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# DOES AMERICA HAVE THE WILL TO STOP AIDS?

BEN MERRILL\*

Where there is no vision, the people perish.

Proverbs

Why then has it been so difficult to get a control program out to the local level? It is complex and I can't understand all of it. If I had to blame one thing it would be the hunger for power.

Don Francis' Journal  
March 23, 1985

In the last quarter of 1993, Arthur J. Lawrence, Ph.D., Acting Deputy Director of the National AIDS Policy Office, gave each of his staff members Frank Ryan's book entitled *The Forgotten Plague: How the Battle Against Tuberculosis was Won—and Lost*.<sup>1</sup> Lawrence's generosity was not to be lost on this staff member. The thesis of Ryan's work is that the scientific community rested too soon on its laurels. What should have been eradicated was not. The complacency of the world community led to the introduction of an even more feared multi-drug resistant tuberculosis.

The reintroduction of tuberculosis is largely due to tuberculosis patients. These patients stopped taking their medication when the disappearance of their early symptoms tricked them into thinking they were "cured." The consequence of their mistaken reliance was the evolution of a particular strain of tuberculosis that was resistant to the limited qualities of drugs taken. Thus, the early cessation of treatment led to a strengthened and drug-resistant germ.

Now beginning its second decade, and more firmly entrenched in the world communities it infects, AIDS has come to dominate scientific discussions world-wide. And, now becoming linked to AIDS in a new pandemic, is the threat of TB-AIDS, whose march across shared frontiers will surely strain the world's social, medical and financial resources.

In the United States alone, the government is spending more than 1.3 billion dollars a year on AIDS research and over 6 billion

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1. FRANK RYAN, M.D., *THE FORGOTTEN PLAGUE: HOW THE BATTLE AGAINST TUBERCULOSIS WAS WON — AND LOST* (1992).

dollars a year in goods and services for the AIDS infected communities. We must ask the question: "Does America have the will to stop AIDS?"<sup>2</sup>

*The second wave.* Following the early years of the AIDS rampage across America's cultural centers and creative groups, the incidence of AIDS dropped dramatically in gay ghettos. In 1982, San Francisco's male population contained 18 AIDS infected men for every 100 uninfected men. By 1985, less 1% of San Francisco's males were infected with AIDS. This drop occurred despite the fact that real behavior changes did not become vogue in those communities until 1987. Where the message of life took hold, it appeared that the twin combination of public education and peer pressure was leading to a decrease in the spread of AIDS in ghettoized gay communities (a new "trojan woman" seemed to emerge in these communities: no sex without condoms). Indeed, the disease, thwarted in these initial fields of exposure, turned its spread to communities of color, adolescents, and drug users. Populations in communities with poor health care access and inadequate health information were particularly vulnerable to the spread of AIDS.

Today, however, it appears that the incidence of AIDS is once again increasing in the traditional gay communities. In 1993, San Francisco's male population contained 2 AIDS infected men for every 100 uninfected men. More disturbingly, the ratio of AIDS in young men under 25 years of age is 4 infected men for every 100 uninfected men.

These figures portend news of a new assault by the disease: an assault that appears to overcome years of safe-sex practices and the reinforcement and education of peer groups. This new wave of the disease, quietly discussed among gay groups for the last year, finds its roots in older gay men in depression, fatalism, and nihilism. This wave has also spread to younger gay men who refuse to recognize the risks of unprotected sex.<sup>3</sup>

*What is required as part of the national will?* In the early 1980s, the initial stages of the epidemic, the AIDS virus spread among gay men on both coasts because we didn't know what caused it. When suspicions pointed to sexual transmission, the politically charged issue of closing bath houses was deemed politically unacceptable. Acting purely from a public health perspective, the clubs should have been closed. But political forces, using the arguments of a right to associate, a right to property, and a right to privacy,

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2. Through September, 1993, there were 339,250 reported cases of AIDS in America. *HIV/AIDS Surveillance Report*, (Centers for Disease Control and Prevention, Atlanta, Ga.), Oct. 1993, at 3.

3. Jane Gross, *Second Wave of AIDS Feared by Officials in San Francisco*, N.Y. TIMES, Dec. 11, 1993, at 1.

succeeded in keeping the clubs open much too long.<sup>4</sup>

Now, thirteen years after the first diagnosis of AIDS, America faces a new challenge. AIDS is now spreading its death and disease among new populations: African-Americans,<sup>5</sup> Hispanics, women, infants, and intravenous drug users. There are also new waves of the disease in both heterosexual and homosexual adolescent youth and, as indicated above, in gay ghettos and among gay men who were long thought to have been educated in the ways of prevention and behavior modification.<sup>6</sup> Yet, when we examine each of these new venues for AIDS, we encounter political and social struggles for power and lost opportunities for saving people.

*Prisons.* At first blush, no other American institution would provide a better HIV/AIDS training environment than prisons. Here, where behavior is so tightly and rigidly controlled, it would appear that public health observers would find the ideal conditions for implementing practices that would surely stop the spread of the disease. However, this has not been the case. Despite the seemingly perfect training environment, public health officials have failed to utilize American prisons as a training ground for HIV/AIDS. Consequently, the spread of HIV/AIDS continues to be a problem in the American prison system.<sup>7</sup>

It is now time for public health officials to begin using prisons as a training ground for HIV/AIDS. There are a number of reasons why prisons are ideal for such testing. First, prison populations are finite. Second, they are susceptible to peer group training. Third, prison populations are testable on a random and anonymous basis. Fourth, prisoners can be provided with condom and dental dam barriers to protect against sexual transmission of HIV. Finally, prisons provide the opportunity for concentrated education programs. Prisoners are truly a "captive audience." Yet we seem to lack the political will to address and educate these Americans.

We deny that sex occurs between prisoners although we know that it does occur. We say that simple, proven systems of protection should not be allowed within the prison system because it sends a

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4. The history of this debate is well documented by Randy Shilts. See *generally* RANDY SHILTS, *AND THE BAND PLAYED ON: POLITICS, PEOPLE, AND THE AIDS EPIDEMIC*, at 19-20, 23-24, 153-55, 304-07 (1987).

5. Indeed, gay men of color have been over-represented since 1985.

6. Before the new wave of AIDS struck the traditional gay population, it was commonly believed that this community discovered a new expression of intimacy: one of caring, touching, feeling, expressing, and above all else, safe sex.

7. The Federal Bureau of Prisons reports that only 1% of its prison population is infected with HIV/AIDS. But careful analysis suggests that this is *twice* the prevalence in the non-imprisoned population. In state prisons, 2.3% of the inmates are infected with HIV/AIDS. As reported by the Bureau of Justice statistics department, there are 17,479 inmates in prison who are infected with HIV.

"double message" when in fact it does not. By denying sexual prophylactics in prisons, we are saying that we are unwilling to admit that sexual encounters are occurring in our prisons. And while some would argue that an AIDS prevention program will not work in prisons until we determine what the true purpose of prisons are,<sup>8</sup> a public health perspective demands the distribution of condoms and dental dams in our prisons, as well as the implementation of bleach and needle exchange programs.<sup>9</sup>

But we do none of these. We do not distribute condoms in federal or state prisons.<sup>10</sup> We have no needle exchange programs in prisons, denying the very existence of injecting drug users in those institutions. We do not routinely test prisoners for AIDS. We do not provide education programs to teach prisoners about safe sex or clean needles. We fail miserably to educate our prison populations on HIV/AIDS issues although we know that 93% of them will be released from prison with little knowledge of safe sex practices and with a strong likelihood of returning to routine drug use on the streets.

*Drug-using communities.* The National Academy of Science has noted: "When the disease of HIV/AIDS becomes self-sustaining within the heterosexual population, it will be because of intravenous drug use."<sup>11</sup> There is no doubt that AIDS is spreading faster in drug-using populations because of shared needles than in communities practicing unsafe sex. The ease of transmission from blood to blood contact and the number of injections shared between users dramatically increases the opportunities for the spread of HIV/AIDS.

While we know what must be done, we are held back by political and moral considerations. The simple public health tack would be to distribute clean needles while reinforcing proven prevention methods and getting as many people into treatment programs as possible. But needle-using populations do not have political leverage and we do not have a national strategy on needle exchange programs.

Notwithstanding detailed research,<sup>12</sup> with every delay, these

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8. What are prisons for — rehabilitation, detention, retribution or removal?

9. See THE EXPERT COMMITTEE ON AIDS AND PRISONS, *HIV/AIDS IN PRISONS: A WORKING PAPER OF THE EXPERT COMMITTEE ON AIDS AND PRISONS*, (forthcoming April 1994) (manuscript at 74-82, on file with author).

10. There are six pilot projects which distribute condoms in state prisons in America.

11. See THE NAT'L RES. COUNCIL OF THE NAT'L ACAD. OF SCIENTISTS, *AIDS, SEXUAL BEHAVIOR AND INTRAVENOUS DRUG USE* (Lincoln Moses et al. eds., 1989).

12. Peter Lurie, M.D., MPH, *The Public Health Impact of needle Exchange Programs in the United States and Abroad*, School of Public Health, University

populations are being written off. People continue to argue that the distribution of needles only serves to encourage the further abuse of drugs. However, this argument ignores the concept of harm reduction and the interim stop-gaps necessary to halt the spread of the disease in the face of its ever-spreading growth.

*Prevention.* The sources of AIDS transmission are well-known. And excepting the occasional fluke, such as a single dentist who infected six of his patients or two adolescents who shared a safety razor, it does not take a college education to figure out how to stop AIDS. Yet the condom controversy rages far and wide across America. Until recently, pictures of open condoms were as rare as discussions of their use on soap operas. Campaigns were designed to be cute rather than informative, and advertisements provided viewers with a false sense of security and a belief that AIDS only happens to other people.

The strategies are easily discernable, but a national plan with the will to talk frankly and boldly is yet to be born. We know which multi-language cultures need to hear the message. We know that the message must be clear and direct. And we know that a demonstration of the use of condoms is the best, and often the only, educational message we can send. Yet all of this is kept off the television screen and out of popular print.

We continue to send our teenagers to the movies before they go home and have sex, yet we protest the opportunity to give them a preview on the movie screen of the possible consequences of their sexual interactions. While they may be trapped in a movie house watching previews of coming attractions featuring death and mayhem, we object to previews on the screen showing safe sex or discussing the use of condoms. The movie industry and theater owners should be ashamed for opposing such opportunities to educate their viewers.

Although we know that thousands use hotel and motel rooms everyday to have sex, we refuse to allow the distribution of condoms in these hospitality suites while allowing the placement of hundreds of thousands of Bibles. The hospitality industry should be ashamed for opposing such opportunities to educate and protect its patrons.

We fly hundreds of miles to be with loved ones and to renew our pledges of love and care, yet refuse to show safe sex clips to captive audiences who are aboard planes on their way to see loved ones and make love to them. The airline industry should be ashamed for objecting to such opportunities to provide public service announcements to its users.

In an age of AIDS, "safe sex" is "educated sex" and every opportunity must be viewed as a lost opportunity unless steps are taken to educate and reinforce safe behaviors. Why is this so?

*Sex and death.* The sexual act in America is an act that has long been avoided, put out of sight — but not out of mind. Death too is best handled off-stage rather than in the living rooms and parlors of our family homes. The wake is long since past, and children are often kept home from funerals lest they have nightmares of dying and death before they are "mature" enough to handle such universal questions.

And although the pain associated with childbirth is often assuaged by the joy of bringing a life into existence, the pleasure of sex is not often spoken of, or if done, is done in hushed and whispered tones. Sexuality is not a part of our public discussions and the pleasures of sex are not topics of the day.<sup>13</sup>

We have cast sex among associated images of disease (syphilis, herpes, AIDS, etc.) and death. These images are reinforced in the public's *mind* while the public's *eye* is assaulted with the young, the svelte, the beautiful. Advertising campaigns are made or broken upon their ability to associate sex with beauty and a sex-crazed world. Gay men are not above this conditioning, and like lemmings to the sea, are often correctly cast as indulging in an orgy of sexuality, which now only leads to AIDS and death. Any attempt to end the spread of AIDS in the United States must begin with a change in how, when, and where we talk about sex.

*AIDS, cancer, and research.* Already the opposition is arguing that America is spending too much money on AIDS research. Those suffering from cancer, heart disease, Alzheimer's, multiple sclerosis, and other chronic conditions have begun to ask, "Why is AIDS getting all of the money?" The answer to this is simple. We are still in the beginning stages of an epidemic. The curve of this plague is still increasing around the world. Up to fourteen million people are believed to be infected in Africa and many, many more than that in southeast Asia. Whether or not HIV/AIDS has peaked in America is immaterial because the number of those becoming infected is on

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13. The stories carried in The Washington Times on October 21 and 22, 1993, around the speech of National AIDS Policy Coordinator, Kristine M. Gebbie, urging such discussions in public were grist for the journalistic mill, giving rise to an attack by Pat Buchanan and Phyllis Schafley on CNN's "Crossfire" television show on October 22, 1993. See Joyce Price, *Aids Czar Tells Americans to Seek Their Pleasure in Sex*, WASHINGTON TIMES, Oct. 21, 1993, at 1 (covering speech by National AIDS Policy Coordinator, Kristine Gebbie, that urged American educators to change their views on sexuality and to stop relying on abstinence as the only way to prevent the spread of AIDS); Frank Murray, "Abstinence" Added to Sex Message, WASHINGTON TIMES, Oct. 22, 1993, at 1 (discussing Kristine Gebbie's latest press release that advocated abstinence as another method to prevent the spread of AIDS).

the rise. Additionally, the number of those infected and beginning the progression into opportunistic infections is steadily increasing. The delivery of health care systems and the drugs necessary to stop preventable opportunistic infections, is growing, not diminishing in costs. And the disease is robbing our country of its young people, not at the end of long productive careers, but at the beginning of what should be, but will not be, decades of creativity and productivity.

*Challenges and a conclusion.* Whether one is a Splenglerian, believing that the world will end in a last gasp after ages of slow decay and decline, or a Toynbean, believing that the world continues in its ageless cycles of birth and rebirth, the challenge of AIDS is best faced by facing ourselves. Carl Jung's discussions of the psyche of nations and the recent resurgence of neo-Nazi skinhead actions have caused many to wonder if Germany is not destined to once again relive its past. We must also be willing to confront our collective selves and ask "What is required of me" in this "time of cholera?"

The will to stop AIDS is no different than the will to conquer a continent or to eradicate smallpox. It is a tenacious will that will not let go; like Jacob who wrestled with the angel "until thou bless me," the will must be to persevere against all odds and do what must be done. We must set aside moral and religious constricts in favor of life and the pursuit of prevention and cure. We must not become mired in moralistic and ultimately destructive political posturing. Each delay means another life in jeopardy, another life lost.

When faced with the challenge of tuberculosis, those who put their ultimate faith in the drug streptomycin were finally rewarded. But not without considerable sacrifice to their careers and even their personal finances. In 1945, George Merck, of the pharmaceutical company by his name, made a crucial and timely gift of a million dollars worth of streptomycin to the Medical Research Council for further testing. This was at a time when European groups were seriously questioning the efficacy of streptomycin as a treatment for tuberculosis. It was the communities affected by tuberculosis that proved to be the testing ground for the ultimate breakthrough that resulted in a cure.

And so it is for AIDS. Notwithstanding the protocols established for the proper and correct testing of drugs established by the scientists and drug companies, it is the infected communities who have put their lives on the line to advance the treatment and cure of AIDS. It is those communities who have said: "Give us what you have and we will take the chance." It is the will of the infected which calls forth the will of a nation to take the steps necessary to stop AIDS. The will to lay down our differences and treat one an-



other with compassion and care; the will to break down the barriers of prejudice and exclusion and embrace the affected communities, be they white or black, straight or gay, rich or poor. The test of our nation's will will be how we treat the disenfranchised and the politically impotent and how we reach out to the drug user, the prisoner, the welfare recipient, and the teenager. It is in identifying and exercising this will that we may hope to ultimately confront and beat the pandemic of AIDS. We must remove whatever stands in our way of defining and pursuing a national will to stop AIDS and in doing so, redeem ourselves and the world around us.