EIR Feature

Can the HIV depopulation of Africa be stopped?

by Linda de Hoyos

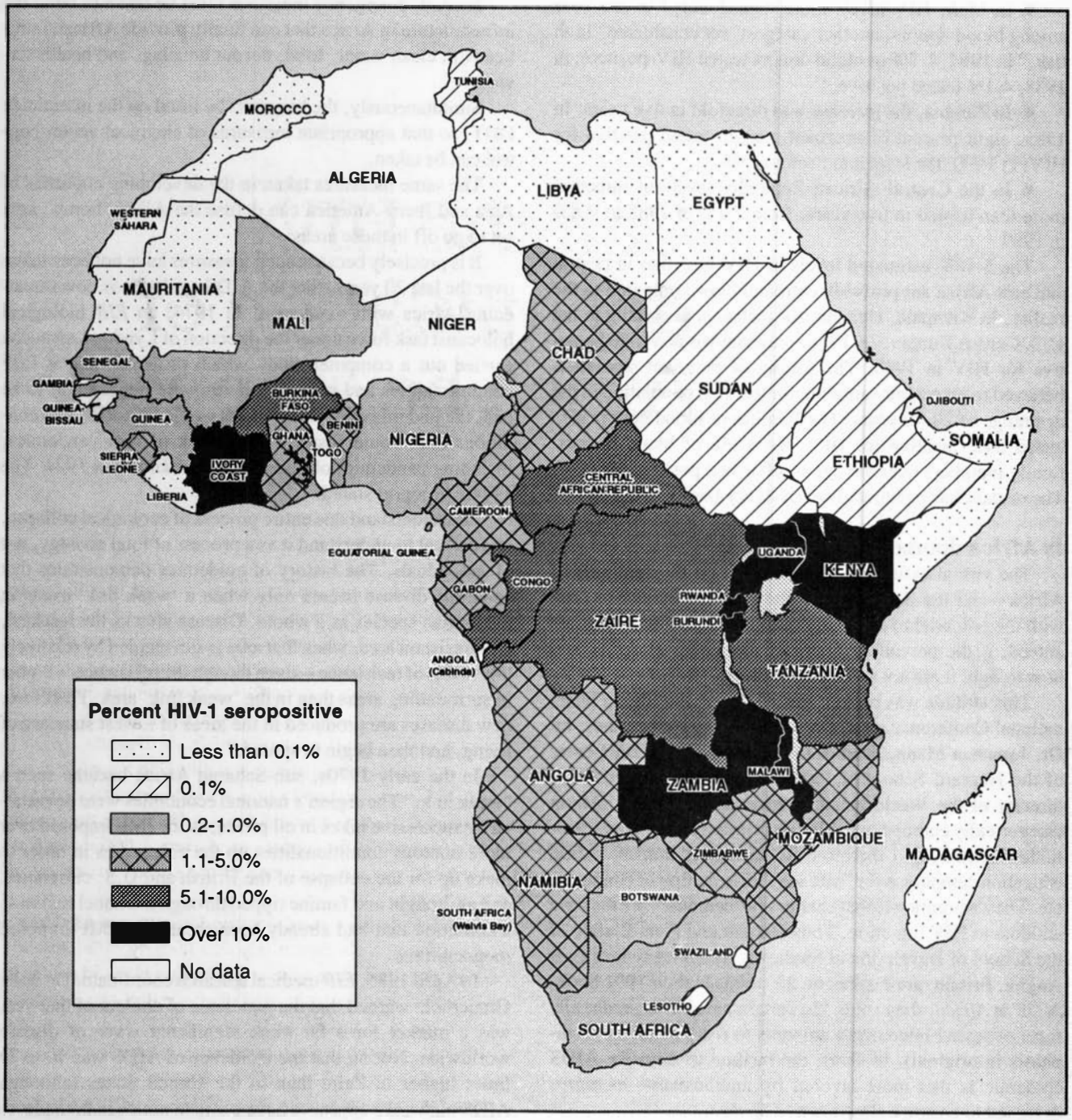
In late June, the AIDS epidemic on the continent of Africa made headline news with the report from two British researchers, Dr. Roy Anderson of the Imperial College of Science and Technology, and Robert May of Oxford University, to a conference in Nairobi, Kenya, that, according to their mathematical projections, the AIDS epidemic would soon turn Africa's population growth rates downward, and that Africa would soon enter a period of negative population growth.

The truth of the Anderson-May report is incontestable. In Uganda, AIDS is now referred to as *namuzisa,* "the one who causes extinction." In a conference of the Zimbabwe National AIDS Council in late 1991, it was projected that 700,000 people out of a total population of 10 million would die of AIDS within the coming few years. That is a crude death rate of 70 people out of every 1,000 *dying from AIDS alone*. For comparison, the crude death rate in the United States for *all* causes was 9.9 per 1,000 in 1991.

AIDS is projected, according to the United Nations International Children's Emergency Fund (Unicef), to reduce life expectancy in Africa by 30%! Already in Africa, most sub-Saharan countries have a life expectancy below 50 years. In East Africa, where the AIDS epidemic has hit hardest, the mortality rate is expected to rise by at least 20% in the near future, because of AIDS. Already, in the southern Africa region, 10 to 15 million children have been orphaned by the death of parents struck down with AIDS, or the African "slim disease."

HIV, the virus that is one of the principal causes of AIDS, is believed to have infected more than 10% of the populations of Kenya, Uganda, Malawi, Burundi, and Rwanda. In these five countries alone then, at least 6,350,000 people are infected with the HIV virus, based on the total population estimates for 1990 of the United Nations Development Program. In the Ivory Coast, Central African Republic, Zaire, and Tanzania, it is estimated that between 5 and 10% of the population are HIV-infected. Assuming only 5% rates for these countries, another 3,895,000 people are HIV-infected.

FIGURE 1
AIDS strikes Africa



Source: U.S. Census Bureau.

Data compiled by the U.S. Census Bureau also show an escalating rate of the spread of the HIV infection in Africa:

- In Malawi, the HIV level among pregnant women, who are not considered a high-risk category, has increased *tenfold* over the last five years. In 1985, the tested rate was 2%. In 1990, the rate was 22.8% of pregnant women having

the AIDS virus. The 22.8% level also indicates that the estimate of 10% infection for the Malawi population is likely too low.

- In Mali, HIV levels more than doubled in one year among blood donors, another category not considered "high risk." In 1987, 1.7% of blood donors tested HIV-positive; in 1988, 4.1% tested positive.
- In Zambia, the increase was threefold in five years. In 1985, eight percent of pregnant women tested positive for HIV; in 1990, the level had risen to 25%.
- In the Central African Republic, levels of infection more than tripled in five years, from 2.1% in 1985 to 9.8% in 1989.

The 5-10% estimated levels of HIV infection in central and east Africa are probably extremely low compared to the reality. In Kampala, Uganda, for instance, according to the U.S. Census Bureau, 28.1% of pregnant women tested positive for HIV in 1990. The testing of pregnant women is believed to give a fair sampling for the total population in the age range of 20-40 years. The families of blood donors also tested 34% positive for HIV. Even 6% of blood donors' family members over the age of 60 tested positive for HIV. The disease has penetrated nearly every family in the city.

Is Africa doomed?

The virtual extinction of human life on the continent of Africa—and the detonation of the AIDS epidemic in Asia with the potential to kill many millions more—will be guaranteed, if the prevailing views of the nature of AIDS and how to fight it are not swiftly overturned.

This attitude was best expressed during the Eighth International Conference on AIDS in July in the Netherlands, by Dr. Jonathan Mann, head of the International AIDS Center of the Harvard School of Public Health and former AIDS director of the World Health Organization (WHO). Mann categorically claimed that AIDS is primarily a sexually transmitted disease, and therefore its remedy is known: public education campaigns for "safe sex," distribution of condoms, etc. The assumption is that changes in "behavior" are the only antidote to HIV infection. Tony Barnett and Piers Blaikie of the School of Development Studies at the University of East Anglia, Britain, are explicit on the point. In their 1991 book, *AIDS in Africa,* they state: "In certain areas of Uganda, *any* form of sexual intercourse amounts to risky behavior" (emphasis in original). In short, the method to stem the AIDS epidemic is that most favored by malthusians—measures designed to ensure a slowdown of *births*.

At the root of such a prescription is a fraud. As this report will offer evidence to show, AIDS is an environment-related disease whose epidemic spread can only be checked by classic public health measures.

The AIDS epidemic is absolute proof that the survival of Africa requires the immediate suspension of all conditionalities imposed by the International Monetary Fund and any other public or private, allied credit institution. The systematic looting of the economies of Africa by the IMF and the commodity cartels must be brought to an immediate halt.

Second, emergency measures must be taken to build the infrastructure in Africa that can finally provide African families with clean water, food, decent housing, and health services.

Simultaneously, the ban must be lifted on the insecticide DDT, so that appropriate measures of chemical vector control can be taken.

The same measures taken in the developing countries of Asia and Ibero-America can defuse the AIDS "bomb" now set to go off in those areas.

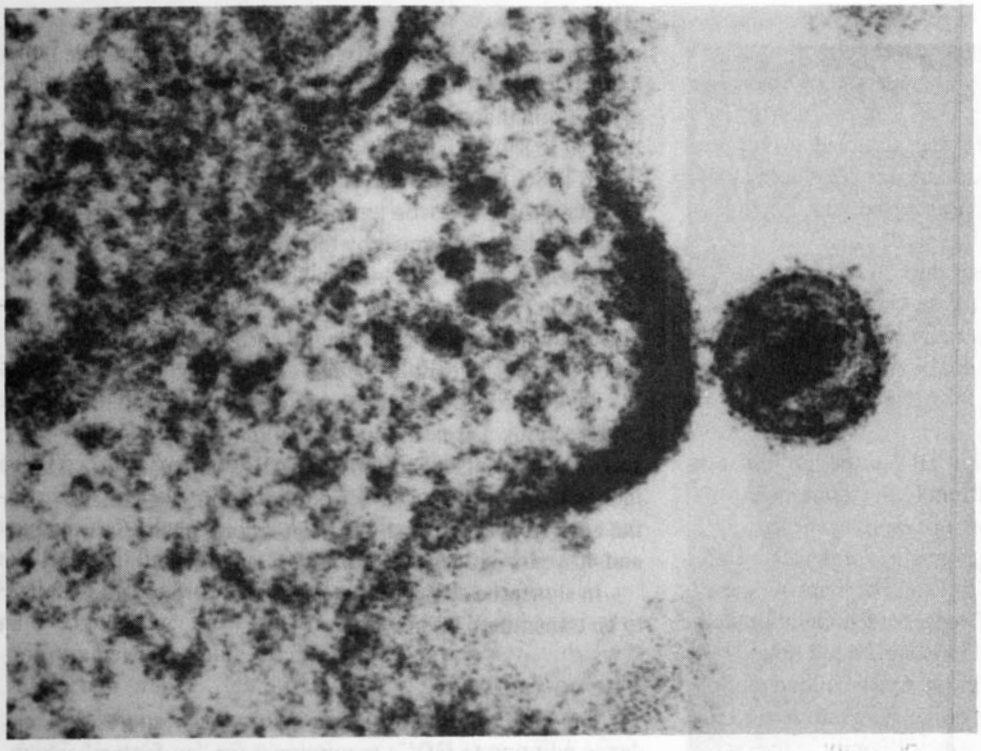
It is precisely because such measures have not been taken over the last 20 years, that the AIDS epidemic is now threatening Africa with extinction. In 1974, an *EIR* biological holocaust task force under the direction of Lyndon LaRouche carried out a computer study which projected that if IMF conditionalities and related policies were not brought to an end, the underdeveloped countries would be hurled into conditions that would foster the outbreak of new pandemics, including pandemics of diseases *not yet known in 1974*. The 1974 *EIR* report stated:

"To understand this entire process of ecological collapse, it is critical to understand it as a process of total ecology, not of individuals. The history of epidemics demonstrates that epidemic disease occurs only when a 'weak link' exists in the human species as a whole. Disease attacks the weakest, least resistant area, when that area is surrounded by relatively low levels of resistance—even though the resistance is higher in surrounding areas than in the 'weak link' area. Therefore, new diseases are produced in the areas of lowest standard of living, and then begin to spread."

In the early 1970s, sub-Saharan Africa became such a "weak link." The region's national economies were devastated by successive hikes in oil prices; as the IMF imposed ever more onerous conditionalities on the economies in order to make up for the collapse of the British and U.S. currencies; and as drought and famine ripped through the Sahel region—a condition that had already been created by IMF-imposed monocultures.

In April 1985, *EIR* medical research coordinator Dr. John Grauerholz warned that the pandemic of cholera of that year was a marker for a far more significant wave of disease worldwide. Noting that the incidence of AIDS was 10 to 20 times higher in Zaire than in the United States (although AIDS outbreaks appear to have come to notice in both places in 1981), Grauerholz stated that "cholera, malaria, AIDS, and other diseases are . . . growing so luxuriantly in Africa, that they will hardly remain confined. Under such conditions, mutation to more virulent forms, and increased transmissibility will occur."

Grauerholz's warnings were corroborated by the groundbreaking work of Drs. Mark Whiteside and Carolyn Mac-



The AIDS virus (HIV-3) is shown budding off from a T lymphocyte. The spread of AIDS in Africa underlines the importance of factors which the science establishment has brushed aside: the possibility of insect transmission, and HIV's interaction with co-factors that also act to suppress the immune system.

Leod, who studied the AIDS outbreak in the town of Belle Glade, Florida. Their work showed that if people were forced to live in Third World conditions of poverty in United States, high levels of HIV infection and AIDS disease would be the result (see interview).

As this report will show, the HIV virus flourishes in sub-Saharan Africa in an overall environment of a total breakdown in public health. Seen in that context, it becomes obvious that attempting to stop the AIDS epidemic with condoms is like trying to put out a forest fire with spit. Furthermore, in order to maintain the illusion that AIDS is primarily a sexually transmitted disease and therefore "condom-bound," the WHO has acted to suppress or ignore the following avenues of investigation:

Insect transmission possible

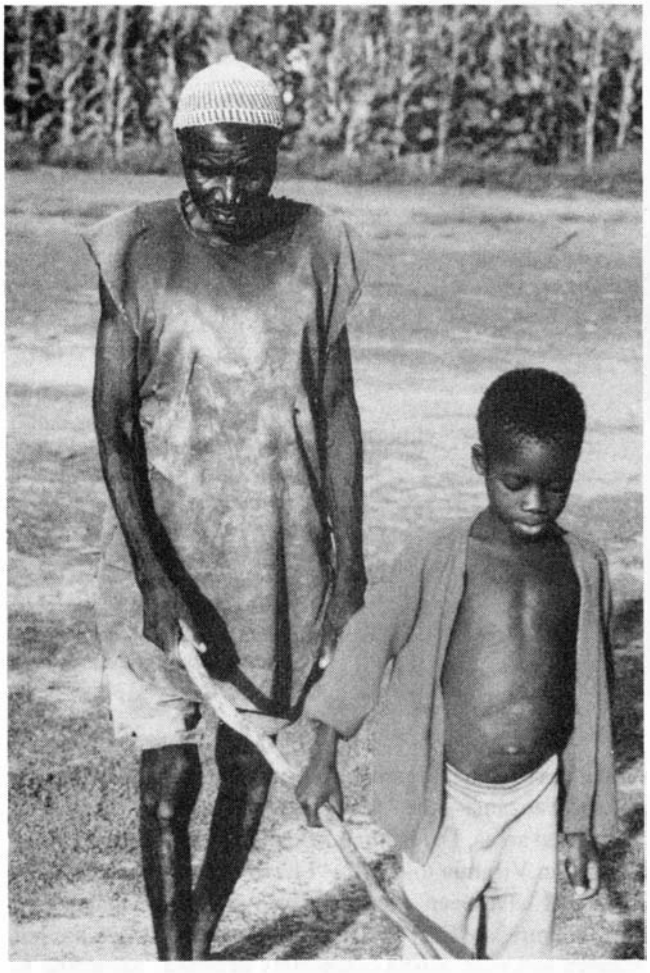
Although reports such as Anderson and May's give an accurate picture of the rapid rate of spread of the AIDS epidemic in Africa, the ferocity with which "slim" has already hit the rural districts of central and east Africa has tended to be suppressed. In 1991, the Center for International Research of the U.S. Bureau of Census published a report that by the year 2015, the African population could be reduced by 50 million as a result of AIDS. The center implied that HIV infection was far higher in the cities than in the countryside, stating that "since rural populations constitute the majority of many African countries, tremendous potential for expansion of HIV infection exists in most countries."

However, reports have been emerging from Africa for the last two years, that AIDS has already raged through the rural areas of Zaire, Uganda, Kenya, Central African Republic, and Tanzania—the "AIDS belt." AIDS has already been in the rural areas, Dr. Ishmail Abdallah of William and Mary College in Virginia told *EIR*. "I have seen entire villages in Zaire that have been wiped out by AIDS." In Uganda and other countries of East Africa, it is known that AIDS has left villages and even towns completely deserted, according to Dr. Patrick Usanga, a Nigerian medical relief doctor and president of the Golden Cross Foundation. "You can quote me on that. It is common knowledge in Africa."

As early as April 1988, the Swiss *Revue Internationale de Défense* reported that "according to information gathered in October 1987 from sources close to the American embassy in Nairobi, Kenya, satellite photos show a large expansion of wild vegetation in the eastern part of Zaire. AIDS seems to be the cause of the disappearance of entire communities in those regions previously densely populated."

The ravaging of rural areas to levels of 80-90% HIV infection points to the significance of factors which the WHO and the Centers for Disease Control in Atlanta, Georgia have brushed aside: the possibility of insect transmission of the HIV virus, and HIV's interaction with co-factors that also act to suppress the immune system.

The efficiency of insect transmission as the cause of spread of disease cannot be overestimated, especially in Africa. More people die each year from mosquito-borne diseases worldwide than from any other single cause, according to *Hunter's Tropical Medicine*. In Nigeria and other areas of Africa, mosquito-borne yellow fever wipes out entire villages every year, reports Dr. Usanga, with village populations



A West African man blinded by onchocerciasis is led by a small boy who may already have the disease himself. Onchocerciasis is one of Africa's major health problems, and a leading cause of blindness. It is spread by a parasite carried by blackflies.

never fewer than than 1,000 people! Epidemics of yellow fever have been known to kill 100,000 at a time in Africa. Similarly, African sleeping sickness, transmitted by the tsetse fly, killed more than half a million people in a Zaire epidemic in 1905-6, and nearly two-thirds of the population around Lake Victoria.

Can HIV be transmitted by insects?

In May 1992, the German journal *AIDS Forschung* concluded that "the prevalent opinion that it is practically impossible for even a few infectious units of HIV to be transferred by blood-sucking insects, is not supported experimentally." The publication reported on experiments in which stable flies in laboratory captivity were fed with herpes simplex virus (HSV) type 1 and human immunodeficiency virus type 1 (HIV-1), with HIV-infected human T lymphocytes and with uninfected lymphocytes suspended in cell culture medium. "Minutes later, spontaneous regurgitated blood was collected and investigated. Both the lymphocyte viability and the HSV and HIV infectivity were found to persist, permitting the assumption that some, potentially ten, cell culture infectious units of cell-free or cell-bound HIV may be transferred."

In 1986, scientists in South Africa had demonstrated that HIV could survive for an hour or more in bedbugs. That study had been prompted by the report that 40% of surveyed African HIV-infected children from 1 to 24 months of age had *mothers who were not infected!* Subsequent study at the U.S. National Institutes of Health showed that HIV survives up to 48 hours in certain species of mosquitoes.

Dr. Ricardo Veronesi, president of the Brazilian Society of Infectious Diseases and consultant to WHO, has also shown that the age distribution of AIDS and malaria is nearly identical, with lowest infection among young children and the elderly, and greatest infection among adults between 20 and 40 years of age (69% for AIDS and 62% for malaria).

In short, the answer is "yes," it may be possible for HIV to be transmitted by insects.

The co-factors

The WHO-CDC nexus also assiduously ignores the evidence pointing to HIV's requirement for "co-factors" which "kick" the HIV retrovirus into activity. These co-factors, which are already acting to depress the immune system, are precisely the factors that make sub-Saharan Africa the "weak link" in the global ecological holocaust produced by IMF policy.

- **Malaria**—With the banning of DDT, anopheles-mosquito-borne malaria has been on a steady rise since the 1970s. In Africa, more than 100 million people are afflicted with this disease; over 1 million Africans die of malaria each year. Two hundred million people have malaria worldwide, making it possibly the most significant global co-factor for HIV. Chronic malaria is associated with tropical splenomegaly syndrome, a disorder of the immune system which creates an increased susceptibility to severe infections, including malaria itself.

- **Protein-energy malnutrition (PEM)**—Although kwashiorkor and marasmus are the diseases of severe protein-energy malnutrition, a full 72% of the children of sub-Saharan Africa are considered malnourished, according to the United Nations Development Program report of 1991. This is a major factor in the under-five-years mortality rates of 20-30% in African countries.

This chronic malnutrition has a devastating impact on the immune system. "In a vicious downward cycle, an infection causes a worsening of malnutrition, thereby making the host more vulnerable to infections and to further deterioration of nutritional status," reports *Hunter's Tropical Medicine*. "PEM in particular is associated with a breakdown of cellular immunity, as a consequence of the deletion of the lymphoid tissue which produces the lymphocytes responsible for cellular immunity (CMI). The degree of impairment is directly

related to the degree of malnutrition." The CMI is the chief defense, also, against tuberculosis, which has been on a steady rise in Africa.

Further, *Tropical Medicine* states, "serum proteins that help combat infections are also reduced drastically by malnutrition. . . . The complement system, which enhances certain antibacterial and antiviral reactions, is also depleted in PEM."

• **Other diseases**—Because of the denial of infrastructural and technological development to sub-Saharan Africa, a person living in Africa is constantly bombarded with infection from diseases which have long been wiped out in other parts of the world. Polio and leprosy are high on that list, for example. Many of these diseases—cholera, schistosomiasis, typhoid, and gastroenteritis—are simply caused by the lack of clean drinking water and sanitation. These diseases are often a grave danger during the dry season, when people are forced to go to contaminated streams for water, instead of just collecting water from rain.

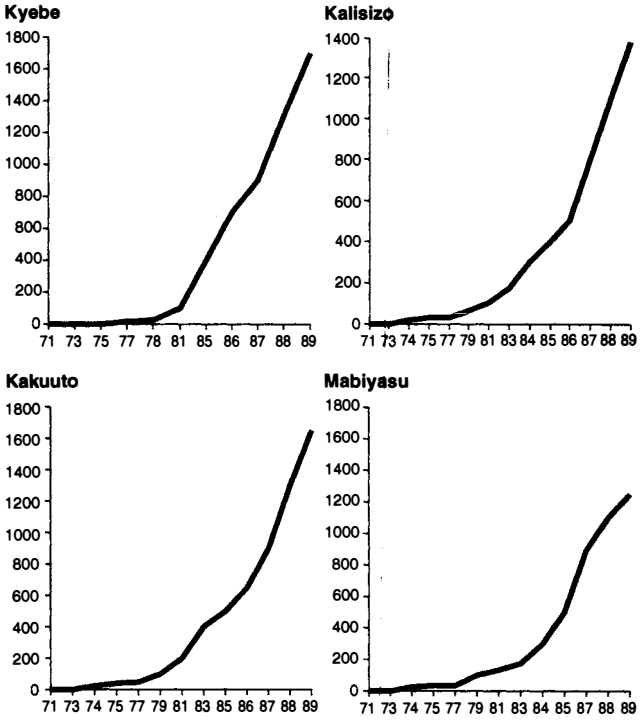
Further, an African is far more likely to become seriously ill or even die from such diseases. Cholera is a disease that can be cured with $5 rehydration packets. But in Africa, it is a killer. In 1991, 14% of all cholera patients were dying in Zambia—the highest death rate worldwide. During the 1991 epidemic, 12.9% of cholera patients died in Nigeria; 12.3% in Cameroon; 12.1% in Niger; and 10% in Chad. These figures are likely gross underestimates, since as Dr. Usanga points out, in Nigeria, cholera can kill everyone in a village in one fell swoop. Since these deaths are in rural areas, they go largely unreported.

• **Arboviruses**—As Dr. Mark Whiteside has postulated, arboviruses—that is, insect-borne viruses—are a suspected co-factor in activating the HIV retrovirus. Aside from the viruses of the bunyaviridae family (see interview) which usually carry with them no symptoms, there are other such arboviruses which have caused major epidemics, particularly in the east and central African countries of the AIDS belt. These include Ebola virus, which broke out in Zaire in 1976; the Marburg virus, of which there was an epidemic in 1980 in Kenya; Sindbis fever, which has a high incidence in Uganda and broke out in epidemic form in South Africa in 1974; and Rift Valley fever, which also affects cattle. The incidence of these fevers is likely far higher than reported, particularly in the last decades, since they are more likely in rural areas where there is little or no health care and reporting of disease.

The extremely high incidence of these co-factors in Africa is the explanation for why such high levels of HIV seroprevalence exist in Africa, compared to any other geographical region. Another factor is the total collapse of health care in sub-Saharan Africa since *EIR* issued its 1975 pandemic warning.

In 1985, Dr. André Dodin, general secretary of the Society of Exotic Pathology in France, had told *EIR* that health services had collapsed throughout Africa, in large part because of the impact of the oil crisis on African economies. As a result, he said, diseases that in the past had been under control were now reappearing. "When there were nurses out everywhere in the bush, and doctors in the centers, these diseases were under control. Now the nurse is disappearing, the posts in the bush are disappearing, everything disappears with them. There is necessarily a regression in hygiene and health."

FIGURE 2
Cumulative numbers of deaths of parents in four counties of Rakai district, Uganda



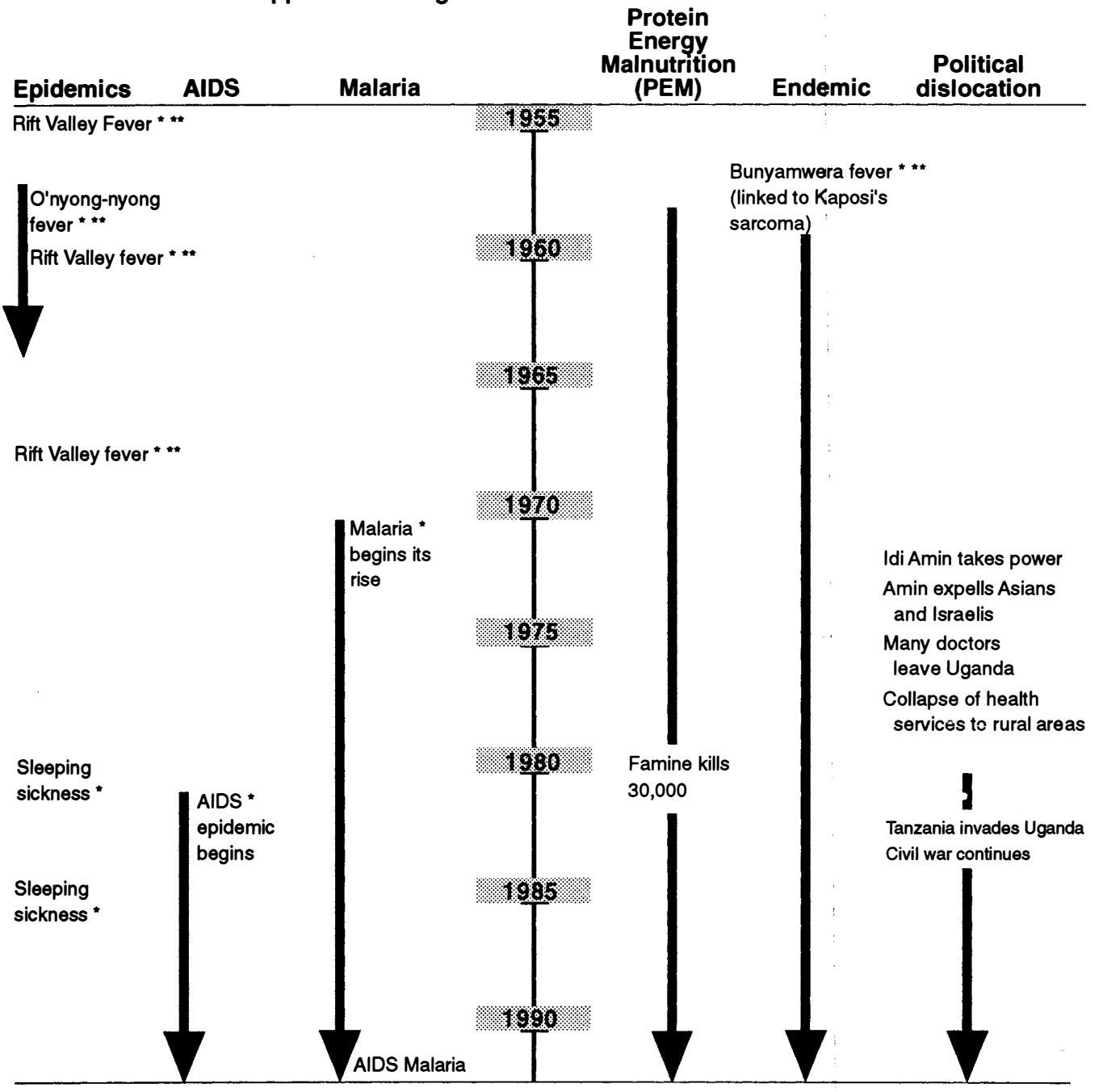
Source: *AIDS in Africa*, by Tony Barnett and Piers Blaikie

In Nigeria, Dr. Usanga reports, the health services have been in a state of collapse since the IMF's "Structural Adjustment Plan" was imposed on the country in 1986. Today Nigeria spends less than 2% of its gross national product on health care per year. Under 5%, he says, health care is basically nonexistent. Since 1984, no state government in Nigeria has been able to hire a medical doctor. Rural clinics and hospitals have simply been abandoned. This is the case throughout sub-Saharan Africa, with many countries having experienced the breakdown far earlier.

The case of Uganda

All of these factors which destroy the health and immune system of individuals are present in full-blown form in Ugan-

FIGURE 3
Factors for immuno-suppression in Uganda



* acts to suppress immune system
** arbovirus

da, where HIV-1 seroprevalence is close to 30% in urban areas. In certain rural areas, particularly those along the coast of Lake Victoria, AIDS has wiped out the "parent" age group in the villages, leaving no one to work the individual farms (see **Figure 2**).

In its first decade of independence, the Ugandan government made health a number-one priority. Sleeping sickness was wiped out by vector control; 22 hospitals were built; vaccination programs were established with outreach into the countryside; health care was 10% of the national budget.

Over 70% of Ugandan children were vaccinated against tuberculosis, a disease which had been widespread throughout the 1940s and '50s.

With the advent of dictator Idi Amin in 1971, Uganda began its descent into biological holocaust. By 1973-74, health services were in a state of collapse. By 1974-77, the death rates in the counties of Rakai district began their takeoff, four years before deaths from "slim" were ever noticed. In 1979, the Tanzanian Army marched its way across the entire country. The invasion got rid of Amin, but also wreaked havoc on the Ugandan economy.

In 1980 and again in 1985, the areas around Lake Victoria were assaulted by epidemics of sleeping sickness (trypanosomiasis). "Uganda is the most serious situation in Africa regarding tryopanosomiasis," Dr. Peter de Raadt of WHO told *EIR* in 1985. "There is a complete breakdown of vector control in Uganda since Idi Amin's time. I was there in the 1960s and saw not one case of sleeping sickness." In 1985, the outbreak affected 20,000 people.

Today, in Uganda, there is one doctor for every 23,000 people; a mere 3% of the country's gross national product is used for health care. According to a health survey carried out in 1989 by the Ugandan Health Ministry, 46% of the children in rural areas are moderately to severely stunted, reflecting a general condition of chronic malnutrition. The mortality rate for children under five years of age is 180 out of 1,000—close to 20%. Of the children under five years surveyed, 41% were reported to have had fevers in the four weeks prior to the survey. "It should be noted," the report said, "that malaria is endemic in Uganda and therefore most fevers in children are attributed to malarial infection." Of the rural households surveyed, 1.7% had electricity and 0.0% had refrigerators.

The survey had been carried out with a grant from the U.S. Agency of International Development. The purpose was to discover how best to foster birth control in order to lower fertility rates.

But lowering fertility rates is hardly the problem in Africa. Condom distribution is hardly the answer to the AIDS epidemic. As Mr. As Sy, head of the Third World Project in Senegal, reported to the WHO conference in July, "Loads of condoms are being sent to villages where people are just lying there, already too sick or too old to have any use for them."

The case of AIDS in Africa exposes the truth of AIDS everywhere: The HIV virus is the result of the collapse of the physical economy under the dogmas of the IMF and British system free trade. Reversal of the AIDS epidemic requires 1) overturning of the malthusian-motivated lies of the WHO and CDC, and 2) full-scale mobilization to carry out the public health measures whose effectiveness history has repeatedly proven.

Any other approach constitutes criminal protection of the AIDS killer.

Interview: Dr. Mark Whiteside

'Safe sex' will not stop AIDS epidemic

Dr. Mark Whiteside of Key West, Florida, was one of the first to draw attention to the environmental factors associated with AIDS. His views were based on work he carried out with Dr. Carolyn MacLeod and the Institute of Tropical Medicine in Florida, on AIDS cases in poor neighborhoods in Belle Glade and Miami, Florida. The implications of this work have been systematically stifled by the Centers for Disease Control and the Centers' insistence that AIDS is almost exclusively a sexually transmitted disease. Linda de Hoyos interviewed Dr. Whiteside on July 27, 1992.

EIR: You have done a lot of work with patients with AIDS since 1988. Do you still stand by your view that AIDS is basically a "tropical, environmental-based, probably insect-transmitted disease, with secondary blood transmissions"?
Whiteside: Yes.

EIR: When we talk about AIDS at this point, what do we mean by AIDS? What would be a diagnosis?
Whiteside: AIDS still remains the same. It is a defective cellular immunity where it reaches a point that you develop opportunistic infections, or Kaposi's sarcoma. That's what we call AIDS. The definition might change to the point that anyone with antibodies to HIV and less than 200 total T-cells would as qualify as having AIDS. But that has not formally happened.

EIR: Do you consider that there is a major difference between infection with HIV and AIDS? Is HIV necessarily causal to AIDS?
Whiteside: I never thought it was the only cause of AIDS. I've accepted it as the most important marker for the disease. You can get exposed to HIV and make antibodies in a few weeks to a few months, and it may be 5, 10, 15, 20 years before you come down with full-blown AIDS.

EIR: The African "slim disease" seems to have a very rapid onset. There are immediate symptoms which are recognized as AIDS—dry cough, diarrhea, herpes zoster. Is that similar to AIDS in the United States?
Whiteside: AIDS varies a little bit depending upon geography. In the tropics, there is more wasting and diarrheal dis-