Commentary

GOING BEYOND THE MEDICAL: UNDERSTANDING VIEWS OF HIV/AIDS FROM THE MARGINS

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Exploring the connection between HIV/AIDS and sex work is no longer a new phenomenon and is evident with the extensive scholarship on the matter over the years by different social scientists and medical practitioners (see Hernandez and Imperial, 2009; Tan, 1995; 1998; 1999). This, however, creates an impression that male sex work and HIV/AIDS should always go together and not separate from each other because the latter is generally considered as one of the risks that comes with participating in the activities involving the former. While I have a dilemma with this inseparability due to its capacity to limit our understanding and exploration of male sex work as a social phenomenon, I still recognize that HIV/AIDS remains significant in the discussion, and much more relevant now with the need to address the status of the epidemic in the Philippines (Gangcuangco, 2019). To demonstrate this perceived connection, Tan (1999), in his study, explored the role of risk among male sex workers and even provided a classification of the said HIV-at-risk group: ranging from call boys, masseurs, and to macho dancers. Other literatures have explored this in connection to the concept of men-having-sex-with-men and have used quantitative methods, apart from the qualitative ones (MSM) (Hernandez and Imperial, 2009). This is beneficial from a policy perspective where the statistical data helps in crafting guidelines and coming up with comprehensive approach in solving the epidemic, and these numbers must also consider the behavioral changes in crafting and proposing interventions towards the epidemic.

Given these directions, what makes this writing timely is how it provides a glimpse of how macho dancers, a subgroup of male sex workers and are also considered part of the men-having-sex-with-men (MSM) group, perceive HIV/AIDS in the recent times. To put things in context, doing research on gay bars and macho dancers remains limited, which is also evident with the scant published and unpublished literature on the topic (see Canete 2011; Pastor, 2014; 2020; Tolentino, 2009). In addition, these literatures have not paid much attention to HIV/AIDS discourses but focused on power relations, political economy, history, representation, and gender and sexuality debates, which is considered a welcoming development too.

At this point, however, I want to clarify, as an anthropologist, that I am not against discussing or putting primacy on the issue of HIV/AIDS when it comes to male sex work; instead, I wanted to focus more on other aspects because notions of agency, sexuality, and life histories remain underexplored, and one can examine how behaviors shape the outlook and attitude towards the virus and its peculiarities. The assumption that guides this focus is the belief that having a thorough understanding of other dimensions of sex work and HIV/AIDS, such as attitudes, dispositions, and beliefs can help in coming up with policies that are culturally responsive and facilitate a change in outlook and behavior.

Drawing upon the fieldwork I conducted, which started December 2019 and ended exactly before the implementation of the quarantine in Metro Manila around mid-March, I examine the views of male dancers about HIV/AIDS in their involvement with sex work. Most of the male dancers that I have interviewed started in the industry at age of 18 while the oldest ones are on their mid-30s (Pastor, 2020). Given the age range and the current trend of HIV epidemic, the dancers belong to the high-risk group (Gangcuangco, 2019).

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Prior to proceeding with this commentary, I want to direct the attention towards the ambiguities and the debates that emerge on how macho dancers are viewed as sex workers and to the idea of sex work, particularly with how it is defined, because there is a conflict between the one who defines and the one being defined in this case. Lutnick and Cohan (2009) defines sex work as trade of sexual services for compensation. Weitzer (2000), on the other hand, reiterates that sex work includes exchanges involving physical encounters and stimulations that do not require direct contact. Taking my cue from these definitions, macho dancing is inevitably viewed as a form of sex work, and this still persist in the public consciousness. However, one notable observation among macho dancers is their resistance towards the stereotype by reiterating that the nature of their job in gay bars and clubs is to perform onstage and function as guest relations officers offstage, and sexual acts are not allowed inside the premises of the clubs.

This resonates with the proposition that the connection between striptease or stripping and sex work is indirect due to the lack of sexual penetration involved (Egan, Frank, and Johnson, 2005). At best, the acts performed by macho dancers are simulations and stimulations of sex through dance (Tolentino, 2009). Also, the dancers perceive themselves as entertainers in a strict sense of the word. In addition, there are clubs that show erotic performances where certain dancers are expected to dance naked, and not all are required to do it (Pastor, 2014). This one, however, could be categorized as sex work due to minimal physical contact and immediate financial exchange. Also, guests are given an opportunity to touch a dancer's private parts for a certain amount of money.

These situations reveal that macho dancers shifts from being a dancer to a sex worker and vice-versa but with a choice to practice one or both. However, in general, the bars and clubs also decide if a macho dancer should show off some more skin. This is evident with how certain dancers have to strip while others do not, which also reveals who among the "models" – the term used to describe macho dancers inside the clubs – are sellable (Pastor, 2014). One observation is that physically good looking macho dancers are generally not required to dance naked on stage while those who are below average in terms of appearance have to do the "all the way" – the jargon used to describe a macho dancer dancing naked on stage with an erect penis (Pastor, 2014). This practice is not implemented in all gay bars and clubs but there are certain establishments that do so (Pastor, 2020). Even so, this challenges the conventional view that macho dancers are sex workers though it would still take a lot of time to put this kind of perspective to be accepted by the public. It is important to note that some of dancers have admitted that they have been involved with guests and clients outside the bar and rendered services in various forms such as being an escort, engaging in sex, and dancing in bridal showers since these are lucrative. Others have expressed clear reasons for not involving themselves in such activities and opt to focus on the work at the clubs, and one of the reasons heavily cited is HIV/AIDS, and there are three impetus with this: outlook towards HIV/AIDS as a deterrent, the persistence of stigma, and the presence of interventions.

Certain dancers treat HIV/AIDS as deterrent for a number of reasons. Julian[2], a macho dancer in his late 20s and has been with a certain club for three years, has expressed that he fears contracting sexual transmitted infections from clients: *"Takot ako mahawa sa sakit. Yung tulo. HIV. Mga ganyan. Kaya iniiwasan ko yung makipag-sex sa guests. Mahirap na magkasakit. Sumama, sige lang."* (I am afraid of getting infected with gonorrhea, HIV, or anything like that. That is the reason why I avoid having sex with guest. It is hard when you get sick. It is fine if I just accompany them). However, Julian added another dimension to this: *"Ayoko rin talagang gawin kahit minsan gipit na kasi di ko alam kung meron palang sakit yung guest. Tapos what if maipasa ko pa sa misis ko. Mahirap na. Kaya mas madalas, dito lang ako sa trabaho sa club. Ayoko rin masira yung pamilya ko."* (I really do not want to do even if there is an immediate need because I do not know if the guest is sick. Also, what if I pass it on to my wife? It can be difficult. Because of that, I always stick to the work at the club. I do not want to destroy my family in such a process).

This demonstrates that while HIV/AIDS is used as deterrent in engaging risky sexual behaviors, it has a strong connection to kinship relations and social obligations based on how it is articulated. Certain dancers, who are in a committed relationship, whether with a live-in partner or a wife, are conscious of the health risks that comes with the job. To refrain from participating in risky sexual behaviors is an exercise of responsibility towards the self and others.

The question, however, is how much do they know about these issues surrounding sexual health and this is important because macho dancers are considered at risk. This can still be explored and remains relevant today given the high transmission rate of HIV that persists in the country (Gangcuangco, 2019). It also presents another impetus: are the dancers educated by the bars and clubs' management about sexual health? There should also be intervention of the part of the establishments and not rely solely on government led ones. In more case-specific terms, can relationships and social obligations compensate for the lack of a comprehensive sexual education when it comes to HIV and would it be enough of a deterrent for male sex workers to participate and engage in risky sexual

[2]All the names used in this article are pseudonyms to protect the identity and privacy of the individuals involved.

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behaviors that comes with the job? While one case demonstrates this as seen above, it is also worth exploring if such deterrence is possible for those single and not in a relationship. Its counterpart also proves interesting: does this absence of a deterring factor increase appetite for risky behavior? One cannot overlook how economic and financial need can influence the involvement of the macho dancers in behaviors that exposes them to HIV/AIDS.

In addition, does this knowledge of HIV/AIDS comes from a position of stigma? It is important to note an irony in these instances wherein preventing one's self from contracting HIV/AIDS is an act of being of responsible that is motivated by fear instead of genuine concern towards one's own sexual health. Julian's case might be a fair starting point to develop an inquiry on the connections pointed out. Meanwhile one of his colleagues, Van, has a different situation: *"Alam naman ng pamilya ko pati ng girlfriend ko na ganito trabaho ko. Practical na lang tingin nila. Di na nagtatanong ng kung ano kasi nabubuhay naman eh. Nabibigay naman gusto. Pag may labas labas kasama yung guest, pumapayag ako sa ganun. Basta safe. Malinis. Ayoko naman sumama sa guest na madumi. Kahit ganito ginagawa ko, maingat lagi ako."* (My family and girlfriend knows my job and understands its practicality. They do not even ask much about it as long as I can provide the needs and wants. Whenever I go out with guests, I usually agree to have sex as long as it is safe and clean. I do not want to accompany guest who is dirty. I still have to be cautious).

Van's point of view and experience differs from that of Julian. The degree of openness towards having sex with guests is informed and motivated by the economic benefits that come with it. Practicing safe sex is a standard for Van since he has multiple sexual partners despite being in a committed relationship. Even if safe sex is practiced, there are also clear parameters that are at work and condom use is a fixed standard. Trevor, Julian's fellow dancer and the youngest among the informants, has a narrated different experience, but his story is operating along similar lines: *"One time, pinilit ako makipagsex nung bading na client ng walang condom na gamit. Siyempre umayaw ako. Kung ganun lang din naman, wag na. Alam ko magkakasakit ako pag ganun. Ayoko magkasakit."* (There was one incident where a gay client asked me to have sex without using condoms. I refused and told him that if such will be the case, we better stop. I am certain I would get sick with it and I do not want to).

While there is a consensus that unprotected sex increases risk and exposure to HIV/AIDS, is it automatically correct to assume that such sexual act results into contracting the diseases or is this sentiment driven by panic? In addition, even if safe sex is the sensible course of action for both situations, is there a conscious personal effort, on the part of the macho dancers, to get tested despite its accessibility and readiness? Does condom usage reduces the need to get tested and increases the confidence that one does not have HIV? This question is even complicated further with the presence of pre-exposure prophylaxis (PrEP) and anti-retroviral (ARV) drugs in the Philippines, which are used to battle HIV/AIDS, including the awareness or the lack thereof regarding the benefits these medications provide. This also means that discourse on safe sex and HIV/AIDS should also go beyond condom use.

Another discomfort that I have is this: have we thoroughly considered that the macho dancer's understanding of safe sex and HIV prevention is solely based on using condoms or not, and this may be extended to other at-risk groups? In addition, how do sex workers perceive the notion of *malinis* (clean) and *madumi* (dirty) towards their potential clients? This duality is also used against the macho dancers based on morality, which strongly condemn sex work because it is immoral. This one is a complicated matter because of how these are articulated and reveal gender biases. Despite such, it is worth noting how the *malinis-madumi* debate play out. Is this based on appearance? One may look healthy but can have HIV. One may also "appear" unhealthy but does not have the virus. Is this based on sexual attitudes; such as if one participates in protected or unprotected sex, and if this is the case, how do macho dancers know prior to any transaction with the guests? Consequently, do dancers base this discourse based on experiences during transactions?

Are the use of these term indicative of stigma towards HIV, to the guests, who is generally gay and *bakla*, or to both? In general, there remains a tendency to equate HIV/AIDS to the gay community despite the presence of advocacy groups and information campaigns and one that cannot be denied is that male sex workers are among those who strongly exhibit such behavior and the contradiction involved where they also participate in it (Tan, 1999).

Amidst all these situations that involve HIV/AIDS and macho dancers, whether direct or not, one of the interesting findings I had in the field is that certain gay bars and clubs regularly requires HIV screening, even provides, tests to its employees. Zen, a former macho dancer turned manager in the one of the gay bars, have mentioned this. According to him, *"ginawang protocol yun dito sa bar kasi gusto rin na boss na malinis dapat mga dancers. Walang sabit."* (It has become a practice here at the bar since our boss want to make sure that the dancers are clean and free of any diseases). J.A., from another club, reinforced that "*kaya tinangkilik rin bar namin kasi alam ng mga tao na malinis mga dancers dito."* (guest patronize the clubs because the workers are safe). While these are welcoming developments, I find it hard to come into terms with is how HIV/AIDS testing is connected to bar patronage. The most plausible view that I have from such practice is how gays bars and clubs subtly admits that all of its male

ISSN 2651-6837

dancers are sex workers and involved in sex work in some form or another, despite the observation and claims by the dancer where not all of them fits the bill. What is commendable, however, is how the implementation of it becomes a form of HIV/AIDS preventive measure. It would be important to investigate if the practice is present and found in all the gay bars in the Philippines or if this is reserved only for upscale bars. One consideration for this is how the status and reputation, including the revenue of the clubs, provide the means to procure such service for its workers. Another is this: does the presence of testing increases confidence towards the bar and its workers? Does HIV/AIDS testing encourages participation in the economy of male sex work?

These cases presented provide insights on the attitudes and actions towards HIV/AIDS. How do these relate to each other? The observation is that male sex workers' views reveal that they cannot be considered ignorant of the dangers posed by HIV/AIDS, but their knowledge rests on being miseducated that allows stigma to persist and fear to dominate their mindset. This miseducation is traceable to how the understanding of HIV/AIDS never got out of the discourse of death, where contracting the disease remains to be viewed as a death sentence, and this results into a black and white view towards the virus: either you avoid it or accept the demise to come anytime soon. It is discomforting to admit that this stigmatized view, to an extent, can prevent HIV transmission but it is equally disturbing to know that there are some people, who struggled with HIV/AIDS, accept death even if it is preventable.

Family relationships also take a part in this debate because the stigma is embedded in it. The irony is that while these kinship ties mean no harm, they can amplify and complicate the problem in the long run even if these relations can be potentially effective to police risky sexual behavior. It is also within the family that these problematic views about HIV/AIDS are cultivated and passed on from one to the other, and may be even generational. The question of well-being and HIV/AIDS also plays a vital role familial contexts and debates, and this has been explored in local contexts (see Gonzales, 2013). However, it is important to examine how biases and stigma on HIV/AIDS are articulated, lived, and reproduced within the family, see a trend in such kind behavior, and do the appropriate steps to reduce it.

Does culture have a role to play in these concerns? It does because the persistence of stigma is grounded on the upbringing of people in a conservative, religious environment that treats HIV/AIDS as a result of immoral acts, even frames it as a form of divine punishment and relates to the framing of homosexuality as lifestyle (Osteria and Sullivan, 1991). Most of us agree that a comprehensive sex education is the way to go to counter these problematic biases, but if the component remains purely grounded on the medical debates and developments without critiquing culture that this education tries to correct and change, we keep going in circles. It is not enough that we present the scientific concerns and technicalities surrounding the virus and sexual health or to continuously obsess over numbers and figures. We have to locate the preventive measures in the larger cultural scheme of things, particularly in the daily lives and thinking of people.

These educational goals should also be reflected in policy intervention. There remains a need to address the disparity with the implementation of HIV/AIDS prevention strategies, especially with issues concerning class and accessibility. While testing is free and accessible, do people avail it? Another is even if we have guaranteed access to HIV drugs, such as ARVs, to people who need it, and it is provided for free, why is it that certain individuals still do not avail of these service and eventually ends up with complications that result to death? What are the underlying problems that inform these "refusals" towards treatment and medication? Is there enough information and awareness about nature and availability of such services? How do we address the knowledge gap in this scenario?

Also, is there stigma among medical practitioners towards HIV/AIDS patients and to those who would avail of related services? As it turns out, stigma and discrimination exists among health care providers and exhibiting such behaviors do have an effects the outlook of people living with HIV/AIDS, and can be extended to individuals who want to know their health and status (Lopez, Ramiro, and Roxas, 2017; Ortega, Bicaldo, Sobritchea, and Tan, 2005). While these are valid questions, I also want to highlight that none of the informants I had have mentioned anything about anti-retroviral drugs and pre-exposure prophylaxis drugs. I do not discount the fact that some of them might be aware of it, since it is mentioned that some received regularly HIV tests. However, since some of them have demonstrated stigma in the way they look at HIV, it is also equally plausible that they do not have awareness of these progresses. It is possible that they only participate in testing and are after acquiring a negative test result and disregard other aspects of HIV because what matters is not contracting the disease, which also means that they are still clean and clear.

Next question to ponder is this: is the government investing enough in healthcare programs? To have the HIV/AIDS drugs available is one thing, to make its distribution expansive and national is another thing. The approach on HIV remains concentrated in urban and developed areas of the country and still out of reach in the rural and far-flung areas (Gangcuangco, 2019). This still shows that the Philippine healthcare system remains limited and

ISSN 2651-6837

underdeveloped, and far from the ideal – one that is universal and comprehensive. If we can achieve this universal health care system, then this offers an opportunity for male sex workers to be in charge of their sexual health.

One of the longstanding views on male sex workers and HIV/AIDS is that both are considered immoral because it goes against religious norms. In correcting and challenging this view through the use of education, there is a need to wrestle against the view that sex is immoral and promote the thinking that sexual drive and libido are natural, primal instincts that should be acted upon responsibly – not violently and aggressively. Amidst these concerns, is there still a belief that despite being an epidemic, HIV/AIDS only affects a minority, and should not be a top priority? Does this thinking or belief have an impact on how male sex workers avail of medical services that should be made accessible to them in the first place, including those members of the population who are considered at risk? By denying sexual education, are we also closing the opportunity for people to make a conscious choice and explore the options that are available in taking care of one's sexual health?

These questions are posed and important to be engaged because while we idealize education as effective tool to address stigma, to correct sexual biases, we have to make sure it has a strong institutional backing. As an anthropologist, I recognize that we should treat HIV/AIDS beyond the number of cases and deaths. We have to understand that these figures are not just statistics, but a manifestation of the lack of systematic, comprehensive take on HIV/AIDS. I fear that the approach on addressing HIV/AIDS on remains fragmented and uncoordinated since there are sectors that remains on the margins of HIV/AIDS treatment, medication, and advocacy. Are the advances present in testing and treatment enough to encourage a change in behavior? Given the rising number of cases in the recent years based on the available UNAIDS data[3], we have to rethink the strategy because it says otherwise. The dialogues I had with male sex workers reveal that we are still lagging behind when it comes to advocacy campaigns, testing strategies, and behavioral approaches. The case of male sex workers is just one among the countless groups and kinds of people that show how HIV/AIDS prevention in the Philippines still needs reworking.

What do these reveal? As an anthropologist, I present two views: either the behaviors change that fast that the current approaches on HIV/AIDS prevention do not work effectively as it is supposed to be or the methods of addressing the epidemic are not entirely responsive to the behavioral trends, which remain outside the policy discussion and debates. I have to point out that while HIV/AIDS is a medical condition, it has a set of behaviors that come with it, and examining these should inform how we craft mechanisms to address this old virus problem in the contemporary setting.

[3]For UNAIDS data, see: https://www.unaids.org/en/regionscountries/countries/philippines

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