

The Politics of AIDS¹

by

Brian K. Murphy

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If we are to believe what we hear, human acquired immunodeficiency syndrome (AIDS) is an apocalyptic scourge that threatens the 21st century. This belief is promoted and reinforced by international medical authorities, multilateral institutions, governmental and non-governmental aid donors, and media conglomerates, and has become the commonplace in the streets and the halls of power. The information exists, however, to contradict this popular perception.

The medical-scientific propaganda on AIDS which declares that HIV equals AIDS, equals Death, has been a strategic campaign on the part of international and national medical authorities, justified on the basis of the need to generate funds for research and medical treatment, and the age-old rationale of the need to frighten people into a course of action deemed to be “for their own good”. Countervailing facts, however, are known and accepted within scientific circles. The real controversy — also age-old — is about whether this information and its implications should be shared openly and critically — that is, democratically — with ordinary citizens at the receiving end of the AIDS scare.

What does it matter? This issue is not academic. A radical shift is necessary in the investigation and analysis of AIDS and its effects if we are to acknowledge and address the social and economic conditions which promote AIDS. Such a fundamental re-thinking of the issues will inevitably entail confronting vested interests and conventional wisdom, and provoke differences of opinion within legitimate communities of concern, including AIDS activists themselves. However, nothing less is sufficient if we are to protect AIDS "suspects" — those considered, on the basis of race, origin, gender, sexual-orientation, or class, to be at high-risk for infection and transmission — from the excesses which arise when fear, ignorance and prejudice over-ride objective evidence and individual rights. And nothing less is sufficient if we are to help those actually susceptible to chronic immunodeficiency and associated life-threatening diseases,

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especially the poor and indigent in our own communities, and in the poorest countries of the South.

The issue is justice. The factors in the development of chronic immunodeficiency are largely social and political, rather than biological. The measures which could effectively prevent or remediate chronic immunodeficiency are neither expensive nor complicated. The medical and pharmacological treatments (none of which are truly effective) are both expensive and complicated. Neither prevention nor treatment are available to those most at risk — the poor, the wretched, the ill, the addicted, the ignorant. They are certainly not available in the Third World.

In spite of all the misinformation and faulty data, however, the fact that medical science has got it wrong does not mean that there is no problem. To the contrary. The situation is more grave than medical science and AIDS activists present. But this situation is not new, nor is it the result of HIV and AIDS. Rather, it is the terrible ongoing historic reality of life-threatening immunodeficiency as the chronic condition of the poorest and least defensible. The villain is not a virus; it is poverty itself. And the cure is not medicine; it is justice. And the hysteria around AIDS clouds the issue.

The AIDS scare obscures the historic plight of unhealth, misery and death among the poor. And it hypothesizes a biological agent that obscures the social and political roots of the chronic immunosuppression that only worsens the vulnerability of the poor to life-threatening disease. This is not an epidemic; it is merely cruelly endemic, a bi-product of the material conditions of the poor. It is not a disease; it is a crime.

Let's examine some very basic facts about AIDS. It is generally assumed that the human immunodeficiency virus (HIV) is the cause of a terrible epidemic called AIDS, a clinically-defined disease with an identifiable cause (the virus), with a pattern by which the disease is contracted and communicated (sexual contact), and with a diagnostic test by which the presence of the AIDS infection (ie. HIV) can be detected. On this basis, and some questionable mathematics, we have the grimmest projections of deaths by AIDS in the tens of millions throughout the world by the mid-1990s.

The facts readily available in the medical literature present another reality:

- AIDS is not a disease; AIDS is an artificial medical construct which defines a condition which includes chronic immune suppression (ie. acquired immunodeficiency syndrome — AIDS) and a slew of opportunistic life-threatening conditions and potentially fatal diseases to which the immunosuppressed individual is susceptible (there are more than two dozen diseases presently included in the ever-expanding official definition of AIDS). A person is usually diagnosed with AIDS when they exhibit symptoms of one or more

these diseases, and test positive for HIV, or if they exhibit symptoms of these diseases, even in the absence of evidence of HIV infection, and the doctors want a causal diagnosis which is more definitive than the existing known risk factors.

- Chronic life-threatening immunodeficiency is not new, and clinical descriptions exist going back at least a century, when modern medicine began to emerge. Nor is HIV itself a new virus, with some estimations dating it back hundreds of years.

- There is no single infectious agent, including HIV, that can be identified as the sole direct cause of chronic life-threatening immunodeficiency. HIV has been demonstrated to be itself neither necessary nor sufficient to cause AIDS, although it may be one of many possible co-factors, or simply one more (and largely innocuous, if ubiquitous) opportunistic infection.

- The status of HIV seropositivity in itself, without other symptoms of unhealth, is neither an illness, nor a marker of illness.

- The test for HIV seropositivity is not intended to detect the presence of the virus but rather the presence of certain antibodies. These are the natural immune responses of the body which have, at some time in the past, fought off the virus, thereby providing immunity. It is the apparent presence of these antibodies which some have considered to be evidence that a person is carrying infection, and can spread the disease, thereby rationalizing the practice of HIV testing as a diagnostic tool.

- Tests used to predict the presence of HIV antibodies are extremely fallible (often producing, as in the case of the ELISA test, as many as 4 out of 5 false positives in random testing). 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, all of which, in the absence of HIV, can generate positive results (ie. seropositivity) in clinical HIV tests.

- Those testing positive on tests designed to predict the presence of HIV antibodies do not necessarily carry HIV antibodies, let alone HIV itself, and those who carry HIV antibodies do not inevitably develop chronic life-threatening immunodeficiency.

- HIV itself is not a sexually-transmitted infection in the conventional sense; rather HIV is transmitted in blood and blood products, most commonly through transfusions and re-used syringes. HIV is rarely present in human reproductive fluids, including semen, and

even more rarely in quantities sufficient to cause infection; to the contrary it is semen itself, when introduced directly to the bloodstream, for example in anal intercourse, that is a potent and critical immunosuppressant.

- Regardless of the health status of the sexual partner, it is virtually impossible for a healthy, non-drug-using individual to be infected with HIV, or to develop the AIDS condition, directly as a result of vaginal coitus or any other of the myriad universal sexual practices, with the possible exception of the habitual practice of receptive anal intercourse. On the other hand, chronic infection and antibiotic treatment of the real sexually-transmitted diseases themselves, such as syphilis, gonorrhea, chancroid and chlamydial infections, create serious risk for the development of chronic immunosuppression.
- Healthy, non-addicted women, including prostitutes, are at no specific risk of contracting AIDS; in particular, healthy pregnant women, new mothers, and new-born infants, regardless of whether they have been designated HIV seropositive, are at little risk of developing chronic life-threatening immunodeficiency, although they are among those most at risk to the dangers of AIDS treatments and prophylactics.
- Developing chronic immunodeficiency and symptoms associated with AIDS does not, and should not, inevitably lead to death.
- Medicine cannot cure AIDS. Pharmaceutical treatments prescribed for AIDS-related symptoms are immunosuppressive in themselves and can deteriorate 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, radiation and chemotherapy, heroic surgery (such as organ transplants and other radical surgical interventions), as well as toxic AIDS treatments themselves, such as AZT, especially when used with people who, in spite of testing positive on HIV tests, have no symptoms of illness.
- Alternative social-health therapies, including a combination of radical changes in life conditions (sanitation, hygiene, change in or removal from conditions of material deprivation or poverty), and social-sexual practices (eg. avoidance of classic venereal disease through protected sex, arrested drug use), along with intensive nutrition and fitness therapies have had success in remediating chronic immuno-deficiency.

In spite of these facts, commonplace in scientific literature if not the popular press and the public pronouncements of international health organizations, 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, and in ignoring these approaches is in itself dangerous and deadly.

The difficulty with presenting this position is that it appears to fly in the face of all that we know. It is not only a minority position, but an extremely marginal one — a fringe position, perhaps. But this merely points to the fashion by which popular perception and conventional wisdom are formed, rather than to the objective weight of scientific evidence and professional opinion. Having been challenging the AIDS orthodoxy within my own community for several years, I am only too aware of the difficulty and risks of attempting to provoke this debate. But the debate is necessary and long overdue. And finally there are serious cracks in the previously impermeable shield of the medical-scientific community, cracks which reveal that the position of this essay in fact is not marginal at all.

Most recently this position has been extensively reviewed and documented by Dr. Robert Scott Root-Bernstein, a professor of Physiology in the Department of Biology at the State University of Michigan in East Lansing, Michigan, in a landmark text, *Rethinking Aids: The Tragic Cost of Premature Consensus*. This book should be priority reading for all concerned with health and social justice issues, no matter where we live, but particularly in the Third World, and most particularly in Africa which is presently the most vulnerable theatre for AIDS misinformation and hysteria (the book includes an entire chapter comparing the course of acquired immunodeficiency in North Americans and Equatorial Africans).

Dr. Root-Bernstein, a clinical researcher himself in the field of immunology, has carried out an exhaustive survey of the scientific literature on HIV and AIDS, and demonstrates that the evidence for the HIV link is tenuous and unproven (although he has not dismissed entirely the role of HIV as a secondary co-factor in a synergistic model of the AIDS condition). He explains that this is a subject of great controversy in the corridors of science, if not in the 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 before the legion of dissenting voices finally began to be heard.

Dr. Root-Bernstein offers an extensive list of proven non-viral causes of immuno-suppression, many of them treatment-related themselves (such as chronic antibiotic use, or blood transfusions), or social/health factors (such as malnutrition, addiction, unsafe sexual practices, and stress), as well as endemic diseases and environmental factors. He points out that the presence of HIV is not a precondition for clinical AIDS diagnosis, and in the large majority of cases worldwide, it has not even been tested; and that there are several documented cases of diagnosed AIDS where HIV has been demonstrated not to have been present.

Many people of course will ask on what basis, then, AIDS is diagnosed. The answer is that the diagnosis of AIDS is largely arbitrary. AIDS itself is not a disease, but an ever-shifting medical construct with a constantly growing list of almost 30 associated diseases. Called “opportunistic infections”, these are diseases (none of them new) which when contracted lead to a diagnosis of AIDS. The diagnosis is reached sometimes merely if there is no other apparent reason to be sick. More often, 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.

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”. Root-Bernstein explains how the incidence of AIDS can suddenly multiply “by definitional fiat”. He concludes, “...a significant proportion of the the continued explosive growth of AIDS throughout the past decade 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.”

This has astounding implications in areas of the Third World where any or all of these 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 insider's view presented by Root-Bernstein of the quality of what passes for AIDS science, and the long-festering controversy about AIDS and its causes, has not merged with popular consciousness. But this is largely because popular consciousness is formed by images rather than by information, and those who control the proliferation of images have a great deal of influence over conventional wisdom.

The media are predisposed to present exotic and deadly diseases which attack humans, with science and medicine as the stalwart army trying to build an adequate defence. The public are all the more susceptible when the exotic disease not only responds to prurient sensationalism (AIDS as a sexual disease, AIDS as punishment for evil and perversion) but also bears the hallmark characteristics of mainstream prejudice regarding sexual orientation and homophobia, race, poverty, and images of the Third World.

There have been, of course, attempts to counter hysteria and medical over-reaction, although these have not been received with the same popular attention that is given the spectre of death stalking sinners, deviants, and slum-dwellers the world round. Still, many health practitioners, social activists, journalists and scientists have long been asking basic questions and sounding a warning that social and medical cures being introduced amidst popular clamor may well be worse than the disease. In doing so, these critics have risked the outrage of conventional practitioners, as well as the AIDS activist community, and much of what they have had to say has been lost in the din of superficial repetition of the press releases of the AIDS industry.

This censorship cannot be allowed to continue. Ron Labonté, an alternative health activist recently stated in *Canadian Dimension*, "The poverty of the germ theory lies in its hegemony over how we understand health and illness, just as the tragedy of modern medicine lies in the monopoly which, within capitalism, translates into iatrogenic and abysmally wasteful economic incentives to drug, cut and treat".

It is impossible to overstate this case in a world which is locked into these complex and deadly assumptions. The way we address and resolve these issues will be very influential in regard to how AIDS will be dealt with everywhere in the World. This is particularly so in the Third World, as governmental aid donors, multilateral organizations, and the international non-government sector increasingly participate in promoting and implementing AIDS programs in the Third World. Already we are seeing a diversion of attention worldwide from the chronic problems caused by the conditions of poverty, war and repression (realities which kill literally tens of millions every year), to this elusive and exotic scourge which touches the apocalyptic fears of each of us.

An example are claims made in 1987 by Jon Tinker of the UK-based Panos Institute. In an interview with *Contact*, the magazine of the Canadian Council for International Cooperation (CCIC), Tinker argued that AIDS "is going to be one of the dominating development issues for the rest of our lifetimes". He warned that, as a result of AIDS, several Third World countries will move within one decade into negative population growth, even 10-20% lower than at present; and that "the names and numbers in the

gathering death march, those who are going to develop AIDS between now and 1995, are already carved in stone".

This may be good propaganda. But it is not good science, and it is bad politics and bad public education. But it is a practice which has persisted.

When I wrote an essay responding critically to the approach and claims of Tinker and the Panos Institute, the essay was met by a cold official silence within the NGO community. But seven years later in 1994, the evidence still does not exist to justify the rhetoric AIDS activists and the international development community used in 1987, and continue to use. And while there still is no objective validity for this rhetoric, it represents a view very widely held within humanitarian and social development organizations, both domestic and international. It is a view that is challenged only at great risk to personal and professional reputation, and critics are often accused of being guilty of everything from ignorance and cruel insensitivity to malicious homophobia (the ultimate slur of AIDS activists against those who question the orthodoxy).

It is important that we seek and provide alternative information on AIDS. The public can be, and must be, better informed. Increasing confusion and fear is caused not by people's real experience with AIDS, but by speculation out of proportion with the scale and meaning of events in the real world. The worst effect of this phenomenon is ignorance and prejudice, and threats to human rights and opportunities not only for genuine AIDS victims, but also for those suspected of carrying the disease, and specific groups in society considered susceptible (for example, immigrants and refugees from Third World countries, especially Africans and Caribbeans).

The Reality and the Myth: the Extent of the Problem

One argument against being too cautious with these matters is the argument that we have a rampant and deadly crisis on our hands, which 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 and hazardous. It is not only the wrong side of a very touchy issue, but in engaging in a numbers game we risk falling into a polemic which diverts attention from the reality that, regardless of the diagnosis, legions of poor and marginal around the world are ill and dying as a direct result of the wretched conditions of their lives. Still, a challenge to the epidemiology of AIDS must be made, because numbers are used to justify the preoccupation with AIDS, and behind these numbers lies the essential paradigm which itself must be confronted if we are to get past hysteria to health.

The public in countries around the world is constantly barraged with headline such as "AIDS virus claiming one victim a minute" (this one is from the Ottawa Citizen, but we have all seen them time and again). These claims are not only inaccurate, but are even revealed to be inaccurate from close reading of the statistics which are often provided in the article itself.

The following are World Health Organization (WHO) statistics for the diagnosed incidence of AIDS, as of June 1993. The totals in these statistical updates from the WHO are cumulative since 1979, and reflect all cases ever reported worldwide, living and dead. There is no other endemic or epidemic disease on which such cumulative statistics are maintained. Almost half of all persons represented in these figures are no longer living. Therefore, the number of diagnosed and reported persons in the world actually living with the effects of this syndrome at any time (recognizing that not all cases get identified) are considerably fewer than the numbers indicate at first glance.

As of June 1993, in North America there had been 210,376 cases of disease ascribed to the effects of the AIDS syndrome (about 35% of all cases worldwide). Of these, about 150,000 were no longer living; on that date, therefore, the actual number of persons in the United States suffering the effects of AIDS was about 75,000.

The global figure of all cases reported, living and dead, in the sixteen years between 1979 and June 1993, was 611,589. About 35% of these were in North America, as we have seen. The remaining 401,213 cases were distributed among all the countries of Western Europe (78,049) and the other continents, including the Third World. Sub-Saharan Africa accounted for 210,376 cases, with all other regions combined reporting the remaining 74,129 cases.

The frequent explanation for these low figures is that very few countries have the capacity to diagnose AIDS, and in any case they resist reporting the true incidence because they do not want to admit to the problem.

This response has never had a great deal of empirical integrity, with the pressure that these governments have been under to bow to the agenda of WHO and other international institutions, and the funds made available to governments willing to accept AIDS as a priority. Given this pressure, together with the tremendous interest and resources invested in tracking down and reporting AIDS by the multilateral and non-governmental humanitarian sector, not to mention the lucrative pharmaceutical industry and its associates in the medical training and research field, I think that we can have general confidence in these numbers. There is little doubt that they are not absolutely accurate,

and the actual incidence is higher than identified. But the idea that the actual incidence of AIDS is worse by a factor of five, ten, or twenty has no basis.

When we combine this with what we know of the critical limitations of diagnostic criteria and procedures, and the controversy over the "cause" of the AIDS condition, we really must ask again about the nature and extent of this problem. It is important that resources be devoted to understand and respond to the phenomenon of widespread immunosuppression and its potentially deadly effects. But, with respect to the loose vocabulary of the media and some in the international humanitarian and medical fields, this is not an epidemic by any scientific definition, and its spread has not had any of the mathematical characteristics of an epidemic.

It is the premise that the cause of AIDS is primarily viral, together with the social-sexual theories about the spread of the so-called "AIDS virus", which lead to a prediction of an epidemic, not the observable facts. If the theory was correct, both about the virus, and sexual transmission, the present modest numbers would be impossible. Indeed there would be no controversy, because the numbers in Canada and the United States, where diagnosis and reporting is aggressive and rigorous, would already be astronomical. In fact, they are not astronomical, they are not increasing but decreasing, and they remain insignificant in absolute and epidemiological terms. The numbers reveal none of the mathematical characteristics of an epidemic. And increasingly we are seeing this question being asked even in the popular media, when only a few years ago headlines predicted only apocalypse.

For example, in January, 1988 the Toronto Globe & Mail carried a report on statements about AIDS (Jan 27/88 , "Hundreds of millions risk AIDS, forum told") by an official of the World Health Organization. While the headline declared a risk to "hundreds of millions", the quoted official qualified his statements to such an extent that the qualifications became more revealing than his main idea. Admitting a lack of "precise figures", he said that it is "likely" that this large number "may" have "behaviors" which could make them "potentially vulnerable to infection with HIV" (which the article tells us is "the virus which causes acquired immune deficiency syndrome"). We know now that these predictions have not come true, and the premises upon which they are based are false.

In fact, only months later (March 21/88) we see an article titled, "AIDS epidemic may have hit peak in African nations", in which the Ottawa Citizen reported an interview in which Dr. Robert Ryder (at the time Director of the anti-AIDS program in Zaire, and an official within the WHO reporting network) explained that there has been no evidence of any increase in AIDS in Central Africa in several years. In this article it is reported that

in a series of recurrent studies conducted over the four years prior to 1988, the results consistently confirmed that the incidence of "infection" (ie. positive blood tests) had not increased, and was not increasing (and this in spite of tests that were notorious for generating false positive results).

A more recent article on AIDS in Zaire by Jean-Yves Nau reinforced this conclusion, reporting that the incidence of HIV sero-positivity in the adult population in the capital of Kinshasa remained stable (about 7%) and that "this proportion has not increased in several years". The article also revealed that while many psycho-social-sexual theories abound about why this is so (most centering on the continuing fantastical, and unscientific, pre-occupation with African sexual practices), in fact no one knows, and basic flaws in the medical paradigm remarkably does not seem to be one of the possibilities under consideration.

Yet over this same period — over years, going right back to 1984 — we were hearing relentless claims about the rampant, indeed exponential, increase in AIDS in Africa. Kinshasa itself has become the very symbol of this apparent seething African decadence in the popular North-American media. Clearly the reporting, and the debates, are not rooted in actual clinical reality. But finally, at the beginning of this decade we began to see articles questioning the statistics.

In the Ottawa Citizen of February 9, 1990 we see "Increase in American AIDS cases slowest ever"; while the March 16, 1990 Montreal Gazette asks, "AIDS epidemic over? Controversial US projections say it actually peaked in 1988". Later the Ottawa Citizen reports that "Canadian AIDS cases fall short of prediction". On November 17, 1990 the Toronto Star ("Canada's AIDS reporting misleading, professor says") reported on studies released by Dr. Ian MacNeill, Chairman of Statistical and Actuarial Sciences at the University of Western Ontario, which conclude that, "Canada's AIDS reporting system is seriously flawed, warning of widespread epidemics which haven't materialized". Professor MacNeill stated that the forecasts and figures released by the Canadian Federal Centre for AIDS are inaccurate and of little use to researchers or as basic data for developing policy or deciding changes to the health care system.

As early as June 1988 an article in the newsmagazine South, entitled "How paranoia fuels the AIDS epidemic", warned that "the other AIDS epidemic [the world-wide media-fuelled hysteria about the disease] may pose as insidious a threat to society as the physical spread of the disease — its symptoms are xenophobia, intolerance and overreaction".

As stated earlier, this generalized confusion and fear is caused not by direct experience with AIDS, but by speculation out of proportion with the scale of events in the real world. Prevailing preoccupation about AIDS among most Canadians, for example, could not be based in direct personal experience since, as of January 1, 1994, there have been only 9,083 cases of AIDS, including 6,187 deaths, diagnosed throughout all of Canada in 16 years (of which cases, only 5% were women, and 1% children). As in the United States, most of the recent increase in diagnosis in Canada is due to the retroactive inclusion of new diseases within the diagnostic definition of AIDS, rather than the discovery of new cases. Compared to other deadly conditions, such as breast cancer and heart disease, for example, which are far more prevalent, or the horrendous incidence of traffic deaths and occupational accident and disease, this number of cases in and of themselves would have relatively miniscule direct impact on 28 million Canadians, very few of whom have ever met a genuine sufferer of AIDS.

Rather, the reaction is based in perceptions gleaned from the press and other media. Unfortunately this perception is often reinforced by advocates in the humanitarian community, and by our medical authorities in their efforts to protect the "public good". And the World Health Organization persists in its estimates in mid-1993 of a total 13 million AIDS cases, with a projection of 30 million (notably less than the predictions of five years ago) by the end of the century. We can simply have no confidence in these numbers.

Obscuring Injustice: the Medicalization of Underdevelopment

Ultimately, however, the issue should not be about numbers. Whatever the numbers, they are too high. And no matter how high, they still do not begin to reveal the scope and scale of the problem of unhealth and mortality in the Third World, and among the poor in the industrialized countries of the north. In spite of the unreliability of WHO data, there is still cause for serious concern, not because of HIV and AIDS, but because chronic immunosuppression is the chronic condition of the poorest and least defensible. And as I argued at the outset, the villain is not a virus; it is poverty. And the cure is not medicine; it is justice. The information and projections issued by WHO and others cloud the issue and obscure the lived reality of the poor.

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 in the fashion as has been done with such fanfare for AIDS? This would be far more relevant and useful data.

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; 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 Third World.

Every one of these most-common afflictions are also among the most serious factors leading to the development of chronic life-threatening immunodeficiency. 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 surveyed by Root-Bernstein about the link between immunosuppression and historic endemic conditions and diseases only 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. 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 Third World, and increasingly common among the poor in the 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 amebiasis 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 themselves 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 where AIDS is supposedly epidemic. Malnutrition is known to critically increase susceptibility and vulnerability to parasitic infections and their effects. As well, the profound immunodeficiency that accompanies acute undernutrition 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 Third World, 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 of long-standing diagnosis of 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, Africa, and most recently by researchers at the University of Western Australia and the Royal Perth Hospital (reported in the June, 1993 issue of *BioTechnology*), indicate that malaria infection (and several other infections, including tuberculosis) triggers the same basic

immune response and antibodies as HIV, resulting, even in the absence of HIV, in clinical seropositivity on HIV tests (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 1985-86, 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 cause immune suppression themselves, 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), considered by North American doctors to be a rare condition, was the first opportunistic disease associated diagnostically with AIDS. Root-Bernstein demonstrates 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 (admittedly controversial) theories linking malaria and Epstein-Barr virus as co-factors in Burkitt’s lymphoma, whose sufferers exhibit symptomatic conditions similar to AIDS.

- 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 itself, 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 antivirals (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 Third World (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);

~ Psychotropic agents and tranquilizers (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, 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 life-threatening 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, and eventually develop, chronic life-threatening 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 Third World 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 Third World populations where these virtually ubiquitous practices exist.

None of this information 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, and independent of HIV. Even within the

mainstream and among the more affluent, other than persons who are at risk due to specific conditions (eg. hemophilia) or treatments (eg. transfusions) quite independent of life-style, immunodeficiency occurs virtually exclusively among people who, along with participating in hazardous sexual practices, most specifically receptive anal intercourse, have created in their lifestyle many of the critical risk elements (poor nutrition, addiction and drug abuse, chronic infections and antibiotic use) associated with poverty.

Meredith Turshen of Rutgers University and her French colleague, Annie Thebaud-Mony, have warned that AIDS is the most recent, and worst, manifestation of what they refer to as the “medicalization of underdevelopment”

This warning is at the heart of the issue. There is no need to hypothesize a dramatic and virulent viral agent; there is no need to invent the scourge of AIDS to explain the misery so pathetically exploited in the media as it simplistically repeats AIDS propaganda. The existing scourge of racial oppression, poverty, chronic malnutrition, ignorance, drug abuse, and their companion illnesses are bad enough. In fact they are far worse — as the statistics for the most common maladies above illustrates — than the meagre statistics and flawed projections of the AIDS industry, which only serve to divert attention from the grim situation that already exists.

Misinformation on AIDS obscures. The AIDS scare obscures the day-to-day reality of unhealth, misery and death among the poor. And in hypothesizing a biological agent, it obscures the social and political roots of the chronic immuno-suppression that only worsens the vulnerability of the poor to life-threatening disease, an inevitable bi-product of the material conditions of the poor.

Root-Bernstein warns 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.”

We do not have to create impressions of an inevitable cataclysm to justify concern about chronic life-threatening immunodeficiency, nor to promote the best possible collective measures to deal with it. We should avoid the temptation to drama and hyperbole, no matter how deep our sympathy for present and potential victims. And then we should concentrate on the real problems of the suffering and inflicted: the problems of health, not disease.

In the long run these are social problems, not medical problems, and require political and social interventions. Before medical science and charity, what is required is universal social and economic justice, for without justice the scourge of chronic immunodeficiency and its opportunistic diseases will remain as universal as the existence of poverty itself.

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Brian Murphy is a activist, author, and policy analyst, working with Inter Pares. He is author of Transforming Ourselves, Transforming the World, An Open Conspiracy for Social Change, ZED Books (London) and Fernwood (Halifax), 1999.