’Prevention for Positives’

The CDC takes a radical right turn toward mandatory testing-and shaming gay men with HIV

January 1, 2004 By Walt Odets

As a clinical psychologist, I have long helped critique and develop HIV prevention by and for gay men. I have seen the realized utility— as well as the unrealized potential—of this often psychologically insightful, culturally sensitive work. Judging the results of this work inadequate, however, the Centers for Disease Control and Prevention (CDC) has announced an initiative that essentially eliminates the kind of prevention gay men have conducted over these past two decades.

Released last year, “Advancing HIV Prevention: New Strategies for a Changing Epidemic—United States, 2003” actually offers little that is new. Instead, it invokes the “enforcement” model that spawned the discipline of public health in the TB epidemic of early 20th-century America. This retreat to what the CDC labels “proven public health approaches” is a normalization of the epidemic that some policymakers (few of them gay) have argued for almost since the discovery of HIV. I believe that these approaches are completely unproven in this historically unique epidemic—and that, as an expression of the right-wing forces that now control CDC funding, the initiative is an attempt to institute massive only-semi-voluntary HIV testing that has little to do with prevention. The proposal, if implemented, threatens serious harm to the emotional and physical well-being of gay men in the U.S.

In the initiative, the CDC mandates HIV testing as a “part of routine medical care,” even though many “ordinary” medical settings—a physician’s office or a clinic—cannot provide counseling for those contemplating the difficult issues of HIV testing. Contending that such requirements “should not be a barrier to testing,” the CDC proposes “simplified procedures” that dispense with counseling. For those testing positive, the CDC requires involuntary sexual-partner notification and “prevention and care.” But the CDC provides no description of what “prevention for positives” might be. And HIV negative gay men, who are presumably the ultimate beneficiaries of prevention, are nowhere mentioned.

The single element of the proposal that is new is also one of its most disturbing. This is the apparently central role for HIV positive men in preventing new infections. The enforcement model has long posited the idea that identification and behavioral control of the “disease carrier” is the key to protecting the “public at large.” Large-scale testing is the key to identifying the disease carrier.

The promotion of massive routine testing as prevention—meaning the primary prevention of new infections—is simplistic and troubling. Testing, per se, is not prevention, just as the collection of automobile accident data is not driver education. We do not prevent new infections by simply finding out who is already infected. The CDC presents the initiative as a prevention plan by claiming that only those who know they are positive can decide not to transmit HIV. By its own statement, however, three-quarters of HIV positive people in the U.S. do know they have HIV. Yet there is no evidence that HIV is disproportionately transmitted by those who don't know. The CDC asserts that those who are newly diagnosed reduce behaviors that expose others. However, both the data and my own observations as a psychotherapist suggest that knowing one's status changes behavior with steady partners much more than with "anonymous" partners. While the CDC cites the efficacy of "proven public health approaches" in managing other STDs—a question in itself—the incentives to test and notify partners are very different with HIV than with more benign, more easily treated STDs like gonorrhea or syphilis. Finally, in support of its plan, the CDC notes that during 2000, fully 31 percent of those who tested positive for HIV did not return to learn their test results. For many important reasons, people are ambivalent about testing and knowing their result. Involuntary partner notification will enhance neither the incentives to test nor the desire to return for results.

The CDC's arguments would seem more intelligible were its proposal based on a requirement for *in*voluntary—mandatory—testing. Perhaps the CDC is counting on only a small minority questioning the components of *routine* medical care, resulting in the "semi-voluntary" testing of many who would otherwise not willingly be tested. This idea is troubling and the trouble is compounded by the proposal's failure to require that the patient give explicit consent for the test or be informed of the consequences of a positive test.

While the CDC now seeks to normalize handling of the epidemic, there have always been, and still are, many good reasons for innovative approaches to HIV prevention for gay men. Among these are the unusual medical course of HIV infection; the concentration of infection in communities defined by sexual orientation; the very high levels of infection in these communities; the special political, social and psychological issues of these communities; and the well-founded fear of social and economic discrimination. In 2004 these issues have not changed. What has changed, in addition to the American political climate, is the relatively new acknowledgment from gay men that we do continue to infect each other. That acknowledgement is crucial to improving our prevention, but it has also made us vulnerable to society's impatience—and to imposed, simplistic solutions like those from the CDC.

That gay men continue to infect each other should be no surprise to anyone concerned with human life. Our emotional lives—not least in sexual matters—are complex, often befuddling. Our prevention results, however, can be improved by understanding how and why our work has fallen short of its potential. The numbers of infected men, and the ease with which our feelings about HIV became entangled in our feelings about being gay, generated a central paradox for prevention efforts that we have never been able to confront, let alone resolve: *How do we authentically support the lives of infected men while telling uninfected men that it is important to remain uninfected?* In the face of that paradox—and in fear of scapegoating positive men for transmitting

HIV—much of our prevention work has retreated into a peculiar, confusing equivocation that focuses on universally prescribed behaviors but leaves our *purpose* unmentioned. We have spoken about using condoms and, positive or negative, having "safe sex." But since the debut of the HIV test in 1986—and the discovery that fully *half* of us were infected—we have rarely dared speak explicitly about the sole purpose of primary prevention, which is keeping HIV negative men uninfected.

What is an appropriate role for positive men in prevention, a role that the CDC would now make central? In principle, most of us would agree that positive men have *some* role in minimizing new infections. But as gay men and gay men with HIV—highly sensitive to the potential for stigmatization on both fronts—we have maintained a public silence about this issue. When HIV is transmitted, a positive person is always involved—and it is certain that the transmission is not always accidental or unknowing. A recent issue of *AIDS Education and Prevention* reports a study of 367 HIV positive New York and San Francisco gay men in which 23 percent acknowledged having, in the previous three months, unprotected insertive (top) anal sex with an HIV negative or unknown-status partner. These men, the authors wrote, "perceived less responsibility to protect their partners from HIV" than other men in the study. This is a disturbing but credible finding. And it is one that we—not the CDC or its right-wing funders—must address. We have spent the entire epidemic trying to demonstrate that we are "good boys." It is time to acknowledge that, being human, we are neither perfect nor perfectly clear about our problems and their solutions. The purpose of such an acknowledgment is not to vilify positive men, 59 percent of whom, according to the study, have *no* unprotected anal sex.

Positive men must neither be assigned the entire task of prevention nor become the object of society's frustrations and pain with the epidemic. The scapegoating of positive men by gay communities—or their criminalization by society—would accomplish nothing for prevention and do irreparable harm.

Over the last 20 years, the prevention work by and for gay men has accomplished something new and important in the world of public health: an authentic, insightful look at human feelings and sexuality. It is this, above all, that the repressive political forces now speaking through the CDC would crush. In place of insight, they would have us retreat into shame about being gay, about having HIV and about imperfect results from a sustained effort that has been fundamentally decent, sound and right. If not merely good-looking statistics but the real quality of human life is our concern, simplistic approaches to prevention in sexual matters—those of the CDC or those of our own, sometimes confused, community efforts—will achieve little. The current unhappy condition of American consciousness must not bully us into confusion, shame or apology. We must insist on a renewed effort to address the important issues for gay lives in the epidemic: how to live as honestly, as self-acceptingly and as happily as possible. All else being equal, that pursuit must include the minimization of new HIV infections by means respectful to all gay men. We can do this, and we should.

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