

Chapter 19

Understanding cultures of sexuality: lessons learned from HIV/AIDS education and behaviour change among gay men in Australia

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Abstract

Understanding sexual behaviour change in response to HIV/AIDS has been an enduring puzzle for those working to stop the pandemic. Gay communities in the developed world have rapidly achieved a remarkable level of behaviour change in facing the epidemics they have weathered. What might we learn from the example of the Australian gay communities that might be useful for other communities and populations? It was gay men who invented the idea of 'safe sex'; and some of the 'heterosexual' epidemics may be less heterosexual than we think. An important lesson from the fact of significantly reduced HIV transmission in gay communities is that prevention education works. Second, the concept of 'community' seems to contribute to successful behaviour change by creating a collective sense of commitment to stopping HIV. Third, all communities are different and have different resources to contribute. It is important to work with each community's own capacities. Each community's 'sexual culture' is an important resource. Understanding 'sexual culture' provides rich resources for prevention education. Finally, we need three sources of research knowledge to help us produce effective prevention: epidemiology; social-behavioural monitoring; and cultural and educational research.

In 1993, I was asked to review the international literature on HIV/AIDS-related behaviour change among gay men for the journal *AIDS* (Dowsett 1993). It was an interesting and revealing exercise because gay men have often provided an important indication of new steps and stages in the pandemic as a result of their position at the centre of the earliest epidemics in the developed world. They have also been a central part of the global response to AIDS, particularly in modelling community-based prevention education, and volunteer care and support for people with HIV and AIDS. We have learned much from their efforts.

A good deal of our understanding of the importance of sexual behaviour change has also been formed from research undertaken among gay and other homosexually active men around the world (see, for example, Stall *et al.* 1992). These findings from nearly eighteen years of research are rich in detail and have led to considerable development in our understanding of how effective health promotion works and how behaviour change is complex to achieve and sustain.

At times, these research findings and models from gay and other homosexually active men's responses to the pandemic have been applied to other populations affected by HIV, sometimes usefully, sometimes erroneously. Indeed, there has sometimes been a translation of

these ideas from gay and other homosexually active men in the West to other populations of men-who-have-sex-with-men in the developing world—a less than useful translation at times. While there is some evidence of the emergence of gay communities in the developing world, it is fairly obvious that most of the sex between men in the world does not happen within the Western cultural formation called ‘gay’ (see, for example, Khan 1999).

However, there is increasing recognition of the part played by sex between men in all our HIV epidemics now. The denial that occurred for too long in this pandemic, often framed by the spurious claim that homosexuality was a Western importation in the developing world, is consistently being refuted by recent research in Africa (Moodie 1988; Murray 1995), the Middle East (Murray and Roscoe 1997), South and Southeast Asia (Jackson 1995; Tan 1995; Jenkins 1998), Oceania (Jenkins 1996; Speith *et al.* 1998) and Latin America (Schifter and Madrigal 1992; Parker 1999). This research reveals traditional and longstanding cultures of male eroticism that undoubtedly have played, and will continue to play, a part in this pandemic. It may be that our so-called ‘heterosexual’ epidemics are not so heterosexual after all.¹

This refusal to recognize such cultures of male-to-male eroticism is often tinged with what is termed ‘homophobia’, or an irrational fear of homosexuality. During the final plenary session of the Twelfth World AIDS Conference, held in Geneva in 1998, it was suggested that Western gay men should vacate the international HIV/AIDS field. This was undoubtedly fuelled by anti-gay sentiment and is a recipe for disaster. After all, gay men working in HIV/AIDS globally are now among the world’s longest-serving and most experienced AIDS workers. Their leadership, skills and experience have much to offer established and emerging epidemics, and in modelling care and support for people with AIDS.

I have just returned from Bangladesh, where researchers are investigating a number of traditional and new patterns of sex between men, already implicated in the growing HIV epidemic there (Jenkins 1998). Also, studies of young people undertaken in the mid-1990s with the initial support of the World Health Organization’s Global Programme on AIDS (WHO/GPA) and, subsequently, the Joint United Nations Programme on HIV/AIDS (UNAIDS) in Cambodia, Cameroon, Chile, Costa Rica, Papua New Guinea, the Philippines and Zimbabwe, found same-sex activity occurring among young men (and among young women) in each country (Dowsett *et al.* 1998). It is clear then that same-sex activity and its potential for HIV risk have both traditional and emerging cultural forms in every place on the planet when we have looked for them with open minds, a clear focus on the health issues involved with HIV/AIDS and a refusal to let moralistic political agendas get in the way of good public health.

Even though the particular experiences of gay men and gay communities in the pandemic may not be the same as those of women and other men elsewhere in the developed and developing worlds, there may be general lessons we can learn from the responses of those gay men and their communities. These lessons might help other populations newly at risk for HIV infection. They might also assist in developing policy and programmatic responses that minimize the impact of HIV infection and AIDS on other communities affected by it. Nowhere is this clearer than in helping us think about sexual behaviour change.

¹ There appears to be less concern about the importation of that other Western term ‘heterosexuality’, also invented in the nineteenth century, even though it may seriously distort our understanding of sexual cultures in many non-Western countries and our understanding of their HIV epidemics (see Patton 1990).

It is important to remember that it was gay men who first invented the idea of 'safe sex' in the very early 1980s (Callen 1983), working out from an understanding of their own sexual activities and relationships that condoms used for penetrative sex and a foregrounding of non-penetrative sex practices would stop, or at least hinder, the transmission of whatever it was that caused AIDS. HIV, as we now know it, that is, the virus, was not then a certainty. Those gay men were right, and the world has gone on to mobilize the idea of safe sex as its central prevention strategy ever since.²

It was also these same gay men who started developing the first prevention resources and activities, mostly without the assistance of government programs and financial support in the early 1980s. For example, in Australia the first messages about condom use for gay men were carried in a gay community newspaper in 1981 (*Sydney Star Observer* 7 June 1981), and the first pamphlet that contained a message about what eventually became AIDS was distributed by a group of gay men in Sydney in 1982, using material borrowed from the San Francisco gay community and paid for by the gay men themselves (Sister Mary Third Secret of Fatima 1993).

This is not a new story. All over the world, communities organizing themselves started HIV prevention and care activities, long before most governments acted. Early gay community initiatives occurred throughout the developed world and were soon happening in Brazil, Malaysia, Thailand and South Africa. The same story can be told of the earliest volunteer care and support activities for people with AIDS, initiated in New York, Sydney, Amsterdam, London and other places in the early 1980s. This is even true for research: it was gay men who offered their blood and their behaviour to the earliest biomedical and social research. In Australia, the first such studies began in 1983, and the first behavioural research study in Sydney I worked on from 1986 with colleagues arose from an initiative of the gay community itself approaching academics to form the kind of research collaboration that distinguishes the Australian response to HIV/AIDS (Kippax *et al.* 1993).

Even with the efforts of our gay communities, HIV remains a major health threat to gay men in Australia (National Centre in HIV Epidemiology and Clinical Research 1999). Unsafe sexual behaviour still occurs (Crawford *et al.* 1998), and we cannot afford to be complacent despite steadily falling rates of infection, which are finally confirming that our programs of prevention have worked. For example, in San Francisco in April 1999, I had the opportunity to visit the Center for AIDS Prevention Studies, one of the world's major HIV social research institutes. There, it was noted that HIV prevalence in the San Francisco gay community, once the worst-affected in North America, had dropped from about 50 per cent to approximately 20 per cent. The explanation was that accumulated deaths, along with new men joining the community, and successful prevention through sexual behaviour change over eighteen years, had contributed to this drop in prevalence.

This is important for it tells us that prevention works and that we might only see its effects over longer time periods than our political masters or public health bureaucrats would like to accept. It is clear that our scientific measurement processes need to be tailored to the actual history of the epidemic itself rather than the duration of anyone's political power or a funding cycle. On this issue, the experience of gay communities parallels that of some non-gay communities that responded similarly to early epidemics, such as in Uganda and Thailand. These

² Some countries use 'safer sex' and others use 'safe sex' to describe the same prevention strategy. Australia chose, as a policy, to use 'safe sex' and this is the usage followed in this chapter.

offer useful lessons to other communities affected by AIDS. In particular, sharing those lessons of good prevention practice is important, as recent efforts by UNAIDS reveal (Malcolm and Dowsett 1998).

There are other important issues in the account from San Francisco and from other gay communities around the world: what is it about gay communities themselves and what they have achieved that might offer clues as to their success? What led some of the world's most stigmatized and oppressed subcultures facing the devastation of the earliest and, in the West, among the heaviest death tolls, to produce such effective behaviour change so quickly as to turn their epidemics around? How did they develop out of the raw material of their very lives the successful education and prevention resources, messages and activities that have produced that change? Why did gay men so readily take up the use of condoms when their sex lives never had need of them before?

In 1993, in reviewing the behavioural evidence from around the world, I found a common thread, one not noticed then as readily as it is now, one that should not surprise any social scientist or public health specialist (Dowsett 1993: S258):

The overall nature of sexual behaviour change and success of preventive education is well-documented. The various models used to explain success in this area have much in common. These analyses have found information about AIDS and knowledge of HIV transmission, the effects of peer education and support, input from factors such as self-efficacy or self-esteem, perceptions of risk, availability of and access to condoms, and contact with the effects of the epidemic to contribute to the processes of behaviour change. The evidence on anti-body testing is equivocal. However, there is an important and consistent sociodemographic contribution to behaviour change in the findings, suggesting that larger social constructs such as the effects of oppression or inequality might underlie the more psychological components of behaviour change. This possibility is supported by a strong theme increasingly found in the literature. Whether configured as 'culturally defined interpersonal acts', social 'norms', 'informed social support', social networks, or community 'attachment' or practice, there is a definite social and collective character to the behaviours and processes being monitored, which transcends the simple aggregation of individual practice.

Many reports were finding something collective, something that noted groups, peers or communities rather than individual activity, even though the research methods themselves were focused almost exclusively in accumulating individual evidence. I concluded:

These findings challenge us to re-conceptualise sex not merely as an inventory of practices, but as a multifaceted social and cultural product, the logic of which lies in the interactive potential for endlessly re-living and re-learning intimate pleasures within changing patterns of relations (Dowsett 1993:5258).

That statement, now six years old, still rings true for me after thirteen years of researching HIV/AIDS among gay communities in Australia, among young people in developing countries, and after my recent exposure to the emerging and potentially devastating epidemic in Bangladesh. This is one country where we might easily prevent a disaster by simply learning the lessons of elsewhere quickly.

This finding in the literature review of something collective, something cultural driving successful behaviour change was not new to me. I had suspected in Australia that the gay community was achieving something more than merely changing individual behaviour for a long time. In 1988, WHO/GPA asked me to report on gay men in Sydney and their responses to the

epidemic (Dowsett 1990). I reported that reading the behaviour-change data, coupled with an investigation of educational activities being undertaken by gay communities in Australia, led to the conclusion that gay communities were working hard to create a 'safe sex culture' in their educational activities, using the idea of 'a community acting together to protect itself' (Dowsett 1990:191). This notion of a safe sex culture is not merely a documentation of aggregated behaviour change; rather, it is a framework of ideas, practices, images, language, preoccupations and activities that insinuate safe sex directly into the centre of daily life for gay men. It means that any involvement in gay life is also an immersion in HIV/AIDS and in its key concern of developing, sustaining and living with safe sexual practice.

This idea of a safe sex culture is widely used in Australia, if sometimes contested, but it does seek to register the importance of collective action, mutual commitment and cultural underpinnings in stopping our epidemic. In this formulation, sexual behaviour change is never conceived of as simply an individual act; rather, behaviour change reflects reciprocity in sexual relations, the meanings of sex to groups or clusters of people, and the structuring of sexual activity by historical and cultural forces that are not always immediately obvious to the observer. Perhaps, that is why much early HIV behavioural research did not notice it at first.

The lesson here for all communities fighting HIV/AIDS is to identify that collective action and mutual commitment and those cultural underpinnings as resources to mobilize to the cause of HIV prevention and to care and support for people with AIDS. Each community's resources will be different—richer in some cases, thin on the ground in others—but any cluster of affected people with common circumstances, interests, history or location will have a version of these resources to use and build on. This will apply to sex workers, injecting drug users, villages, people with haemophilia, and so on. Sometimes this mobilization is called 'empowerment' or 'community development'. It is ultimately the same dynamic process as the gay communities exemplify.

There is a second factor involved here. The gay communities in Australia, as marginalized and stigmatized subcultures, had a strong sense of themselves as collectively effective and responsible for their own survival, engaged as they were at the start of the epidemic in a serious struggle of liberation from oppressive laws and discrimination. That most of these laws have been reformed during the time of the epidemic says something remarkable about Australia and its commitment to human rights. The gay communities are also rightly proud of achieving these reforms, which have been important in supporting their fight with HIV/AIDS.

There is a profound sense of ownership of HIV/AIDS among Australian gay men, particularly among the generation hardest hit by the epidemic. Gay communities also sensed early that unless that ownership was recognized and jealously guarded, other partners in our national fight with AIDS might not sustain a focus on the gay communities and their needs. Just as anti-gay sentiment and homophobia lead to that denial of same-sex eroticism in many countries mentioned earlier, a turning away from gay men undoubtedly happened in Australia for a time in the late 1980s and early 1990s when government funds, educational efforts and research largely turned their backs on the needs of gay men. Other communities, sex workers in particular, have experienced similar marginalization in many countries during the pandemic.

During that period in Australia, we saw perhaps the most radical period of AIDS activism in our gay communities (Ariss 1997). Ariss notes that early forms of advocacy for and by people with HIV and AIDS in demanding better access to possible treatments and a sharper focus on their needs drew heavily upon the form and rhetoric of gay rights activism. Here again, a cultural

legacy of community mobilization, political savvy, leadership, and tried and true forms of activism from the gay community were central in achieving such victories. There are many similar moments. The struggle to convert the notion of 'AIDS sufferers or victims' to 'people living with HIV or AIDS' draws from earlier struggles of gay men and lesbians to refute the idea of homosexuality as illness and demand sexual equality and acceptance as fully human. Those struggles have profoundly affected the global vision of people with HIV/AIDS and of how communities affected by it might have a say in any country's response to its epidemic. Another example is the notion of 'coming-out' as a person with HIV/AIDS. Such coming-out undoubtedly responds to very real circumstances of oppression and stigmatization experienced in different forms in various countries. But the idea that such stigmatization is best met with a politics of identifying publicly as a person with HIV or AIDS was originally borrowed from the notion of coming-out as 'gay' in response to homophobia and discrimination.

The argument here is that gay men's culture, its sexual underpinnings, the effects of oppression and discrimination creating a sense of self-protection and struggle, the strong emotional bonds that suffuse sexual relations, a shared sense of a hidden history recently proudly revisited, and other cultural elements that help glue the gay communities together have been brought to bear on many and varied aspects of HIV/AIDS, including the dramatic, collective transformation in sex practices that has led to the remarkable reduction in infections experienced in Australia. Academic models of behaviour change commonly neglect these cultural and collective elements for a psychologistic understanding of behaviour as merely individualized, rarely interpersonal, and inevitably decontextualized.

That said, safe sex culture is more than a framework for understanding behaviour change on a collective level; it also describes the raw materials used in education and prevention itself. In understanding any epidemic, we need good epidemiological and behavioural monitoring. They tell us the patterning of the epidemic and the starting points for interventions—the hot spots if you like. But the dynamics of any epidemic cannot be understood on this evidence alone, and these sources offer very little to help develop the content and form of actual health education programs. For example, knowing in a given country that HIV-incident infections are occurring significantly more among young women in cities and that urban young people are still engaging in significantly higher levels of unprotected intercourse than adults only identifies the target audience and site for prevention interventions. It offers no ideas, resources, images or content on which to draw in the design and delivery of those interventions. For these, we must draw on the cultural resources of the populations or communities we work with. Prevention education is cultural production, and many in the HIV/AIDS field who have worked hard for years developing programs and delivering services to communities know only too well the need for cultural appropriateness and for images, language, messages and forms of delivery relevant to, and affordable among, our peers.

This is something else the gay communities have taught us. The Australian gay communities established this type of education very early, often with controversial images, sexually explicit ones that instinctively drew on the structure of gay communities as 'sexual communities'. This notion of sexual communities can be readily applied to sex workers too, but will not work as well with heterosexual activity, unless there is a strongly developed sense of community among heterosexually active people as such and of a character similar to, and as readily mobilizable as, that which exists among sex workers and among gay and lesbian communities. Ascertaining the sexual culture of any such community is a central research task for effective health education, because all communities are differently structured. Where sexual

culture and sexual community do coincide, the task is easier to undertake if there is the will to do the digging.

Sexual communities are observable in other populations that adhere for reasons such as ethnicity, religion, age and generation, location or historical ties. This was recognized by WHO/GPA and UNAIDS in commissioning those seven studies mentioned earlier of contextual factors affecting sexual risk-taking among young people in developing countries (Dowsett *et al.* 1998). This cross-cultural research program noted, among other things, the importance of traditional sexual beliefs and activities, the pressure from modernization, the use of space by young people to create legitimate places for developing relationships, and evident gender imbalances with much recognition of the dilemmas facing young women but little understanding of the sexual isolation of many young men. The studies also noted specific vocabularies used by young people for sex, young women's keen desire for sexual experience, notable same-sex experience and interest, the diminishing value of virginity, and the rather less than useful contribution of many parents.

The point here is that, just as non-gay people usually know little of the complexity of gay communities and the expression of their sexual cultures, young people are developing their own meaningful and complex sexual cultures right under our very noses. We often cannot see those cultures or will not recognize their legitimacy. If we are to reach our young people with safe sex messages, then we must work with the cultural resources young people themselves provide and we must include them in the task. Just as we have worked successfully with the cultural elements of modern gay life here in Australia to frame and construct our HIV prevention messages in images, terms and forms accessible and appropriate to our gay communities, so developing prevention anywhere needs to draw on the sexual culture of the communities we work with.

This means we need to ensure that, as well as epidemiological and behavioural surveillance, we undertake adequate and focused cultural and educational research to ensure that our interventions are focused and draw effectively on the resources our communities themselves present for use. Just as important is the recognition that it is this collective energy structuring community life that gives shape to our interventions and contextualizes the messages we offer.

Communities are formed differently. Some have long histories and deep bonds. Others are formed by immediate circumstances and emerging interests. HIV/AIDS has affected many differently formed communities and these have responded differently according to the resources and sense of communality they possess. Gay communities as we know them today are very recent phenomena, yet they have developed very effective responses to the pandemic. They reveal something about how 'community' works, what it draws on, and how it can be mobilized for common purposes. This is particularly the case when we realize that our sense of community increasingly relies less on kin or shared origin and history in many countries. The meanings of community change; and our understanding of what community is needs to change with it.

Gay communities in their struggle with HIV/AIDS have taught us all that the meanings embedded in those aspects of community life and mobilized in interventions most effectively drive behaviour change by making it a shared commitment to survival and security. Any prevention efforts need to recognize that the engine for stopping the epidemic lies in community, and that in the culture of our communities we shall find the sources of success in producing effective and sustained behaviour change.

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