AIDS apocalypse in Africa: worse than the Black Death

by Jonathan Tennenbaum

Barring a near miracle, AIDS will kill more people in Africa alone over the next 5-10 years, than died in the 14th century bubonic plague. This is the unavoidable conclusion from data presented at the Fourth International Conference on AIDS and Related Cancers in Africa, held in Marseilles, France on Oct. 18-20. The picture which emerged there, presented in the calm, detached manner of medical professionals, was no less than apocalyptic.

From epicenters in the urban centers of Western and Central Africa, the AIDS viruses are inexorably spreading into the African interior. The epidemic is following the highways to reach the rural areas which were mostly untouched up to two years ago, and where 75% of Africans live. While the numbers vary from region to region, the rate of infection in the general population of many urban centers has reached the range of 10-20%, with percentages reaching up beyond 50% in some of the young-adult age groups. In many rural areas the rate of infection has already reached several percent. Meanwhile there are scattered reports of a near saturation of the population in some areas, indicating the potential for explosive, nonlinear jumps in the African AIDS epidemic.

Due to the vast size of Africa, the minuscule resources available for systematic surveys, as well as an anomalously high rate of ambiguous test results (see below), it is impossible even to give a rough estimate of the total number of infected persons in all of Africa. But, it is certainly in the tens of millions. Unless a scientific breakthrough occurs to give us a cure for AIDS in the immediate future—an unlikely prospect, given the miserable state of research today—these people are all doomed. We could see an entire continent go under if the breathtaking speed of HIV spread is not halted soon.

The director of the AIDS Program at the World Health Organization, Dr. Jonathan Mann, predicted for Africa that due to the effects of AIDS alone, "population growth in urban centers will be reduced by 25-50%" in the 1990s, and there is "a potential for negative population growth in some areas after the year 2000." Judging from the data presented at the conference, that is a gross understatement.

Research teams from most of the African nations presented results of the most detailed test surveys for AIDS virus infection completed in Africa so far. Based upon testing of selected groups, this data permits one to estimate the prevalence of infection in some areas. We present just a selection of these estimates.

Among blood donors in Uganda (who are usually family members or friends of people receiving transfusions, and are therefore fairly representative of the general population) 24.6% are infected in Entebbe, 20% in the town of Mbarara, 18% in Rubaga, 15% in Nabasero. In the Rakai district of Uganda at least 12% of the general population is infected in rural areas. Among pregnant mothers there, the figures are even more dramatic: 10.6% in 1985, 13.6% in 1986, 24.1% in 1987. Of the patients hospitalized in Uganda's capital Kampala, 61% are AIDS-infected!

A survey of adult food-handlers from towns along the trans-African highway in Kenya yielded 25.3% infected in Mombasa, 19.4% infected in Kisumu, 23.3% infected in Busia, 10% in Bungoma, 7% in Eldoret.

A survey of the general population of the Ivory Coast yielded more than 7% infected in the urban areas. But among men aged 25-34 years, the percentage was 17.3%! The survey of a rural zone yielded 5% of the general population infected. A clinic for children suffering from malnutrition showed the following evolution in the rate of HIV infection among the children: 0% in 1980, 8.3% in 1986, 10.3% in 1987, 13.1% in 1988.

Among so-called "low-risk groups" in Tanzania, in the city of Morogoro, 22% of hospital inpatients, 18% of health clinic outpatients, 11% of pregnant women, and 4% of persons going to dentists were found infected.

A survey of blood donors in Zambia revealed about 10% infected in the urban centers and 3% in rural towns. In Bangui, Central African Republic the prevalence of infection doubled each year from 1984 to 1988, reaching a level of 9% in the general population, and 20% of all hospital admissions there are attributed to the effects of HIV infection. But hospital admissions are no longer a measure of HIV-related disease; as a research group from the Dabou

Protestant Hospital in the Ivory Coast reported, "In 1988, 31% of hospital patients were found positive and in 1989, 30% were also found seropositive. . . . This apparent stability in the positivity rate may hide a significant increase among patients, since the diagnosed AIDS cases were systematically hospitalized in 1988, whereas in 1989, they are sent home when it is felt that no proper treatment could be offered to them."

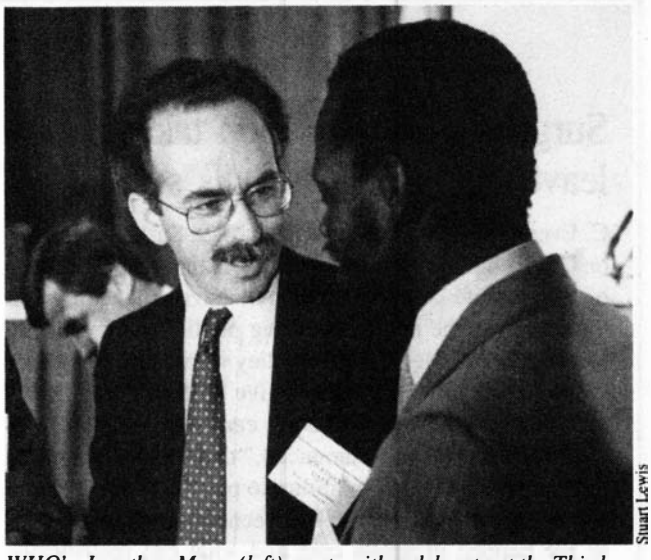
Many of the surveys presented revealed a new feature in HIV epidemiology: Among adults, the percentage of women infected is often significantly higher than that of men. It was repeatedly emphasized that AIDS will have a devastating effect on the next generations, because of the high prevalence observed among pregnant and child-bearing-age women. The AIDS virus is passed on to the child in over half the pregnancies.

A hopeful note was the low rate of infection found in Nigeria, which one speaker suggested might be a "buffer zone" for AIDS in Africa. The reason for the very low prevalence (0.07% among 45,000 sera tested) is not clear. Perhaps the "wavefronts" of infection have simply not yet reached Nigeria, which is situated between the two main epidemics, the one to the North, in West Africa, and the one to the South, in Central Africa. Or perhaps some unknown factor is increasing the resistance of the Nigerians to infection? Hopeful speculations were voiced about some undiscovered virus which might have conferred immunity to HIV, but were generally regarded as extremely unlikely. Mauritania also has an apparently very low prevalence, in spite of its location in the middle of the zone of spread of HIV-2.

But it might be much worse. . .

A recurring theme in the conference was the extremely high rate of ambiguous test results, suggesting either a dramatically different immune reaction in Africa as compared to the U.S. (for example) or possibly the presence of additional viruses of the HIV family not yet identified. It was in fact exactly the occurrence of "false positives" to the original AIDS tests which led researchers some years ago to discover a second strain of the HIV virus, HIV-2, which predominates in West Africa and appears to cause AIDS in the same way as the original strain, HIV-1.

The normal AIDS test procedure is to first screen with a simple test called ELISA, which, however, gives some false positive results. The blood of those persons testing positive with ELISA is then tested with a much more precise (but more expensive) test method known as the Western Blot. The latter measures the response of the immune system to each of several proteins contained within the HIV virus type used to make the test. Only when a clear pattern of response to several of these is demonstrated is the subject regarded as a "confirmed positive" and judged to be infected. In many of the studies, a high proportion (up to 30% or more) of ELISA-positives showed a peculiar "incomplete" profile on the Western Blot. The most likely interpretation of this is the presence of a not-yet-identified virus somewhat similar to and yet distinctly different from HIV-1 and HIV-2, and which is spreading in many areas along with the other two. If this new virus or viruses turns out to cause AIDS, then many of the AIDS infection figures will have to be revised drastically upward.


Stuart Lewis

WHO's Jonathan Mann (left) meets with a delegate at the Third International AIDS Conference in June 1987. Dr. Mann's current assessment of the AIDS threat is a gross understatement.

Austerity means mass murder

African speakers and participants I spoke to referred to a disastrous situation in the health system, especially as regards medications and equipment. This means that most AIDS cases are hardly receiving treatment, or even simple pain killers, which are often lacking. The cost of treating a single AIDS patient for a single week with the drug AZT, is equivalent to three months' salary in Zaire! The cost of a single AIDS test exceeds the total yearly health expenditure per capita in much of Africa! Thousands of people continue to be infected by blood transfusions, because only a fraction of the hospitals—often those supported by charitable groups—can afford to test all their blood donors. Moreover, as a result of debt payments, IMF-imposed currency devaluations, and loss of hard currency income due to collapsing raw materials prices, the real cost of medicines (nearly all of which must be imported) has gone up some 500% during this decade.

The catastrophically low living standards and poor sanitation in much of Africa has played a crucial role in accelerating the spread of HIV as well as aggravating the course of disease among those already infected. In a survey of 274 AIDS patients in Dar es Salaam, Tanzania, it was found that only 63% of AIDS patients were still alive one week after diagnosis, and only 7.5% survived after three months. This compares with an average survival time of much more than a year

Surgeon General Koop takes leave of office—and his senses

C. Everett Koop formally retired as U.S. Surgeon General on Oct. 1, but not before thoroughly extinguishing the last of any pro-life convictions he may have retained during his tenure as the nation's leading public health official. Koop ended his term with a volley of articles and interviews exhorting Americans to give up their "high hopes of what medicine and health care can do for them."

"It's clear," Koop announced, "that those high expectations are outpacing our ability to pay for them. In other words we have a clear gap between what we would like to see happen in health care and what can realistically happen." In other words, just as he told thousands of victims of AIDS to go die in hospices because the country was not going to spend the money to save them, and just as he told the terminally ill that at times, withholding treatment that might prolong life is the best medicine, he is now telling all Americans that we have to triage some of the sick and elderly because their care costs too much.

Koop called on President Bush to form a blue ribbon commission of insurance agents, doctors, health policy groups, and Congress to stir a bipartisan movement for national health care. "That's how we got Social Security," Koop said. "We had people from both houses of Congress, Republicans and Democrats, who espoused the cause of social security, took it back to the floors of Congress, debated and got the legislation passed. And unless we do that, we can't win." The commission's aim would be to design a one-tier medical system that Koop alleges will "give a certain right of health care to everybody in this country."

In one interview, Koop pointed to the increasing cost of employee health care plans to industry and cited the fact that the telephone workers and Pittston coal miners strikes were both over the issue of lost or shrinking health care benefits. "The bottom line," he said, "is this: We cannot compete in foreign markets with the way we handle our health care system." He said the "laissez-faire economy works best for all of our citizens, but the health-care marketplace, although laissez-faire, is not freely competitive . . . has no moderating controls working on behalf of the patient." He blasted "the virtual absence of self-regulation" by health care workers, hospitals, and doctors as well as "the absence of natural marketplace controls as competition in regard to price, quality, or service." Where has Koop been for the last ten years while cost-efficiency experts on state and federal levels have gouged hospital budgets to the bone while cutthroat competition from health maintenance organizations (HMOs), preferred provider organizations (PPOs), and numerous other hybrids, went on to cannibalize what was left of health care delivery?

Protecting the insurance companies

One of the "specters" behind the high cost and wastes of medical care today, Koop says, is the high malpractice premiums doctors must pay, usually out of their own pocket, and the practice of defensive medicine so they will not be sued. Koop's solution is to "profoundly" restructure Medicare/ Medicaid, because, he says, "the health care system satisfies its own uncontrolled economic needs at the expense of every other sector of American society." Koop completely circumvents the culprits behind most of his complaints—namely, the insurance companies. Odd that Koop, like many of those proposing national health care, is not calling for federal regulation of the insurance companies, and demanding that these sharks open their books and prove their "losses" related to medical expenditures and malpractice.

Koop endorsed by name the state of Oregon's new health care rationing plan which states that "all persons have an equal opportunity to receive available services." It also says that as the budget shrinks, so do the available services.

While health insurance companies had worked to soften Oregonians up by rigging public opinion meetings over which patients should be denied care, and what services could "society" afford, medical ethicists were brought in to prioritize all health services to be rendered on the basis

in the United States.

The financial situation of many African countries is desperate. Even the minuscule amount of help supplied by the World Health Organization, the European Community, and various governments and private agencies, has meant the difference between having virtually no AIDS data, no medication, and no countermeasures at all against AIDS spread, and the totally inadequate, but at least existent testing and clinical activity going on today.

total WHO budget for AIDS, for all activities around the world, is less than the AIDS budget of the single state of California, excluding San Francisco! What Dr. Mann did not say is that the WHO is not even spending this pathetic sum properly, but instead is manipulating AIDS policy in a vicious and very dangerous way.

As in every single previous conference co-sponsored by

of their cost-benefit analysis. Death services—euthanasia and abortion—were given highest priority. Services lowest on the list are to be eliminated as funds dry up. Thus, it is only "fair" that Oregon refuses to pay for expensive life-saving interventions, in favor of "improving" childhood immunization programs and prenatal care for impoverished mothers. According to Koop, "That was a tough decision to make. But, in the economy of things in the world of which we live, it's the kind of rationing of which I think, we'll be seeing more and more."

No longer saving infants

What a sad irony it is that the rationing Koop so heartily endorses today will target for triage exactly those sick infants Koop worked to save years ago while at Childrens' Hospital in Philadelphia. Back then he defied both death and the limits of known medical science by saving hundreds of severely handicapped newborns whom no other physician would think of treating. "Basic" health care will effectively expunge Koop's and others' life-saving interventions and all future pioneering techniques that would stack the medical-surgical "deck" so that future generations of critically ill newborns could live. Such newborns would be written off under Oregon's new law because such patients, besides being too expensive to treat, would be seen as having a poor "quality of life." This makes them not worthy of life—or of the state's resources to save them.

What Koop has forgotten or has never truly understood is that medicine's sole priority must be saving the patient, and taming lethal diseases like AIDS. If science exists at all, it exists to serve mankind. Only this notion so defined is the basis of all that professes to be pro-life. Economic science so defined and applied means we may one day look forward to an industrial transformation of the disease-ridden nations of Africa.

In the case of the United States, instituting such a moral economic program would signify a complete abrogation of any adherence to a "fixed" notion of economics that steadily drives up the numbers of unemployed, homeless, and uninsured. Koop simply joins plenty of other policymakers, many of whom rank themselves as "pro-life," whose economic views demand that we must accept a shrunken economy appropriate to a post-industrial America—at whatever cost to human life. With this basic sanctity of life principle compromised, it is then quite lawful and not at all shocking that Koop's pronouncements, from teaching schoolchildren about using condoms and "safe sex," to telling the elderly the "most reasonable thing" is not to try to save the life of terminally ill patients, but "to stand back and let nature take its course"—are increasingly evil. Unfortunately, we can expect more of the same.

Commenting on his recent resignation, Koop said it was time to move on to bigger and better things. Was he thinking about the bit role he will play in the latest sequel to the motion picture, *The Exorcist*? Koop explained his decision to appear in the movie with the following incoherent statement: "I think the occult is playing a larger and larger role in American Society. . . . I think there are some things about it that are hokey, but there is a very real satanic-worshiping group in this country, and I have been involved in public-health issues with that three times in eight years. I think Shakespeare was right when he said that we don't know everything in earth and heaven. I'd say we only have a very small smattering of what's really yet to be known."

Does it sound as though Koop is unable or unwilling to distinguish between that which embodies a fundamental nurturing of human life and that which is evil and preys on mankind? What would inspire the man serving as the nation's foremost public health spokesman, to sit for a formal photo portrait by Robert Mapplethorpe, the same man who photographed a six-year-old girl hiking her dress to reveal herself *sans* underwear, or in another shot, one man urinating into the mouth of another?

Koop once warned, "We must be careful that we do not teach the elderly that they are worthless. They are not necessarily entitled to heart transplants and teflon hips, but they are entitled to the same care and compassion as younger members of our society." We shudder as it becomes increasingly clear just what he means.

—Linda Everett

the WHO, there was no discussion of evidence pointing to AIDS transmission by casual contact and by insects, and proposals for combatting AIDS spread were nearly exclusively limited to the infamous "safer sex" campaign. And yet Dr. Mann admitted, in response to a reporter's question, that "only 40% of infections could be prevented" by the measures proposed by the WHO, even if lavishly funded! In that case, he said, the rate of infection would only double, rather than triple, in the 1990s.

No one discussed the alternative of an all-out war against AIDS, as proposed by Lyndon LaRouche as far back as the October 1985 announcement of his campaign for the U.S. presidency in 1988. LaRouche demanded a halt to economic austerity policies, classical public health measures as earlier applied to the case of tuberculosis and other infectious diseases, and a "Manhattan Project"-style crash program to de-

velop a cure for AIDS. Leading AIDS experts have admitted that this approach would work, but is "politically unfeasible" given the do-nothing attitude of advanced-sector governments. But, given that an alternative exists, is the adoption of the WHO policy—which admittedly would mean allowing entire nations of Africa to be wiped out—anything else but calculated murder?

The evolution of AIDS

Various studies presented at the conference confirmed earlier data indicating an extremely high rate of genetic change in the AIDS viruses. Once a person has become infected, the virus "colonizes" various tissues of the body, for example, lymph nodes, blood cells, or the brain. Each time the virus goes through its reproductive cycle in the cell, new variants are produced and selected, adapting to the particular tissue type in which they grow. Furthermore, the malignancy of these variants appears to grow as the disease progresses. If the infected person transmits the infection to another person, the clinical course of disease in the second person will depend upon which of the growing number of variants was transmitted. The more people are infected, the faster the AIDS viruses will evolve.

A somber note was added by University of Alabama researcher G.M. Shaw, who presented data showing that the concentration of AIDS virus particles in the blood is vastly larger than is commonly assumed, particularly in the late stages of the disease. His studies indicate that titers of a million infectious particles per milliliter may be common among persons sick with AIDS. This compares with the levels attained in the viremic phase of equine infectious anemia, a disease of horses caused by a virus quite similar to HIV; in that phase, the disease is easily transmitted from animal to animal by flies. Given that AIDS patients in Africa are commonly sent home rather than hospitalized, we must expect an explosion of insect-transmitted AIDS in the villages as soon as the number of AIDS victims reaches a critical level.

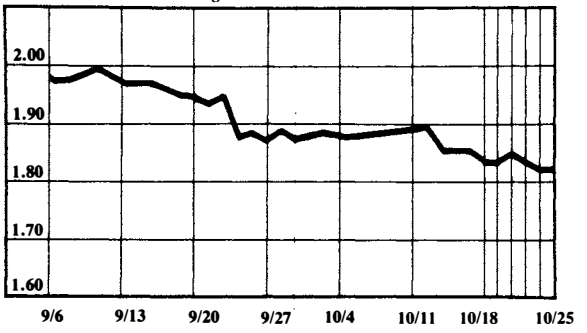
Africa has become a breeding ground for evolution of a vast and growing AIDS virus family, including emergent strains of great pathogenicity. The new "mystery strains" suggested by the ambiguous test results may be part of this. Leading researchers have warned of a possible "nightmare" development: the emergence of a strain adapted to spread by the respiratory route, like the common cold. At that point *homo sapiens* would be virtually doomed to extinction! As the AIDS tragedy in Africa unfolds, the probability of such an event grows larger with every passing day.

If for no other reason, people all over the world must realize that the fight against AIDS in Africa is not just a life-or-death issue for Africans, but will to a large extent decide whether mankind as a whole will survive this pandemic. Africa must be saved, at whatever the cost. Otherwise we may all become victims, in a real-life version of Edgar Allan Poe's chilling story, "The Masque of the Red Death."

Currency Rates

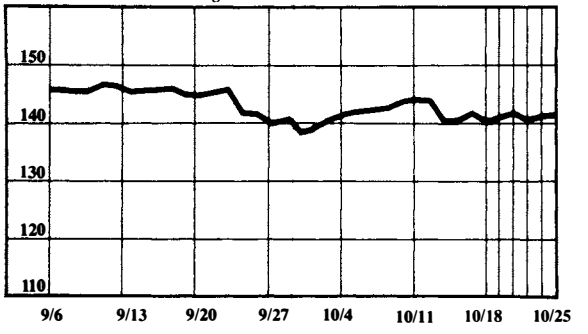
The dollar in deutschemarks

New York late afternoon fixing



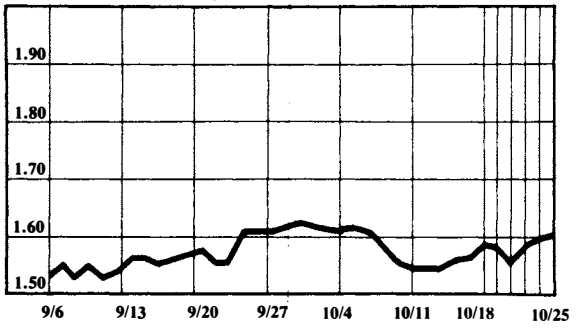
The dollar in yen

New York late afternoon fixing



The British pound in dollars

New York late afternoon fixing



The dollar in Swiss francs

New York late afternoon fixing