Industrial Engineering Journal

ISSN: 0970-2555

Volume : 52, Issue 4, April : 2023

A STUDY ON SEXUAL BEHAVIOUR INTERVENTION IN URBAN COMMUNITY

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Abstract

Sexual health is a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. Thus sexual health is the experience of the ongoing process of physical, psychological, and socio-cultural well being related to sexuality. It is evidenced in the free and responsible expressions of sexual capabilities that foster harmonious personal and social wellness, enriching individual and social life. It is not merely the absence of dysfunction, disease and/or infirmity.

Key Words: Sexual behavior, Intervention, Urban Community

Introduction

Sexual health is the experience of the ongoing process of physical, psychological, and socio-cultural well being related to sexuality. Sexual health is evidenced in the free and responsible expressions of sexual capabilities that foster harmonious personal and social wellness, enriching individual and social life. It is not merely the absence of dysfunction, disease and/or infirmity. For Sexual Health to be attained and maintained it is necessary that the sexual rights of all people be recognized and upheld. It is an approach to sexuality founded in accurate knowledge, personal awareness and self-acceptance, such that one's behavior, values and emotions are congruent and integrated within a person's wider personality structure and self-definition (WHO, 1975; Rosser et al., 1995; Coleman, 1997).

Review of literature

Brian Mustanski.et.al. (2006) the study conducted on “I can Use a Condom, I just Don’t: The Importance of Motivation to Prevent HIV in Adolescent Seeking Psychiatric Care”. Youth continue to show high HIV infection rates, and adolescents with mental health problems are especially at risk. The study used longitudinal data to test a cognitive-behavioral model of risky sexual behavior among 175, ethnically diverse urban adolescents seeking mental health services. Path analyses of the cross-sectional data revealed that motivation was a strong predictor of behavioral skills and sexual risk taking. The model explained 42% of the variance in Sexual Risk Taking with age included—29% without age. In the longitudinal path analyses, Motivation had a significant negative effect on levels of Sexual Risk Taking 6 months later, controlling for Information, Behavioral Skills, age, and baseline levels of Sexual Risk Taking. These longitudinal effects explained 60% of the variance in Sexual Risk Taking. These results underscore the need to address motivational factors in HIV prevention programs designed for adolescents with mental health problems.

C. Perry et. al. (2008) in the study entitled “Meeting the Sexual Health Care Needs of Young People: A Model that Works?” presents that the young people have been identified as a specific group who experience poor sexual health and there is scope for improving this if sexual health services are sensitive and relevant to their needs. This paper reports on the work of two services which were set up specifically for young people, exploring whether the model of service provision adopted was successful in engaging this group. Routine monitoring data (anonymous) in relation to all contacts with the services were collected. After the services had become established, short questionnaires were administered to young people using them. For service one, 425 contacts were recorded over 34 service sessions. Of these, 149 were new clients: 52% young men (78) and 48% young women (71), with a mean age of 14 years. There were 259 repeat contacts: 74% with young men (191) and 26% with young women (68). For service two, 399 contacts were recorded over 61 service sessions. Of these, 118 were new clients: 32% young men (38) and 68% young women (80), with a mean age of 16.8 years. There were 274 repeat contacts: 40% with young men (108) and 60% (166) with young women. All of the young people were generally very satisfied with the services they received. The youngest young people were less likely to indicate that they would have accessed other sexual health services. The study indicates that young people of both sexes, between the ages of 11 and 19 years, can be engaged by sexual health services, if provision is modelled on ‘best practice’ and what is known about the sexual health service needs of young people.

Engagement with such services is a prerequisite for addressing the diversity of sexual health needs young people are likely to have in contemporary society and the findings of this study in relation to gender and age are particularly pertinent.

Stephen A. Maisto et.al (2004) conducted an experiment on "The relationship between alcohol and individual differences variables on attitudes and behavioral skills relevant to sexual health among heterosexual young adult men". The purpose of this experiment was to investigate the effects of alcohol, alcohol sex expectancies, and sexual sensation seeking on determinants of sexual health behavior according to the Information-Motivation-Behavioral Skills (IMB) model. The participants were 48 heterosexual young adult males who attended 2 laboratory sessions. During Session 1, participants completed a set of screening and individual differences measures, and during Session 2 they were randomly assigned to 1 of 3 beverage conditions: control, alcohol (0.65 g alcohol/kg body weight), or placebo. Following the experimental manipulation, all participants completed measures regarding attitudes toward condom use, intention to engage in risky sex, and condom use negotiation skills. The results showed that participants who consumed alcohol had poorer negotiation skills and greater intention to engage in risky sex compared to participants who did not drink alcohol. Although alcohol did not affect any dimension of attitude regarding condom use, attitude about condoms' effects on sex, as well as sexual sensation seeking, were correlated with both intention ratings and skills. Multiple regression models, including both attitudes and sensation seeking showed that attitudes accounted for 20-25% of variance independent of beverage condition in predicting intention ratings and skills. The findings were consistent with past research showing that alcohol consumption can have detrimental effects on determinants of sexual health behavior and that individual differences factors can enhance the power of models like the IMB to predict such behavior.

Routledge, et.al (2003), conducted study on "Beliefs concerning sexual health problems and treatment seeking among men in an Indian slum community". This study explores the sexual health problems and treatment-seeking behaviour of men in a Mumbai slum population. Men consider wet dreams, masturbation, early ejaculation, sexual weakness, and other semen-related issues as serious sexual health problems. Suppression of sexual desire was one of the major causes perceived by men for wet dreams, whereas masturbation was seen as the major cause for perceived early ejaculation and distortion in the shape of penis. Excessive loss of semen in any form, including through masturbation and frequent intercourse, was seen as causing most sexual health problems. These beliefs impact on subsequent

behaviour, including treatment seeking. In this community-based study, about 45% of men reported to be currently suffering from one or more sexual health problems. One in every four who reported experiencing any problem sought treatment, mostly from the private sector that included a large number of unqualified and untrained providers. The present analysis stresses the importance of understanding these issues for sex education programmes and argues that traditional sexual health providers should be made an integral part of community-based STD/HIV/AIDS prevention efforts.

Methods and material

The present study shaped within the participatory action research process and intervention design. The purpose of study was to cover the larger section of the population, so as to validate the intended sexual health model. The assumption to cover a large section of population of the Sanjeev Nagar slum community in Gulbarga city (Karnataka State) was to improve sexual health status of the general population. A sample of 221 respondents with 111 women and 110 men proportionately consented to take part in the action research. A psychological scale of Sexual behavior and attitude developed by Dr. Yashvir Singh was selected to collect data through interview method. The scale measures the permissiveness and restrictiveness of sexual behavior.

Results

During the intervention process, sexual behavior issues were identified and correspondingly intervention design was formulated and executed. Process was so designed as to make the community involve and own the research process. Focus group discussions (FGDs), technical sessions, brainstorming sessions, lectures and exhibitions were conducted. Subsequently, the effect and change in the sexual behavior of the male and female target groups was significant. The study could come out with an intervention process model, which could be replicated and scaled up to promote the sexual health well-being of the urban community.

Socio-demographic Tables

Table 1.1 Age Distribution of the Respondents

Age-group	Frequency	Percentage
>20 yrs	18	(08.1)
21-30 yrs	132	(59.7)
31-40 yrs	56	(25.3)
41-52 yrs	15	(06.8)
Total	**221**	**(100)**

The above table shows the age distribution of the respondents. Out of 221 respondents, more than half of them fall in the age range of 21 to 30 years, 1/4 of the respondents are 31 to 40 years old, about one tenth (8%, 6%) of the respondents are respectively less than 20 years old and 41 to 52 years of age. The sample of study indicates a majority (71%) of them are in the productive age range of 21 to 40 years.

Table 1.2 Sex Distribution of the Respondents

Sex	Frequency	Percentage
Female	111	(50.2)
Male	110	(49.8)
Total	**221**	**(100)**

The table explains the gender representation in the study. Out of 221 respondents, a majority of them (more than half) are females and less than half are males. From the table it is apparent that representation of females and males is more or less equal.

Table 1.3 Educational Status of the Respondents

Educational status	Frequency	Percentage
Illiterate	108	(48.9)
Primary	49	(22.2)
Secondary	48	(21.7)
Pre-University	14	(06.3)
Degree	02	(00.9)
Total	**221**	**(100)**

The table describes the educational level of the respondents. Almost half of the respondents are illiterate. One fourth of the respondents have completed primary and secondary education respectively. 6.3% of the respondents have studied Pre-university and a very small number (2) of them are graduates.

Table 1.4 Occupation of the Respondents

Type of occupation	Frequency	Percentage
Not working	30	(13.6)
Mansion	27	(12.2)
Coolie	120	(54.3)
Vegetable Vender	006	(02.7)
Mechanic	007	(03.2)
Govt. Servant	005	(02.3)
Tailor	009	(04.1)
Shopkeeper	001	(00.5)
Others	16	(07.2)
Total	**221**	**(100)**

The table explains that more than half of the respondents are dependent on coolie occupation. A considerable amount (14%) of the respondents is housewives. 12% of the respondents are involved in building construction work. A large number of the respondents are vegetable vendors, mechanics, Govt. servants, tailors and shopkeepers. About 7% of the respondents are involved in the occupations like carpentry, flour making, finance and driver.

Table 1.5 Income Distribution of the Respondents

Income	Frequency	Percentage
No income	46	(20.8)
>20000	83	(37.6)
20001-60000	83	(37.6)
60001-120000	07	(03.2)
<120000	02	(00.9)
Total	**221**	**(100)**

The table shows the annual income of the respondents. More than 1/3 of the respondents fall in the income slab of <Rs. 20,000/-, and Rs.20,001/- to Rs.60,000/-; whereas 1/5 of the respondents are not having any income. A very less number (3%) of the respondents have income of Rs.60,001/- to Rs.1,20000/-, and only 0.9% have the income of more than Rs.1,20,000/-.

Table 1.6 Type of Shelter of the Respondents

Type of shelter	Frequency	Percent
Kuccha	87	(39.4)
Pucca	134	(60.6)
Total	**221**	**(100)**

The above table explains the type of shelter of the respondents. More than half (60%) of the respondents have pucca houses since government has provided them Ashray houses.

Results and Discussion

Tables of Sexual Behaviour and Attitude

Table 1.1 Statistics SBAI scale used

Scales used	Mean	SD	Variance	Range	Minimum	Maximum

Sex Behavior Attitude Inventory(SBAI)	63.20	4.573	20.908	35	44	79

The above table 1.1 clearly shows about gained status in sexual behavior and attitude, sexuality, marital adjustment and life satisfaction of the respondents. In case of the sexual behavior and attitude, on an average the respondents have scored 63.20. This is comparatively high scores with respect to the minimum score which was found to be 44. Respondents obtained scores ranging from 44-79. Standard deviation was found to be 4.573 and the variance among the scores of the respondents is 20.908.

In this research, in the pre-intervention stage, Sexual behavior and attitude inventory scale was administered. Intervention was carried for seven months with various social work tools like Focus Group Discussion, orientations, one to one discussion, lecture method, demonstration, brainstorming sessions were used. On completion of intervention, same sexual behavior and attitude scale was administered and scores were analyzed and is presented in table 2.3

Table 1.2 Statistics of Sex Behaviour Attitude Domain

Domains of SBAI	**Mean**	**SD**	**Variance**	**Range**	**Minimum**	**Maximum**
Permissiveness	29.05	3.054	9.324	18	21	39
Restrictiveness	34.15	2.818	7.940	17	23	40

Data show about the domains of the Sexual behavior and attitude that is Permissiveness and restrictiveness. The respondents have scored on an average 29.05. This is comparatively high scores with respect to the minimum score which was found to be 21. The respondents obtained scores ranging from 21-39. Standard deviation was found to be 3.054. And the variance among the scores of the respondents is 9.324.

The above data express the domains of the sexual behavior and attitude that is restrictiveness. The respondents have scored on an average 34.15. This is comparatively high scores with respect to the

minimum score which was found to be 23. The respondents obtained scores ranging from 17-40. Standard deviation was found to be 2.818. And the variance among the scores of the respondents is 7.940.

Table 1.3 Variance in Sexual Health due to Intervention

Aspects of sexual health	**Pre-Intervention**			**Post-Intervention**			**t-value**	**df**	**P**
	Mean	**SD**	**Variance**	**Mean**	**SD**	**Variance**			
Sex Behavior attitude inventory	63.20	4.573	20.91	58.19	2.616	6.843	17.889	220	.00

Table 1.3 compares pre-intervention and post-intervention scores obtained by respondents on various aspects of sexual health such as sexual behavior and attitude, sexuality, marital adjustment and life satisfaction.

Comparing the statistics related to scores obtained by respondents on sexual behavior and attitude, it was found that initially mean score was 63.20 which has changed to 58.19. There is a substantial change in standard deviation of the scores from pre-intervention to post-intervention. It is almost half of the previous value. So is the case with change in variance in pre-intervention and post-intervention scores on this parameter, there is decrease in scores by one-third.

To know whether there is significant difference in pre-intervention and post-intervention scores, t-test was used. The result of t-test shows that the difference in scores was statistically significant. The statistically significant results of the intervention suggest that the respondents showed considerable amount of improvement in sexual behavior and attitude due to intervention.

Table 1.4 Variance in Sex Behaviour Attitude Inventory Domains due to Intervention

Domains of SBAI Scale	Pre-Intervention			Post-Intervention			t-value	df	P
	Mean	SD	Variance	Mean	SD	Variance			
Permissiveness	29.05	3.054	9.324	35.10	1.971	3.885	-30.408	220	.00
Restrictiveness	34.15	2.818	7.940	23.08	1.919	3.684	55.390	220	.00

Table evaluates pre-intervention and post-intervention scores obtained by the married respondents on two aspects of sexual health such as permissiveness and restrictiveness which are domains of sex behavior attitude inventory (SBAI).

When Compared the statistics related to scores obtained by respondents on permissiveness which is domain of sex behavior attitude inventory, it was found that before intervention, the mean score was 29.05, which has changed to 35.10. There is a substantial change in standard deviation of the scores from pre-intervention to post-intervention. There is change in variance in pre-intervention and post-intervention scores on this parameter, there is increase in scores.

It was found that the scores obtained by respondents on sexual behavior and attitude domain restrictiveness, initially mean score was 34.15, which has reduced to 23.08. There is an expected change in standard deviation of the scores from pre-intervention to post-intervention.

To evaluate, if there is a difference in pre-intervention and post-intervention scores, t-test was applied. The result of t-test shows that the difference in scores was statistically significant. It may be inferred that by implementing the social work intervention there is statistically significant difference in restrictiveness which is the domain of sexual behavior and attitude inventory post-intervention and pre-intervention scores.

Conclusion

Comparatively more married male respondents have gained high scores on Sexual behavior attitude inventory than female respondents. It may be because men are more exposed to sexuality related issues and events. They are quite open and hence they are likely to have higher adoptability towards sexual behavior and attitude.

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