Global Public Health

ISSN: 1744-1692 (Print) 1744-1706 (Online) Journal homepage: https://www.tandfonline.com/loi/rgph20

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To cite this article: P. Boyce , M. Huang Soo Lee , C. Jenkins , S. Mohamed , C. Overs , V. Paiva , E. Reid , M. Tan & P. Aggleton (2007) Putting sexuality (back) into HIV/AIDS: Issues, theory and practice , Global Public Health, 2:1, 1-34, DOI: 10.1080/17441690600899362

To link to this article: https://doi.org/10.1080/17441690600899362

Global Public Health, January 2007; 2(1): 1–34

Routledge
Taylor & Francis Group

Putting sexuality (back) into HIV/AIDS: Issues, theory and practice[1*]

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Abstract
After more than twenty years of programming and activism aimed at stemming the sexual transmission of HIV (and addressing the needs of those most vulnerable to infection) the HIV/AIDS epidemic continues to grow worldwide. Taking up this concern, this paper argues that one of the reasons why HIV prevention has had limited success is because of inadequate conceptualization of human sexuality in such work. Giving sexuality a more prominent position in responses to the epidemic raises a range of issues, including theorization of gender, understanding of sexual subjectivity, the significance of pleasure (or lack of pleasure) in sexual decision-making, and conceptualization of sexual behaviour and culture. Taking these themes forward entails asking significant questions about the underlying paradigmatic and methodological commitments of mainstream HIV/AIDS research, especially the tendency to reproduce accounts of human sexuality as if it were a measurable form of conduct only. Advocating new approaches that take the meaning and symbolic value of sexualities into account complicates established orthodoxies in the field whilst offering potential for more effective HIV prevention strategies.

Keywords: *Sexuality, HIV/AIDS, gender, programming, interventions*

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*This paper will be published in Global Public Health Volume 2 Number 1 February 2007.
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ISSN 1744-1692 print/ISSN 1744-1706 online
DOI: 10.1080/17441690600899362

Introduction

Sex has been at the heart of HIV/AIDS from the very beginning. During the early days of the epidemic, it became evident that unprotected sexual intercourse was the most common route of HIV transmission globally. Epidemiological and behavioural surveillance quickly indicated that whilst gay and other homosexually active men were initially more likely to be affected (Watney 2000, Bolton 1995), sexual orientation had nothing to do with the biological transmission of the virus *per se*. Rather, specific unprotected sexual acts allow HIV to pass from infected individuals to their sexual partners.

The realization that the micro-organism responsible for damage to the immune system was transmitted sexually arose out of the experiences of some gay men in North America during the late 1970s and early 1980s – prior to the isolation of the virus and the medical definition of AIDS. At the same time, members of gay communities instigated health promotion measures such as condom use for anal sex (Callen and Berkowitz 1983). After the identification of HTLV-III/LAV (later HIV) as the viral cause of AIDS, the concept of safer sex came to be consolidated, and across the world safer sex promotion continues to be the key HIV prevention message – although it takes different forms in different contexts and is subject to culturally and politically specific moral loading, as discussed below.

Despite enhanced knowledge of sexual risk, the majority of cases of HIV transmission continue to take place through unprotected sexual intercourse (UNAIDS and WHO 2005). Transmission through unprotected heterosexual sex is a common mode of transmission in most parts of the world. However, in many countries large (and in some cases greater) numbers of infections remain the result of sex between men. Some of these men may see themselves as homosexual, bisexual or gay; others may not relate same-sex sexual acts to a discrete sense of sexual identity (Aggleton 1996).

In parallel, all over the world countless thousands of people see themselves as somehow 'immune' to HIV infection by virtue of the fact that they have what is commonly considered normal sex – penetrative vaginal intercourse with a regular partner – believing that HIV is only transmitted through 'deviant' and 'promiscuous' sexual acts. Conversely, however, in countries throughout Asia, Africa, and Latin America, the major risk of HIV transmission to faithful married women is often seen to be through their husband or regular male partner (Buve et al. 2002, Maitra and Schensul 2004).

These facts raise critical issues for the conceptualization of sex and sexuality in HIV prevention. After more than 20 years of activism, policy, and programming, aimed at averting a global HIV epidemic, it seems that something is still missing. While not intending to suggest that it is the only cause, this paper argues that a limited conceptualization of human sexuality in HIV and AIDS work constitutes the major barrier to effective HIV prevention worldwide.

All over the world, people are prevented from speaking out openly and honestly about the causes of the epidemic – by politicians and government officials who will not listen and will not lead; by civil society organisations keener to promote

what is considered normative behaviour than support individuals in sexual development and expression; by religious and moral leaders who cannot accept the diversity of human sexuality; by educators and prevention workers who are too embarrassed to talk openly about sex; and by the tendency of people all over the world to pretend that the global epidemic of HIV is of diminishing concern. Such issues are addressed in this paper by considering some of the ways in which sex and sexuality have been marginalized in HIV and AIDS programming and by examining what might be involved in putting sexuality (back) into responses to the epidemic.

Some definitions and conceptual underpinnings

Some clarification of terms is required in order to frame the argument presented in this paper. 'Sex' is a word with various possible meanings. A definition developed for the World Health Organization (WHO) in 2002 emphasizes sex as biological, a physical attribute that divides people according to gender.

> Sex refers to the biological characteristics that define humans as female or male. While these sets of biological characteristics are not mutually exclusive, as there are individuals who possess both, they tend to differentiate humans as males and females. (WHO 2002)

Whilst admitting scope for ambiguity, the WHO guidelines nevertheless reflect common (nominally Western) understandings of sex as biologically intrinsic. This kind of biologically deterministic interpretation originated in sixteenth century European thought and articulates closely to what is now often spoken of as gender – that is the social characteristics associated with masculinity and femininity (which may vary both interpersonally and across culture) (Weeks 2003). Throughout much of the Western world, the nineteenth century saw the expansion of the term 'sex' to include physical sexual acts (between sexes). Thus sex emerged as a *practice*, a verb – something that is 'had' (to use English vernacular) (Weeks 2003: 4).

The idea of sex, however, has not simply developed through uniform, universal linear progression – the same in all places. Different cultures have evolved different understandings of acts that from a nominally Western perspective might be designated as sex, but which elsewhere may be thought of differently. Anthropologists, for example, have described how ritualized 'homosexual' acts between men in some societies (such as Melanesia) may not be conceived as sexual by participants, but rather as rites of passage – inductions into adult masculinity (see, for example, Herdt 1994). Similarly, contemporary research on male-to-male sex, in the context of HIV prevention, has shown how men in many cultures do not necessarily designate explicit sexual meanings to acts with other men that, from an outsider (Western) perspective, might be designated as sex (Khan 1996, 2001, Parker 1991, 1999, Lancaster 2002, Boyce, in press).

This said, it is too simplistic to assert that what sex is or is not is entirely dependent on culture. Individuals may derive pleasure and erotic meaning from 'bodily experiences' (conducted with others or alone), even if their culture does

not explicitly designate such acts as sex *per se* (Jenkins 2004). Contextual understanding of the practices of men who have sex with men in India, for example, reveals that whilst research indicates that many such men may simply designate such acts as 'fun' or *maasti,* this does not necessarily preclude erotic intent on the part of men practicing such acts, even if these are not explicitly conceived as sex (Khan 1996, Boyce, in press). To take another, more general example, a person may be intensely sexually aroused by a conversation with somebody whom they find attractive, interpreting the interaction as a sexual experience. For the other participant, however, no sexual intent may be recognized, admitted or desired.

President Clinton's famous assertion that he 'did not have sexual relations with that woman' ('eatin ain't cheatin') attests to the variability of meanings that can be attached to erotic acts, which may or may not be given sexual connotations depending on the contexts in which they are enacted, (mutually) perceived and judged. Given such subjectivity, there is considerable ambiguity about what sex is or is not in all contexts. Sexual acts are constituted in complex amalgamations of cultural and individual meanings, achieved in interpersonal and *intra*-personal practices.

As a form of expression, a sexual act can express virtually anything. Across cultures and histories the meanings of sexual acts, sexual relationships and the socio-political environments in which these take place, vary profoundly. Context, in its fullest sense, must be understood in order to design appropriate behavioural and structural interventions. A considerable proportion of all interpersonal sexual acts are forced or non-consensual, and may not even include the notion of pleasure. In some scenarios, having sex may be viewed as hard or dangerous work; a social duty; a way of obtaining protection, shelter, food, or drugs; an act of theft; a means to defile a person; an act of political defiance; a method of warfare; a way to get good grades, and so on. Any attempt to generalize messages about safer sex cannot but fail.

In order to be successful HIV prevention needs to be particularly sensitive to these complexities existing at multiple levels. On the one hand, successful prevention strategies must be concerned with the 'biological acts' that can transmit HIV, regardless of whether these are explicitly conceived of as sex by the people enacting them. On the other hand, successful health interventions require subtle understandings of the inter-related cultural and subjective meanings that frame sexual practice – indeed define what sex is in any given interaction. This is the only way in which attempts to prevent sexual transmission of HIV can hope to intervene in the specificities of sexual risk.

'Sexuality' is an equally complex and contested term and much of this paper will be taken up with an examination of this subject. Like sex, sexuality is ambiguous, constituted in social, moral, cultural and legal contexts, whilst potentially experienced as intrinsically personal. WHO differentiates sexuality from sex by stressing its cultural constitution, in contrast to the putatively biological attributes of sex.

> Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors. (WHO 2002)

This is an encouraging development for HIV and AIDS work, signaling a move beyond enumerative approaches to sexuality research focused on quantifying frequency of sexual acts, for example (Aggleton 2004). However, this move also raises complex issues concerning how to think about sexuality. In particular, how exactly might more conceptually informed and theoretically nuanced understandings of sexuality improve HIV prevention and AIDS care?

This paper takes up some of these challenges. The analysis presented offers a counterpoint to much current work – particularly approaches to HIV prevention which imply that talking about the issues without explicitly mentioning sex and sexuality, or exhorting individuals to 'stay safe' with euphemisms such as 'abstain' and 'be faithful,' are sufficient to bring about risk reduction. Instead, speaking about sexuality honestly and openly is emphasized as being programmatically and politically critical to HIV prevention success.

Nevertheless, complications in making sexuality more apparent also need to be considered. HIV prevention often offers narrow understandings of sexuality, premised on simplistic correlations between sexual identity and practice. Whilst such approaches have been instrumental in exploring sexual risk there is a danger that such strategies diminish sexuality to reductive classifications. HIV prevention measures premised on such understandings run the risk of underestimating sexuality as a *pervasive* and *broad-based inter-personal* and *cultural* phenomenon, which may have little to do with socially evident categorizations or explicit articulations of sexual intent. Motivations for sexual activity (and the potential for sexual risk) may have a tangential relationship to sexuality *per se*. This paper considers practical and conceptual issues arising from these concerns – stressing their potential for more innovative approaches in HIV prevention and AIDS care.

Concepts and contexts: Sexuality in HIV/AIDS interventions

During the course of the 1980s, as AIDS became a global concern, a gross lack of understanding of sexuality around the world became rapidly apparent (Gagnon and Parker 1995: 10). For example, the inadequacy of terms such as homosexual and heterosexual to capture the complexity and diversity of human sexuality (especially but not only across cultures) emerged as a serious problem (Gagnon and Parker 1995: 11). It also became obvious that many of the categories used to describe sexual experience in Western cultures did not necessarily make sense when addressing HIV/AIDS elsewhere.

Moreover, within cultural contexts, meanings attached to sexual terminology were seen to differ across generations and between individuals. For example,

research conducted by Rosenthal et al. (1990) in the early 1990s in Melbourne, Australia, revealed that for many young people the term 'monogamy' meant serial monogamy – with relationships in this age group generally lasting for less than a year. Given this, health promotion messages that advocated monogamy as a risk reduction strategy were potentially misleading, or at least failed to grasp the behavioural diversity and multifaceted scope for partner exchange and viral transmission encompassed *within* monogamous relationship patterns.

This warning resonates with current dilemmas in HIV prevention globally, arising from the resurgence of abstinence and faithfulness as intervention messages in recent US government funded HIV and AIDS programming (Girard 2004). The diversity of sexual partners, practices and risks that may *actually* take place within the context of putatively 'chaste' and/or 'faithful' relationships, present serious challenges for HIV prevention. A recent study of the sexual behaviour of HIV positive women in New York City, for example, found considerable variation in condom use in the context of long-term, monogamous sexual relationships, as well as across sub-cultures. Reasons for this varied considerably. Some women were unable to insist on condom use, even with sero-discordant partners who were aware of women's positive diagnoses. In such circumstances women were only able to use condoms consistently in their steady relationships with men who were strongly committed to protection, whether the men were also HIV positive or not (Simoni et al. 2000).

HIV prevention work that simply reiterates interpretations of monogamy or abstinence as 'safe' fails to grasp differences between the values associated with particular forms of sexuality and the realities of sexual life and risk. Throughout the history of the epidemic, close scrutiny of sexual classifications and practices in both Western and non-Western contexts has revealed significant discrepancies between the sexual behaviours associated with particular forms of sexual relatedness and identification, and the way people actually practice sexuality. For example, it has become clear that it is not only 'gay men' who have (unprotected) anal sex with other men (Dowsett 1996); and it is not only people who identify as 'sex-workers' who exchange sex for money, goods or favors (Aggleton 2004: 4, Hunter 2002).

HIV prevention interventions have had to confront the fact that sexuality is not a coherent, regular site of neatly matched sexual identities and practices – behaviourally obvious and universally classifiable. Rather sexuality is an eclectic, often culturally opaque, attribute of human experience – bound up with desire, fantasy, bodily expression, power, gender and understandings of self, conceived in practices and sentiments that may be far from socially apparent (or even obviously sexual).

These are not new concerns. Before HIV and AIDS, theorists had for some time been interested in the cultural and historical specificity of terms used to conceive sexuality (Newton 1972, Padgug 1979, Weeks 1985, Foucault 1990). Jeffrey Weeks, for example, has illustrated how ideas of sexuality as a discrete attribute of human experience took shape during the course of the nineteenth

century in Western Europe. This was an outcome of historically specific intellectual currents, which saw an enhanced interest in the classification of particular sexual desires. The concept of sexualities as specific ways of defining people who exhibit particular forms of attraction emerged in this climate (Weeks 2003). Gender came to be the most socially salient marker of sexual orientation – attraction to people of the same or opposite sex leading to the designation of people as homo- or heterosexual, respectively, with the former generally pathologised category predating and defining the limits of heterosexuality (Foucault 1990, Sedgwick 1990: 8–9).

Historiography of this kind relativised contemporary understandings of sexuality, which could no longer be regarded as an intrinsic attribute of 'self', biologically inherent as it were (Gagnon and Parker 1995). Rather, sexuality came to be seen thereafter as the historically specific outcome of intellectual and cultural processes and, as such, an attribute of human experiences intimately bound up with the language and knowledge systems of the post-enlightenment era.

Cross-cultural research has similarly emphasised the cultural specificity of sexuality. Since the 1980s, anthropology has begun to explore ways in which sexuality has no categorical or experientially inherent unity, but rather is locally constructed, conceived in respect of culturally specific beliefs and knowledge (Vance 1991, Kulick 1995, Rubin 2002). From an ethnographic point of view, there is no universally stable category that is sexuality (Lancaster 2002) – no sexual 'it entity', as Gilbert Herdt has put it (1991: 483). Instead, anthropologists have stressed culturally diverse ways of experiencing and conceiving erotic experiences. These may not relate to cultural conceptualizations of 'sexuality' in any straightforward way, as the assemblage of bodily practices, desires, and beliefs marked as sexuality in one context may take shape differently elsewhere – and indeed may not be thought of as sexuality in explicit terms. Sexuality is, thus, isomorphic across cultures, not simply influenced by dissimilar social beliefs and values, but actually culturally constructed in context (Vance 1991).

Finally, it is relevant to note that critical theorists such as Judith Butler (1990, 1993) and Eve Kosofsky Sedgwick (1991) have drawn on historiographic and anthropological material (Newton 1972, Foucault 1990) to explore the performative aspects of sexuality as they relate to gender and social categorization. The work of these and other writers accents the ways in which sexuality takes shape in practice, in ways that are far more fluid and variable than the essentialist categories used by society to designate specific types of sexuality (such as homo- and heterosexual) (Bristow 1997). Work of this kind addresses dissonance between discourse and practice – emphasizing sexuality as a product of both mundane bodily activities and social and cultural meanings.

Crucially, sexuality is not simply a cultural construction but is also an embodied practice. As such, the acts and understandings that give sexuality meaning are constantly open to re-interpretation by social actors, as dissonance between the lived realities of sexual practice and the social categorizations used to

define sexuality is a daily reality – even if not always consciously reflected on by social actors. Such perspectives have been an influence on the development of queer theory and politics, for instance, which (broadly speaking) has stressed ways in which sexual experience cannot simply be subsumed under rubrics such as gay or straight, homo- or hetero-, nor, indeed, necessarily conceived as a coherent sphere of practice or subjective experience (Butler 1990, Sedgwick 1991, Elliston 2005).

For HIV and AIDS, the theoretical perspectives briefly sketched out above are epidemiologically imperative because they emphasise how sexuality is socially constructed and practiced in ways that do not necessarily match preconceptions. Patterns for the sexual transmission of HIV do not simply correspond to public norms of sexual life, or standardized socio-sexual categories. Rather, viral transmission is intrinsic to ways in which sexuality is culturally obscured, and practiced in ways that may be far from socially self-evident or public. The critical importance of this understanding has, over the last 20 years, instigated a diverse range of social scientific work on sexuality in relation to HIV and AIDS. Theory and research in this field has emphasised the malleability of human sexuality, as it is socially and culturally constructed and made meaningful in embodied personal practice, rather than simply being a biological, universal drive or instinct – pretty much the same everywhere (Patton 1990, Dowsett 1996, Parker 1999, Setel 1999, Aggleton 2004, Pigg 2005). Taking these issues seriously is seen as the only way in which HIV prevention measures will be able to adequately address the cultural and inter-personal complexity of *actual* sexual risk scenarios and avert HIV transmission.

Whilst HIV and AIDS have catalysed new theorising and research on sex and sexuality the programmatic influence of such work is at best scattered and at worst minimal. Mainstream policy and programming (both internationally and in many national AIDS programmes) has tended to minimize theoretical perspectives on sexuality in favour of biomedical approaches. This has reversed the dominant trend of sexuality research in the second half of the twentieth century, which had witnessed an increased pre-eminence of sociological, ethnographic and psychological studies (Gagnon and Parker 1995). By reasserting links between sex and disease, AIDS has revitalized biomedically influenced approaches to research on sexuality, beyond what had become established as the conventional areas of medical specialism; obstetrics, gynaecology, psychiatry and sexual health (Vance 1991). Given this, whilst sexual practice has been placed firmly at the centre of debates concerning HIV transmission and AIDS prevention, bio-medical emphasis has shaped policy and research in the field – determining how sexuality is understood (Pigg 2005).

Peter Aggleton, for example, has written of major resistance to overt discussion of sexuality which he encountered in the early 1990s, whilst an employee in the World Health Organisation's former Global Programme on AIDS;

> At that time, scant attention was paid to sexual meanings, motivations and desires. I well remember members of one meeting looking aghast when I suggested that there may well be all

> manner of 'sexual' activities that are never talked about let alone described as sex – the activities that occur between men in prisons, for example (Simooya and Sanjobo 2001), between uncles and nephews beneath blankets in South Asian households (Khan, 1996), between Catholic nuns (Curd and Manahan 1985, Fisher 1998), or between girls and their teachers in schools in Zimbabwe (Shumba, 2001). All this was seen as tangential to the main mission – namely, the enumeration of a limited range of 'sexual risk behaviours' in the adult general population (Aggleton 2004: 4).

Predominant paradigms in HIV/AIDS work typically privilege the accumulation of empirical information about sexual behaviour, focusing on research measurements such as the frequency of sexual acts, rates of partner exchange, patterns of sexual networking, and so on. Such positivist approaches seem epidemiologically useful because they offer an ostensible map of sexual life, either amongst a given population or within an environment studied. Research findings appear rooted in fact, providing critical information about sexual risk and HIV transmission and locating sites at which interventions might be best directed for maximum effect. As such, predominant HIV research neatly coheres with development agendas, which typically require auditable depictions of the beneficiaries of interventions, such that the effectiveness of health promotion strategies may be measured and their cost effectiveness evaluated (Adams 2005).

This information is also ostensibly useful for agencies that want to either demonstrate or appraise the value of a particular HIV prevention strategy – for example, illustrating how people may report practicing safer sex after a health promotion campaign. However, such enquiry rests on limited empirical depictions, as if sexuality is a transparent object of study – which can be made sense of through accounts of sexual activity. The tendency in such research is to produce uniform explanations of sexuality, as if it were a form of rational, measurable conduct. Behavioural diversity may be taken account of and change in sexual practices emphasized (perhaps as outcomes of HIV prevention). However, behavioural quantification alone is analytically insufficient to conceive the cultural depth, individual richness, inter-personal complexity, social diversity, and practical malleability of human sexual experience.

The interpretation of sexuality accented in predominant HIV and AIDS research is quite dissonant from the conceptual approaches advanced in much social theory. As noted, theorists of sexuality have generally stressed the importance of understanding how sexuality is *made meaningful* in lived practice, in reference to the symbols and values of any given cultural context and in respect to variance between social categorization and the subjective experience of social actors. Such ideas are especially relevant when considering the limitations of behavioural research, because in many social contexts the idea of sexuality as culturally transparent and behaviourally measurable may not make much sense. This can produce tension between the expectations of people researching sexuality and the sexual knowledge of people being studied. Thus, for example, Philip W. Setel has observed of his research on sexuality in the context of HIV/AIDS in Tanzania, that '[t]he precision of meaning that I sought in assessing sexual meanings in the context of relationships was not a preoccupation that many informants shared' (Setel 1999: 91). This did not mean that the people with

whom Setel conducted research did not talk about desire, and indeed sexual pleasure was a popular topic of conversation. However, this largely 'informed private thought and action [...], "culture" was either silent or hostile on these matters' (Setel 1999: 92).

This is an important observation because the social meanings and understandings self-achieved by people were not simply ascribed by culture, giving rise to apparent, predictable and recordable sexualities. Rather, concepts of personhood were achieved in practice, and were not always consciously reflected on (Setel 1999: 90). For Setel, this is a critical point in evaluating the conceptualization of sexuality in HIV prevention, since in Kilimanjaro, the study site where his work took place, he notes, '[t]he AIDS educators cookie-cutter abstractions of sex, sexual contact and risks were virtually meaningless without being related to the context of some sort of story about people' (Setel 1999: 90). It was only meaningful to talk about sexuality with respect to specific incidents and practices. The abstract idea of sexuality was simply not relevant.

Such observations raise complex questions for research on, and understanding of, sexuality in HIV and AIDS work, implying cultural contexts of sexuality that by their nature are immune to empirical investigation alone. Thus, although sex may be most apparent in terms of specific behaviours, for example, these may not necessarily be known as sexuality *per se*. This is a critical concern for HIV and AIDS work, stressing the need for culturally sensitive HIV prevention strategies that do not simply appropriate 'local' terms for sex and attach these to putatively universal biological models for understanding sexual life and health. Rather, it is vital to explore contextually specific practices and risks. These may not be conceived by people through socially uniform models of sexuality. As such, it is vital for research to look at sexual life as an attribute of experience that is potentially disconnected from cultural constructions of sexuality, perhaps having as much to do with how people may act in discordance with social norms and expectations. This may disrupt taken for granted assumptions about the subject of sexuality research and, indeed, may entail exploring social, cultural, inter- and intra-personal practices and values that, from an outsider's point of view, may appear to have little to do with sexuality, health or even HIV transmission (Pigg and Adams 2005).

The intellectual weight attached to biomedical knowledge in AIDS programming prevails against the use of more conceptually nuanced and diverse understandings of sexuality in HIV prevention. Thus, even when 'other' cultural conceptions of sexuality are taken into account, these are often simply regarded as 'folk models' or popular (mis)conceptions. Stacy Leigh Pigg's analysis of a statement on sexuality and HIV/AIDS in Africa, made by the virologist Dr. Malegapuru William Makgoba, reveals how an apparent plea for culturally informed understandings of sexuality in HIV and AIDS work actually privileges mainstream biomedical knowledge. A Reuters report on Dr. Makgoba represents his position thus:

> African scientific and government leaders need to recognize that the AIDS crisis in this region is not just about statistics and treatments, Dr. Makgoba said, but involves a complex interaction between science, politics and culture. 'The challenges facing science and its development today are no longer predominantly technical but largely social'.
>
> Research into the particular cultural backgrounds and sexual practices of Africans is almost nonexistent [. . .] with no focus being placed on combating the sexual mythologies, taboos, and ignorance that inform the sexual behaviour of many African men and women . . . 'The whole subject of human sexuality in Africa is . . . based on hearsay', Dr. Makgoba told Reuters Health. Addressing sexuality scientifically 'will make a lot of difference to people, both in the developed and developing countries' (from www.reuters.com excerpted in Pigg 2005: 44)

As Pigg observes, on the one hand Dr. Makgoba signals the need for socially and culturally-oriented approaches to HIV prevention, as opposed to purely technical strategies. However, this assertion is immediately undercut by a call for scientific work, which in Dr. Makgoba's terms, may overcome the irrational mythologies that inform understandings of sexuality in Africa:

> Dr. Makgoba's lecture leaps from a view of sexuality that could foreground the social (and the local) to a view of sexuality that emphasizes the biological and the universal). Dr. Makgoba anchors the call for a scientific approach to sexual behaviour in biological processes. For him, a 'frank and open' public consideration of sexuality is one that makes it an object of medico-scientific knowledge, and this knowledge is assumed to be objective and neutral (Pigg 2005: 45).

A recent UNAIDS policy position paper on 'Intensifying HIV prevention' (2005) offers a similar approach to analyzing culture (and sexuality), outlined in the following terms.

> *Cultural norms and beliefs.* HIV transmission is fueled by a variety of factors, including most importantly, the local context created by local norms, myths, practices, and beliefs, as well as social, economic and human security realities. HIV prevention efforts must be tailored to respond to those norms, practices and beliefs that hamper HIV prevention. Simultaneously, those norms, practices and beliefs that potentially can support HIV prevention need to be fully harnessed (UNAIDS 2005: 14).

It is welcome that culture is given attention in these prevention guidelines. Scant reference to such matters has been made previously by UN system agencies, and few other international agencies working on HIV/AIDS accent culture in such explicit terms. Nevertheless, the statement raises critical issues that need to be explored further in order that the intentions outlined may be taken forward effectively. The instrumentalist view of culture put forward in the quote above has limitations, whilst the language used displaces the focus of discussion. Crucially, the subject of the excerpt is obscure – cultural beliefs and myths about what exactly? Since the subject of the statement is HIV prevention, this may be taken to imply beliefs, myths and norms pertaining to disease or illness, which is certainly important. However, it is reasonable to conclude that what is also being implied in the guidelines is sexuality. Given that sexual transmission is the predominant route of HIV transmission worldwide, beliefs, practices, norms and myths pertaining to sexuality need to be taken account of in culturally sensitive HIV prevention.

Making this clearer makes the limitations of the UNAIDS guidelines more apparent. The guidelines set up a contrast between knowledge about sexuality in 'cultural contexts' and knowledge about sexuality useful for HIV prevention. Effective HIV and AIDS work is seen to require a coming together of these knowledge systems – either as mutually supportive or via the overcoming of folk myth via the rational application of knowledge about sexuality that will better enable HIV prevention. This is a well-intentioned proposition. However, in terms of the statement the implication is that there is a 'correct' understanding of sexuality and sexual risk and something lesser, which is cultural belief, which may or may not be helpful.

The contrast is revealing because it shows how knowledge about sexuality is valued in HIV and AIDS work – with 'scientific', biomedical models given preeminence. Thus, even though the guidelines on cultural norms and beliefs insist on sensitivity to culture, they nevertheless favour scientific knowledge. This reiterates a positivist, rational approach to sexuality. Such an approach implies that a single perspective can both explain and address HIV and AIDS, which is a diverse and intractable phenomenon, warranting commensurately multifaceted approaches if the epidemic is ever to be halted (Berger 2004: 47). Given this, cultural attitudes towards sexuality need to be integrated into effective prevention, rather than simply seen as barriers.

This is not in any sense to dismiss the UNAIDS guidelines on culture. Indeed, given the predominantly biomedically oriented focus of many international approaches to HIV and AIDS to date, the focus on culture is highly progressive. However, it is to consider seriously questions raised by an intention to emphasize culturally informed approaches to sexuality in HIV and AIDS work, as opposed to purely technical solutions to viral transmission.

Rationalization and resistance: Knowledge and power in HIV prevention

Elizabeth Reid (2004) has spoken about the current state of play in HIV prevention in the following terms:

> The consensus at the international HIV/AIDS conference in Barcelona [in 2002] was that prevention technologies and techniques are known: what is needed is the political will and funds. In the past two years, both the political will and the funds available have increased. [...] Nevertheless the reality is, in the words of Catherine Campbell (2003:1), that people continue to knowingly engage in sexual behaviour that could lead to premature and painful death, and the best-intentioned efforts to address sexually driven epidemics often have little effect. [...]
>
> Sexually driven epidemics require analytical frameworks that capture ... the 'thickness' of the realities that gave rise to them. ... They would then be able to elucidate the ways in which sexual behaviour is often not under the control of an individual's rational and conscious choice. This is the rationalist fallacy that has shaped, and undermined, the response to date, the fallacy on which the Barcelona consensus, and ABC and other directive strategies are based (Reid 2004).

Catherine Campbell's (2003) work, cited here, accents the profound implications of rationalist, biomedically driven approaches to HIV and AIDS – they cost lives. People are contracting HIV because HIV prevention is failing. HIV

prevention is failing, in large part, because of inadequate approaches to sexuality, premised on rational models of sexual conduct. Such models have some value in respect to conceiving situations in which people are evidently disempowered and consequently unable to make choices about sexual safety. For example, sex workers who may be compelled to abandon condom use in order to keep a client. However, more generally such scenarios have limited explanatory power. They do not do enough to explain, for example, why some forms of sex work may be safe (Dowsett 1999). Moreover, they fail to explain why ostensibly empowered and informed people still practice unsafe sex (Berger 2004:49). Clearly, safer sex is not about information or technical responses alone.

As Reid (2004) observes, the concerns outlined above take on particular significance in the contemporary political climate pervading much global HIV and AIDS programming and funding. Attitudes associated with non-heterosexual, non-monogamous forms of sexuality, and the use of condoms, propounded in ABC (Abstinence, Be faithful, use Condoms) models of HIV and AIDS programming, put forward by the US President's Emergency Plan for AIDS Relief (PEPFAR), instigate a moral agenda. This has helped to further marginalize progressive and creative attitudes towards sexuality in HIV prevention, which might address behavioural and motivational complexities informing sexual risk, in favor of an emphasis on abstinence and faithfulness. The effect is to curtail conceptualization of sexuality in HIV and AIDS work, whilst constraining understanding of sexuality in people's lives – as something to be suppressed in practice.

This articulates closely with orthodox values held in many countries in which public talk about sexuality is strongly disfavored and in which forms of sexuality other than heterosexual monogamy are heavily stigmatized or socially denied. This has been a prevailing way of characterizing sexuality in HIV/AIDS work in many African countries, in which the ABC policies have been most heavily promoted. Such representations particularly augment denial about male homosexuality in much of Africa, limiting the scope of socially acceptable mainstream HIV prevention discourses (Patton 1999, Niang et al. 2003, Berger 2004).

Denying programmatic attention and analytical complexity to sexualities other than heterosexuality, and especially heterosexual monogamy, compounds the structural vulnerabilities that help to make many sexual minority populations more vulnerable to HIV infection in the first place. They instigate a contrast between good sex and bad sex or, what Jonathan Berger has called 'dirty sex'- which consists of sex with '"unacceptable" sexual partners, such as people of the same sex and commercial sex workers, and those that involve "unacceptable" practices, such as anal sex and sado-masochism' (Berger 2004: 48).

Berger argues that the prevalence of HIV in Southern African countries suggests that many more people practice 'dirty' sex than the heterosexual monogamous sex that many put claim to.

> It [. . .] seems reasonable to infer that the high levels of HIV infection seen in Southern Africa can only be explained by a much higher prevalence and incidence of 'dirty sex' than is generally admitted, particularly by those who also engage in 'clean sex'. If this is true, it has two key implications for public health policy. First, it requires that the state and other important role-players invest resources into appropriate research that aims to give as accurate and comprehensive a picture as possible of how society actually has sex. Second, it means designing and implementing HIV prevention programmes that move beyond the sanitized paradigm of sex without desire, viewing sex as more than that which gives expression to and nurtures warm and fuzzy monogamous relationships (Berger 2004: 51).

ABC policies are dangerous precisely because they accent a 'fuzzy' interpretation of sexuality – diminishing the capacity for programmes to address non-heterosexual monogamous forms of sexuality in anything other than pejorative terms. Clauses within PEPFAR guidelines, for example, make it clear that these moneys may not be used for activities that advocate for the legalization or practice of prostitution and sex trafficking, and may not be provided to any organisation that does not have a policy opposing prostitution and sex trafficking. While this restriction does not technically prohibit the provision of health care to sex workers, and while the US Agency for International Development and the Department of Health and Human Services have released guidelines for implementation of this pledge requirement, these have neither defined the phrase 'opposing prostitution', nor described permissible and impermissible activities (SIECUS 2005). As a result, prevailing trends in policy and programming have tended towards conservative interpretations of PEPFAR guidelines – limiting capacity for effective prevention with stigmatized populations. This has helped to undercut the positive attention to sexuality and health that the Cairo consensus went some way towards instigating 11 years ago (Gruskin 2004).

Critically, recent US government policies have galvanized the arguments of those who call for conservative approaches to sexuality (both nationally and internationally), emphasizing family planning, and the 'normative' values pertaining to sexual life attenuate to such positions (Gruskin 2004). HIV and AIDS have always accentuated prejudices directed at 'out-groups' who have been associated with the disease (usually sexual minorities) (Fordham 2001, Parker and Aggleton 2003). The epidemic has galvanized discrimination against those seen as sexually illegitimate. Current ABC guidelines are an obvious outcome of such values, literally applying political authority and capital to determine the kinds of sexualities that may be prioritized in HIV and AIDS programmes and interventions funded under PEPFAR.

Resistance to PEPFAR-legitimized prejudice illustrates how bringing sexuality back into HIV and AIDS is not simply an epistemological act, but a *political* one too – requiring overt resistance to power. In international HIV and AIDS programming this is complex, because systemic approaches can conspire towards orthodoxy. UN system responses to HIV and AIDS, for example, are generally constrained to politically neutral positions, given the need to win consent in the international arena, and the variety of actors whose points of view have to be taken into account (Cameron 2000). National governments may act more autonomously, but may not have sufficient will or economic and political power

to do so. Dissidence does occur however. For example, in the year 2005 the Brazilian government turned down US$40 million of PEPFAR money because conditions attached stipulated that funds could not be distributed to organisations that did not have an explicit anti-prostitution policy:

> The director of Brazil's HIV/AIDS programme explained. "Brazil has taken this decision in order to preserve its autonomy on issues related to HIV/AIDS as well as ethical and human rights principles". The Brazilian government and many organisations believed that adopting the PEPFAR condition would be a serious barrier to helping sex workers protect themselves and their clients against HIV infection (http://www.avert.org/pepfar.htm).

The Brazilian government's action can be seen as a radical assertion motivated by the need to keep sexuality in HIV and AIDS programming, in order that prevention might be effective.

The concerns outlined above stress issues involved in bringing sexuality (back) into HIV and AIDS work. Sex positive approaches are needed, emphasising consensual sexuality as pleasure and not denying analysis, policies, and programmes that address safer sex in these terms. This is vital for the promotion of safer sex. In the Philippines, for example, adolescent health programmes have emphasized the dangers of 'PMS', an abbreviation that is used by researchers, policy-makers and programme implementers to refer to premarital sex (Tan 2002). The term itself evokes pathology, focusing on sex as a problem in itself. Few programme advocates would dare to speak of the possibilities of 'safe' premarital sex which is pleasurable and respectful. In fact, one could argue that the continuing stigmatization of PMS itself prevents young people from practicing safe premarital sex because bringing condoms on a date implies preparations for sex that is declared, at least in public rhetoric, as wrong under all circumstances (Gammeltoft and Nguyen 1999).

Asserting the value of more 'open' approaches to sexuality is a political act, especially in the contemporary funding climate. Taking this concern seriously means recognizing different ways in which knowledge about sexuality is produced, and the significance of this for HIV prevention. Sexuality is not separate from systems of knowledge. Rather, sexuality and knowledge are intimately symbiotic, implicated in one another through systems of power applied at the point where the body and the social converge in sexual practice, as Foucault famously argued (1990).

Moreover, the manner in which sexuality is lived in different societies is intrinsically linked to power/knowledge (which are combined systems in Foucauldian terms). Social hegemonies affect how sexuality may or may not be talked about, seen as socially legitimate or even recognized as sexual. Scientists (both social and biomedical) producing knowledge of sexuality are directly implicated in systems of knowledge and power – as the information they produce is embedded in political, ideological, intellectual and gendered paradigms that determine how sexuality is framed in research, policy and programming (Dowsett 2004, Reid 1996). This is poorly understood in prevailing HIV and AIDS studies, which are frequently premised on the idea of sexuality as a socially discrete

phenomenon – independent of the systems of research that produce information about it.

Such perspectives, as we have argued earlier, have misleading and unintended consequences for HIV and AIDS interventions, which generally fail to see how the particular versions of sexual life they produce are the reflection of particular paradigmatic, political and programmatic commitments. Major conceptual innovation is required in order to enable HIV and AIDS work to move on from limited, biomedically-oriented, positivist approaches towards paradigms that address sexuality as it is conceived in cultural construction, symbolic value, subjective meaning, embodied practice, erotic or non-erotic intent, gendered negotiations and power relations. Developing the conceptual grounds for such paradigmatic innovations requires closer scrutiny of existing interventions and policies, so as to better understand the kinds of messages about sexuality being put forward, and the prevailing assumptions underscoring current agendas.

Mixed messages: Sexuality and health in HIV prevention

The connection between sex and health, reinforced by the medicalization of sexuality in much HIV and AIDS work, may seem necessary and indeed inevitable; an outcome of fundamental links between sexual practice and viral transmission. Nevertheless, whilst connecting sexuality and health has been intrinsic to many HIV programmes, the emphasis on this link is problematic. The tendency to reduce understanding of sex to safe or unsafe acts, as if conscious reflections on risk (and potential infection) motivate sexual practice in straightforward ways, reiterates the rationalist fallacy discussed above. The effect is to narrow conceptualization of social actors to people whose sexual behaviour may or may not transmit HIV.

Preoccupation with such concerns underpins many of the dominant research paradigms in the AIDS field today, reiterating (as was stated earlier) methodological fixations on quantifying risk, rates of partner exchange, condom use, and so on, as if such knowledge might indicate how best to stop the epidemic. Whilst such quantitative information may be useful in helping to build epidemiological profiles and asserting 'statistically valid' and 'evidentially strong' cases for investment in specific HIV prevention strategies, such approaches foreclose broader conceptualization of sexuality and prevail against more informed understandings of risk.

At an inter-personal level, problems with drawing explicitly rational correlations between sexuality and health are perhaps most evident in accounts of sexual motive. Mary Huang Soo Lee (2004) has explored some of the problems inherent in rationalizing sexuality, discussing a case study of a 28 year-old, educated and employed woman in Malaysia, who fell in love with and married a man who was living with HIV. She did not practice safe sex despite counseling because: 'I want to catch the HIV [and] die with him. I want him to feel that he was really loved'. In her analysis of this response, Mary asked: 'If [the woman] becomes sick and dies, did she die from AIDS or did she die from sexuality'?

Similarly Vera Paiva (2004) has reported the following statement given by a person living with HIV, admitted to a hospital in São Paulo, Brazil:

> [At] the exact moment I was infected by HIV, I was *not* 'getting infected'... I was deeply in love, wanting to be with my love, in a joyful and long desired moment of bodily and spiritual pleasure, longing for all the moments we would be together ... from that magical moment, sharing hopes and sensitiveness.

These sentiments offer a direct reflection on how sex is motivated by desire and romantic love. In the respondent's retrospective account, the potential of infection was not considered in the instant of viral transmission – indeed a transcendental connection beyond the purely physical was visualized.

Other narratives may tell other stories. For example, 'At the exact moment I was being infected I was... earning a living; having casual fun with a stranger; being forced against my will; committing (or being subject to) an act of war; securing a bed for the night; getting out of an awkward situation; having sex with or fulfilling my duty to my husband'. A myriad of scripts can catalyse and 'make sense' of sexual activity, giving social and symbolic meaning to acts that cannot simply be understood as the outcome of simple biological imperatives (Simon and Gagnon 1984). This is not to imply that the meanings of sexual activity are purely a matter of random narrative choice.

Certainly many young women who marry or sell or trade sex may be choosing from very limited options. As Salim Mohammed (2004) has stressed, sex may be subject to 'varying levels of volition and coercion'. In the slums of Kibera in Nairobi, for example, the boundary between refusal and consent can be sometimes blurred. Young women may be encouraged to exchange sex for money and gifts, not only in order to meet everyday needs but also for companionship, for the pleasures that can be involved, and in hopes of finding someone who one day may provide for them.

Desires, by their nature, are often experienced as beyond rational choice, as a compulsion of the body (even if socially constructed). Moreover, the power exerted through sexual relations means that for many people sexual acts may have little to do with choice, as the sexual body becomes a site for social control, gendered negotiations, racial conflict, etc.

Given the complexity of sexuality as a social and personally intimate phenomenon, health promotion messages that stress sex as an act simply related to health are inevitably partial. This is not to say that health cannot be successfully linked to sexuality in HIV prevention. The successes of safer sex campaigns in stemming serious HIV epidemics in countries such as Thailand, Uganda, and Senegal, indicates that people have been willing to incorporate understandings of risk and health into sexual decision making (UNAIDS, 2001). However, the emphasis on the creative and pleasurable possibilities of (safer) sexual behaviour, that have been necessary to maintain an interest in safer sex amongst target constituencies in most successful safer sex campaigns, illustrates that desire, as opposed to health alone, is recognized as a significant motivating factor. Health information is not enough to sustain widespread levels of safer sexual practice in

communities and societies, even in sex acts over which the participants have choice.

Problems with limited visions of sexuality in HIV prevention are well illustrated by increased incidence of unsafe sex amongst some gay men, increasingly reported in the UK, North America, and Australia, a practice sometimes described as 'barebacking'. Various explanations have been put forward to account for this phenomenon, including the increased availability of anti-retroviral drugs in Western countries, which has fundamentally ruptured the AIDS equals death equation. Another explanation is that younger generations of gay men, who have not been exposed to the foreboding messages of 1980s HIV prevention, have normalized the epidemic, such that HIV infection no longer presents a sufficient motivation to sustain safer sexual activity. Yet other explanations stress the symbolic weight that may be attached to unsafe sex – as an indicator of trust in romantic love (Jones 1999).

Another possible explanation is the transgressive value that may be attached to unsafe sex. Crossley (2002) has argued that safer sex has helped to set up the idea of the good, healthy gay citizen – living according to normative values that prioritize a long and healthy life. Drawing on Odets' (1995) and Mallinger's (1999) work, Crossley argues that the failure of generic HIV prevention, to engage with gay sexuality other than in reductive terms of condom promotion and overly simplistic interpretations of gay men's sexual motives and lifestyles, may have actually fostered the grounds for practices such as barebacking – as a cultural reaction to the limited vision of sexuality put forward in predominant prevention paradigms (Crossley 2002, see also Martin 2006)

Discussing a related but different scenario, Mohammed (2004) has described the structural vulnerabilities that enhance risk of HIV infection amongst urban slum dwellers in Kenya. In this setting, lack of income for some reduces sexual choices, such as sex workers who 'engage in unprotected sex for the sake of higher fees'. Mohammed observes that over the last three years, HIV programmes in Kenya have begun to pay more attention to the way in which 'socio-economic and cultural contexts of sexuality have a direct bearing to the transmission of HIV'. However, in doing so they have tended to ignore sex *per se*, with the result that 'HIV is still spread beneath the programming surface'. Such an observation illustrates how a programmatic awareness of HIV infection in relation to broader public health issues, such as poverty, can occlude a focus on sexuality with negative consequences for HIV prevention work.

Of course, sexual risk cannot simply be understood by focusing on sexual acts alone. Sexuality is intimately embedded in social life; a site for the negotiation of self and other bound up with economies of exchange and power. Risk occurs in sexual activity but the antecedents of risk may take shape beyond what refers to as the performative sphere of sex itself (Reid 2004). This is clear where sexuality is neither negotiated nor consensual as, for example, in the rape of women, transsexuals, and others. However, for many women, sexuality, reproduction, infection, the desire to parent, and ideologies of femininity, are interconnected.

As Reid (2004) has stated, 'for most women, sexuality is complicated by consent, redolent with reproduction, fraught with self-interrogation, discomfort, the performative act so often focused on the other. Death has always been a constant companion, through childbirth or violence or a death of the spirit'. Yet, addressing such structural contexts alone will do little to prevent HIV transmission unless the ways in which sexuality is embedded in social structures (through people's interaction within cultural settings and values) is given explicit emphasis within future programmatic responses.

The issues outlined above indicate how making connections between sexuality and health may not be beneficial in HIV prevention, unless sexuality is adequately conceived. This is complicated when language and broader cultural values regarding sexuality are taken into account – especially as these may be dissonant from the values of HIV-related research. Understandings of sexuality (across culture) may not be characterized by linguistic and conceptual associations with health. Indeed, such connections may not be salient outside biomedical knowledge systems and popular (nominally Western) cultures informed by them.

Pigg (2005) has observed that the development of HIV prevention programmes in Nepal has required community workers engaged in health promotion to forge discursive links between sex and health in HIV and AIDS education campaigns. Internationally funded, generally biomedically driven AIDS work may simply see this as a matter of finding culturally sensitive terms for universal aspects of sexuality. Pigg observes that a more fundamental linguistic construction has been necessary in Nepal, because conceptual correlations between health and sex had little prior cultural salience. Health interventions make these connections, often in community-based workshops designed to elicit such vocabulary – labeling the terms arrived at as local terms for STIs, sexual health, etc. However, these are linguistic constructions achieved in the health promotion milieu – produced by the perceived exigency of having to come up with such terms. As such, the expressions arrived at seem artificial. They may be put forward as culturally inherent in health promotion discourses, but they are far from universally known. As Pigg observes;

> I was told by AIDS workers that they found something odd about the materials, something that didn't fit into the slot left open in the curriculum for listing their culture's values and beliefs about sexuality. What felt strange and foreign to them was the relentless attention AIDS work paid to the act, the behaviour, the practice, the precise naming of body parts and desires – an excision of sexuality, as 'sex', from its imbrications in morally saturated interpersonal connections. This excision was also variously seen as necessary, emancipatory, useful, vulgar, pointlessly impersonal, morally dangerous, erotic and so on. But always it was seen as ever-so-subtly not entirely 'Nepali' (Pigg 2005: 50).

In this instance, asserting connections between health and sexuality in HIV/AIDS work meant that the ideas produced had little obvious relevance to the culture they were intended to reflect and inform (through HIV prevention practices). Practical complexities of addressing sexuality and health in culturally sensitive terms in HIV prevention are further accented by Graham Fordham (2001) who observes that whilst the idea of 'HIV risk groups' has been subject to

critical deconstruction elsewhere, in Thailand the concept has continued to exert a high degree of influence over the way the epidemic has been analysed and responded to. This has augmented a 'wave theory' approach to HIV epidemiology, in which the virus has been depicted as moving from putatively discrete risk groups into the general population. HIV was initially recorded amongst injecting drug users, then men who have sex with men, and, especially in the so-called second wave of the epidemic, female sex workers, who are said to have transmitted the virus to heterosexual men who then transmitted HIV to their wives, other women and so forth (Fordham 2001).

According to Fordham, the wave model of HIV infection is both conceptually and biomedically flawed. In the first instance, it rests on a reductive belief that members of society can be unproblematically demarcated as if they were specific 'sexual types' or risk groups. Secondly, and crucially, molecular biology has challenged the underlying epidemiology of the model, showing that different 'subtypes of HIV-1 have been responsible for the majority of HIV infections throughout the country, demonstrating that the AIDS epidemic amongst IDUs in 1988 was largely independent of the epidemic which later developed amongst the heterosexual community' (Fordham 2001: 267).

Despite evidence to the contrary, however, wave models and associated ideas of HIV risk groups prevail in both popular and programmatic responses to HIV in Thailand. In particular, these have perpetuated accepted prejudices associated with female sex workers as if this were epidemiologically valid knowledge. The generally accepted orthodoxy is that 'it is the second wave of HIV amongst female prostitutes that is responsible for moving HIV into the broader heterosexual population and that this should be the primary focus of prevention efforts' (Fordham 2001: 267). Such assessments conflate a range of perceptions and values. In particular, the validity attached to the intrinsic moral agenda reduces capacity to respond to the epidemic in a more comprehensive and effective manner, whilst galvanizing coercive prevention work with sex workers. Ultimately, the value judgments and stereotyping on which current HIV prevention strategies are based derive from an idealized vision of Thai sexual life. This conspires with hegemonic cultural values, which emphasize the sexual morality of the general population and especially the pre-marital virginity of women. In this context, women sex workers are marked as morally transgressive and as such are readily cast as agents of HIV transmission. This is a limited analysis as Fordham observes:

> Research which stressed generally high levels of Thai sexual morality [. . .] failed to come to terms with many crucial (from and HIV/AIDS perspective) aspects of Thai sexual culture (and Thai sexuality) and instead had the effect of tautologically portraying HIV/AIDS as a problem of aberrant behaviours on the part of individuals who, on the basis of their behaviour, became classified as members of specific risk groups. Moreover, this genre of research tended to attribute such individual deviance to individual moral failures to control bodily desires (Fordham 2001: 274).

In Thailand (as elsewhere) epidemiological models and public health responses reflect popular sexual moralities. However, because prevailing paradigms in HIV

and AIDS research generally fail to understand sexuality as a discursive construct the implications of such moral values are generally minimized or ignored in health-based HIV prevention strategies. Rather, cultural values about sexuality are taken at face value, with little understanding of how HIV and AIDS programmes may be culturally instrumental in turning such moral approaches into biomedical and epidemiological 'facts'. Thus, female sex workers may be subject to rights violating prevention measures in the name of epidemiological evidence rather than moral force.

Gendering vulnerability: Women, men and trans-subjects in HIV prevention discourses

In HIV and AIDS work, *women's* sexuality has arguably been most subject to reductive moralities in the name of health promotion. Jonathan Berger (2004) has explored the implications in reference to the way HIV/AIDS in sub-Saharan Africa has been depicted as a heterosexual epidemic. This representation acquiesces to patriarchal hegemony, conspiring with a uniformly heterosexual representation of African men's sexuality (and depiction of women in respect of this). On the one hand, this has foreclosed serious attention being given to male-to-male HIV transmission in Africa (Berger 2004, Patton 1999), a situation that is only recently being addressed (Niang et al. 2003, Donham 1998). On the other hand, this limited understanding of HIV and AIDS epidemiology both derives from and reinforces a conceptualization of 'African women' as passive victims in much mainstream HIV prevention discourse – as vulnerable to HIV transmission as they are subject to masculine domination. As Berger argues:

> [. . .] the attempt to find a single theory to explain a complex phenomenon tends to overplay vulnerability in a way that risks entrenching the realities of many women's lives. Conceived of as desexualized beings trapped in men's power and promiscuity, African women are simply waiting to be infected. In suggesting a solution that lies primarily in changing power relations so that women can protect themselves from those men that cannot be made responsible, the discourse of vulnerability risks rendering the essence of gendered relationships as immutable and unchanging (Berger 2004: 47).

This model of women's subjugation simply restates stereotypical relations and archetypal conditions of risk rather than conceiving more complex circumstances of sexual practice, vulnerability and, more importantly, scope for change in sexual practice. This is dangerous because it misses the point; misconceiving the *actual* gendered sexual subjectivities and relations that drive the epidemic. Redressing this problem means complicating overly simplistic interpretations, and especially of women's sexuality.

> Given that '[s]ex, power and risk lie at the heart of understanding HIV/AIDS in contemporary South Africa' (Walker et al. 2004: 20), the gender and vulnerability analysis can and must be complemented by a focus on sexuality, even if it means challenging the very beliefs that many people hold dear. It may, for example, mean accepting that women enjoy sex for the sake of sex; that some married men enjoy having sex with other men as well as their wives; and that cultural practices such as virginity testing may be placing young men and women at risk of infection. More disturbing for policy-makers and implementers, it may mean recognizing that many of our HIV

prevention programmes are fuelling, rather than putting the brakes on, the further spread of the epidemic (Berger 2004: 47–48).

Whilst evidence confirms that women may be at enhanced risk of HIV transmission through unprotected vaginal intercourse with infected men (as compared to the risks of female to male transmission in the same sexual act), focusing on such risks rests on an extremely narrow vision of women's sexuality; as subject *only* to heteronormative, patriarchal domination. Men are similarly reduced by such accounts, their risks and vulnerabilities made more difficult to interpret in analytical frameworks that stress masculine power and autonomy (Dworkin 2005, Mane and Aggleton, 2001).

Men's vulnerabilities may be emphasized in analyses that complicate the subject category 'men'. One way of doing this has been to introduce race or sexuality as instrumental, affecting power relations between 'different' men. However, such arguments are basically variations of assumed patriarchy (seen as stratified according to other criteria). These perspectives reflect the tendency in much HIV and AIDS work to reiterate understandings of men as (sexually) dominant – reflecting socially pervasive processes whereby masculine authority is naturalized, almost universally seen as a fact of life. Acceptance of male sexual aggression and dominance are intrinsic to such beliefs; acts of sexual penetration literally seen as embodying and symbolizing such values.

It is important to recognize, however, that male dominance is not simply a natural and inevitable part of life, but is maintained and reproduced in day-to-day discourse and action (Bourdieu 2001). Arguably, such daily practices mostly do in fact commonly reproduce women's domination by men – such that the seemingly natural fact of male dominance is socially replicated. However, Sherr (1996) points out that the countless repetition of studies in the HIV literature, which point out women's lack of power or vulnerability, may have the effect of perpetuating the very imbalance that they set out to describe. She argues that a more multifaceted understanding of the ways in which women react to HIV-related events could provide a viewpoint from a female perspective and a different basis for analysis (Sherr 1996: 34–35). The particularities of daily life are such that the complex range of actions through which gender relations are (re)produced allows for dissonance, variation, and sites of resistance – practical ways in which women are not simply acquiescent (Chodos and Curtis 2002). Sexuality cannot simply be understood through a presumption of male dominance, because *actual* sexual acts are more varied and malleable. Indeed, safer sex promotion is premised on the idea of sexuality as a site of creative dissonance from expected power norms (Vance 1991) – and the (unprotected) penetrative sexual acts stereotypically associated with dominant assumptions of (hetero)sexual practice.

Successful HIV prevention work with female sex workers, for example, has actively challenged the premise that women are simply sexually dominated by men, stressing ways in which women may be able to control sexual transactions and make choices in selling sex. Collective action amongst sex workers has been vital in enabling female and male sex workers to create cultures aimed at

promoting condom use and safer sexual practice, enabling female sex workers to participate in policy discussions on HIV and broader human rights issues. The success and vitality of such work derives from a stress on women as both sexual subjects and agents – subsumed by patriarchal interpretations and resistant to gender-normative expectations (Delacoste and Alexander 1987). This emphasis has emerged most notably in gender and sexuality activism by sex workers themselves, who have often used art, performance, and sex work itself as tools for exploring and articulating the meaning of sexuality and gender in their lives. This is both linked to and independent of HIV vulnerability and does not preclude attention to women's gender-based structural vulnerabilities, including the place of commercial sex in patriarchal hegemony, within which men's control of women's sexuality is structurally inherent. Re-examination of sex workers' agency has its origins in the mid-1980s, when men and transgendered people joined the sex workers rights movement. This occurred as a result of HIV which had led to the movement becoming increasingly informed by queer thinking and gay, lesbian, bisexual and transgendered (GLBT) rights activism and theory, which complicated pre-existing feminist work that conceived sex work primarily as a site for women's subordination only (Overs 1998).

The need to separate sexuality from gender in social theory has been notably advanced by Rubin (1999). For Rubin, feminist analyses (including her own early work), that sought to conceive women's sexual subordination as entirely a product of heteronormative male dominance, lack sufficient explanatory power. Such analyses, for example, do little to make sense of lesbian sexuality. On the one hand, lesbians may suffer oppression in ways strongly related to female subject positions, but in other ways subjugation, and capacity for resistance to it, may have more in common with gay men, transsexuals, sex workers, and queer subjects. Understanding of social stratification and prejudice premised on sexuality rather than gender are necessary in order to conceive these issues, and indeed to comprehend the social construction of sexuality and sexual risk more generally (Rubin 1999: 170).

One of the ways in which this is important for HIV and AIDS work is it enables the development of epidemiological understanding of women's sexual risks that are not entirely dependent on conceiving women as merely passively vulnerable to men. This makes the variety and capacity for sexual risk clearer – not simply understood as played out in binary, gender-normative power relations. This is important for many reasons. As Dworkin has recently noted, 'the 'first case' of HIV transmission between women has been recorded – associated with blood on sex toys (Dworkin 2005: 616). It is hard to conceive of this kind of risk through heteronormative analysis of sex/gender. More broadly such work enables women to become visible in the epidemic other than being viewed through relations with men (with the limited capacity for women's agency in risk reduction implied by such a viewpoint).

Differentiating between sexuality and gender not only enables women's sexuality to become more visible (in its complexity and diversity), it also offers

analytical scope for conceiving of sexual subjects who do not 'fit in' to gendered sexual stereotypes. This was vital in much AIDS activism in the USA during the early 1990s, which drew on queer approaches to sexuality to highlight how 'heteronormativity disabled effective interventions into the spread of HIV/AIDS' (Elliston 2005: 23).

Transgendered and transsexual persons in particular have been especially marginalized in responses to HIV/AIDS[2]. In some contexts, this has been attributed to the general social invisibility of transgendered and transsexual persons. However, in HIV and AIDS work, trans-people are frequently excluded because their sexual and gendered subjectivities do not fall into socially dominant categorizations – such as hetero-, homo-, male or female – but rather disrupt such classifications. Given the tendency in much HIV intervention to want to slot beneficiaries into measurable, definable social categories – to literally make people visible in such terms – trans-people have inevitably tended to fall outside prevailing agendas.

This interpretation helps to explain the lack of programmatic attention in societies where people who might be understood as transsexual or transgendered are socially apparent. Thus, for example, even to this day the highly visible and culturally pervasive *katoey* of Thailand are not separately monitored in HIV surveillance – such that little is known about their specific risks or prevention needs (Jenkins 2004: 32). As has happened with trans-people in other countries, *katoey* are generally addressed in HIV prevention via programmes aimed at men who have sex with men and/or sex workers. Such strategies are profoundly insensitive to the terms through which the majority of *katoey* self-identify in respect to 'third' or socially interstitial gendered classifications of sexuality.

Subtle understandings of gender and sexuality are needed to disentangle these issues. Programmes that integrate networks of transgendered people are needed to apply such understandings in prevention (Bockting et al. 1999). Such work cannot only enable more meaningful and effective HIV programmes with trans-people but can inform more conceptually developed approaches to sexuality across the range of programmatic HIV and AIDS interventions, moving beyond the premise on 'fixed', measurable sexual categories toward a comprehension of sexuality as irregular and variable in people's experience – and the multi-faceted possibilities of sexual risk entailed.

Putting sexuality back into HIV/AIDS: Resisting repression and processing experience

Throughout this article we have aimed to examine some practical problems and conceptual issues involved in giving sexuality a more prominent and appropriate focus in HIV and AIDS work in general, and HIV prevention in particular. A lack of conceptual clarity about sexuality has been accented and the consequences of not giving more thought to sexuality in HIV and AIDS interventions have been explored. The arguments put forward point to a number of questions to which urgent responses are needed. Among them are: how do we go about putting

sexuality back into responses to the epidemic; what strategies may offer adequate articulations; and what might be potential complications?

In the first instance, putting sexuality back into HIV/AIDS work means talking about sex in explicit terms. This entails engaging in educational discourse about sex, sexuality, health and HIV/AIDS in ways that are meaningful and cogent to the people addressed by them. It is always a mistake to make presumptions about the kinds of language through which people conceive sexuality. Explicit talk about 'sex' in many contexts may not be appropriate or meaningful, and HIV prevention measures need to be especially sensitive in this regard. Simply imposing the discursive categories used to frame sexual behaviour in mainstream HIV and AIDS research, and creating cultural equivalents to such terms in programmatic measures, can lead to misinterpretations about the social, moral and interpersonal context of sex and sexual risk.

At the same time, however, it will not do for HIV prevention strategies to simply displace sexuality as a focus of discussion out of presumed sensitivity to cultural contexts. A fine balance is required – bringing sexuality back into the centre of responses to the epidemic, whilst being aware of the diffuse, complex and often far from obvious ways in which sex and sexuality are fundamental to people's lives. Strong analytical commitments are needed to achieve successful work of this kind, and these must be matched by forward-looking political and funding responses that support innovative ways of addressing sexuality.

Against this background, putting sexuality back into HIV and AIDS may be regarded as something of an act of liberation – retrieving something that has been repressed by orthodox programme strategies. This is a tempting conclusion, and indeed, given the mechanisms of power and knowledge that have shaped the predominantly conservative ways in which sexuality is understood in HIV/AIDS research, such a viewpoint is salient. It certainly enables a better understanding of the need for sex positive approaches in HIV prevention. When well formulated and implemented, sex positive strategies have the potential to influence norms, trigger discussions of consensual versus non-consensual sex, as well as improve self-image and technical aspects of sexual performance, a highly valued objective world-wide. Rather than repeatedly castigating people for their 'unsafe' sexual behaviour, safety can be wed to pleasure. This can only occur if explicit lessons can be taught and HIV educators themselves have sex positive attitudes and knowledge.

'Sex positive' HIV programming is often understood as increasing emphasis on promoting and celebrating pleasure, diversity and sexual rights. Sometimes it simply means de-emphasising essentialist, sex negative views that condemn all sex other than sanctioned heterosexual activity. But while these are steps in the right direction, sex positive HIV programming cannot afford to be limited. HIV prevention needs to address people who practice sex for any of the many reasons that are unrelated to pleasure and desire. Perhaps selling sex is the most obvious example of this, although it applies also to sex borne of marital duty or peer pressure, for example. Sex workers, for whom commercial sex is an occupation

and not an expression of desire, have used a sex positive approach to posit commercial sex as valid within the sexual landscape. Sex work activists have argued that clients' right to sexual pleasure gives rise to their right to provide it, safely and without shame (APNSW 2005).

Conceiving of putting sexuality (back) into HIV/AIDS work as an act of resistance to moral value systems, that might repress it, raises important questions about how to think about sexuality as both a social and individual experience. Sexuality may be repressed in the discursive regimes of mainstream HIV policy and programming. However, it is important not to confuse this with a belief that people's sexualities are simply repressed at a personal level – as if sexuality were an innate drive suppressed by conservative social forces. The idea that people *have* a sexuality, which may be repressed *within* the individual, has been deconstructed by contemporary conceptual approaches to, and related activism on, sexuality (Khanna 2005: 93). As explored in this paper, queer and other social theorists have stressed sexuality as culturally constructed, conceived in recursive interplay between social structure and inter- and intra-personal practice. From this perspective, interpretations of sexuality as simply a repressed impulse need to be contextualised and re-evaluated.

The conceptualization of sexuality as repressed in both talk and practice has largely prevailed in Western thought since the nineteenth century. Sigmund Freud's *Three Essays on the Theory of Sexuality* (1905) articulated a key trope in the repressive theorization of sexuality. For Freud, the repression of a putatively innate, polymorphous sexuality, is seen as central to the formation of human identity. This is far from a straightforward process, and ways in which various aspects of repressed childhood sexual desire become manifest in adult neuroses is intrinsic to the psychoanalytic project. Sexual repression, from a Freudian perspective, is thus seen as an inherent but unstable aspect of human cultural experience.

This repressive model of sexuality has been challenged by historical research. Foucault's reformulation of what he called the 'repressive hypothesis' (1990) highlighted ways in which social regimes that had previously been seen to suppress sexuality were actually hyper-aware of it. This assertion led to a reexamination of the Victorian era, for example, which had heretofore been interpreted as a time of widespread sexual repression. Following the reconstructive work of writers such as Foucault (1990) and Weeks (1985), this period is now seen differently, as a time of extensive concern about, and surveillance of, sexuality. Sexuality was not so much repressed in this era as 'brought forth' via a multi-faceted range of discourses and practices, designed to police moral conduct.

This way of conceiving sexuality enabled a reformulation of the relationship between power, sexuality, and the individual. Moral authorities and dominant social attitudes could be seen as not so much repressing sexuality (into the human body) as giving it cultural life (as a means of practical control). This model complicates the relationship between power, sexuality, embodiment, and knowledge – emphasising sexuality as conceived in discursive regimes, rather than as

simply a natural desire. People's seemingly innate sexualities thus came to be seen as the products of any given era or cultural context.

Taking this stance seriously means that putting sexuality back into HIV and AIDS work cannot be understood as an act of resistance only – as if liberal prevention discourses were simply a way of making sexual life more open, and potentially safer. This is not to say that speaking more frankly and articulately about sexuality in HIV prevention does not counter regimes of silence. Indeed, in many societies, HIV and AIDS work provides one of the most direct contexts for talk about sex and is doing much to promote cultures of sexual safety. Nevertheless, speaking about sexuality does not simply open up spaces into which sexuality may burst forth as a natural, unmediated, expression of the sexual *truth* of any given culture or society. Rather, in addressing sex, HIV and AIDS work frames sexuality via specific discourses, associated with health, risk and the exigencies of prevailing programmatic paradigms.

Sexuality is constantly evolving in response to the discourses that conceive it – as sexual language, practice, knowledge and subjectivity are intimately symbiotic. Developing this understanding in the context of intervention entails tracing concomitant effects of HIV and AIDS work on sexuality. This should not only be in terms of simply measuring changes in sexual behaviour (as an outcome of interventions), but also in terms of comprehending HIV and AIDS programmes as culturally instrumental, informing the production of new sexual subjectivities; affecting the sexual cultures and understandings of self that they address.

Vihn-Kim Nguyen's (2005) analysis, of ways in which local sexual subjectivities have been reformulated in Côte d'Ivoire in response to HIV and AIDS work, offers a relevant example. Interventions have had a particular effect on understandings of self amongst men who have sex with men in this context:

> ... in the early 1990s, growing awareness of the seriousness of the AIDS epidemic instigated a response on behalf of international donor institutions that championed 'breaking the silence' around sex, as well as the 'self help' and 'empowerment' of people living with HIV and AIDS. As NGOs made available an array of social technologies and norms, initially through pedagogical approaches to sexuality and sexual education, these fostered a culture of openness and disclosure around intimate issues (Nguyen 2005: 247–248).

The educational strategies described helped to create a cultural demand for testimonials – as ways of forging new public forms of identification, claims to social rights and recognition premised on explicit accounts of sexuality (or open identification as HIV positive).

> As a result, these confessional technologies conjugated with the narratives and the material effects they produced of existing social networks, and were tactically taken up by individuals to fashion themselves and address a broad range of material needs and desires. Thus AIDS prevention efforts, and the NGO mechanisms through which they were disseminated, allowed homosexual men to organize a quasi public space legitimated by a culture of sexual openness within which 'gayness' – in this case one of the many possible narratives of sexual identity – could be cautiously affirmed (Nguyen 2005: 248).

Nguyen describes a process of sexual identity formation inexorably bound to the 'iterative practice of telling the self' conceived within HIV prevention

strategies (Ngyuen 2005: 265). Sexuality in this example is not simply documented by HIV and AIDS work, countering pre-existing silence. Rather HIV/AIDS interventions are shaping the cultural conditions within which contemporary (homo)sexual subjectivities are being formulated.

Such processes have consequences for the effectiveness of HIV prevention. Paul Boyce (under review) has described a similar scenario in respect to the formulation of contemporary male-to-male sexual subjectivities in India. He observes how particular role-oriented identity categories of male-to-male sexuality have been popularized in HIV prevention. These, in turn, feed back into the cultural context, informing new forms of sexual identification. In this scenario, the term *kothi* has been particularly popularized as a category of sexual subject – premised on feminized gender identity and archetypically associated with a receptive role in anal sex with other men. *Kothis* have thus been seen as especially vulnerable to HIV infection, and activism premised on this concern has been especially significant in HIV and AIDS work with men who have sex with men in South Asia.

In predominant HIV and AIDS research, *kothi* is commonly represented as 'traditional', a culturally inherent subject position – with common and predictable behavioural practice and risks. However, it is notable that the term was not widely used in South Asia prior to the epidemic – and ensuing interventions (Cohen 2005, Boyce under review). Rapid popularization of the term suggests that many men who have sex with men, including those who may be penetrated during (unsafe) anal sex, are being excluded from current intervention models. For many such men, *kothi* is an entirely unfamiliar word – and indeed the concept of identity based on such acts is anathema. HIV and AIDS research has been instrumental in making the *kothi* category salient – essentially reproducing findings about *kothis*, who have been predetermined as a key cultural category within predominant research models, rather than within the cultural context and scenarios of sexual risk *per se*. This is not to suggest that the model is not now meaningful to many men – as it has been increasingly taken up popularly, but to stress that unreflexive emphasis on *kothis* in HIV and AIDS research and programmes propounds a reductive and limited vision of male-to-male sexual life in South Asia. Research conceived in a positivist, HIV and AIDS research paradigm, appears to be uncovering sexualities that were (always) already present rather than comprehending their instrumentality in shaping contemporary sexual cultures and understandings of and risk within them.

The issues described arise, in part, from an insistence that 'sexual cultures' can be empirically documented (through surveys and interviews), as if sealed spheres of cultural conduct – with HIV interventions and AIDS research acting as neutral ciphers for such information (Pigg 2005: 53). Accounts of sexuality are fed into and reified within mainstream HIV and AIDS work and reproduced as cultural *facts,* as if such findings were extraneous to the emphasis placed on them in programmatic models. In part, such processes derive from a methodological reliance on verbatim accounts of sexual life, wherein reported behaviour is often

taken 'as a direct reflection of observable reality' (Lambert 1998: 1004). Reliance on people's *accounts* of their sexualities alone tends to reduce sexual subjects to one-dimensional cultural stereotypes – especially when such accounts are 'fixed' in research as predictable measures of behaviour and slotted into static models of identity. Moreover, representations of this kind may look culturally and personally informed, precisely because they rely on the elicitation of personal narratives.

This problem is compounded, as representations of sexuality as a 'fixed' attribute of self have been vital in sexuality politics. Claims to sexual rights in many contexts have been premised on assertions of sexuality as fundamental, not socially constructed but inherent, and as such inviolable (Waites 2005). Discourses of this kind have been significant within HIV and AIDS activism, especially for politically marginal subjects (such as men who have sex with men, sex workers, transsexuals, etc). Assertions of HIV vulnerability amongst such populations have been wed to rights-based frameworks – premised on claims made in terms of specific sexual categorizations. Mainstream HIV and AIDS research and policy influenced by such activism synchronizes with such claims, appearing culturally informed because conversant with them. The problem is that the cultural information emphasized derives from specific political agendas. Representations of sexuality within these have been imperative in claiming rights and raising awareness of structural vulnerability within the epidemic. However, they should not be made to function as straightforward models of sexuality or cogent indicators of vulnerability. Sexuality research needs to consider the discursive function of such categorizations – to contextualise and analyse the cultural and personal meanings reproduced rather than taking them as the *truth* of sexuality and risk *per se* (Boyce in press).

This is not to propound unnecessarily abstract or theoretical interpretations but to stress that the 'real world' of sexuality is far more complex than purely empirical research or rights-based claims allow. Sexuality is not stable, locked into the body, or manifest through coherent social categories, and related behaviours. People's inherence within sexual subjectivity is partial and irregular (Hemmings 2001). Without comprehending this, HIV and AIDS work is in danger of propounding misleading and reductive accounts of sexuality, as if these were progressive models for intervention (Vance 1991). Without wanting to dismiss the well-meaning intentions informing such approaches, HIV-related activism and research needs to begin asking more critically informed questions about sexuality.

Crucially, putting sexuality (back) into HIV and AIDS work is not an act but a process. Sexuality is not a 'thing' that can be simply placed into policy and programming, accounted for through standardized approaches. Sexuality is a variant assemblage of practices, meanings and perceptions – not consistent or uniform in people's experience, but fragmented and nuanced across a range of engagements. People account for, or script, sexuality in various ways, which may not relate directly to the way it is enacted (Simon and Gagnon 1984). Mainstream HIV research, in contrast, narrows sexuality down, in attempts to conceive sexual risk through measurable variables and epidemiological indicators. Such ap-

proaches are at odds with the way sexuality is experienced in 'real life'. Given this, much existing HIV research is dissonant from its own subject, conceived in paradigms that inevitably offer partial and ultimately misleading accounts of sexual life. Moreover, proceeding in this fashion, evaluative HIV and AIDS research tends to miss the measure of its own effects. As observed, programmatic interventions are instrumental in shifting understandings of sexual subjectivity. The significance of such changes does not register well within the behavioural indicators or culturally essentialist paradigms of prevailing HIV/AIDS research. However, these shifts may constitute the most significant effects of HIV and AIDS work, signifying sexuality as inherently inscribed within, and affected by, culture, of which HIV-related interventions have become a part. Recognizing this offers a way to integrate constructivist approaches to sexuality into HIV and AIDS work, without jettisoning the criteria, strategies or concerns of mainstream programming. Reflexive approaches are required, attuned to both the cultural and subjective complexity of sexuality and the pervasive effects of HIV and AIDS interventions – beyond those measured in positivist evaluations and studies.

At the end of the day, putting sexuality back into HIV/AIDS requires political, epistemological and financial commitments to new forms of research and programming – more expansive in scope and subtler in focus. It entails incorporating conceptualizations of sexuality that move beyond categorization of the sexual subject, accounts of behaviour (change) and attempts to quantify risk alone. Whilst such research has been vital in illuminating patterns and contexts of vulnerability over the last twenty five years, it has limited analytical value when it comes to conceiving the intricacy of sexuality as lived, and the actualities of sexual risk as experienced. More complex understandings of sexuality in AIDS work hold the potential to enable more sophisticated and effective HIV prevention strategies. Such approaches are needed, now more than ever, as we move forward into the next generation of an epidemic that continues to present profound challenges to human sexuality and our collective survival.

Notes

[1] The argument put forward in this article was developed by Paul Boyce, who was the principal author, and draws upon work across a range of contexts. The paper was conceived in response to a series of presentations given at a special symposium on sexuality and HIV/AIDS held during the 10th International Conference on AIDS in Bangkok in July 2004. The co-authors, credited above, each presented at this forum. Of those presenters, some have made specific written contributions to this final draft. Elizabeth Reid made valuable contributions regarding theorization of, and programmatic responses to, women in the epidemic, as well as to the discussion of critiques of rational approaches to sexuality in HIV/AIDS programming. Carol Jenkins contributed to the argument on sex positive approaches in HIV/AIDS research, as well as helped to stress the importance of conceiving sex as other than related to pleasure. Michael Tan added a section on young people's sexuality in the Philippines, as well as contributed to broader discussion on HIV/AIDS policy in the USA and internationally. The other co-authors chose to let their original presentations stand as their main contribution, and these are cited at specific points in the text. Cheryl Overs did not present at the symposium but contributed to the discussion of sex work and problems related to sex positive approaches in HIV prevention. Peter Aggleton organized the

symposium from which this article is derived, coordinated contributions from co-authors and made a number of contributions to the overall argument. We are grateful for sponsorship from the Ford Foundation, who funded the symposium, and to Susan Kippax and Purnima Mane who chaired it. The views expressed are those of the authors alone.

[2] The terms transgender and transsexual encompass a broader variety of behaviours, subject positions and socio-cultural formulations – and there is not space here to do sufficient justice to these. Nevertheless it is generically notable that despite data stressing the enhanced vulnerability to HIV infection amongst 'trans-people' in many societies, they have been inadequately served by HIV prevention strategies.

References

Adams, V. (2005) Saving Tibet? An Inquiry into Modernity, Lies, Truths and Beliefs. *Medical Anthropology*, 24, 71–110.

Aggleton, P. (1996) Introduction. In P. Aggleton (ed.) *Bisexualities and AIDS: International Perspective* (London: Taylor and Francis).

Aggleton, P. (2004) Sexuality, HIV Prevention, Vulnerability and Risk. *Journal of Psychology & Human Sexuality*, 16(1), 1–11.

APNSW (Asia Pacific Network of Sex Workers) (2005) *Making Sex Work Safe* (Bangkok: APNSW).

Berger, J. (2004) 'Re-sexualising the epidemic: desire, risk and HIV prevention' (Braamfontein: Interfund) Development Update. Available at http://www.sarpn.org.za/documents/d0001195/2-Re-sexualising_the_Epidemic-Jonathan_Berger.pdf (Accessed 12 May 2006).

Bockting, W.O., Rosser, S., and Coleman, E. (1999) Transgender HIV prevention: Community involvement and empowerment. *The International Journal of Transgenderism*, *3* (1+2). Available at http://www.symposion.com/ijt/hiv_risk/bockting.htm (Accessed 28 February 2006).

Bolton, R. (1995) Tricks, friends and lovers: erotic encounters in the field. In D. Kulick and M. Willson (eds) *Taboo: Sex Identity and Erotic Subjectivity in Anthropological Fieldwork* (London: Routledge, 140–167).

Bourdieu, P. (2001) *Masculine Domination* (trans. by Richard Nice) (Cambridge: Polity Press).

Boyce, P. (in press) Moral Ambivalence and Irregular Practices: Contextualizing male-to-male sexualities in Calcutta/India. *Feminist Review*.

Boyce, P. (under review) 'Conceiving kothis': Role, agency and anthropology in the construction of male-to-male sexualities in India.

Bristow, J. (1997) *Sexuality* (London: Routledge).

Butler, J. (1993) *Bodies That Matter: On the Discursive Limits of "Sex"* (New York: Routledge).

Butler, J. (1990) *Gender Trouble: Feminism and the Subversion of Identity* (New York: Routledge).

Buve, A., Bishikwabo-Nsarhaza, K. and Mutangadura, G. (2002) The Spread and Effect of HIV-1 Infection in Sub-Saharan Africa. *The Lancet*, 359, 2011–17.

Callen, M. and Berkowitz, R. (1983) *How to Have Sex in an Epidemic: One Approach* (New York: News from the Front Publications).

Cameron, E. (2000) The Deafening Silence of AIDS. *Health and Human Rights*, 5, 7–24.

Campbell, C. (2003) *Letting Them Die: Why HIV/AIDS Prevention Programmes Fail* (Bloomington: The International African Institute in association with Indiana University Press).

Crossley, M.L. (2002) The Perils of Health Promotion and the 'Barebacking' Backlash. *Health: An Interdisciplinary Journal for the Social Study of Health Illness and Medicine*, 6, 47–67.

Chodos, H. and Curtis, B. (2002) Pierre Bourdieu's Masculine Domination: A Critique. *The Canadian Review of Sociology and Anthropology*, 36, 397–412.

Cohen, L. (2005) The Kothi Wars: AIDS cosmopolitanism and the morality of classification. In V. Adams and S. Leigh Pigg (eds) *Sex in Development: Science, Sexuality and Morality in Global Perspective* (Durham: Duke University Press).

Curd, R. and Manahan, N. (1985) *Lesbian Nuns: Breaking Silence* (Tallahassee: Naiad Press).

Delacoste, F. and Alexander, P. (1987) *Sex Work* (San Francisco: Cleis Press).

Donham, D. L. (1998) Freeing South Africa: The 'Modernization' of Male – Male Sexuality in Soweto. *Cultural Anthropology*, 13, 3–21.

Dowsett, G. (1996) *Practising Desire: Homosexual Sex in the Era of AIDS* (Stanford: Stanford University Press).

Dowsett, G. (1999) Commentary. The Indeterminate Macro-Social: New Traps for Old Players in HIV/AIDS Social Research. *Culture, Health & Sexuality*, 1, 95–102.
Dowsett, G. (2004) Baring Essentials: Science as Desire. *Sexuality Research and Policy*, 1, 69–82.
Dworkin, S. (2005) Who is Epidemiologically Fathomable in the HIV/AIDS Epidemic? Gender, Sexuality, and Intersectionality in Public Health. *Culture, Health and Sexuality*, 7, 615–623.
Elliston, D. (2005) Critical Reflexivity and Sexuality Studies in Anthropology: Citing Sexuality in Research, Theory, Ethnography and Practice. *Reviews in Anthropology*, 34, 21–42.
Fisher, F. (1998) Making a Transition Between Elective Asceticism and Secular Life: A Life Narrative Study of Former Roman Catholic Nuns. Doctoral thesis. (San Francisco: Institute for Advanced Study of Human Sexuality).
Foucault, M. (1990) (trans. by Robert Hurley) [1976] *The Will to Knowledge: The History of Sexuality 1* (Harmondsworth: Penguin).
Fordham, G. (2001) Moral Panic and the Construction of National Order: HIV/AIDS Risk Groups and Moral Boundaries in the Creation of Modern Thailand. *Critique of Anthropology*, 21, 259–316.
Freud, S. (1905) *Three Essays on the Theory of Sexuality* (London: Hogarth Press).
Gagnon, J.H. and Parker, R.P. (1995) Introduction: Conceiving Sexuality. In R. G. Parker and J. H. Gagnon (eds) *Conceiving Sexuality: Approaches to Sex Research in a Postmodern World* (New York: Routledge).
Gammeltoft, T. and Nguyen, M.T. (1999) *Our Love Has No Limits* (Hanoi: Nha Xuat Ban Thanh Nien).
Girard, F. (2004) Global Implications of US Domestic and International Policies on Sexuality. New York, International Working Group on Sexuality and Social Policy. Columbia University, Centre for Gender, Sexuality and Health. Available at http://www.sms.mailman.columbia.edu/cgsh/iwgssp_english.pdf (Accessed 28 February 2006).
Gruskin, S. (2004) Keeping the Connections in 2004. *Health and Human Rights*, 7, 1–3.
Hemmings, C. (2001) Partiality, Feminist and Queer Research. *Cargo: Journal of Socio-cultural Anthropology*, 3, 226–241.
Herdt, G. (1994) *Guardians of the Flutes: vol. 1, Idioms of Masculinity* (Chicago: University of Chicago Press).
Herdt, G. (1991) Representations of Homosexuality: An Essay on Cultural Ontology and Historical Comparison, Part I. *Journal of the History of Sexuality*, 1, 481–602.
Huang Soo Lee, M. (2004) Presentation at the special symposium on Putting Sexuality back into HIV/AIDS held during the 10th International Conference on AIDS held in Bangkok.
Hunter, M. (2002) The Materiality of Everyday Sex: thinking beyond 'prostitution'. *African Studies*, 61, 99–120.
Jenkins, C. (2004) Male Sexual Diversity and Culture: Implications for HIV Prevention and Care. Prepared for UNAIDS, 2004. Available at www.alternatevisions.org
Jones, R.H. (1999) Mediated Action and Sexual Risk: Searching for 'Culture' in Discourses of Homosexuality and AIDS Prevention in China. *Culture Health & Sexuality*, 1, 161–180.
Khan, S. (2001) Culture, Sexualities and Identities: Men Who Have Sex with Men in India. *Journal of Homosexuality*, 40, 99–115.
Khan, S. (1996) Under the Blanket: Bisexualities and AIDS in India. In Aggleton Peter (ed.) *Bisexualities and AIDS: International Perspective* (London: Taylor and Francis, 161–177)).
Khanna, A. (2005) Beyond Sexuality. In A. Narrain and G. Bhan (eds) *Because I Have a Voice: Queer Politics in India* (New Delhi: Yoda Press).
Kulick, D. (1995) Introduction. The sexual life of anthropologists: subjectivity and ethnographic work. In D. Kulick and M. Willson (eds) *Taboo: Sex Identity and Erotic Subjectivity in Anthropological Fieldwork* (London: Routledge).
Lambert, H. (1998) Methods and Meanings in Anthropology, Epidemiology and Clinical Encounters: the case of sexually transmitted disease and human immunodeficiency virus control in India. *Tropical medicine and International Health*, 3, 1002–1010.
Lancaster, R. (2002) Subject Honour, Object Shame. In R. Adams and D. Savran (eds) *The Masculinity Studies Reader* (Massachusetts: Blackwell).
Mallinger, S. (1999) Gay Today: About anal sex, barebacking: Slogans aren't enough. Available at http://gaytoday.badpuppy.com/garchive/viewpoint/040698vi.htm.
Maitra, S. and Schensul, S.L. (2004) The Evolution of marital Relationships and Sexual Risk in an Urban Slum Community in Mumbai. In R.K. Verma, P.J. Pelto, S.L. Schnsul and A. Joshi (eds)

Sexuality in the Time of AIDS: Contemporary Perspectives from Communities in India (New Delhi: Sage).
Mane, P. and Aggleton, P. (2001) Gender and HIV/AIDS: What Do Men Have To Do With It? *Current Sociology*, 49, 23–38.
Martin, J. (2006) Transcendence Among Gay Men: Implications for HIV Prevention. *Sexualities*, 9, 214–235.
Mohammed, S. (2004) Presentation at the special symposium on Putting Sexuality back into HIV/AIDS held during the 10th International Conference on AIDS held in Bangkok.
Newton, E. (1972) *Mother Camp: Female Impersonators in America* (Englewood Cliffs: Prentice-Hall).
Niang, C. Ibrahim, Tapsoba, P., Weiss, E., Diagne, M., Niang, Y., Moreau, A. M., Gomis, D., Wade, A.S., Seck, K. and Castle, C. (2003) It's Raining Stones': Stigma, Violence and HIV Vulnerability Among Men Who Have Sex With Men in Dakar, Senegal. *Culture, Health and Sexuality*, 5, 499–512.
Nguyen, V-K. (2005) Uses and Pleasures: Sexual Modernity: HIV/AIDS, and Confessional Technologies in a West African Metropolis. In V. Adams and S. Leigh Pigg (eds) *Sex in Development: Science, Sexuality and Morality in Global Perspective* (Durham: Duke University Press).
Odets, J. (1996) *Health psychology* (Milton Keynes: OU Press).
Overs, C. (1998) (an interview with) 'International Activism: Jo Doezema interviews NWSP Coordinator, Cheryl Overs'. In K. Kempadoo and J. Doezema (eds.) *Global Sex Workers: Rights, Resistance and Redefinition* (London: Routledge).
Padgug, R. (1979) Sexual Matters: On Conceptualizing Sexuality in History. *Radical History Review*, 20, 3–24.
Paiva, V. (2004) Presentation at the special symposium on Putting Sexuality back into HIV/AIDS held during the 10th International Conference on AIDS held in Bangkok.
Parker, R.G. and Aggleton, P. (2003) HIV/AIDS Related Stigma and Discrimination: A Conceptual Framework and Implications for Action. *Social Science and Medicine*, 57, 13–24.
Parker, R.G. (1999) *Beneath the Equator: Cultures of Desire, Male Homosexuality, and Emerging Gay Communities in Brazil* (New York: Routledge).
Parker, R.G. (1991) *Bodies, Pleasure and Passions: Sexual Culture in Contemporary Brazil* (Boston: Beacon Press).
Patton, C. (1999) Inventing 'African AIDS'. In R. Parker and P. Aggleton (eds) *Culture, Society and Sexuality: A Reader* (London, Philadelphia: UCL Press).
Patton, C. (1990) *Inventing AIDS* (London: Routledge).
Pigg, S.L. (2005) Globalizing the Facts of Life. In V. Adams and S. Leigh Pigg (eds) *Sex in Development: Science, Sexuality and Morality in Global Perspective* (Durham: Duke University Press).
Pigg, S.L. and Adams, V. (2005) Introduction: The moral object of sex. In V. Adams and S. Leigh Pigg (eds) *Sex in Development: Science, Sexuality and Morality in Global Perspective* (Durham: Duke University Press).
Reid, E. (1996) HIV and development: Learning from others. In L. Sherr, C. Hankins and L. Bennett (eds) *AIDS as a Gender Issue: Psychosocial Perspectives* (London: Taylor & Francis).
Reid, E. (2004) Presentation at the special symposium on Putting Sexuality back into HIV/AIDS held during the 10th International Conference on AIDS held in Bangkok.
Rosenthal, D., Moore, S. and Bumen, I. (1990) Ethnic Group Differences in Adolescents' Responses to AIDS. *Australian Journal of Social Issues*, 25, 220–39.
Rubin, G. (2002) Studying sexual subcultures: Excavating the ethnography of gay communities in urban North America. In E. Lewin and W. L. Leap (eds) *Out in Theory: The Emergence of Lesbian and Gay Anthropology* (Urbana: University of Illinois Press).
Rubin, G. (1999) Thinking sex: Notes for a radical theory of the politics of sexuality. In R. Parker and P. Aggleton (eds) *Culture, Society and Sexuality: A Reader* (London: UCL Press).
Sedgwick, E. K. (1990) *Epistemology of the Closet* (London: Penguin Books).
Setel, P.W. (1999) *A Plague of Paradoxes: AIDS, Culture and Demography in Northern Tanzania* (Chicago: The University of Chicago Press).
Sherr, L. (1996) Gender, psychology and HIV infection. In L. Sherr, C. Hankins and L. Bennett (eds) *AIDS as a Gender Issue: Psychosocial Perspectives* (London: Taylor & Francis).

Shumba, A. (2001) Who Guards the Guards in Schools? A Study of Reported Cases of Child Abuse by Teachers in Zimbabwean Secondary Schools. *Sex Education*, 1, 77–86.

SIECUS (2005) U.S.-Based Aid Groups Receive Ultimatum: Pledge Your Opposition to Prostitution and Sex Trafficking or Do Without Federal Funds. Policy Update, July 2005. Available at http://64.233.179.104/search?q=cache:-wnlubi1GlYJ:www.siecus.org/policy/PUpdates/pdate0192.html+pepfar+%2Bsex+work&hl=en&gl=uk&ct=clnk&cd=9 (Accessed 28 February 2006).

Simon, W. and Gagnon, J. (1984) 'Sexual Scripts'. *Society*, 22, 53–60.

Simoni, J.M., Karina, L.W. and Dawn, K.N. (2000) Safer Sex Amongst HIV+ Women: The Role of Relationships. *Sex Roles: A Journal of Research*, 42, 691–708.

Simooya, O. and Sanjobo, N. (2001) 'In but Free'. An HIV/AIDS Intervention in an African Prison. *Culture Health and Sexuality*, 3, 241–251.

Tan, M.L. (2002) Premarital Sex (PMS) and Moral Panic. Discussion paper presented at a meeting, 'Family Planning New Worlds' organized by the Bill and Melinda Gates Institute for Population and Reproductive Health of the Johns Hopkins Center for Communication Programs, Baltimore, MA, December 10, 2002.

UNAIDS (2001) *HIV prevention needs and successes: A Tale of Three countries – An Update on HIV Prevention Success in Senegal, Thailand and Uganda*, UNAIDS, Geneva.

UNAIDS (2005) Intensifying HIV Prevention. UNAIDS Policy Position Paper. Geneva, UNAIDS. Available at http://data.unaids.org/publications/irc-pub06/jc1165-intensif_hiv-newstyle_en.pdf (Accessed 28 February 2006).

UNAIDS AND WHO (2005) Epidemic Update 2005. Geneva, UNAIDS and WHO.

Vance, C. S. (1991) Anthropology Rediscovers Sexuality: A Theoretical Comment. *Social Science and Medicine*, 33(8), 875–884.

Waites, M. (2005) The Fixity of Sexual Identities in the Public Sphere: Biomedical Knowledge, Liberalism and Heterosexual/Homosexual Binary in Late Modernity. *Sexualities*, 8(5), 539–569.

Walker, L., Reid, G. and Cornell, M. (2004) *Waiting to Happen: HIV/AIDS in South Africa – the bigger picture* (Cape Town: Double Story Books).

Watney, S. (2000) *Imagine Hope: AIDS and gay identity* (London: Routledge).

Weeks, J. (2003) *Sexuality: Second Edition* (London: Routledge).

Weeks, J. (1985) *Sexuality and its Discontents* (London: Routledge and Kegan Paul).

WHO (2002) Sexual Health. Available at http://www.who.int/reproductive-health/gender/sexual_health.html#1(Accessed 28 February 2006).