

Masculinities, sexualities and HIV/AIDS

by Shivananda Khan

“Men make a difference” — a catchy slogan promoted by UNAIDS over the last couple of years. The intention here was to acknowledge that it was men’s attitudes, gender power, masculine constructs, sexual practices and decisions, and control that required being addressed if effective and sustainable HI V/AIDS prevention programmes were to be developed. It was a recognition that focus on women only was an inadequate response often leading to failure.

In NFI’s work in South Asia, the question of social and cultural definitions were of great significance. The term “MAN” was problematic in this context, and the only way we could move forward was to understand constructions of masculinity and sexuality in the plural. It meant moving away from essentialist and biological determinism of masculinity and sexuality into a framework that sees a range of differing masculinities and sexualities. How else to understand a self-identified kothi’s sense of self, behaviour, and choices, where in one social setting they demonstrated a gendered performative role to attract “manly” partners” but which also had a psychological sense of meaningfulness and significance, but in another they performed as husbands and fathers. At the same time, these “manly” partners did not appear to have a sexual identity, but a gender identity, that of “manly man” who defined the self-identified kothis as “not-men”, and who also had wives and/or sexually accessed other women as well. And along with this was the existence of both kothi-identified males and “manly” man who performed as both penetrator and penetrated.

Data from a range of Social Assessment among MSM (primarily self-identified kothis) in the South Asia region indicated that a substantial number of “men” from the general population had sexual encounters (if not long-term relationships) with such kothis. For example, in Sylhet Bangladesh, 200 such MSM reported sex encounters with 8800 partners in one month. Likewise in Hyderabad, a similar cohort size reported sex with 8200 partners in a similar period. Further these assessments indicated that those who were married, whether kothis or non-kothis, frequent sex with their wives was common.

A recent survey by Bandhu Social Welfare Society in Bangladesh amongst nonkothis who visit a range of “cruising sites” in Dhaka, indicated that male-to-male sex was substantive and across the economic and social spectrum. Of the 1096 men interviewed, over 20% reported their last sex partner as female, but for those below the age of 25, only 7% did so.

The categories of homosexual, heterosexual and bisexual had a limited currency in understanding the sexual phenomena in South Asia. Similarly, the emergent AIDS category of men who have sex with men is also becoming inadequate. The term is used to signify a “target group” but for a growing number of males who have sex with other males, who have no access to sexual identity formulation or find no personal resonance with current categories, this label promoted by AIDS agencies is being taken up as an identity. This growing confusion of categories, labels, identities, and HIV/AIDS prevention strategies is further compounded when we begin to deal with cross-

categories, such as female partners of MSM, or male IDUs who also have sex with other males (or is it MSM who use intravenous drugs).

Of course there are males in South Asia who have developed sexual or gendered identities, such as gay or kothi, and newly emergent categories brought on by AIDS prevention work amongst them, such as dubli or chava, double-decker, do-paratha — meaning both ways , or a small number of “manly” men who now call themselves panthis, adopting the kothi label for them. And within the hijra/kothi gradations, a host of categories of ever finer distinctions that relate to castration, dress codes, selling of sex, etc.

However, if we are too look at STI/HIV infection risks, we need to explore the whole range of male sexual behaviours, and not only look at categories. We need to understand the whole range of masculinities and sexualities in the region if we are truly to address the issues of safer sex and risk reduction.

NFI has always promoted a two-pronged strategy to address these concerns. Firstly to develop community-based sexual health programmes working with self-identified kothis (or gay men) as they tend to be the most socially excluded, marginalised, stigmatised and highly vulnerable, to empower them to practice safer sex with their “manly” partners, and also any female partners. The second component is to work with other sexual health programmes who address the needs of occupational groups (such as truck and rickshaw drivers), as well as reproductive and sexual health clinics to address the issues of anal sex behaviours.

Both components are equally vital if we are to ensure that an effective HIV/AIDS prevention response to male-to-male sexual behaviours is developed.