Sexuality and Sexual Health in South Asia

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The debate concerning the development of effective prevention programmes in regard to STDs and HIV/AIDS in South Asia, has become an issue of deep urgency for these countries. But unless these programmes are specifically appropriate to the cultural frameworks of South Asia in which sexual behaviours occur then they will be ineffective, and may actually lead to the opposite effect.

To begin to consider developing appropriate strategies and programmes, we must explore the dynamics of gender constructions, sexuality, sexual behaviours and sexual health within these cultures. For if we do not construct the debate effectively, if we cannot clearly define the parameters of what we mean by the term ÒsexualityÓ, if we do not understand the cultural frameworks within which sexual behaviours arise and operate, then we will not be able to develop effective prevention methods.

India already has an STD, Hepatitis B and HIV/AIDS epidemic. The ability of South Asian governments to cope with the health care needs of people living with AIDS is already compromised by the strains placed upon health delivery systems that currently exist. Primary, secondary and tertiary care are stretched beyond their capacity to deliver effective sexual health promotion and care because of funding shortages, other priorities, denial, invisibility of issues, economic pressures, fear, sexism, sexophobia, homophobia, and ignorance.

It is currently estimated by the World Health Organisation and others that there are some 1.5 - 4 million people living with HIV infection in South Asia. Further, within the next decade, this figure is likely to reach up to 20 million such infections. The Harvard AIDS Institute's estimates are even higher, some 40 million infections. South Asia has the fastest rate of increase of HIV infection in the world, and by 2020 will have more people living with HIV/AIDS than the combined numbers of the rest of the world (if not before). While currently, it is estimated that one in four reported STD infections in the world is given by an Indian.

The main route of transmission in South Asia appears to be penetrative sexual behaviour. Whilst WHO estimates are defined within heterosexual/homosexual dichotomies, stating that 70% of all transmission is through heterosexual intercourse, such use of this terminology can be challenged in the context of sexual dynamics and behaviours within South Asia.

Within the context of South Asian cultures, the terminological use of heterosexual and homosexual frameworks do not exist in the sense they are understood in the West. The diametric oppositional frameworks of this terminology creates an artificial understanding that has no specific relevance to the actuality of people's lives. Therefore, we cannot realistically say that there is a heterosexual or homosexual transmission. All we can say is that there is sexual transmission within a specific behavioural basis, i.e. vaginal or anal intercourse. What this means is that while sexual behaviours exist across the range of human sexual behaviours, they cannot be fitted into an identity based structure which the terminology of ÒheterosexualÓ and ÒhomosexualÓ implies.

The fluidity of South Asian male's sexual experience, the framework of sexual invisibility, gender segregation, South Asian homosociability, male ownership of public space, South Asian shame cultures, sexual invisibility, community ÒizzatÓ, compulsory marriage and procreation, the current lack of personal identity-based sexual behaviours, South Asian gender constructions, male and female roles as frameworks of adulthood, and so on have a central impact on actual sexual behaviours that are not clearly defined within the terms ÒheterosexualÓ or ÒhomosexualÓ. Similarly actual sexual practices and with which gender they are practised, are not clearly defined either by these terms.

The impact on women's sexual and reproductive health HAS to be seen within this context.

In other words, determining male sexual practices in the larger context as well as the personal, is an essential component of any women's reproductive and sexual health strategy.

To develop appropriate strategies for addressing these issues, we therefore need to understand the dynamics of sexuality, the constructions of gender, the psycho-social frameworks of sexual behaviours and the contexts in which they exist. And these must be developed and understood within appropriate cultural frameworks. Unfortunately, in the development of HIV and STD prevention and outreach programmes within South Asia, sexuality, identities, and sexual behaviours have been conceptualised within Western understandings and constructions. In the context of these programmes, we can almost say that our gender constructions, sexual behaviours and identities have once again been colonised through the casual adoption of a specific understandings and conceptualisations of human behaviour that have

arisen through Western cultures. Not that these Western constructions are invalid, but they are inappropriate within the South Asian cultures.

The whole discourse of sexuality and sexual behaviours, and thus prevention strategies, arises from Western constructions of individuality, personal identities and sexualities. Gender identities, sexual roles and thus personal identities, arise within the context of a psycho-social and historical dynamic. Perceptions of who we are, what we are and what we do will therefore have different meanings within different cultures.

The urgent necessities that have arisen from the rapid spread of HIV infection and the lack of any specific ÒcureÓ for AIDS, has meant that the only strategy available to governments is prevention. There are really only two specific methods of prevention:

a. ÒDon't do it!Ó
b. ÒDo it safely!Ó

The first approach regarding sexual behaviours is often the one most favoured because of its tone of high morality. Both governmental and non-governmental agencies, particularly in developing countries in utilising this approach have stated recourse to a perceived historical dynamic and corrupt Western influences. In other words, risky sexual practices have arisen in our cultures because of the influence of the West. The other part of this strategy is to utilise specific religious and scriptural texts to support the Òdon't do itÓ strategy.

Neither of these approaches will work. Firstly because there is a denial of sexual histories within our countries, and in a perverse way, this denial, and often suppression of such histories, arise within a Western context as part of their ÒguiltÓ cultural frameworks. Thus Indian officials can say that there is no homosexual behaviours, or there is no extra-marital sex, or pre-marital sex, or if they do exist it is at very small levels. The actual evidence states dramatically otherwise. While the use of religious and scriptural texts as the mechanism of prevention denies actual human behaviour, and the histories of these religions and their social interactions in the cultures which sustain them. After all professing to be a Hindu, Muslim, Christian, Sikh, Buddhist, etc. has not stopped behaviours which have been deemed against the specific tenants of these religions. And, of course what about those who have no specific religious faith? The truth of the matter is that South Asian cultures, based on the dramatic differences between public and private spaces and framed within concepts of shame and honour, lead to risky behaviours and particularly sexual behaviours to be psycho-socially invisible. Public messages around culture, religion,

anti-West, etc. will not have the desired effect because they ignore the constructions of sexual behaviours. Or why do people do what they do? How? When? Where? With whom?

Sexual behaviours do not arise into practice out of nowhere. They have a context, a history based both on time and place, they arise from frameworks of desire which also have a construction based upon cultural and social dynamics.

For example, in a culture where girls and women are ÒpolicedÓ 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 procreation 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 non-penetrative sex is not seen as sex but as ÒmastiÓ - ÒplayÓ, who is the most sexually available object?

The denial of histories of gender constructions, sexualities and sexual behaviours by various discourses of both Western and South Asian origin have had a central impact in understanding the conceptualisation of gender identities and sexuality in South Asia . No Indian research institution has dealt with this denial. Instead they have only perpetuated the invisibility of these histories. Further, the current construction of sexuality arising from Western discourses is often ahistoric and the only sexuality that is seen as relevant is that of penetrative heterosexuality. Perversely, any other form is categorised as ***deviant and Western.***

This reduces the rich histories of sexualities to an oppositional dichotomy between concepts of heterosexuality and homosexuality which are a consequence of certain Western historical frameworks and understandings of sexuality.

Further, the construction of patriarchal social systems, the enforcement of compulsory marriage, procreative necessity of boy children, and the frameworks through which sexual behaviour and desire manifest themselves over the centuries, has created a pattern of destruction, marginalisation and denial concerning alternate sexualities and their histories. A dominant sexuality has historically emerged which has claimed precedence over all others as a system of social control which enables male power to take on a singular social role.

Alternate histories which often existed as traditions of the periphery are being lost at various levels due to the dominance of procreative ideologies at the rural level and the overwhelming construction of any tradition from solely a procreative heterosexual basis. Older alternate mythologies and histories are manipulated, deformed, and mutilated to suit rural male patriarchal ideologies which leads to women being the repository of tradition but not its interpreters. This creates rural economies where there is a gender segregation of labour, boy children as rural capital, and control of land, economic and cultural resources by men which are recreated within urban spaces. This also leads to the construction of desire and sexuality only from the standpoint of the rural patrilineal male which is then romanticised by various urban discourses as traditional authenticity. In other words denial of alternate sexualities and matrilineal traditions are perpetuated both from within and without.

Further with the impact of various forms of colonialism, dating from Vedic times, monotheism, orientalism, various forms of nationalism, fundamentalism, orthodoxy, etc., have all contributed to the destruction of much localised alternate traditions, whether of dance, theatre, literature, visual art, songs and lifestyles. This has meant an almost complete invisibility of alternate sexualities. Rather than a pluralistic vision emerging, only procreative and penetrative sexuality is seen as socially acceptable. Traditions expressive of sexual diversity are seen as ***dirty, deviant and perverted, and the work of evil, over sexual, devouring women.***

This overwhelming denial and silencing of histories and cultures of sexualities means that the only framework available is that which has emerged in the Western countries. Though these can be useful as comparative tools, they cannot be the main basis of understanding the complex psycho-sexual social matrix of South Asia.

The world view as expressed in South Asia, has been formed by the central concepts of Vedic Brahmanism, Islam, Christianity and also of Ayurvedic and Western medicalisation of the body and sexuality. Male and female roles have been strictly defined, and any public transgressions of these roles is severely punished through stigmatisation, social exclusion, exile, physical abuse and even death.

The resultant psycho-social constructions of sexualities, the denial of different expressions of sexualities, the socio-political control of sexualities, has resulted in a cultural development that demands compulsory marriage and procreation, 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. For women who desire other women, there is no social space for such a development. Concepts of personal choice, of privacy, become lost. There can be no development of individuality.

Desires have a history, both personal and social, as well as political, in the way they are expressed and manifested. They do not cease to exist as these histories are changed and reformulated. Nor do they cease to exist if such histories are denied or made invisible. But desires are constructed to fit in with the social constructions.

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 gender of the sexual partner which 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.

But because of this terrible silencing and denial of these histories from various ideologies, an almost total exile situation has emerged. In trying to resist this exile a closeted and schizophrenic state of being has emerged where the person tries to assimilate into society through marriage and having children, yet expressing alternate sexual desires in purdah, in darkness, shame and in silence.

Within the context of the current concerns (if not panic) about sexual health in South Asia, in particular, rape, cervical cancer, STDs, Hepatitis B and C and HIV infection, as well as the alarming increases in sexual dysfunctions amongst women and men, it becomes an urgent necessity to explore the issues outlined above, to formulate strategies that make visible these alternate histories, that deconstruct the frameworks of contemporary sexuality, and to reconstruct them in the light of the historical discoveries being made.

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 and sexual/emotional desires, that empowers people to make positive decisions about their own sexual health and others, then this whole voyage of discovery becomes a social imperative. It is only through such positive choices that any effective prevention programmes can be developed, that women's sexual health be addressed appropriately.

Summary

Within South Asian cultures, personal identities are not based upon the sense of self, but rather of an extended family. This consists of our siblings, our biological parents, uncles, aunts, brother and sister-in-laws, all their resultant children, and so on. In other words, who we are arises from where we are in the extended family network. The person has a family and a community identity in which the sense of personal identity is subsumed. The focus of the self is not upon individuality but upon kinship. Our languages clearly express this, in that we have terminologies for all these relationships.

Within our cultures there are specific understanding of malehood and femalehood. These are defined by duties and obligations to the marriage partner, family and community, The man is not a man until he is married. The woman is not a woman until she is married and with her first child (often this could mean a boy-child). To be a single person after a certain age is seen as shameful, a dishonour to the family, often an aberration or sickness. Marriage is often seen as a ÒcureÓ for loneliness.

South Asian languages do not have specific expressions for homosexuality, heterosexuality, bisexuality as nouns or as adjectives. What exist are terms that express differing forms of sexual behaviours but these terms are often abusive and male dominated and refer to specific acts of penetration. In the context of these terms, the viewpoint is very much imbedded within what is malehood and femalehood. Sexual behaviours are within constructions of what is deemed appropriate behaviour for men and women. In these constructions, who does the penetrating in a sexual act becomes important for self-definition.

Sexual behaviour therefore is not an expression of a personal identity. Rather it often becomes one of opportunity, accessibility and personal desire for sexual discharge. The phrase Òbody tensionÓ is an expression of this discharge.

In terms of the cultural frameworks that construct South Asian sexual behaviours, the following points need to be remembered:

* Marriage is considered a duty and family obligation, not one based upon personal desire and choice.

* Marriage is also seen as compulsory.

* To be single is seen as an aberration. Cultural beliefs dictate that a person is not an adult until married.

* The central objective of marriage is the production of children, specifically male children.

* Sexual pleasure based upon desire, or lust, for one's wife is sometimes considered shameful. The Wife holds a special place in this regard. She is the Mother. A place of honour, for it is she who is charged with the responsibility of upholding family tradition, and the rearing of children. Sex with one's wife is often seen as a duty.

* This leads to a concept of sexual pleasure being permissible outside of the marriage context.

* Since there is no identity structure around the gender choice for sexual pleasure, what matters is more to do with the sense of malehood and concepts of masculinity.

* Thus, concepts of identity revolve around ideas of penetration. The penetrator is still ÒmanlyÓ, the penetrated is Ònot a manÓ.

* Further what matters is not the pleasure of the partner, but the pleasure of the self. Sexual behaviour becomes one of sexual discharge.

* Gender segregation, female virginity, loss of honour, and so on often make it easier to access other males for sex than females.

* Such accessibility is also made easier because of the extended family systems, and the homosociability of South Asian cultures.

* The sense of shame and dishonour arises from a public (community) perception about personal behaviour and the need to fulfil one's (public) duty.

* Since the concept of sexuality and sexual behaviours is bound up within concepts of sexual discharge, this often leads to frequent sexual partners, rather than forming continuous sexual liaisons with a single person.

* Often the gender of the sexual partner is irrelevant.

* This can be expressed by the statement ÒThe person has a relationship with his wife, but has sex with othersÓ.

* Women are much more supervised and policed by family and community, than men.

* This makes it somewhat difficult for women to carry out socially illicit sexual encounters/relationships.

* The penalties for women are of a much greater intensity.

* It is easier for women to access other women than men.

* Within 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.

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