

The Political Economy of AIDS

by

Brian K. Murphy

Schmalhausen's Law is a general principle that organisms in unusual or extreme conditions, at the boundary of their tolerance for any one aspect of their life conditions, are extremely sensitive to stressors in all aspects of their life conditions. Thus malnutrition inhibits the immune system and makes people more vulnerable to infection. Pesticide poisoning can prevent absorption of vitamin A, and this in turn reduces the T-cells and macrophages that are part of the body's defences. Diabetes makes bacterial infections more dangerous. Diarrhoea can make it easier for pollutants to pass through the lining of the gut, while any sexually transmitted diseases that irritate the reproductive tract facilitate the entry of HIV. Social and emotional stress and anxiety reduce immune capacity. Poor people are often afflicted by multiple insult, allowing even more ailments to accumulate. Therefore any struggle against poverty and racism and abuse based on gender is also a public health issue, and the health of a community has to be looked at not only disease by disease but also as a whole. Vulnerability itself becomes an object of study...

The single-minded reliance on chemical therapies leaves us vulnerable ... A whole-system strategy for confronting infectious disease has to be much broader than traditional medical and public health efforts. Health is determined in a much larger arena that includes land use, demography, pollution and waste disposal, wildlife and agriculture, poverty and inequality.

~ Richard Levins, John Rock Professor, Harvard School of Public Health¹

No health issue has so galvanized the world and public attention as has the acquired immune deficiency syndrome (AIDS). The acquired immune deficiency syndrome is a condition in which a person's immune system is severely compromised and left vulnerable to a broad range of infections and diseases that debilitate and can lead to death. It is a medical construct that captures many disease phenomena in one basket for purposes of investigation, diagnosis and treatment. Within this complex syndrome there are many factors. No one factor — including the various viruses associated with immunodeficiency — is alone sufficient to bring on the onset of chronic acute immune deficiency. The most determinant predictors of immune suppression and associated disease, in the north and the south, are factors directly related to social and economic status or to medical treatment itself. And increasingly, front line workers in the "fight" against acute immune deficiency are asking that resources be prioritized in the area of basic health promotion.

Closely read, the in-house literature of the international health institutions and multilateral development agencies explains all of this. Acquired immune deficiency

syndrome is multifactorial, and social factors predominate. Yet there has been a tendency to obscure these fundamental understandings for fear of “confusing” people, undermining prevention programs, and eroding political support for program funding and continued investment in pharmacological research. Extensive resources are available for those who develop their programs within the conventional medical framework, and most programs and public education campaigns are built uncritically on the “HIV/AIDS” metaphor and image. It is far easier to mobilize support to fight disease than to fight poverty and injustice.

Those advocating a comprehensive and balanced approach in health programming and public education do not insist that poverty is the sole cause of extreme and chronic immune suppression, nor that viruses and microbes can be declared with certainty to have absolutely no role. Indeed, most resist precisely the notion that what is called AIDS is a single phenomenon or that it has a sole and solitary cause. They do say that the factors and conditions that lead to such immune suppression are dominant among poor populations, that the poor are the most vulnerable, and that it is on poverty and its roots that we should focus. A virus is a convenient and simple “target” to rationalize medical responses, but it also obscures other factors that would focus responses on long-term social and economic transformation of the conditions that make people vulnerable to the diseases that take advantage of chronic immune deficiency. The role of medicine — that is drugs — in resolving the crisis can only be very limited, and there is controversy about the actual effects, negative and positive, of pharmaceutical approaches.

Such a fundamental re-thinking inevitably entails confronting vested interests and conventional wisdom, and provokes differences of opinion within legitimate communities of concern, including among AIDS activists. However, nothing less is sufficient if we are to help those susceptible to chronic acute immunodeficiency and associated life-threatening diseases, especially the poor and indigent in our own communities, and in the poorest countries of the South. And nothing less is sufficient if we are to protect AIDS “suspects” — those considered, on the basis of gender, race, origin, sexual-orientation or class, to be at high-risk for infection and transmission — from the excesses that arise when fear, ignorance and prejudice over-ride individual rights.

The issue is justice. The primary factors in the development of chronic acute immune deficiency are largely social and political, rather than biological. The measures that could effectively prevent or remediate such immunodeficiency are neither expensive nor complicated. The pharmacological treatments — none of which are truly effective, and all of which are toxic and dangerous — are both expensive and complicated. Neither prevention nor treatment are available to those most at risk. They are certainly not available among the most marginal populations in the Global South² and will never be

accessible to them on any meaningful scale. And to the limited extent that pharmaceuticals do become available, it will be at the expense of investments in community health and social transformation that, in the final analysis, are the most effective responses to the phenomena presently attributed to AIDS.

Aids and its treatment

Let's examine some very basic facts about AIDS, readily available in medical literature. While not commonly understood, these facts are available within the orthodox medical paradigm. What is controversial is merely whether these facts should be made clear in mainstream AIDS "messaging".

- AIDS is a medical construct that defines a condition which includes acute and chronic immune suppression ("acquired immune deficiency syndrome" — a.i.d.s. — now known as AIDS), and a slew of opportunistic life-threatening conditions and potentially fatal diseases to which the immunosuppressed individual is susceptible. There are over thirty such opportunistic conditions and diseases presently included in the expanding official definition of AIDS. In most industrialized countries, a person is diagnosed with AIDS when they exhibit symptoms of one or more of these conditions, and test positive for HIV antibodies. More typically in the Third World, the diagnosis happens when a person exhibits symptoms of two or more of these conditions, even in the absence of evidence of HIV — which is usually not tested — and in the presence of other existing known risk factors.
- There is no single infectious agent, including HIV, that can be identified as the sole or independent direct cause of chronic life-threatening immunodeficiency. Several co-factors are always present and necessary to bring on severe chronic immune deficiency and its associated conditions. All on its own, HIV is not sufficient to cause acute immunosuppression, and in the presence of other active co-factors is not necessary, although it may be one of many possible co-factors; it may also be simply one more — and perhaps innocuous, if ubiquitous — marker of the condition.
- The status of HIV seropositivity in itself, without other symptoms of unhealth, is neither an illness, nor an infallible marker of illness. Similarly, high "viral load" estimations based on low T-cell counts is by itself neither an illness nor an infallible marker of an impending illness.
- The test for HIV seropositivity is not intended to detect the presence of the virus, but rather the presence of certain proteins that indicate antibodies to HIV and many other antigens. These are the natural immune responses of the body when it has at some time in the past fought off the antigens, thereby providing immunity. It is the apparent

presence of these proteins that is considered to be evidence that a person is carrying the virus and can spread it, thereby rationalizing the practice of HIV testing as a diagnostic tool. However, the tests themselves carry a manufacturer's disclaimer that they are not diagnostic tools and are incapable of identifying the presence of the virus.

- Tests used to predict the presence of HIV antibodies are extremely fallible. More critically, these tests are not able to specifically and exclusively detect antibodies to HIV, being equally sensitive to the immune response generated by other known antigens such as lymphocytes, semen, various autoimmune conditions, as well as antibodies triggered by endemic conditions such as malaria and tuberculosis — and even hormones released naturally during pregnancy. All of these, in the absence of HIV, can generate positive results in clinical HIV tests.
- Those who test positive on tests designed to predict the presence of HIV antibodies do not inevitably develop chronic life-threatening immunodeficiency.
- HIV is not a sexually-transmitted infection (STD) according to the conventional classical definition, and is not categorized as such by the U. S. Centers for Disease Control; rather HIV is transmitted in blood and blood products, most commonly through transfusions and re-used syringes. Viruses are not living entities but incomplete and, as a rule, passive genetic fragments. HIV is a relatively weak and tenuous particle by normal viral standards, rarely present in human reproductive fluids, including semen, and even more rarely in quantities sufficient to cause “infection”.

Regardless of the health status of the sexual partner, it is virtually impossible for a healthy, non-drug-using individual to develop the AIDS condition directly and solely as a result of vaginal coitus or any other of the myriad universal sexual practices. On the other hand, chronic infection and antibiotic treatment of the real sexually-transmitted diseases, such as syphilis, gonorrhea, chancroid and chlamydial infections, create serious risk for the development of chronic immunosuppression. It is for this reason that “safe sex” is a prudent practice, regardless of any concern for HIV itself.

- Non-addicted women who are in good health are at no special risk of developing acute life-threatening immunodeficiency as compared with the rest of the population. In particular, healthy pregnant women, new mothers, and new-born infants are at no special risk of developing AIDS, although they are among those most at risk to the dangers of the biotoxins and chemotherapies that pass as AIDS treatments imposed on those unfortunate enough to be diagnosed as HIV positive.

- Anti-viral drugs cannot cure AIDS. Pharmaceutical treatments prescribed for AIDS-related symptoms are immunosuppressive in themselves and can exacerbate the condition in the long term; existing evidence indicates that AZT and similar treatments neither extend the life of people with AIDS, nor significantly retard the development of symptoms in people who have tested HIV positive.
- One of the most significant factors in the development of chronic life-threatening immunosuppression is medical treatment itself, for example the prolonged use of antibiotics and other drugs, recurrent blood transfusions, heroic surgery (such as organ transplants and other radical surgical interventions) and radiation and chemotherapy. This includes the toxic AIDS treatments themselves, and the combined “cocktails” used to temporarily mitigate the negative effects of these drugs. These so-called anti-viral drugs are fiercely biotoxic chemotherapies, many of them originally developed during research for intervention with terminal cancer patients, and they have precisely the same debilitating impact on the body that cancer victims and their families have come to fear and loath.
- Alternative social-health therapies have had some success in remediating chronic immuno-deficiency. Such therapies include a combination of radical changes in life conditions (for example improved sanitation and hygiene, or change in or removal from other conditions of material deprivation or poverty), and social-sexual practices (eg. avoidance of classic venereal disease through protected sex, stopping drug use), along with intensive nutrition and fitness therapies — often the basis for local traditional medicine undermined by the incursion of the industrial medical model.

These facts are commonplace in scientific literature. Yet AIDS continues to be misunderstood, not only by the person-on-the-street, but by frontline medical and social workers. The mainstream medical-scientific model continues to ignore synergistic social health models and the potential of preventative measures and non-medical treatment of conditions such as chronic immunosuppression. In stubbornly ignoring these approaches, and aggressively marginalizing their proponents, this model is itself dangerous and deadly.

Acknowledging the debate

Presenting these facts publicly brings down the wrath of those heavily vested in the HIV/AIDS paradigm. But the debate is necessary. There are serious cracks in the wall that protects the imposed “consensus” and suppresses the debate within the medical-scientific community. It is for this reason that the banner of censorship is being wielded and waved so furiously.

Over ten years ago, the evidence concerning the conventional interpretation of HIV and AIDS was extensively reviewed and documented by Dr. Robert Scott Root-Bernstein, a MacArthur Foundation “genius” award winner and a professor of Physiology in the Department of Biology at the State University of Michigan in East Lansing, Michigan, in his landmark text, *Rethinking Aids: The Tragic Cost of Premature Consensus*.³

Root-Bernstein, who is a clinical researcher in the field of immunology,⁴ carried out an exhaustive survey of the scientific literature on HIV and AIDS. He demonstrates that the evidence for a primary and exclusive causative role for HIV in the development of acute immunodeficiency is weak and tenuous, although — along with most health activists who seek a moderation in the extreme medical model and pharmacological approach to AIDS — he does not dismiss entirely the role of HIV as one of many possible secondary co-factors in a synergistic model of the AIDS condition. He explains why this is a subject of great controversy in the corridors of science, and why the controversy is systematically misrepresented — or simply ignored — in the mainstream media. And as an insider of the medical-scientific establishment he explains in direct and critical terms why this tragedy of bad science and misinformation has unfolded for so long. In the intervening years, the gaps in the science have only widened, in spite of the continued interventions of renowned experts such as Root-Bernstein.⁵

At the heart of the matter are an extensive list of proven non-viral causes of immunosuppression, many of them treatment-related (such as chronic antibiotic use, or blood transfusions), or social/health factors (such as malnutrition, unsafe sexual practices, and stress), as well as endemic diseases and environmental factors.

Can we imagine the political impact if world-wide cumulative statistics for such diseases as hepatitis, malaria, tuberculosis, or simple malnutrition, each of which take millions of victims annually, were kept and widely reported cumulatively over 20 years in the way that has been done — uniquely — with AIDS? Although these figures do not get the same public attention, WHO reports that well over 20% of the Earth’s more than five billion people are sick or malnourished at a given time, with the ten leading maladies being: Hepatitis B, 2 billion; Tuberculosis, 1.7 billion (WHO estimated in 2003 that almost 33% of the human population passively carried the TB bacillus, although only about 2-3 million are stricken at any one time); Anemia, 1.5 billion; Hookworm (ancylostomiasis), 700-900 million; Roundworm (ascariasis), 700 million; Diarrheal diseases (amoebiasis and giardiasis), 680 million; Whipworm (trichuriasis), 500 million; Malaria, 270 million; Iodine deficiency, 200 million; and Schistosomiasis (parasitic infection), 200 million. Obviously many of these maladies are suffered concurrently by hundreds of millions of people worldwide, most in the Global South, and many such as TB are increasing yearly.

Every one of these most-common afflictions are also among the most serious factors leading to the development of chronic life-threatening immunodeficiency. And every one is more prevalent and active than HIV. When suffered in combination with chronic malnutrition and its vitamin deficiencies (particularly vitamins A, B6, B12, as well as thiamin, riboflavin, nicotinamide and carotene), critical immunosuppression is inevitable and, if not remedied, so are the opportunistic infections that lead to death.

A quick review of some basic information about the link between immunosuppression and historic endemic conditions and diseases underscores the importance of focusing on socio-economic factors in the prevention and treatment of chronic life-threatening immunodeficiency.

- HIV is not the only viral marker of profound immunodeficiency, nor is it the most common. Cytomegalovirus (CMV) and Epstein-Barr virus (EBV) are at least as common, and usually antecedent to HIV, and all three are virtually always found in combination with at least some of a host of other concomitant infections long endemic in the Global South, and increasingly common among the poor in industrialized countries, including:
 - Herpes simplex virus, hepatitis B virus (HBV), and human T cell lymphotropic viruses (HTLV — also associated, for example, with leukemia);
 - Mycobacterias (associated with tuberculosis, leprosy, and complications of pneumonia, hepatitis, diarrhea and dementia);
 - Mycoplasmas (non-specific immunosuppression, and complications of pneumonia and proctitis);
 - Candida and other fungal and yeast infections (Cryptococcus, Trichosporon, Histoplasmosis, Blastomyces, Coccidioides and Aspergillus species);
 - Various parasitic diseases, including trypanosomiasis (sleeping sickness), Plasmodia (malaria), helminths (parasitic worms such as nematodes, flatworms, tapeworms and roundworms), filariasis (worm causing elephantiasis, among other things), and other parasitic infections, such as Cryptosporidium species (causal agents of severe and prolonged diarrhea);
 - Bacterial infections, especially sexually-transmitted diseases (notably syphilis, gonorrhea, chancroid and chlamydial infections), and pyogenic (pus-producing) and septicemic (blood) infections (often related to, among other factors, intravenous drug abuse and septic medical treatment);
 - Protozoan infections, especially Pneumocystis carinii (causing pneumonia), Toxoplasmosis (associated with dementia), and Entamoeba and Giardia lamblia (causing amoebiasis and giardiasis, resulting in severe chronic diarrhea);
 - Diabetes.

- Parasites such as helminths, and parasitic infections such as trypanosomiasis, schistosomiasis, amoebiasis, and giardiasis not only in and of themselves cause

significant immune suppression, but also increase the risk of anemia in pregnant women, which in turn increases the risk of low birth weights and malnutrition in newborns; in addition, these infections are often transmitted from the mother to the unborn child, jeopardizing the infant immune system independently of other risks.

- Malnutrition is universally prevalent in countries and regions identified as “epicentres” of AIDS. Malnutrition is known to critically increase susceptibility and vulnerability to parasitic infections and their effects. As well, the profound immunodeficiency that accompanies acute under-nutrition leads — as result, for example, of even small deficiencies of critical nutrients such as Vitamin A — to a marked increase in mortality during other infectious disease.
- *Pneumocystis carinii* pneumonia (PCP), one of the supposedly rare diseases that most definitively marked the onset of AIDS in North America, is neither new nor so very rare. Identified in 1911, vulnerability to PCP is related to, among other things, prolonged Vitamin A deficiency in drug addicts and alcoholics, and has been commonly diagnosed among the malnourished in the Global South, particularly among young children in Africa and Asia suffering from Kwashiorkor. (Root-Bernstein pointedly asks, “Why do we call a patient who dies of *Pneumocystis pneumonia* [independent of HIV] unfortunate, but one who dies of *Pneumocystis pneumonia* and HIV an AIDS tragedy?”)
- There is a similar history with respect to other infections, such as systemic *Candida* fungal (yeast) infections, now one of the most prevalent opportunistic infections associated with AIDS, but to which people with calcium deficiencies, general malnutrition and diabetes have always been at particular risk.
- In tropical Africa, diagnosed AIDS has been concentrated almost entirely in regions where malaria has long been endemic. Studies in South America and Africa indicate that malaria infection (and several other infections, including tuberculosis) triggers the same basic immune response, resulting, even in the absence of HIV, in clinical seropositivity on the tests used (ie. “false positive” results).

Root-Bernstein points out that children who survive malaria are still often iron-deficient and immune-suppressed due to malaria-associated anemia, commonly treated by blood transfusions (in one year he studied, for example, almost 70% of the 13,000 transfusions performed at Mama Yemo Hospital in Kinshasa were given to children with malaria). Not only are blood transfusions in themselves profoundly immunosuppressive, but the transfusions also carry the risk of transmitting the most common infectious viruses (eg. Hepatitis B, CMV, EBV, HLTV). In addition, malaria and other parasitic infections such as schistosomiasis and filariasis themselves cause immune suppression, as do most of the

antimalarial and antiparasitic drugs which are commonly used, and over-used, to treat or prevent these diseases.

- Sickle cell anemia, common in black equatorial Africans, and some other populations, is a genetic hemoglobin defect which, while detrimental to oxygen transport, incidentally protects against malaria. As with malaria, blood transfusions are a common treatment for sickle cell anemia, and the recipients are vulnerable to the same risks, both from the immunodeficiency induced by the anemia and blood transfusions, and the potential of infections transmitted by the blood transfusions themselves.
- Kaposi's Sarcoma (KS), long considered by North American doctors to be a rare condition, was the first opportunistic disease associated diagnostically with AIDS. Root-Bernstein demonstrated that in fact KS, along with Burkitt's lymphoma, has been endemic at high rates in central African countries (representing almost 10% of all cancers) for at least as long as records are available, since the mid-1950s. Particularly notable are the high rates of Kaposi's Sarcoma in African children in these regions, especially those suffering from malaria. Bernstein also reports theories linking malaria and Epstein-Barr virus as co-factors in Burkitt's lymphoma, whose sufferers exhibit symptomatic conditions similar to AIDS.

In the mid-90s, after the original publication of Root-Bernstein's book, it was publicly confirmed by the U.S. Centers for Disease Control that Kaposi's Sarcoma — the original AIDS disease that led to the invention of AIDS as a construct — is not caused by HIV at all. Scientists working independently of the AIDS researchers had conclusively identified another virus as the source of KS, sometimes erroneously referred to as the Kaposi's Sarcoma virus, but actually related to Human Herpes Virus-8.

In spite of this revelation, to this day most doctors and AIDS activists continue to associate Kaposi's Sarcoma with HIV and AIDS, especially in the African context. Not incidentally, some evidence has been recently marshalled that acute immunosuppression may also be brought on by Human Herpes Virus-6, a hypothesis also being ignored by the mainstream of AIDS science.⁶

In addition to the synergistic interplay of this host of endemic conditions, diseases and infections prevalent in regions with a high risk of chronic life-threatening immunodeficiency, there are similarly a plethora of other known agents of critical immunosuppression which interact dynamically with each other, and with the endemic pathologies we have listed. These include:

- human semen, when introduced to the bloodstream;

- chronic high-dose use of virtually all addictive and recreational drugs (including cocaine, heroin, morphine, codeine, amyl and butyl nitrates, marijuana and alcohol);
- chronic use or acute high dosages of common pharmaceutical agents, especially antibiotics, including the common drugs such as penicillins, chloramphenicol, tetracycline, streptomycin, kanamycin, gentamycin, neomycin, among others, as well anti-virals (such as acyclovir, ribavirin, retrovir and zidovudine — “AZT”), and antimicrobials (such as trimethoprim, sulphonamides, pyrimethamine);
- antiparasitics used to treat parasitic worms, protozoa and amoeba so common in the Global South (particularly antiparasitic imadazole drugs such as Clotramizole and Ketoconazole, and many of the antimalarials, especially chloroquine);
- steroids (for example, cortisone, used to treat asthma, rheumatism and arthritis, and corticosteroid creams, used to treat inflammation caused by various venereal infections, such as herpes simplex); one of the critical factors in the lung disease that ultimately kills so many AIDs victims — and more recently many victims of SARS — as well as long-term cancer patients, is the use of corticosteroids which can destroy the lungs’ capacity to breathe efficiently and effectively, or to resist pneumonias;
- psychotropic agents and tranquillizers (especially chlorpromazine, imipramine, phenothiazines, and their various derivatives, whose chronic use has been long-associated with oral candidiasis, high rates of pneumonia, and other severe infection).

• In addition to pharmaceuticals, other conventional medical interventions inevitably have an effect on the body’s immune capacity. Anesthesia is a profound immunosuppressant, as is surgery itself. Few interventions are as immunosuppressant as a blood transfusion (quite aside from the risk of incidental viral infection), and sustained periodic or regular blood transfusions cannot help but lead to chronic immunodeficiency. Virtually all hemophiliacs, who require regular transfusions and infusions of blood products to control an inherited condition in which blood clotting is impaired, are at permanent risk of chronic immunodeficiency, regardless of the presence of HIV or other common viral markers of AIDS.

Finally, and in the light of all this information, the rarely-publicized but well-documented problem of the “antibiotic epidemic” in the Global South can only make more frightening the already endemic risks of chronic life-threatening immunosuppression. The widespread and indiscriminate over-the-counter black market trade in antibiotics, the pervasive self-treatment of incidental and chronic infection, and antibiotic treatment administered by self-ordained local “doctors”, on their own are capable of creating

serious and pervasive immunosuppression among populations where these virtually ubiquitous practices exist.

None of the information presented here is new. This is particularly the history of the poor, not only in the Third World, but also in North America where by far the majority of diagnosed AIDS, and of undiagnosed immunodeficiency, occurs among the poor, the socially marginal (particularly ethno-minorities), and the derelict.

The clear implication is that the preponderance of chronic life-threatening immunodeficiency is related to long-standing social and endemic causes other than HIV. Even among the more affluent — other than persons who are at risk due to specific conditions (eg. hemophilia, sickle cell anemia, malaria) or treatments (eg. transfusions, long-term use of certain pharmacological agents) — immunodeficiency occurs virtually exclusively among people who have created in their lifestyle many of the critical risk elements (addiction and drug abuse, poor nutrition, chronic infections, including STDs, and antibiotic use) usually associated with poverty. They have developed an “impoverished” immune system in an affluent body.

Dr. Root-Bernstein points out that the presence of HIV is not a pre-condition for clinical AIDS diagnosis in Africa and other parts of the Third World, and in the large majority of cases worldwide it has not even been tested. Many people of course will ask on what basis, then, AIDS is diagnosed. The answer is that the diagnosis of AIDS remains largely arbitrary. As clarified at the outset, AIDS is an ever-shifting medical construct with an expanding list of over 30 associated diseases. Called “opportunistic infections”, these are diseases — none of them new — which when contracted can lead to a diagnosis of AIDS. Increasingly even diseases not officially listed — most particularly tuberculosis — are casually designated as “HIV-related”. Usually, the diagnosis of AIDS is offered in spite of several serious prior immune-compromising conditions which, in fact, make the AIDS diagnosis redundant and superfluous.

AIDS is a conceptual basket into which an increasing number of these common conditions have been dumped, then the lid put over top and the basket itself counted as one disease. This has obscured the nature, complexity and possible remediation of the individual conditions while offering no benefit whatever to those suffering these conditions who, to the contrary, are now presumed to be dying and beyond cure.

Discussing the ever-changing and expanding definition of AIDS, Root-Bernstein argues that ongoing definition alterations are “social and economic, not scientific”, sharing Erik Eckholm’s analysis from the New York Times that “the definition [of AIDS] has become

a political as well as a medical question”⁷. Root-Bernstein explains how the incidence of AIDS can suddenly multiply “by definitional fiat”. He concludes,

...a significant proportion of the continued explosive growth of AIDS ... has been fueled not by the transmission of AIDS to new groups of people, but rather by the inclusion of previously excluded groups of people into the category of AIDS...One could justifiably argue that the AIDS epidemic is due at least partially to the grouping of two dozen causes of death under one rubric rather than to a new disease.⁸

This has grave implications in areas of the Global South where any or all of these pre-existing debilitating and often deadly infections are endemic, and chronic immunodeficiency from social causes, most notably malnutrition, has been a blight since long before the “discovery” of AIDS.

The perception of AIDS as one overwhelming disease has been very influential in regard to how AIDS is dealt with everywhere in the world. This is particularly so in the Global South, as governmental aid donors, multilateral organizations, and the international non-government sector participate in promoting and implementing AIDS programs in virtually every country.

We have seen a diversion of attention worldwide from the chronic problems caused by the conditions of poverty, war and repression — realities that kill literally tens of millions every year. The growing amount of international aid money devoted to AIDS related programs has skewed health funding to the extent that the preponderance of all health spending in Africa now goes into AIDS programs, and obscures other development issues that demand critical attention.

The AIDS model has not merely impacted the emphasis of funding but has also influenced the way that health care is carried out. We have seen the practice of medicine skewed, to the detriment particularly of the weakest and most marginalized, and to women. Under the belief that HIV and AIDS are inevitably terminal, many people in the global south suffering from various endemic conditions are left without appropriate treatment, in a cruel system of triage that ultimately confirms the prophesy — they die, unattended. The diagnosis of AIDS is deadly, not necessarily because of the illness but because of the treatment that follows from the diagnosis itself, including the stigma and social isolation that flows from the constant association of HIV/AIDS with illicit and “perverted” sexual practices.

Human rights and the medical model of AIDS

The impact that should be the greatest concern is how the AIDS model has intruded on the reproductive health and rights of women. Pregnant women and their children have become the single most important target of AIDS science. It is they who have become the test subjects, and it is on their backs that the quest to “halt the spread” has been placed. In many places it has become common — with the sanction of local and international health authorities — to discourage and even forbid breastfeeding, the single most critical factor in protecting the infant and establishing the infant immune system.⁹ In addition, cesarean section is now commonly recommended, and often imposed, upon poor mothers testing positive for HIV (this is true in Canada and the United States as well as in the poorest nations on earth where a cesarian section is hardly a safe procedure).

The very worst excesses that accompanied the coercive population control model of “family planning” that prevailed in the Global South for thirty years — before the critique finally began to be heard in the period leading up to the 1994 International Conference on Population and Development in Cairo — are now re-occurring under the banner of the AIDS model, ironically ignored by the very movement that so valiantly campaigned over thirty long years for women’s reproductive rights and freedom.¹⁰

Added to these perverse practices that have become normal in “development medicine”, it is now a common practice to feed — and impose if necessary — “anti-viral” chemotherapies to gestating mothers and their infants, in spite of the clear evidence that these chemicals are profoundly toxic both to the woman and to her developing child in the womb and in the first months after birth. Told not to smoke or use alcohol during pregnancy for fear of damaging the developing fetus, these same women and their infants are fed — often under coercion or in the absence of informed consent — AZT and other chemotherapies and biotoxins whose very purpose is to disrupt the replication of DNA and other cell development processes, and which profoundly compromise the immune system in doing so. The only possible justification for such practices is the belief that these women and their children will ultimately die anyway. This practice is common in Canada and the United States, and increasingly common in Africa, where the right to buy and administer these drugs has become a rallying cry of international health advocacy.

Finally there is the grave question of human experimentation. Medical experiments on humans, particularly in central and southern Africa, are being justified by the AIDS model in ways that are unprecedented. Vaccine research now leads the way, but all manner of human drug testing is being undertaken in Africa, with the support of national governments, that could never be contemplated outside the assumptions implicit in the AIDS model. This trend is reinforced by the global preoccupation with AIDS that

dominates foreign aid budgets of virtually all OECD nations — including Canada’s — and the funding priorities of major globalized philanthropists such as Bill Gates.

It is important that we continue to seek and provide alternative information on AIDS. The public can be, and must be, better informed. The worst effects of this phenomenon are ignorance and prejudice, and threats to human rights and opportunities for genuine AIDS victims, as well as for those suspected of “carrying” the disease. Specific groups in society considered susceptible are also the most vulnerable — the indigent poor, minorities wherever they live, women and children as described above, and immigrants and refugees coming to Canada and other industrialized nations from “non-white” Third World countries, especially from Africa.

Obscuring injustice: the medicalization of underdevelopment

One argument against the plea for restraint that I am making is that we have a rampant and deadly crisis on our hands, and this crisis demands social risk and forthright responses, including some curtailment of individual rights in deference to the rights of the wider group. To challenge this view is difficult, because in questioning the utilitarian calculations of the international public health establishment, we risk falling into a polemic that diverts attention from the reality that legions of poor and marginal around the world are ill and dying as a direct result of the wretched conditions of their lives, and the acute immunosuppression that is the chronic condition of the poorest and least defensible.

As I argued at the outset, however, the central villain is not a virus; it is poverty. And the critical cure is not medicine; it is justice. Meredith Turshen of Rutgers University and her French colleague, Annie Thebaud-Mony, long ago warned that AIDS is the most recent, and worst, manifestation of what they refer to as the “medicalization of underdevelopment”¹¹

This warning is at the heart of the issue. Root-Bernstein noted that

“AIDS may continue to plague modern society, just as other preventable infections...plagued our forebears, because of the close-mindedness of the very physicians whose job it is to diagnose, treat and prevent these diseases. A century ago, they let patients die by denying that germs had anything to do with diseases. Today they may be letting them die by insisting that the germ is everything.”

He concludes that the importance of the many studies demonstrating that control of immunological risk factors can lead to quite effective control of AIDS is that,

“...they demonstrate the continued validity of one of the oldest and most fundamental truths of medical science: Public health measures are always more

effective in controlling disease than are all the medicines in the world. Neither vaccines nor medicines have led to the virtual elimination of typhoid, cholera, typhus, or plague in the industrialized countries of the world. These required nothing more than the simple expedients of improved sanitation, sewage systems, and the control of pests...If we want to control AIDS, it is not vaccines, antiretroviral drugs, or other medical miracles we need. We need to solve the social, economic, health education and medical care problems that create the conditions that permit AIDS to develop in the first place.”¹²

We do not have to create impressions of an inevitable medical cataclysm to justify concern about chronic life-threatening immunodeficiency, nor to promote the best possible collective measures to deal with it. In the long run these are social problems, not medical problems, and require political and social interventions. We should concentrate on the fundamental problems of the suffering and inflicted: the problems of health, not disease. Before medical science and charity, what is required is universal social and economic justice, for without justice the scourge of chronic acute immunodeficiency and its associated opportunistic conditions will remain as universal as the existence of poverty itself.

© Brian K. Murphy, January 2004

Brian Murphy is a activist, author, and policy analyst in global development issues, working with the Canadian international social justice organization, Inter Pares. In addition to many major papers and journal articles, he has contributed to several books and is the author of *Transforming Ourselves, Transforming the World, An Open Conspiracy for Social Change*, ZED Books (London) and Fernwood (Halifax), 1999; also available as *De la pensée à l'action: la personne au cœur du changement social* (trans. Geneviève Boulanger), Ecosociété (Montréal), 2001..

¹ Levins, Richard, “The re-emergence of infectious diseases on the public health agenda”. The paper appeared in *Third World Resurgence* #155/156 (Third World Network, Penang), and was submitted by TWN at the October 12-15, 2003 conference, “Within and Beyond the Limits to Human Nature”, sponsored by the Heinrich Böll Foundation and the Institut Mensch, Ethik und Wissenschaft. The full paper is available at: <http://www.biopolitics-berlin2003.org/docs.asp?id=176>. One of the world’s foremost biomathematicians, Richard Levins is the John Rock Professor of Population Sciences at the Harvard School of Public Health and a visiting scientist at the Institute of Ecology and Systematics in Cuba.

² This paper refers to the “global south” rather than “developing” nations, or simply “the south”. While, for historical reasons, the people experiencing the most profound and intractable structural poverty are concentrated in the southern latitudes, they are not found exclusively in the southern hemisphere; nor are all southern nations, or those within these nations, impoverished and marginalized equally in the sense that this term is usually used. “Global south”, a term introduced by Waldon Bello, among others, is used here as a metaphor for the phenomenon of pervasive entrenched deprivation, economic marginalization, and political disempowerment concentrated within an identifiable group of countries.

³ Root_Bernstein, Robert, *The Tragic Cost of Premature Consensus*, MacMillan/Free Press, NY 1993.

⁴ Root-Bernstein is one of the world's most eminent scientists and science historians, whose formative years included extended stints as a research assistant to both Thomas Kuhn and Jonas Salk. See the extensive curriculum vitae for Root-Berstein at <http://www.pwias.ubc.ca/geninfo/people/cv.root-berstein.pdf>

⁵ see, for example, Robert Root-Bernstein and Stephen J. Merrill, "Etiology and Pathogenesis of AIDS", in: Standish, LJ, C Calabrese, ML Galantino, eds. *AIDS and Complementary & Alternative Medicine: Current Science and Practice*, St. Louis, MO, Churchill-Livingston/Harcourt/Mosby, 2001. Root-Bernstein's curriculum vitae referred to in the previous endnote cites several other examples.

⁶ See Regush, Nicholas, *The Virus Within*, Viking (Penguin Group), Toronto, London, New York, 2000.

⁷ Eckholm, E., "Facts of life. More than inspiration is needed to fight AIDS", in *New York Times*, August 1, 1991, Section 4, page 1, quoted in Root-Bernstein, *The Tragic Cost of Premature Consensus*, p.64.

⁸ Root-Bernstein, *The Tragic Cost of Premature Consensus*, p. 67

⁹ This policy is only now beginning to grudgingly be reversed, see "Breastfeeding best for infant, HIV mothers in Africa told; Research shows health benefits for the newborn outweigh the risks of transmitting disease through milk", By Stephanie Nolen, in *The Globe and Mail* (TORONTO) Tuesday, Jan. 6, 2004 [<http://www.theglobeandmail.com/servlet/ArticleNews/TPPrint/LAC/20040106/AFRICA06/TPInternational>].

¹⁰ For one treatment of these issues, see *Uncommon Question: A Feminist Exploration of AIDS*, by Women's Health Interaction (WHI, Ottawa, August 1999). *Uncommon Questions* is a discussion paper that explores, from a feminist perspective, dominant HIV/AIDS theory ("common knowledge"), and explores (through "uncommon questions") alternative theories, facts and analyses on the relationship between HIV and AIDS. It reflects on the construction of knowledge about AIDS, vested interests in the AIDS "paradigm", and challenges readers to re-think, from a human rights and social justice perspective, the nature and implications of chronic acquired immune deficiency, and whether toxic treatments are appropriate for pregnant women and children. It poses the question, "What if conventional thinking about AIDS is wrong?" *Uncommon Questions* includes an extensive bibliography, as well as an annotated appendix on alternative activists, theories and organizations. The discussion paper is available at <http://www.web.ca/~whi/eng/uncommon.html>.

¹¹ See Turshen, Meredith and A. Thébaud-Mony, "Combattre le SIDA au nom de la "civilisation"? in *Le Monde Diplomatique*, April, 1991:24.

¹² Root-Bernstein, op cit, pp 367-368.