Bad Advice: How Not to Have Sex in an Epidemic

Like the paired snakes of the caduceus, pathology and homosexuality became intertwined when medicine propped up a post-Enlightenment decline in religious authority by transforming moral disapproval into diagnoses of disease. Sex between men entered public health discourse as "gay bowel syndrome," decades before methodologically sound social surveys demonstrated that heterosexual couples account for a much larger proportion of episodes of anal intercourse than male dyads.[1–3] Only a few years elapsed before a much more ominous condition came to the attention of US public health officials through the June 5, 1981, issue of the Centers for Disease Control and Prevention's weekly newsletter, *Morbidity and Mortality Weekly Report*.[4,5] Gay-related immune deficiency (GRID) immediately eclipsed gay bowel syndrome. Although acquired immune deficiency syndrome (AIDS) quickly displaced GRID with a suitably generic descriptor for an equal opportunity infection, HIV still pathologizes homosexuality while most religious denominations continue to vilify it.

DIVISIVE IS AS DIVISIVE WAS

Unlike most other communities that denied the real threat of AIDS to their future survival, newly emergent gay communities of the early 1980s addressed AIDS with such alacrity and dedication that it almost seemed as if they had presumed themselves diseased and had simply been waiting for a definitive diagnosis. Gay community mobilization to address AIDS remains an exemplar of a remarkably rapid, highly effective establishment of self-help programs by a beleaguered population that had scarcely begun to organize itself.

Yet the failures of AIDS prevention, the resurgence of indicator sexually transmitted infections (STIs) such as syphilis and rectal gonorrhea, and the appearance of unforeseen outbreaks such as recent clusters of lymphogranuloma venereum suggest that we remain as ill-equipped to control STI epidemics among stigmatized sexual minorities as we were a quarter-century ago.

More starkly now than at any time since the early months of the Reagan presidency, when AIDS emerged, fundamentalist Christian religious right (FCRR) political hegemony in the United States makes problematic any prevention efforts that mitigate the risks from forms of sexual expression proscribed by FCRR values. Other global fundamentalisms are equally malign or more so toward sexual minorities, but the United States considers itself an enlightened, secular, democratic state. With public health agencies pressured to withhold information about the proven protective benefits of condoms and deny resources to programs that address the realities of sex outside marriage among mutually monogamous male–female couples, only value-neutral biomedical strategies such as a vaccine, microbicide, or oral prophylaxis with antiretroviral drugs seem capable of being effectively deployed among sexual minorities. Even biomedical strategies may fall victim to moralistic scrutiny, a challenge that already threatens the rollout of vaccines against human papilloma virus infection.[6]

BEHAVIORAL CONFABULATION

It seems unwarranted to celebrate the effectiveness of

prevention programs for reducing risk among gay men. The incidence of HIV and other STIs began to decline dramatically among urban gay men years before the first federal funds were allocated for proactive prevention programs in 1987. Although considered a cornerstone of HIV prevention, HIV counseling and testing reduces risk neither reliably nor durably among those testing negative.[7] Only a few rigorous studies of interventions for gay men have shown effectiveness, and only for behavioral or biological surrogate markers that are not necessarily predictive of HIV incidence.[8] The most labor-intensive counseling strategy evaluated to date has demonstrated no sustained impact on rates of HIV acquisition.[9]

Even among programs considered sufficiently effective to warrant federal support, a disproportionately small number have received resources sufficient for effective translation and implementation. FCRR politicians have worked doggedly to deny resources to programs that speak in sexual terms that are meaningful and motivating to their carefully selected gay male target audiences.[10]

An unexplained trend toward riskier sex emerged, in multiple cities, between 1993 and 1995, as measured by rising rates of gonorrhea and syphilis among gay men.[11] Although highly active antiretroviral treatment (HAART) was blamed for a relapse to unsafe sex, HAART was not proven effective for HIV treatment until 1996 and not widely prescribed until 1997.[12] Nonetheless, fear that optimistic pharmaceutical advertisements misleadingly glamorized life with HIV prompted some public health officials to mount a counteradvertising campaign stressing that "AIDS is no picnic." But the campaign also reached those using HAART, who may have found in the same posters a rationale for unsupervised drug holidays. And nonadherence seems to play a far greater role in generating community-acquired antiretroviral drug resistance than does unsafe sex.[13]

An epidemic increase in crystal methamphetamine use, despite the direct threat posed by the drug, did not initiate barebacking (having sex without condoms) as a practice or promulgate "barebacker" as an identity. Even when researchers acknowledge that use of this drug may follow rather than facilitate HIV infection, they presume that drug treatment is a priority for curbing the further spread of HIV.[14] This latest drug panic offers little insight into the most alarming aspect of the current epidemic among men who have sex with men: disproportionately high HIV acquisition among young African Americans.[15]

WHEN MESSAGES MISFIRE

In the mid–1990s, the presumed risk of unprotected fellatio declined when one crossed the US border into Canada—or perhaps when one read the advice of a different local newspaper pundit. A decade later, although a comprehensive investigation demonstrated no special virulence for a "superstrain" of HIV within 5 months of its much ballyhooed announcement, allusions to the new menace continued to appear in the media.[16,17] Today, many gay men know that antiretroviral treatment adequate to contain plasma viremia is believed, on the basis of persuasive observational data, to minimize or even abrogate infectiousness. Yet health promotion counselors and antiretroviral prescription packages all warn of the potential for HIV transmission even when a person with HIV is receiving antiretroviral treatment. Apparent contradiction may undermine cautionary advice in the absence of clarifying explanations that population-based averages and individual risk calculations differ, and that specific cofactors may up-regulate HIV in genital compartments even when peripheral blood measurements remain unaffected.

The eye-catching visuals of a recent "Stop the Sores" antisyphilis campaign targeting gay men in southern California fail to include the most important ones: actual pictures of the sores. Secondary syphilis rashes barely receive a mention, although they are also infectious, are more persistent than transient primary lesions, and are readily ignored, misinterpreted, or misdiagnosed. Imprecise self-identification and referral underscores the need to facilitate periodic screening. However, screening through private physician practices and public health clinics may be unpalatable for men who have sex with men, gay-identified or not, who fear discovery or cling to denial; who feel compromised by the lack of privacy, brusqueness, or insensitivity they may encounter in these venues; or who seek to avoid prosecutorial demands that they identify sexual partners who may be nothing more to them than yesterday's screen name.

Resurgent syphilis rates not only measure increased numbers of sexual partners and declining condom use, but also may herald the waning relevance of a traditional control paradigm of case finding by self-referral, diagnosis, treatment, and contact tracing, a strategy that never anticipated normative high-turnover group sex and 24–7 solicitation of partners via the Internet. It seems well worth considering whether an effective way to augment syphilis control would be to devise and widely distribute a self-testing kit that could be administered in private, with facilitated access to treatment referrals. Would the net impact of such a kit offset the current mediocre utilization of public services that equate counseling with a stern warning about the wages of sin?

A GOOD LIFE

We can and should condemn the harmful consequences of FCRR influence, protest the inadequate development and deployment of publicly funded prevention programs, criticize self-serving confusions of cause and effect, and feel dismayed when prevention campaigns miss their mark. But the gay community has yet to do its part to promote prevention. If an effective HIV vaccine is built, will gay men come? Maybe not. Well-informed, well-served, empowered gay men have so far declined to take advantage of financially subsidized, expedited access to a hepatitis B vaccine regimen consisting of 3 nearly painless injections over 6 months.[18,19] While waiting for the wondrous nostrum that will abort or shield against HIV infection without the unpleasantness of latex or urethane barriers, the gay community cannot begin too soon to identify strategies to promote effective utilization of such biomedical methods.

Yes, it is entirely defensible to demand, for male cohabiting couples, the same economic opportunities, civil liberties, and legal privileges accorded to male–female dyads electing similar domestic arrangements. Yes, vows of mutual devotion, fidelity, respect, support, and other attributes of attachment are as plausible between individuals of the same sex as between opposite-sex pairs. But no, it does not seem sensible to expect that a cacophonous political system, numbed mindless by the strident drumbeat of FCRR moralizing, would invest in promoting safer sodomy.

Gay organizations have found it much easier to use circuit parties celebrating gay sexuality to raise funds for HIV care than to use those funds to reduce unsafe sex at circuit parties. Barebacking as a prevalent fashion, as well as a profitable commodity for the erotica and cyberdating industries, calls for what has hitherto been conspicuously lacking: effective counteradvertising that eroticizes safer gay sex.[20,21] In addition to substantial resources under autonomous community control, this would entail a sustained investment of commitment, vision, and creativity. For public health, the larger, unmet, challenge is to cultivate a shared, holistic apprehension of health among gay men and to create and support institutions that foster it.

The most profound absence is the saddest. Evicted from almost every flock, modern gay men have neither credible formulaic answers for, nor much of an incentive to keep their attention fixed on, the ultimate question: What, besides hot sex, constitutes a good life? ■

Michael Gross, PhD

About the Author

Michael Gross, a former associate editor of the Journal, is an independent consultant, Long Beach, Calif.

Requests for reprints should be sent to Michael Gross, PhD, 315 W 3rd St, #712, Long Beach, CA 90802 (e-mail: m144@earthlink.net).

This editorial was accepted February 28, 2006.

doi:10.2105/AJPH.2006.087395

Acknowledgments

Successive revisions of this editorial benefited greatly from the insightful comments, constructive suggestions, and thoughtful editorial recommendations of the *Journal*'s editor-in-chief and associate editor, 2 anonymous peer reviewers, and my wise, witty, and eloquent friend Gloria Weissman, as well as from the daily testimonials, struggles, and triumphs of other friends as they seek to make their way in the life to which it refers.

References

1. Roehr B, Gross M, Mayer M. *Creating a Research and Development Agenda for Rectal Microbicides that Protect Against HIV Infection.* New York, NY: American Foundation for AIDS Research; 2002:5–7.

2. Smith G. Heterosexual and homosexual anal intercourse: an international perspective. *Venereology.* 2001;14:28–37.

3. Brody S, Potterat J. Assessing the role of anal intercourse in the epidemiology of AIDS in Africa. *Int J STD AIDS.* 2003;14:431–436.

4. CDC. Pneumocystis pneumonia—Los Angeles. *MMWR Morb Mortal Wkly Rep.* 1981;30(21):250–252.

5. Fee E, Brown TM. Michael S. Gottlieb and the identification of AIDS. *Am J Public Health.* 2006;96:982–983.

6. MacKenzie D. Will cancer vaccine get to all women? *New Scientist.* April 16, 2005:8. Available at: http://www.newscientist.com/channel/sex/mg18624954.500. Accessed March 2, 2005.

7. Koo DJ, Begier EM, Henn MH, et al. HIV counseling and testing: less targeting, more testing. *Am J Public Health.* 2006;96:962–964.

8. Compendium of HIV prevention interventions with evidence of effectiveness, from CDC's HIV/AIDS Prevention Research Synthesis Project. November 1999 (revised August 31, 2001). Available at: http://www.cdc.gov/hiv/pubs/hivcompendium/hivcompendium.htm. Accessed April 5, 2006.

9. Koblin B, Chesney M, Coates T, EXPLORE Study Team. Effects of a behavioural intervention to reduce acquisition of HIV infection among men who have sex with men: the EXPLORE randomised controlled study. *Lancet.* 2004;364(9428):41–50.

10. Gross M. The second wave will drown us. *Am J Public Health.* 2003;93:872–881.

11. STDs among men who have sex with men. Available at: http://www.cdc.gov/std/stats01/2001PDF/SFMsm2001.pdf. Accessed April 10, 2006.

12. Palella FJ Jr, Delaney KM, Moorman AC, et al. Declining morbidity and mortality among patients with advanced human immunodeficiency virus infection. HIV Outpatient Study Investigators. *N Engl J Med.* 1998;338:853–860.

13. Blower SM, Aschenbach AN, Gershengorn HB, Kahn JO. Predicting the unpredictable: transmission of drug-resistant HIV[published correction appears in *Nat Med.* 2003;9(1):146]. *Nat Med.* 2001;7:1016–1020.

14. Beckett, M, Burnam A Collins RL, et al. Substance use and high-risk sex among people with HIV: a comparison across exposure groups. *AIDS Behav.* 2003;7:209–219.

15. Millett GA, Peterson JL, Wolitski RJ, Stall R. Greater risk for HIV infection of Black men who have sex with men: a critical literature review. *Am J Public Health.* 2006;96:1007–1019.

16. Carter M. HIV-positive men may use "POZ parties" to reduce risk of spread of HIV, but other health risks may be involved. September 30, 2005. Available at: http://www.aidsmap.com/en/news/1C5EE17F-4304-4519-85AC-A139C9E47A76.asp. Accessed April 10, 2006.

17. Poz parties create HIV superinfection. September 30, 2005. Available at: http://www.rainbownetwork.com/Health/detail.asp?iData=24343&iCat=21&iChannel=16&nChannel=Health. Accessed April 10, 2006.

18. Mackellar DA, Valleroy LA, Secura GM, et al. Two decades after vaccine license: hepatitis B immunization and infection among young men who have sex with men. *Am J Public Health.* 2001;91:965–971.

19. Yee LY, Rhodes SD. Understanding correlates of hepatitis B virus vaccination in men who have sex with men: what have we learned? *Sex Transm Dis.* 2002;78:374–377.

20. Herek GM, Gonzalez-Rivera M, Fead F, Welton D. Original research: AIDS educational videos for gay and bisexual men: a content analysis. *J Gay Lesbian Med Assoc.* 2001;5:143–153.

21. Wright K. Is fear the best way to fight AIDS? January 6, 2006. Available at: http://www.thenation.com/doc/20060123/wright. Accessed April 10, 2006.