J'ACCUSE

Cuba and AIDS

Traditional epidemiology solved the AIDS crisis in Cuba before it began.

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DR. Tom Coburn, a low-key 50-year-old family GP who practices obstetrics, mostly for Medicaid patients, in Muskogee, Oklahoma, is the front-runner for the title of Gay Activists' Public Enemy Number One. It is a designation he is happy to contend for.

In his other job as a Republican congressman ("not my *profession*, I'm a doctor"), Coburn is the author and primary sponsor of HR-1062, The AIDS Prevention Act of 1997. All the major liberal, civil-liberties, gay, and AIDS organizations—the ACLU, the Gay and Lesbian Medical Association, NOW, the AIDS Action Council, Gay Men's Health Crisis, People for the American Way, and so on—are in full assault mode against the bill, which if enacted would do something to the AIDS epidemic we've never done before: apply to it the standard public-health disease-containment measures of routine testing of at-risk individuals (although individuals should have the right to refuse testing), confidential reporting by name of those infected to local health authorities, and aggressive partner notification. In other words, it will make public-health personnel treat AIDS—the number one killer of Americans aged 25 to 44—like any other infectious disease.

AIDS, in partial fulfillment of its own championship in the annals of epidemiology (winner, "Most Politicized Disease in the History of the Whole World"), has never been attacked with these measures. Why? Because of a judgment call about who would get hurt. When AIDS weighed in in full force in the mid 1980s, the gay community decided that the disease hurt homosexuals vulnerable to a hostile society at least as much by pitilessly outing them as it did by killing them. Standard public health is about identifying the infected in order to prevent further transmission, but with AIDS, identification was the problem. The gay community, with the best of intentions, believed that the messy, complex, often desperate job of protecting the public health against contagion could be made nice and not hurt anyone.

This decision produced a rather astounding display of political power. After intense lobbying on the part of gay organizations, state and local public-health officials ultimately with the avid support of the mighty Centers for Disease Control (CDC), made AIDS the first epidemic treated as a civil-rights issue and a threat to individual privacy. All sorts of violations were presented: people with AIDS being expelled from their homes, losing their jobs, being dropped by their insurers. But the greatest threat was that the government would use the virus as an excuse to conduct a new holocaust. This was an explicit and constant warning by the gay and civil-liberties organizations—and they told us there was a country that actually did it: Cuba. Cuba set up concentration camps. Juanita Darling in the *Los Angeles Times* of July 24 recounted in (relatively) moderate tone what these organizations have been saying for years: "Cuba has been notorious for its draconian treatment of people infected with the virus that causes AIDS: The government has rounded up everyone infected with the human immunodeficiency virus and locked them in sanitariums until they developed AIDS and died." The Cubans, we were told, used traditional epidemiology—testing, reporting, and notification—to track down and persecute homosexuals, and were we to use these measures in the U.S., they would surely be deployed in the same way. So we did not.

What we did instead was use sex education, condoms, and needle exchange, essentially asking people to learn how HIV is transmitted and then to be careful. Columbia University's Ron Bayer created a name for this brand new civil-rights-centered public health—"AIDS exceptionalism"—and in the U.S. all efforts to combat this epidemic have thus been made to pass a high-minded-sounding test: they must not hurt the

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civil liberties or personal fortunes of the infected. The practice of epidemiology, created by John Snow in the London cholera epidemic of the mid 1880s and used since then to combat tuberculosis, polio, syphilis and gonorrhea, influenza, and on and on, has in the case of AIDS been fundamentally altered.

Rep. Coburn with his bill is demanding a re-examination of the way our country has responded to this public-health crisis. He is doing this in a forward-looking way: HR-1062 aims to get AIDS treated from now on like other diseases from TB to hepatitis A. But what makes HR-1062 so controversial is its retrospective aspect. It calls the past silently but inescapably into question.

AT 9:00 A.M. on March 13 at the press conference introducing the bill, Rep. Coburn stepped up to the lectern in the Rayburn House Office Building, looked at the reporters (in the seats), his allies (behind him), and AIDS organizations' spokesmen (grimly lining the walls like prison guards anticipating a riot), and began, "I am convinced that a hundred thousand deaths could have been averted if we had adopted these basic public-health measures in the first place." Expand this statement and it reads: Tom Coburn believes that at least a hundred thousand people, mostly gay men, who should be alive today are dead because certain people, again mostly gay men, with the best of intentions, used their political power to suspend disease-control measures for AIDS.

This is why HR-1062 is, although Coburn has never put it this way, much more than just another bill: it is an accusation. It is the epidemiological equivalent of a class-action lawsuit, an assertion that gay leaders, abetted by their liberal allies, committed mass manslaughter by instituting policies which ensured that in this medical conflagration a virus would use their own people as kindling.

Coburn's is an observation increasingly echoed by the medical establishment. On a national radio show a few weeks after Coburn's press conference, Dr. Frank Judson of Denver's Public Health Department stated: "I have no doubt that lots of people have become infected and lost their lives as a result of these irrational policies we've chosen to follow." Which lends credence to statements of Rep. Coburn's such as: "Public health works, and the people who have died of this disease should have been provided it."

But wait. There's more. Arguably worse than slaughtering your own is slaughtering others. The rate at which people are becoming infected with AIDS is thought to be slowing down only within one demographic group: gay men. Coburn points out that it is growing, at a rather astounding rate, among blacks, Hispanics, and women, most especially women who have sexual relations with intravenous drug users. If Dr. Coburn is correct in saying that "the new public health" took gay lives, then gay men demanding that these same policies be applied to others at-risk is both breathtakingly nearsighted and breathtakingly irresponsible. The political repercussions are chilling. What, to take a for-instance, would happen if the black community were to decide one day that traditional epidemiology would have prevented the transmission of HIV to tens if not hundreds of thousands of black people? Or that the problem of skyrocketing rates of HIV infection among blacks could have been averted but was not owing to gays' blind, dogmatic adherence to self-interest?

Dr. Coburn's accusation is only as solid as the data on which it rests. And here is where things get odd. There are, in fact, excellent data. They come from a country which has bent over backward to care for its citizens infected with HIV, probably spending more on AIDS in proportion to its GNP than any other nation. It has also instituted a traditional epidemiological regimen against AIDS. It has the most successful AIDS-containment policy of any country in the world. The country is the same one accused of carrying out a holocaust against AIDS sufferers: Cuba.

The first AIDS case in Cuba surfaced in 1985. If AIDS began as a gay disease in the United States, in Cuba it first turned up in heterosexual soldiers back from their country's military exploits in Africa; that 1985 case was a soldier returning from Mozambique. In Africa, anal intercourse, the most efficient way of spreading the virus, is a quite common means of preserving technical virginity in girls. The rate of sexually transmitted diseases (STDs), which also greatly facilitate transmission, is also extremely high. The sanatariums, in Cuba, were built by the army for the country's returning heroes; persecution of homosexuals had nothing to do with it. In fact, when the disease spread to homosexuals, the sanitariums were among the few places where gay couples were allowed to live together openly. Furthermore, the sanitariums provided and provide the best medical care available in Cuba, 3,500 calories a day, and AIDS-prevention information, not to mention ice cream and air conditioning. Since around 1989, AIDS sufferers have in general been able to choose whether to stay in a sanitarium or live at home, and it has often been difficult to get people to leave.

In any case, as tools for combatting AIDS, the sanitariums are of secondary importance. The real story is the public-health policy Cuba put in place. And this was fiercely and completely traditional. Dr. Jorge Perez, the head of the Pedro Kouri Institute for Tropical and Infectious Diseases and the architect of Cuba's anti-AIDS plan, told me recently in Havana, "From the beginning we treated AIDS like an STD." This meant testing, reporting, and partner notification. "I as a doctor don't have to have someone's permission to test them," said Perez. "I don't ask. Testing isn't mandatory, but I simply prescribe a test when I have good reason." In most of the United States, this is illegal when the test is for HIV.

"We have a very active screening program," said Dr. Rigoberto Torres, "testing risk groups, pregnant women, inmates." Again, these practices, which are standard public-health procedures, have been almost entirely blocked in the U.S. by ACLU lawsuits and AIDS political activism, as has contact tracing, which is acknowledged as the most efficient, cost-effective way of identifying infections in subgroups of populations. Studies in the U.S. have shown that partner notification finds more infected people then any other method, and it finds them earlier, when their T-cell count is higher and their prognosis is better.

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For the most part, however, we Americans don't notify, or we don't notify effectively, simply because it

might "invade people's privacy"—a privacy that has already been invaded by a deadly although treatable virus. Of testing, reporting, and notification Perez says, "These three things are the key of the Cuban [traditionalist] program. We have now done 2 million tests in a population of 11 million, and virtually all sexually active people have been tested. The main source of infected people we get is through contact tracing, about 50 to 60 per cent."

THE results of Cuba's program speak for themselves. In 1997, 45,000 people out of the 260-million American population will become infected with the AIDS virus, and so far over 362,000 Americans have died; Cuba, with an 11-million population, has since the start of the epidemic seen 1,681 infected. So far, 442 have died. Control for the population difference, and here is what you get: There have been 35 times more AIDS deaths per capita in the United States than in Cuba. (Of all Americans alive since the start of the epidemic, AIDS has killed 0.14 per cent of them; in Cuba, it has killed 0.004 per cent.)

Compare Cuba to New York City, with its population of around 7.5 million: An estimated 128,700 New Yorkers live with AIDS or HIV, and 63,789 have died. Is very urban New York an unfair comparison? Take Ohio, a Midwestern, predominantly rural state with a population almost exactly the same size as Cuba's: an estimated 10,000 to 18,000 people are HIV positive (this is only an estimate because Ohio doesn't permit HIV reporting), and there have been 9,238 cases of AIDS. Illinois, also Cuba's size, estimates that 30,000 of its citizens are currently HIV-infected (Cuba: 1,239). It has had 19,507 AIDS cases (Cuba: 1,681) and counting.

Look at it another way: In 1993 (the last year for which there are figures) the World Health Organization reported that the U.S. had 276 annual new cases of AIDS per million people. Puerto Rico, another Caribbean island but with one-third Cuba's population, had 654. Brazil was at 75.4, Mexico at 46, and Argentina at 48 per million.

Cuba was at 7. And Cuba's pediatric AIDS system cares for a total of 5 children, whereas Pennsylvania, with the same population, has 122. In the U.S. in 1996, there were 678 pediatric AIDS cases reported to the CDC, which means that our per-capita figure for children with AIDS is 6.5 times higher than Cuba's.

The figures are neither a statistical trick nor Castroite propaganda. (Castro had nothing to do with Cuba's AIDS program, by the way; it is people like Perez, Torres, and Manuel Santine, Cuba's chief epidemiologist, who created and run it.) Cuba's health-care standards are approximately equal to ours; its infant-mortality rate, a good overall indicator, is 11 deaths per 1,000 live births, near the 7 figure of the U.S., UK, and France. (Canada's is 6. The Dominican Republic's and Mexico's are 35 and 34 respectively.) And one epidemiologist told me of the AIDS stats: "Cuban figures are absolutely reliable and dependable. Surveillance is quite good because they have essentially universal testing and an excellent tracking system. We trust the Cuban figures more than any other country's, where there is underreporting and misdiagnosis, but, um, don't quote me on that." He meant the United States; the CDC will tell you there could be anywhere from 650,000 to 900,000 Americans infected with HIV; it is the lack of traditional testing that prevents the compilation of a more accurate figure. In Cuba, meanwhile, there are reportedly 1,239 people living with HIV, and the number is probably quite close to exact. If we take the CDC's upper figure (the estimates of some experts are higher) and put it on a per-capita basis, there are around 31 times more HIV-positive Americans than Cubans.

Besides demonstrating the success traditional methods have against AIDS, the Cuban example also challenges our strategy of throwing condoms at the problem. One American working on AIDS in Cuba told me he had seen "extraordinarily low condom use." Although some condoms of Dutch manufacture are now available, Cuba for years imported Chinese condoms, which were of notoriously low quality—they were actually used by Cubans not in bed but at the market as chits to buy sugar—and yet the infection rate is still dramatically lower than America's. This shouldn't be the case if condoms are the answer and if old-fashioned public health doesn't work.

"You haven't changed much, Cecil."

This is not to say that the Cuban model *per se* would be right for the United States. It isn't, most specifically the sanitariums. Elinor Burkett, a former AIDS reporter for the *Miami Herald* with extensive experience in Cuba and the author of *The Gravest Show on Earth: America in the Age of AIDS*, notes: "What's different in Cuba is that people don't think about individual rights. Most Americans think that when we're balancing social good with individual rights, we err toward the latter. Cubans are trained in the opposite mentality, so my friends in the sanitariums . . . believe there's a social good coming out of it." There is also the medical fact that isolation for HIV, a difficult-to-get virus, is unnecessary provided there are 1) testing and notification to alert those infected and 2) transmission education for them.

Nor is it to say that no exceptionalist methods work. On June 27, the American Medical Association emphatically supported needle exchange, a favorite exceptionalist method that clearly helps reduce HIV transmission. Nor is the exceptionalist Weltanschauung completely wrong. In America, the abundant discrimination visited upon homosexuals and the HIV positive did indeed create problems for traditional public-health methods. However, the public-health answer is to challenge the discrimination, not eliminate good epidemiology.

Opposition to such epidemiology has, in this country, reached ludicrous proportions, actually compromising medical care. Miss Burkett offers her own personal example. "In the United States, when you go in for a surgical procedure, you get tested for everything, which is just good medicine—but not HIV. A few years ago, I had lymphoma. Here is a disease that is 63 times more common among HIV-positive people. I had just been tested and knew I was negative, but my doctors didn't know that. So I go in and I wait for them to suggest I get an HIV test.

And I wait and I wait and I wait. And the day I'm starting chemotherapy I ask my doctor why he didn't test me. And he got very defensive. He said, 'Well, I can't test you without your permission, that's the law.' I asked: 'Well, why didn't you suggest it was medically wise?' I knew the answer perfectly well: I was a straight, white, upper-middle-class woman. But it was completely medically irresponsible, because as a doctor you are going to treat my lymphoma quite differently depending on whether I'm HIV positive or HIV negative. Because of these policies, we are giving *heart* transplants without routinely testing people. Which is insane. I just don't understand how you're going to practice good medicine without routine testing."

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FROM the point of view of HR-1062, what is interesting is that Miss Burkett is echoing the GP from Oklahoma almost word for word. He is a Christian Coalition Republican and she is a devout self-described "old lefty" with numerous gay friends who nevertheless will tell you, "These old [exceptionalist] policies were born out of a reality which, if it ever existed, certainly doesn't any more."

The Burkett/Coburn symmetry illustrates a subtle shifting of alignments. Dr. Thomas Coates, Professor of Medicine and Director of the Center for AIDS Prevention Studies at the University of California at San Francisco, is as adept at surviving in the cauldron of left-wing San Francisco AIDS politics as anyone. Dr. Coates recently supported traditionalist measures. His change of heart was prompted by the evidence from AIDS programs abroad: "In the end, the HIV and STD epidemics are unnecessary," he said. "No other industrialized country has these problems. Europe and Australia and New Zealand have gone after these diseases with traditionalist methods *and* with non-traditionalist, new methods supported by the exceptionalists, and have essentially taken care of them."

The AIDS organizations' resistance to traditionalism is still emphatic, but then cold hard reality is not their strong suit. These are the people who brought you the seductive lie that condoms are the universal answer to all diseases that ride on human sexuality. Gay men have swallowed this, but the condom solution has failed. Coburn contends—and while it is perhaps unprovable it is very interesting—that trust in condoms actually contributed to an *increase* in transmission of HIV and STDs through increased sexual activity multiplied by the condom breakage rate.

Moreover—and this should alarm the gay community—despite the current decline in the rate of HIV transmission among gay men, one must note that statistically we are still, as Michael Fumento put it, "the rats [carrying the] fleas of the new plague." Given human nature, today's decline and the desire to believe that the epidemic has been "conquered," accompanied by the inevitable slipping back into unsafe sex and renewed promiscuity, may mean our regaining plague leadership in the future. Gabriel Rotello, a *Newsday* columnist and a gay man who has bucked AIDS dogma, noted recently in his book *Sexual Ecology* that the backlash has already begun. "Editorial boards . . . have moved to distance themselves from gay-run AIDS groups they once unquestioningly supported. Liberal politicians have begun asking tough questions in private while becoming noncommittal in public. Friends of gay people have begun to wonder aloud at the high rates of unsafe sex and transmission."

In the end, the public-health response to AIDS is not an easy problem. Do we, by implementing effective policies, hurt the small number of individuals who will, inevitably, be outed and risk being fired from jobs, and thereby save many times their number from exposure to a devastating virus? Or do we hurt a large number of individuals by refusing to implement policies to combat the disease that will poison their bodies? One of Dr. Coburn's allies answers the question succinctly: "The AIDS community forgets that the ultimate violation of civil rights is being infected with AIDS." And 35 times more deaths per capita under an exceptionalist regime indicates that, somewhere, something went very, very wrong.

Back on Capitol Hill, Tom Coburn will spend the fall working hard on his bill. It aims to chart a new course on AIDS policy, but it is a very delicate matter when under the old course thousands of people have already died and thousands more are sick and the figures seem all out of proportion and you have this nagging little question of responsibility. Dr. Coburn might prefer not to get into it at all (it could certainly complicate the debate), but the fact is, and he knows it, that the mere existence of his bill is forcing an entire political community to step up and calmly respond to the accusation of mass manslaughter. They are not particularly calm at the moment. But you would be hysterical, too, if someone said to you, "Through everything you've worked for, by everything you believe, and with everything you've fought to maintain, you have helped to kill a hundred thousand human beings." □

Personalized Jokes

When it comes to offending people, nothing fits the bill like ethnic jokes.

E. V. KONTOROVICH

HERE's a great joke for you. An Irishman, a Jew, and a black are in a boat together. The boat starts taking on water—no, sorry, I can't tell this one. Getting away with this joke would take an entire committee. An Irishman would say the Irish part before passing the baton to a Jew, and so on. For our culture prohibits making fun, whether in malice or in jest, of any ethnic or racial group except your own.