THRIVING

Gay Men's Health in the 21st Century

ERIC ROFES

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INTRODUCTION BY
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Preface

In an interview with the French HIV-prevention activist Olivier Jablonski in November 2004 (see chapter 6), Eric Rofes envisioned the book you will now be reading:

> I have always intended to write the third book in the trilogy that began with Reviving the *Tribe and Dry Bones Breathe,* and have been keeping notes and files, but I won't have time to work on that project for another year or two. That book will focus on the nascent gay men's health movement in the U. S. and tackle some of the contemporary debates about barebacking, crystal usage, gay skinhead culture, and Internet sex.

Pretty much on target Eric began to compile that collection of essays and transcribed speeches. His editor at that time Sara Miles smoothed the rough passages and kept Eric alert to consistency. After Eric died on June 26, 2006, Sara asked me to continue that pleasurable task. The book before you is not complete; Eric had much more to say on what I've always considered—and I think he'd agree—his most passionate and committed cause: a more holistic approach to gay men's health.

On the advice of one of Eric's coworkers in the gay men's health movement, I've placed "Desires as Defiance" first in this collection. It represents Eric's latest, as of his death, thinking on gay men's health and the obstacles erected by what he never stopped calling the well-meaning public health establishment and its gay allies in the HIV/AIDS-prevention oligarchy.

The chapters following the first are arranged in order of when they were first written or delivered at a conference or speaking engagement. All were reviewed, revised to varying degrees, and some updated, so don't be disconcerted if you come across a reference in context that doesn't jibe with the chronological scheme of chapters 2-9.

Only the first essay is followed by a list of references. Keeping in mind that this is an incomplete manuscript, I don't know whether Eric had intended to provide such for the other essays. As a serious academic he certainly realized its importance. But perhaps the activist writer may not have wanted to interrupt these powerful calls-to-action with academic references of little interest to the average gay guy he always kept in mind as a reader. I don't think it's hyperbole to claim that Eric always wrote for communities of practice.

Those of us who greatly admired Eric's courage in putting himself out there and his tenacity in not being worn down by considerable resistance had hoped that the publisher of the first two volumes in his projected trilogy would oversee this collection. Sadly, they declined that honor. Chris Bartlett and Tony Valenzuela, two of Eric's closest co-activists in the gay men's health movement (see their Introduction to this book), as well as Eric's husband and executor Crispin Hollings and I, felt strongly that Eric's thinking on an issue as crucial as keeping gay men healthy should be disseminated as quickly and widely as possible. Putting it on his website, his enduring cyber-home, is firmly within the democratic tradition of equal access Eric endorsed in all his work.

As you will discover if you're new to Eric's writing on the health and welfare of gay men over the past thirty-some years, much of the thinking—and at times agonizing—contained in these chapters is far in advance of what is now, finally and at a painfully slow pace, starting to bear fruit in the AIDS/HIV-prevention establishment. I doubt that Eric will get any thank-you's for putting his strident voice out there beyond the safe comfort zone where many activists work and live.

While I can claim credit for the final editing of Eric's manuscript—and responsibility for any remaining errors—its stunning design and the scrupulous care in preparing the manuscript for Eric's website are the work of Dan Derdula and Jeff Brandenburg.

—Will Seng
November 4, 2007

Introduction

As activists in the gay men's health movement, we both worked with Eric Rofes as fellow trainers, organizers, conspirators, rabble-rousers and friends. Despite our deep sadness at having lost him in June of 2006, we introduce this volume of his mostly unpublished work on gay men's health from a place of hope and excitement to inspire activists and admirers of Eric's work to continue on with his ideas. In the area of gay men's health, he helped to crystallize a vision that was at one time completely invisible: a vision of gay men's health broader than HIV and AIDS alone. Only ten years ago, the paradigm for thinking of gay men's health was largely one of HIV prevention and care. The AIDS crisis had understandably become the lens through which we thought about community health. But Eric, with a cadre of activists from around the world, saw that this limited focus needed to be expanded in order to strategize for the overall health of gay men.

Eric was well known as a vocal and astute cultural critic. His powerful analysis articulated in his two most important books, *Reviving the Tribe: Regenerating Gay Men's Sexuality and Culture in the Ongoing Epidemic* and *Dry Bones Breathe: Gay Men Creating Post-AIDS Identities and Cultures*, arguably the most influential texts on gay men and AIDS of the 1990's, were in many respects theoretical foundations for the American gay men's health movement. In these books he tackled with searing insight the complex and varied meanings gay men derived from the AIDS epidemic. Deeply influenced by early feminist work on women's health and by contemporary researchers from Australia, the UK and Europe, Eric detailed how "post-AIDS" and the "Protease-Moment" had fundamentally changed gay life.

Eric was deeply compassionate and believed that gay communities were fundamentally smart, savvy and scrappy. He was resistant in principle to any theory that dared to treat gay men as children, diseases, or demons. He had lived through the early years of gay liberation, through the darkest years of the AIDS epidemic, and into the more hopeful post-protease years. He traveled around the world to share ideas and to listen to the experiences of the global gay community, spending time organizing in Berlin, London, Sydney, Paris—not to mention the hundreds of locales he visited in the United States, from small rural towns to our gay metropolises.

Eric organized huge national summits and participated in small local think-tanks and forums. He insisted that gay leadership depended as much upon relationships and shared community as it did upon ideas and action. He learned many of these ideas of leadership from the women's health movement, which he frequently referenced and acknowledged. In his gay men's health work, he was a thoughtful feminist who, while staking out the need for a gay-male focused health movement, also invested time in broader LGBTI health concerns. As a self-proclaimed sissy, he understood how oppression of women was directly related to his own oppression and that of other gay men. He was one of those rare gay men who had decades-long friendships with women and borrowed their ideas (from Suzanne Pharr to Jewelle Gomez) in constructing our gay men's health movement.

Eric was famously a proud member and stalwart defender of the sex and party cultures of gay men as vital sites of engagement and critical thought. He was a non-monogamous, kinky leather bear *and* community organizer *and* scholar and writer, and he accomplished this without breaking himself apart so that, through him, research was sexy and pleasure had gravitas. He insisted that most gay men in their erotic adventures are not sick, immature or vestiges of a bygone era rebuked by AIDS, but are instead brave innovators ever-expanding the possibilities of intimacy and play even and especially in the context of risk.

Sometimes Eric's honesty about his personal sex life made people feel uncomfortable—as if somehow the seriousness of his work were diminished by his personal stories. But this discomfort was a gift of Eric's: he helped his readers, fellow organizers and community members to see those hidden niches where shame and fear bind us. One of his strategies as an organizer was to say the

things that others were afraid to say, regardless of how it made others feel about him. He understood the work of shifting paradigms requires confrontation, discussion of change, and jolting people out of their accustomed ways of operating.

In the following pages we share his words and thinking, both of which reveal this bold visionary and lusty gay man who told us difficult things, who organized dinners to dish the dirt, who annoyed us with his persistent demands of high standards and accountability, who listened intently to our deepest shame, who wrote the sorts of things that made your skin tingle, who flirted with men at the barricades, who allied himself with those who most needed allies, who bore countless pains and countless joys. We encourage you, as Eric would, to read, to write, to organize, to say those difficult things, to love passionately and broadly, to insist upon the compassion and commitment for ourselves and each other that he consistently showed for us.

— Chris Bartlett
Tony Valenzuela

CHAPTER 1

DESIRES AS DEFIANCE:

GAY MALE SEXUAL SUBJECTIVITIES AND RESISTANCE TO SEXUAL HEALTH PROMOTION

My sexual desires are usually linked to transgression. While some people organize their erotic impulses around a safe and cozy domesticity, I move towards what's forbidden and dangerous. I am drawn to not what's clean and tidy, but instead, to what's dirty and messy. I'm enticed by what's risky, vanished, or exiled, not by what's safe and socially celebrated. For me, sexual fantasy and activity are closely linked to the taboo, as if my carnal yearnings are linked to flouting conventions, challenging social expectations, and defying cultural norms.

I don't think I'm unusual. When I look at cultural products marketed to stimulate desire—items ranging from romance novels and daytime soap operas to magazines such as *Playboy* or *Hustler*—I notice the focus on transgressing boundaries and resisting social norms. Whether it's the soap operas featuring married men engaging in secret affairs with their secretaries or the pin-up girl wearing spiked heels and holding a whip, these texts suggest that simple domesticity and narrow cultural conformity don't carry a huge erotic charge. What's sexy doesn't seem to be purity, but the desecration of purity. Unless boundaries get violated—unless we move from the mainstream to the margin or over the edge—our culture can't get off.

At the same time, I do not believe everyone organizes his or her sex in this way. While I might seek out partners from populations who violate the social expectations placed upon people of my social stratum (I seek men, rather than women; I seek working-class men rather than middle-class men), or engage in sexual activities considered taboo (promiscuity or sadomasochism, for example), many people clearly find pleasure and sexual fulfillment with partners and activities that do not transgress status quo social expectations. When I recently heard a colleague suggest that long-term married couples that enjoy a lively sex life actually do so only by fantasizing about other partners during intercourse or finding another way to bring the taboo into their erotic activities, I disagreed. Extrapolating from our own organization of desire to the entire population seems both arrogant and without evidence.

Sexual Subjectivity and Resistance to Social Norms

Cultural messages and social institutions encouraged me from a young age to organize my sexual desires around "love," a vague and underexamined term that held out the promise of "one true love" in exchange for immersing myself in the culture of romance. I saw movies, read books, listened to rock music, and enjoyed TV situation comedies that directed me into managing my emotions and desires narrowly: I was encouraged to "fall in love" with a woman of my same race and class, marry, and procreate. Feminist and cultural studies scholars have documented the powerful ways in which social and cultural forces have conspired to create a patriarchal culture of romance (Seidman, 1991; Seidman, 1992); Holland & Eisenhart, 1990), enforce heterosexuality (Rich, 1979), and regulate sexual desires and practices (Rubin, 1984).

If one does not believe the landscape of one's sexuality is genetically or biologically determined (including one's sexual orientation, partner choice, erotic preferences, and fetishes) or that sexuality narrowly emerges out of individualized psychological and familial dynamics (Whisman, 1995; Archer, 1999; Scarce, 1999; Terry, 1999; Fausto-Sterling, 2000), what alternative explanations are available? If one looks critically at naturalized understandings of sexuality, such as "I'm gay because I was born that way," or "Growing up with an absent father made me homosexual," is the only alternative to argue that social and cultural forces determined the directions of one's sexual interests? Can we carve out an understanding of the genesis of our desires, practices, and identities that involves an element of choice? Does sexual subjectivity allow for agency?

Despite a powerful societal drive to steer the masses like sheep in specific directions, resistance emerges alongside compliance. When the engines of the culture universally aim to imprint bodies and desires with the mark of heterosexuality, some fraction of the population moves towards homosexuality; when the masses are powerfully encouraged to distinguish between the sexes and organize desire in monosexual ways, some portion of the populace will resist and move towards bisexuality and defiance of rigid gender norms. If vaginal intercourse between a married male/female couple in so-called missionary position is culturally privileged (Rubin, 1984), is it any surprise that many people are instead powerfully drawn to oral sex, anal sex, and sex outside of matrimonial vows?

Hence lesbians, gay men, bisexuals, and transgenders are produced by the culture itself as rebellious by-products of a drive to sexual and gender conformity. Likewise, we find peo-

ple whose extramarital affairs bring with them a special charge because they are culturally forbidden. We can identify middle-age men pursuing women half their age and people who fetishize race, ethnicity, or socioeconomic class. For many, the forbidden becomes desired; taboo produces cravings; the return of the repressed is made corporeal and can be witnessed as an enormous hunger.

Would the individuals within these specific populations—lesbians, married people engaged in extramarital affairs, people involved in intergenerational relationships—identify themselves as "cultural resistors" if asked? Would they claim identities as "sexual renegades"? Would they acknowledge ownership and pride in their outlaw desires?

Probably not, particularly during a cultural moment in which increasingly diverse practices and ways of being have been naturalized, biologized, or geneticized (Scarce, 1999). More likely such sexual nonconformists would default to a simple explanation: "I was born this way." Whether discussing sexual orientation, preferences for specific sex acts, powerful erotic fantasies, or the ways our sex is organized, we're encouraged to respond as if desires are hardwired into our bodies.

Hence individuals whose sexualities are organized around transgression, face a stark explanatory choice: they alternately can choose biology and maintain that they were genetically driven to be gay (or enjoy sex with multiple partners, or prefer kinky sex), or opt for a social and psychological explanation and insist that they were raised in a setting that produced them as gay. Few seem willing to consider their own volition in the production of desires, fantasies, and practices.

Does something or someone else organize my entire sexual subjectivity or do I have a portion of agency that actively allows me to proceed in certain directions and not others? Does my "choice" to be a gay man fall along the same axis as my "choice" for kinky sex? Am I simply someone who opts for the outlaw category in all erotic areas? Or was I born defiant and therefore can excuse my kinks and twists as "not my fault"? These questions considered through the work of the late French sociologist Pierre Bourdieu, might emerge as: Does my identity as a gay man emerge from a pre-existing outlaw habitus? Or does my identity as a sexual outlaw emerge from a pre-existing gay habitus? (Bourdieu, 1982)

Health Promotion and Childhood Defiance

How does a subculture's relationship to the taboo affect that group's relationship to health and safety? What would it mean if some men came to define themselves as gay men, not because of a specific gene, but because on some level—perhaps, again drawing on Bourdieu, a level different from that of conscious and rational choice (Bourdieu, 1987)—these men organized their gender and sexual identities as acts of resistance to the status quo? What would it mean for some young men to move towards directing desire towards other males as a strategy of circumventing the institutions of heterosexuality, patriarchal masculinities, or an anti-pleasure culture? How would our work with health promotion be transformed if many gay men—or many people of all genders and sexual identities—constituted their sexual subjectivities in part out of a deep-seated impulse to resist?

My own coming of age in the 1960s and 70s suggests that looking at sexual subjectivities through this lens may produce useful possibilities. When observing me I at five- or six-years old, some might explain my avoiding the rough and tumble of sports and boy-culture, in favor of jumping rope or playing house with the girls, as evidence that I was homosexual, or at least gender nonconforming, from an early age. Despite my father's insistence that I play baseball and other adults' overt disapproval of my activities and girlish ways, I risked social disapproval and parental punishment to sneak away and play hopscotch. When viewed through superficial contemporary explanations for the genesis of sexuality, this behavior is evidence enough to prove I was born homosexual.

Such activities, however, could just as easily be seen as indications of a strong-willed and strategic child who willfully violated social norms because he had assessed the political underpinnings of boy-culture. In my six-year-old fashion, I noted the power dynamics, read the cultural semiotics, and opted out.

Cultural messages that real boys played sports and that gentle, gender nonconforming boys were sick or sinful, and that girl-culture was unimportant and without social value, could be considered a form of "health promotion" directed towards my boy self. My father's anguished talks attempting to convince me to be a "real" boy and play basketball with him could be understood as a father-son health intervention. Health promotion was at the core of the second-grade teacher phoning my mother because I was spending my free time baking pretend pies in our classroom's Easy-Bake oven. Most powerfully, health promotion may have been directed at me by the gangs of boys who'd taunt and bully me, chiding me to walk, gesture, cross my legs, and inflect my words in gender-conforming ways.

Could these activities, messages, and rituals be understood as aimed at promoting my health and safety by coercing me into a traditional gender identity? If I'd only accede to this particular health promotion campaign, rather than stubbornly resist, I wouldn't have that bruise under my eye, the ever-present terror of the bully, and the extra twenty pounds around my waistline.

As I entered adolescence, the age grouping commonly viewed as particularly needy of a range of health promotions, I was met with a series of new interventions. This pivotal and problematic life stage is seen as offering prime opportunities for health promotion activities related to diet, exercise, automobile safety, substance use, and sexual conduct. Thus Boy Scout handbooks provided boys like me with basic first-aid technique but also warned us away from playing with knives, experimenting with matches, or venturing alone into unknown wilderness areas. Health classes in junior high schools forced our eyes to view graphic films filled with the evidence

of what happens to teenagers who get behind the wheel of a car inebriated, fall under the influence of the evil weed, or engage in the evils of masturbation.

We came to know precisely how we were expected to rhetorically respond when tested on our knowledge of these health risks or questioned by our parents. Did these campaigns succeed at leading us to chasten our ways or did something more complicated occur? Could these activities have served to introduce us to a range of previously under-considered possibilities marked by risk and danger that our teenage subjectivities experienced in diverse and unpredictable ways? In what ways did adolescent health promotion—and the biases and power dynamics inherent in these campaigns—serve instead to brand specific activities and social practices as "cool," and others as "nerdish"?

When teen health promotion interfaces with teen subjectivities, does a simple, linear equation of HAZARD + WARNING = DETERRANT result? Or could some adolescents "choose" other options, such as HAZARD + WARNING = ATTRACTION or HAZARD + WARNING = HAZARD x HAZARD? In what ways did my already- perfected best-little-boy-in-the-world persona function simply to disguise my dawning move towards outlaw status? Did my values collude with a maturing sense of personal agency to create a decision-like strategic process resulting in me embracing precisely those activities which health promotion was attempting to scare me away from?

Could my incipient binge drinking in high school be understood not simply as a mindless, uncritical "adolescent rebellion" but as a choice to defy the infantilizing of an age-cohort of people who cross-culturally and trans-historically have been granted the privileges and status of adulthood? (Aries, 1965) Was my eventual dabbling in drugs in college triggered by a kind of resistance to the class and age biases included in this health promotion? At precisely the moment I was instructing my body to transgress almost two decades of dictates and fully enact rebellious sexual desires, was I also choosing to resist the dictates of other brands of health promotion?

With this narrative, I am asking the reader to consider that sexual desires, preferences, and practices might be understood as neither driven by inherent biological forces nor as rooted in the narrow familial patterns traditionally called upon to distribute responsibility for deviance (weak father / strong mother), nor as fully determined by overwhelming social and cultural forces. Instead I am suggesting that a form of selection might take place outside the realm of rational choice that is best understood as rooted in alternative ideals and counter-hegemonic ethics. Rather than seeing my gender-nonconforming self and my homosexuality as rooted in deficits (e.g., a lack of effective male role models), could they be understood as forms of resistance to the values incorporated in traditional masculinities or the heteronormative sex/gender system? (Connell, 1995; Rubin, 1984)

On a cultural level, a huge amount of what could be understood as "health promotion" takes place to produce a population that sees itself as monosexual, understands the sexes as "opposites," and directs erotic impulses toward the other sex. This kind of health promotion is woven fully into the apparatus of the culture and finds its way into all cultural products, institutions, and everyday social practices. Throughout my childhood and adolescence this triad colluded in a powerful attempt to overdetermine me as masculine and heterosexual.

Constructed much like contemporary American anti-smoking campaigns, the illustrations of masculinity in Sports Illustrated or my Boy Scout manual powerfully functioned in a manner parallel to today's anti-smoking magazine ads; warnings and threats by my parents served the same purpose as the labeling on cigarette packaging ("hazardous to your health"); the 'disappearing' of the lives of lesbians and gay men from the public sphere functioned as today's ban on tobacco use in restaurants and bars. Powerful cultural efforts demand all of us avoid tobacco use, yet still some young people 'choose' to smoke. With all images of gender nonconformity and homosexuality mocked, derided, or exiled from the pubic sphere, still I moved towards men. Evidence of no options (biology) or a powerfully resistant sense of entitlement and agency?

What I remember most about the years before my consciousness evolved an adult intellect and ability to rationally reflect are three things: a disdain for a pecking-order social world of competition and power abuse, an appreciation of forms of social organization valuing nurturance and cooperation, and a keen, strategic ability to negotiate with subtle defiance through social worlds I was situated within.

What would it mean for health promotion if what we've named "gay men" were actually a grown-up clan of active resistors to heteronormative and patriarchal values? How might the assumptions behind social marketing campaigns and other forms of health promotion be challenged by this possibility? In what ways might a large strain of resistance within this particular population's make-up, social relations, and landscapes of desire, function to undermine, complicate, or throw some surprising curveballs into these efforts?

Is Health Promotion Placing Gay Men at Increased Risk?

I have written extensively about ways in which health promotion focused on safe sex and HIV prevention for gay men may have resulted in producing precisely the desires and activities such efforts were intended to diminish (Rofes, 1996; Rofes, 1998). I've wondered whether a dozen years of "use a condom every time" messages didn't serve to move sodomy from margin to center in the gay male sexual imaginary. With a barrage of health promotion messages repeatedly flashing before our eyes through magazine ads, billboards in gay enclaves, lapel buttons and t-shirts, banners in gay pride marches, posters at sex venues, and safe-sex packets distributed at health conferences, how did we respond? Did these activities truly fit the Geneva Convention's understanding of health promotion as "the process of enabling people to increase control over, and

to improve, their health"? (World Health Organization, 1996) As a gay man with little interest in anal intercourse before the epidemic and a large interest after a decade of prevention efforts, did health promotion elicit an unexpected response from my sexual subjectivity closely linked to defiance?

When safe sex campaigns began in the United States and clarified that risk was most closely associated with anal sex, I felt fortunate: the danger was contained in an act that did not appear on my "top ten list" of sexual activity preferences and one in which I rarely participated as either a "top" or a "bottom." I recall questioning whether HIV prevention efforts should count me as among those they'd "saved" from infection, because the primary transmission route was not within my sexual repertoire. I could easily wear a button claiming "Good Gay Men Practice Safe Sex 100%" because, to me, this took little effort and exacted no price.

By the late 1980s, American HIV prevention leaders insisted that the gay populace had been educated and had fully transformed its sexual practices. Some AIDS education programs actually shut their doors, considering their work complete. Personals in gay publications during these years contained no references to unprotected anal sex and typical social banter among gay men included the assumption that everyone was practicing safe sex all the time. Anal sex absent a condom had become a forbidden act that gay men publicly renounced in exchange for an identity as a socially responsible gay man. A previously despised population was extended citizenship in exchange for repudiating the forbidden act. (Keogh, 2001; 14-15)

Not only did safe sex campaigns function to create a hegemonic view of "acceptable" gay male sexual activity, but also these health promotion campaigns may have included elements that functioned as triggers for resistance. Does including "safe" in the term "safe sex," serve only to reduce the heat or the charge surrounding the act? Or does a population that has already opted for risk over safety in the way we organize our gender and sexual identities, consider "safe" equivalent to "status quo," "heteronormative," or "boring," and hence move towards the unsafe? Does an appeal to safety and social responsibility as central to these campaigns actually spark a counter-response from many gay men, especially in a world where now the vast majority of HIV transmissions appear to be occurring through heterosexual vaginal intercourse?

Some HIV-prevention groups appear to understand barebacking, in part, as a militant resistance to the colonization of a community's sexuality:

> In the last few years gay men have gotten serious about the right to fuck without condoms. After all, practically every straight guy in the world gets to do it without being told they are irresponsible, foolish, suicidal, or homicidal. A lot of guys think we should have the same right. Barebacking is a right…Barebacking is liberation…Barebacking is defiance. (San Francisco AIDS Foundation, 2000, December)

Do gay men detect biases against our sexual values and sex cultures in health promotion that replicate ways in which health promotion during our childhoods and teen years seemed determined to steer us into traditional heteronormative masculinities? Peter Keogh raises important questions about the politics of health promotion that powerfully confront what we may be facing:

> …when health-seeking behaviours are to be encouraged, such as avoiding the transmission of HIV through sexual contact, the opposed notions of coercion versus voluntarism come into play. Questions emerge: should choice and individual self-determination be promoted at the expense of larger epidemiological imperatives? How is health and choice to be promoted? When these questions are asked about a group to whom choice and freedom have traditionally been denied and where the disease in question threatens to stigmatise those who contract it, these questions become particularly poignant. (Keogh, 2001; 3)

When "barebacking" emerged on the American scene in the late 1990s, some argued that such a renegade movement should have been expected to emerge as a backlash against fifteen years dominated by a brand of health promotion they characterized variously as simplistic, patronizing, disempowering, sexphobic, and homophobic (Elovich, 1999, June; Scarce, 1999, June). As the silence surrounding unprotected anal sex was replaced in a brief period by a still burgeoning discourse within the queer public sphere, did the emerging debates (focused on condomless bareback sex parties, the risk in ever forgoing condom use, the websites extolling the glories of exchanging semen) serve to resolve issues of risk and safety or simply affirm to the masses of gay men what they already knew: that anal sex and semen exchange are the "hot" act for today's sexual outlaw?

Was There Much New About the "New" Wave of HIV Prevention?

During the two year period 2000–2001, a series of HIV-prevention campaigns for gay men appeared in the United States, Australia, and England in the pages of gay publications and in posters, brochures, and websites. Considered a "new stage" of HIV prevention, these campaigns created much public debate for stepping beyond the "use a condom every time" efforts of the 1980s and 1990s. These campaigns included Terrence Higgins Trust (THT) and Community HIV and AIDS Prevention Strategy's (CHAPS) "Facts for Life" and "In Two Minds?" campaigns in England; Gay Men Fight AIDS' (GMFA) "Enjoy Fucking?" and "Bareback" campaigns, also in England: the AIDS Council of New South Wales' (ACON) "Give a Fuck" campaign; the San Francisco AIDS Foundation's (SFAF) "The New Epidemic" four-part ad series, and San Francisco's Stop AIDS Project's "HIV Stops With Me" campaign.

All these efforts are focused upon high-quality visuals and powerfully explicit texts. Most feature graphics depicting gay men, including several campaigns that use photographs of a diverse collection of "regular" gay men. The campaigns seem to share a desire to avoid being explicitly prescriptive or directive and instead model what Peter Keogh (2001) has aptly cited as the "normative" (14):

> They illustrate healthy ways of being. The significance of this shift from prescription to normativity cannot be underestimated. Health promotion now constructs gay men as no longer intrinsically risky individuals, but rather sees them as having a capacity to manage risk… As health promotion seeks to regulate by means of incentive rather than censorship, it talks about more than behaviours, engaging instead in a socially constructed task that goes to the heart of the individual. This might be defined as promoting gay citizenship. (14-15)

A review of these efforts intended, in part, to respond to barebacking and reports of upswings in sexually transmitted infections suggests that HIV education efforts may continue to be operating out of the same problematic assumptions, manipulating gay men's desires and practices in uncertain ways, and producing the precise activities they were created to counter. The shift away from prescription, however welcome, may benefit no one, if the privileged alternative is participation in a cleaned-up, wholesome gay citizenship. For gay men whose sexualities include an element of transgression, this might offer simply a different target against which to rebel.

I maintain three major concerns about these ambitious efforts. First, the campaigns continue the two-decades-long tradition in HIV-related health promotion of emphasizing anal sex. Such a relentless emphasis sends an implicit message that this is the primary sexual activity bearing risk for transmitting HIV for gay men along with a message that this is the preeminent and most desirable act within the sexual repertoire of the gay male populace. ACON's "Give a Fuck" campaign attempts to play off of the multiple meanings of the word "fuck," yet simultaneously hammers home through language and explicit graphics that fucking is the ultimate act of gay male sexuality. Likewise, GMFA's "Enjoy Fucking" campaign includes three powerful visuals, all highly stylized images of two men fucking, with the observer's eye then drawn to the words "Enjoy Fucking?" as the uppermost text and with the largest typeface in the ad. While the follow-up line, "You Can Reduce the Risk!" is intended to direct the viewer to consider prophylactic measures, the emphasis on "Enjoy Fucking?" seems likely to buttress a cultural norm that one should enjoy this particular act and that one may be less of a man (or less of a gay man) if one does not share a significant interest in anal sex.

Secondly, all these campaigns are focused on barebacking—anal sex without condoms—yet continue explicitly to be designed as condom campaigns. An activity occurring without a condom is intruded upon repeatedly by condom discourse. All eight of THT and CHAPS's "Facts for Life" posters close with the line, "It's worth remembering that condoms, used properly, stop HIV." Likewise, ACON's "Give a Fuck" campaign posters close with the line, "Using a condom and lube is the safest way to have casual anal sex." GMFA's "Enjoy Fucking" campaign ads end with text stating "Condoms and plenty of water-based lube still provide the safest fuck," and every one of THT and CHAP's "In Two Minds?" posters that includes text repeatedly highlights condoms. While the designers of these campaigns may have attempted to shift from the prescriptive "Use a Condom Every Time" message to the less explicitly directive "It's worth remembering that condoms, used properly, stop HIV," the intrusion of condoms into the text and the repeated use of a tag-line that seems almost parental (even patronizing) makes these efforts less of a departure than they perhaps think.

Thirdly, all these campaigns attempt to offer individual gay men a nuanced trade-off that may be much more complicated than the campaigns' designers are willing to face. While these campaigns reflect a shift in social norms away from earlier efforts that categorized all acts of anal sex without condoms as unacceptable towards categorizing certain acts of anal sex without condoms as unacceptable (barebacking between two men of different antibody status; barebacking between two HIV- lovers not in a monogamous relationship), they continue to rely on categorization of sex acts and sexual actors as "good" and "bad." In Stop AIDS' "HIV Stops With Me" campaign, we're offered repeated images of the "good" HIV+ person, which encourages viewers to imagine the counterpart, the "bad" HIV+ person. GMFA's clever and graphically original" Bareback" campaign contains three ads focused alternatively on the gay man who is "negative and so is my boyfriend," the HIV+ man who enjoys barebacking but "only with other positive men," and the HIV+ man who does not ever bareback ("It's not worth the worry"). SFAF's barebacking ad in their "The New Epidemic" campaign asks, "If we're going to bareback, can we do it without fucking over everything else?" Again, the appeal is to barebackers to be 'good gay citizens' and put social responsibility ahead of personal preferences, pleasure, or meaning.

Hence these seven campaigns, considered by many to be part of a progressive new era of health promotion, by failing to consider a resistant impulse within many gay men's sexual subjectivities, may actually be implicated in perpetuating the very activities they aim to diminish. By continuing to single out anal sex and address it outside of a context of other sexual activities, they may continue to be producing increased desire for this act. By making the slight shift from prescriptive directives about condom use to suggestive directives about condom use, they may generate a rebellious dislike or overt hostility not only to the cumbersome nature of condoms but to the attempt to colonize gay men's most intimate sexual practices. By continuing to function as arbiters of the morality of specific sex acts and specific gay men, and refusing to move entirely

beyond the paradigm of authority and judgment, these campaigns may continue to trigger resistance rather than compliance. And even without one's questioning the ethics and politics of producing "goodie" and "baddie" gay men, such suggestion-based campaigns may be experienced by many gay men as simply the latest installment in a lifetime of problematic relationships with health promotion.

Vexing Questions

In an article providing information about "The New Epidemic" campaign, the San Francisco AIDS Foundation newsletter explains, "The purpose of the ads is to capture the attention of our target population and stimulate some new thinking about complex issues." (San Francisco AIDS Foundation, 2000, December)

If 'thinking' and rational-choice decision making are the primary activities determining the sexual activities of most gay men, information-based intervention that offer new data, new perspectives, and new possibilities might be the best way to reduce unprotected anal sex. If most gay men do not share a significant element of resistance in their response to health promotion, this new wave of prevention efforts might achieve great success. Yet if this resistant element is present in a large portion of the population targeted by these campaigns, the efforts might result in increasing precisely the activities they are attempting to diminish.

Astute critics have raised questions about ways in which traditional health promotion might face special challenges with HIV prevention:

> Sexual health promotion can be difficult in many settings in which other health promotion is not. These problems are severely compounded when addressing sex between men due to the social taboo of homosexuality generally and discrimination against gay men in particular. (Hickson et.al, 2000; 6)

Yet few have examined closely the ways in which gay male sexual subjectivities might feature kernels of resistance that pose formidable challenges to traditional health promotion models. This oversight raises vexing questions with profound implications for our work with gay men: If resistance to health promotion is deeply rooted in the sexual subjectivities of a large portion of gay men—and if this resistance is linked to our production of ourselves as gender-nonconforming and sexual outlaws—will any forms of health promotion serve to improve the health and wellness of gay men?

Where Does HIV Prevention Go Wrong?

Most contemporary discussion of HIV and gay men today romanticizes gay men's AIDS response in the 1980s and blames current shifts in gay men's attention to AIDS issues and sexual practices to either the new treatments, young men's supposed sense of invulnerability, or the so-called complacency of contemporary gay men. Health providers and activists alike, unable to consider big picture questions about gay men's identities and desires, default to shaming and fearmongering. The primary approach to education and prevention continues to be an attempt to re-create the crisis culture we inhabited in the 1980s. Absent the urgency linked to catastrophic decimation, preventionists seem at a loss about what to do.

Am I the only one frustrated by bankrupt rhetoric attempting to explain a complex health challenge?

I am not an AIDS denier. I do not pretend that gay men's sexual cultures do not present a range of health challenges. I am simply someone who demands new and clearer perspectives on the contemporary situation. When are we going to admit that HIV disease among gay men of all colors is not going away anytime soon, and create long-term strategies to promote sexual health, instead of repeatedly defaulting to the same tired, state-of-emergency approaches which haven't worked over the past ten years? In the long run, such a strategy will be more effective in saving lives and increasing community health and well being than the constant recycling of panic/terror approaches that continue to predominate.

Many thoughtful gay men hunger for a deeper and more complex analysis of what's going on in our communities. We no longer trust AIDS experts because they've shouted "Fire!" in this theatre too many times. Health advocates frequently mistake our boredom at their superficial and vapid analyses for complacency about the health of our communities. We care deeply about the well being of gay men's communities; we are simply enraged at the repeated manipulation of statistics and emotions in the name of HIV prevention. And we hunger for vision: a new vision for HIV prevention, a new vision of gay male communities, a new vision of gay men's health and wellness.

I recently published on a gay news website an editorial viewpoint that attempted to open up new ways of thinking about HIV prevention, crystal use, and gay men who occasionally have sex without condoms. I was attempting to offer new vision. I understood the risk of attempting to offer new thinking and introduce complex concepts in a brief article on a popular website, but I did my best to inject some fresh thinking about risk-taking and the hazards of social marketing into a discussion which has become predictable and, at times, trite. At the same time, despite my awareness of the challenge I was taking on, I had not expected the rage reflected in some of the letters of response from readers. A sampling follows:

Patrick Syring from Arlington, Virgina, wrote:

> "Your advocacy for barebacking and party drugs is abhorrent and disgusting. Gaymen like you tarnish the rest of us who play safe and cherish life more than you do. I hope you die painlessly but quickly."

Anthony Altieri wrote:

> "Your article is one of the stupidest things I have ever seen in print. You are obviously a fucking idiot…You cannot blame people's self-destructive behaviors on prevention campaigns. Have you ever heard of a little thing called "personal responsibility"? Probably not. There are plenty of reasons people make unwise decisions: addictive behavior, loneliness, desperation, isolation, lack of purpose in their lives, lack of education, but I am confident you will NEVER find a case of 'I have uprotected sex and use drugs because I saw a poster telling me to use a condom.' The aids [sic] epidemic has been ongoing since the early '80s. DEAL WITH IT. USE A CONDOM YOU FREAKING MORON. Please do us all a favor, unplug your computer and refrain from subjecting the world to any more of your bullshit. Go sit quietly in your bedroom with the lights off, avoiding the realities of life. You seem to be pretty good at that anyway."

Why do conversations among gay men about HIV, barebacking, crystal use, and bathhouses get so ugly and divisive? Why are they argued in such a vehement manner? Are they simply another example of internecine warfare driven by personality conflicts, ego battles, and bad manners? How can we make sense out of distinct visions that seem to underlie these debates: one which argues that the crisis moment of AIDS has passed for gay men and one which berates gay men for taking a single step beyond the bomb shelter we've inhabited since the early 1980s? Why is gay men's sex so frequently the target of such contentious debate and demonization? How did we reach a point where there are such deep divisions among gay men about sexual health and safety? And in what ways do vehement responses to new vision effectively serve to keep out of our movement fresh, innovative thinkers offering fresh analyses?

Effective Prevention Efforts Require Recognition of the Contemporary Context: Today's Experience of HIV is Fundamentally Different than in 1985

In the mid-1980s, the organizations attempting to limit the spread of HIV in gay male communities marshaled a variety of "facts" about AIDS as part of an effort to shift gay men's sexual practices during a frightening era. Because we knew few gay men who survived HIV for more than a year or two after diagnosis, we discussed HIV infection as lethal and believed that each friend who tested positive was facing a death sentence. As the tidal wave of deaths hit urban centers from 1989 to 1994, we depended on the all-too-common experience of attending frequent funerals and memorial services to drive home the fatal dangers one faced when taking risks with sex or needles. When we reached the point when nearly 50% of the gay men in San Francisco and New York gay ghettos were HIV+, we reminded men that half their sex partners were likely to be infected, and instructed them to use condoms every time.

Gay men created sexual health strategies motivated perhaps more frequently by what we experienced among our friends and in our daily lives than what we read about in the brochures and ads produced by our newly initiated AIDS prevention organizations. We looked around us at the actual experiences occurring among our friends and neighbors, and integrated those realities into what we did with our desires and our bodies. We were savvy enough to take in a range of evidence that we were now in a dangerous and threatening environment, evaluate it through a lens of our values and health beliefs, and begin to enact it through our socializing, relationships, and experiences in gay men's sexual cultures.

HIV prevention among gay men in the 1980s was acclaimed internationally because it quickly and skillfully funneled emerging epidemiological data, confusing and often contradictory biomedical findings, and complicated sociocultural trends into campaigns tailored to the cultural norms of urban gay male populations. The brochures and ads seemed to affirm what we were already observing in our daily lives and buttress many of the strategies we set in motion to maximize health and protect us from danger. Because there was little dissonance between the suggestions emerging from AIDS prevention groups and the evidence we noted in our everyday lives (and the values of our various communities and subcultures), prevention work seemed like effective community organizing that truly was rooted in our communities.

Those of us launching the early prevention efforts knew gay men were not dumb and we counted on their resilience in the face of this huge tragedy and their commitment to survival. Huge debates—long forgotten—occurred during the earliest years of AIDS prevention about whether we should encourage a dramatic shift in gay men's social and sexual patterns. Should we advise men to limit their number of sex partners? Would it be wise to promote monogamy for male couples? Should the bathhouses and sex clubs around the nation be closed? Should public sex spaces (beaches, parks, rest areas) be policed and shut down for the sake of preventing infections among gay men?

While there were dissident voices, a community consensus emerged that discouraged a move in this direction. Realizing that deeply entrenched features of gay male culture reflected authentic values and preferences rather than reflecting oppression or pathology, we knew not only that such changes were daunting tasks to take on, but that adopting the role of the finger-wagging school marm or calling for the wholesale restructuring of gay men's collective desires and sexual cultures might backfire. If our campaigns and organizations were going to maintain credibility and support (and effectiveness) they needed both to reflect the actual "facts" of AIDS as they were emerging at the time, and fit alongside the social and sexual norms of the community.

Some people believe this is where AIDS prevention went wrong in the early years. They suggest that we weren't ambitious enough and were cowed by the fear of being labeled "politically incorrect" or "sex-negative." They argue that AIDS among gay men in the United States would look much different today if gay male leadership at the time demanded the closure of bathhouses, sex clubs, and public health spaces, advocated for fewer sex partners, and promoted monogamy as a cultural norm. They believe that the vast spread of AIDS among gay men was caused by two profound failures: the failure of homophobic government leaders to take immediate steps to contain HIV and the failure of gay male leaders to take immediate steps to constrict the sexual opportunities of gay men.

I believe that AIDS prevention did not go wrong during these early years. Indeed, I believe the data show that the early years of the epidemic were a singular moment when community-based education efforts worked in consort with the emerging realities of AIDS in gay men's everyday lives. Sure, hindsight suggests instances where our judgments erred or community warfare got the best of us, but for a period of about five or six years, rectal gonorrhea rates, surveys of sexual practices, and HIV infection trends within gay male populations suggest that basing our prevention efforts on the "facts" as they existed in the social worlds of gay men brought us tremendous success. Today we can argue about the epidemiological data from the period and debate the causes for this change, but we cannot deny that for a short period of time there was a tremendous shift in the sex of gay men throughout the United States.

Fast forward to the present moment: Many of our leading AIDS organizations and prevention groups no longer attempt to affirm the "facts" of HIV as they are evident in gay men's everyday lives. Instead, they see their job as trying to convince gay men that the facts of HIV from 1985 remain facts twenty years later. Many of them apparently believe that we are in the same crisis moment we entered in 1985, that HIV is as big of a disaster as it was back then. They demand that the facts of the 1980s guide our sex practices today. And they attempt to pull off an odd turn: In the treatment arena they throw a pep rally for HIV+ men, presenting optimistic visions of current and future pharmaceuticals, while in the prevention arena they marshal horror stories for HIV- men about the current drugs' side effects and supposedly high rates of treatment failure.

Significant numbers of gay men of all ages apparently support this effort to keep gay men locked in 1985 understandings of the epidemic. The men who trashed my writing on the website seem to believe that the HIV context has not changed enough to allow for gay men to let their guard down at all. To these men, we are still in the midst of a health crisis, HIV is not a manageable disease, and a continuance of campaigns urging men to use condoms every time is precisely what gay men need to continue to protect themselves.

But many other gay men now have developed a very different understanding of HIV than the one promulgated in 1985. HIV means something different to them today than it did to their counterparts two decades ago precisely because of what they see around them, what they experience in their everyday lives. What they know from infected friends and neighbors provides ample evidence that much has changed. Not only do we understand the natural history of HIV infection differently than we did two decades ago due to multi-year research projects, but pharmaceuticals are now altering that natural history course in new and profound ways. In addition, the people in our lives today who are infected with HIV seem entirely different than the people with HIV in our lives two decades ago: their overall health, their thinking about their future, their energy levels, the shape of their bodies and the look of their faces are entirely different from two decades ago. We can debate forever whether HIV today remains a crisis, remains a lethal illness, and remains an enormous tragedy for gay men's communities; but gay guys not immersed in the formal structures of AIDS/HIV's organizational life or debates at public health conferences continue to create their own contemporary set of "facts" out of the realities of their everyday lives.

We will never know what would have happened if the facts of the mid-1980s had remained firmly entrenched as undisputed facts governing gay men's experiences with HIV today: if there had been no progress in treatment; if there were no such thing as long-term non-progressors; if people who acquired HIV today found themselves facing swift and ugly deaths as often as many did in the earliest years. The pages of weekly gay papers still could be filled with obituaries; but they are not. Everyone we know who tested HIV+ in the 80s could be dead; but they are not. Half of the gay men who populate bars, bathhouses, online chat rooms, and gay dating services still could be infected. But, instead, that figure is under 15% in most urban centers and in the high-impact cities of the 1980s, San Francisco and New York, currently fewer than 25% of the gay men are HIV+.

The Role of Gay Journalists: We Need a Savvy, Independent and Educated Voice Scrutinizing Prevention Efforts

Contrary to what today's HIV-prevention leaders seem to believe, young gay men cannot accurately be characterized as irresponsible, reckless, or lazy and gay men as a group are neither ignorant nor unsophisticated. We are not mindless sheep, willing to ignore very real changes in the way HIV is situated in our lives. We are also not lacking in self-esteem or filled with an internalized homophobia that drives us to self-destruct. Nor are we naive or delusional, believing we are invulnerable to harm or disease. If prevention efforts are less effective today than they were a decade ago, it may be because much of contemporary gay male HIV prevention work refuses to accept fully the altered social, biomedical, and cultural realities in which today's gay men operate. And those few programs which have attempted to move with the times have been unable to deeply conceptualize and envision what an

authentically new generation of HIV prevention might look like. Many find it difficult to imagine models of public health work not dependent on creating a community mindset of crisis, or relying on terror, panic, shame and guilt as primary tools to shift community norms and alter social and cultural practices.

Journalists working for the gay and mainstream press often unintentionally churn out the bulk of the discourse that works to seal gay men in the time bubble of 1985. Rather than creating a cadre of independent, shrewd and astute writers knowledgeable about theories of public health promotion and the history of public health, AIDS, and disease prevention, the media more commonly provide an uncritical platform for prevention leaders to scold, childe, rant, gripe, and prevaricate. They embrace the same paradigms and worldviews as most of the workers in AIDS organizations, researchers evaluating HIV prevention, and public officials funding (or not funding) HIV-prevention efforts. It becomes a closed system, where there are few voices puncturing a rigid mindset and a narrow perspective. When journalists attempt to assert independence from the AIDS establishment, it is usually focused on personal attacks on leaders of AIDS organizations and rarely on the foundational assumptions that guide their work.

I have a file of articles from local gay papers across the nation that demonstrate this tendency to uncritically allow the underlying assumptions of AIDS leaders to go unexamined. In one article that captures the common logic of prevention leadership today, the director of a Seattle-based program discussed his placement of "bogus personal ads" seeking partners for bareback sex. He received "a large number of responses." At the same time, he also insists "We are seeing a lot of new infections within committed relationships." We can't fault the director for using anecdotes and pseudo-research in the media, as this is typical media fare in many fields today. But we can fault him for appearing so desperate to convince gay men that they're still living under a state of emergency that he points his finger everywhere, one moment at the sex pigs and the other at men in couples. And we can fault the media for not asking for evidence or, at the very least, a clarification of what he is attempting to say.

A media alert from this same organization insisted "alarming HIV infection rates among gay men" in the early and mid-1990s inspired the founding of the group, yet their materials for a barebacking forum reference similar "alarming" new infections years later. Like many AIDS organizations, this group appears compelled to come up with an explanation-of-the-moment for continuing infections among gay men and attempts to extend year by year the crisis-driven experience of AIDS among gay men. The organization's leadership consistently insists that the AIDS crisis is not over for gay men, even as the world of today for gay men bears almost no resemblance to the authentic crisis moment of AIDS in the mid-1980s. Yet gay publications continue to grant them wide berth in putting forward their thinking.

The largest-circulation gay newspaper in the San Francisco Bay Area has done its part to fan the flames of crisis and ensure that thoughtful analysis of gay men's sexual health does not appear in its pages. While an editor writes that he is convinced barebacking "is a real problem," and argues that his newspaper needs "to bring it out into the open," the paper feels no parallel obligation to discuss the topic with intelligence, evidence, or critical analysis. There is no dearth of thoughtful health activists, researchers, epidemiologists and gay men's health providers in the area, yet the paper devoted two front-page stories on barebacking exclusively to an interview with a New York journalist who has never worked in HIV prevention, has no degrees in public health, education, or social psychology, and has never researched—nor apparently read anyone else's research—on barebacking.

In a bizarre, take-no-prisoners interview, the journalist—with no seeming self-awareness—attributes new infections among gay men to no less than ten factors: the "glamorization" of barebacking, a "spoiled-brat" mentality among gay men, failure of prevention campaigns to use fear tactics, ads for protease inhibitors presenting images of buff and hearty men with AIDS, the supposed claims of gay writers (Andrew Sullivan and myself) that "AIDS is over," young gay men's lack of personal experience with AIDS deaths, the transgressive nature of gay men's sexuality, young men's self-indulgence, and the immaturity of gay men's cultures. As he grasps for an explanation, his editors mindlessly promote the journalist as the defining voice about barebacking. What might the consequences be for the local response to barebacking, gay men's health, and HIV prevention?

Defaming Gay Men Is No Way for Prevention to Gain Credibility with Gay Men

Today we find ourselves in a situation where many uninfected gay men are engaging in sexual practices heavily informed by the realities of the current moment: most of the men we have sex with are not HIV+; many of the positive men have diminished levels of HIV in their semen; becoming infected with HIV no longer means imminent decline or an automatic death sentence. HIV+ men are further informed by the fact that highly respected medical researchers continue to disagree about the possibility of re-infection with more dangerous strains of HIV. Even the National Institutes of Health have told us that the statistical risk from a single act of unprotected sex is much less than the 50:50 ratio many of us believed it was in the 1980s.

What is amazing to me is that despite HIV prevention continuing to hammer home "use-a-condom-every-time" messages, despite the repeated predictions by most public health authorities and journalists that a "second wave" of HIV will wash over gay men any time now, regular gay men have found ways to find erotic pleasure and sexual fulfillment while minimizing the risk of new infections.

It seems just as common for leaders to speak about these matters without ever having reviewed research or studied related evidence as it is for them to read the research locked into pre-existing out-of-date perspectives on HIV/AIDS. Just a few years ago there was a rash of media reports capturing the perspectives of national leaders confronting what they believed to be a huge shift in gay men's sex practices. One executive director of a national AIDS group claimed that studies showing a rise in the rectal gonorrhea rate among gay men in San Francisco and an increase in gay men reporting unprotected anal sex suggested that a moment of "national complacency" has taken hold and that young gay men "are cavalier in their attitude about both recreational drug use and HIV risk." Reading these recent epidemiological reports through the crisis-tinted lenses of the AIDS establishment, it was clear to me that this AIDS leader could not imagine two men fucking without condoms as anything other than "a romanticizing of unsafe sex." This man's organization, around this same time, issued a press release under the title "Unsafe Sex Spike Signals New Crisis" in an attempt to extend the emergency mentality of the 1980s into the new millennium.

Journalists at the local newspaper discussed above promptly inserted themselves into the discussion, using naive understandings of science and faulty reasoning to affirm their long-held perspectives. Drawing very loosely on these same CDC studies, as well as documents from their local health department, the editor wrote:

> Newly documented information...shows that STDs and HIV are increasing among Gay men in Seattle and across the United States. Many therefore fear a new tide of suffering and death which may strike a new generation of Gay men, just when it appeared we might have turned the corner of the epidemic and put the worst of the AIDS epidemic behind us.

Studies from the Centers for Disease Control that showed changes in the gonorrhea rate in San Francisco ignited drama, hysteria, and a smug "We told you so" attitude from AIDS organizational leadership and gay journalists around the nation. While the studies document behavior changes that may or may not be a cause for great alarm related to the escalation of HIV rates, reasonable and independent thinkers might draw different conclusions from the data. For example, if most of the gonorrhea cases were among already-infected men, our concerns might be more appropriately directed towards the creation of broad sexually transmitted disease prevention campaigns, rather than HIV focused efforts.

The rectal gonorrhea study contrasted strangely with seroconversion data in San Francisco that showed, not a rise, but a decline and a leveling off of new infections among gay men since the mid-1990s. While many of the press reports about this rise in rectal gonorrhea jumped immediately to "this-is-a-return-to-the-1970s" rhetoric, almost all journalists failed to note that San Francisco's rectal gonorrhea rate was still a tiny percentage of what it was before our education work of the 1980s was initiated.

Likewise, the much ballyhooed report of upswings in gay men reporting unprotected anal sex (from 30% in 1994 to 39% in 1997) can only be legitimately understood as a "problem" if one maintains the AIDS absolutist position of the 1980s: goodie gay men use a condom every time. This same shift in sex practices could suggest many things besides the trumpeted upswing in new HIV infections. Social scientists are aware that people's response to sex surveys is closely linked to current cultural norms. Hence the shift could signify the transformation in community discourse from a time when all gay men in the media represented themselves as having 100% safe sex, to a time when some men began speaking openly about unprotected sex and debates flared over barebacking subcultures. This shift in discourse might well make it safer for surveyed gay men to "fess up" to such sexual activities. The shift could also suggest that more gay men were aware of the lower level of HIV in gay communities and the diminished level of viral load in many men's semen. And consequently, sometimes chose to get fucked without condoms in circumstances where they performed the mental calculus and determined that their risk might be minimal.

I am not arguing that changing gay men's sexual practices raises no significant questions and merits no concern from advocates in a gay men's health movement. Nor am I declaring current treatments a panacea or that we don't face significant challenges with HIV continuing in the gay community, especially among men of color. Instead, I am arguing that the willful misreading of epidemiological data, the continued churning out of crisis-based press releases, and the escalating depiction of gay men—particularly young gay men—as dumb, self-destructive, and irresponsible, have enormous consequences for effective community organizing around gay men's health. They weaken the credibility of our community-based media, AIDS groups, and gay men's health organizations. If many gay men no longer look towards AIDS prevention leadership as their reliable sources of advice, prevention leaders have no one to blame but themselves.

When young gay men are being depicted as self-centered, uncaring hedonists lacking any sense of responsibility to others, who is being lazy, irresponsible, and self-destructive here: gay men in their 20s and 30s, or journalists and AIDS leadership? It may be more convenient to pin current failures in prevention on rank-and-file gay men, blame young gay men, and point the finger at all whose sex falls outside the narrow dictates of use-a-condom-every-time mantras than to take a fearless and searching look at the current state of prevention. How common it is to find articles where journalists interview prevention leaders about supposed increases in HIV rates, and the prevention leaders shake their heads and target one group of bad-boy gay men or another (young gay men, barebackers, crystal users, circuit party goers…). Do they even consider whether their own effectiveness or funding should be called into question?

Let's state here what isn't ever supposed to be stated in print: prevention efforts targeting gay men since 1995 have been sorely in need of re-visioning, re-direction, and retooling. This is common knowledge even within the AIDS establishment. When talking among themselves or with colleagues at national HIV prevention meetings, prevention leaders freely admit that they haven't a clue about what to do to influence the sexual activities of gay men's communities. This is one reason why, when the Bush administration began shifting prevention funding for gay men toward efforts targeting HIV+ men, there was little community response; attempts to create resistance failed miserably. How can gay men's communities get excited about preserving the funding for AIDS prevention groups when we neither respect nor value their recent efforts?

By willfully misrepresenting gay men who organize their sex and relationships outside the crisis-driven dictates of 1980s prevention, AIDS leaders and journalists cross an important line. They find it convenient to use all-too-willing mainstream media, amidst a growing political climate of homophobia and sexphobia, to divide gay men into good and bad. If they wonder why popular support for AIDS groups is plummeting among gay men, they need look no further than their own press releases, media statements, and prevention brochures. If you patronize and defame gay men, don't act shocked when we no longer support you.

Instead of bringing together a savvy and creative brain trust to generate a multi-issue, activist gay men's health movement, much of the leadership in the gay community continues to see our AIDS work as separate from the broader public health context in which gay men live our lives and have our sex. Instead of creating a new generation of HIV prevention rooted in the altered (and ever-changing) facts of HIV infection in 2006, we recycle the education models and supposedly common sense assumptions of the 1980s, making—at best—mild adjustments.

At the same time we continue to enlarge the ever-widening credibility gap between rank-and-file gay men and the very institutions that many of us created, funded, and populated as volunteers. Until AIDS leadership ceases to patronize the common gay man by presenting us with "facts" which have little likeness to the realities of our lives or the findings of balanced biomedical research, or treat us with contempt, they ensure the further erosion of their funding and volunteer base in gay communities.

Creating an Epidemic of Epidemics Is Not the Same as Effective Prevention

One of the ambitious items on the agenda of a gay men's health movement is to blanket the nation with gay men's health and wellness projects, much as we did with HIV prevention programs in the mid-1980s. We want to see a gay men's health project in every state and a gay men's health summit occur in every part of this country. And we want these health projects to be radically different from the HIV prevention programs that currently exist throughout the nation.

Creating a broad, holistic approach to gay men's health and wellness is the mission of such a movement. While aggressive work on HIV and AIDS must remain critical, we need to expand dramatically beyond a narrow focus on HIV and address the many health issues faced by gay men of all colors and all generations. We need to replace bankrupt tactics of fear-mongering and panic-creation as our primary ways of reaching out to gay men and adopt a long-term strategy not vulnerable to the toxic cycle of crisis/ cure that have been repeatedly foisted on the gay male population.

This toxic cycle repeatedly introduces a new crisis-of-the-moment into the public discussion of gay men's health and sexual cultures. During one short period in 2000, gay men read about alarming outbreaks of syphilis among gay men in over a dozen U.S. cities, often linked to Internet chatrooms. Next, the Gay and Lesbian Medical Association sounded the alarm on a "club drug epidemic," highlighting a "severe increase in the abuse of methamphetamine, ecstasy, ketamine, gamma-hydroxburyrate (GHB) and nitrates (poppers)" by gay men. And soon after, the web site GayHealth.com announced "New Epidemic Threatens Gay Community," and highlighted a study showing a "startling increase in anal cancer" in gay men. To top this all off, San Francisco's AIDS leadership and mainstream media declared that San Francisco's "long-feared and often predicted new wave of HIV infection is here" for gay men and highlighted an alleged "surge" in new infections among that city's gay men," a surge that, just a few years later it became apparent, never took place.

Do these reports reflect an accurate interpretation of the epidemiological data, or does the need to grab media attention, funding opportunities, or the ears of policymakers lead to overstated claims, sensationalistic headlines, and problematic interpretations? The same health officials who initiated media reports about the "surge" of infections and triggered international headlines about a tripling of HIV among San Francisco gay men, soon backpedaled from their initial statements and apologized for their exaggerated claims. Yet the "second wave" of HIV among San Francisco gay men had already been accepted uncritically and endlessly repeated by journalists internationally. Even though no convincing corroborating empirical data was present (nor did any emerge), the world was led to believe that gay men in San Francisco tripled their infection rate and brought upon themselves a new cycle of cataclysm and destruction.

Who holds health officials, journalists, the public health department responsible for this defamation of the gay male community in San Francisco? Not our gay public officials and liberal straight mayors: they corroborate the sound bites and repeat the "new wave" mantra ad nauseum. Not editors and journalists at our gay newspapers or the science reporters at the San Francisco Chronicle or New York Times. They provide bully pulpits for the health officials and offer no critical

lens, nothing approximating investigative journalism, no independent editorial viewpoints. Only a few lone voices—usually individual gay men writing letters to the editor in gay tabloids weeks or months later—challenge the statements of health officials and the addiction to crisis constructs that appear to dominate current discussions of gay men's health. Does the overuse of the crisis construct dull sensitivity to authentic emergencies? Does a repeated use of epidemic threats save lives or take lives?

The second issue raised by these reports of new epidemics is the painting of simplistic portraits of a diverse community or complicated subculture. Whether talking about the gay community at large or specific subcultures such as gay men of color, circuit party participants, young gay men, crystal users or barebackers, journalists, researchers, policymakers and activists too easily offer uninformed perspectives without any real knowledge of the population they're talking about. Is it any wonder gay men feel defamed by the ways our cultures are discussed in health circles? Is it any wonder gay men seem alienated from the health establishment?

How do we know what we know about the lives, sexual practices, attitudes towards health, and identities of young gay men? Until recently, very little funded research has been allowed to occur with this population, and most people read newspaper clippings or short e-mail blasts rather than actual research studies. Yet it's so easy for people to extrapolate from their own unreliable adolescent memories or jump to conclusions based on popular cliches about youth that bear no resemblance at all to the day-to-day experiences of queer youth today.

If anyone doubts that homophobia and moralizing continue to play a role in the way gay male subcultures and sexual practices are discussed, they should simply compare the horrified tone of the coverage devoted to gay men who fuck without condoms to the empathic coverage devoted to uninfected women impregnated by HIV+ husbands. Journalists seem wholly able to empathize with women who take health risks because having a baby is meaningful to them (and many within the gay men's health movement strongly support the right of women to choose, even when HIV is involved), yet these same journalists appear fully unable to fathom that some gay men take risks because specific sex acts are valuable to them and receiving semen carries profound and powerful cultural meanings. Sex acts that produce babies are easily seen as valuable. Sex acts that simply produce pleasure, meaning, and identity—especially the act of anal sex for many gay men—are seen as disgusting, diseased, and easily expendable.

Such highly questionable reports lead me to believe that gay men are either the target of an outbreak of epidemic panics on the part of medical authorities or the codependent victims of a public health system deeply addicted to crisis approaches to public health. These reports motivate my determination to be part of a large and powerful gay men's health movement neither crisis-driven nor reliant on terror and shame tactics. They lead me to seek others who want to make a long-term commitment to community health and wellness, and to do so using new strategies, new tactics, and new paradigms.

Gay men do not need a new state-of-emergency declared periodically. At the same time, we do not need to pretend that significant health challenges do not threaten some of our subcultures. We need a broad, multi-issue gay men's health movement that reaches beyond HIV and values our cultures and our lives while working to strengthen our communities and our cultures over the long haul. We need a movement that will support aggressive research to explore the factors that contribute to some gay men's risk-taking behavior and examine the value we place on sex, health, and our life spans, while refusing to stigmatize us because our priorities may diverge from white, middle-class, heterosexual norms. We need a movement that recognizes not only our risk-taking and transgression, but also our creativity, determination, and resilience in the face of adversity.

Is Social Marketing Prevention or Colonization?

Might the methods used for HIV prevention drive, rather than quell, new infections and other health challenges facing gay men?

The overarching terrain of gay men's sex—our desires, sexual subcultures, and sex itself—was profoundly traumatized by the advent of AIDS in the 1980s. Having struggled during the 1970s to achieve some degree of community self-determination and individual empowerment around sex, the arrival of AIDS shattered much that we had gained. It was as if a bomb had been dropped in the early 1980s and ground zero was gay men's sex.

Over the past quarter century, we have suffered nothing less than the colonization of our bodies and desires by a well-intentioned HIV prevention industry. We have been 'educated' to death. Under the rubric of "safer-sex education," we've been told what to do and what not to do, shamed and guilt-tripped incessantly. We have been messaged and marketed to a million times. We have been directed, instructed, commanded, suggested to, harangued, and manipulated—all by people who believe that if you tell people repeatedly what to do or not to do with their sex, they will comply.

I once felt this way. Now I don't. Today I wonder what nearly 25 years of messaging has done to gay men's ability to enjoy their bodies and erotic lives and maintain sexual health and functionality.

I think about prevention activities that have become accepted "best practice" in gay men's communities: people standing outside bars offering condoms, ads saying "use a condom every time," taglines on computer profiles reminding us to "play safe!," agreements we sign at sex clubs pledging safe sex only, t-shirts that tell us how to fuck, posters trying to scare us away from substance use, buttons encouraging us to get tested for syphilis.

This attempt to micromanage and control gay men's sex lives by HIV prevention specialists has led us to a dangerous place where a minority of gay men turn to substances to escape attempts to regulate, control, and direct our desires. We can all agree that crystal meth is often destructive, but we need a more nuanced understanding of what draws men to crystal in the first place. We must avoid simplistically accepted notions of "low self-esteem" or "homophobia" as the itch crystal is scratching, or as the engines driving men to fuck without condoms, or use steroids, or drink too much, or use tobacco.

AIDS prevention campaigns targeting gay men (whether it's "use a condom every time" or "HIV stops with me" or anything else) and the complicated, sometimes counterintuitive effects they have on our desires may be contributing to crystal use, unprotected sex, and, new infections. The more forbidden we make these activities, the more desirable they might seem to the sexual imagination. Has the massive use of social marketing as the primary tool in HIV education and prevention caused a condom backlash among some? While social marketing might be useful for the simple presentation of non-directive information, such as basic information about how infection might occur, HIV prevention for gay men has almost never been non-directive. Instead social marketing has become the primary way well-intentioned public health leaders have attempted to control the bodies and desires of gay men.

I think more than anything we need a few years of "time out" from directive AIDS prevention work for gay men. Foisting a constant cycle of crisis and terror on gay men trying to go about their daily living is part of what drives substance abuse, sexual disempowerment, depression, and other mental health challenges.

I think gay men need time out, time on our own, to heal, to discover, and to return to a place where our sex and desires and bodies are things of joy and excitement, pleasure and intense spiritual connection; where sex is celebration rather than compulsion.

Can We Finally Tackle the Real Issues Affecting Gay Men's Sexual Health?

When will prevention efforts begin to tackle the big-picture issues that drive HIV infections among gay men? We know that all social problems can be addressed in one of two ways: (1) we can attack them in a state of crisis; use guilt, shame, and just-say-no tactics, and hope they diminish; or (2) we can look at the root causes that drive the social problem. Feminists have long argued that eliminating violence against women demands a transformation of power dynamics between men and women, a change in the economic dependence of many women on their boyfriends or husbands, and an examination of that romance and martyrdom inculcated in girls through popular culture, country-music songs, and gender organization in K-12 schools. If gay men are similarly to address deeply rooted challenges like HIV infection (or smoking rates or domestic violence), we too will need to go beyond the state-of-emergency model to look at the community and cultural contexts that support and fuel these challenges.

Certainly some gay men respond to crisis-driven approaches to HIV prevention by practicing safe sex most or all of the time. I believe these are mostly middle-class, middle-aged, educated, white gay men who operate primarily out of their intellects and truly make rational choices about what they do with their bodies. I think many researchers and service providers fit into this group. To me, these people show an extraordinary ability to avoid health risks that most of us regularly embrace: they choose brown rice over French fries; they never use illicit drugs or drink and drive; their few vices are indulged with moderation.

Most people do not share this select group's ability to minimize health risks consistently in their everyday lives. While aware of the range of hazards involved in sex, drug and tobacco use, dietary indulgences, and speeding in automobiles, risk itself is not the overarching factor that guides most people's social practices. These activities offer pleasures and meanings that many health experts ignore, deny, or minimize. Most of us engage in activities which have a risky edge not because we hate ourselves, are stupid, or seek harm. Humans—by and large—are not guided primarily by the intellect. We do these things because they add something to our lives that we really want—that we truly value.

Instead of bemoaning the failures of young gay men and gay men of color to not follow use-a-condom-every-time dictates, prevention leaders must accept that, for many gay men, HIV risk is no longer the primary factor informing the anal sex practices of gay men. A more complex look at the pleasures and meanings men experience from anal sex might suggest new prevention pathways.

What's keeping us from asking some of the difficult questions about anal sex, the primary mode of HIV transmission among U.S. gay men? After all, if we're trying to reduce HIV transmission among gay men, we're primarily talking about altering our relationship to butt sex. Whether we're using HIV prevention funds to run hot advertising campaigns, organize gay bowling tournaments, present a sexual health fair, or diminish gay men's alienation and isolation, what we're really hoping for is a change in the ways gay men fuck one another. So rather than establish more coffee houses for queer youth or hold more forums on crystal use, let's make a commitment to understanding anal sex in more complex ways. It might feel great to fuck or get fucked, but any sexual thrill is ultimately about much more than simple physical pleasure. And in the United States, we know so little about what anal sex means to gay men, how we develop the desire to fuck or get fucked, and why many men find semen exchange to be the most valuable part of this sex act. Let's begin to explore some core questions about anal sex between men.

First, how much of gay men's drive towards anal sex is related to our complicated relationship to masculinity? Few researchers have wanted to open this Pandora's Box, but I'd

argue that a population of men who either grew up being persecuted for not fulfilling proper gender roles, or as adults are considered to be "not real men," carries with it an intense need to come to some kind of peace with masculine ideals. For many men, sex is a place where we play out a range of gender issues. Do we feel more traditionally manly when we fuck a guy good and hard? When we enjoy another man penetrating us deeply and powerfully? Does climaxing inside a man's butt—skin-to-skin—satisfy a need to feel like a "real man"? In what ways does anal sex satisfy some men's need to experience masculinity in a way that mutual masturbation or oral sex does not? Since gender plays out differently in different ethnic cultures, what is the relationship between white, Black, and Latino masculinities and the practice of anal penetration?

Second, how many of us are sexually turned on by cozy romantic moments and sweet, gentle men and how many of us are aroused by activities, partners, and articles of apparel that seem transgressive? What role does the forbidden play in the erotic impulses of a population that embraces an identity (loving other men) that is itself transgressive? How successful have we been as a community at eroticizing condoms or mutual masturbation? Why do the best selling gay porn videos and magazines feature police officers, truck drivers, and muscle-bound athletes, rather than male nurses, accountants, and modern dancers? How much demand is there for videos exhibiting only masturbation activities, compared to those capturing butt fucking, with or without condoms? Until health promotion workers come to grips with the powerful role that transgression plays in the sexual imaginations—and sexual practices—of many gay men, they will continue to naively inspire new and taboo desires for precisely those activities that carry risk. I might not have even been thinking about eating a cookie, but once you tell me to keep my hands out of the cookie jar, all of a sudden, I'm overwhelmed with a desire for that chocolate chip wafer.

Third, it may be time to confront head-on the generational component to anal sex among men. Several studies have turned up a problematic finding: a large portion of the infections occurring in gay men under the age of 25 may well be a product of sex with older gay men who are seropositive, including many middle-age men. What's this about? Because of social taboos surrounding sex between people of different generations, we have very little research about the interpersonal dynamics and sexual negotiations that occur between adults of different ages. While we know that gay male cultures—like mainstream cultures—are socially segregated by generations, we also know that numerous sex cultures offer opportunities for erotic contact that cuts across generations. How can gay communities that have yet to critically examine the daddy/boy dynamic (inside and outside of the leather scene), the ageism visited upon young, old, and middle-age gay men, and the powerful age-based attractions and revulsions that weave their way into our desires, tackle sexual health and sexual risk between men of different generations? And how can we do this in a helpful and analytical way, rather than in a judgmental and divisive manner?

This final point seems key, as gay men remain in the midst of an ugly and divisive sexual civil war that's raged for the past five years—through the debates on circuit parties, sex panics, barebacking, and now crystal meth. Horizontal hostility and personal bullying among gay male activists, organizers, journalists, and public officials are approaching an all-time high. Shame and disapprobation are being marshaled big-time as gay men point the finger at one another's sexual practices and erotic fantasies. The Radical Right doesn't have to take the time to entrap gay men, expose our sexual practices and kinky web sites: we are doing that work for them!

I believe many gay men hunger for an alternative and healing vision of gay community, vastly different from what exists currently in the queer public sphere. While creating a community that embraces health and wellness seems critical to all of us, during a time when queer community sites, public sex spaces, and bookstores and publishers focused on gay literature are evaporating in a shifting economy dominated by corporate and real estate interests, it sometimes seems as if the very foundation of community life has been stolen out from under us.

Gay men building the gay men's health movement are motivated by continuing concern about HIV/AIDS, but also additional health challenges, such as mental health, addiction, cancer, and heart disease. We embrace a big-tent vision of the community, founded on our belief that healthy people emerge from a healthy community context and that HIV transmission will diminish as community wellness increases. Hence we aim to build a multi-racial, multi-issue movement that favors long-term solutions over quick fixes, brotherhood over violence, and a focus on the assets of our communities rather than our deficits.

Continuing to focus narrowly on HIV transmission will not work in a world in which reasonable gay men understand AIDS very differently than we did two decades ago. But creating powerful broadly based gay men's health promotion activities ultimately will impact HIV transmission.

Not only has what it means to harbor HIV changed radically in the past two decades, but what it means to be gay, to be a man, to be African-American, to be young—all have shifted dramatically. Continuing to employ crisis-moment tactics during an era when most reasonable gay men experience HIV as awful, but not the end of the world, will prove increasingly ineffective as time passes. Let's roll up our sleeves and address gay men's health in a long-term, sustained, and thoughtful way.

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CHAPTER 2

BUILDING A MOVEMENT FOR SEXUAL FREEDOM DURING A SEX PANIC

This address was delivered at the Second Annual Summit to Resist Attacks on Gay Men's Sexual Civil Liberties, November 13, 1998, in Pittsburgh, Pennsylvania

One year ago in San Diego, over a hundred activists came together to organize a visible resistance to what we'd experienced as an emerging puritanical gay male consensus about sex and morality. Three key forces were the engines behind the meeting: (1) the repeated failure of most national and local gay groups to consider sex and sexual freedom as a central part of their agenda; (2) a rising anti-sex fervor in newspaper articles and books written by self-identified gay men; (3) a growing response to continuing HIV infections among gay men by many AIDS organizations and gay leaders marked by an acceleration of strategies heavily dependent on moralizing, hysteria, and shame.

We called our meeting the National Sex Panic Summit and that weekend we made valuable connections, grappled with key theoretical questions, and educated ourselves about the history of moral panics during this century. Isolated organizers working in different parts of the nation met new comrades. We debated the distinction between ongoing patterns of harassment and an escalating moral panic. We spent endless hours drafting and debating a document called "A Declaration of Sexual Rights" linking the history of our movements with the current attacks on sexual self-determination. In short, we did organizing work: the good, hard, grunt work required to define an issue, ignite activism, and begin to chart out an agenda.

We did this work under stressful conditions. The National Gay and Lesbian Task Force appeared embarrassed by our presence and its leaders trivialized our concerns. A number of mainstream gay and lesbian activists accused us of undercutting efforts to achieve gay marriage, protect the rights of gays in the military, and promote a portrait of gay men as repentant and chaste. A few leading progressive organizers saw our work as simply a patriarchal attempt to win more sexual privilege for men and understood our efforts as about dick-dick-and-only-dick rather than about social change and human freedom.

The Backlash of 1997

None of us were prepared for the backlash we would face in the weeks and months following the summit. Our modest organizing efforts became the focus of news stories, editorials, and opinion pieces which misrepresented who we were, mischaracterized our work of the weekend, and willfully misled the public about our politics and our vision. The lead organizer of the summit, Tony Valenzuela, was pilloried in the local and national press and positioned as our summit's sacrificial lamb. In an action reminiscent of those of the McCarthy period, the president of the Log Cabin Republicans issued a very public call demanding that every national gay organization publicly distance itself from our summit and denounce our efforts. Our small gathering became the focus of the lead news story in the *New York Times* section "The Week in Review," where we were mocked and derided as sexual renegades, diseased pariahs, and a throwback to the 1960s.

I understood the backlash in two primary ways. First, we'd committed heresy. By daring at the public level to value sex, pleasure, and the benefits which emerge from our sexual cultures—and to argue that monogamists have no corner on the market on ethics, values, or morality—we broke ranks with the gay rights movement's primary strategy of assimiliationist politics. We showed it for what it really is: a bankrupt, Faustian bargain which displaces authentic human rights with a narrow package of concessions, a politics which privileges cultural conformity over cultural pluralism and affirms the status quo over the status queer.

The second way I understood the backlash was that we had hit a nerve, pushed a button, unleashed a fury which Freud might call the "return of the repressed." By discussing sex openly and explicitly, and by publicly discussing anal sex as a valuable, meaningful act for many gay men, we shattered a powerful taboo which had taken root during the crisis years of the AIDS epidemic. We'd become accustomed to expecting fags to maintain a public silence about the wide discrepancy between the ways many AIDS groups publicly represented gay men's sex lives, and what we knew was really occurring in gay communities throughout the nation. To hear a young man talk about getting fucked and taking semen up his butt—without the usual expressions of horror, regret, or "I've learned my lesson!"—was more than many people could stand. We shattered the silence and punctured a lie that was the foundation upon

which so many people constructed their public identities as "respectable" gay men during this gay rights era. By standing as examples of gay men who appear before the public unapologetically as neither members of monogamous gay couples nor de-sexed celibates sacrificing personal lives to the demands of community work, we achieved a bad-boy status among those who continue to grovel before a community self-image as the best little boys in the world.

Hence last year's sex summit achieved what we set out to achieve. We met one another and began to share strategies, tactics, and organizing tips. We supported each other personally and professionally to continue our principled work in gay communities even as the social supports for our politics and our visions continued to erode. And, perhaps most importantly, we created an alternative voice within gay male communities, a critical voice of resistance to the demonization of gay men's sex. During an era when many forces discourage those who believe in the power of the erotic as a central component of social change from speaking out, we found a way to assert our vision and our values into the community dialogue.

The Challenges We Face in 1998

We come together this weekend, just one year later, to continue our efforts to transform the position of sex and desire in gay men's communities. I know how difficult this work is today. It was one thing to speak out on behalf of promiscuity or open relationships in 1969 during a cultural moment which valued freedom, personal transformation, and communitarianism; it is quite another thing to do this work just 30 years later, during an era which considers the 1960s a failed experiment and places productivity over pleasure, caution over adventure, the nuclear family over the tribe. Have no illusions: those of us in this room do not share a singular vision, nor do we agree on a range of controversial issues related to our work. But we are here because we have chosen to continue the work of sexual liberation during a time of increasing repression, escalating moral panic, and the return of sexual shame.

My aim for us today and this weekend is three-fold. I want to show those who thought a media-trashing would destroy our efforts and force us underground, that we are here for the long haul and will continue to do the methodical, plodding work of building a resistance to their narrow, misguided agenda. We are not going away. I also want to show that—contrary to what our critics say—many of us do this work out of a commitment to gay men's health. Over half of the collective organizing represented at the summit this year works each day to improve the health and safety of gay men—at AIDS and public health organizations, gay community centers, and gay men's health projects. We believe the use of shame, terror, and punishment as central tools of disease prevention is a key cause of men's alienation from their bodies and desires. We have no doubt that our work at this summit focused on empowerment will contribute to improving the sexual health—and the mental and spiritual health—of gay men.

My final aim for this summit is for us to find a way to break through the barriers that prevent us from successfully organizing our resistance in every part of this country. We must consider seriously the profound roadblocks we face doing this kind of work in the current cultural moment. I want us to share tactics, lessons learned, resources, and bright ideas which will help us create savvy organizing responses and mobilize a mass movement in support of sexual civil liberties and the rights of all people to organize their sex and relationships outside traditional family values.

To achieve these ends, it's important for us to think back over the 12 months since we last convened and assess the state of sex panic facing gay men throughout the nation. I want to highlight critical incidents and what I consider to be the central core issues emerging in 1998 and I want to suggest some lessons we might take away from specific case studies of our organizing efforts. So settle back in your seats and let me take you on a highly subjective tour of the past year.

Four Core Issues

When we last convened, New York City was in the throes of a major effort led by Mayor Giuliani to rid the city of commercial sex businesses. We debated whether New York was experiencing the usual ongoing harassment and crackdowns or whether a sex panic had emerged. Over the past 12 months I believe it is clear that a multi-pronged, and amazingly pernicious attack on sexual freedom has occurred to benefit commercial real estate interests and a smug, moralistic mayor. While New York's Sex Panic group continued to meet and organized several effective actions and public education campaigns, pro-sex forces have faced tremendous barriers, splintered and lost membership at precisely the moment of most urgent need for resistance. Many understandably feel dispirited and pessimistic about the potential to hold the line against the police, zoning boards, media hacks, and politicians. As the situation in New York City continues to intensify, I believe it is appropriately understood as the key urban site of moral panic in the nation today.

The second core issue of the past year involves the moral panic churned up by the media in response to cruisers in bathrooms, parks, and truck stops. To borrow Keith Griffin's analysis, this year over forty television stations and hundreds of newspapers thought a great way to gain viewers during sweeps week was to report 'normal' behavior which has occurred for decades as if it were noteworthy, shocking, and a danger to respectable citizens. Many chose the "sexual predator" angle and insisted they were coming to the defense of innocent children. The leading trade publication for television producers which annually creates a list of hot story ideas fanned the flames by suggesting TV news shows run pieces on public sex in their local areas. These journalistic forays into the "underworld" of men's sex cultures have been an explosive challenge for local organizers.

The third hot issue—and one with which all of us must grapple, however difficult it may be—involves the escalation of attacks on adult men involved in consensual relationships with young men in their teens. I am talking here about 22 year old men imprisoned for having sex with 16 year olds. The homophobic enforcement of age of consent laws have profound ramifications on gay male youths' isolation and identity-formation, and the escalating campaigns against their sex criminalize and demonize a very wide range of people, relationships, and behaviors under the guise of protecting "childhood innocence." In an era in which Megan's Law is used not only to persecute gay men who got busted for bathroom sex 30 years ago, but also non-violent adult men who formed consensual relationships with 16 year old gay-identified youth, we have to recognize that the moral panic facing gay men is not limited to bathroom cruisers, circuit boys, or sex workers. The hysteria surrounding this issue has led to life-time parole or extended sentences for some sex offenders who already have served their time in prison, sweeping new censorship laws, mandatory reporting laws that turn health providers and counselors into arms of the state police, and efforts to perpetually hound sex offenders who had served their prison time out of jobs and housing anywhere in the nation. Because the "save our children" rhetoric is a powerful tactic in a range of sex panics, I believe it is time—perhaps past time—to open dialogue with gay men and others who have been organizing in this important arena.

Finally, we must look at the ways in which the current panic surrounding HIV is leading to repressive measures against sexually-active people with HIV— measures we fought long and hard to defeat just a decade ago. What does it mean, during a moment in which many gay men no longer experience AIDS as a crisis, that communities of color and indigent populations are hit with the passage of laws which gay men successfully resisted a decade ago? A legislative backlash has instituted laws which report the names of people with HIV, notify partners, and imprison people with HIV who engage in unprotected sex. Why are some white gay leaders who led the opposition to such laws a decade ago now the leading advocates for such laws? What are the implications of these new laws for the sexual freedom and civil liberties of people with HIV—including gay men of color with HIV?

Key Successes of 1998

I want to highlight a number of successes we've achieved this year because I believe, as Saul Alinsky frequently insisted, "We need wins." I choose to highlight three efforts here where gay men—through grassroots, collaborative organizing—brought about some key victories which offer lessons for all of us.

First I want to highlight the work of a small group of gay male health workers in Portland, Maine. In March, shortly after the citizens of Maine became the first state to repeal a statewide law protecting people from discrimination on the basis of sexual orientation, the police chief, perhaps sensing an opportunity to strengthen morality codes, put forward a proposal to the city council for an ordinance that would criminalize and crack down on consensual, out-of-view sexual activity— the kind of activities that may occur in a car or a dark corner of a dance club. Savvy activists immediately moved to establish a small, grassroots committee to generate resistance. They spread the word through the community, engaged in intense lobbying and media work, and succeeded in getting this so-called lewd activity ordinance defeated by a vote of 7-2.

What worked here was that local AIDS leaders used the connections garnered through their AIDS work to get public testimony from the former director of the state's health department, key civil rights leaders, and even the grand dame socialite of Portland, a 94 year old blueblood woman who's been a leading volunteer and AIDS philanthropist. What also worked here was that a critical mass of gay men who felt no shame about their sex and the sex cultures of their community pulled together quickly, did the grunt work of organizing, and then celebrated a victory.

The second achievement I want to highlight is the important work done by a small group of health activists at this year's National Lesbian and Gay Health Conference in San Francisco. I was a member of this group and we wanted to create a presence at this key national event. By working collaboratively, paying attention to the details of organizing and marketing, and building bridges to people with whom we agree 80% of the time, rather than making them into "the enemy," we were able to shift the conference discussions about gay men's sex and drug use away from the punitive, just-say-no approach so popular these days among anxious, exhausted health providers, and towards more complicated understandings of issues such as barebacking, muscles, circuit parties, and public sex. We raised the level of public discussion up several huge notches.

Third is the truly impressive work done in Detroit by the Triangle Foundation and its attorneys. By forming an active and aggressive group comprised of lawyers—including former prosecutors—activists, and former victims of entrapment, the group has staged informational outreach programs at rest areas and parks, met with police officials, waged a savvy media campaign to counter the police rhetoric on public sex, and begun to put together ground-breaking legal challenges to entrapment. This energetic and principled group has been able to prevent legislation aimed at censoring the Internet, halt the use of Megan's Law for men entrapped at public sex venues, and put on trial the entrapment practices of the police and the moral panic practices of the media.

What's especially wonderful about the work of the Triangle Foundation is that thanks to the leadership of Jeff Montgomery we are able to witness a mainstream gay organization which, in 1998, has taken on entrapment and sexual civil liberties as a key part of its agenda. What's also impressive here is that people occupying a range of positions which carry some stature and hence some risk—attorneys, executive directors, community organizers—are willing to put themselves on the

line and stand up for what they believe. By forging a working group with a commitment to ending entrapment, I believe the Triangle Foundation offers us a model which should be adapted to local gay male communities throughout the nation to address not only entrapment, but also sex club closures, media moral panics, and the overarching moralizing suffusing our communities.

I also want to flag for you some of my personal heroes and heroic events of the past year because they show how individual gay men—and key community organizations—can make a valuable contribution to our efforts to resist shaming and sexual repression. Here I think of Edmund White, who published a piece in an otherwise awful issue of *The Advocate* which offered no apologies for a lifetime of promiscuity and nailed sex-negative critics for their contradictions, self-delusions, and mendacity. I think of Michael Bronski, whose new book *The Pleasure Principle* cuts to the heart of our culture's sexual repression and should be required reading for all activists for sexual freedom.

I want to applaud the new leadership of *OUT* magazine for bringing onboard Dan Savage and Pat Califia, two social critics who write about sex shamelessly and in all its complexity. I also want to affirm the work of HIV prevention workers at Gay Men's Health Crisis in New York who have withstood repeated attacks by a local gay paper aiming to replace their harm reduction approach to gay men's sex and drug use with simple-minded shaming and downright dumb social marketing campaigns. I also want to highlight the work of a group of Boston-area educators, health activists, criminal justice workers, and organizers who have crafted a thoughtful and powerful statement called "A Call To Safeguard Our Children and Our Liberties," which begins to tackle the 'Save Our Children' construct and confront the real challenges facing children and youth in our nation.

Finally I want to highlight my celebrity hero of the year, George Michael, who responded to his very public entrapment by not only coming out of the closet (finally!) as a gay man, but by appearing on television talk shows unashamed and unrepentant, and for producing a new single and a video titled "Outside," which is a powerful statement affirming sexual freedom and denouncing police repression.

Dangerous Trends

Perhaps it would be useful to point out two other dangerous trends which we've faced this year. First I want to highlight the continuing challenge we face working on sex issues not only with the mainstream media, but with the queer press as well. *The Advocate* continues to lead the way, sensationalizing gay men's sex to sell papers, and encouraging readers to link public sex, fetishism, and multipartnerism with danger, disgrace, and disaster. They are not alone.

Yet the winner in this year's contest for most horrifying commentary in the gay press must go to columnist Jennifer Vanasco, who used the suicide of a gay man in Arkansas after he'd been outed in the local paper for public sex to express her "happiness" that such men get busted, applaud the use of shame and disgrace as methods of policing, and blame the victim for his own demise. Showing no knowledge of the long history of such suicides or the unequal enforcement of public sex codes, and no empathy for the dead man, Vanasco reached her lowest point when she insisted, "Lesbians should get a big chuckle out of the idea that these men have sex in public because they're oppressed," and attempted to create a wedge between lesbians and gay men.

The second dangerous trend is the rise of sexual McCarthyism we've witnessed this year. This is a complicated matter, one which is linked to Kenneth Starr's public release of grand jury documents about the President to the media. I use the term "Sexual McCarthyism" as sort of a dangerously misguided extension of "outing." In this case, you don't out someone's sexual orientation, you out their sexual interests, activities, or desires. Just a month ago, a New Hampshire paper linked a state Democratic leader in a legislative race to defeat an incumbent Republican to a gay organization which sponsors "leather nights" and "rubber orgies." The paper attempted to defeat Rick Trombly by portraying what they suggested were his "quaint homosexual fetishes." In this case, it didn't work: with 94% of the vote in, Trombly was ahead of his opponent with 52 to 48% of the vote, and I believe he won the race. No suicide, no disgrace, no defeat.

In Lawrence, Massachusetts, a local paper outed a member of the city's school board for engaging in Internet searches for a three-way with his girlfriend. He was forced to resign his post. This is Sexual McCarthyism. On hearing that a gay male watersports club was planning a Palm Springs weekend of parties, local officials in Cathedral City unsuccessfully attempted to ban the Waterboys from their area. This is another form of Sexual McCarthyism.

Activists for sexual freedom might argue that if sexual diversity is good, what's wrong with outing an individual's fantasies, sexual practices and kinks? Perhaps we should all walk around with our desires printed in black marker on our forehead? Perhaps it's okay to "out" the practices of our opponents? One sex activist in San Francisco sent a public letter to newspapers and zapped it out over the Internet after he saw a city official who'd opposed the opening of a bathhouse in San Francisco at a local porn theater. When I visited Provincetown this summer, tongues were abuzz because a popular writer who embraces marriage and neo-conservative morality supposedly had spent his vacation in leather bars and at the Dick Dock. When a Board member at GMHC died recently, a local gay paper found it useful public health strategy to expose that he had died of a drug overdose, not AIDS, and use his particular circumstances to undermine the organization's credibility and deride their work.

These are complicated matters. I don't pretend there are easy answers here. But I do fear that our organizing efforts will be hurt rather than helped if we feed into the frenzy to expose, embarrass, and publicly disgrace people on the basis of their

sex lives. People on "our side" of these issues love to gossip about the supposed sex lives and imagined or real contradictions of those with whom we disagree. When I'm exhausted by these sex debates within our communities, I sometimes want to enumerate which lesbian activists cheat on their lovers, which executive directors love to be tied up, and which gay male public officials fetishize specific body parts, races, or articles of clothing. But I resist this urge to use the tactics of the Right to further our progressive agenda, because at night, when I go to sleep, I have to face myself and be accountable for the tactics I've used. And ultimately, I want to celebrate all of our sex—from vanilla to kink—and not demonize specific interests and acts as part of a narrow, short-sighted agenda.

Rather than respect our opponents' rights to their opinion and tackle their thinking head on, some of us mock their ambiguities and have no empathy for any conflicts they might have. I cite this here because I believe that Sexual McCarthyism is escalating and that those who stand to lose the most are those with transgressive desires. I encourage us to resist the urge to use such tactics. I trust that those who disagree with us do so primarily out of their intellectual position.

Why Is Organizing So Difficult?

There is much we can learn from less-than-successful efforts of the past year which force many of us to confront precisely how difficult it is to organize a resistance to attacks on sex and sexual cultures. It is important to realize how tough it is to do any kind of grassroots organizing these days on any issue outside the mainstream. Many of us like the identity of being community organizers but when the grunt work gets tiresome, when the conflicts between individuals get ugly, when racism, classism, and sexism divide us and leave us enraged and dispirited, many of us would rather stay home and watch *Ally McBeal* or *South Park*. So we retreat into roles as journalists, health workers, nonprofit managers, public officials, business people, and tell ourselves we're still doing activist work.

There are many ways to contribute to social change, but there is a difference between grassroots organizing and writing a book. There is a difference between being an organizer and being a city councilor. I want to be a voice affirming the value and heroism of long-term commitment to democratic processes of community organizing. We may hate the endless meetings, be sick of licking envelopes, feel frustrated working across different identities and political visions, and be drained by community cannibalism, but we've got to continue doing the work. When the going gets tough, true organizers find a way to keep going. No one will give you rewards for your work, but social change cannot happen without old-time grassroots community organizing.

There is a particular challenge these days organizing around sex. Because of the rise of Sexual McCarthyism—inside and outside gay communities—the stigma of speaking out, defending principles, or participating at meetings like our summit, is more than many people can bear. For some it's a matter of risk and cutting their losses. We all have to consider ways in which defending buttfucking or sex in parks sits alongside our current employment and our future job prospects. While I want to be a voice urging us to be bold, I also want justice-minded people to approach this work with open eyes and I trust each of us to decide what kinds of risks we can take. While we need to gently push each other to be courageous, we also need to withhold our judgments and accept that a range of legitimate factors keeps many people from participating in this work. We must take this into account in our organizing.

For some, the primary barrier to speaking out and organizing around sex issues is a five letter word: shame. Many people believe their desires are wrong, their turn-ons are sick, and the way in which they organize their sex is shameful. You might love sucking dick through a glory hole or spending hours in the AOL dungeon chat room, but not only do you not want anyone to know about it, but you won't ever take steps to fight for your right to continue to enjoy these activities. Just as the shame about being gay limited our movement in the 1970s to a handful of people willing to openly own their gay and lesbian identities, shame about getting fucked, licking boots, or good old vanilla promiscuity limits participation in efforts to support sexual freedom.

A final major challenge to this work that I want to cite is the difficulty of conveying messages about sexual liberation to a hostile media and a public—which increasingly includes a queer public—which hears of our work and thinks, "What planet are they on?" During an era where the Right has so successfully undermined and redefined concepts of liberty, freedom, and democracy, and the Left has run from issues of the body, desire, and sex, how do we frame our arguments in language which is neither esoteric nor trite? When sex has been so devalued and so demonized that placing the word "sex" alongside "freedom," makes many people smirk, how do we articulate our beliefs that promiscuity may be as moral as monogamy, that the right to choose an open relationship may be as ethical as choosing celibacy?

A Strategy for 1999

The current cultural moment is ripe for our organizing efforts. Our work will be neither easy nor simple, but the public debates about the President's sex life have taught me a great deal about the American public's views of sex. I argue that the fact that the public has continued to support the President despite powerful attempts by Kenneth Starr, Newt Gingrich, and the mainstream media to discredit and shame him, has everything to do with our work of gay liberation of the past 25 years. We have been in the vanguard of insisting that people's right to hold jobs is independent of the way they organize their sex and relationships. We have argued that this separation is key to democracy and pluralism. While it is clear that the media has never embraced this position, I believe we've been heard by the public in a major way. This gives me hope.

Our work will not be easy. I find it ironic that Het Amerika may be becoming more open-minded on certain sex issues—and that the public clearly understands that marriage and sex are often complicated, untidy matters—just as gay communities are becoming increasingly narrow-minded. Alan Wolfe's recent sociological report on middle-class morality shows that an influential sector of the public is liberal and tolerant about all populations *except* lesbians and gay men. They believe sex is inherently dangerous, volatile and best kept private. This leads Wolfe to advocate for the de-sexing of homosexuality and spurs forward a Human Rights Campaign vision of gay people who prioritize faith and family over the alternative forms of organizing sex and kinship, which are where most gay men live their lives. Our biggest challenge is finding a way to make sure groups which often were founded and built by transgressive queers—groups like GLAAD, and the National Gay and Lesbian Task Force, and Lambda Legal Defense, and local gay and AIDS organizations—continue to do some small amount of work which is risky, outside-the-box, and beyond-the-safe-and-status quo.

I want to close this talk by suggesting directions for our organizing over the next year. First, creating a coalition of all of the different groups facing the threat of a moral panic over sex seems important to me. We must continue our internal efforts focused on gay men's communities, but we need to link up with allies organizing sex workers, pornographers, sado-masochists, and others, as well as those working for sexual and reproductive freedom for women. I believe next year's summit might best be conceived as a broad-based coalition effort where we play one small part. With this in mind, I offer two suggestions for our own continuing efforts. First, we must find a way to overcome or resolve powerful divisions within our group concerning entering coalition work with gay men organizing around intergenerational relationships. Second, we must examine why our efforts and our participation are so white, and how racism and whiteness together shape what we prioritize and with whom we work.

Next, I recommend that we become involved in local efforts building towards the 50 state gay-rights marches next spring and that we use these efforts as a way to create networks of activists who are working towards sexual freedom. At the very least, these marches must make the repeal of sodomy laws a top demand. We might use these marches to meet colleagues sharing a similar vision, or inject into the march some pro-sex visibility.

Third, I believe that the work they've done in Detroit organizing an ongoing strategy and response group focused on entrapment and preserving gay men's sexual civil liberties should be replicated in every part of this country. During our work this weekend, I urge you to seek out folks from the Triangle Foundation, learn how they organized their resistance efforts, and consider folks in your hometown who might want to contribute to a similar ongoing effort in your area. I'd like to meet again a year from now and hear that there are at least a dozen "entrapment action groups" or similar efforts in different parts of the country.

Finally, I want to encourage our work over the next year to continue to highlight prominently the linkage we see between sexual liberation, public health, and social change. Over the past 20 years I've worked on a range of gay men's health issues. I've written a book on gay people and suicide, directed a multi-purpose gay health center, led AIDS organizing efforts, and founded programs for gay youth. In every case, the repression of sexuality through guilt, shame, moralizing, and terror has been a major barrier to health promotion. There is no need to create a false opposition between health and freedom, sex and the spirit. Nor is there any need to pretend that sexual cultures do not face their own specific health challenges. Yet to allow those advocating for the displacement of sex from a central position in gay cultures to represent themselves as health-minded and us as disease-promotion is not only wrong, it is dangerous. Let our work this weekend continue to integrate a commitment to democratic freedoms, social change, and sexual health.

CHAPTER 3

CHALLENGES TO FORMING A GAY MEN'S HEALTH MOVEMENT

The challenges of gay men's health are clear. Throughout the nation, groups of public health officials, AIDS prevention organizers, and journalists seem surprised at the rise of barebacking subcultures, vexed by crystal use, and disheartened by rises in rates of sexually transmitted diseases among gay men. Yet they're at a loss: These professionals, formed by AIDS and HIV work, cannot face the fact that that the collective gay male psyche has moved irrevocably beyond the crisis moment, and they continue to resist the arrival of a new model of health work that goes beyond the "use-a-condom-every-time" mantra.

Ordinary gay men may be hungry for innovative ideas to appear, but the closed system of HIV work—the collusion between researchers, service providers, public health departments, and journalists—presents a formidable barrier both to new thinking about HIV and to broader discussions of gay men's health. When an entrenched and institutionalized system holds captive public discussion in any particular field, it is nearly impossible to introduce new thinking and new paradigms and have them take hold. While most public officials, gay journalists, HIV workers, and academic researchers likely do not see themselves as part of a closed system, the conferences they attend, forums they organize, grant proposals and news stories they write are dominated by a narrow view of history and a limited vision of what needs to occur. Cognitive psychological approaches to HIV prevention and the medical model exclude almost all other approaches.

I've had many rich conversations with people who have exited the field of HIV work and, after a year or two, find their eyes opening and mind clearing to allow for new ways of understanding the challenges we face. While people are all in the thick of it, they seem unaware of the profound power that institutions and bureaucracies have to control the ways we understand our objectives and articulate our work. Powerful forces narrow our thinking, restrict our options, and reduce the possibilities for diverse actions.

What does it mean that very few of the people doing the work of HIV prevention among gay men actually have the time to read books, articles, and scholarly research in the field? I ask this after visiting countless prevention organizations and gay men's health projects over the past decade and asking the people doing the work, those creating the campaigns, writing the brochures, and counseling the gay men, about their current reading in the field. How do they stay abreast of the field's latest developments? Overwhelmingly I have heard one version or another of "I don't have time to read." When I probe more deeply, I hear about how the structure of organizational life, the nature of work tasks, and the organization of time ensures that there is little time devoted to reading, analysis, and probing discussion of the understandings and assumptions that underlie HIV prevention work with gay men today. Time and time again I hear how staff meetings are places where administrative business and campaign coordination take place, and that little or no time is devoted to probing discussion of the field.

This was brought home to me most powerfully when I was interviewed by a person who had recently assumed a position of national leadership focused on HIV prevention. While I was flattered he had traveled to San Francisco, in part, to meet with me and hear my perspectives, I was first surprised and then annoyed that he had not read any of my writings on prevention that I have produced over the past 20 years. Feeling a bit embarrassed at my self-centered assumption that he would have done so before visiting me, I asked about other writers on HIV and gay men: Gabriel Rotello, Hector Carrillo, Raphael Diaz, John Peterson, George Ayala, Walt Odets, Chris Bartlett, Gary Dowsett, Peter Keogh, Michael Hurley, Ralph Bolton, Ron Stall and Kane Race.

Some of the names brought grunts of recognition, but most did not. At best, this man, now in a major position of authority and able to influence the creation of future generations of HIV prevention work, had read newspaper interviews with some of these writers or op-ed articles in the gay media.

I don't understand how people think they can take responsibility for this critically important and highly sensitive work—influencing gay men's psyches, sexualities, and bodies—without immersing themselves in the rich field of research, theory, and analysis that now exists. We wouldn't allow someone to take on the task of ensuring the reliability of airplane engines without a thorough immersion in the field, yet the bulk of

people working in HIV prevention—including many of the leaders of HIV prevention programs—don't have time to read, think, analyze, and probe.

In part, this explains the situation we find ourselves in today. Caught in a narrow preoccupation with one specific threat, and locked into an epidemic moment that no longer exists, community-based organizations and public officials have lost sight of any bigger picture. Thus it should surprise no one that, in most parts of the country, no one is watching out for the overall mental, physical, social and spiritual wellness of gay men. Local government task forces monitor gay men's rate of HIV infection, but, beyond that, no one feels responsible for the broad health and wellness of our communities. This leaves many of us hungry for bold leadership to emerge on gay men's health, broadly defined. We're starving for projects that address our bodies and our spirits as whole persons attempting to navigate through the broad range of contemporary challenges.

The most effective moment in our effort against AIDS came when we faced similar chaos at the start of the epidemic. When the powers charged with protecting public health initially offered, at best, ambivalent support and lukewarm leadership, we rolled up our sleeves and hunkered down to the work of taking care of our own. This was a time before there was a mass professional class of openly gay physicians, psychologists, social workers, researchers, and public health workers. Grassroots gay activists, MCC ministers, directors of gay men's choruses, and organizers of gay sporting leagues led the work at this time. Gay shopkeepers became AIDS educators; lesbian political leaders sat on the early AIDS task forces; managers of discos, leather bars, and gay restaurants worked with the few openly gay health workers in their cities to craft the first prevention brochures.

The disco anthem of the period, "Sisters Are Doin' It For Themselves," resonated with gay men of that era. It's time we dance to that tune again. A new generation of leadership must emerge to provide a balanced sense of urgency to the contemporary conditions of gay men's lives. The time is ripe for a gay men's health movement to arise out of the charred embers of our community's AIDS moment. Essentially, we must replicate for gay men's health precisely the community-based AIDS response we generated between 1981 and 1986. This movement must be powerful, rooted in our many subcultures and different communities, and willing to work independently of the formal public health structures of the nation.

Critical Gaps Beyond HIV

After two and a half decades of building an AIDS infrastructure to address a crisis of enormous scale, now that the collective consciousness of gay men's communities is no longer transfixed on that horror, with what are we left? We certainly need a regenerated AIDS movement to continue the hard work ahead for all affected populations. Yet a cursory glance at the gay geography of most parts of our nation reveals some critical gaps:

- In almost all cities, counties, and states no organization, institution, or group of leaders has taken meaningful responsibility for overseeing the overall health and wellness of gay men; public health departments don't do it, HIV offices don't do it, gay health clinics don't do it, and gay political leaders don't do it.
- A comprehensive plan for improving gay men's health does not exist in any area, to my knowledge, nor does any entity feel responsible for creating such a plan, organizing accompanying wellness efforts, and monitoring their progress.
- We have thousands of community-based organizations focused on HIV/AIDS but one could count on two hands the number of freestanding comprehensive gay men's health projects that exist. We have hundreds of groups with names like "Stop AIDS," but very few organizations operating under a "gay men's health project" banner. And most of the groups that have moved towards a "gay men's health rhetoric" remain focused narrowly on HIV.
- While in most urban centers numerous groups work on a specific aspect of gay men's health (mental health, violence, sexually transmitted diseases, HIV/AIDS, addiction recovery), these organizations usually lack meaningful coordination and rarely have provided activist leadership on health issues; they tackle a piece of the challenge, but in uncoordinated ways and without an overarching understanding of community health and wellness.
- In most parts of the nation, several official governmental bodies are charged with overseeing HIV/AIDS prevention, services, and housing; I am not aware of a single public body anywhere in the U.S. that is charged specifically with overseeing the health and wellness of gay men.
- In the wake of a catastrophe as powerful as any earthquake that has hit a major metropolis, there has been no formal discussion of rebuilding our gay male communities in the wake of AIDS and no strategic planning has taken place that has thoughtfully considered the revival and redevelopment of gay men's cultures. In 1987, we held a national "War Conference" to refine our strategies and accelerate our efforts against AIDS; at this time, we would benefit from a national summit focused on redeveloping gay male community structures, rituals, networks, and organizations.
- The hundreds of gay political clubs in the nation have exerted little leadership on gay men's health—or LGBT health in general, for that matter—often equating gay men's health with HIV/AIDS; they have rarely been a

force encouraging the planned, strategic redevelopment of gay men's communities.

Some parts of the country *are* moving boldly into this new phase of health work. Gay men's health projects have begun to sprout up in places as diverse as Philadelphia, Key West, Boulder, Minneapolis, and Salt Lake City. Massachusetts's Public Health Department spearheaded needs assessments of gay men, created targeted planning processes, and created public bodies and community-based efforts to improve gay men's wellness. Visionary summits aimed at comprehensive gay men's health issues have occurred in Hartford, Phoenix, rural Maine, Georgia, Delaware, and a dozen other parts of the country.

What Is To Be Done?

It's time for ordinary gay men throughout the nation to create local gay men's health movements that strategically emphasize our diversity, respect our subcultures, prize our history and traditions, and refuse to pathologize homosexual identity, practices, or desires. We might do what we did two decades ago and create innovative efforts—informal, community-based task forces and projects outside the formal structures of government or public health oversight—to respond to the contemporary conditions facing gay men at this time. To suggest a few efforts worth consideration, we might launch savvy grassroots efforts focused on crystal use and other party drugs, harm reduction planning for barebackers, and the challenges of aging facing the nation's surviving gay male populace.

At the same time, we might insert into public discussions an intense dialogue about gay men's holistic health and ask candidates for public office to demonstrate knowledge of the panoply of gay men's health needs and stand prepared eventually to provide resources for our efforts. In particular, activists throughout the nation should:

- Form a representative body that takes responsibility for overseeing the health and wellness of gay men of all colors and generations in their city, county, state, or region.
- Create a ten-year plan focused on gay men's health, organize a range of efforts suggested by the plan, enumerate specific benchmarks and goals, and monitor progress on an ongoing basis.
- Establish free-standing, storefront gay men's health projects that provide non-patronizing, non-judgmental sources of information and support from volunteers within our communities; these projects should be focused on specific neighborhoods, racial/ethnic populations, and sexual subcultures, rather than on specific diseases or health challenges.
- Initiate the formation of a body charged with coordinating existing gay male health services in a way that is meaningful to potential consumers of services.
- Demand that political organizations which purport to represent us continue to prioritize HIV/AIDS but expand their notion of gay men's health to new areas.
- Meet regularly with journalists and impress upon them the importance of creating knowledgeable reporting on gay men's health issues that is savvy, smart, and independent of both public health authorities and gay men's health organizations.
- Organize a visionary community-based planning effort aimed at reviving and rebuilding gay male community amidst a changing HIV epidemic.

These efforts might have been initiated in urban centers like New York and San Francisco ten years ago, once it was apparent that the collective mindset of the gay male populace had moved beyond the AIDS crisis phase. If they had been, community health leaders might now feel more able to work effectively in an equitable partnership with the masses of gay men who participate in those cities' subcultures and nightlife. If the collective brain-trust of the nation's health leadership is disheartened by the barebacking parties, surprised by syphilis cases linked to Internet chatrooms, and discouraged by crystal use, they might understand that our failure to create a broad agenda for gay men's community-building and health promotion has left us vulnerable to a range of health hazards.

Having noted no formal, mass effort to revive community life after our urban gay village was decimated, gay men have done just what we did before AIDS, what we did before Stonewall: create our own identities, rituals, and subcultures underground, launch new venues and new aesthetics, and forge lives that offer us pleasure, meaning, and fulfillment. We could have done this in partnership with health experts; researchers who had been knowledgeable about gay men's dance cultures, substance use, and sexual scripts *could* have influenced the developing circuit party scene or the bareback subcultures in the early 1990s. Instead, locked into a 1985 mindset, researchers and public health workers largely missed out on that opportunity.

It's time that a new generation of visionary, health-minded leaders emerge to work with the masses of gay men in our nation in tackling the formidable tasks ahead.

CHAPTER 4

WHY A GAY MEN'S HEALTH MOVEMENT?

In 1999, I was part of a four-person collective which convened a pioneering national event focused on gay men's health. "The National Gay Men's Health Summit: Building a Multi-Issue, Multicultural Gay Men's Health Movement" brought over 300 people from all over the United States, as well as from Canada, Denmark, and Australia, to a retreat hotel in Boulder, Colorado. While conceptualized as a one-time event, the summit quickly grew into a biannual event that serves as an incubator for new thinking and innovative programming focused on a new generation of community organizing and health promotion for gay men. At this first summit, my opening remarks laid out the history, philosophy and goals of our effort. The following is an adaptation of that speech.

This event grew out of the National Lesbian and Gay Health Conference (NLGHC), an annual convergence of health activists which celebrated its 20th anniversary in July 1997 in San Francisco. When a group of veteran organizers and colleagues in the LGBT health movement learned that the sponsoring group had undergone organizational crisis and might not hold another conference, we began discussing possible ways to continue some of our work together. For the last few years, a group of us had organized a track of sessions at NLGHC which had attempted to grapple with emerging gay men's sexual cultures and new directions for HIV prevention. We began to discuss hosting our own mini-conference to move this work forward, and to break the stranglehold HIV/AIDS held on gay men's health organizing.

We began with no financial resources, and we knew of no deep pockets who would fund this summit, so we chose a low-key grassroots organizing strategy. It might surprise you but, until this morning, our four-person collective had never held a face-to-face meeting. We communicated almost entirely by e-mail. By crafting a powerful "Call to the Boulder Summit" and promoting it through the Internet and gay newspapers, we generated wide participation, along with our sole source of funding: a grant from DuPont Pharmaceuticals.

Early on, we made a controversial decision to focus this conference narrowly on gay men, even though we consider ourselves part of a broad LGBT health movement. For while we believe in solidarity among lesbian, gay, bisexual and transgendered people—and while we will be delighted to join efforts to initiate a new annual LGBT health conference—we also believe there are times when circumstances and limited resources compel us to organize separately to overcome our particular challenges.*

We also aroused some controversy because our collective unabashedly called for increased attention to issues such as substance abuse, heart disease, prostate cancer, and hepatitis. This led to some activists depicting us as believing that AIDS no longer needed attention and resources. We want to be clear that HIV/AIDS remains a central part of our agenda. While we believe major shifts are occurring in the ways gay men experience and make sense of HIV, we don't think AIDS has been cured or that continued activism in this area is not needed. We know that gay men of different races and classes are forging increasingly distinct relationships to HIV based on distinct experiences with access to treatments, prevention efforts, and institutionalized racism. But we believe future AIDS prevention work with all gay men will only be effective if it is embedded in a broader, holistic gay men's health movement, and if it takes seriously the range of mental, physical, emotional, and spiritual health needs of gay men.

At this conference, we're offering over 100 sessions on issues ranging from anti-gay violence to alcoholism, STDs to steroid use, mental health to microbicides to masculinities. There are sessions targeting the health needs of men of color, rural men, gay male youth, aging gay men, homeless men, men in prison, and gay men with HIV; programs that focus on specific subcultures including bears, circuit boys, leathermen, and sex workers. We include a track of "model programs" highlighting innovative efforts already underway. We address provocative issues such as barebacking, public sex, and promiscuity; we confront emerging health challenges such as hepatitis C, tobacco use, and the needs of gay men with chronic illnesses distinct from HIV.

Our program raises new ways of looking at our health, along with some uncomfortable questions: Can we create healthy gay cultures without challenging promiscuity? What role should U.S. gay men play in the health of our brothers worldwide? What should our relationship be to the women's health movement? We intend to learn a great deal, here, about gay men's real health—not just our illnesses or problems.

We want the people at this summit to come away ready to inspire our communities to prioritize gay men's health and wellness. We want to spark specific organizing efforts which

will make gay men's health as central to our lives over the next two decades as HIV/AIDS has been for the past two decades.

To proceed, we need to understand some history. Our collective, and many other gay male health activists, spent years feeling frustrated as we watched AIDS become a totalizing metaphor for gay men's health, as Philadelphia activist Chris Bartlett puts it. We'd attend the annual health conference seeking cutting-edge sessions on gay men's mental health, youth issues, or substance abuse and find little that was not narrowly focused on HIV. We wondered what had happened to the gay men's health movement of the 1970s: Where had our creativity, insights, and talents gone?

Before AIDS, there was a nascent gay men's health movement in this country— albeit a small, under-resourced and grassroots one. It was manifested most notably in community-based sexually-transmitted disease clinics which emerged out of the free clinic movement of the 1960s and would become some of our most prominent mainstream AIDS service organizations—Whitman-Walker in Washington, D.C., Howard Brown in Chicago, Fenway Community Health in Boston among them. The 1970s were also a time when gay men developed models of peer-based counseling, addiction recovery programs, and suicide prevention services to meet our communities' needs. In fact, much of our communities' extraordinary response to AIDS in the 1980s was made possible by our organizing work of the 1970s: our early networks of queer social workers, doctors, nurses, psychologists, and activists, and the existence of gay community centers, gay newspapers, early men of color networks, and gay bars, bathhouses and discos.**

But the development of a complex and powerful gay men's health movement was interrupted by the onslaught of AIDS. Many of our leaders and institutions applied their energies and resources to the burgeoning epidemic—and we are grateful they did.

Still, the resources and talents of the 1970s were redirected to fighting AIDS, away from a broader gay men's health movement. Of course, the work continued in quieter, less-prominent ways, and often with very limited funding. Often the gay health movement became intertwined with HIV organizing in surprising and confusing ways. For example, the number and size of LGBT community centers has expanded impressively over the past 15 years, and many centers have become full-scale social service agencies meeting a broad range of health needs. The expansion of services focused on gay youth and gay men of color also occurred during this time, as savvy proposal writers convinced funding sources that strengthening the overall health of our communities was effective AIDS prevention work. Yet the coherence of the work left a lot to be desired—-and it was often framed and defined by the exigencies of AIDS funding.

And this brings us to the point we are at now, in 1999, and the many questions we hope to confront here in Boulder. Do gay men's health issues merit attention, resources, and activism in and of themselves, or only when they are implicated in the spread of HIV? Should we demand that the health bureaus of our local, state, and federal governments include gay men's health prominently in their health initiatives? We've created a range of national organizations overseeing our nation's AIDS response, advocating for community needs, and troubleshooting emerging threats related to the epidemic. Should there be a national organization to oversee gay men's health needs beyond AIDS? What organizations serve as our sentinels, troubleshooting new and emerging health threats?

These are enormous questions, and we don't expect to answer them all here at this event. But we would like to set forth five specific work objectives so that we can most effectively learn from our time together.

- First, we very much hope to see the energy of this summit trigger the expansion of gay men's health projects throughout the nation. We want to see conferences, organizations and networks formed which champion broadly defined gay men's health issues. We want to see projects emerge from various gay male ethnic and racial groups which define and prioritize specific communities' health agendas. We want to form local and national groups that will take responsibility for oversight and planning for the health needs of our diverse populations. We hope some of you will leave here eager to organize a local summit on gay men's health, establish a gay men's health project, or research gay men's health beyond HIV.

- Second, we want to see gay activism come alive and focus as much on issues such as anti-gay violence or access to health care or STD treatment programs as on HIV/AIDS. A decade ago, we united under banners proclaiming Silence = Death, but today the silence surrounding non-HIV related gay men's health issues is deafening. We want gay men out in the streets demanding universal health care for all, full funding for mental health services and the development of new technologies to promote gay men's sexual health. And we want the gay media to take all gay male health issues seriously, and not limit their focus to HIV.

- Third, we want to come away with concrete outcomes. We have planned action sessions throughout the summit, and urge you to participate in them. We will attempt to create a publication focused on gay men's health, an algorithm for doctors to use when gathering a sexual history from gay men, a public statement from gay men under the age of 35, and mechanisms to continue our work after this summit has ended. And we will look for other ways to make our ideas reality. Underlying this summit is a spirit of optimism: we believe that the mix of 300 extraordinary people will produce countless organizing projects over the next few years. We urge you to be part of making that happen in very concrete ways.

- Our fourth objective is to support men under 35 years old to take on leadership roles in our health movement, reframe existing questions to fit their own interests and needs, and assert their voices loudly. During the gay liberation period, our movement's leaders were primarily in their teens, twenties, and early thirties; few thought it odd that a 22-year-old would be the editor of a gay paper or author of a political manifesto. Today, gay people 30 and under are often classified, or condescended to, as "youth" and offered mentorship programs to learn from activists of my generation. It has been exciting for me to be the only member of this summit's organizing collective who's over 30. We want to keep putting forward the voices and leadership of young men as our work continues.
- Finally, we want to transform the ways in which we think about and evaluate gay men, shifting away from a perspective which exoticizes, demonizes, and pathologizes our bodies and our lives. We intend to seek a model which recognizes the tenacity, survival skills, and overall resilience of our cultures and communities. What would it mean to see gay men as resilient: as people who have suffered physical assault, religious abuse, and political violence yet emerged emotionally intact and spiritually strong? What would it mean to understand our gender play, kinship networks, and sexual cultures not as pathetic products borne of a homophobic society, but as adaptive survival strategies which have served us well? At this summit, we'll examine several sides of the issues and cultures which often get scrutinized in limited ways. We might decry the substance abuse occurring at circuit parties, for example, but also understand that gay men by the thousands find something valuable—something life affirming—about the mixture of music, drugs, and men dancing together. We might look at how non-monogamy and friendship networks strengthen our bonds of community in ways quite uncharacteristic of most cohorts of American men.

These five objectives guide our work this weekend. We intend to create a gay men's health movement that will build momentum outside the toxic cycle of crisis and resolution which frames most contemporary health organizing. Join with us in igniting a movement that will sustain itself against the capricious whims of media attention or funding. Join with us to create a multi-issue, multicultural, multi-generational gay men's health movement which will sustain us for many, many decades.

Afternote:

The response to this first national summit took all of us by surprise. The entire organizing process took only four months; as the event approached, we had no idea whether we would draw more than a hundred participants. There are three points I think were most striking about this first summit.

To begin with, the Boulder summit was one of those rare events where people came with few preconceived notions and hence could work collaboratively to puncture the powerful culture typical of professional health conferences. Because the event had no prior reputation and no large organizational supporters or foundation donors, it seemed to attract only true believers and others seeking fresh vision. These men and women can be credited with doing the heavy lifting of creating the initial vision for today's gay men's health movements.

Secondly, it became clear during this first summit that few people wanted to base our movement in traditional institutional structures. There seemed to be little interest in forming a national gay men's health organization, electing officers, or structuring our work through 501c3's. Instead, there was tremendous energy directed towards sparking localized, grassroots approaches, including local and regional gay men's health summits, support networks focused on specific health challenges, and list-servs and other Internet communities. And participants at this first summit called for a second summit—one year later—that would allow them to follow up on a variety of projects initiated at the Boulder summit.

Finally, this first summit, coming towards the end of President Clinton's second term, drew not only grassroots organizers and service providers, but also key national, state, and local health bureaucrats. The Department of Health and Human Services sent at least four key staffers. Several administrators from the Centers for Disease Control participated discreetly in the event. And key health directors, researchers, and administrators of government health programs joined us at Boulder during the founding moments of this movement. Thus, from this early event, the gay men's health movement found itself allied with strangers in high places, and the focus of the curiosity of top-level policymakers.

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[*] It is important to note here that a small group of lesbian health organizers encouraged our team of gay men to organize autonomously. In particular, Marj Plumb, veteran organizer in San Francisco, argued that the Lesbian Health Movement was blossoming and that this would be a good occasion for gay men to put energy into "getting their act together on issues beyond HIV."

[**] Two new books begin to capture this important community history: John-Manuel Andriote's *Victory Deferred* (1999), which captures for the first time the leadership gay men have provided in leading our nation's effort against AIDS, and Cathy Cohen's groundbreaking book *The Boundaries of Blackness* (1999), which documents the critical early leadership provided by African American gays and lesbians in igniting a response from Black communities throughout the nation.

CHAPTER 5

WHAT IS A HEALTHY GAY MAN?

When a small group of men organized the 1999 National Gay Men's Health Summit, we were not looking to create an annual event. We had neither the resources nor time to take on such a task, and we believed that our efforts to transform a rigid, bloated, and bureaucratized HIV-prevention system were best carried out from outside traditional organizational structures. The main problem we faced, however, was how to organize and sustain this work on an ongoing basis.

At that first summit in Boulder, Colorado, participants demanded a second summit one year later. Thus a new collective came into being, taking up the volunteer task of organizing the second National Gay Men's Health Summit, which was scheduled for July 19-23, again in Boulder. The four original collective members (Mark Beyer, Matt Brown, Kirk Read and I), all white men, returned to make a renewed commitment to organizing the event and we were joined by two men of color (David Acosta and J. Carlos Velazquez). Once again hosted by the Boulder County AIDS Project at the Regal Harvest House Hotel in Boulder, this time around we were granted seed funding from DuPont Pharmaceuticals, which eased some of the stress related to the financial side of organizing.

This time around it became clear that the summit had caught the attention of gay men's health organizers throughout the nation (and beyond). Over 500 people attended, including federal workers from the Centers for Disease Control and Department of Health and Human Services, as well as researchers, activists, counselors, medical providers, and directors of LGBT health centers. After considerable feedback from the first summit, the organizing collective made sure there was strong programming focused on wellness, spirituality and holistic health. Special sessions were held on health issues related to circuit parties, gay men of color, trans gay men, and men over 50. Pre-summit institutes included day-long sessions focused on barebacking, young gay men, men of color, spirituality and health, health policy, and "Manifest Love," Dave Nimmons' workshop subtitled "Finding New Ways of Being With and For Each Other."

I kicked off the event on Wednesday night with a keynote intended not only to frame the four-day summit, but to provide an overarching vision of what felt like a nascent movement of people eager to look at gay men's health organizing from a new vantage point.

Last year's first-ever gay men's health summit in Boulder was an occasion for more than 300 people to share in a spirit of exchange and mutual support across differences in identity, politics, and experiences. I was delighted to hear different viewpoints put forward in a spirit of mutual exchange rather than in a competition to see who was right or who would win.

We were very clear last year—as we are this year—that if we want to continue to create a multi-issue, multicultural gay men's health movement that tackles heart disease as well as HIV, anti-gay violence as well as addiction, syphilis as well as suicide, we cannot find ourselves talking only to those with whom we fully agree. A spirit of loving can envelop our gathering—a huge kiss, if you will—even as we're frank about our differing viewpoints on gay men's health.

Over the past 12 months: Facing an Outbreak of Epidemics

Last year's opening plenary address was entitled "Why Gay Men's Health? Why Now?" We put forward the need to blanket the nation with gay men's health and wellness projects, much as we did with HIV prevention programs in the mid-1980s. We called for a gay men's health project in every state and a gay men's health summit to occur in every part of this country.

I feel more determined now than I did one year ago to be part of creating a broad, holistic approach to gay men's health and wellness. We need to expand dramatically beyond a narrow focus on HIV and address the many, many health issues faced by gay men of all colors and all generations. We need to replace bankrupt tactics of fear-mongering and terrorizing as our primary ways of reaching out to gay men, and adopt a long-term strategy that is not vulnerable to the toxic cycle of crisis / cure we regularly foist on the gay male population.

In the last year, we've all heard reports that gay men are facing a broad array of threats to our health and wellness. First, we read about alarming outbreaks of syphilis among gay men in over a dozen U.S. cities, often linked to Internet chatrooms. Next, the Gay and Lesbian Medical Association sounded the alarm on a "club drug epidemic", highlighting a "severe increase in the abuse of methamphetamine, ecstasy, ketamine, gamma-hydroxburyrate (GHB) and nitrates (poppers)" by gay men. More recently, the web site GayHealth.com announced "New Epidemic Threatens Gay Community," and highlighted a study showing a "startling increase in anal cancer" in gay men. And then San Francisco's AIDS leadership and mainstream media declared that San Francisco's "long-feared and often predicted new wave of HIV infection is here" for gay men and highlighted an alleged "surge" in new infections among that city's gay men."

These reports raise critical issues worth talking about. First, we need to know if they reflect an accurate interpretation of the epidemiological data, or if the need to grab media attention, funding opportunities, and the ears of policymakers has

led, in some cases, to overstated claims, sensationalistic headlines, and problematic interpretations. The same health officials who initiated media reports about the "surge" of infections and triggered international headlines about a tripling of HIV among San Francisco gay men, for example, already have backpedaled from their initial statements and apologized for their exaggerated claims. Yet the "second wave" of HIV among San Francisco gay men has already been accepted uncritically and endlessly repeated by journalists around the world. Even though we have no convincing corroborating empirical data, the world now believes gay men in San Francisco have tripled their infection rate and brought onto themselves a new cycle of cataclysm and destruction.

The second issue raised by these reports of new epidemics is the painting of simplistic portraits of a diverse community or complicated subcultures. Whether we are talking about the gay community at large, or specific subcultures including gay men of color, circuit party participants, young gay men, or barebackers, it is too easy for journalists, researchers, policymakers, and activists to offer uninformed perspectives without any deep knowledge of the population they are talking about.[1] Is it any wonder gay men feel defamed by the ways their cultures are discussed in health circles?

How do we know what we know about the lives, sexual practices, attitudes towards health, and identities of young gay men, for example? Very little funded research has been allowed to occur with this population, and most people read news clippings rather than actual research studies. Yet it's so easy to extrapolate from one's own adolescent memories, or jump to conclusions based on clichés that bear no resemblance at all to the day-to-day experiences of queer youth in the year 2000.[2]

If you doubt homophobia and moralizing play a continuing role in the way gay male subcultures and sexual practices are discussed, just compare the horrified tone of the coverage devoted this year to gay men who fuck without condoms to the sympathetic stories about uninfected women who are impregnated by their HIV-positive husbands. Journalists seem wholly able to sympathize with women who take health risks because having a baby is meaningful to them, yet these same journalists appear unable to fathom that some gay men take risks because specific sex acts are valuable to them and receiving semen might carry profound meanings. Sex acts that produce babies are seen as valuable; sex acts that simply produce pleasure and identity—especially the act of anal sex for many gay men—are seen as disgusting and diseased.

These reports on gay men's health have a serious impact. What happens when gay men are told on an almost-monthly basis that they are threatened by new epidemics—first syphilis, then circuit drugs, then anal cancer, then a new wave of HIV? Does the overuse of the "crisis" construct dull sensitivity to authentic emergencies? Who is served by the constant chain of crises branded onto the foreheads of gay men? Does a repeated use of epidemic threats save lives or take lives?

Perhaps gay men are simply another population victimized by sloppy journalism, underfunded research, and well-intentioned but shoddy readings of epidemiology. While at times it feels as if gay men are the target for an outbreak of epidemic panic triggered by medical authorities and public health leaders who have become a bit too comfortable with the crisis construct, at other times it seems as if our failure to organize effectively leaves us vulnerable to these approaches. In any case, the cultural obsession with crisis and panic leads me to feel even more determined to be part of a large and powerful gay men's health movement neither crisis-driven nor reliant on tactics of terror and shame.

I say this because gay men do not need a new state-of-emergency declared—about drug abuse, anal cancer, or HIV/AIDS. At the same time, we don't need to pretend that significant health challenges aren't threatening some of our subcultures. We need a movement that will support aggressive research to explore the factors that contribute to some gay men's risk-taking behavior, examine the value we place on sex, health, and our life spans, and refuse to stigmatize us because our priorities may diverge from white, middle-class, heterosexual norms. We need a movement that recognizes not only our risk-taking but also our determination and resilience in the face of adversity.

Our Not-So-Hidden Agenda: Catalyzing the Organization of Local and Regional Gay Men's Health Summits

This week, we invite you to become active supporters of our not-so-hidden-agenda. Our vision is to take the energy, creativity, and spirit of the folks converging on Boulder and use

[1] While I was disheartened at the time at what felt like the collusion of journalists, researchers, policy-makers, and activists feeding each other the data and drama necessary to encourage regular waves of health panic among gay men, there were pockets of good and useful work taking place throughout the country, often without receiving significant attention in the mainstream media or the mainstream queer media. This was precisely the time that savvy researchers began looking closely and thoughtfully at circuit-party culture (I think here of Pat Case of Harvard and Chris Carrington at San Francisco State University), the subcultures of Black and Latino men (Raphael Diaz at San Francisco State University, John Peterson at Georgia State University, and George Ayala at AIDS Project Los Angeles), and gay men's community-based efforts to navigate health and desire (I'm thinking here of Australian researchers Gary Dowsett, Michael Hurley and Kane Race, along with Peter Keogh and colleagues at SIGMA Research in the United Kingdom). It was also the final moments of the Clinton administration, and four months later we'd all be reeling from the election of George W. Bush and an eventual cataclysm for the financing of public health, the ethics of health research, and the integrity of health promotion and HIV prevention.

[2] Ritch Savin-Williams' research into queer youth, involving a review of existing research biases and new ways of framing identity and community, was emerging at this time. Eventually published in 2005 by Harvard University Press as *The New Gay Teenager*, Savin-Williams took us a bold step forward out of the pathologizing lens through which we've long viewed queer youth.

it to galvanize a gay men's health movement throughout the United States. We ask you to consider using the next few days to generate ideas and make connections that will allow you to organize gay men's health summits in your local area. Our aim is to come out of this weekend with a list of several dozen summits that will occur over the next 18 months and that collectively will reposition health and wellness in the agenda of gay men's communities from Key West to Kentucky, from Macon, Georgia to Missoula, Montana, from West Hollywood to Western Massachusetts.

Our organizing collective does not hold a single perspective on what these summits should look like. You can see how we conceptualized and structured this national summit, but we don't pretend to know what best meets the needs of the gay men in your area. Perhaps in your rural county, it would be most beneficial to host a health summit focused not only on gay men but also lesbians, bisexuals, and transgender people. You have our support to head in that direction! Maybe the racial politics of your urban community are such that you believe your energy would be best spent organizing a summit on the health needs of gay men of color. Go for it! Or perhaps you want to offer ordinary gay men the opportunity to learn about an entire range of health concerns and wellness programs that they might find helpful, and organize a health fair where they can get tested for STDs, experience a chiropractic adjustment, participate in a support group for single middle-aged gay men, get their blood pressure checked, and talk with health professionals and other gay men about their experiences with Viagra. Again, we say to you, go forward and organize it!

As you plan, consider a few issues that we have struggled with as we've organized the program for the next few days:

- **Before the organizing gets started, bring together a broad group of people working with various populations and subcultures of gay men you hope to target.** If you are aiming for a broad summit spanning diverse populations of gay men, pay particular attention to those who are not usually in the room. Make a special effort to create a local gay men's health movement that is racially diverse, spans generations, welcomes men with a range of disabilities, and includes poor and working-class gay men. And please recognize that a long-term approach to gay men's health means not only tackling the politics of homophobia and sexism, but also grappling with racism, classism, ableism, and—increasingly—ageism. This isn't about being politically correct, it's about ensuring that our health movement includes those gay men who have historically had the least access to health care and medical services.
- **If there's anything we've learned from two decades of AIDS organizing it's that improving the health of marginalized populations requires political advocacy.** When the head of HIV prevention at the Centers for Disease Control becomes alarmed and points her finger at young gay men becoming infected with HIV, let's hear her, but let's also help her see how the CDC and the entire federal health system need to take greater pro-active measures to improve the wellness of young gay men. Let's remind them that in almost every state in this nation, precisely zero federal dollars are directed to supporting gay youth programs; our nation's annual federally funded health survey of America's youth continues to occur without a question asking respondents to identify their sexual orientation; and that during eight years of a Democratic administration, the FDA has not approved a single condom for anal sex. Our gay men's health movement must redirect policymakers from pointing their fingers at individuals and subcultures, to confront the social and political forces that collude in creating "at-risk" populations.
- **Our local and regional summits must reach beyond the "true believers" and capture the interest and participation of those gay men who have the power to influence the behavior, risk-taking, and quality of life of significant subcultures of gay men. We must engage the popular men, the opinion leaders, trendsetters, and local hunks.** We need to remember that our early HIV prevention efforts were successful precisely because we had very little public health infrastructure to rely upon: we had to move boldly into gay male communities and subcultures to create a cadre of leaders and activists who could tackle the challenges we faced. As you begin to envision those who will make up the rank-and-file of a gay men's health movement in your area, don't primarily think of nurses and social workers and policymakers and psychologists; instead think of bartenders and chorus members, popular drag queens and tough leather daddies. Consider enlisting producers of circuit parties, Internet Web masters, organizers of a local gay bowling league, and local MCC ministers. My point here is that we limit ourselves by separating our movement for gay men's health and wellness from the ordinary men who make up the day-to-day life of our communities. We need to involve them centrally in all our efforts, not as our followers but as our leaders, our creative brain-trust, and as colleagues who often have a clear sense of how to inspire their friends to become involved in a significant way.

What is a Healthy Gay Man? What is a Healthy Gay Community?

We want to ask you to think about what a healthy gay man is. Is it someone who is physically fit, not too skinny and not too musclebound? Can a gay man be considered healthy if he's overweight? Smokes? Is HIV-positive? Is a healthy gay man someone who never drinks alcohol or uses drugs? Would you consider someone to be healthy if he regularly took allergy medication? Anti-depressants? Ecstasy?

We want you to think tonight—and think deeply—about the beliefs and the biases you bring to this question. How do you determine if YOU are healthy? What relationship do your own values and everyday social practices have to your perspective on this question? We want you to ponder this deeply because we believe that behind all of the contentious gay male debates about health, sex, and identity are radically different assumptions about what we consider to be "healthy." By becoming more mindful of our own beliefs here, we can better come together in a broad, inclusive gay men's health movement.

Can you be a healthy gay man at the age of 85? At the age of 16? Do healthy gay men have sex at rest stops? Do they go to sex clubs? Are all healthy gay men sexually versatile or can you be a total bottom and still be considered healthy? Can you be a total top? Can you be into SM? Can you be attracted to guys who are much older than you and still be healthy? Can you be attracted to much younger men? Do you know any gay men living on public assistance whom you consider healthy? Are there any bleached-blonde gay men whom you'd consider to be healthy? What about 300-pound bears? Do you know any immigrants who do not yet speak English you'd consider healthy gay men? Can you be a healthy gay man and be born a woman?

Behind these queries lie some powerful and fundamental existential questions. Is there a relationship between healthiness and length of lifespan? Will I have lived a healthier life if I live until 97, rather than dying at the age of 45? What relationship does quality of life have to healthiness? Could a short life filled with meaning and pleasure be considered healthier than a long life absent of joy?

What makes an HIV-positive man healthy or unhealthy? Can a gay man with HIV be healthy if he has only 20 T-cells and has a high viral load? Where would you consider positive men on protease inhibitors on the healthy scale? What about an HIV-positive man who has been infected for a dozen years and never been on a single medication? Are positive men healthier if they treat their HIV with Chinese herbs, acupuncture, and yoga? Would you consider a gay man with HIV healthy if he did not believe that HIV causes AIDS?

Is a healthy gay man someone who has sex once a day? Once a week? Once a month? Could you consider a celibate gay man to be healthy? Do you know any men involved in monogamous relationships you'd consider to be healthy gay men? Any men in open relationships? Any single gay men? Do healthy gay men use a condom every time they have anal sex? Are there any barebackers you'd consider healthy? Are all healthy gay men spiritual? Do they all attend religious services regularly? Are there gay men who attend Catholic church services whom you'd consider healthy? Do you think a gay man who's married to a woman could be healthy?

I've spent a great deal of time this month wondering if I am a healthy gay man. When I consider myself to be healthy, I think of certain everyday activities in my life. I go to bed at 9:00 most nights and get up around 5:00 to go to the gym. I work out with weights and spend 30 minutes on the Stairmaster. I try to eat fresh fruits and vegetables, try to avoid red meat and sweets. I don't smoke and don't drink and haven't used recreational drugs for over twenty years. I attend regular meetings of several support programs. I am HIV-negative, have never been hospitalized, and my cholesterol level and blood pressure are normal.

At the same time, I have allergies and take Allegra to control them on almost a daily basis. I am prone to skin rashes, which I treat with acupuncture and herbal treatments. I have lower back problems and see a chiropractor each week for an adjustment. I tend to over-eat and wish I could lose a few pounds. While I generally think of myself as a happy person and have worked to minimize stress in my life, occasionally something throws me for a loop and I'm overwhelmed by depression and panic attacks. I've never tested positive for syphilis or gonorrhea, but I've had crabs and scabies many times.

But then more questions pop up, about areas of health and wellness that are trickier to define. Am I a healthy gay man if I am often attracted to men who look much like me: other white Jewish or Italian men? Other bears? Am I healthy if I like guys my own age? If I've lately been messing around with a guy in his early 70s, and another one who is 23, does this make me unhealthy or more healthy? Would a new interest in men of other racial and ethnic backgrounds suggest that I am becoming healthier?

If I eat too much junk food, is this indication that I have low self-esteem? I drink at least three Diet Cokes a day; does consuming the artificial sweeteners and caffeine suggest I am not very healthy? My lover thinks that I work all the time and don't take enough "down time" away from my teaching, writing and organizing. Am I actually a workaholic?

Do I gain points on the "healthy scale" if I don't fuck without condoms? Do I gain more points if I rarely fuck or get fucked these days? Or would a lack of fucking cause me to lose points and be a not-so-healthy gay man? Do I lose points if I rimmed a stranger last weekend? If I tied someone up and called him nasty names? Do I lose even more if someone tied me up and talked real dirty to me? Am I a healthy gay man if I seem to have relatively little sexual energy and only climax a few times a week? If I fantasize about getting penetrated without condoms, does this indicate I am generally unhealthy and self-destructive? Would I be even more unhealthy and self-destructive if the person I fantasized about penetrating me was a straight man? A police officer? An HIV-positive man?

These queries and others run through my mind as I consider the question "What is a healthy gay man?" I don't believe there are easy answers to these questions, for me or for any individual, but I think they are worth considering as we begin our work together.

CHAPTER 6

INTERNATIONAL PERSPECTIVES

Working internationally has helped me gain enormous perspective on my work in the United States. Over the past twenty years, I've visited think tanks, given talks, engaged in collaborative research efforts, and participated in meetings dealing with serious health challenges facing gay men in Australia, Israel, Germany, the United Kingdom, Canada, and New Zealand. I've attended international AIDS and gay conferences with colleagues from India, Barbados, Guatemala, Russia, Slovakia, Uganda, South Africa, and Japan. I've been part of a group of 30 men from about 8 different countries participating in an "international tri-city think tank" on gay men's health that brought us to San Francisco, Sydney, and London over an 18-month period, for a collective examination of the barriers we face in creating a new generation of health work for gay men.

International work has contributed greatly to my understanding of gay men's health and my work in the United States. The perspectives of colleagues struggling with parallel issues in different social, economic, cultural, and political contexts have enriched my thinking enormously.

In November 2004, I was contacted by Olivier Jablonski, an AIDS activist in Paris, who told me about a new and radical AIDS prevention group that had formed in that city as a break-off of ACT-UP Paris. WARNING was formed by many longtime ACT-UP Paris members who hoped to tackle HIV from a new perspective. Several members of the group had read my 1998 book *Dry Bones Breathe: Gay Men Creating Post-AIDS Identities and Cultures* (Haworth Press), and found my analysis of San Francisco in the 1990s applicable to Paris in 2004. We developed a two-year working partnership: the questions sent my way from French activists forced me to clarify my thinking and defend my perspective.

This interview, conducted by Olivier Jablonski, was posted on WARNING's website (www.THEWARNING.info) in November 2004.

Interview with Eric Rofes by Olivier Jablonski of WARNING, the radical French HIV-prevention group

Bonjour Eric Rofès.

You've been known to me through two of your books: Reviving the Tribe *published in 1996, mostly concerned with finding solutions to re-dynamize the gay community in the face of the AIDS epidemic; and* Dry Bones Breathe *in 1998, in which you insisted on the utmost importance of the protease moment, and the mandatory reconfiguration of the whole AIDS field. Can you sum up when, why and how you've been involved in the fight against AIDS?*

My AIDS work began as a gay activist in my 20s in Boston in the very early days of the epidemic, when I was the leader of the Boston Lesbian and Gay Political Alliance (1982–1984) and organized the first massive rally and march in Boston to demand government response to AIDS, worked to put the epidemic on the political agenda of public officials in Boston, and crafted the first AIDS prevention brochure for Provincetown, a nearby gay-oriented resort.

I then moved to California where I was the executive director of the Los Angeles Gay and Lesbian Community Services Center (1985–1988), a large agency serving lesbians, gay men, and people with AIDS. In addition to overseeing our HIV prevention work focused on gay and bisexual men, and our medical, testing, legal, and counseling services to people with HIV, I also was a leader in the successful fight against the 1987 AIDS Quarantine Initiative, a statewide voter initiative written by right-wing extremist Lyndon LaRouche which called for the isolation of people with AIDS. During this time, I was a founding member of the Los Angeles AIDS Commission and also was the director of the 1987 National Lesbian and Gay Health Conference and National AIDS Forum in Los Angeles.

I was part of the historic June 1, 1987 protest at the White House that saw the national coming out of ACT UP, and was the co-chair of the WAR Conference, an emergency national meeting of gay and lesbian leaders to plot political strategy in the face of an uncaring Reagan administration. I next moved to San Francisco to direct Shanti Project (1989–1993), a pioneering agency providing buddy support, transportation, and housing to people with AIDS and joined the boards of the National Gay and Lesbian Task Force and National Lesbian and Gay Health Association.

All this time, I was also a journalist, writing articles in the gay press focused on HIV/AIDS among gay and bisexual men in the United States. I wrote an important piece for OUTLOOK magazine in 1989 that was titled "The De-Gaying of AIDS" and this led me to study more energetically the effects of HIV/AIDS on gay men's communities in the

United States. This led to my 1996 book *Reviving the Tribe: Regenerating Gay Men's Sexuality and Culture in the Ongoing Epidemic* (Haworth), and my 1998 book *Dry Bones Breathe: Gay Men Creating Post-AIDS Identities and Cultures* (Haworth). These days I'm a professor at Humboldt State University here in California and teach community organizing and leadership skills, as well as courses in the fields of education, women's studies, and multicultural queer studies.

How do you envision the 25 years of the AIDS epidemic? Are there stages and changes in the paradigm of the disease?

Let me make clear that my focus and expertise have been on gay-identified men in the United States. From this perspective, I see the past 25 years as divided into several specific moments:

- The Dawn of the Epidemic (1980-1984) when a new disease emerged in gay men's communities and our communities struggled between panic and denial, as we attempted to gain information about what was happening to us, educate our community, and create advocacy, service, and education organizations to respond to the epidemic. This was a period of mounting confusion and anxiety.
- The Rock Hudson Moment (1985-1987) when the mainstream media and public officials in the United States first began to seriously grapple with AIDS, gay and lesbian communities began to respond energetically to the epidemic by volunteering in AIDS care and AIDS prevention organizations, and attempting to influence public policy and legal responses affecting people with HIV such as the closing of bathhouses and the potential quarantining of people with AIDS. This was a period of intense fear.
- The Crisis Moment (1988-1993) when gay men's communities in the United States experienced cataclysmic levels of death and destruction due to AIDS. These years saw the building and institutionalization of major AIDS service organizations, the inflow of large financial and human resources into the fight against AIDS, and the creation of an AIDS response infrastructure. This was a period of intense grief (i.e., the AIDS Quilt) and intense rage (i.e., ACT UP).
- The Protease Moment (1994-1997) when important changes—including new treatments—forced gay men's communities to rethink their relationship to HIV disease. This era saw the shattering of a unified gay community response to the epidemic as (a) the disease became contained and manageable among many white gay communities while it reached crisis levels among gay men of color, (b) people with HIV began to have vastly different experiences with treatments and different understandings of what it means to have HIV, (c) a younger generation of gay men emerged with different understandings and relationships to the epidemic. This was a period of uncertainty, hope, and renegotiation of the ways in which gay men's communities responded to AIDS, understood what it meant to be infected and forged community sexual norms.
- The Post-AIDS Moment (1998-2003) when mainstream gay communities backed away from an energetic and narrow focus on HIV and began to integrate AIDS as an ongoing and unremarkable feature of community life. HIV became understood as "chronic" and "manageable" among privileged gay men, as it continued to decimate communities of gay men with limited access to treatments (men of color, drug-addicted men, men living in poverty). During this time, the AIDS response infrastructure experienced shifts in funding and status, and many grassroots AIDS organizations restructured, merged, or closed their doors. The advent of the Bush administration brought censorship and narrowing of HIV prevention campaigns and sexual research projects. This was a period for many gay men of moving beyond AIDS and charting new life courses.

In Reviving the Tribe, *you insisted on the consequences in terms of mental health of the continuing AIDS epidemic among gay men, and especially on the trauma of so much death.*

I believe that nations, cultures, communities and individuals who have certain extreme and intense collective experiences where their safety is threatened and their humanity is degraded—I'm thinking here of people who lived through the bombing of Hiroshima, Jews during the Holocaust, Africans brought as slaves to the United States—suffer bizarre forms of collective trauma. This is parallel to the experience of other traumatized populations: children experiencing repeated violence and abuse, women locked into marriages where battering and rape regularly occur.

I think that many circles of men who identified closely with gay male community life experienced a tidal wave of loss during the first dozen years of AIDS. The losses most obviously included lovers, friends, and colleagues, but extended to losses of community rituals, spaces, symbols, and meanings. The intensity of living through those years had profound mental, emotional, physical, and spiritual health consequences for many of us. These consequences included the shattering of our social networks and life expectations, changes in our relationship to our health, bodies, and sexualities, and powerful and dramatic shifts in our emotions, including anxiety, terror, numbness, depression, ennui, rage, guilt, and shame.

Time has helped some individual men to heal and brought them back into the land of the living. Other men sought help—spiritual guidance, mental health support, sexual healing—that shifted them into a better place. But many gay men who are still living today in my country remain shattered victims of the epidemic, their souls and lives profoundly damaged and distorted. In *Reviving the Tribe* I attempted to draw attention to this possibility and called for a major collective

effort to revive, restore, heal, and redevelop gay communities in the United States.

You were among the few people who had a long-term analytic vision about the acceptance and integration of the epidemic in our lives, without staying in a passive state, at a moment when protease inhibitors weren't even there. For you, at the time, the fight was also about the long term: is this long-term vision still necessary?

I have refused to accept that HIV disease must remain a permanent feature of gay men's communities. I believe HIV has done horrible things to gay men's ability to love one another, enjoy their erotic lives, and build community together. It has been as destructive as a terrible earthquake or a flood, and it continues to present profound challenges to community building and community health and wellness. Yet HIV is now firmly entrenched in our communities and will not disappear quickly or easily. This is why I have argued that we need to let go of "crisis moment" responses to the epidemic that may have worked in 1987, but are not working in 2004. Instead, we need to pull our most knowledgeable people together to create a 100-year plan to reduce and eliminate HIV among gay men's communities. I believe some kind of long-term vision and some kind of plan to fight AIDS for the long haul is incredibly important.

*In '95, the new treatments weren't available. You proposed a regeneration of the gay community***, and** *a new vision, because gays must integrate the realities of this epidemic and have a larger project than AIDS, a project which would affirm life: "We Must De-AIDS Gay Identity, Community, and Culture." Is this regeneration truly necessary? Isn't it a return to pre-AIDS time, with a strong commercial scene, aimed at sex and no more? And don't you think it could stop the AIDS fight?*

These are really good questions and I think about them a great deal. First off, my recommendations were not made for Europe; they were articulated as specifically made for U.S. mainstream gay communities. They emerged out of my research into the long-term effects that living under extreme conditions had on the human psyche and on community health. By 1990, it was clear to some of us that some men were already emerging form the bomb shelters, insisting on getting back to life rather than continuing to live within the crisis construct of AIDS. This led me into conversations with many people about what we might do to care for our community and to avoid self-destruction if the epidemic continued uninterrupted and without change.

I began to feel as an activist, and as a person with great love for gay men, that we had to allow men—for their own mental health and well-being—to exit the state of emergency and return to the land of the living. This did not mean ignoring AIDS or pretending it wasn't there, but it did mean that it had to be okay for men to move forward with their lives and not remain captive to the epidemic. In *Reviving the Tribe*, I created a proposal for gay men's communities that included both removing the intense AIDS focus from gay community life ("We Must De-AIDS Gay Identity, Community, and Culture") and committing ourselves to an ongoing effort to care for the sick and prevent the further spread of HIV ("Community Commitment to Combating AIDS Must Continue"). I believe these can both occur simultaneously and that, in fact, for most gay men and gay male communities in the United States, this is precisely what has happened over the past few years. We no longer have the intense solo focus on HIV but we continue major efforts to fight the epidemic.

I think regeneration is very necessary both for individual men and for gay communities. Living in bomb shelters or in states of emergency for prolonged periods of time has terrible consequences. No one should demand that any community remain trapped in such states for long periods of time.

As for your other questions: First, gay men's cultures before AIDS were not "aimed at sex and no more." They were sites of intense social and cultural development and community building. The decade that preceded AIDS, the 1970s, is now caricatured by some as only about sex and drugs, but that is not what history shows us. This was an amazingly creative and energetic period where many American gay men made profound changes in their lives and came together to create community practices, rituals, social structures, and organizations that had never before existed. It was a decade when men, despite facing threats (violence, discrimination, social disapprobation, family exclusion), took great personal and professional risks in order to live authentically and build community with other men. To see the pre-AIDS era as "aimed at sex and no more" ignores the many tremendous contributions of gay men during that era to American culture and to gay community life.

Second, I think our efforts against AIDS will be damaged most heavily not by men integrating AIDS and moving forward in life, but by forcing legions of men to remain locked in a state of emergency. Not only will our organizing efforts be impeded by burnt-out, continuously enraged, and self-destructive activists, but we will be unable to do the work necessary to plan long-term solutions to our problems.

On the recognition of this trauma and the reaction to your proposals, how have American gays reacted?

My sense is that my book *Reviving the Tribe* helped some gay men reframe the epidemic and rethink their relationship to AIDS activism. I know some men saw themselves in my discussion of trauma and took steps to initiate healing. The book created a huge amount of debate. Part of this is that during the 1990s one could not write about AIDS and avoid creating controversy, but part of this was that I was saying things that were seen as heretical by many colleagues in the AIDS establishment. I think one of the signs of trauma is that one feels very threatened by new thinking and new ideas and responds with anger and rage. Many of the AIDS books written during that period (1994-1998) provoked widespread controversy.

Do you think another form of trauma linked to AIDS and HIV infection remains and still has consequences?

I need to think more about this question. Initially it makes me wonder if many of the people with HIV who embraced Highly Active Anti-Retroviral Therapy (HAART) didn't experience another huge life trauma when they were transformed from weak and dying people into more energetic and hopeful people living with a chronic disease. I'm not sure if this should be classified as "trauma" or whether something else is going on.

Fortunately, the HAART therapies came in, and you were among the first to proclaim the end of AIDS as a crisis.

When saying AIDS is no longer a crisis to mainstream gay communities—these are communities in the United States that are primarily but not entirely white and middle-class—I am not saying AIDS isn't profoundly important and worth fighting. I am saying that the moment when gay men as a class authentically experienced AIDS as a crisis, when we were terrified, confused, and panicked, has ended. This does not mean that individual men do not move into a crisis stage, but, as a community, we think about and experience AIDS very differently in 2004 than we did in 1984. For those of us who lived through the crisis era, when we were going to funerals weekly, couldn't walk down the street in gay enclaves without seeing wheelchairs and men with canes, and opened up the pages of our community newspapers to dozens of obituaries, it is clear that we are living through a very different moment now.

For you, the time after the protease moment is a Post-AIDS era? What do you mean by that? evolved till now?

I think the Protease Moment initiated the Post-AIDS era in mainstream gay communities in the United States. By this I do not mean that people do not still become infected with HIV, or that AIDS no longer merits our attention and our energy. I am aware that other communities, including people of color communities in the United States and many nations in Asia and Africa, have now entered their own crisis moment. By "post-AIDS" I am suggesting that mainstream gay communities have moved beyond the "AIDS crisis" moment and into a different era that is even more confusing and challenging, but that reflects major shifts in our community's experience of living with HIV disease.

You questioned the relevance of the work of the organizations fighting AIDS in a chapter labeled "The Final Days of AIDS Inc." Some of these organizations are no longer of use according to you, others should restructure themselves. Why?

I believe that AIDS Inc., which is an entire sector or industry that was created to combat the epidemic, is a collection of organizations, institutions, and rituals that are crisis-driven and that seem to need to be crisis-driven in order to do their work. I believe they are best focused on those communities that are currently experiencing their own "crisis moment" of the epidemic. I argued that in many parts of the United States, those organizations and rituals are properly based in communities of color (including communities of men of color who have sex with men) today, rather than in mainstream gay communities.

When they are focused on mainstream gay men's communities, they seem to use guilt and manipulation to try to pull gay men back into a crisis state. They are unable to comprehend that the bulk of gay men involved in community life—bars, organizations, rituals, dance parties, sex clubs—are not in a crisis state and have exited the bomb shelters. Because the AIDS professionals are wearing glasses that are tinted with the "crisis lens" of AIDS, they react in problematic ways to gay male cultures, social organization, and sexual practices. I argued in the book, and I believe this has come true, that the components of AIDS Inc. will either have to restructure and rethink themselves in profound ways, or they will become less and less meaningful to many gay men and mainstream gay men's communities.

Why did you propose that they evolve to integrate gay men's health in a broader way than AIDS only?

In the United States, AIDS groups reported a sharp fall-off in participation in support groups and educational programs after 1992. Many of us at conferences wondered what we could do to grab the attention again of gay men, how we could again bring about strong and active participation. One group surveyed their participants and found a huge hunger for information about other health issues beyond HIV. When they started offering programming about other issues—prostate cancer, depression, sexually transmitted diseases—they found participation increase. We also realized that many other gay men's health issues affected whether someone remained uninfected—issues such as substance use, mental health, genital health—and other issues were involved in keeping positive men healthy. These days I feel the most effective work on HIV prevention doesn't even mention HIV, but is focused on sexual empowerment, personal well-being, and broader mental and spiritual health.

There is right now in France a debate on the new forms of HIV infection prevention. Two schools are facing each other: on one side the associations which support a condom-every-time credo; on the other, the harm reduction angle. What's your opinion?

I cannot speak for France because I do not know your local culture and history. All health promotion work must be rooted in local cultures and history. In my country, I believe the "use a condom every time" credo ends up causing more problems than solutions for certain populations of gay men, even while it might support and assist others. I don't think most gay men benefit from directive approaches to prevention: "do this" and "don't do that." I think most men need information and support as they navigate through the pleasures and risks of sex.

There's no scientific study on the effectiveness of risk reduction. Is this a way to explore all the same?

We don't have any studies that illustrate the long-term effectiveness of the condom credo either. I do believe we need to offer various approaches to gay men because different populations of gay men will benefit from different approaches. I do believe some gay men respond best to the directive, use-a-condom-every-time approach. At the same time I believe that approach may have contradictory effects on other populations of gay men.

We see regularly news on the relationship between crystal meth and risky behaviors. Do you think this link is that obvious?

I think people spend a HUGE amount of time and money trying to understand sexual behavior that they consider risky. They seem to think it is bizarre that gay men would ever have anal or oral sex without a condom. So they find ways to "prove" that we have unprotected sex because of (a) a lack of "self-esteem," (b) internalized homophobia, (c) depression, (d) the trauma caused by so much AIDS-related loss, (e) the fact that young gay men have not experienced any AIDS-related losses, (f) crystal use, (g) a death wish, (h) internet chatrooms (i) inaccurate assumptions that our partners are negative.

Most men, I expect, engage in unprotected sex because of the meanings they take away and the pleasures the act provides them. The act of getting fucked and having the sperm dumped in a condom may have very different meanings for a man than getting fucked and having the sperm shoot deep inside your butt. Like it or not, using a condom changes the meaning and the practice of anal sex in significant ways. For some men, the meaning and pleasure comes from having another man's sperm deep inside his ass. If you add a condom to the picture, that meaning and pleasure will not occur.

I want to say this next part carefully and respectfully. I am not sure I believe that using crystal causes men who otherwise would not get infected with HIV to become infected. Studies show correlation not causation. I know many newly HIV-positive men believe crystal is what caused them to seroconvert, but I'm not sure I am convinced. My colleague Tony Valenzuela argues that the crystal epidemic has its roots in what is unresolved in gay men about AIDS. This makes me wonder whether the stresses, anxieties, confusion, and trauma of HIV, along with the havoc AIDS continues to wreak on gay men's identities, serve as a pathway into crystal use for many men. I wonder if all of the unresolved trauma that I write about in *Reviving the Tribe* might be a catalyst for crystal use.

What Tony wonders is whether positive men haven't figured out how to "do" the lives they didn't plan on living in the long term, especially while in this limbo between life sustaining meds and a cure. He argues, "We still, subconsciously, live as if our days are numbered, even with this reality of chronic but manageable. We all learned this grand lesson of living in the moment, understanding life could end tomorrow and so therefore cherishing today. But ironically, that is not a sustainable existence. I think positive men long to take life for granted. Seizing the day as this precious gift, indefinitely, is too much to bear. We're not wired that way."

This makes me wonder whether many gay men who are still uninfected experience different, but parallel, confusions and contradictions that move some of them towards substance use. And whether the fact that AIDS is now endemic to gay male communities brings with it the culture of AIDS that Tony discusses, and hence drives substance use.

I think most Western societies are cultures of pleasure so I don't begrudge gay men their share of pleasure. I think gay men mostly have a culture of management of risk in the United States, despite the fact that most HIV prevention organizations seem to believe we don't. I think most gay men do a good job of negotiating their sex so that they maximize pleasure and minimize risk. And most of us do this without the support of our HIV prevention organizations. In fact, many of us do this despite the hurdles thrown in our path by HIV groups.

The 90s have been rich in authors and essays on AIDS. They've been the occasion for polemics on the responsibility of promiscuity, on recreational drug use, on risky behaviors. You heavily criticize the founder of Act Up Larry Kramer, Gabriel Rotello and Andrew Sullivan.

I did critique Kramer and Rotello, but generally find Andrew Sullivan's writings on HIV/AIDS helpful and enlightening.

Yes, there was a spate of essays and books during 1995-2000 that could be seen as polemics about gay men and AIDS; there haven't been many since that time. I think publishing houses recognize that there may not be a huge market for such books, that gay men's primary interests are focused elsewhere. At the same time, I think the conflicts that emerged during that period in the 1990s were not pleasant or fun for any of us. Gay men took sides in this debate and some long-time friendships were destroyed. This might also discourage people from diving into the wreck of AIDS writing.

Do you share the opinion of Harvey Fierstein on the culture of disease between gay men?

I greatly admire the theatrical work of Mr. Fierstein, but I think his writings about this "culture of disease" are uninformed and I know they are unhelpful to our communities. He writes as if finger wagging or guilt and shame are all we need to change sexual practices among gay men. I much prefer people admitting what many people within HIV prevention have admitted for almost a decade now: that since HIV has become broadly entrenched in our communities, we don't really know what to do to reduce or eliminate it from our community. It is my belief that the guilt and the shaming continue to drive the epidemic rather than reduce it. Such finger wagging might make Mr. Fierstein look like a good, responsible gay man, but I don't believe it helps us fight HIV.

Right now we can see in Europe a few nasty bugs coming back like shigellosis, LGV, syphilis, even sexual transmission of hepatitis

C. Rotello evoked the gay New York before AIDS, marked by a high prevalence of tropical diseases. To again find all these illnesses roaming around, what does it make you think?

It makes me think we need to improve sex education and health education throughout our culture, and ensure that all people have access to quality medical care and free condoms. It also makes me think we need to work to reduce shame and guilt around sex, eliminate the laws that make specific types of sex illegal, and end the Puritanism that infuses our culture.

Is there something still to be done among gay men? Something new?

This is the question we have been asking for about 10 years in the United States. Most people answer it with simple answers and short-term approaches: new ways to market messages to gay men, as if social marketing were the entirety of effective health promotion; or advocating for gay leaders to denounce those who have unsafe sex. I believe we need to move away from short-term solutions and look towards long-term approaches, and I have been arguing that there are a few things we might do:

- We might create a long-term plan to reduce HIV among gay men. By "long-term," I mean that we need to create a 100-year plan that aims to bring down the level of HIV in successive cohorts of gay men. I believe this will be a slow and gradual process, but that it will not happen without planning. The idea that we can stop HIV today among gay men if everyone just behaves themselves is naïve and unhelpful. I've dreamed of a series of long meetings that bring together some of our best researchers, activists, organizers, and theorists from many different disciplines and begins to envision a path forward. I called for this 10 years ago. Thus far, none of the powers that be in the United States have embraced this call.
- We might initiate a major community-wide process of confrontation with the powerful effects that the epidemic has had on gay men's communities and cultures and face all the ways our lives have been damaged by the epidemic. This needs to be the first part of a larger plan for reviving and redeveloping the infrastructure of gay community and culture and focuses on community healing. It involves healing ourselves and our culture from the profound traumas of the crisis years.
- We might engage in broader work that focuses on creating gay men's health movements that are intended to provide information and support to communities of men on a wide range of health issues and that understands the need to work towards the overall wellness of our subcultures and communities. This would be an activist movement focused on removing laws that oppress gay men, increasing sex education for all communities, and directing research funding to diverse technologies and treatments to reduce the spread of HIV.

On which issues are you working now?

I continue to work on gay men's health issues and contribute energy to building gay men's health movements in the United States.

I have been working on gay men's health issues since the 1970s when I wrote my first book looking at suicide among gay men and lesbians and founded several programs to support queer youth. My 30 years of community involvement have always included a major thread focused on community health and wellness. Through good times and bad times, when my work is popular and when it is unpopular, I continue to work for the health and wellness of queer communities.

You might think I've "gone in another direction" because many of my recent publications have focused on public schools and education reform in the United States. This has been the other major thread in my career: during my activist years in Boston I worked as a teacher, school administrator, and child advocate. These days I work as a university professor and direct a program focused on educating elementary school teachers. I've recently published a book on charter schools, a recent school reform initiative in the United States. In the next year, I am publishing two additional books focused on reconceptualizing our work on gay and lesbian issues in education.

I'm currently writing two additional books. One is a social history of gay men's cultures in the United States from 1972 to 1983, the pre-AIDS decade of bathhouses, discos, and protests against Anita Bryant. I've been doing that research for 10 years. The other book is an organizing manual for queer activists and a personal memoir organized around 35 central incidents in U.S. queer activism over the past 30 years.

I have always intended to write the third book in the trilogy that began with *Reviving the Tribe* and *Dry Bones Breathe,* and have been keeping notes and files, but I won't have time to work on that project for another year or two. That book will focus on the nascent gay men's health movement in the U.S. and tackle some of the contemporary debates about barebacking, crystal usage, gay skinhead culture, and Internet sex.

* * *

In early 2005, I was invited to Paris to present a private talk to members of WARNING and some of their colleagues, intended to clarify my work and clear up any confusion that emerged from the language gap. That talk took place at a bookstore, La Librairie les Mots à la Bouche, on March 16, 2005. A transcript of it appears below.

I also enjoyed a series of meetings with WARNING members and others at this time and began to learn about the epidemiology of HIV/AIDS in France and about the organization of gay male cultures in Paris.

WARNING then organized a landmark meeting in Paris in November 2005 which seemed intended to stir up some new thinking about the usefulness of holistic approaches to gay men's health in France. WARNING received significant government funding for this two-day conference and brought to

Paris numerous gay men's health movement leaders from the United States, Australia, Canada, Switzerland, and the United Kingdom. As expected, the event was quite controversial, as local health officials and AIDS organizations maintained a firm commitment to narrow prevention approaches (use a condom every time; any unprotected sex is forbidden under any circumstances), and two members of ACT-UP Paris mounted a feckless protest when one American gay men's health leader who had written extensively about the politics of barebacking began his talk.

I came away from my visits to Paris with a belief that Europe is much like the United States in at least one way. Certain cities and nations remain locked in 1980s crisis approaches to HIV prevention among gay men, while others have moved into newer approaches in line with an emerging gay men's health movement.

Understanding Unprotected Anal Sex: Beyond Dumb, Deluded, or Self-Destructive

The focus of my talk tonight will be on understanding motivations for unprotected anal sex among gay men in 2005, beyond simple-minded explanations of dumb, drunk and low self-esteem.

I mostly want to raise questions and reflect on our work in the fields of AIDS prevention, gay men's health, and gay political organizing, and talk with you about the situation in France. I want to thank all my friends at WARNING for inviting me tonight and in particular thank Harriet and Brett who'll be doing the translating from English into French.

But I want to be very clear about one thing. I am going to talk about things like sex, health, and the body. And these are each based on particular cultures. I 'm not familiar with your culture. My work is focused on gay-identified men in the United States: I can't pretend that what goes on in the United States applies to France. You will need to make those decisions for yourself.

I like to explain upfront that I speak explicitly about sex. I don't use clinical terms. I use words like "fuck" and "cocksucking." I do this because I want my works to be meaningful to regular gay men who usually use these kinds of words in my country. I do not intend to offend anyone by the use of these terms; hence I like to signal in advance that you might hear such language in my talk.

First, I want to talk briefly and candidly about HIV prevention in the United States. I began my HIV prevention work in 1983: those of us who do the work often don't have time to read research or think about theories.

When I was writing *Reviving The Tribe*, it became clear to me that many people working on prevention in the United States had felt like we'd hit a wall in our work. We did not know what to do next. We knew things that we did 10 years earlier were not working anymore, but we were not sure what to do. I felt that we needed to ask new questions: questions about what sex meant to gay men, what love meant to gay men, and whether the prevention work we did when we felt a real crisis around us in 1985 might still work in 1995.

The question asked by journalists, researchers, and prevention workers was "Why does any gay men get fucked without a condom?" We asked that question back in 1995 and we ask that question today. Why does any gay man get fucked without a condom in 2005?

When I started my prevention work back in 1983, I think I believed that if organizations in the gay community told gay men to not get fucked without a condom, gay men would not get fucked without a condom. I believed it made sense. I believed that people did with their dicks and their bodies only things that made sense.

Today I've changed. I now think that people do not mostly have sex from their rational minds. I think most gay men have sex for other reasons and that, for most men, the rational mind is only one small factor in determining what sexual activities take place.

On one hand, it seems very frustrating to many of us that men get fucked without using condoms. People know in their rational mind that they could become infected with a potentially life-threatening disease by getting fucked without a condom. They have this knowledge. Why, then, do they do it?

On the other hand, we know that cross-culturally and trans-historically, the meaning of penetration and the exchange of semen have tremendous meanings for many people. I used to say that using a condom changes nothing. Now I feel this statement does a tremendous disservice to the meanings that men make of penetration and semen exchange. It suggests that sex isn't meaningful and specific, as if it were like "Don't eat chocolate ice cream; eat vanilla ice cream. The two are basically the same."

I think it is useful to divide gay men in my country into several different populations. One group is made up of gay men who never have had anal sex—throughout their lifetimes or during the past few years. How does HIV prevention work for these men? Then there are gay men who I think can realistically enjoy anal sex with condoms all the time. For these men, there is little change in pleasure or meaning when using the condoms. Next there is a population of gay men that do not want to become infected with HIV but, for a variety of reasons, use condoms most of the time, but not all of the time. And then there are men who never use a condom.

I think the challenge of prevention today is that these distinct groups of gay men need very different information, support, and resources from one another. They do not need the same message or the same work or the same type of support from AIDS organizations.

In 1990, we began a conversation about whether HIV prevention as a field had any responsibility to the men who would sometimes choose not to use condoms. For almost a decade we had said, "use a condom every time." Then we found that some men—and eventually this grew into a large portion of men—would occasionally not use a condom.

What are we to do when confronting such men?

Some people believe that AIDS organizations simply need to speak louder or more frequently, and more men would follow their advice. Others believe we need to meet gay men where they are, and work with them in their current situation, not where we wish they would be. Do we give them information that might assist them in minimizing harm if they are going to occasionally forego condoms? Do we ignore these men entirely?

In the United States we have not answered these questions for ourselves over the past fifteen years. Frankly, the situation I see is that those of us working on gay men's health or HIV prevention have the conversation among ourselves; regular people, rank-and-file gay men who are not working in the prevention system, have a very different conversation. Sometimes it feels as if we're speaking two different languages.

In my country today I believe that a major problem is that much of our AIDS education work is directive or authoritarian. We tell men what to do. And I think, increasingly, men don't want to hear it.

For example, I think that when we say "you are bad when you do not use condoms" we end up unknowingly encouraging some men to forego condoms. The more we use guilt and shame and tell people exactly what to do, the more I think some men desire to do the opposite.

These days, I am trying to understand why some people take certain kinds of risks. I'm looking not at the literature of AIDS, but of the literature of people who jump out of airplanes without parachutes. I am looking at people who sign up for jobs as firefighters, or go into emergency situations where they might die.

I think that we don't know right now why it is exciting for people to take certain risks. The book I'm currently reading, *Edgework: The Sociology of Risk-Taking,* has nothing gay in it. There is nothing about HIV/AIDS in it. But it is the first thing I've read in 10 years that is really starting to assist me in understanding why some men get a thrill out of doing precisely what we have told them not to do.

Q & A

Is not one of the problems in prevention the basic lie that with or without condoms it's the same regarding pleasure?

Yes. I think those of us in prevention in the United States did tremendous damage to our credibility—and to that of HIV-prevention—by saying there was no difference. Some men lose their hard-ons when they try to use a condom; some men don't like the feeling of getting fucked with a rubber. There are some men for whom the entire point or meaning of anal sex is for the sperm to end up inside them. We have to take these beliefs seriously if we hope to do effective work.

Have you seen the film "The Gift," a documentary on HIV-negative men who seek to become infected with HIV and enter into a group which seems to represent a certain ideal or bad-boy image for the community? What do you think of "bug chasers"? How much of this phenomenon is real?

I have seen the film. I thought it was sensationalistic and unscientific and I am unclear on the motivations of the filmmaker. I find it a dangerous film. I think that "bug chasers" are a tiny population in reality but a much larger one in the fantasy-world of cyberspace.

In prevention, we often see two men fucking and we filter it immediately through the lens of AIDS or HIV prevention, and we see the act as primarily about risk. For many real men, however, the act of fucking is not primarily about risk. It's about many other things. It is about love; it is about pleasure, about who has power, about who is the man, about what kind of man you are, about what kind of woman you are; it's about a lot of things. And AIDS educators might wish the men would see the act also as about primarily safety and HIV, but, for most of them, other things are going on. Other priorities are dominating their mind at the time, whether they are at a bar, in the bedroom or at a sex club.

This is where I fear that all the messages about "use a condom every time", "have sex this way, not that way", or "don't go to sex clubs," have a very powerful and problematic effect. I think, for many men, all those messages, on a subconscious level, bring out a desire for freedom from pressure, freedom from rules, freedom from guilt.

In our own culture there is so much that is tightly controlled, so much is directive—do things this way, not that way—dress this way, go to work, go here, go there. We are all very regimented and controlled. I think sex has often been a place where people become free from all of that control and regimentation. Thus our interventions in the sex arena face particular challenges.

In France, it has never been possible to demonstrate that prevention campaigns have had an impact on risky behaviors. In fact the campaigns had no effect on them. It was the reality of the death toll which had this effect and not the campaigns. Do you agree with this interpretation? What can you say about the USA?

It's hard to know. First, I think that the first 10 years of HIV prevention and education in the United States had a huge impact. I do not think people, gay men, in most places in the United States, would have seen people with AIDS or know someone who died before 1985. Certainly gay men in San Francisco and New York had the experience of a face-to-face confrontation with dying friends, but this was not necessarily true, even in Boston, Denver or Seattle and similar places. So to me, HIV prevention got the word out. There is another question, about the ways to change sexual behavior, or needle injecting behavior. And this is what we don't have the research to know how to do. I believe that gay men in the United States in 2005 desire more anal sex than gay men did in 1980. I believe that 25 years of prevention focused almost entirely around one act has produced a generation of men who believe, like President Clinton, that getting fucked is the only

sex act, that everything else is foreplay. I use this as an example of one of the things we need to think about—how do desires come to be?

I do not believe that I was genetically born, for example, to tie up men and urinate on them. I do not believe that the desire to suck dick is a genetic thing. I think the desires are culturally created through very complicated processes. For some of us, that process involves finding yourself desiring to do precisely what you are forbidden from doing.

I travel frequently to North Africa. I have a Moroccan boyfriend. Even with all the prevention messages, I don't take precautions with him. And it may be a philosophical question, I don't know, because he says justly that imagination, love is more important. For 10 years now I've been in a relationship with him, I've not used precautions. I know he is in danger. WHY? And there is a question that interests me greatly. Many gays are depressive. In depressed moments, I take risks. My question is: Even with all the messages, it doesn't work! What should be done?

I cannot speak to your own condition directly, as I do not know you and I am not a clinician. In my country, I think that the violence and the oppression against gay people lead some people to be depressed. We live in a country where the religious Right now rules; a president who's a Christian; a Congress controlled by the theocratic Right. This is a very difficult time for gay people.

At the same time, I do not think that most men have unprotected sex because they are depressed. In the U.S., we frequently talk about depression and low self-esteem among gay men. These, supposedly, are the reasons why people have unprotected sex, or use drugs, or eat French fries and fried foods, or drive fast, or smoke, or jump out of airplanes wearing parachutes.

I do not buy it. Many of the men who I know who have unprotected sex have very strong self-esteem. They believe they deserve to have the kind of sex they want, sex that gives them pleasure and meaning.

I believe we really need to stop telling men what to do in a directive way. We might provide information; we might offer suggestions. But the heavier and more directive our efforts are, the greater rebelliousness and resistance we might incite.

I think providing spaces for men to talk among themselves about sex, even without a use-a-condom-every-time message at the end, will make men feel more empowered to have the kind of sex they want and to take the safety measures or risks in sex they want to take.

Recent studies show that the bareback community is essentially dominated by HIV-positive men. Do you think that the prevention discourse, which is mainly aimed at HIV-negative men, is creating a fracture or split between positives and negatives?

Probably. I am more concerned that messages that are delivered to a universal audience are not meaningful to anyone. In my country, for many years, we feared a split between positives and negatives. That split mostly has not happened. I was a negative guy who was running an AIDS organization in the U.S. city of greatest impact. My two best friends were dying of AIDS at that time, 1990. There was no way I wanted to marry a positive man. Then I saw this hot man in a bar one night. Even before we had sex that night, I knew that he was positive, because he said so. The fact that he was handsome and sexy all of a sudden was more important to me than my rule about not going for positive guys.

I don't think it is unusual in the U.S. to see language in online profiles saying "I only want positive men," or "I only date negative men." I've hooked up with a number of men saying they "only want positive men" (I am HIV-negative) and, when I tell them my status, still want to have sex with me. They say, "OK. Come over, anyway."

My current concern now is not that we will have a split occur between positive and negative men, but that we will have an escalation of targeting or demonization of positive men. This is now escalating in HIV-prevention in the United States. We have campaigns that create the "good" positive man and the "bad" positive man. The "HIV Stops With Me" campaign is designed to do just that: to create a model of 'good citizen' positive men, who are doing the 'right' thing by pledging to never infect a negative man. Of course we want to encourage positive men to avoid infecting others. That is not the point. But a campaign like this does so much more than that. At the same time as it encourages poz men to act responsibly, it puts forward to the world the idea that many poz gay men are irresponsibly infecting others. It also encourages rebellious poz men to move towards antisocial identities as an act of transgression. I think the implications of this campaign are potentially serious and I wish such campaigns would cease immediately.

We also have recent campaigns such as 'HIV Is No Picnic" which demonizes positive men by putting images of incontinent, facially-wasted, buffalo-humped men repeatedly into the media. I consider that campaign nothing less than defamation against positive men, all supposedly for the sake of putting fear into negative men. It seems like a very unhappy tradeoff.

What do you think about sex without condoms between poz persons?

What do I think about sex between two men of any similar status? I don't like to answer because I may become preachy and judgmental. And I don't think that helps anyone. If I knew two positive men who came to me for advice about whether they should have unprotected sex, I would likely ask them more questions than tell them what to do.

What's the future for organizations fighting AIDS?

In my country, there is not a good future ahead. For the most part, people in the organizations do not feel confident about what they are doing, in terms of prevention. And for the most part, regular gay men look at prevention workers today as if they're from another planet. That might be an exaggeration,

but I feel in my country HIV prevention workers have become seen as the goodies. They provide support for other goodies (and I am speaking to you as a goody) to keep being goodies. But I've always argued that for me—and for people like me—we don't need prevention to help us stay negative. And I fear that when prevention writes off the baddies, at the same time they help to create a larger, hotter, baddie culture.

The question I'm asking myself involves the film "The Gift." I've been very surprised by a generally expressed opinion which tends to say that the norm is to fuck without condoms. I've got the impression that when you are talking to different categories of the gay male population, it's certainly not the same message which should be given to each.

Second question: what is the impact of porn on men's sexual behavior?

I think the first question we have to ask is whether messages are the best way to work with sex. In the U.S., we work with gay men's sexual health in the same way we sell McDonald's hamburgers. We have advertisements in papers, we have slogans on t-shirts, billboards, on the sides of buses. I have questioned whether social marketing is the best way to work with men's sex, if it is effective in reaching men in the way we want to reach them. I think there are real questions about the effectiveness of social marketing and whether it accomplishes what we hope it accomplishes. So my question is not what message we should give people, but what should we be doing in prevention instead of selling hamburgers.

We had a long debate in the U.S. about pornography. If you see pornography as tying up guys and pissing on them, even if you have never desired to tie guys up and piss on them, then all of a sudden, you want to piss on them and tie them up: This is how one argument goes, how some people see the workings of porn. What I do believe is that what some men do sexually does actually have an effect on other men. I think sex is profoundly social, so I can see the concern, but I don't think it's so simple as "I fuck without condoms, so everyone else is going to fuck without condoms." If we had better funding for sex research, we'd be at a different place in this epidemic. For example, we don't know how fisting began, and developed, and expanded and contracted in the U.S. in the 70s. But if we did know that, it would help us enormously in our HIV-prevention work. So I think the porn question is complicated and we don't have easy answers today. Instead of asking the question, many people act as if they know the answer.

People have talked a great deal about different categories of guys: the ones who like having protected sex, others who do not, others who have unprotected sex from time to time. I believe there is something that should be added to this conversation. We need to talk about the young ones starting their sexuality today, who don't have the same long-term vision of sexuality that the older ones who are 20 or 30 years old. How can we adapt messages to take into account the level of experience, the kinds of life diverse men have had? For example, I have lost no friends to HIV/AIDS. I have had friends become ill, but none have died. Because of this, my experience and my vision are not the same as men older than me.

I don't believe that you need to know people with AIDS who have died in order to be safe. Young men in my country seem very different than men in their 40s or 50s like me. Men of the exact same culture, white Jewish American culture, but 30 years younger than me, have very different relationships to their body, to their sex, to masculinity than a man who grew up when I did.

I think we observed this first with piercing and tattoos. We saw young gay men wear clothes and shave their heads or do other things in ways that seemed odd to us older men. I know men who are 25 years old who have no problem jumping into a mosh pit. I'd never do that.

By this I mean I think that many younger men's relationship to safety and risk and the body is very different than most men of my generation. So I don't think the younger men need messages that were created for old guys. They need support to come together with men of their generation to see how to create communities and cultures around sex and risk and safety that fit with their desires. In the U.S., this is precisely what is happening, except it is occurring with almost no involvement of gay or AIDS organizations. It's happening truly at the grassroots level.

I remember in 1992, when I joined AIDES, we had a training. In a 30-person group, all had lost someone because of AIDS. It was their motive to join in the group. I don't agree with you.

I did not mean to suggest that during the crisis moment of AIDS, direct contact with infected or dying people was not a motivation for involvement in service work, prevention, or activism. But getting HIV today is quite simply NOT the same as getting HIV in 1988 or 1992. When you were told you had AIDS in 1988, you thought you were going to die, and soon. Even before protease inhibitors, by 1993, we knew many people with HIV who did not die, who were doing fine. We knew long-term survivors, people who had been infected for 12 or 13 years. We knew people taking the existing treatments who were able to keep working and we now know people taking all kinds of medication who are doing very well. Yet you inspire, I think, a core question: Is the only way to encourage men today to be safe to pretend that becoming HIV positive today is the identical horrific experience it was back in 1988? Some groups in the U.S. do precisely that, and yet many people—perhaps most gay men—just don't believe them. They lose their credibility with gay men. This does not suggest that getting HIV today is a picnic, but it does suggest what we've long known about sexual health promotion: you've got to find ways to meet your audience where they are at, not where you want them to be.

In WARNING, we think that what is needed is to find ways to spread more love and more confidence in the community, rather

than encouraging suspicion and stigmatizing messages. Would love and confidence be more effective in reducing HIV? What do you think?

This is, in part, what the gay men's health movement in the United States is trying to do. We came to realize that we had, in some ways, pathologized gay men as a class. We medically stigmatized them in the same ways that our enemies have stigmatized us. We made sex between men dangerous and disgusting.

I think this has had a tremendous impact on gay men today. We told them not to trust other men, because men lied about serostatus. We told men that their preferred ways of making love they should never again do in their lives. We took the holocaust of AIDS and made it worse. We raised it to the second power.

I wrote in *Reviving the Tribe* about the importance of finding ways to redevelop gay community in a caring, loving, fun way. And that is the reason why 10,000 men in the U.S. go to the White Party in Palm Springs and maybe 100 men might go to an AIDS forum in San Francisco. This is not because men are dumb or in denial. It's because they seek a place of fun and pleasure and community. And this is generally not provided to them through AIDS groups or even gay groups today. So many men created it for themselves, and the circuit-party scene is just one example.

I have great faith that regular gay men will create the world they want. Gay men have been doing it for years. Even in hard times, we know what is valuable and meaningful for us and we go out and create it. That is why I put a photograph on the cover of *Reviving the Tribe* that shows men dancing in a 1970s disco and on the cover of *Dry Bones Breathe*, a picture of a circuit party in the 1990s. While I don't think such spaces are the only models of gay men's health, I do think they are examples of sites that are tremendously valuable to gay men.

CHAPTER 7

GAY BODIES, GAY SELVES

[Published in White Crane Journal *(Fall 2005) as "Gay Bodies, Gay Selves: Understanding the Gay Men's Health Movement]*

Gay men are healthy, happy, and life affirming.

We're creative, strong, and resilient; more than almost any other male population, we think outside the box, take responsibility for our actions, and care for ourselves and others. We know how to get what we want and we know how to create lives that are satisfying and fulfilling.

In fact, we've developed our own home-grown social networks, support structures, and communal rituals, all of which are more functional, nurturing and sustaining than monogamous couples and nuclear families. More than most others, gay men know how to find community—even when it's hidden—and build community, even in the face of formidable obstacles.

I make these claims based on what I've observed over thirty years of living as a gay man who's maintained deep involvement in gay community life and lived most of his adult years in urban gay enclaves. I offer what I've learned to anyone hoping to become a contributing part of something called the "gay men's health movement." If you don't take as your starting point that most gay men are already happy, healthy, and successful, this movement isn't for you.

Nothing convinces me of the healthiness of gay men's communities *more* than our relationship to HIV/AIDS. I say this knowing that our infection rate for HIV is precisely what most concerns those who see gay men as tragic, diseased and self-destructive and motivates them to repeatedly harangue us. The annual incidence of new HIV infections among gay men, between 1 and 2 percent each year over the past 10 years, is put forward as proof that we've returned to our wicked ways. Because 1-2% of uninfected gay men become infected with HIV each year, many people believe we are an irresponsible population unconcerned with our own health and that of other gay men.

While we might wish we could reach a point when no new infections occur among gay men in a single year, we know that once a disease becomes endemic to a population—as HIV has become endemic to American gay men—it requires radical interventions, such as vaccines or new technologies, to eliminate.

Twenty-five years into the epidemic, with a few geographic and population-specific exceptions—exceptions that are important and which merit resources and attention—gay men have shown that the large majority (70-80%) of us are capable of remaining uninfected. If we have brought the infection rate for gay men in most parts of the nation down below 20%, this suggests that more than 80% of us are capable of doing what needs to be done to stay uninfected. Twenty-five percent of gay men in San Francisco and 15% in New York are HIV positive: even in these major gay centers, three out of four of us remain uninfected.

This is a big deal, but it is never the focus of the doomsayers. It confounds what they think of us. In fact, it came as an extraordinary realization to me. If the majority of gay men can do what needs to be done to prevent HIV infection, we must be doing something right.

The past 25 years has been a time when an inaccurate and phobic portrait of gay men as sick and self-destructive has been put forward, accepted as true, and taken hold as a central part of deeply ingrained public beliefs about gay men. In fact, I believe that the very systems created to protect and care for gay men—HIV prevention, addiction recovery programs, even gay-oriented mental health programs—use as foundational building blocks a pathology-focused understanding of gay men. Perhaps most extraordinarily, this same belief that gay men are damaged and dangerous has started to infuse some of the projects that are being created in the name of the "gay men's health movement."

In most of America today—including in most gay centers, health clinics, and AIDS prevention programs—many look at gay men's sexual practices, socializing patterns, and cultural norms as troubling. Professionals examine gay male subcultures, shake their heads, and point out what's problematic. Whether the subculture involves urban street youth, bears, circuit boys, Black MSMs, barebackers, muscle boys, or leather men, someone will always point out substance abuse, obesity, narcissism, low self-esteem, food disorders, and internalized homophobia as major issues. You can create programs, write grants, establish projects, and make speeches decrying the "epidemic of epidemics" facing gay men; you can express surprise and dismay at the sexual practices of gay men, and you can identify homophobia, internalized or externalized, as the dominant force influencing gay male life today.

But you will be wrong. You'll win grant funding. You'll get great press coverage. You'll sell books. You'll win community service awards. But you're wrong.

You'll be popular, though, because such thinking buys fully into the dominant thinking about gay men that reigns throughout American culture today. Whether taking the form of pity or disgust, sincere concern or superficial empathy, blaming or shaming, the overarching understanding of gay men's lives today is one of tragedy and pathos. Why are they so sex obsessed? Why do they do so many drugs? Why do they use steroids, work out obsessively, and dye their hair as they age? Why do they have to cruise all the time? The overarching belief seems to be that gay male culture is immature, irresponsible, and irrational.

These views have been put forward for over 25 years by both conservative, radical right, up-front enemies of equality for gay people, as well as liberal thinkers who rhetorically embrace the humanity of gay men, even as they condemn it. Why is the initial impulse of so many people—liberals and conservatives alike—to mistake creative and life-affirming pockets of gay male life as sick and self-destructive? What is the difference between arch-conservative Paul Cameron citing gay men's sex, sexual values, and sexual cultures with disgust and disapprobation, and liberal Larry Kramer citing gay men's sex, sexual values, and sexual cultures with disgust and disapprobation? What is it about the various ways we mix masculinity, sex, and pleasure that must be censured and derided by both the left and the right?

Those of us who were there in the early days of the gay men's health movement look at gay men today—and at the communities where gay men come together, establish bonds, and celebrate—and see creativity, caring, and audacity. We're delighted and impressed with new generations of gay male styles, rituals, identities, and subcultures, even as we remember that gay men have always had an amazing ability to keep inventing bold, new ways of being, even in the face of commodification, backlash, and internal wars.

In fact, we know that for many gay men homosexuality is a helpful and protective factor. It adds to the assets and gifts one gets from one's original or home community in key ways:

- Gay men are more mindful than most others and think out of the box, resisting limited social categories and societal directives. The simple experience of claiming our sexuality, identifying other men to have sex with, and entering gay community encourages mindfulness and creativity.

- As a class, gay men are skilled at both caring for themselves and caring for others. What some mistake as selfishness in gay men is often a kind of self-care rarely criticized in other men: the ability to understand and prioritize one's own desires and needs. Gay men balance this self-care with a sense of altruism—caring for others in the workplace, neighborhood, and community.

- Gay sexual culture allows us to make contact with men of other classes, races, and generations and form alliances which are richer and more diverse than those of most heterosexual men. Not only do we have sex with men different from us, but we form friendships and build community—however imperfectly—across stark identity lines.

In some ways, we take our lead from the women's self-help movement of the 1960s, 70s, and 80s—a movement that powerfully influenced gay liberation and gay men's health organizing at that time. When women declared "Our Bodies, Ourselves," they were shattering centuries of patriarchal pathologizing of women's bodies and their lives. By working with other women to create new models of empowered health care and disease prevention, groups such as the Boston Women's Health Book Collective, the Santa Cruz Women's Health Collective, the National Black Women's Health Project, and others, created a powerful model for marginalized populations—including gay men and people with HIV/AIDS. They made a radical break with the dominant medical model along with all of its embedded biases, values, and priorities.

My Journey into the Gay Men's Health Movement

I've been interested in the health and wellness of gay male communities since my earliest years as an activist, organizer, and writer. In my early twenties in Boston, I was a member of the *Gay Community News* collective and wrote regular feature articles on topics including anti-gay violence, queer youth, and depression and suicide among lesbians and gay men. I was fortunate to be involved in founding some of the nation's first advocacy projects for LGBT youth, served as an openly gay representative on a state social service council and at the White House Conference on the Family in 1980, and wrote the first book on gay people and suicide.

I was drawn to this work, in part, because I believed that the silences surrounding homosexuality and the way gay people's life trajectories were impacted by homophobia needed to be changed. I was also drawn to this work *because* of challenges I faced as a young man coming out in the early and mid-1970s. I became part of a movement, in Boston and beyond, that took on the massive project of changing the social and political position of homosexuality in our nation in order to improve the health, well-being, and life chances of a socially stigmatized and much-hated population. But at that time I didn't think of myself as part of a gay men's health movement. I was part of the lesbian and gay liberation movement.

During this same moment, I was tremendously influenced by feminist organizing, including the efforts of lesbian feminists throughout the United States. I was often one of the few men at women's music concerts; I joined picket lines at reproductive health centers that stood up against anti-choice activists; I avidly read the work of Adrienne Rich, Barbara and Beverly Smith, Cherrie Moraga, Gayle Rubin, Amber Hollibaugh,

Andrea Dworkin, Mary Daly, Jewelle Gomez, Dorothy Allison and Audre Lorde. While always aware that my obsession with lesbian feminism was far from altruistic, only in hindsight do I believe that I was mining feminist theory and practice for ideas and models that could be applied to gay men. Even when I disagreed with specific analyses of patriarchy or recommendations for specific forms of activism, feminism taught me more about issues of power, privilege, and resistance than any other literature or practice during that era.

At the same time, I was diving head first into gay male social spaces and the sexual cultures of the 1970s. Like most young gay men at the time, I found myself entering a world with values and norms very different from the social worlds I'd inhabited previously. I was drawn to gay bar life, disco dancing and leather clubs. I found myself in rooms packed full of men; in discos where hundreds of men were gyrating, sweating, and shouting as they danced. I found myself meeting a wildly diverse array of men and going back to their homes. I was exposed to men living in conditions vastly different from my own college dorm: public housing, working-class shared apartments, upscale urban penthouses. I had the privilege of observing men up close, often men from other races and classes, distinct from my own middle-class Jewish, Long Island background.

My early time in gay community life was profoundly influenced by the Stonewall political moment and the hippie-counterculture gay lib society. By the time I was out of college in 1976, that moment had pretty much ended, morphing into both the commercialized disco-bathhouse culture of the 1970s and the mainstream gay rights movement. At the same time, gay liberation—influenced, I believe, by feminism—exerted a powerful influence over the ways many of us thought about health, safety, and the wellness of gay men. In fact, the only observations and analyses of gay male life that seemed to bear any resemblance to the worlds in which I found myself came from gay liberationists.

I now see myself as the fortunate recipient of the hard work of gay liberationists who had created new ways of thinking about gay men's health—thinking that is often either totally ignored today or diminished and mocked. Responding to pre-liberationist beliefs that gay men as a class were sick, sinful, and criminal, the gay liberationists broke new ground in seeing gay men otherwise. Among the key understandings I took from gay liberation were:

1. Gay is good. While many people now look back on the "gay is good" moment as inconsequential, simpleminded, even trite, this notion struck me in 1975 as truly revolutionary. Not only were gay liberationists challenging the idea that gay is bad, but they were challenging the liberal notion that sexual orientation is neutral. From gay liberation I learned that the enactment of homosexuality itself, and the claiming of a gay identity, were powerful, transformative, and good. Gay was not sick, diseased, or bad. Gay was not value-neutral. Gay was good. Gay was very good. Gay was excellent.

I've been struck by the different paths lesbians and gay men took on this "gay is good" issue. Back in the 1970s, through lesbian-feminism, dykes had no trouble asserting that their claim to a lesbian identity was a powerful and positive move into values and lifestyles that were healthy and life affirming. They understood that the movement was about creating new forms of social organization, cultural rituals, and worldviews that offered much that was valuable to the world. And over the years, dykes have provided a wonderful model of addressing health challenges in a specific population (in their case, cancer and substance abuse) without allowing the concept of disease and the illness construct to merge with the community's identity and take it over.

Gay men tried to do the same thing in the 1970s: address health challenges without defaulting to a "we are a diseased population" model. However, in the years following gay liberation, we lost most of the language and political analysis to rhetorically affirm the value of the new worlds we were creating.

Discos might be "fun"; leather culture was "edgy"; bathhouses were "wild" and "ecstatic," but, except on rare occasions, we didn't articulate the valuable political ramifications of the new social order we were creating.

Lesbians had feminism, which led to their creating a huge array of publications, texts, cultural institutions, and organizations explicitly founded on the linkages between lesbian identity and feminisms. While a few gay men embraced the small and problematic "men's liberation" movement, gay men (for the most part) avoided a political meta-analysis of their lives and simply dove into the work of pioneering new cultural norms, new ways of being men, and new forms of social organization. Because so many of us stepped outside the arenas that served as intellectual incubators for new analyses of gender and sexual identities, and instead immersed ourselves in cultural spaces that were incubators of new gender and sexual identities and new relationships to traditional forms of masculinity, we left ourselves vulnerable to a backlash against the new gay masculinities. The dykes could fall back on the words of Audre Lorde, and others; few gay men put forward books that articulated the political value of the emerging gay male cultures. And those who did (for example, John Preston, Ivo Dominguez, Jr., Dennis Altman, Michael Bronski) attracted few readers to their political writings.

The backlash against gay as good emerged subtly during the first decade of AIDS; debates about gay sex practices, illness, and contagion quietly but steadily eroded our new barriers of defense against pathologized notions of male homosexuality. Many of us were distracted by unanticipated and overwhelming demands on our time as our friends, lovers, and neighbors grew weak, sick, and demented.

It's not surprising that few of us could see this particular conceptual backlash heading our way. Even as we put forward to the public evidence indicating that gay men were behaving responsibly, that the epidemic had chastened our cultures, and that gay men were exiting the bathhouses and enrolling en

masse in volunteer programs to care for the sick and dying, we were affirming—through our defensiveness—the pre-gay-lib beliefs that gay men were one-dimensional, sexually obsessed, irresponsible adolescents.

During that first decade of AIDS while we were changing diapers and emptying bedpans, society, including gay male society, was reevaluating its beliefs about gay men, after only a few years of the gay-lib-inspired rethinking of gay male culture. AIDS affirmed pre-liberation views of gay men as diseased. The backlash effectively erased any substantive memory of "gay is good" from gay men's understanding of themselves and their communities and cultures. In its place a powerful return of the "gay as pathology" or "gay is diseased" construct emerged, a construct that, by the 1990s, moved into a dominant position in the minds of gay journalists, AIDS prevention workers, and gay political leaders. .

By 1995, anyone seriously expressing even a limited notion of "gay is good" about gay men was seen as delusional, in denial, or seriously disturbed. Instead, a pathologized vision of gay men and gay male culture took hold: circuit parties were bad; the leather scene was bad; the gay ghetto was bad; young gay men were bad.

2. Gay men can take care of themselves. I came into a community where I quickly learned that gay men could care for themselves and care for each other. Not that this was a community without internal problems, or that, pre-AIDS, we didn't face significant health challenges. At the same time, my mentors schooled me in the caring spirit of the times: that we lived in a world where almost all institutions were hostile to our kind and if we were to survive and thrive, we had to take care of our own.

On the micro-level, this involved sharing information about health providers who were gay-friendly or offered non-judgmental treatment for sexually transmitted infections. It involved sitting out sex for a week when we were being treated for gonorrhea. It involved participating in fundraising efforts—before AIDS—to support the founding of gay centers, addiction recovery programs, STD clinics, and mental health services. The decade preceding AIDS, often depicted today as a time when gay men selfishly pursued their own sexual urges and did little to support community wellness, was actually a time when men in urban centers took on the public health establishment and forced it to support the creation of STD prevention materials and services specifically for us.

On the macro level, this spirit of caring for our own created dozens of organizations and projects devoted to gay community self-care. This was a time when gay men in dozens of urban and rural locations joined with lesbians and transgender people to force Alcoholics Anonymous and other 12-step programs to incorporate the specific needs of sexual minority alcoholics and addicts. It was a time when gay publications throughout the nation regularly provided coverage of STD threats, information on treatment locations, and detailed material about self-care and prevention.

Many people today believe that the massive and much heralded gay response to AIDS in the1980s was new and without precedent, providing evidence of a surprising shift in the commitments of gay male communities throughout the nation. Nothing is further from the truth. Our model of volunteer-based care for people with emotional, physical or practical needs emerged from the same hippie-gay lib spirit that created drop-in centers, crash pads, and emergency job programs for gays and lesbians in the 1970s. Our fundraising walks and mass events built on similar already-existing events in urban gay centers that previously had raised money for gay STD clinics or mental health services or other public charities. What the nation witnessed in the massive gay response to AIDS in the 1980s was an expanded version of earlier efforts focused on caring for ourselves and caring for others that had emerged prominently in the 1970s.

3. Political action and protecting the health and wellness of the community are inextricably linked. Gay liberation mentors explained to me early on that there was a strategic connection between gay activism and social services, the same connection that many other marginalized populations articulated back in the 1960s and 1970s. The early days of gay liberation made it clear that many men needed venues that would assist them in healing from the assaults of societal homophobia. Gay clinics, community centers and rap groups were designed as spaces to support that healing in a community-based model. Hence gay political activism was intended to change the world so that fewer people would suffer and be damaged by homo-hatred, and gay health work was about healing people so they might re-enter the political movement as whole people. Activism, itself, was healing; health work, itself, was activism.

Back in those days we did not divide our work on gay community projects into "health work" and "political work." Working in gay STD clinics was political work. Working to end anti-gay discrimination was health work. One of the benefits of being cast outside all traditional mainstream systems was that we were left on our own with our own renegade way of understanding our work. When we attended events such as the New England Gay Conference or the Southeastern Lesbian and Gay Conference or the Maine Gay Symposium, politics, activism, health, and culture were entwined. Our lives led us to understand on a visceral level the powerful political underpinnings of community health and wellness.

I brought these three foundational beliefs—gay is good, the value of taking care of our own, and the inherent linkage between gay politics and health work—to my work in gay community centers and AIDS organizations in the 1980s, even as the world around me was shifting rapidly back into a disease model of homosexuality. Gay groups were taking on a professionalized work force of medical providers, mental health counselors, and addiction recovery workers that favored distanced, academic knowledge over community-based home-grown wisdom. As director of the Los Angeles Gay and

Lesbian Community Services Center, which Morris Kight and Don Kilhefner founded, I worked with a powerful team of gay men and women to provide an array of social services to LGBT people using models that empowered rather than infantilized or made people dependent on a human services bureaucracy. When I moved to San Francisco to direct Shanti Project, a pioneering AIDS care group, I found myself working with hundreds of volunteers under unbelievable pressure to provide care for people with HIV, using a model that allowed people with HIV to maintain control over their health and medical decisions, rather than passing it to professional case managers, as is now more commonly the case.

These models and systems of care were founded on the belief that people should control their own bodies and their own health care. Professionals were there only to assist these activities, not to direct or manage them. Any attempt to shift control onto professional health providers was understood as damaging, disempowering, and, ultimately, anti-gay. Learning from the feminist self-help movement, we understood the central role of power and authority in promoting or undermining health. We wanted to support the creation of powerful communities.

How Gay Became Sick Again

During the first decade of AIDS response, many of us were so caught up in the day-to-day work of prevention, care, and political activism that we didn't note the profound shift occurring in the ways social institutions, health care providers, and gay men themselves looked at gay men's relationship to health. While internal community battles were clearly about whether we still believed gay was good or whether gay men could care for themselves and each other (I'm thinking here about struggling with how to have sex in an epidemic, the closing of bathhouses, or making a distinction between being an "AIDS victim" and being a "person with AIDS"), many of us were so focused on the tasks at hand that we barely had time for big-picture thinking. Before we knew it, the 1990s had arrived, the tidal wave of AIDS had crested, and we were looking out over a vastly different landscape of gay men's health with vastly different understandings of gay men's communities and cultures.

By 1993, it became clear to many of us that one of the most pernicious consequences of AIDS was the way it re-pathologized homosexuality, particularly male homosexuality. And the most painful part of this return to gay-men-as-diseased-pariahs was that gay men were the most prominent mouthpieces espousing these beliefs. The same voices that spent a decade over-stating, over-praising, over-citing gay men's "sensible" and "prudent" response to HIV/AIDS—the gay medical establishment, gay public officials, gay mental health workers, and queer journalists—now seemed intent to balance their earlier pronouncements with an intense demonization of gay men, gay social structures, and, particularly, gay men's sexual cultures.

All of a sudden, it seemed as if the wisdom of gay liberation was a relic: the sweet, dated rhetoric of another era. Clearly an epidemic as extreme as HIV demanded more than self-care, more than "*gay-is-good*" sloganeering, more than political action linked to health services.

In the minds of many, AIDS proved that gay liberationists had been wrong. Gay men were, in fact, not capable of caring for themselves and others. Not only did homosexuals bring this epidemic onto themselves, but they were responsible for HIV becoming endemic by repeatedly and knowingly infecting one another. All of a sudden gay men became damaged goods—damaged by homophobia, damaged by AIDS, damaged by out-of-control sexuality, damaged by addiction. Damaged goods demanded a paradigm of health promotion focused on surveillance, control, discipline, and punishment—a paradigm that treats adults like children, a model focused on the colonizer and the colonized.

Hence by the mid-1990s, the dominant understanding of gay men and health was one where gay men were seen as spinning out of control, incapable of self-care, and terribly self-destructive and irresponsible. Medical providers, researchers, journalists, and AIDS prevention leaders—gay and straight—looking at our sex, substance use, community rituals, and social structures seemed almost unified in their assessment: gay men sought pleasure at the expense of health, self-care, and community responsibility. Even a thoughtful, well-planned 1994 conference—the National Summit on HIV Prevention for Gay Men, Bisexuals and Lesbians at Risk, held in Dallas and hosted by the Gay and Lesbian Medical Association—deteriorated into frustrated finger-pointing and blaming. I recall one respected lesbian leader wagging her finger and expressing her frustration and her horror that gay men couldn't keep "keep their dicks zippered up" during a health crisis.

Throughout these years, some of us tried to offer more nuanced arguments rooted in our gay liberation values. We tried to understand gay men's behavior from our own perspectives: What were gay behaviors really about? What needs were being met? We tried to approach community controversies with an eye towards empowerment rather than punishment. When debates flared in 1996 about circuit parties, bathhouses, and bare-backing, we tried to offer arguments that understood gay men's sexual cultures outside a pathology model. We held two "Sex Panic" summits alongside the National Gay and Lesbian Task Force's Creating Change in San Diego and Pittsburgh, where about two hundred of us came together to provide ideological and personal support for fighting local battles for sexual freedom, during an era when the tide of public opinion had clearly turned against us. But much of the mainstream media and the gay press depicted us as delusional, sex-obsessed perverts out of touch with the realities of the times.

The forces that saw gay men as essentially sick, diseased, and irresponsible became dominant on the pages of newspapers and at AIDS conferences. Whether the topic was new infections among young gay men, bare-backing, crystal use, circuit parties, or even same-sex marriage, the discussion was

dominated by an overarching vision of gay men as sexually obsessed, self-destructive, and uncaring. At worst, we were seen as menaces to society. At best, we were excused as victims of societal homophobia, racism, and indifference. In both cases, we were seen as deficient: deficient in self-control, deficient in social responsibility, deficient in health and wellness.

This rhetorical frame for gay men's cultures began to seep into the consciousness of regular gay men and soon appeared to dominate the thinking of gay men themselves. It became common to run into friends, tricks, and social acquaintances who repeated the new party line about bare-backing or circuit parties or crystal use; some of us recoiled in disgust and disappointment. All of a sudden a rank and file gay male population saw itself and others through the disease lens. It was a return to pre gay-lib days. The homophobes had won the battle!

When we attempted to work in partnership with friends in HIV prevention organizations we faced surprising challenges. They'd repeatedly affirm that they shared our beliefs about gay men and health, embraced "sex-positive" values, and were committed to "empowerment" (a term that had, by the 1990s, been so overused and misused that it immediately made some of us skeptical), and then they'd launch advertising campaigns that were condescending, patronizing, and deeply anti-gay. An AIDS prevention industry clueless about how to limit new infections tried almost anything, including buying into all the foundational assumptions of the right that gay men were evil vectors of disease.

It came as no surprise that gay men began to see one another not as brothers and caregivers and lovers and comrades in gay liberation, but as opponents, threats, and enemies to one another's health. HIV prevention asked us to treat every man we had sex with as if he were infected, in order to ensure compliance with the condom code, even when not necessary. We were told to distrust men's revealed antibody status because "men lie." We were force-fed campaigns like "HIV stops with me," which worked to drive home—in case anyone doubted it—that there were legions of positive men out there eager to pass on their virus to vulnerable, clueless uninfected men.

The sorry state of HIV prevention, the effective re-pathologizing of gay men as a class, and a rising sex panic emerging from the collusion of gay male journalists and neoliberal public officials finally drove some of us to organize. Not only did public conversation about gay men in the early and mid-1990s cause tremendous heartache and inspire contentious internal community splits, it also motivated some of us to intervene in the discourse and organize alternative sites where more progressive analyses might be shared.

The Creation of a Gay Men's Health Movement

In 1998, when the annual National Lesbian and Gay Health Conference, which drew together people working on LGBT health issues nationwide, ceased to exist—its host organization went bankrupt—discussions took place about finding a new organization to host the event. At the time, lesbian activists wanted to organize on their own for a few years and several key leaders encouraged gay men to begin "to get their act together beyond HIV/AIDS." This motivated me to work with a small group of other activists—all under the age of 30—sharing similar values and visions, to issue a call to the first national gay men's health summit.

Coming as much out of frustration with HIV prevention work as from the sex panic sweeping over gay communities nationwide, our team of good-hearted organizers volunteered to do what needed to be done to create a space where people concerned about the health and wellness of gay male communities could come together outside the paradigm of disease and self-destructiveness.

The origins of the term "gay men's health" are rooted in the gay liberation movement and at least one organization using the term in its title remains from that period (Berkeley's Gay Men's Health Collective). However, during the 1980s, after New Yorkers named their first AIDS organization "Gay Men's Health Crisis," the term gay men's health seems to have become a euphemism for AIDS. As activist Chris Bartlett has pointed out, HIV so overwhelmed the community that "gay men's health" became synonymous with "HIV/AIDS."

When we began agitating for a national "gay men's health" summit in 1998, we seized on the term in an attempt to strategically move its meaning beyond HIV/AIDS. Our intent was twofold: (1) we hoped to promote a holistic view of health that incorporated not only medical and mental health but emotional, political, spiritual, and community health concepts as well; (2) when we did focus on health threats to gay men, we wanted HIV/AIDS simply to be included as one of the many ailments facing gay men, alongside cancer, heart disease, street and domestic violence, syphilis, obesity, and addiction.

After eight years of intensive gay men's health organizing efforts occurring outside the purview of any national gay organization, we have finally succeeded in creating an alternative to the disease model of working on gay men's health issues. While far from dominant, it is being embraced by more and more organizers and more and more rank and file gay men who sense that there is something very wrong with how journalists and medical experts continue to talk about gay men's communities.

The model we put forward at the first three gay men's health summits (2000, 2001, 2003) included at least three beliefs that contrast dramatically with the beliefs of the disease model.

1. We believe that gay men, at root, are individually and collectively healthy, reasonable, life-affirming, and successful in creating fulfilling and meaningful lives.

2. We take an asset-based approach to gay men's communities, rather than a deficit-based approach; we look at and build on inherent community strengths, resources, skills, and values that demonstrate gay men's commitment to survive and thrive even under formidable circumstances.

3. We share in a commitment to approaching gay men as people who have made a baseline commitment to self-care, community-care, and disease prevention. Of course there are gay men who appear unreasonable and destructive to themselves and others, but we believe the current paradigms take this small group as representing all gay men. Accordingly, we refuse to separate ourselves and our movement from these men or to create programs only for "goodies" and avoid the "baddies"—or write them off as inhuman or antisocial.

We organized our small group of national summits with the intent of dispersing these ideas and values widely in a manner that was decentralized, unstructured, ultimately beyond our control. Inspired by Alberto Melucci's work on contemporary social movements and Michel Maffesoli's work on neotribalism, we believed that conceptual shifts can result from new, creative organizing techniques. We rolled up our sleeves, got down to work, and now, several years later, see a changing landscape to which we have contributed.

I know I share the joy and satisfaction of many organizers who've marveled at the growing influence our nascent gay men's health movement has had and the many projects and events that seem at least partially inspired by our work. By 2005, over 30 local and regional gay men's health summits had been held throughout the nation, not only in urban centers such as New York, San Francisco, and Seattle but in Wilmington, Delaware; Salt Lake City, Utah; and Hartford, Connecticut. Summits have been held focused on African-American and Latino gay men, rural Southern men and young gay men.

We find ourselves at an unusual moment now, where the term "gay men's health" has acquired a certain cachet and is being increasingly taken up by a diverse range of projects and used in several different ways. Not all of these projects attempt to tackle the range of health challenges facing gay men. Few of the projects attempt to shift to a wellness model and away from the disease model of gay men's cultures and communities. Also surprising to many of us is the way the term has been embraced in other countries, especially Canada, the United Kingdom, Switzerland, Australia and New Zealand, and, recently, France; we have been surprised by the large numbers of international participants at the first three national gay men's health summits.

Gay men's health activities currently take the form of organizations, projects, and campaigns and appear to cluster in at least three different models:

- **Projects focused on community wellness that tackle a range of health challenges facing gay men, and were not originally HIV organizations:** These include not only many of the national, regional, and local gay men's health summits, but also organizations such as San Francisco's Magnet and Seattle's Gay City Health Project. These efforts tackle a broad range of challenges to gay men and attempt to use holistic, sex-positive, and gay-positive approaches. Outside the United States, programs such as Dialogai in Geneva include a strong health and wellness focus.
- **HIV/AIDS organizations that substitute "gay men's health" language for "HIV prevention," and also begin to work broadly on non-HIV health issues affecting gay men's communities:** Dozens of AIDS organizations throughout the English-speaking West have incorporated "gay men's health" in their organizational name or as the name of a project under their jurisdiction, but few seriously take on a broad menu of health issues facing gay men and fewer still resist the disease model. But some projects do take on health issues broadly, including the Institute for Gay Men's Health, a joint project of AIDS Project Los Angeles and Gay Men's Health Crisis that defines health broadly to include spiritual and community health and appears to conscientiously avoid using the pathology model when scrutinizing subcultures of men who have sex with men. Philadelphia's Safeguards began as an HIV prevention organization for gay men and has now broadened into an LGBT health advocacy agency. Internationally, Australia's ACON has more recently also shifted from solely HIV/AIDS to a broad LGBT health matters, as have the Terrence Higgins Trust and Gay Men Fighting AIDS, both in London.
- **HIV/AIDS organizations that substitute "gay men's health" language for "HIV prevention," even as they continue largely to work narrowly on HIV/AIDS:** Tucson's Gay Men's Health Project, which augments a strong HIV prevention focus with social activities, is an example of this type of effort, or San Francisco AIDS Foundation's Gay Life program, which maintains a narrow objective, solely HIV prevention, though it might tackle it through other health issues affecting infection rates, such as programs currently being developed to fight crystal use among gay men. New Zealand AIDS Foundation's Gay Men's Health Teams seem to fit this model as well.

The work ahead seems daunting but the path forward seems clear. We must work hard to augment narrow HIV prevention programs for gay men with a full range of activities addressing the overall holistic wellness of local and regional gay men's communities. At the same time, we need to focus on affirming the overarching framework of community health that we bring to these efforts. Our goal is not only to blanket the nation with diverse gay men's health projects as we blanketed the nation in the 1980s with HIV prevention projects. Additionally, we need to shift from seeing gay communities and subcultures as problematic or diseased to seeing them as healthy, happy, and life affirming. This is the bottom line for any gay men's health movement.

Recently I attended a dance party, one of the many evenings of intense music and cavorting available to thousands

of gay men in my city each weekend. I looked over the crowd of primarily twenty-something and thirty-something men, shirtless, gyrating, arms reaching to the heavens. I thought immediately of how the doomsayers criticize this population of young gay men, saying things such as, "I didn't work my ass off during the past 30 years to create a culture of drug use and unprotected sex and self-centered me-me-me attitudes. This is not what the gay movement was all about. This is not what we envisioned when we tried to save lives during the worst of the AIDS years. This is not the world we were trying to create."

And then I realized something surprising and simple. As someone who has spent the last 30 years working on gay liberation and AIDS activism and sexual liberation, what I saw before me was *precisely* the world I was trying to create. When we fought during the 1980s and 1990s to prevent gay men's sexual cultures from being destroyed, when we worked to preserve certain values about gender play, friendship, and erotic desire, when we quietly worked behind the scenes to ensure that certain spaces would survive gentrification and public health crackdowns, we were fighting to preserve the ability of new generations of gay men to create worlds of pleasure and desire. As I looked out over the sea of dancing men, I realized, despite all the battles we've lost in terms of politics and discourse and the media, gay men and gay sexual cultures have managed to survive and, indeed, thrive.

CHAPTER 8

RECONCEPTUALIZING & REINVIGORATING OUR WORK WITH GAY MEN'S COMMUNITIES

Despite the rhetoric deployed by many of us who work to improve the health and wellness of gay men's communities, there is no single, unified "gay men's health movement" in the United States in 2007. As is true for all contemporary social movements, what is dubbed the gay men's health movement is inspired by our collective imagination, a collaborative vision that propels our work and connects a range of diverse—and sometimes contradictory—activities.

Sometimes it feels more accurate to refer to gay men's health *movements*, recognizing distinct efforts that operate along independent, parallel tracks. At other times, it feels useful to use the term "gay men's health movement," to capture the full range of projects and activities that share the overall objective of promoting the health and wellness of gay men's communities. In this chapter, I will talk about the gay men's health movement, acknowledging upfront that it's impossible to reflect the nuances and complexity of this movement with total accuracy.

What Are the Origins of the Gay Men's Health Movement?

Today's gay men's health movement in the United States traces its roots directly to five main health-related efforts over the past 40 years: (1) the free-clinic movement of the 1960s; (2) the feminist women's health movement of the 1960s and 1970s; (3) the gay male STD movement of the 1970s; (4) the AIDS activist and prevention movements of the late1980s; and (5) the LGBT health movement spanning the past three decades.

Many gay men have never had access to this history, and so have little understanding of the deep roots today's gay men's health movement has in different social justice movements of the late 20th century. Yet today's work promoting community health and wellness for gay men would not have been possible without the political work of progressive movements in the 1960s and 1970s, including the Black Power and civil rights movements, women's liberation, and the student anti-war movement. The politics of this era ignited, among other things, a collective rethinking of long unexamined concepts of "health," "disease, and "community wellness." And a variety of marginalized communities, especially poor people, people of color, and women began to put forward radical critiques of the dominant systems of health care and the medical model on which it rested.

For gay men of the era, a collective concern for sexual health and wellness was the catalyst for a re-examining the community's relationship with public health systems and the medical model, just as mental health issues like depression, suicide and internalized homophobia triggered a reexamination of the broader LGBT community's relationship to psychiatry, psychology, social work and counseling. In the 1970s, well before AIDS appeared, gay men and their allies in many metropolitan areas became concerned about sexually transmitted disease treatment and prevention. As the sex cultures of the period broadened and took root, and as masses of gay men emerged from the closet, gay men's communities were confronted with a range of diseases and ambivalent relationships with public health biases and practices.

A review of the historical record of this era reveals that gay men often challenged public health authorities to provide targeted STD information to the gay male population, advocated for openly gay public health workers in community clinics, and demanded non-judgmental treatment for a range of ailments. In many cities, including Boston, Los Angeles, Baltimore, Milwaukee, and Chicago, gay men—along with lesbians and non-gay allies—who were dissatisfied with the response from public health workers and city officials organized their own STD testing sites and funded their own sexual health education campaigns through the nascent gay press.

These efforts gave birth to the venereal disease (VD) clinic at the Los Angeles Gay Community Services Center; Gay Health Night at Boston's Fenway Community Health Center; Baltimore's Chase-Brexton Clinic; Chicago's Howard Brown Health Center; Whitman-Walker Clinic in Washington, D.C. and several other specialized sites supporting gay men's health and wellness. Originally organized and staffed primarily by volunteer physicians, nurses, phlebotomists, and public health educators, these organizations struggled to find funding, community support, and organizational stability. They represented the first large, multi-city effort to protect the health and wellness of gay men, and these health programs were distinctly sex-

positive and culturally rooted in the gay liberation movement. In other cities, such as San Francisco, public officials exhibited enough openness to input from gay men that the local community did not put energy into creating its own non-profit clinic; instead gay activists and health workers targeted specific city clinics and made them into gay-responsive health sites.

The core values and objectives of the gay men's STD movement of the 1970s appear closely linked to pioneering work taking place in the feminist self-help movement during the early years of women's liberation. Both women and gay men during this era faced a medical system that did not share our values and was not designed to meet our needs. When abortion was still illegal, pioneering feminist groups took the lead in providing women with access to safe abortion services, even, on occasion, training lay women to perform abortions. Feminists of the era organized self-help groups where women explored their bodies, using speculums to learn about the inside of their vaginas, teaching one another how to examine their breasts, and asserting ownership of their own bodies. This was the era that produced pioneering books such as *Lesbian Health Matters* and *Our Bodies, Ourselves,* both of which helped to export concepts such as self-help and community empowerment into mainstream thinking.

Lesbians deserve credit for bringing concepts and values of the feminist self-help movement to gay men. Many feminist health slogans of the era would soon be applied to gay men's health organizing: "We cannot live without our lives," "Our bodies, our lives: Our right to decide." During the 1970s, most lesbians and gay men inhabited gender-specific social networks, spending their time in sex-segregated bars, music festivals, and social organizations. There were, however, notable exceptions, including rural lesbians and gay men and those involved in co-sexual political groups like Boston's *Gay Community News* collective**.** Yet the gay movement provided a space where, at least potentially, gay men and lesbians could participate in highly charged and politicized dialogue across gender differences. Community centers, MCC churches, and new professional organizations of gay nurses, physicians, psychologists, and social workers became sites where lesbians and gay men interacted. Thanks to dialogues born out of these spaces, the gay STD clinics of the 1970s shared in the feminist self-help movement's commitment to self-help and community empowerment, and learned to be suspicious of medical science and public health authorities.

In the early 1980s when the community-based response to AIDS began, lesbians, bisexual women, and straight feminists were on board from the outset, helping to shape the values and politics of the early AIDS movement. This influence can be seen in early prevention campaigns, a focus on community-based self-help volunteer efforts, and the creation of community-based watchdog groups that kept gay men's needs and values center stage as early policies were debated, formalized, and institutionalized. Feminist influence was also reflected in the overarching awareness of the linkage between politics and community health.

Those who spearheaded these three groups—the gay men's STD movement, the feminist self-help movement, and the AIDS movement—became the largest constituencies of an LGBT health movement that began in the 1970s, but would expand dramatically during the 1980s and 1990s. Through organizations such as the National Lesbian and Gay Health Association and the Gay and Lesbian Medical Association, and at annual meetings of professional organizations such as the American Nursing Association, the National Association of Social Workers, and the American Psychological Association that included gay and lesbian caucuses, employees and volunteers from hundreds of community centers, clinics, formal and informal health-specific programs came together, shared best practices, and served as a brain trust for emerging community concerns. Meeting annually after 1978 at the National Lesbian and Gay Health Conference, the nascent LGBT health movement supported the development and education of a professional cadre of health workers, researchers, medical providers, and policy experts. Almost everything we know today about the health needs of this population—and the best practices for responding to these needs—emerged out of the underpraised LGBT health movement.

The initial work on gay men's health issues was interrupted, though not fully halted, by the AIDS epidemic. The bulk of community resources, personnel, and expertise developed in the 1970s became channeled towards HIV/AIDS. While individual providers continued their service-delivery work and gay men's domestic violence, mental health, STDs, and addiction recovery were addressed, AIDS overshadowed everything. It became difficult for advocates to find funding for non-HIV gay men's health work: hence grant writers became skilled at explaining the many ways in which homelessness, violence, and substance abuse were linked to HIV. New York City's major AIDS organization could adopt the name "Gay Men's Health Crisis," and no one thought the work focused on any health challenges besides HIV disease. By the early 1990s, gay men's health work remained largely focused on HIV/AIDS, while independent efforts to address lesbian health needs and the health concerns of bisexuals and transgender people were steadily gaining traction.

The Birth of Today's Gay Men's Health Movement

How then did new, autonomous efforts begin in the mid-1990s that resulted in a new wave of gay men's health organizing? What forces finally began to break the stranglehold HIV maintained on gay men's health work?

The early 1990s, before the arrival of the hopeful new HIV treatments mid-decade, were an odd and confusing time for gay men's health organizing. By 1991, in most parts of the nation, the intense energy of ACT-UP had started to wane and it was unclear what, if anything, was going to replace it. Many people began to recognize that HIV prevention tactics, seen as extremely useful in the 1980s, were no longer effective in

the 1990s. A cultural shift had taken place that threatened the "use-a-condom-every-time" model of prevention; new ideas and programs were needed. Many articulated this shift as the difference between asking men to eschew semen exchange for a few years under emergency conditions and demanding they give it up for a lifetime. Others saw it as a generational transition: the men flooding into gay male social and sexual spaces had come of age when AIDS was already endemic to community life. Certain approaches that "worked" under crisis conditions and in an emergency moment might not work once the community started to normalize HIV as a predictable feature in everyday life.

Accompanying this shift was a dawning recognition that HIV among men of color had to become a top priority for AIDS organizations and that work with gay men of color had to use broader and more holistic methods than had been used with mainstream, privileged and affluent white communities in the 1980s. Issues such as homelessness, legal status, literacy, unemployment and substance use became central factors affecting HIV prevention, treatment, and care. Common gay male health issues first examined during the 1970s such as depression, isolation, substance use, and sexually transmitted infections became once again important to address.

During the mid-1990s, health educators and community organizers noticed an increasing resistance on the part of many gay men to anything having to do with HIV/AIDS. Education programs and support groups that explicitly highlighted HIV were unable to attract large audiences. Participation in AIDS walks started to decline dramatically. Books and publications focused on HIV/AIDS had difficulty finding an audience. Part of this dynamic involved burn-out and part involved the growing disaffection many men felt for the culture and politics of HIV organizations. Whatever the reasons, HIV concerns no longer had the same powerful draw for masses of gay men as they had in the 1980s. By broadening the agenda, shifting the frame from AIDS to gay men's health, many organizers hoped to reengage community energy and improve individual men's health and wellness.

The early 1990s were a moment when HIV-negative gay men began to organize and see themselves as having health concerns and medical needs distinct from HIV. Increasingly, these men began to assert themselves and demand that the resources and energy of the community be expanded beyond HIV/AIDS. Some challenged why HIV-prevention would target men who were already infected with HIV. Others raised concerns about ailments facing aging uninfected gay men who were not receiving care and guidance from the AIDS health system. Landmark books probing the experiences of HIV-negative men revealed that the stresses of living through the epidemic had taken their toll even on the uninfected. Some of the men most involved in organizing around HIV negative issues became early leaders of the nascent gay men's health movement.

In 1995, the Gay and Lesbian Medical Association (GLMA), under the leadership of Ben Schatz, convened an urgent national meeting in Dallas intended to confront a new rise in HIV infections. Several hundred people responded to the invitation, producing a three-day series of speeches, workshops, and working groups pondering future directions for AIDS prevention work with gay men. It brought into one space—perhaps for the last time—community leaders who believed it was time to curb what was seen as the "sexual excesses" of gay men's communities and leaders who supported health measures aligned with the sexual liberation ethos.

For me, the GLMA conference served to ignite today's gay men's health movement. The public discussion at the conference had a sense of urgency that made many of us feel that something—anything—must be done to prevent the loss of future generations of gay men. Over meals, at the bar, in the hotel pool, several of us began talking about the concept of a gay men's health movement.

In the mid-1990s, we began to see the creation of specific programs and organizations to meet a broad range of gay men's health needs. In Seattle, in 1995, Gay City Health Project was formed out of a sense that narrow HIV-prevention approaches were no longer working for local gay men. In Philadelphia in 1997, a pioneering HIV-prevention group boldly shifted its mission and programming to address gay men's health challenges, broadly defined. Under the leadership of Chris Bartlett, Safeguards surveyed its volunteers and clients and learned that they were hungry for the organization to address issues ranging from depression and diabetes to prostate cancer and heart disease. Over a two-year period, the board and staff of Safeguards worked with the group's volunteers to transform the organization into the nation's first multi-issue gay men's health project of this new era.

The final years of the 1990s brought forward a spate of books focused on health issues affecting gay men, often from vastly different political perspectives. Two books published in 1997 ignited major debates about the sex and drug cultures of gay male communities: Gabriel Rotello's *Sexual Ecology: AIDS and the Destiny of Gay Men* and Michelangelo Signorile's *Life Outside - The Signorile Report on Gay Men: Sex, Drugs, Muscles, and the Passages of Life.* In 1998, Robert Penn, working in cooperation with the National Lesbian and Gay Health Association, published the *Gay Men's Wellness Guide*, a comprehensive manual for gay men, followed in 1999 by graduate student and activist Michael Scarce's book *Smearing the Queer: Medical Bias in the Health Care of Gay Men* and, in 2000, Daniel Wolfe's *Men Like Us: The GMHS Complete Guide to Gay Men's Well-Being*. These books became fodder for discussion, debate, and reflection as a broader gay men's health movement began to coalesce.

The first National Gay Men's Health Summit, in Boulder, Colorado, in the summer of 1999 was promoted by a diverse coalition of organizations and individual gay health activists who felt the time was right to bring together people working on broadly defined gay men's health issues and grappling with the proper frame for such efforts. The organizers struggled for nine months to find a financial sponsor, until Boulder County

AIDS Project took on legal responsibility for the summit and agreed to serve as fiscal sponsor. Then a collective formed and expeditiously began the work of organizing the program, fundraising, and summit logistics.

I was one of four collective members who took on the task of organizing the first national summit. Looking back, I realize that my colleagues and I took personal and professional risks during the planning process. We titled the event a "summit" rather than a "conference" so as to capture the urgency we felt. We did not have any idea of the number of people who might be drawn to this kind of event or what their interests and motivations might be. We began our organizing hoping 150 people might attend; we had no major sources of funding, so we planned cautiously, assuming a shoestring budget.

Over 300 people attended that first gay men's health summit, including not only gay and bisexual men, but women of all sexual identities, transgender people, and straight men committed to gay men's health. The program for that summit tackled such broad health issues as alcoholism, heart disease, cancer, violence, mental health, tobacco use, drug abuse, and SM safety. And the program was balanced by workshops on activism, spirituality, rural organizing, sexual meanings and erotic pleasure, gender identity, and cross-generational conversations. By refusing to limit our understanding of health work to diseases and medical models—and by encouraging regular gay men to share their expertise as workshop presenters—we aimed to break through the professionalism, limited sources of knowledge, and medicalized culture that dominated the AIDS conferences we had become accustomed to attending.

While the organizing collective saw this as a one-time summit, the participants, by the end of the weekend, had different ideas in mind. At the closing session, participants called for a second summit one year later. That second event, held in 2000 in Boulder, was organized by a larger collective that included gay men of color. The second summit attracted over 500 participants. Organizers then decided to focus their efforts the following year on creating local and regional summits. Over 20 smaller gay men's health summits took place across the nation during 2001, effectively dispersing throughout the nation the idea of an imaginative, innovative gay men's health movement.

By the time we met again at the third National Gay Men's Health Summit, in Raleigh, North Carolina, in 2003, the concept of a gay men's health movement had caught on throughout the nation. Local communities had begun to initiate specific programs modeled on the emerging gay men's health movement.

At the deepest level, new gay men's health projects had been launched in at least a dozen locations; these projects were places where people worked on a broad range of gay men's health issues, busting beyond the narrow AIDS medical model. In about half-a-dozen cities, people created formal and informal networks of organizations providing services to gay men and began talking about coordinating efforts, adopting a strategic planning approach, and initiating activities such as needs assessments, streamlined service delivery systems, and centralized intake systems.

Several dozen AIDS prevention programs changed their names or added subtitles to their organizational letterhead, including words such as "gay men's health project" or "health services to gay men", even though most continued to provide only narrow HIV prevention services. After five years of a new wave of gay men's health organizing, we began to see changes in discourse and the development of new programs, campaigns, and services to meet the ongoing needs of gay men's communities. To the uninformed spectator, the emerging movement might seem haphazard, unplanned, and random. Nothing would be further from the truth.*

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* Landmark events of today's gay men's health movement include:

1997 (Philadelphia): Transformation of *Safeguards* from HIV focus to broad Gay Men's Health focus

1998: Robert Penn's *Gay Men's Wellness Guide* published, followed by Daniel Wolfe's *Men Like Us: The GMHC Complete Guide to Gay Men's Well-Being* (2000)

1999 (Boulder): National Gay Men's Health Summit I: 300 participants

2000 (Boulder): National Gay Men's Health Summit II: 500 participants

2000-2002: Over 25 local & regional gay men's health summits held in the U.S.

2001-2003 (Sydney, London, San Francisco): Tri-City International Think Tank on Gay Men's Health

2002 LLEGO Encuentro includes one-day Latino Gay Men's Health Summit

2002 BlackGay Men's Call to Action

Institute for Gay Men's Health organized

Black Men's Research Initiative

Tri-City Think Tank

2003 (Raleigh): Gay Men's Health Summit III: 400 participants

2003 Opening of Gay City's Health Clinic (Seattle) and Magnet (San Francisco)

2004 GMHC (New York) and APLA (Los Angeles) open Institute for Gay Men's Health, focused on men of color

2005 (Salt Lake City): Gay Men's Health Summit IV: 300 participants

2005 (Paris): French Gay Men's Health Summit draws international participation

2005-present: Expansion and diffusion nationally and Internationally

Characteristics of Today's Gay Men's Health Movement

While the organizers of today's gay men's health movement have operated outside of a single, formal organizational structure and without dedicated funding streams, it would be wrong to believe that the movement simply "happened"

without forethought, debate, and planning. There are core characteristics of the movement:

- **The G Word is Central:** The movement is focused on gay men, not lesbians, bisexuals, or transgenders. While some efforts are focused on men who have sex with men, or men on the down low who do not identify as "gay," such projects often have an ambivalent relationship to the gay men's health movement. Overall, today's gay men's health movement sees itself as one part of a broader LGBTI health movement, yet is unapologetically focused on the "G." From the beginning, the gay men's health movement has faced challenges from people who don't think gay men should be organizing on their own, or who believe that the narrow category of "gay men" is simply a social construct and has no practical use in the health field. We've often wondered why it seems politically acceptable to have a national lesbian health conference or a national meeting on transgender health, but it's not okay to organize a gay men's health summit. As long as people continue to do the work with a sense that they are part of a broader LGBTI health movement, and acknowledge upfront that they are focused on that narrow sliver of "self-identified gay men," I believe they can proceed with integrity.
- **New Models of Organizing are Deployed:** The movement is deliberately and self-consciously loose, sprawling, without a single, core home institution. No one has sought to create a national organization or a formal institution overseeing a gay men's health movement. The movement has no elected leaders or appointed czars. Instead, organizers believe that the smartest strategy is to create events like the summits, where new thinking can be shared, debated, and adopted.
- **Events are De-professionalized:** While today's gay men's health movement involves doctors, nurses, social workers, psychologists, and researchers, a strong attempt has been made to encourage participants to step outside of their professional roles. At the national summits, for instance, participant nametags have only names and cities, not titles or professional affiliations. This reflects a longstanding sense that a movement comprised of representatives of service-providing or educational institutions might be less likely to adopt activist approaches than one in which people participate as individuals.
- **The Movement is Community-based and Affirming of Diverse Subcultures:** This movement is grounded in the authentic sites and locations of gay men's communities and respects the diverse subcultures which gay men inhabit. For example, at national summits there have been pioneering workshops on "bear health," circuit party health promotion, SM safety, and transgender gay men. In all cases, the aim is not to focus narrowly on "what's wrong" with specific communities and subcultures, but to examine the range of factors that draw gay men to such communities, and look at the assets and liabilities of such subcultures.
- **Organizers are Dependent Upon the Kindness of Strangers:** Because today's gay men's health movement is organized in a decentralized and anarchistic way, it is heavily dependent on the generosity of individuals and organizations. Gay men's health organizing has been supported and expanded thanks to concrete support from HIV/AIDS organizations, progressive governmental health bureaus, LGBT organizations and networks, and several key foundations and private donors.
- **While Informally Initiated, the Movement is Strategic and Principled:** Movement organizers often have a strong background in social theory and public health research; they design events and create goals based on both their theoretical knowledge base and their field knowledge of gay men's communities. There is a focus on clarifying the values and beliefs that drive particular projects or campaigns, and on how to link principles to specific programs, events, and rituals.

The Six Foundational Principles of Gay Men's Health Summits, Projects, and Campaigns

What are the guiding principles of today's gay men's health movement? Is it possible for anything as dispersed and decentralized as this movement to abide by specific principles or adhere to certain values? How do these principles function in the day-to-day work of gay men's health summits, programs, projects, campaigns and organizations? What appears below is a series of principles that have been proposed, discussed, debated, altered, and debated again at over two dozen meetings of gay men's health organizers. They have not been certified or endorsed by any specific body; hence they do not represent the consensus principles of any organization or event. For me, however, they function as guiding principles behind all events and work that I perform related to gay men's health and wellness.

What follows here are the principles that form the foundation of my own work on gay men's health today.

1. Replace the HIV-centric paradigm of health advocacy for gay men with holistic models that integrate (but do not default to) HIV.

We need to redirect gay men's health work away from a narrow, and sometimes solo, focus on HIV/AIDS, into broader and more holistic approaches that respond seriously to the range of health challenges facing gay men. For example, rather than fight crystal abuse because it might lead to HIV seroconversion we might also consider that addiction is itself a major challenge to the health and wellness of gay men's communities.

2. Temper our use of the crisis paradigm in our work on HIV and any emerging health challenges, and prioritize programs

with long-term impact over swift and dramatic emergency responses.

A viable gay men's health movement will never be pieced together utilizing a crisis-of-the-moment approach to health promotion. Such approaches used repeatedly with HIV, syphilis, crystal and other issues play into a toxic syndrome of crisis and burnout that ultimately benefits no one and leaves masses of gay men jaded and suspicious of messages from health authorities. As Tony Valenzuela, an early voice in the gay men's health movement, has written, "Because the house once fell on us, we believe it's always just about to fall again." Encouraging such hypervigilance and constant emergency conditions undermines creating sustainable and life-affirming cultures and communities.

3. Challenge deficit-based models for work with gay men and replace them with asset-based approaches.

The dominant discourse in public health, as well as in the press, related to gay men continues to see our weaknesses and failings, rather than our strengths and achievements. Our communities are seen as self-destructive and out-of-control and uncaring; our cultures are seen as disgusting, self-defeating, and without values. We talk about gay men as passive victims, rather than active agents attempting to create meaningful lives amidst formidable challenges. I believe this is the major barrier we face in attempting to create joyous and self-caring communities. Gay men's health movement activities must identify and use the many assets in individual gay men and in gay men's communities and subcultures.

4. Strategically and politically confront structural forces challenging the well-being of gay & bi men.

Health promotion and service provision should never be cut off from political activism, especially in marginalized communities. If gay men learned nothing else from the AIDS epidemic it should be that our bodies and our lives—and our healthcare—are profoundly political. The gay men's health movement must understand the health impli- cations of the fight to end marriage discrimination; the effects of bullying and anti-gay violence on the mental and physical health of gay male youth; and the ways in which job discrimination affects a community's health and wellness. Likewise, concrete matters such as poverty, illiteracy, and homelessness have profound health implications. Not only do gay political organizations need to work with gay men's health activists to bring about structural changes that will improve community health, but gay male health movement workers need to explicitly participate in political organiza- tions and efforts.

5. Embrace a "big tent" vision of community, respecting diverse ways of organizing sex and relationships among gay men. Shame and guilt are the health hazards, rather than specific sex practices and sex cultures.

One of the major areas of disagreement among people working on gay men's health issues centers on sexual practices, subcultures, and community values. From the early days of this movement, debates have emerged around issues of promiscuity, public sex, bathhouses and sex clubs, barebacking, sexual addiction and cybersex. Most of us recognize that sexual cultures of gay men that focus on multi-partnerism bring special and serious challenges to our work improv- ing community health. Some of us have adopted a "big tent" approach, welcoming monogamous men and sex pigs alike into the movement. For example, we've had workshops on sexual addiction at the national gay men's health summit, but also workshops that criticize the concept of "sexual addiction" as having homophobic roots.

6. Launch efforts that are neither overtly nor covertly sanitizing, sanctimonious or moralistic.

I believe that most men who identify as gay have experienced a lifetime of moralistic messages. While I do not believe this should lead us to cede the field of "morality" to bigots (for example, I believe violence, discrimination, and oppression are immoral acts), it does suggest we should tread carefully around tactics that deploy guilt, shame, or a narrow vision of morality. For the population of gay men most at risk, sanctimonious or sanitizing messages may result in an effect quite different from the one we seek.

These principles inform any work I do around gay men's health (for example, when someone sends me a new crystal meth campaign in draft format and seeks my suggestions, I review the campaign in light of these specific principles.) They embody my values and beliefs about what is useful—what works and what doesn't work—with gay male popula- tions. They represent my best thinking at this time, about how our movement's efforts needs to proceed if we are to produce work that truly reflects a love and appreciation for gay men, gay men's cultures, and gay men's challenges in today's world.

Some people who work, write, and organize on gay men's health issues maintain principles vastly different from my own. The differences concern me, even as I value and appreciate that someone devotes time and energy—often as a volunteer—to work on behalf of our communities.

What concerns me even more, however, is my belief that the vast majority of people participating in gay men's health work—and here I include HIV-prevention workers, mental health clinicians, STD counselors, medical providers, addiction recovery leaders, researchers, and policymakers—are operating without an explicit sense of their own values and the principles underlying their work. Most have never gone through a process of self-examination and values clarification to come up with a series of principles to guide their work.

I make this claim after years of asking people simple questions that seem to surprise, offend, or confuse them. One person sent me a series of posters from an HIV-prevention campaign. He was quite proud of the work he and his colleagues had done in crafting the campaign. He eagerly awaited my response, which he anticipated would be praise, as the campaign is well funded and graphically impressive. My first question,

however, disappointed him. I asked, "What is the primary objective that motivates this campaign?"

Another person, a longtime HIV-prevention leader, wrote a powerful article about HIV prevention and men of color. It was impassioned and called for organizations to make a real commitment to educating men of color about HIV. He sought my feedback before completing the article. Before I could provide him with feedback I asked, "What do you believe needs to happen to reduce seroconversions among gay men of color?" My friend responded defensively. When I apologized and attempted to defuse the situation by citing specific researchers and studies which attempt to probe the underlying causes for the profound disparity in infection among African American and Latino gay men, he angrily withdrew the draft of the article from me.

When I ask such questions, I am not trying to be a difficult person. I am trying to gain a sense of what people believe and what they value, because all of our work will be most effective if it is linked to our beliefs and values. Otherwise, I fear, we simply emulate or replicate others' work and sometimes we do this at tremendous cost to gay men and tremendous cost to our own integrity.

Gay men of all colors and classes are a challenging population with which to work on health matters. People who choose to work in this field should feel obligated to take seriously the challenges we face and the complexity of the issues with which gay men grapple. They should be expected to have baseline knowledge of up-to-date academic work in the field.

What Men Want

It is difficult for people working on gay men's health summits, conferences and organizational workshops to create programming that is meaningful to gay men and that will attract large numbers of participants. While we've learned that narrow, information-based seminars have a role to play in gay men's health events, we've also realized that people prefer participatory sessions rather than workshops or panels where they are talked at for 90 minutes.

For example, when we create the programming for a national gay men's health summit, we shape it to meet the needs and interests of gay men. We've learned this the hard way, like many gay men's health and AIDS organizations. We've offered workshops and activities that no one chooses to attend. At other times, we underestimate interest and place a workshop on a topic that we believe few will find interesting in a small conference room for 20 people. One hundred and fifty people show up.

These days we shape all of our events to address several core needs which seem of great interest to a wide spectrum of gay men. These men seem eager to explore their longings for intimacy and connection with other men. They want to understand the meanings of specific sex acts (like penetration or the exchange of semen) and explore the relationships between various racial, ethnic, and class-based masculinities and these sex practices And they want to examine the ways transgression, risk, and taboos interact with queer men's sexual desires, practices, and subcultures..

Gay men from many backgrounds seek to grapple with the emotions, pleasures, and wounds emerging from childhood and adolescent experiences with boys and men. They are looking for ways to support healing from traumas including violence, abuse, homophobia, racism, poverty, AIDS and addiction. They want to tap into sources of resilience, creativity, determination, humor and playfulness in diverse gay men's cultures.

Men of all ages want to look at ageism toward gay male youth and toward elders, and the ways in which privileged masculinities of youth present challenges to and opportunities for well-being as men age. And they want to revive and recreate community rituals, social structures, and networks to replace those lost during the AIDS years.

Key Features of the Gay Men's Health Movement

It is not…	It is…
HIV focused	Holistic
Deficit-driven	Asset-driven
Individual focus	Relational focus
Directive	Informative
Fear-based & Moralistic	Trusting & Celebratory
Monocultural	Multicultural
Self-Esteem Building	Community-Building
Professionalized	Grassroots
Unitary	Multiple

CHAPTER 9

RECYCLING CRISIS

Now That It's Over (1998)

Is it possible for a community to inhabit a state of crisis for 20 years? This is one of the critical questions which underlies current community debates about gay men's shifting understandings of HIV disease. While rank-and-file gay men have integrated the day-to-day reality of HIV into our lives and moved forward, some AIDS groups and a cadre of increasingly hysterical gay journalists seem determined to corral gay men back into the bomb shelters.

They rant about old diseases and new diseases, second waves and third waves of AIDS, and arrogantly wrap themselves in the belief that they're doing a service to a gay community in denial about sexual health risk. If they're right and gay men in their 20s suffer a volume of HIV-related loss parallel to men in the 1980s, they'll smugly assume the mantle of visionary sage. If they're wrong, who will blame them for caring? Who will even remember?

I will. And those struggling to create new, effective ways of working with gay men's sex in a shifting epidemic context will remember those journalists and AIDS leaders who—absent a concrete plan of their own for promoting gay men's sexual health—spent their energies attempting to undermine the work of others. For even if one does embrace the ravings of Michelangelo Signorile, our own Jerry Springer, or buy into the 'science' of Gabriel Rotello, or resonate with the cult of crisis and morbidity which some AIDS groups are attempting to preserve, what kinds of efforts should be initiated to improve gay men's sexual health? Absent the points to consider at the end of Rotello's books—suggestions which he has deemphasized (and some would say backed away from) in speeches to several gay groups—what actions do the crisis-mongers' arguments suggest?

If the journalists and AIDS leaders seem to have no specific agenda for gay men's health promotion and HIV prevention, some of their acolytes seem all too eager to take certain radical steps. As I've traveled around the country speaking to people about my book *Dry Bones Breathe: Gay Men Creating Post-AIDS Identities and Cultures*, I have met numerous gay men who seem ready to embark on heightened efforts to crack down on gay men's sexual cultures. They share passionately three beliefs which I don't: (1) HIV is raging out of control among gay men; (2) Protease inhibitors will fail most of the gay men who are taking them; (3) Most gay men have declared "AIDS is over" and gone back to business-as-usual 1970s style.

I have seen no empirical data which supports any of these conclusions. While gay men continue to become infected with HIV and some gay men die of AIDS, gay men may be the only population in the United States who can claim to be successful at gradually reducing the level of HIV seroprevalence among successive age cohorts. Over our successive life spans, my cohort (men in their 40s) will have suffered a level of HIV-related loss which is higher than men in their 30s will suffer, which is likely to be higher than that which men in their 20s will suffer. While protease inhibitors seem to fail some people with HIV/AIDS, failure has tended to be focused on those who have been treated with many other pharmaceuticals. People newly-infected with HIV and those who have not been heavily treated seem to be doing much better on the cocktails. Only a highly selective reading of the papers presented at the recent Geneva conference (1998) allows one to default to the "protease inhibitors have failed" argument.

Perhaps the most dangerous myth put forward by the followers of the crisis-mongers is their insistence on seeing anyone who steps outside the bomb shelter as "in denial" about HIV. They see two options for gay men: crisis or cure. They falsely claim that those of us who say gay men's experience of HIV disease has changed believe the epidemic is over. Yet while they continue their sad, tired battle cry, most of us are in the process of carving out some middle ground between the two. We no longer experience HIV disease as meaning an inevitable death, and we no longer authentically inhabit the state of crisis which our community entered in the mid-1980s. This does not mean we don't care whether we become infected. It does not mean we believe HIV disease is a picnic or that AIDS isn't becoming a crisis to other communities about which we care. It does not mean that we don't give money, use a condom, volunteer our time, or care about people with HIV. It simply means we have accepted the reality of HIV in the world we inhabit, have taken steps to minimize risk, and won't feign shock, surprise, and terror to fit into their tired worldview.

Recently an AIDS group in my area closed its doors, claiming it had lost the ability to attract volunteers because people mistakenly believed protease inhibitors were a cure and AIDS was over. Increasingly AIDS groups are defaulting to this explanation when they can't attract volunteers, raise money,

or draw participants to their workshops. It's so much easier to make this claim than acknowledge their inability to effectively craft outreach efforts or their lack of skill at fundraising or designing meaningful programs. Instead of getting off their high horses, rolling up their sleeves, and addressing the challenge of activism and organizational development in a shifting epidemic climate, they misrepresent their target populations and leave the fields without learning an important lesson: community organizing requires you to meet people where they're at, not where they were ten years ago or where you'd like them to be.

AIDS as gay men understood it in the 1980s is over. HIV infection no longer guarantees a swift and ugly death, the volume of death experienced in gay male communities has decreased dramatically, and our sexual cultures have been reborn. This means everything has to change: our service organizations, prevention programs, activism, and rituals like the Quilt. It's time for everyone involved in the effort against HIV disease to recognize this shift in gay communities and see it for what it is: a life-affirming response to cataclysmic loss.

Spending 20 years in a state of emergency takes a tremendous toll on the human spirit and results in the shattering and fragmentation of community bonds. Successful public health campaigns are not built on rhetorical crisis, sexual guilt, and social stigma. They focus on education, empowerment, and community building rather than sensationalistic sound bites, moralistic crackdowns, and public disapprobation. Attempting to terrorize gay men, and make us into quaking zombies alienated from our dicks and our desires, doesn't save lives; it *takes* lives. Only by acknowledging gay men's changing experience of HIV disease and building community beyond crisis can our health promotion efforts have a chance to succeed.

The Chasm Widens between S. F. Gay Men and Public Health Authorities (2000)

"S.F. HIV Rate Surges" proclaims the banner headline in last Friday's *San Francisco Chronicle*. The article spotlights results from San Francisco's five voluntary HIV test sites indicating a rise in the percentage of people testing positive from 1.3% in 1997, to 2.6% in 1998, to 3.7% in 1999. One epidemiologist ominously notes, "These are sub-Saharan African levels of transmission. . . .We may have squandered an opportunity to extinguish this epidemic." The director of a local research institute insists prophetically, "This is a harbinger of what is going to happen all over the country. . . .What happens in the HIV epidemic usually happens here first." Linking quotations from health department officials, medical experts in the Centers for Disease Control, spokesmen for local AIDS organizations, and AIDS activists, a consensus of doom emerges: it's time to declare a new state-of-emergency for San Francisco's gay men.

This story and subsequent wire-service accounts and articles in the *San Francisco Examiner, New York Times*, *Washington Post* and dozens of other daily papers inspire a number of questions. Has the HIV epidemic in any other U.S. city actually followed the trajectory of San Francisco, a city where a higher percentage of gay men have been infected than in any other U.S. city and where needle exchange has limited infections among addicts? Could the rise actually reflect a response to recent campaigns urging folks who'd resisted testing for the past 15 years to reconsider in the wake of new treatments? Has the sample population shifted? Have tests administered outside these clinics exhibited a similar rise? Why does a figure of 3.7% encourage a comparison to sub-Saharan AIDS when test sites I worked in during 1985-1988 in Massachusetts and Los Angeles experienced much higher rates of positive tests? And is the reference to AIDS in Africa simply a strategic device intended to tap into stereotyped jungle-visions of disease-infested Africans, hence inspiring plague terror among San Francisco's gay men?

Yet before one can even ask these questions, San Francisco's AIDS leaders divert our attention in the articles and, attempting to explain the upswing in new infections, point their fingers directly at gay men. A spokesperson for a local AIDS group cites "a disturbing trend toward complacency." The research institute director argues, "There's a sense that the drugs have taken care of the problem." He then insists "There's a responsibility issue here," and identifies HIV-positive gay men as the culprits. One prominent activist angrily concludes, "The very thing that makes this happen is stupidity, ignorance and arrogance." None of these articles quote anyone willing to finger the city's HIV prevention organizations that receive millions of dollars to reduce HIV transmission; none critique the health department's master plan for preventing HIV among gay men. Instead, blame is directed unequivocally at the gay male population.

This crisis/blame response by AIDS leaders suggests that they see themselves in the position of trainers or instructors to recalcitrant gay men. It reminds me of some elementary school teachers' responses to their students' poor grades on statewide achievement tests: "What do you expect? Do you know what their parents are like?" or "She just really isn't very bright," or "He is simply too lazy to do well in school." Rarely do teachers—who are paid to facilitate student learning—acknowledge their part in student failure. Instead they prefer to point the finger, deflecting attention from themselves onto individual students.

Is blame necessary when an urban center faces a health threat? What would it mean if health officials in San Francisco responded to this new data by saying, "We know that gay men in our city face a huge challenge and we are committed to working in partnership with them over the long-haul to diminish HIV transmission"? What would it say about their relationship with the gay male population of San Francisco if any one of the AIDS leaders told reporters, "Our research and program design may not have moved swiftly enough to meet gay men's changing experience of the epidemic. We've all got to put our heads together and consider new strategies appropriate to the shifting environment"? Would it be possible for

an AIDS researcher to tell the media, "We know that asking some gay men to never again have unprotected intercourse is not realistic. For most people, changing sexual practices and altering sexual meanings do not occur easily or quickly. We are committed to working with gay men as they forge their own paths through this very difficult challenge"?

Yet the viewpoints captured in these recent articles simultaneously sidestep and exacerbate a formidable challenge of which everyone is aware, yet to which no one wants to admit: a wide chasm has opened between rank-and-file gay men who patronize the city's bars, dance parties, sex clubs, and chatrooms and the city's AIDS and public health leadership. This might explain, in part, why surveys show that most gay men are no longer following the safe-sex directives of AIDS prevention organizations, HIV education group meetings have difficulty extending their reach beyond a core group of true-believers, and why San Francisco gay men at first glance may appear "complacent" when observed by AIDS leaders. Many gay men might appear to be unconcerned about AIDS when they actually are seething with hostility at the ways health authorities—including AIDS organizations and gay male AIDS leaders—seem expert at manipulating gay men's emotions while appearing clueless about the complicated factors that might contribute to their sexual practices.

The lock-step consensus within San Francisco AIDS leadership may explain why a range of dissident views about HIV/AIDS may be afforded an ever-widening audience among local gay men. After a decade of annual proclamations about a second wave of HIV hitting the local gay community, this week's panic seems like a tedious rerun and the attempt to terrorize us back into the bomb shelters of the mid-1980s falls flat. Gay men are well aware that the factors contributing these days to unprotected sex are complex and rarely are new infections the result of a deficit of intelligence or a lack of information. By defaulting to simplistic categorizations of newly infected men as dumb, drugged, or deluded, AIDS leaders risk deepening gay men's alienation from the very public health authorities they should consider as their primary partners in prevention.

San Francisco cannot afford to let the gap widen between its gay male populace and its public health leadership. Sound-bite analyses of complex social phenomena might succeed at convincing policy makers to maintain AIDS funding levels, getting soccer moms to participate in the AIDS Walk, and encouraging journalists to devote front-page space to AIDS. Yet they might also deepen gay men's alienation, not because most gay men want to see AIDS funding decreased or because they don't value AIDS prevention, but because they expect health officials—especially AIDS leaders in San Francisco—to exhibit a deeper and more respectful understanding of gay male cultures and sexual practices. They don't want finger-wagging father figures or guilt-tripping Nancy Reagans as health authorities; they want AIDS leaders who will work with them as equitable and respectful partners in promoting gay men's health.

Unlike some AIDS dissidents' response to this latest alarm, I believe there is reason for concern about the health and wellness of local gay men. But I don't believe a frenzy of press releases and a melodramatic response to data trends do anything more than intensify the problem and diminish the credibility of the city's health establishment in the eyes of gay men (and others). Nor do I believe pathologizing our sexual practices while parallel practices between men and women are discussed cautiously and empathetically, does more than rekindle many gay men's long-standing (and merited) distrust of medical science.

In the past six weeks, I've been alerted to three distinct "alarming new epidemics" sweeping gay male communities. First, the Gay and Lesbian Medical Association sounded the alarm on a "club drug epidemic", highlighting a "severe increase in the abuse of methamphetamine, ecstasy, ketamine, gamma-hydroxburyrate (GHB) and nitrates (poppers)" by gay men. More recently, the web site GayHealth.com announced "New Epidemic Threatens Gay Community," highlighting Dr. Stephen Goldstone's study showing a "startling increase in anal cancer" in gay men. And now our AIDS leadership and mainstream media declare that San Francisco's "long-feared and often predicted new wave of HIV infection is here." I have come to believe that gay men are either the targets of an outbreak of epidemic panics on the part of medical authorities or the codependent victims of a public health system deeply addicted to crisis approaches to public health.

Gay men do not need a new state-of-emergency declared—about drug abuse, anal cancer, or HIV/AIDS. Nor do we need to pretend that significant health challenges do not threaten some of our subcultures. We need a broad, multi-issue gay men's health movement that reaches beyond HIV and values our cultures and our lives while working with us over the long haul. We need a movement that will support aggressive research to explore the factors that contribute to some gay men's risk-taking behavior and examines the value we place on sex, health, and our life spans, while refusing to stigmatize us because our priorities may diverge from heterosexual norms. We need a movement that recognizes not only our risk-taking but also our determination and resilience in the face of adversity.

Gay men have proven ourselves capable of impressive accomplishments. Not only have we altered sexual practices and contained the spread of HIV in a manner unheard of in most other populations, but, working with lesbian, bisexual, and transgender colleagues, we have dramatically shifted the social position of homosexuality in America in a single generation. We have proven ourselves capable of inspiring profound social and cultural transformation. By continually marshalling terror, drama, and panic as tactics intended to grab our attention and chasten or redirect our desires, health advocates do us a disservice. By forging respectful partnerships with rank-and-file gay men and working in meaningful ways with our diverse subcultures, AIDS leaders might diminish the credibility gap that has emerged and again enjoy success at mobilizing mass community action.

Nowhere is this more apparent than in the marketing of this year's AIDS Walk (2006). "I walk because I miss my

Uncle Rod" says a doe-eyed child gazing down at me from a banner flying over Castro Street. The surest indication that the AIDS Walk no longer resonates in a meaningful way for many gay men (or do the benefiting agencies no longer seem useful to many gay men?) is the dramatic shift to raw sentimentality and tugs at the heart strings.

Gay Men Confronting Upswings in Syphilis, Gonorrhea, and HIV: Disease Prevention for the Long Haul (2003)

We must begin a fearless and searching community-wide conversation about gay men and sexual health immediately.

I'm not calling for a finger-pointing tirade about gay men who are driving up HIV and other sexually transmitted disease rates; nor am I seeking to get mired, once again, in a debate about who are the good gays and who are the bad ones; and please save me from narrow conversations focused on guilt, blame, shame or quick-and-easy solutions. I want something entirely different.

A decade ago, some of us, coming from differing political perspectives, argued that it was time to open up a dialogue about ways to influence the trajectory of the sexual health of gay and bisexual men of all colors over a large expanse of time—say 50 or 100 years. Some of us believed that, absent such a discussion, we would continue to cycle haphazardly through upswings and downturns of sexually transmitted disease trends and ultimately do little to improve community health and wellness.

This idea was quickly stifled: condemned by some as needless fear-mongering and others as promoting the "social engineering of gay men's sex." The machinery of public health and HIV-prevention continued to do its work for another decade, prioritizing quick fixes and short-term approaches to challenges many of us suspected demanded long-term strategic thinking and a massive investment in the redevelopment of gay men's communities.

Thus we find ourselves at a moment of significant upswing for syphilis, gonorrhea, and HIV in many urban centers. And once again we have voices defaulting to ever more predictable solutions about what is needed. They want a gay male leader to summon up the courage, stand tall, and boldly speak "the truth": any queer man who has unprotected sex is responsible for fueling epidemics of illness and morbidity; all HIV+ men who penetrate tricks without disclosing their HIV status are doing something unethical, even evil; this generation of queer men is literally fucking itself to an early death and should look to no one for sympathy or support—not older gays, not lesbians, not liberal straights, and certainly not government-funded social services.

Many people believe that pointing the finger at the transgressors of safe-sex norms and identifying them as irresponsible and unethical vectors of disease is effective public health strategy. These people look at rising rates of STDs and upswings in rates of new HIV infections, and ask why bold voices articulating such 'responsible' perspectives have not been raised. They speculate about what happened to the leadership that successfully motivated men in numbers with no historical precedent to use condoms in the 1980s? What, they ask, has become of that daring queer leadership that catalyzed ACT-UP chapters and brought the nation's medical establishment and health bureaucracies to their knees? They wonder aloud if there is a gay male leadership that knows the difference between morality and immorality, social responsibility and self-centered irresponsibility, right and wrong.

And, the truth is, whoever steps forward to play this role will receive his share of rewards—from journalists, the public health establishment, and that portion of the gay community that hungers for a "hero" unafraid to condemn "bad behavior" within our ranks. He'll be praised for his bravery at condemning those outlaw queers who are alternately considered self-loathing, drug-fueled, and hell-bent on continuously cycling through decimation for the sake of a nostalgic notion of sexual freedom. He'll do much to mitigate complaints that responsive and responsible gay male leadership is not taking the bull by the horns; but he'll be doing little to actually reduce new sexually transmitted infections.

If this 'hero' spoke out on the editorial pages of the *New York Times* and at press conferences at the National Institutes of Health, would he successfully catalyze a shift in the sexual practices of gay men throughout the nation? If the leaders of every gay health clinic and every AIDS organization in America collectively took out full-page ads in the gay press proclaiming "Gay Men Are Fueling Sexually Transmitted Epidemics Today. Practice Safe Sex Every Time!" do we expect to see a dramatic shift in sexual norms and a decline in cases of syphilis? If someone organized Elton John, George Michael, RuPaul, Rufus Wainwright and Ricky Martin to produce a "We Are the World" type of song titled "We Always Play Safe!" would we see a halt to new HIV transmissions?

I think not. Such efforts may, in the short term, make it look as if the leadership of the gay male community is responsibly tackling tough issues, but they would only divert us from the more important, and much more difficult task: creating a long-term strategic plan focused on improving the sexual health of gay male communities.

Because, despite the escalating civil war inside gay men's communities about sex, health, and HIV, most of us who share a commitment to the health and wellness of gay men are likely to share certain general beliefs. We are concerned about increasing rates of syphilis, gonorrhea, and HIV among gay and bisexual men. We want to see fewer sexually transmitted infections, less HIV, and decreased mortality rates among queer men of all colors, generations, and locations. We believe people who know they have HIV or other sexually transmitted diseases and expose others to infection are socially irresponsible.

We are also united behind one stark reality: none of us truly knows what to do to counter infections that are now endemic to U.S. gay male populations. None of us can explain with

any confidence how to swiftly, dramatically, and permanently turn around these ominous trends—not those who advocate for a return to forecasts of disaster and crisis rhetoric, not those who argue for information campaigns and free condom distribution, not those who endorse the public damning of barebackers and the shunning of newly infected people, not those who once again drag out the "let's scare the pants off them by showing how horrible it really is to be infected with HIV" approach.

We cannot spend another decade without initiating a new and groundbreaking discussion about long-term approaches to the sexual health of gay men over the course of the 21st century. How might we engage in strategic interventions into the mass erotic imagination of gay men in order to support community health and wellness? What new technologies need to be developed to make anal sex safer and how might we ignite more energetic research in these areas? How do diverse social forces produce desires for specific sex acts and influence the sexual practices of masses of gay men and what can community-based planning do to affect these forces?

Today, it's time to initiate this conversation, however daunting and problematic. The leadership we truly need on gay men's health would bring together the best researchers, most visionary thinkers, and most compassionate advocates and tackle this profound challenge.