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HIV Panic

Part One: Demystifying the Epidemic

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Editor's Note: Trevor Hoppe is a senior Political Science major and Sexuality Studies minor. He would like to thank Professor David Halperin from the University of Michigan for assistance with this article.

It was an afternoon not terribly unlike many others during my summer life in Charlotte, NC. I was sitting around having cocktails with a few gay male friends chatting about our lives as we casually flipped through television channels. It was just another careless Sunday of recuperation from the previous night's festivities. Any outsider who happened into the kitchen, however, might describe the situation differently. This is because sitting on the counter beside the open bottle of white wine were gauze, a used lancet and a blood sample.

It was my blood drying in the kitchen. I had just begun the process of testing my blood for HIV-1 antibodies. After picking up a commonly available testing system at the local drug store, I planned a small, intimate get-together at my friend's apartment to help make such a grim experience a little livelier. I have an intense phobia of needles, so I forced one of my friends to puncture my finger while I looked away and took a sip of wine. It was painless - at least physically painless. After letting it dry, we sealed up the sample and dropped it in the mail for screening at a laboratory far, far away. Seventy-two hours and a quick phone call later, I learned my HIV status.

Living in a Culture of Fear

While the collection process wasn't difficult, the time between sending off my blood and the availability of my test results wasn't so easy. I get tested for HIV antibodies every six months, and every time I convince myself that this will be the last such experience necessary. Over and over I revisit the grainy memories of sexual acts that fill my imagination - did the condom break, did he look emaciated, did I have any cuts in my mouth? I meticulously review any symptoms I may have experienced in that time. Did I have a fever, had I experienced nausea, was I overwhelmed with exhaustion? I convince myself that one or all of these things have happened and that I'm "obviously" HIV-positive.

You see, like so many Americans - not just gay men - I suffer from an intense fear of contracting HIV and ultimately dying of AIDS. It is one of my worst nightmares, and, like clockwork, I relive it every six months. My trepidation is fueled not just by my own internalized homophobia (e.g. "I'm going to get AIDS because that's what happens to sexually active gay men"), but also by the often misinformed and misleading dialogue on HIV/AIDS that goes on in our country. Every media outlet seems to spew information that targets me (and my sex life) as an "at risk" sexual being because of the sex acts I engage in. Even when I open up safer sex literature I am presented with knowledge that attempts to instill fear deep in my conscious by hinting that the HIV epidemic is growing and that I could be its next victim. Sex, they say, is like Russian roulette. The odds aren't good, so you might as well keep away.

Whether the effects of this fear are positive or negative is disputed. It is certainly at the foundation of the recent controversy about “bug chasers ” in the gay male community. “Bug chaser” is a newly coined term referring to HIV-negative gay men who purposely seek out positive sexual partners to become infected. The story goes something like this: Gay boy engages in safe sex but always fears becoming positive. Gay boy longs for a sexual life free from the ever-present fear of contracting HIV. Gay boy decides that contracting the disease on his own terms provides a relief from the constant anxiety and, therefore, access to a more liberated sexual life. Gay boy gets gangbanged unprotected by known HIV-positive sexual partners and subsequently seroconverts - antibodies develop in his blood as a result of infection. Whether scores of these chasers actually exist is somewhat irrelevant, the story still vividly illustrates the terror that many gay men experience in the face of the epidemic.

The unease that accompanies these trips is certainly connected to the failure of mainstream information sources to communicate solid scientific data about the epidemic to the public. What are the real facts about HIV and AIDS? Not many people know because as a culture we don’t like to talk openly about all things sexual - especially the kinds of sex that carry an increased risk of HIV transmission. In a media culture of sound bites and corporate interests, dialogues on the sexual reality in which we live are squelched.

I want to talk about what no one else seems to be interested in frankly discussing. In part one, I will examine the current state of the American epidemic. I want to talk about the annual number of new HIV infections and about trends that new infections have followed throughout the past 23 years. In doing so, I hope to dispel myths and misconceptions that, until recently, I believed to be scientific fact. In part two, I will explore the biology of the epidemic. What constitutes risky sexual behavior, and how high is that risk? I will explore the most current knowledge on that topic and, in doing so, argue that the HIV panic that has held so many queer men’s sexual bodies captive is largely unfounded. It’s not an easy conversation to begin, but the knowledge is so important to surviving in our culture of fear. This is not a conversation about AIDS worldwide. This is a conversation about our own sexual habitat ? the United States.

A Snapshot of the American Epidemic, Trends

There are many myths and half-truths that are promoted about the domestic HIV/AIDS epidemic. One of the most prevalent is the commonly held belief that new HIV infections are dramatically on the rise here in the United States. In fact, this is far from the truth. New AIDS cases actually peaked in 1993 with 78,954 new infections reported in that year. By 2001 that number had dropped to 24,804 cases and the statistics continue to decline. We are coming close to a return to a number of new annual infections not seen since 1981.
Though the annual numbers of new infections have dropped since 1993, the demographic composition of those new infections has markedly changed over time. For example, the proportions of heterosexuals and people of color making up those new infections have increased since the initial outbreak. Whereas in 1981 71% of new infections were “men who have sex with men” (MSM), this year that number has dropped to 40%. More drastic has been the proportional increase of infected people of color. Whereas in 1981 well over half of new infections were white; today they represent just one-fifth of new infections. Black people in the United States are being disproportionately infected today by a factor of five and make up over half of all new infections. Likewise, Hispanic populations are overrepresented by a factor of 2 with 20% of new infections. By contrast, in 1981 they made up 25% and 14% of new infections, respectively.

HIV doesn’t pick new people to infect by the color of their skin, however. The changing demographics have as much to do with social class as they do with race and ethnicity. The virus is ravaging poor populations here in the United States just as it is across the globe. This is attributable to a variety of factors. One explanation is the immense lack of knowledge about the virus within poor communities and how it gets transmitted. If you don’t know how the virus gets from person A to person B, you won’t know how to protect yourself against infection. Others point to the importance of hygiene in regards to transmission risk. Cuts, lesions, and open sores are an excellent way for the virus to find its way into your bloodstream. Furthermore, while more affluent communities are able to afford the costly protease inhibitor regimen that can combat viral loads, poor communities rarely have access to these life-extending medications. Thus, increased viral loads make for increased levels of transmission.

Connected with this is the lack of health care for millions of Americans, especially working class Americans. People with adequate health care will more readily seek treatment for other sexually transmitted diseases, and thus lower their risk of both becoming infected via sores or lesions and infecting others if they have already contracted HIV.

All of these factors contribute to an unstable situation for our sexual ecology. Public health infrastructure hasn't adequately accounted for the changing face of the American epidemic. HIV is no longer just about gay white men, as it was considered in the early 1980s when it was known as "GRID," or gay related immuno-deficiency - though we are still overrepresented in new infections. The trends that the epidemic has followed can be further explained by examining the facts about sexual transmission, which we will explore in Part 2 of this series.

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