Homosexuality and HIV/AIDS prevention: the challenge of transferring lessons learned from Western Europe to Central and Eastern European Countries

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SUMMARY
In order to stem the rapidly growing HIV/AIDS epidemics in Eastern Europe a transfer of prevention know-how and experience from Western European countries is necessary. The success of such a transfer is contingent on addressing a number of challenging issues. Monolithic ideas of East/West difference need to give way to the growing empirical evidence which not only shows a tremendous diversity but also many similarities among the 51 countries within the WHO European region. These include similarities regarding sexual attitudes and HIV prevention needs. Western constructs such as a gay identity need to be de-emphasized however, when it comes to promoting human rights (and thus improving HIV prevention for men who have sex with men) in Central and Eastern Europe. In asking the question of what should be transferred from Western Europe to other countries, both the strengths and weaknesses of the last 20 years of prevention need to be considered. In terms of Western European research the strength lies in identifying the social structural causes of HIV transmission. In terms of practice, the successes of instituting country-level structures while also working within the gay community are to be emphasized. Shortcomings are evident in terms of reaching men of lower socio-economic status, cultural minorities and sex workers. On such questions, the expertise of Europe as a whole is needed in order to find new answers.

Key words: Eastern Europe; HIV/AIDS prevention; homosexuality

INTRODUCTION
The fall of the Soviet Union has resulted in extraordinary social change, which poses new challenges for public health. One such challenge has been the spread of HIV into previously uninfected populations. Particularly in the former Soviet republics there has been an explosive growth in new infections in recent years (EuroHIV, 2003). However, the overall prevalence of HIV remains relatively low in Central and Eastern European countries, providing a window of opportunity for implementing effective interventions in order to stem emerging epidemics. One aspect of developing effective prevention strategies in these countries will be the successful transfer of expertise and knowledge gained from HIV prevention efforts in Western Europe. Regardless of the specific course of local epidemics, international experience to date has made clear the importance of designing prevention interventions specifically for men who have sex with men as one component of a comprehensive HIV containment strategy. The basic principles for providing effective prevention services to homosexual populations have been discussed extensively in the international
literature and have been summarized as part of the UNAIDS Best Practice Collection (UNAIDS, 2000). These principles have been applied with measurable success in countries and localities where sufficient political commitment and resources have been present (Coates et al., 1996). The purpose of this article will not be to reiterate this discussion, but rather to focus on the specific challenges inherent in transferring the experience and knowledge on homosexual transmission gained in Western European countries to Central and Eastern Europe. This question will be examined in terms of key issues, which need to be addressed in order to make such a transfer possible.

- Separating homosexuality from gay identity.
- Separating human rights from gay identity.
- Highlighting the strengths of Western European research.
- Supporting approaches appropriate to each country and region.
- Avoiding East/West stereotypes regarding sexual attitudes.

**Separating homosexuality from gay identity**

The idea of a gay identity arose from the gay liberation movement, which has its origins in nineteenth-century Western Europe, receiving a major push in the 1960s from the student uprisings in Europe and the civil rights movement in the US. The primary goal of gay liberation has been securing the human rights of homosexual citizens while promoting an identity as gay or lesbian and a lifestyle in which this identity is lived openly in same-sex relationships. To this day, a gay identity is most strongly found among men in Western Europe and in English-speaking countries, more generally. There has, however, been a gradual spread of such an identity to other countries, as well (Pollack, 1994; Altman, 2003). A gay identity is associated with a gay sub-culture, which includes commercial, political, academic and artistic expressions.

The first cases of HIV identified in North America and in Europe were among middle-class, gay-identified men who were part of the gay sub-culture. The strong connection between sub-cultural institutions in Western countries not only provided international networks in which HIV could spread, but also ready-made structures, which could be utilized for prevention activities. For this reason, a majority of public authorities in the West began (often reluctantly) working with gay organizations to develop prevention initiatives (Rosenbrock et al., 2000). The resulting changes in behavioural norms due to this collaboration is considered to be one of the major success stories in the history of public health. As the HIV pandemic has developed, however, we have observed an increasing stratification of new cases in terms of social class and in some countries by ethnicity, as well (Bochow, 1998; Schiltz, 1998; Weatherburn et al., 1999; Stall et al., 2000). Elevated rates of infection have also been reported among male sex workers (Browne and Minichiello, 1996). An important component of this dynamic is the weak or non-existent connection between the gay sub-culture and men of lower socio-economic status, men from minority cultures and male sex workers. These groups of men engage in homosexual acts, but do not necessarily view these acts as being ‘gay’. Rather, a host of other meanings are ascribed, based on the circumstances in which these acts occur (Bloor et al., 1993; de Graaf et al., 1994; Bochow, 2000). HIV prevention has thus been challenged to expand services so as to include all men who have sex with men (MSM), although how best to reach this broader audience remains less clear. The central problem is that MSM is an undetermined heterogeneous population of men who, at some point in their lives, have sexual contact with other men. This stands in sharp contrast to the initial target group for HIV prevention—middle-class, gay-identified men from the majority culture—which was relatively homogenous, concentrated and easily defined.

Independent of the discourse on HIV/AIDS, gay men and MSM in Western Europe and in English-speaking countries, there has emerged a body of research showing a variety of forms of institutionalized homosexual and bisexual behaviour in various parts of the world, including Europe. Several of these forms, integrated into local tradition and social norms, are far older than the gay liberation movement (Schmitt and Sofer, 1992; Aggleton, 1996; Mendès-Leité, 1996). Other differences regarding sexuality within Europe itself have also been documented, for example those between Northern and Southern Europe as related to frequency of sexual activity, age of sexual initiation and range of practices by gender (Sandfort et al., 1998).

In applying the research and practice of HIV prevention for homosexual men as found in the
West to Central and Eastern Europe, it is thus important to consider the landscape of homosexual behaviour in each particular country. Clearly, even where culturally appropriate, the gay liberation movement does not yet have the level of infrastructure and general social support in Central and Eastern Europe as in the West, given the relatively short period of time in which it has had to organize. However, there may be other differences in how homosexuality is lived and understood which need to be taken into account. Basic research on homosexuality as practiced in each particular country is indispensable in this regard (e.g. Stanekova et al., 2000; Amirkhanian et al., 2001).

HIV prevention for homosexually active men in Eastern and Central Europe cannot assume the same pattern as that in countries, which at the start of the HIV epidemic already had an established gay sub-culture. And such a sub-culture cannot be organized solely on the necessity of providing prevention services. For this reason, each country needs to find its own way to reach at-risk men without the benefit of ready-made structures. On the other hand, all countries in Europe are currently faced with this very same challenge—reaching men who are not gay-identified—thus providing a common problem to which all countries in West, Central and Eastern Europe can contribute their ideas. The situation of Eastern and Central European countries highlights a deficit, which has existed in the prevention activities of all countries in Europe, but which has received inadequate attention.

**Separating human rights from gay identity**

UNAIDS Best Practice guidelines regarding HIV prevention for homosexually active men (UNAIDS, 2000) include support for measures to end the stigmatization and criminalization of homosexual behaviour as an important foundation for prevention. Hostility from the social environment not only makes homosexually active men difficult to reach, but also has consequences in terms of target groups adopting and following-through with risk reduction measures.

Within the gay liberation movement there has been a debate over the years as to the relationship between assuming a gay identity and being emancipated. This has been played out in the conflict between essentialists (those who see homosexuality as a fundamental aspect of a person’s nature) and constructivists (those who see homosexuality as being largely a social construct). Regardless of which view is deemed to be correct, the constructivist position (including post-structural analysis) has made the important contribution of exposing the cultural relativity of sexual identity. On the basis of such research it is difficult to imagine a construct for being homosexual which would be applicable in all places at all times. This calls into question to what degree any particular identity can be held as being necessary for the effectiveness of HIV prevention or any other health promotion measure.

As Brookey and Miller (Brookey and Miller, 2001) suggest, the insights of post-structural thought can be used to direct the focus of sexual rights movements to the removal of homophobic responses and other forms of discrimination, without supporting any particular identity. In realizing the principles of UNAIDS this would mean removing legal and other social barriers which punish the practice of homosexuality, but without necessarily promoting a gay identity or any other particular form of homosexual expression. The challenge to European countries in this regard is to avoid equating human rights for sexual minorities with any particular idea of how homosexual should be lived. This allows for the basic non-discrimination principle for effective prevention as described by UNAIDS to be fulfilled without succumbing to the above-named error of equating homosexuality with gay identity. Even within countries with an active gay rights movement, it has been observed that focusing legislative debate on particular identities or lifestyles imposes constrictions on homosexual people who in actuality make up a diverse population (compare with Smith and Windes, 1999).

The central intergovernmental bodies of Europe have been very active in challenging human rights violations in member countries, based on European conventions and other instruments. Since the Treaty of Amsterdam in 1999 discrimination based on sexual orientation has been recognized explicitly by the EU as an area of action. Although in recent decades the legal restrictions against homosexuality have generally been more severe in Central and Eastern Europe as compared with Western European countries, ongoing law suits within the EU make clear that human rights for homosexuals is not an East/West issue, but a challenge for all countries. In separating human rights issues from a discussion of particular lifestyles, a basic level of protection can be achieved while allowing for each
country to resolve other specific issues such as marriage, adoption, etc. (see overview in ILGA-Europe, 2001).

**Highlighting the strengths of Western European research**

The international literature on the evaluation of HIV prevention largely originates from North America, particularly the United States. For example, of the 68 outcome evaluations found in an extensive search of the literature by Oakley *et al.* (Oakley *et al.*, 1995), 50 (74%) were conducted in North America (nine in Europe, nine in other regions). Of the 110 studies on sexual health interventions for young people reviewed by Peersman and Levy (Peersman and Levy, 1998), 92 (84%) were from North America (15 Europe, two developing countries, one other). An extensive literature search was also conducted by the author of this article on studies in English, German and French, using both electronic databases and contact to key researchers. The goal was to identify process and outcome evaluations of community-based HIV prevention, which focus on the sexual transmission of HIV. Of the identified 191 articles 139 (73%) were from the United States (52 or 27% from other countries, 10 of those from Europe). The literature was also searched in the three languages for theoretical and review articles related to the same topic. Of the 58 identified publications, 36 (62%) originated from the US.

An obvious explanation for the disproportionate representation of the US in the literature as compared with other industrialized countries would be the larger scope of the American epidemic as compared with Europe. Not only was the US the first country in which the virus was identified, but it continues to exhibit the most serious epidemic among Western industrialized nations. Epidemiological differences do not, however, explain the virtual non-existence of process and outcome evaluations on community interventions in German and French. Here, cultural differences may be at work, as suggested by Maja Heiner (Heiner, 1992) and Jean-Claude Manderscheid (Manderscheid, 1996). These authors describe a particular emphasis in English-speaking countries on evaluation as an integral part of planning. Both point to a different research tradition in Germany and France, which is not driven by planning imperatives, but rather by questions related to the social determinants and social impact of a given problem. That is, evaluation research in both countries operates less in the interest of immediate political utility and is thus less concerned with the results of specific interventions and more with longer-term social change. The resulting interventions have been primarily at the macro level in terms of legislation regarding such issues as job security, housing availability, etc. The individual social service projects are thus viewed as being supplementary to legislative and structural interventions which seek to address such issues as poverty, class disparities, unemployment, etc. The under-representation of French and German process and outcome studies is likely attributable to this different tradition in terms of the relationship between social policy and research. This tradition is a reflection of the welfare state principles which have shaped social policy in Europe, and which have had less of an influence in the US. State supports and structural interventions have formed the core of European social policy; whereas, the United States has a unique tradition which emphasizes to a greater degree the non-profit and private sector in addressing social problems (compare with Axinn and Levin, 1982; Reinhardt, 1996).

The result of the literature being predominantly North American in origin is that certain issues are highlighted which are not necessarily central to the European discourse. As Peter Aggleton (Aggleton, 1998) has observed, the debate regarding the use of randomized clinical trials for evaluating success and the focus on developing a ‘prevention science’ based on behavioural interventions for specific groups have been important in the US, but of less significance in Europe. Rather, the focus has been on illuminating larger social dynamics affecting the spread of HIV and making recommendations for structural social change. As Maja Heiner (Heiner, 1992) clarifies in her description of evaluation in the social sector in general, this has meant a strong reliance on qualitative methods in line with the interpretative and hermeneutic traditions of social science. Such approaches have also been the foundation of basic research on sexual behaviour and HIV in Europe. The emphasis has therefore not been on risk factors at the individual level, but rather on social and contextual dynamics (Wright, 1998).

Thus, the transfer of experience from Western to Central and Eastern European countries is not
primarily about specific interventions at the micro level, but rather concerns structures which can be put into place in order to best combat the spread of HIV. This emphasis is not only in line with the World Health Organisation (WHO) Ottawa Charter which stresses the political and social causes of disease, but also reflects a growing interest in public health for more comprehensive approaches (Parker et al., 2000). The focus is not on a ‘technology transfer’ in which specific techniques are most important, but rather on methods of analysing social causes and implementing social change in the context of welfare state structures in which public authorities and government funding play a central role. The future development of social policy and public health in Europe as a whole is based on this common tradition. This also implies examining critically all attempts at free-market reform, which endanger public health structures and other effective measures of fighting poverty and disease which had been established within the Soviet Union and other socialist countries.

Supporting approaches appropriate to each country and region

AIDS prevention strategies in Western Europe are very diverse, reflective of national and regional traditions, cultural attitudes, and national and local politics. In spite of this diversity, however, intensive and regular exchange, particularly within programmes supported by the EU, have led to common principles as embodied, for example, in the initiative Europe Against AIDS or in the Charters of EuroCASO and Change, two international associations of European AIDS service organizations (ASOs).

Given the complexities of each national discourse, the different epidemiological situations, and the lack of equivalent data, it is difficult to compare directly one country to another (Weilandt et al., 2001). A look at trends over time do, however, suggest approaches which are more successful than others. For example, a key characteristic of countries which have managed to prevent wide-scale heterosexual transmission has been pro-active harm reduction strategies for drug users. Such strategies have contained the epidemic in this group and thus addressed the primary point of entry into the general population (Nicoll and Gill, 1999).

In transferring the experience of Western European countries to eastern neighbours the focus needs to be on assisting each country to adapt basic principles of HIV prevention to its particular situation at this point in history. This not only includes an acknowledgment of the centralized structures and the lack of self-help and voluntary organizations which were common to socialist countries, but also supporting each country in finding an approach which fits with its current political and social climate. This may mean compromises between the old and the new order, thus deviating somewhat from the practice in Western countries.

A case in point is Hungary, a country which has managed to contain the HIV epidemic at a lower level. As Renée Danziger (Danziger, 1998) argues, this has been achieved by combining new approaches with elements of the old system. The most important means of transmission has been homosexual contact, followed by heterosexual transmission, and to a far lesser extent, intravenous drug use. Already in 1986 the Hungarian government developed a national HIV strategy. In terms of structures more typical in Western countries, one finds in Hungary wide-spread access to free and voluntary counselling and testing, cooperation between public authorities and non-governmental organizations, funding for ASOs (including gay organizations), and targeted campaigns to other at-risk groups (such as young men and sex workers). However, Danziger argues that an important element of the successful strategy has been the mandatory testing of certain populations (blood, organ, sperm and tissue donors; STI clinic patients; prostitutes in police custody; prisoners; and drug rehabilitation patients). In addition, partner notification is also mandatory for those testing HIV positive; the contacted partners are then also required to be tested. The latter measures were instituted in 1988 and are reportedly widely accepted. Thus, Danziger concludes (p. 22): ‘Since 1986 Hungary has developed an HIV prevention strategy which appears to have successfully integrated traditional public health control measures with more innovative HIV prevention programmes. [...] Based on current epidemiological trends, there is reason to believe that Hungary’s unique combination of tradition and modernity is helping to contain the spread of HIV.’

As the situation in Hungary illustrates, the ideal near-term solution may be a strategy which incorporates some but not all of the principles more commonly found in Western European countries. Whether a country is in Western,
Central, or Eastern Europe the ultimate measure of the specific approach taken is the course of the epidemic over time.

Avoiding East/West stereotypes regarding sexual attitudes

Sexuality was reportedly a taboo subject in the Soviet Union as far as the mass media, scientific investigation and education were concerned (Hamers, 2000). There is also evidence to suggest that the socialist system reinforced traditional gender roles in the private sphere, while promoting the equality of women in the public sphere (e.g. Durndell et al., 1995). Such observations have given credence to stereotypes of Central and Eastern Europeans as being generally more conservative when it comes to values and practices related to sexuality. Such sexual stereotyping based on region is not exclusive to the differences between East and West; ideas persist regarding Northern versus Southern Europeans and Catholic versus Protestant countries, which can only partially be supported by empirical evidence (Sandfort et al., 1998).

Comparing sexual attitudes cross-culturally is a very difficult matter, not least of which due to the differences in how sexual beliefs and behaviours are conceptualized and measured in various countries—which itself is reflective of different cultural norms (Hubert, 1998). Recently, standardized data on sexual attitudes from the International Social Survey Program (ISSP) have been analysed for 24 countries by Widmer and colleagues (Widmer et al., 1998), thus providing a unique opportunity to examine comparable information from nationally representative samples. Of the countries included in the study, six were from Central and Eastern Europe (Slovenia, Poland, Czech Republic, Hungary, Bulgaria and Russia) and 14 from Western Europe. The analysis focused on four questions regarding pre-marital sex, sex before the age of 16, extramarital sex and homosexuality. Through a cluster analysis procedure, the countries were grouped according to similar responses. It was hypothesized at the outset that a simple two cluster permissive/non-permissive solution would not explain the variance between countries.

The procedure resulted in six clusters. The percent of attitudes shared among all countries was 81%. Cluster-specific similarities were 14%, and country-specific responses 5%. Two of the clusters consisted of one country only (Japan and the Philippines). The other four included a mixture of countries from various parts of Europe. The cluster termed ‘sexual conservatives’ included the US, Northern Ireland and the Republic of Ireland and Poland. These countries show a stronger than average level of disapproval for all forms of non-marital sex. The cluster termed ‘teen permissives’ consisted of Germany (East and West), Austria, Sweden and Slovenia. In this group, there were relatively high levels of acceptance for sex among teenagers and before marriage. In the third cluster called ‘homosexual permissives’ (the Netherlands, Norway, Czech Republic, Canada and Spain) there was a higher than average level of acceptance of homosexuality and premarital sex, while tending to reject teen and extramarital sex. In the final group of ‘moderate residuals’ there were the countries Australia, UK, Hungary, Italy, Bulgaria, Russia, New Zealand and Israel. Here there was no overarching trend, but rather a heterogeneous group differing little from the overall average scores.

Of course, the results of this study cannot be considered conclusive. However, such an analysis conducted but a few years after the fall of the Soviet Union shows not only a great deal of similarity between all countries surveyed, but also groupings which defy typical popular notions polarizing societies into categories of liberal or conservative based, for example, on political history or religious background. It also suggests relationships between attitudes, which exist regardless of culture, thus providing points for dialogue and joint research.

In promoting the further transfer of HIV prevention experience from Western to Central and Eastern European countries it is important to look for commonalities across the East/West divide, not accepting stereotypes, which lack a basis in empiricism.

CONCLUSION AND SUMMARY

Over 10 years since the fall of the Soviet Union, the question of transferring HIV prevention know-how and experience from Western to Central and Eastern European countries is multi-faceted. Monolithic ideas of East/West difference need to give way to the growing empirical evidence which not only shows a tremendous diversity but also many similarities among the 51 countries within the WHO European regions. This includes similarities between Western countries and their eastern
neighbours regarding sexual attitudes and HIV prevention needs. Western constructs such as a gay identity need to be de-emphasized, however, when it comes to promoting human rights and thus improving HIV prevention for men who have sex with men in Eastern and Central Europe. In addition, the future of a transfer of experience from West to East should be based on a systematic appraisal of what activities have been conducted to date to promote exchange between social scientists, public authorities and the non-governmental sector: which of these activities have been successful and which have not? In which countries is there still a need for transfer and what is that need? Finally, in asking the question of what should be transferred from Western Europe to other countries, both the strengths and weaknesses of the last 20 years of prevention need to be considered. In terms of Western European research the strength lies in identifying the social structural causes of HIV transmission. In terms of practice, the successes of instituting country-level structures while also working within the gay community are apparent. Short-comings are evident in terms of reaching men of lower socio-economic status, cultural minorities, and sex workers. On such questions, the expertise of Europe as a whole is needed in order to find new answers.

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