Behaviour and Identity

Males who have sex with males in South Asia and HIV/AIDS

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In the socio-cultural frameworks of South Asia, the issue of male-to-male sexual behaviours and their impact upon the reproductive and sexual health for both males and females has profound implications for any effective control and management of STIs and HIV infections. In terms of the AIDS epidemic that confronts the region, it is vital that this issue is adequately and appropriately addressed.

There is growing evidence that indicate significant levels of male to male sexual activity, high levels of multiple sexual partners, significant levels of sexual access to females by many of these males including their wives, low levels of condom use and safer sex practices, with all the concomitant risks for HIV and STI transmission from these males to their sexual partners. Gender segregation, economic, age and gender power differentials, adult male ownership of social spaces, low levels of knowledge of STIs/HIV, a homosocial culture, and adult male sexual privileges exacerbate these behaviours.

This invisibility of much of male sexual behaviours is exacerbated by the claim that transmission of HIV in South Asia as based on "heterosexual" intercourse, i.e. vaginal sex, which often allows government, non-government, and international and donor agencies, to ignore the possibilities of wide-spread anal or oral transmission of STIs/HIV. Whilst it is recognised that substantial levels of STD/HIV infections in South Asia are caused by vaginal sex, it also needs to be clearly and openly recognised that with the public and social denial of anal sex behaviours between males and between males and females, its significant role in STI/HIV transmission is grossly underplayed, if not denied completely. Such focusing on vaginal sex as the sole (almost) route often ends up victimising females (particularly female sex workers) as the source of infection and disease, whilst it also often denies the male role in STD/HIV transmission. At the same time such a process by invisibilising the role that anal sex plays in transmitting STIs/HIV ensures that significant levels of sexually active males sees such a sexual behaviour as a safer option. "They have never said that unprotected anal sex can be dangerous, so I have always thought of it as a safer option," as one person reported to Naz Foundation International.

Male sexual identities in South Asia do not fit the Western pattern, and this creates further invisibility of sexual behaviour patterns. Many males who have anal sex with other males also have vaginal and anal sex with females. The majority of males who have sex with males are married. Early sexual encounters by many males are often with another male. But a major

consequence of a heterosexual/homosexual labelling of the AIDS epidemic has meant that if there is any discussion on sexual transmission, males who have sex with males become subsumed within a category of “gay” or “homosexual”. This further marginalised and invisibilises the behaviour. Of course there are gay-identified males in South Asia. But they are overwhelmingly outnumbered by non-gay identified males who have sex with males, who may have differing identities, or who may just engage in male to male sex as semen discharge.

Frameworks of male-to-male sex reflect indigenous identities, often based around gender identification and penetration. Thus we have:

* Kothi: a self-identified feminised male who acknowledges male to male desire but within a framework of gender roles
* Panthi: a label given to “real” men by kothis - these men takes the "active" role in penetration and are primarily from the general male populations. Panthis may actively seek kothis for sex, or may be approached by kothis if they are in the same space as kothis for other reasons, i.e. parks, etc.
* Do-paratha: a label given by kothis for males who penetrate and are penetrated
* Masti: this label is used to define males who have sex with males as part of semen discharge and immediacy, rather than for specific desires for sex with another male
* Gay-identified men - primarily urban, middle-class English speaking

These frameworks indicate complex and diverse cultural specific patterns of male-to-male sexual encounters. Very often male-to-male behaviours do not arise from "sexual orientation" but from different constructions of desire and behaviour. Concepts around heterosexuality and homosexuality arise from Western traditions and social constructions of sexuality. In South Asian cultures, these traditions revolve around family, marriage and children rather than the self. And in cultures that segregate by gender, cultures that are particularly homosocial and homoaffectionalist, living conditions of overcrowding and shared beds, male to male sex is a common phenomenon arising from "body heat", "body tension", immediacy, availability and opportunity.

In this context we can therefore speak of behaviourally heterosexual or behaviourally homosexual. Personal identities are not based upon sexual behaviours and choices. They are based upon class, caste, religion and family.

Such sexual encounters occur within the joint and extended family, in neighbourhoods, in parks, toilets, and cinema halls, in the dark, behind closed doors, under the blankets.

Masculinity in South Asia is not so much a personal sense of self, but around gender roles. To penetrate is its primary function. In that sense a man penetrating another male is still seen as a "manly" male.

And penetration is the focus. Penetrative sex is discharge orientated.

"I don't know who I have sex with. It should be my husband, but I can't say for sure because I never see him "do it." This comes from anecdote report from a research colleague of mine who was working in a Rajasthan village.

"When my husband is ready he makes a sign to me. I go into the hut, and lie on the bed. Someone comes into the room. The room is dark so I can't see who it is. I raise my sari over my head and expose myself to my husband. At least I think it is him, because I have never seen him enter me. I have never seen his 'thing'. I just feel something down there. I don't see anything." Here sex is in the dark, a thing of shame. What mutual pleasure and joy? In - discharge - out.

" It takes on average perhaps four minutes for them to 'come'. A quick in, discharge, out. No lubricant, except perhaps spit, no condom. In the end my arse becomes numb." A comment from a male sex worker in Lucknow, India.

In a number of private conversations with married male participants in a sexual health education workshop in Orissa which I was conducting, all stated that they don't do sex with their wives. This was confusing since all had stated that they had children. Further probing in what constituted sex for these men, led to the understanding that what they did with their wives was not sex, but DUTY. "I do duty to my wife" was the common expression. In the sex act between husband and wife, there was very little affection and foreplay, if any at all, and the actual time for the sex act was less than five minutes! Everything was focused on penetration and discharge. Sex with the wife as duty - not pleasure.

Sex was something else for these men. Sex was what you did outside marriage. And in this context, much of this sex was seen as *masti*, mischief, play. And much of this sex was with other males. Not because they desired other males, but because certain males were much more accessible for penetration.

At the same time, several female colleagues have reported to me that many women see sex with their husbands as WORK! Not something that they actively participated in. Just something they have to do because it is expected of them - receptacles to male discharge.

In a range of situational assessments that I have participated in amongst males who have sex with males in the region, several of the penetrating sexual partners spoke of the urgency of their penetrative sex act, that anus were tighter and more pleasurable than vaginas, and that since they had heard that women were carriers of a dangerous and deadly disease, it made sense to them to use other males for discharge. Again from Rajasthan, is the belief that a women's vaginas after having two children is too loose for the man to enjoy.

I am not saying that this construction is valid for all South Asians, but after four years of studying male sexualities, genders and sexual behaviours in the region, these stories reflect a predominant construction of male sexual behaviours that are self-focused, phallic, penetrative, and discharge oriented.

Male sexual behaviours do not arise into practice out of nowhere. They have a context, a history based both on time and place, on culture and tradition, on myths, on beliefs. It is these that need to be addressed in sexual health programmes. Addressing the actual act, i.e. promoting condoms (which actually sustains the phallic psycho-social constructions and gender biases), handing leaflets out, and warning of the dangers, is not enough. These don't alone change behaviours to sustainable safer practices.

For example, a traditional belief amongst some males is that one drop of semen is equivalent to one hundred drops of blood. Masturbation produces weakness and sickness. To let semen fall is a wasted discharge. One must discharge into something, whomever that something is. Discharge into a condom is not enough.

At the same time another common belief is that men must discharge, that they are naturally lustful. Wives on the other hand are honoured as Mothers, Sisters, and bearers of children, traditionally holding the honour of the family. One can't ask the wife to perform non-reproductive sex acts, such as oral or anal sex. This would be shameful and dishonour her. Such desires should be fulfilled outside the marriage. And as long as it remains invisible, no one will talk about it, it doesn't exist.

Similarly, since the act of penetration is the definer of manliness and therefore worthiness, a man penetrating another male is not perceived as a homosexual, or in the Indian sense a *gandhu*. He perceives himself and is perceived by others, as a man. It is not the sex of the sex partner, but the sexual act that defines gender roles here. The penetrated male therefore is not defined as another man. Male to male sexual encounters are primarily gendered.

Male sexual behaviour therefore is not an expression of a personal identity to a large extent. Rather it often is one of opportunity, accessibility and personal desire for semen discharge. The

phrase “body tension” is an expression of this discharge. And if we continue to promote programmes based on the divisions based on homosexuality or heterosexuality, then such programmes will fail to reduce the incidence of STI and HIV infection.

Even the term MSM is problematic in the context of service delivery. What is a Man? What is a Male? What is Sex?

Within all these contexts, women’s sexual and reproductive health is to a large extent dependent upon male sexual behaviours and the methodologies of their practice. Their constructions are framed by space, time, availability, gender roles, personal desires, opportunity and so on.

For the fluidity of the South Asian male’s sexual experiences and behaviours, the social invisibility of sexual behaviours, gender segregation, male homosociability, male ownership of public space, shame-based cultures, family and community *izzat* and family honour, compulsory and arranged marriage, and within that compulsory reproductive sex, joint and extended family structures, a personal sense of self subsumed into a family sense of self, male and female social roles as definers of gender and adulthood, delayed marriage, all have a central impact upon the constructions of male sexual behaviours that are framed by differing contextual identities.

In a cultural framework where the son is supremely important, where female infanticide is high, where the gender imbalance in the population has led to a preponderance of males in certain parts of the region, and where male sexual practices are excused as long as they remain invisible and do not shame the family, what do we have?

For example, in a culture where girls and women are policed in terms of their behaviour, particularly sexual, where female virginity is prized, where family and community duty and honour is centrally important, where males own the social spaces, where marriage and reproduction is seen as compulsory, where adulthood is defined by these parameters, a culture which is particularly homosocial, where income levels are low, where sexual access to women is therefore marginalised, limited, and sometimes costly, where sexual behaviours are not so much constructed around personal identities but rather around penetrator and penetrated, a culture where male to male sex is not seen as sex as such but as masti – play - who is the most sexually available object?

In a region which has almost 80 million more males that females, this results in psycho-social constructions of male sexualities and behaviours (since women do not have a sexuality or behaviour) which find expression in a cultural development that demands compulsory marriage

and reproduction, particularly of male children, that demeans femininity, that gives no validity and social space for autonomous women, that demeans unmarried individuals, particularly single women and that only confers adulthood and thus social status and responsibility to married people.

Sexual behaviour takes the place of sexuality. Women's sexual behaviour becomes controlled and marginalised, if not denied. Male sexual behaviour becomes self-absorbed, and is reduced to one of discharge rather than based upon a desire for the other person. Sex behaviour becomes depersonalised. Sexuality has no construction. The sex act becomes brutalised whether it is between male and female or male and male. Concepts of personal choice, of privacy, become lost. There can be no development of individuality.

As a consequence, the contemporary South Asian situation with regard to sexualities and their physical expression, indicate a brutalised sexual behaviour, shown by the significant levels of vaginal and anal tearing; of an almost indiscriminate sexual activity by men without regard to the sex of the sexual partner, where behaviour is not defined by any form of identity, but rather by the concept of availability and discharge; by the levels of severe sexual repressions which leads towards moments of brutalised sexual release.

Since sexual release for personal pleasure and discharge - recreational sex is seen as permissible outside of marriage, and access to females is largely socially controlled through "policing", purdah, and family discipline, the easiest sexual object to access is another male.

And what do religions state? Whilst Hinduism has little to say about homosexual behaviours, Islam does not condone such behaviours. But Islam also asks for four witnesses of good community standing for action to be taken. At the same time, the socio-cultural framework in South Asia is not based on personal guilt, but rather on public shame. In other words, if it is not visible, it doesn't exist.

Religious practice in South Asia is a community relationship, a duty, and a responsibility to maintain family and community obligations. Whilst many will have a personal belief, it is in its practice that reflects community honour or *izzat*.

South Asian legal practice reflects the results of the influence of the British Raj. In Bangladesh, India and Pakistan, Section 377 of the various Penal Codes and which speaks of "carnal intercourse against the order of nature" is still in existence. Here punishment is of the order of 10 years to life imprisonment. However it should be noted that there has been extremely few prosecutions.

In Pakistan, alongside the civil law there is also the shar'ia, and here punishment for anal sex is death. But again, the need for four witnesses, or a confusion, prohibits and systemic prosecution of males who have sex with males. Often the existence of this law is used at the local level for blackmail and sexual access to some males, particularly male sex workers.

We know from a range of situational assessments conducted amongst males who have sex with males, that knowledge of HIV/AIDS is almost non-existent; that condom use for anal sex is extremely low, high levels of reported STI symptoms, significant levels of anal bleeding and fissures, low levels of sex education, a range of myths about sexual practice increasing risks, and....

The consequences of unrecognised epidemiological patterns of STI/HIV transmission, whether through denial or invisibility, regarding the management and control of the epidemic should be clearly understood. The impact upon the epidemiological, social and economic frameworks need not be overstated where these have been discussed in other forums over the last 10 years. Clearly at the family level, such behaviours, should they lead to STI/HIV infections, have a devastating impact upon its economic welfare. At the social level, the economic impact upon the country is also clearly recognised.
The majority of males who have sex with males will also have sex with females, many of them their wives. Because the level of unprotected sex in the male to male sexual networks is very high, such behaviours increase the vulnerability of the males themselves, females, in particular married women, in terms of their reproductive and sexual health Further, social and cultural structures such as homoaffectionalism amongst males in South Asian societies, the "apprenticeship" models in working environments, gender segregation, delayed marriages, and the high levels of poverty and unemployment, indicate the vulnerability of young males to STI and HIV transmission from sexual encounters with other males.

So what can we do? Key words here are empowerment, community building, ownership, and knowledge. We need to explore strategies of building new normative sexual practices, promote and encourage safer sex behaviours, and increase access to STI treatment. All these require creating an environment for change. Handing out leaflets and condoms is not enough. Creating the appropriate environment is around community mobilising. But where no community exists, work will need to be done in community building. Amongst males who have sex with males, this means working with kothi -identified sex networks as well as gay - identified organisations, but recognising their differences and their specific constituencies. Peer led initiatives led to "community" ownership of the issues.

But also alongside such strategies we will need to ensure that anal sex issues are adequately addressed as part of any HIV/AIDS prevention strategy and reproductive and sexual health

programmes. Such parallel processes ensure that stigmatised males are empowered towards changing risky sexual practices, whilst the males they access also have access to services, and at the same time, males in general are aware of the issues and supported to change their behaviours. This means any AIDS prevention campaign should address all sexual behaviours, whilst specific programmes such s truck-drivers projects, IDU use projects, slum projects, and so on.

If we are to move towards societies that enable all people to express their best, that gives people the opportunity to develop personhood, that enables people to make choices about their sexuality, gender and sexual/emotional desires, that empowers people to make positive decisions about their own sexual health and others, then we must understand the contexts within which male sex behaviours take place and construct effective sexual health programmes that address both female and male sexual health as complimentary processes, and include within such process all male sexual behaviours without trying to impose constructions of sexuality that have no validity or relevance to what is really happening behind closed doors, under the blankets, behind bushes, inside cinema halls, and other hidden invisible spaces.