per year (Sinha, 2007). The government subsidizes condoms, marketed under the name Nirodh (prevention), which is the local name for condoms, and distributed free of cost through the government health care system. Apart from the varieties of Nirodh (deluxe, ultra deluxe, new lubricated) HLL also produces an array of ultra-thin, dotted, and flavored premium Moods condoms. HLL's social marketing division targets those who can afford to pay only part of the commercial price. Social marketing of condoms has been taken up by NGOs; they package and sell the government or other subsidized condoms at nominal costs and accessible locations. The private sector produces more upmarket colored, flavored, slickly packaged condoms, with erotic graphics and advertisements, and markets them under exciting brand names such as Kama Sutra and Trojan.

In March 2007 HLL released a new product, a premium condom with a vibrating ring, called Crezendo. In mid-May, one state banned this condom, stating that it was a sex toy and against Indian culture. "And sex toys", noted a minister, "can have serious repercussions on the Indian way of life" (Ghosh, 2007). This action triggered impassioned debates about the relationship between Indian culture

and sexual pleasure, with common reference to Vatsyayana's Kama Sutra, and the erotic imagery of the Khajuraho and Konark temples. In a newspaper article, Sen (2007) points out that "reducing the place of sex in India to these iconic works of art and literature is to make a mockery of Hindu traditions". He goes on to quote the cultural psychologist Ashis Nandy: "erotic imagery is very much a part of Hindu texts and paintings". In the Hindu mystic bhakti tradition the devotee often views the divine as a beloved. Interestingly, the soul, even of male saints, is conceptualized as an ardent woman awaiting her beloved, and sexual fulfillment and pleasure are very much a part of the sacred domain. Similarly, Ghosh (2007) quotes Ram Nath Jha, who teaches in the Special Centre for Sanskrit Studies, Jawaharlal Nehru University, in his observation that even ancient philosophical treatises talk of sex as a source of pleasure. Kum Kum Roy, a professor of ancient India, adds that this was mainly directed towards men of the dominant elite groups.

In response, the health minister noted that the 'vibrating condom' was just a variety of condom, developed by HLL to compete with private companies. He pointed out that 50,000 condom vending machines had been installed at bus stops, washrooms, petrol pumps and dhaba (road side eateries), with plans to increase the number to 100,000, and asserted that Crezendo would not be marketed in states that did not want it. The HLL spokesperson also said they would withdraw the product if asked to do so as they did not "want to create any controversy", even though 130,000 pieces had been sold since the launch and no complaints had been received from users or the government (Sinha, 2007).

Female condoms

Female condoms are described as a "traveling technology", an interaction of technology, diffusion and donor agencies that opens a possibility for greater women's empowerment and sexual autonomy. Female condoms made of latex (FC1) were first developed in 1993. Those of the second generation, FC2, made of polyurethane or nitrile polymer, are thinner, softer and quieter, as well as conducting

heat and preserving more sensation, and not requiring special storage as they are unaffected by heat and moisture. Further, they can be used with oil-based lubricants though not all proponents recommend this. In 2007 HLL launched the first female condom, called Confidom, in India. More than 0.5 million pieces have been sold and NACO hopes to increase this to 1.5 million by 2015.

The FDA classifies male condoms as class 2 devices, which need to pass tests only for leakage and breakage. However, it places female condoms as class 3 devices – in the same category as pacemakers, heart valves and silicone breast implants – requiring them to pass more stringent clinical tests. Some in the FDA question whether further clinical trials are necessary to determine how FC2 prevents pregnancy. The Female Health Company (FHC) did not think this necessary, as the product has been used by 12 million women in 77 countries and 3.47 million female condoms were sold in 2008.

The FDA has cleared FC2, and it can be distributed by USAID. Some questions are still open: Is it good or bad to have separate standards for male and female condoms? Does this regulation protect the safety of women? If so, what about all the women in developing countries who have been using such female condoms for more than ten years; have they been guinea pigs? Or are American women losing out?

Emergency Contraceptives

Methods that need to be used correctly and consistently, that require engagement, dialogue, negotiation, and skill building, where the choice of use lies with the person, find little emphasis in the Indian family planning program. In the current program, which promotes family planning in the context of reproductive and child health and rights, promotion of dual purpose condom use is mentioned. Emergency contraception (EC) is also advocated for unprotected intercourse and for failed dual-purpose condom use (torn condom implying failure of Nirodh). The possibility of the

condom's not working, of its slipping or tearing, is a recurrent, unrealistic, fear that is bolstered by such statements. The state's lack of conviction about the efficacy of condoms is demonstrated. The efficacy of medications, on the other hand, is seldom questioned.

Emergency contraceptives have received special treatment. The Drugs and Magical Remedies Act has been reviewed on a case by case basis to allow direct advertisement by the private sector, and these advertisements are being aired on television and displayed on the back of autorickshaws. A news item (Chaudhuri, 2009) noted that though emergency contraception was made available over the counter to prevent unnecessary abortions, women and girls were using it repeatedly – in place of regular contraceptives – resulting in serious reproductive problems. This should be a serious concern in a country where more than half the women are anemic. It is not surprising women and girls are using EC as a primary contraceptive, as advertisements such as the one in box 1 can easily be misinterpreted to mean the EC is a contraceptive. Further, this misuse should have been anticipated as women and girls have long been used to taking hormonal pills to postpone menstrual periods during religious and social functions.

Box 1: Advertising Emergency Contraception

This news story has not been followed up and there has been no public outcry.

i-pill emergency contraceptive pill. Just one pill within 72 hours of unprotected sex is all it takes to prevent a possible pregnancy and a traumatic abortion. Because prevention is better than abortion. Isn't it?

Talking about sexuality and sexual issues

To make informed decisions about sexual issues requires a climate that allows dissemination of accurate and relevant scientific information and a space for the holding of diverging opinions and views. I shall now discuss some salient data regarding the need for sexual education. A survey of 1566 peri-urban (60 kilometers from Bangalore) students in Karnataka revealed the need for sex education that considers gender differences (NIMHANS & Belaku, 2006). When questioned about sources of reproductive and sexual health information, most girls cited female family members (mother, 42%, older sister, 24%), friends, 22%, and teachers, 14%. Boys, though, presented a different picture: friends, 50%, relatives/neighbors, 30%, teachers, 20%. Many more boys cited media as a source of information: television (boys, 46%, girls, 31%); science programs (boys, 27% and girls, 15%); action television (boys, 18%, girls, 3%); sex books (boys, 16%, girls, 2.6%); sex films (boys, 12%, girls, 1%); posters (boys, 12%, girls, 0.6 %). Sex books may be cheap pornographic materials in the local language, often with western graphic materials. We also found a range of grey literature, and pseudo-scientific literature, some written by bona fide medical specialists and others by self-styled "sexologists". They contained Q & A on many sexual issues, including many on premature ejaculation, masturbation, and loss of strength, interspersed with titillating case studies. These magazines were not available in book stores but sold on pavements, streets, bus stands and railway stations. Often they had titles like 'Ideal Husband and Wife'. Other favored magazines such as *Police News* contained highly graphic descriptions of murder and rape. Sex films could be blue films or low budget films with high sexual content and violence. These media tended to reinforce boys' anxieties and legitimize the use of coercion, likening coercion to pleasure.

Key informants felt that in the three years since cable television had become available, the students had become "fast". English language television had become accessible, especially to boys. They reported watching a program called 'Silk Stalking' on the AXN network, which had an opening

shot of a woman putting on stockings. They also watched fashion TV. It is interesting that both key informants and boys find Western television programs and films "sexy". There is little mention of the local language movies, which have highly sexually suggestive dances.

When questioned about their knowledge of pregnancy prevention, 73% of girls and 50% of boys said they did not know. Of those who knew, boys commonly cite condoms (23%), followed by oral contraceptives (8%), abstinence and abortion (6%), and surgery (4%). Girls had less knowledge about all methods except oral contraceptives (13%). Only 5% mentioned condoms; 3%, abortion and surgery; and 2%, abstinence. Fourteen percent of boys and 2% of girls thought premarital sex was acceptable if the girl does not get pregnant. Analysis showed that the common sources of information had low association with accurate information about contraception.

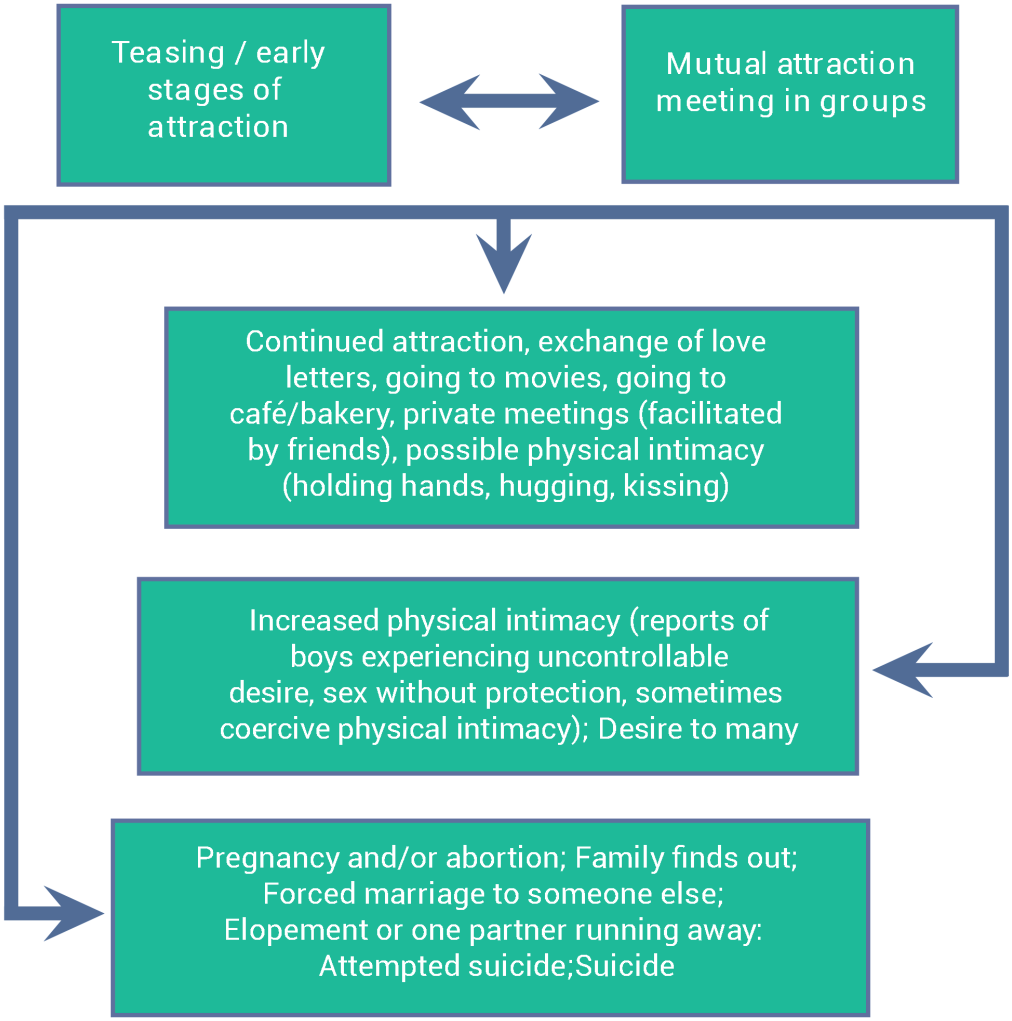
India lacks a comprehensive sex education policy; sex education arises in the health context, involving the need for education on contraceptives and prevention of HIV. Some civil society organizations view sex education as a rights issue but these are in the minority. Sex educational programs in schools do not consider this gender variation in the source of information among students. The finding also brings into question the acceptability of teachers conducting sex education programs. The usual pattern is to assign sex education/family/life skills education to science teachers, as they know how to teach biology, but these teachers usually have little skill in communication or discussing intimate issues. Students' concerns about why they feel a certain way, whether it is right or wrong, are seldom addressed. There is little space for debate and discussion, a space that many girl students felt they needed and that to some extent was met by the study. The boys, on the other hand, felt discussion about sex would arouse them and that such discussions were not necessary.

This study included qualitative data that illuminated boy–girl relationships. Students from rural areas had more interactions with the opposite sex, and these relationships were rarely platonic. Surprisingly, Valentine's Day and Rose Day were very popular. Students said that it is acceptable to

show your interest and love on these days. In a society that lacks a script for boy–girl interaction, expression of love or interest and communication by notes and letters are common. Popular love songs from films are also a means students use to communicate with persons they are interested in.

Box 2: Patterns of attraction amongst youngsters

Representation os reported concepts of attration, love, imtimate physical relationships and possible outcomes*



* The represantantion is not meant to imply a linear and/or underectional progression.

Concepts of love and stages of love relationships are patterned (see box 2). Teasing is part of the initial stage; girls see unwelcome actions, at times bordering on harassment, as problematic (NIMHANS & Belaku 2006, p. 64). Family reactions to love relationships are usually negative and even life-threatening. Girls receive little support from their families if they report teasing and harassment; instead, they are scolded and beaten. They may be asked what they did to invite such attention, and parents may threaten to take them out of school. Options for a girl in a serious relationship are few. Elopement and marriage is one, if the boy too opts for marriage; or parents may coerce girls to marry a partner of their [the parents'] choosing as a means of averting the consequences of a socially unacceptable relationship. The lack of social support for the girl is striking. If she becomes pregnant, she has few choices – abortion is one, suicide or an attempt at it is another. The media and adults reinforce the notion that it is not only an acceptable but a better option where a girl has brought such dishonor to her family.

This is the context of the debate over the need for sexual education. Recognizing the reality of the prevailing situation in the country, the National AIDS Control Organisation prepared educational materials in 2007. Initially five and eventually twelve states banned the material, and one sent it for review, stating that sex education encourages sexual permissiveness in children. NACO clarified that the material with pictures was meant for teachers in senior secondary schools. Still this was thought to be "too brazen and explicit", and hurtful to people's cultural sensitivity. An ex-minister of the conservative Hindu party, Murali Manohar Joshi, opined that sex education would create an "immoral society" and lead to a collapse of the education system. "The proposed sex education modules are an encouragement rather than education about sex", he observed and called for boycotting central government schools if they took up sex education.[52] The director took a strong stand and commented: "Banning sex education is hypocrisy on their part. It is rubbish and totally

52 "Joshi scandalised, but Renuka says let's talk sex," IBNLive.com, July 17, 2007, Retrieved from http://ibnlive.in.com/news/joshi-scandalised-but-renuka-says-lets-talk-sex/45023-3.html.

nonsense that we don't need sex education. Our survey has shown that teenage boys are indulging in casual sex. Fifteen percent of total deliveries in India involve teenage girls". She warned that banning educational material would adversely affect poor students, who depend on schools to provide the right information. She went on to say: "If sex education is not imparted to children, they could make wrong decisions that could have an adverse impact on their future and health".[53]

A year later NACO published a teachers' handbook without explicit pictures or words like intercourse, condoms, and masturbation. The director, finding the issue too important to take a strident tone, thought the "middle path" adopted by NACO would keep the dialogue going. Thirty-three NGOs, who were involved with sexual rights, women's issues and HIV, reviewed the content and felt that the study material is out of sync with the reality of adolescence. So cagey is the text about offending sensibilities that the chapter on conception does not even mention intercourse. One NGO reviewer noted that the section on prevention of HIV transmission makes no mention condoms. Experts cite studies showing that adolescents are sexually active and contend that not talking about safe sex is irrational. Asking young people to abstain will make them curious and they will experiment.

Several prominent organizations have drafted a petition in which they provide ample documentary evidence and cite international agreements and rights, calling for "the urgent revision of the AEP (Adolescent Education Programme) curriculum on sexuality education for all children to be reflective of the 'best interests of the child' rather than proscribing narrow notions of morality, culture and tradition. This would be the first step in creating a comprehensive sexuality education that is gender-sensitive, age-specific and free from negative value judgments, which is essential to help young people lead lives free of fear, disease and violence, and to enjoy physical and mental health and

53 "NACO to review sex education material," IBNLive.com, July 19, 2007, Retrieved from http://ibnlive.in.com/news/naco-to-review-sex-education-material/39925-17.html.

wellbeing".[54]

Despite these setbacks, NACO reports that condom sales increased by five percent during the six months from April to September in 2008. This was attributed to an extensive mass media campaign to encourage discussion as a means of promoting condoms as a socially acceptable health product. TV and radio advertisements and a mobile ring tone to promote the concept of safe sex reached nearly 150 million adult men across India. Half a million people are reported to have downloaded this ring tone, which chants 'condom, condom, condom'. However, the director reported that the campaign to install condom vending machines at public places, including petrol pumps, subways and bus stops, was not as successful. She said: "We were a little mistaken in that effort. In our excitement we installed machines at places which were too public … For example, rather than installing the systems on the roadside, we should have done so in places like toilets to lend some privacy to a potential customer".

NACO is still wary of extending 'safe-sex' campaigns to include the gay community directly. The director said: "There is no point openly promoting the use of condoms by gays at present as it may provoke a backlash. We, however, work through a range of NGOs working on the ground which promote safe-sex for homosexuals".[55] Therefore, with condoms, it is one step forward and two steps backwards. Shifting policies in response to internal and external pressure and the continued reluctance to promote condoms undermine the development of a clear policy.

54 "Open letter on sexuality education." Retrieved from http://www.tarshi.net/programs/public_edu/open_letter_sexuality.asp.

55 "India plays it safe, condom sales go up," Press Trust of India, November 19, 2008. Retrieved from http://content.ibnlive.in.com/article/14-Nov-2008health/india-plays-it-safe-condom-sales-go-up-78181-17.html.

Viagra, generics and Ayurvedic medicines

The Google search engine brings up 63,000,000 hits for the word Viagra on the World Wide Web and 720,000 on Indian web pages.[56] This includes other not necessarily biomedical products such as Ayurvedic Nights and Vita Ex Gold. It is said to be the most widely advertised substance on the Internet, and the subject of a large proportion of spams. In 2005 Microsoft and Pfizer teamed up to file lawsuits against spammers as well as the companies they advertise, especially if they use the term Viagra in their domain name.

Virility, potency, energy, strong sex drive, and vigor are associated with sexual prowess as well as being potent in the sense of having power, or ability to influence. The capacity to achieve an erection or to reach orgasm is also seen as a symbol of manly courage and strength. Conversely, the term impotence not only indicates the inability to have an erection but also general powerlessness and ineffectiveness. The term erectile dysfunction, not having these connotations or symbolic associations, is patently a medical condition.

In keeping with the Ayurvedic concept of the importance of semen, men are concerned with sexual performance. Widely used is a preparation (called Vita Ex Gold) by a reputable Ayurvedic pharmaceutical company, Baidyanath. It is said to contain gold and silver *bhasma* (ashes) and fourteen potent herbs that "increase pleasure and heighten happiness for a longer period". It recharges, reactivates, and refreshes vitality and vigor. Male sex workers (*koti*) that we interviewed reported that they ask the clients they find attractive to take this preparation so that they can "enjoy" for a long time.

56 See Conrad and Leiter (2008) for a discussion on the similarities between direct to consumer advertisement for erectile dysfunction and the strategy adopted in the nineteenth century for the sale of patent medicine.

The information provided on the website is very much in the holistic Ayurvedic tradition. It emphasizes the psychological origin of sexual problems. It states that sex is an integral part of daily life (*dinacharya*). Frequency of sex depends on the constitution of the individual. The website recommends Vajikaran therapy (virilification), that part of Ayurveda that enhances male fertility and potency for more and better sex. However, it points out that any misuse of it may open up a deluge of emotional and psychological complications. For best results, it recommends that the partners should be physically, emotionally and spiritually involved with each other. Further, it explains that touch, smell, food, music and ambience play a vital role in developing, increasing and prolonging intimacy.

Premature ejaculation is identified as the most common problem that shortens duration of intimacy and hinders the couple from attaining orgasm. The most frequent cause of unsatisfactory erection or sexual deficiency is identified as psychological, though men are advised that pathological conditions need to be ruled out. It states that even after treatment the patient's self-confidence needs to be restored. It notes that with the current hectic lifestyle and advancing years, the male desire for sexual intercourse tends to taper off early and sexual intimacy tends to become unsatisfactory. Ayurvedic medicines can rectify this. Medicines are taken with fruit juice, warm milk, honey and other health enhancing substances.

Thus the medication is only a part of the strategy to improve and strengthen sexual function. In this view the problem is located in the person and the social situation. Before Viagra, in biomedicine, the problem was thought to be largely psychological and came under the purview of psychologists and psychiatrists. Physical interventions such as penile insertions and vacuum pumps were seldom used. In contrast, the current biomedical construction of erectile dysfunction pays little attention to factors that lie outside the body, as it is treatable with medication regardless of the cause, be it physical, psychological, interpersonal or familial (Potts et al., 2006:490). Its reductionist view of the body assumes that a healthy functioning male body must be capable of producing a normal erection

that delivers sexual satisfaction (via penetrative sex) to both the man and his partner.

Pfizer deemed 2005 as an opportune time to launch Viagra in India, after India signed various trade agreements and had to fall in line with the patent regime. Earlier Indian patent laws did not recognize product patents, only process licenses. Reverse engineering was used to develop different processes for producing the same product. Hence, generic Viagra (i.e. sildenafil citrate) produced by multiple cost based local and launched it in 30 cities. A tablet of 100mg was priced at about Rs.600, as compared to Rs.25 for the competitors was already present in the market. As India is considered to be a lucrative market, with an estimated 70–90 million men suffering from ED and market research suggesting an existing demand for ED medication in the grey market, Pfizer planned to convert this demand into sales of the original product.

Pfizer imported Viagra, with its distinctive hologram, from France and launched it in 30 cities. A tablet of 100mg was priced at about Rs.600, as compared to Rs.25 for the generic version. In spite of this higher price, Pfizer reported that sales in the first month far exceeded expectation and that it had succeeded in capturing 1.8% of the market, worth Rs.800 million (US$16 million). Pfizer's strategy was to promote Viagra to doctors (urologists, endocrinologists, psychiatrists and STD specialists) and to inform them that the drug was available at a chemist located close to their clinic/hospital. Sales were higher in top-rung cities, and there was hope that this strategy would 'yield more prescriptions in the ensuing years' in other cities as well. Pfizer's strategy was to educate men, potential patients, and doctors about ED, by distributing 'scientific' information, in addition tracking 750 prescriptions given by doctors. With initial success, Pfizer announced that it was confident of capturing 10% of the market within two years.

However, things have not gone well for Viagra in the Indian market. The company has been reticent about Viagra sales figures since March 2006. Local competition has been stiff, with the top three players controlling 65% of the market share. Apart from this, inexpensive counterfeit drugs have

also been packaged and sold as Viagra, and since 2007 growth of the ED market in India has been sluggish.

In a television program organized to mark the tenth anniversary of Viagra, panelists remarked that sexuality in India is either giggled about or frowned upon and that there are no mature debates on it. One asserted that sexual culture is related to youth culture and marginalizes adults – people over 45. That such adults could also want to enjoy a sex life is not even considered a possibility in mainstream society. A urologist agreed with this point of view. He remarked that patients intending to undergo prostate surgery, when warned that their sex life might diminish, said that they are well past that. "But we have to give them the message that it's not over, they are still young enough to enjoy sex," he said. "You've got to give the person a good, healthy life, not just treat their conditions", he explained.[57] Ironically, he added, thanks to the discovery of the correlation between erectile dysfunction and heart attacks, more and more doctors are getting involved in dealing with their patients' sexual histories. This account gives a good indication of Pfizer's market strategy and its attempt to redefine the sexuality of older men. Even though there have been several reports of deaths (109 in Britain) and other health problems related to Viagra use, the misuse of Viagra and the dangers therein have not entered the public discourse.

Viagra for women: new markets

More recently, sildenafil has been found to relieve antidepressant-related sexual dysfunction in women. Antidepressants that control the availability of the brain chemical serotonin are the most commonly prescribed drug for adults in the U.S., where an estimated 160 million prescriptions are written per year. It is estimated that 30 to 70% of women prescribed the drug subsequently suffer

57 "Viagra sales high but sex talk still taboo in India." CNN-IBN, March 24, 2008. Retrieved from *IBNLive.com*, http://ibnlive.in.com/news/viagra-sales-high-but-sex-talk-still-taboo-in-india/62128-17-single.html.

from sexual dysfunction and many stop treatment for this reason (Nurnberg et al., 2008).

It is interesting to examine how this study was conducted. A prospective, parallel group, randomized, double-blind, placebo-controlled, eight-week study, it consisted of 49 eligible patients in the experimental group who received sildenafil and 49 included in a control group who received a similar blue pill. Subjective perception of sexual desire, physical signs of arousal, enjoyment, changes in pain and discomfort and an unclear item termed "partner" were recorded. Women who took Viagra reported significantly more side effects than in the control group.[58]

Both groups improved but the reported change in the women taking Viagra was significantly more/better. It is not clear what this 'better' means, as the authors (Nurnberg et al., 2008) note serious limitations.[59] Yet the authors go on to conclude that it seems clear that effective evidence-based treatments for treatment-associated adverse effects can lead to improved outcomes for major depressive disorder and other conditions requiring extended medication treatment. It is stated that the study was supported by an independent investigator-initiated grant from Pfizer, Inc., which provided sildenafil and the matching placebo but had no other role in the study.

58 Headaches (43% vs. 27%), flushing (27% vs. 0%), transient changes in vision (14% vs. 2%) were more common in the experimental group, while nausea (16% vs. 2%) and anxiety (6% vs. 2%) were common in the control group.

59 'Lack of biological criteria for female sexual dysfunction, assessment instruments with high correlation, and use of analysis-of-variance models for samples assigning integers to ordinal categories of an outcome measure when the phenomenon in question has an underlying continuous scale' (Nurnberg et al., 2008: 403) as well as, reliance on scoring based on subjective responses to different questions for men and women, and the influence of the role of expectations, adverse effects, and treatment response on the outcomes.

Campaigns

Even after more than sixty years of freedom from British rule, the Indian middle class is still burdened by a Victorian puritanical outlook and morality. This colonial legacy, combined with reconstructed notions of the golden Indian past, has led to rejection of the plurality, diversity and syncretic nature of Indian society. The outspoken vocal group that is in the forefront of policymaking, planning and implementation has a disproportionate impact. The diversity of views held by the silent majority is masked. People hesitate to question, or to express divergent views for fear of being branded as immoral, unpatriotic or not subscribing to the Indian tradition. Space for dissension has reduced. At the same time, women are increasingly being educated, getting well-paying jobs, becoming more mobile, dressing differently, and being more assertive.

I would like to present a campaign that using information technology effectively, has rapidly mobilized an otherwise apathetic educated elite. First some background. Recently, women in a pub were attacked (beaten and some injured quite badly) in full view of the public and recorded by television cameras and broadcast to the whole nation a few hours after the incident. The police did not respond swiftly, and the women were blamed for being in the pub. The leader of the right wing group, Sri Ram Sena,[60] said that these women were not behaving the way 'good' women should, that they should have been at home learning to cook for their husbands. This group, like many others of the ilk, has been protesting against the celebration of Valentine's Day and the expression of love between people of the opposite sex. This year the group threatened to force unmarried heterosexual couples seen in public together to marry. In addition, women who were out on their own, especially if they were clothed in non-Indian clothes, were attacked. These attacks

60 Shri Ram Sena (SRS), founded in 2006, aims to organize–consolidate the Hindu society and build a Hindu Nation by preventing conversion to other faiths, and preserving religious structures and practices, as well as preventing adoption of a 'western/non-Indian' life style, safeguarding Hindu women. See the organisation website http://sriramasena.org/index1.html for further information.

seemed to have an ethnocentric element to them as well, as women who could not speak the state language were particularly targeted. In other areas, there have been attempts (threats and violence) to curtail interaction between youth of different religious persuasions. Conservative elements in all the religions are tacitly supportive of this action. The media coverage of these incidents labeled it as Talibanization. This caused more furor, with people protesting, perhaps rightly, that in a Taliban country such debate would not be possible.

A young IT professional formed a group with membership on the Facebook social network website. They called themselves The Consortium of Pub-going, Loose and Forward Women, thus effectively sabotaging the people who would potentially label them abusively. This subversive tactic has been used effectively by other stigmatized groups. They asked all those who did not agree with the action of the Sri Ram Sena to send pink chaddi (knickers) to the leader of the group on Valentine's Day.[61] The originator of the campaign, Nisha Susan, explained: "The chaddi is slang for right-wing hardliners (shorts are part of the uniform) and the saffron agenda, while pink stands for things that are frivolous. The combination is offensive" (Suraiya, 2009). Others have pointed out that pink also symbolizes love. It is also the symbol of the gay movement and stands for a 'soft' communist (not so red). The aim was to reclaim Indian culture one chaddi at a time.

The campaign has been surprisingly successful, over 800 having joined the Facebook group. Collection points were organized and people dropped off packages containing pink chaddi and valentine cards. The campaign caught media attention and received wide publicity. Even older women and men who would probably never go to a pub joined. Some said that they feared what would happen to their daughters in future, and this motivated them to participate. The Ram Sena did not appreciate being ridiculed and predictably labeled the campaign as being un-Indian and not

61 Many have criticized the commercialization and commoditization of days, including Valentine's Day. The Hindu right wing views it as an imposition of Western culture.

befitting Indian women. As a follow-up, to highlight the diversity and beauty of Indian culture, the campaign is asking Indians to make short videos of what they think of Indian culture. These videos will be hosted on You Tube.

The Alternative Law Forum (ALF),[62] which has been at the forefront of fighting for rights, including those of the sexual minorities, has started another campaign called Fearless Karnataka. It is working towards reclaiming lost spaces – Take back the night, take back the street. It is organizing to protest against these incidents, showing solidarity with the 'victims' and raising public awareness by involving bystanders. And, the People's Health Movement[63] has brought together a wide coalition of marginalized groups to contribute to the gender and health section of the People's Health Manifesto 2009, Health for All Now. The manifesto has come out just in time for the Indian general elections. Demands include:

Gender and Health

- Abolish all coercive laws, policies and practices – including the two-child norm – that violate the reproductive and democratic rights of women.

- Stop coercion in the use of contraception; make user-controlled contraceptives available.

- Ensure safety, transparency and accountability in all clinical trials, and guarantee that the post-trial benefits of research are made available to women, even from marginalized groups. Ensure

62 ALF started in March 2000. It is run by a collective of lawyers who recognize that the practice of law is political and that there is a need to address social and economic injustice, and who believe that there is a need for an alternative practice of law. For more details, see http://www.altlawforum.org/.

63 The PHM is a global network of grassroots health activists, civil society organizations and academic institutions from 70 countries, particularly from low- and middle-income countries. http://www.phmovement.org/.

disclosure of funding and of potential conflicts of interest in all clinical trials, medical research and publications.

- Make mandatory the inclusion of women's organizations and women's health advocates on ethics committees, from the national to the local and institutional level.

- Recognize violence against women as a public health issue and ensure provision of necessary services. Ensure prosecution and conviction of violators of the Prevention of Domestic Violence against Women and Girls Act, as well as the Pre-Conception and Pre-Natal Diagnostic Techniques Act.

- Include the topics of 'Violence against women' and 'Sexuality and gender' as part medical and paramedical curricula to equip medical professionals to deal in a sensitive manner with survivors of violence, including domestic violence. Train forensic experts on the social aspects of sexual assault and rape as well as the collection and retention of proof in cases of individual or mass sexual violence.

- Repeal Section 377[64], concerning 'unnatural offenses,' of the Indian Penal Code, and other laws, policies and practices that discriminate on the basis of sexuality.

This manifesto is being distributed to all the political parties and their endorsement is being sought.

64 In a historic judgment the Delhi high court, in July 2009, 'read down' this section as it went against the fundamental rights of citizens.

The condoms and Viagra paradox

It is easy to note the differences between condoms and Viagra. Condoms have been around for a long time, they are, essentially, mechanical devices, and they are not glamorous. Condoms also have negative association with sexually transmitted diseases, and relationships outside marriage ('illicit relationships'). Condoms are for prevention and not pleasure. Although condoms help to prevent conception and sexually transmitted infections, the dual use is not emphasized. Viagra (or Viagra clones), on the other hand, promises pleasure, increased self-esteem, an improved self-image and magical swift action. It is backed by slick advertising and marketing. It is prescribed by doctors whose authority over the sexual domain is deepening and is increasingly unquestioned. In other ways, too, the nature of condom use and Viagra is essentially different. For condoms to work, they need to be used correctly and consistently. Such consistent behavior needs support and reinforcement, which is sadly lacking. Correct and consistent use of condoms needs the partners to be able to talk about sex, to discuss and negotiate. This would mean an equal relationship. Unfortunately this is often not the case.

The persistence of Victorian morality among the Indian middle classes who have disproportionate influence on policy formulation and program implementation has greatly hampered the propagation of condoms. Policies in 'developing' countries are also greatly influenced by other agencies such as The World Bank[65] and the IMF, and the process of globalization that transforms national institutions may be seen as a form of neocolonialism. This is visible in the condom debate, the policies made by PEPFAR and the pressure on India to change its patent laws and comply with the international patent regime.

65 World Bank policies have been largely responsible for the dismantling of the Indian public health system.

There is also a conflation of science and religion, as seen in the propagation of Vedic sciences (which are distinct from scientific discoveries made in India) and the recent pronouncements by the pope on the inefficacy of condoms in curbing the spread of HIV in Africa. This was evidenced by references to an opinion piece published in the *Washington Post* by the senior research scientist of the Harvard School of Public Health, Edward C. Green (2009), entitled, 'Condoms, HIV-AIDS and Africa – The Pope Was Right.' Green's statements on the ineffectiveness of policies promoting condoms in countries with a generalized epidemic, where their use is often inconsistent, are nuanced and couched in caveats. However, the readings of his article in the media, particularly those affiliated to the Church, have been totally anti-condom. After quoting Green, The Catholic Secular Forum makes this observation: "If condoms were the answer, then why is it that New York City, which under Mayor Michael Bloomberg has given away tens of millions of free condoms, has an HIV rate three times the US national average? Furthermore, the promiscuous distribution of condoms in New York has coincided with a spike in sexually transmitted diseases of all sorts".[66]

As for Viagra, it is not doing well in the Indian market, despite the new regulations. Generic sildenafil as well as Ayurvedic and other preparations are able to fare better. It is ironic that after the global economic meltdown, India was the lone voice rooting for 'free trade,' while the countries that had hitherto advocated the free market and privatization were firmly for protectionism and government regulation. A new world order seems to be developing.

66 The Catholic–Christian Secular Forum, 'Movie Angels & Demons, 2 Lac Missing Christians, Pope on AIDS, Hindutvawadi, Molestation ...,' Public statement, March 26, 2009. www.thecsf.org.

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