Beyond Condoms

How to create a gay men's culture of sexual health

June 1, 1999 By Richard Elovich

A couple years ago, as the new HIV cocktails swept across the country, sex advice columnist Dan Savage published an article entitled "The AIDS Crisis Is Over." In it Savage planted a generational flag, proclaiming as safe the unprotected anal sex he was having with his partner—both are HIV negative—and confessing to a little disappointment that he might never get to be a bedpan-changing Florence Nightingale to his only friend living with AIDS, who was quite healthy. I remember talking with a group of friends in their 30s, outraged at Savage's ignorance of the horror of hospital stays, death vigils and weekly funerals. One friend with HIV said, "I'm so sorry my good health disappoints him."

Still, the Savage article—whatever its merits—signaled something important: Notions of AIDS are now more fractured than ever. Behind the half-full, half-empty debates over today's epidemic lies a generation gap. Men more than 35 years old, still living with AIDS or traumatized by surviving the plague that killed off so many of their generation, cannot comprehend the sexual playfulness of men in their 20s and early 30s, who experience AIDS very differently. "How dare they play again," they say. "That's what got us into trouble." The younger generation, bombarded with prevention messages, are AIDS aware but do not identify with the epidemic in the way that the older generation does. We might respond, "Thank God!" Instead, many writers of the older generation think the safer sex sky is falling. They shake their heads, worrying, as Michelangelo Signorile recently did in *The Advocate*, that "the fear is gone." It is painful to watch younger men distance themselves from what many of us have experienced as a holocaust. But some of the hectoring tirades sound like the intolerance of the ex-drinker toward the boisterous behavior of people who still do.

An earlier generation demanded the government get its sodomy laws out of our bedrooms; this younger generation wants the "prevention police" out. Some declare that the sex they have is their own choice, not the community's, but then blame their infection on the failure of HIV prevention. Others enjoy the sexual thrill of looking over their shoulder at an imaginary authority figure as they bend or break safe sex "rules." Many disown the notion of safer sex as an ideology imposed on them by others in response to a crisis that has passed.

Of course in urban areas, infection rates among young gay men are still 3 to 4 percent per year, projecting disturbing rates of infection by the time these men turn 30. In fact, in New York City,

young African-American and Latino gay men are not just experiencing a gay epidemic—they also see AIDS through the illness of a mother, father, brother or aunt. HIV is part of the reality they grew up in. Preliminary data from a recent study of young men in bars, clubs and public hangouts in New York indicate alarmingly higher rates of HIV infection among young African-American and Latino men than among young white men. While 4 percent of white homosexually active 15- to 22-year-olds are HIV positive, this figure is 10 percent for young homosexually active Latino men and 22 percent for similar African-American men. With nearly one in five infected by age 22, some gay men are clearly getting no respite from the epidemic.

The truth is, the "gay experience" has always been incredibly fragmented. A large number of young gay and bisexual men live with their families, unconnected to a gay world except when they are having sex. Many others, though they live on their own, are more attached to a loose network of friends or bar buddies than to a structured gay community. Global conceptions of gay life and AIDS no longer reflect the realities most men are living. This remains one of the biggest challenges for HIV prevention.

Another is the relative success of protease therapies. While these drugs were an amazing development for men who are infected, they did not change anything for HIV negative men. The drugs do not allow gay men to throw away their condoms and celebrate. This change-without-a-change for negative men has created frustrations that most prevention efforts have yet to acknowledge or address.

The discourse of HIV prevention has always been a clash of ideas, information, representations and, of course, personalities. In the early '80s, as the shadow of the epidemic was falling over gay communities across the country, people scrambled to make sense of what was happening, share information and protect themselves and others. No one knew for sure that condoms would save lives. The HIV antibody test wasn't there to tell us who was positive. As gay men became ill and died and as public representations of AIDS as a "gay disease" seemed to confirm that sex between men might be unnatural and fatal, a grass-roots safer sex movement formed.

It was historic. Some experts called it the most rapid and profound community response to a health threat ever documented. Many men made fundamental changes in their sex practices, from scared-sexless abstinence to using condoms, not swallowing cum or giving up fucking. Before the advent of the HIV antibody test in 1985, the instructions to "use a condom every time" and to "cum on me not in me" comprised a simple, trustworthy solution. During what seemed to be a short-term health emergency, men seized on it as an absolute talisman. Practicing safer sex saved tens of thousands of gay men's lives—and perhaps gay pride as well. In a climate of fear and confusion, it promised that sex between men could continue.

As homophobic legislation prevented public funding of HIV prevention, and government indifference reinforced its political nature, safer sex emerged as a resistance movement. Early prevention programs made clear that there could be no real education about safer sex without an assertive rebuttal of homophobia. As it has developed, HIV prevention became, among other things, a series of places and programs where gay men can be visible and can value one another.

As director of prevention at Gay Men's Health Crisis in New York City, I have watched those principles reemerge in the last two or three years, part of a movement to transform HIV prevention across the country, from Milwaukee to Boston, Philadelphia to Seattle, Atlanta to Albuquerque. Two years ago, prevention workers at GMHC developed Beyond 2000, or b.2K, to get 2,000 gay and bi men, regardless of their HIV status, involved in helping uninfected men stay that way beyond the year 2000. In a city as diverse as New York, b.2K has come to mean different things in different communities: African-American men organized Soul Food, brothers healing brothers; younger men involved in the club scene organized Peer 2000, which includes both the legendary voguing House of Latex and outreach at the Christopher Street piers; Latino volunteers organized Proyecto PAPI with the goal of *creando espacios*—creating spaces to talk about both sex and their families and communities. Across the continent, Gay City in Seattle promotes a similar idea: that prevention has to be more than an AIDS lecture—it has to build community. If these programs with broader cultural agendas don't sound like the HIV prevention you're used to, that's because, even as the decade ends, these approaches are not the norm.

As with so many successes, safer sex programs of the '80s eventually became stuck in their formulas. Institutionalized by infusions of government funding, most prevention even now focuses exclusively on behavior change and "relapse" prevention; information and condoms. This prevention model was based on traditional "health belief" theory, that if we have the information about risk smack in our face and access to an alternative, reasonable people will choose the alternative. This safer sex message did get transmitted, becoming, in Australian social scientist Gary Dowsett's apt image, a fog pumped out for the last 15 years: It's in the air, we can see it all around us, everywhere we congregate.

Safer sex rules, however, have never predicted what gay men do. Long before we knew the risk of oral sex was statistically insignificant, the majority of men were not using condoms with oral sex. Research has also been telling us for a while now that many men fuck without a condom—if only once a year. As early as 1988, studies were showing that number at 30 to 40 percent, a figure that is now climbing.

But it is not enough to simply say that men who have unprotected anal sex have "slipped" or "relapsed." Relapse rhetoric assumes that if, after getting the message, men don't use condoms, *they* must be the problem: Either they don't understand the information or they must be drug-impaired or self-destructive. Relapse rhetoric ignores the fact that sex is not just behavior, it's about desire, relationships and our sense of self. If a man wants to have sex without a barrier to be more intimate with his partner, this cannot be dismissed as "irrational." Confronted with such dismissals, men turn off to prevention.

Ultimately, the rhetoric of relapse relies on shame, on the feeling that gay men's sexual desire is out of control and pathological. This sense of shame is palpable in accounts that describe how we had a big "problem"—gay men were promiscuous, fucking each other silly, and, by the way, they partied too much—and how safer sex measures "fixed" it in the '80s. From this perspective, unprotected anal sex came back because gay men are reckless and foolish.

Is the condom-every-time standard we created in an emergency really sustainable over a lifetime? When the shelling first started in places like Beirut and Sarajevo, residents never left their houses. But as the fighting dragged on and on, people started venturing out again, to run errands or visit friends. This was not described as “irrational” or “relapse” behavior. Rather, it was recognized as reasonable.

So the next time you read headlines proclaiming increased rates of gay men having unprotected anal sex, ask how many of them are doing it with people of the same HIV status—and how many with people whose status they don’t know. That most basic distinction—between *unprotected* anal intercourse (without condoms) and *unsafe* anal intercourse (different serostatus)—is glossed over by media hostile to the idea that any unprotected anal sex might be acceptable.

The risk-elimination paradigm is silent on a number of issues critical to HIV prevention: (1) What moves some gay men to pursue unprotected fucking with partners whose serostatus they don’t know? (2) What help do gay men need thinking through risk’s gray areas, such as oral sex or topping in anal sex? (3) What is the connection between sex and drugs for gay men? While substance abuse among some gay men is a real issue, for far greater numbers, there is a continuum of risk associated with drug use from minimal to extreme. (4) What are the differences between positive and negative men’s relations to the moment of HIV disclosure and to transmission? (5) What are the pitfalls men encounter in “negotiating safety”—in deciding not to use condoms with someone of the same HIV status? (6) How do young people relate to risk differently? All of these are crucial to the future of HIV prevention. None of them are addressed adequately by a condom-and-slogan model of HIV prevention.

Finding our way back to HIV prevention that encourages men to grapple with these kind of issues means acknowledging within ourselves those contradictions that the risk-elimination model tries to mandate out of existence. In GMHC trainings for b.2K volunteers, participants usually discover that a split exists between what they believe safer sex is and what they actually did last Saturday night. A 22-year-old who tested negative for HIV on his last test once came to GMHC. Living outside his home after he came out to his parents, he’d been having sex with different partners almost every day. “Will you go down on a guy?” I asked. “If he’s good looking,” he said. “But I won’t let him come in my mouth.” “What if you knew he were HIV positive?” “I wouldn’t go down on him or let him fuck me, even with a condom. That sounds bad, but I’m just being honest,” he said. “So you let guys you don’t know fuck you with a condom and you suck them off, but you won’t do it if you know they are infected?” I asked. At this point he stopped. “Talking about this really freaks me out. I don’t even want to think about it.”

This inconsistent thinking is not confined to HIV negative men. Some positive men describe their decision not to disclose their status in casual sex as a response to the feeling that they are shouldering the entire prevention burden. As one b.2K participant said, HIV negative men are “walking around in la-la land,” refusing to bring up or even think about safer sex or AIDS. Other positive men identified their problem with disclosure as stemming from the all too common experience of being “dropped like a hot potato” once they disclosed to a man who moments before was “all over” them. Wanting not to ruin the mood, positive men may wishfully assume

their partner is positive, releasing themselves from responsibility.

We tend to label this kind of flawed thinking as sexually "impulsive," but even in nonsexual contexts, knowledge of risk doesn't ensure that anyone will take appropriate steps—from getting a mammogram to avoiding fatty foods. Still, this split in consciousness is complicated by sex, especially when flirting with risk becomes part of the erotic charge. For some men, this far into the condom era, it's not safer sex that's hot, it's sex that breaks safer sex rules. "Part of the pleasure of seeking out sex and danger is the *return* from the edge," a friend says. "Will I have enough potion to get back home safely—without a germ or addiction?"

Absent from both alarmist discussion of risky behavior and knee-jerk defenses of sexual freedom is a recognition of the ways desire, pleasure and ambivalence about whether we are really entitled to "get home safely" are all woven together. Plenty of us have a love-hate relationship with our desire. This thing that has brought us moments of intense pleasure, authenticity and connection to other men may also preclude us from being able to bring our relationships home to a welcoming family or becoming parents or feeling that our relationships are "normal" or valuable. Some men are proud to be gay but remain distrustful of their sexual selves. Others have worked this ambivalence into their sexual practices, splitting their sex lives off from their "real" lives, setting up a divide between who we desire and who is "good" for us.

And all of that exists within a single person. What most complicates prevention of sexual transmission of HIV is that it's not just *your* mind that's involved. Any sex involving risk happens with someone else—whether that relationship lasts 10 minutes, two years or a lifetime. And while some of us may identify with a particular sex practice, the reality is that sex is relational, and most of us change what we do depending on whom we're with. It is not enough to say "I'm a top," or "I don't let anyone come in my mouth," because in certain circumstances or with certain people, maybe you'll change your mind. To admit that sex is relational means admitting that you don't have full power. And that's difficult for men.

How then do we acknowledge the power and complexity of sexual relations and still reduce risk? Researchers in Australia use the term *negotiated safety* to describe how HIV negative gay men in both long-term and casual relationships are determining for themselves the boundaries of safer sex practices. Programs like GMHC's borrowed the related idea of "harm reduction"—initially identified with syringe exchange programs seeking to prevent HIV infection among injection drug users uninterested in abstinence—and applied it to decision-making around sex. We moved beyond the "one-size-fits-all" model to help men of both serostatuses think through the values they attach to their specific sexual practices and relationships, as well as the attendant risks, and to support them in forming realistic and individualized risk-reduction strategies. In practice, this means helping individuals to think through specific encounters and to describe in vivid detail both the pleasure and the risks of unprotected anal sex, in terms of who their partner is, what kind of interaction happens (verbal and nonverbal), what kind of scenario unfolds and where (since the environment often shapes the choreography).

The key to this strategy is accepting that every act of unprotected anal intercourse involves risk.

In some cases, the risk is so small that most would agree it can be discounted, as with a couple that has been monogamous since their last HIV negative tests, or a couple in which neither partner has ever had penetrative sex. In other cases, where partners are of unknown or different status, the same encounter can be extremely risky. Between these extremes, however, are a range of situations where the state of affairs is less clear-cut and where most men make most of their decisions most of the time.

Negotiated safety has generated some controversy in the United States, where prevention researchers and journalists alike say that allowing people to talk about their own risky behaviors condones rather than corrects them. But adults learn when they can reflect on their experiences—not when certain acts of sex are forced "back in the closet." Most change theory demonstrates that adults alter what they do by (1) being able to talk about what they are doing without being judged, (2) being in a learning relationship with a coach or peers in which they don't have to defend themselves and (3) discovering for themselves an inconsistency between their thinking and behavior. In the case of sexual practices, it may also mean grappling with some feelings of shame.

Clinical psychologist and HIV prevention pioneer Walt Odets has written that many of us carry into adulthood some of our early shame about the kind of sex we desire. The epidemic has complicated these feelings, so that more than one of us now harbors some confusion about homosexual acts being "bad" because they are homosexual and their being "bad" because they transmit HIV. When someone tells us that he's glad for safer sex because "I never liked getting fucked anyway," it's easy to slide from thinking this man's proclivities were "good" because they may have prevented his getting HIV to thinking they were "good" in some moral sense. This is a destructive confusion.

Says Philip Spivey, an African-American psychologist who helped lay the foundations for GMHC's Soul Food, "For too many black men, it is fundamentally unacceptable in our families, in our communities, to experience our sexuality and desire as anything but 'the problem.' So you have sensitive, intelligent men leaving whole areas of themselves unexplored."

One man interviewed by a Soul Food oral historian described *pain* as the predominant experience he has in relationships with other men. Soul Food tries to create an atmosphere where men can experience themselves unmasked in the presence of other African-American gay men who affirm them—rather than being competitive, hurtful or shut down. "If you can experience that as real, hold on to that, then maybe you don't have to do crazy or impulsive things when you are with gay men," Spivey says. "Instead of 'It just happened,' you can look at yourself long enough to ask, 'What happened?'"

Talking about our sexual experiences helps us to become conscious of them, as unerotic as that may be. Stories in the media about *barebacking* and *bug-chasing* sensationalize our sex while most of us still can't talk honestly about why getting fucked is such a powerful experience that we might want to do it without a condom. Some of us do it and are anxious about it; others of us deny ourselves the pleasure because of our anxiety about HIV; others make decisions about risk for other people. Let's talk about *that*. About how each of us looks and feels as a man getting fucked,

about how a relationship changes when we get fucked or about how we might want to give somebody our asses but not our lives.

Crucial to realistic safer sex strategies is understanding the value of whatever sex is most transformative for us, including anal sex. In the late filmmaker Marlon Riggs' *Affirmations*, a young African-American man describes the voyage that took him from his first experience of getting fucked to, hours later, sharing his exhilaration with a fellow choir member: "We sang praises to the Lord in church that day." None of us will succeed at HIV prevention if we won't embrace and validate that joy.

At a harm reduction training in Milwaukee a few years ago, I asked people in the room to think about an activity in their lives that was very pleasurable or important to them, but that also carried some risk. A woman's hand shot up. "Riding a Harley," she said. I asked her to walk me through what was pleasurable about the experience. And she listed for me: "I feel like I'm racing along and there is nothing between me and the road, no walls, nothing around me. I like the wind blowing on my face. I like the speed. I like the power. I like the humming between my legs." Then I asked her, "Can you describe the risk?" Again, she listed for me: "Skidding, getting hit by a car, going off the road in bad weather." I could see some of the men shaking their heads. "How do you reduce these risks, but hold on to what's valuable to you?" She listed: "Wearing a helmet, taking a low road out of town, and watching the weather." Again men shook their heads. All they heard was the risk. They didn't share her pleasure in riding a Harley. So for them, it was easy to suggest that she eliminate the risk altogether by not getting on a motorcycle in the first place.

How easy it is to dismiss other people's pleasure! If the majority don't like motorcycles, they can easily conclude that everyone should give up such a risky activity. How often have we heard this about anal sex? Odets has written that the assumption that we should take no risk *whatsoever* would only be reasonable if the sex we have were of no value whatsoever. But we take some risk for the things that are important in our lives.

To engage in the balancing act between pleasure and risk, we have to acknowledge two things: There is *pleasure* that we care about, and there is a *harm* that we want to avoid. Whatever progress we've made in HIV treatment and the rights of people with AIDS, if we take HIV prevention seriously, the bottom line is a painful one: HIV is undesirable…in *all* our lives. That's difficult to say, since guys living with the virus struggle to keep a tenuoushold on feeling OK about being infected.

Because there's something hurtful about the division between HIV negative and HIV positive people, we in the gay community feel conflicted about HIV prevention. If I as an HIV negative man draw the distinction, I know that someone who's HIV positive is going to feel that I'm saying there's something wrong with him. The reality is there is something wrong: He has to live a different life because he has a potentially fatal virus. Being conscious of the harm of HIV has to be a part of harm reduction. We have to be able to say that people with HIV aren't undesirable but the virus *is*.

One question echoing throughout this discussion is: How do you put harm reduction into practice? You can count condoms. You can track how many men use them. But asking people to tell you how they think and helping them to expand how they think can seem like a tree trunk you can't quite wrap your arms around. Or it can seem too small, like something you can only do in individual or small group counseling—and how many people can you reach with that?

To do harm reduction, we have to go to where gay men are, not wait for them to come into an AIDS agency or community center. We have to find excuses to talk with many people, by any means: in groups or one on one; planned or spontaneously. B.2K's Soul Food creates conversations at "house calls," apartment-based sex talks modeled on Tupperware parties. San Francisco's Stop AIDS volunteers use a "question of the month" to approach men in spaces where they come to meet one another, reaching up to 400 a month. Other b.2K volunteers criss-crossed the precincts of New York City, managing to get 7,500 gay and bi men to engage in conversation and fill in a short questionnaire about their sex practices, testing patterns, STDs, substance use and contact with HIV prevention. What has been demonstrated around the country is that men do want to talk about how they have sex.

Our experience with b.2K outreach is that for some men, living part-time gay lives, the bathhouse is their only gay experience. If they are standing around in a video room, and a volunteer gets an interesting conversation started that feels alive and relevant and isn't preachy, we find that they are open to talking with other gay men. This intervention adds something rather than taking something away, like the doors off the stalls. The men sometimes approach the conversation tentatively, but they are interested in talking about what they are doing, asking questions and hearing other men's experiences. That sounds just like a workshop, and it is—except we took it out of the office and the group formed spontaneously. And the men often walk away with an experience of themselves that they hadn't had before.

These conversations are also powerful experiences for the volunteers, and when they sit together on the subway afterward to "debrief," sharing experiences of the night, identifying questions that came up, they affirm the value of what they have done and get to talk about themselves, too. The combination of life-changing impact, experiential learning and reflection keeps our outreach volunteers coming back.

As gay men, many of us grew up without a true peer group, without a friend in the same position with whom we could share feelings about our first gay crush or first sexual experience. We certainly did not see our own struggles reflected on television or in the culture at large. When you are planning a move, or deciding whether to change jobs or go back to school, you don't do it without speaking with someone whose ear you value. But with sex, about which we now have to make life-and-death decisions, we are faced with a societal taboo. We now have to break this taboo and create these conversations.

The conversations shouldn't be limited to the familiar forms of counseling or group therapy, either. For example, b.2K's Oral History project is an ever-growing, living archive of how gay men are leading their lives and practicing desire in late 20th century New York City amid a vast epidemic.

One volunteer describes his experience of conducting an interview for the project: “Within a few minutes of listening to my guy, my back straightened up. I thought, ‘OK, this is real, something’s happening here.’” This kind of expansive approach to HIV prevention doesn’t just enforce guidelines; it creates culture.

If prevention is going to be relevant in our lives, it has to be broader than HIV, helping us claim all the erogenous zones of our bodies. When men discover that their asshole is a site of pleasure, they need to be empowered to care about it, talk about it, examine it. I may give my ass up for desire, but it’s still my ass—not my doctor’s and not my sex partners’. Something bad doesn’t have to happen to me because I give my ass up.

For many of us, it’s easier to imagine the new prevention technologies now under development—a handful of pills for post-exposure prophylaxis, microbicide gels or a vaccine. But HIV prevention that truly works will have to recognize that any technology, even a condom, is useless without a corresponding development of consciousness.

Building a culture of sexual health means leaving behind the notion that any part of the gay community is too “hard to reach.” Prevention worker Larry Abrams, speaking of young gay African-American men, speaks for many who feel their lives are left out of accounts of “the community” when he says, “We are not living in the margins, we are actively creating new centers.”

Gay culture has survived bigotry, criminalization and the scourge of AIDS. Now it’s time for it to thrive. The thousands of men across the country getting involved in a new wave of HIV prevention refuse to experience themselves as “marginal” or as “problems.” In helping other men prevent HIV, they get to help themselves, connect with one another, make being gay OK on their own terms. They are inventing and reinventing gay culture everywhere they go. And that’s where prevention has to live—everywhere we are.

TRY THIS AT HOME

Gay men talk plenty about sex, but there’s a lot we never tell each other. New HIV prevention is about breaking these silences. But it takes practice to learn how to talk about desire, danger and shame. Start out slow by focusing on pleasure. First, make a deal with a friend to get together and share your stories in confidence, to let only each other into this very personal space. Talk without censoring yourself, listen without judging him. It’s like spotting a buddy at the gym—he does the pumping, but you help by supporting him through the exercise, lending a hand when he’s uncertain.

1. Close your eyes. Now describe the last guy you fantasized about while jerking off. He may be an image from a magazine, a video, a guy on the street. Let the words flow—don’t be afraid to sound pornographic. What does he look like? What is it about him that turns you on? What’s going on in the sex? What makes you cum? Snap a picture and save it for Step 5.

2. Describe the last guy you had sex with. Maybe you met him on the phone or at a bar, maybe he’s a fuck buddy. What does he look like? What was sexy about him? Who was doing what during the sex? What did you talk about? Try to remember how the sex felt. Snap another picture.

3. Describe the guy you were last in a relationship with. It may have lasted five weeks or five years. Take a picture of a moment when the two of you were having sex. Answer the same questions.

4. Describe your best friend or the person you talk about relationships with. This may be the guy you’re talking to. (Or he may be a she.) What does the person look like? Did you ever have sex? Do you talk about sex? Focus on an image of you and him together. Snap a picture of how it feels.

5. Imagine all four snapshots hanging in your dark room. Which guy was easiest and which hardest to describe? What was it like to tell and hear about which kind of guy each of you is into? How did it feel to use words to describe images of sex? Was it hot? Fun? Frightening? Over time, the two of you will create a language to use to reduce your risk. Spend extra time on the moments that make you uncomfortable. Help each other examine what that’s all about. Remember, these are only words—you control them.

Next week’s exercise: Describe a time you used a condom while having sex and a time you did not. What did your thinking look like each time?

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