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Capitol Ideas column, by Tom Bethell

Capitol Ideas: INVENTING AN EPIDEMIC

The traditional diseases of Africa are called AIDS

Hype about AIDS in Africa has reached new heights. Secretary of State Madeleine Albright and Vice President Al Gore (at the U.N. Security Council) have declared it to be an international security threat -- as grave as warfare. AIDS is now called the leading cause of death in Africa, with over two million deaths last year, and the epidemic in sub-Saharan Africa is spreading "nearly unabated." Seventy percent of all AIDS cases are said to be African. On Newsweek's cover we read of "10 Million Orphans." Meanwhile, in a "Tour of Light," a troupe of orphans from "devastated Uganda" performs on the Kennedy Center stage. There are calls for a new Marshall Plan.

Skepticism about what governments say -- always scarce among journalists -- vanishes completely when it comes to "plagues" and epidemics. At the mention of AIDS, newspaper stories are virtually dictated by public health officials. The New York Times is the pre-eminent example, with other publications trotting behind uncritically. A rare exception is the science journalist Michael Fumento, now with the Hudson Institute. Another is Charles Geshekter, a professor of African history at California State University at Chico. He has made 15 trips to Africa and has written widely about AIDS in that continent.

The author of The Myth of Heterosexual AIDS, Fumento told me that he found the recent reports of HIV infection rates of 25 percent in some African countries to be not believable. The alarmist predictions about the progress of AIDS in this country have not been borne out, he said. African AIDS is an attempt to find the bad news elsewhere. Here, AIDS has not spread into the general population, and never will. It has remained confined to the major "risk groups," mainly intravenous drug users and fast-lane homosexuals. But in Africa, more women than men are said to be infected with the virus. Prof. Geshekter, too, sees African AIDS as a prolongation of the gravy train for public health experts. "AIDS is dwindling away in this country," he told me. The numbers are down. What are the AIDS educators to do? Africa beckons."

Here is an "African AIDS" primer. Over the years AIDS American-style was redefined more and more expansively. In 1993, for example, the Centers for Disease Control in Atlanta added cervical cancer to the list of AIDS-defining diseases, with the unacknowledged goal of increasing the numbers of women. The overwhelming preponderance of males was an embarrassment to infectious-disease epidemiology, given that the viral agent was supposed to be sexually transmitted. AIDS is a name for 30-odd diseases found in conjunction with a positive test for antibodies to the human immunodeficiency virus. Being "HIV positive," then, is the unifying

requirement for an AIDS case. Here is the key point that the newspapers won't tell you. To diagnose AIDS in Africa, no HIV test is needed. The presence of the unifying agent that supposedly causes the immune deficiency, the ID of AIDS, does not have to be established.

This was decided by public health officials at an AIDS conference in Bangui, a city in the Central African Republic, in October 1985. This meeting was engineered by an official from the CDC, Joseph McCormick. He wanted to establish a diagnostic definition of AIDS to be used in poor countries that lacked the equipment to do blood tests. He also succeeded in persuading representatives from the World Health Organization in Geneva to set up its own AIDS program. The appearance of sick people in Zaire hospitals had persuaded McCormick and others that AIDS now existed in Africa-this before HIV tests had even been conducted. And here was something important to write home about: slightly more women than men were affected. Back in America, as Laurie Garrett wrote in The Coming Plague (1994), McCormick told an assistant secretary of Health and Human Services that "there's a one to one sex ratio of AIDS cases in Zaire." Heterosexual transmission had been established. Now we were all at risk! AIDS budgets would soar.

The CDC had an "urgent need to begin to estimate the size of the AIDS problem in Africa," McCormick wrote in his book, Level 4: Virus Hunters of the CDC.

> "Only then could we figure out what needed to be done-and where. This is what is known as surveillance. It involves counting the number of cases of AIDS. But we had a peculiar problem with AIDS. Few AIDS cases in Africa receive any medical attention at all. No diagnostic tests, suited to widespread use, yet existed . . . We needed a clinical case definition - that is to say, a set of guidelines a clinician could follow in order to decide whether a certain person had AIDS or not. This was my major goal: if I could get everyone at the WHO meeting in Bangui to agree on a single, simple definition of what an AIDS case was in Africa,
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> then, imperfect as the definition might be, we could actually start to count the cases, and we would all be counting roughly the same thing."

His goal was achieved. The "Bangui definition," was reached "by consensus." It has proven useful, McCormick added, "in determining the extent of the AIDS pandemic in Africa, especially in areas where no testing is available." Here are the major components of the definition: "prolonged fevers (for a month or more), weight loss of 10 percent or greater, and prolonged diarrhea." No HIV test, of course. What this meant was that many traditional African diseases, pandemic in poverty stricken areas with tropical climate, open latrines and contaminated drinking water, could now be called something else with no fear of contradiction: AIDS.

The Bangui redefinition was published in CDC's Morbidity and Mortality Weekly Report, and in Science magazine (21 November 1986), but you would be hard put to find it in our major newspapers. Take the New York Times, whose main AIDS reporter has long been Lawrence K. Altman. He is himself a former public health officer, and like McCormick worked for the CDC's Epidemic Intelligence Service. He wrote the first newspaper article on AIDS, in 1981, and in November 1985 wrote two huge stories for the Times on African AIDS. "To this reporter," he wrote in the first, "who is also a physician and who has examined AIDS patients and interviewed dozens of doctors while traveling through Africa, the disease is clearly a more important public health problem than many African governments acknowledge." The story filled an entire inside page of the paper, and it included a "box" on the Bangui meeting. It mentioned a "hospital surveillance system to determine the extent of AIDS," but Dr. Altman omitted to say that, in Africa, AIDS could now be diagnosed without an HIV test. [Phone calls were made to Lawrence Altman at the New York Times, and a message was left on his machine, but he did not call back.]

The obvious problem was pointed out by Charles Gilks in the British Medical Journal in 1991. Persistent diarrhea with weight loss can be associated with "ordinary enteric parasites and bacteria," as well as with opportunistic infection, he wrote. "In countries where the incidence of tuberculosis is high," as it is in Africa, "substantial numbers of people reported as having AIDS may in fact not have AIDS." By then, the Times had published another huge series on African AIDS, this one reported by Eric Eckholm and John Tierney. It emphasized the need for condom distribution in Africa ("since 1968, A.I.D. has given 7 billion condoms to developing countries,") but the reporters again overlooked the relaxed definition. The same was true of the Times's more recent series, "Dead Zones."

Unlike dysentery and malaria, of course, plagues and epidemics reward reporters with front-page stories. And the budget requests of public health departments are met with alacrity. It was mutually convenient, surely, even if coincidental, that Altman and McCormick emerged from the same CDC intelligence service.

The loose definition has allowed health officials to conduct small surveys and make sweeping extrapolations to entire nations: AIDS is running rampant! Ten million orphans! (Newsweek might have told us that, in WHO lingo, an "orphan" is someone under fifteen whose mother has died. With life expectancy short, and fertility rates high, it is to be expected that a lot of African children are still under 15 when their mother dies.)

In a forthcoming article for Philanthropy, Michael Fumento comments on the vagueness of the Third World AIDS estimates, "made by organizations that are given more funds if they declare there's more AIDS." He adds:

"The Statistical Assessment Service [STATS] in Washington D.C. has noted recently that the World Health Organization in its latest ranking of

the world's greatest killers dropped TB down the list while moving AIDS up. The best explanation, STATS director of research David Murray told me, is that WHO noted that many Third World AIDS victims also suffer from TB, that both AIDS and TB data are just educated guesses, and so felt justified in simply shifting a huge chunk of deaths out of the TB category into AIDS. He was unable to get anyone from the organization to comment."

That surely is what happened. The CDC added TB to its list of AIDS-defining diseases in 1993, and, with no need for an HIV test in Africa, TB falls under the "AIDS" umbrella. All along, incidentally, someone has been keeping a stricter tally of the AIDS cases actually reported to the WHO. The organization's Weekly Epidemiological Record (Nov. 26, 1999), states that a cumulative total of 794,444 cases of AIDS in Africa has been reported to Geneva since 1982. "Anyone who wants to disprove those numbers should provide better, locally based figures," says Charles Geshekter of Cal State University. "So far, no one has."

In South Africa, which he visited recently, Geshekter found that HIV tests are conducted at pre-natal clinics and the results extrapolated across the country. One problem is that pregnancy is only one of the many conditions that trigger a "false positive result." The reaction is not specific to HIV. Antibodies to many other endemic infections also trigger false HIV alarms. The problem has been well known for 15 years and it alone renders all African AIDS projections meaningless.

Yes, people are dying all over Africa. The continent's population, whether sub-Saharan or supra-, continues to climb rapidly all the same. People are not dying of AIDS but of the diseases that have always afflicted those parts of the globe where the water is not clean and sewage is not properly disposed of. Poverty, unclean water and tropical weather make for insalubrious conditions. They have been exacerbated by civil war and the vast conflict raging in and around Central Africa. During his recent visit, Prof. Geshekter asked a woman from a rural Zulu township what made her neighbors sick. She mentioned tuberculosis and the open latrine pits next to village homes. "The flies, not sex, cause 'running tummy'," she said. Her understanding of public health would seem to be more advanced than that of the highly paid health officers who fly in from Atlanta and Geneva.

A sub-Saharan male-and-female AIDS epidemic implies that Africans have abandoned themselves to reckless sexual promiscuity. Recreational drug use is not alleged, and it is well established that it takes a thousand sexual contacts on average to transmit HIV heterosexually. (That is why HIV has stayed confined to risk groups in the West). Fables of insatiable African truck-drivers and rampant prostitution -- Beverly Hills morals imputed to African villagers -- are attempts to rationalize the equal-gender epidemiology of AIDS in Africa. Moslem countries to the north are less likely to accept this libel, so we may predict that the "epidemic" will remain firmly sub-Saharan. Cairo is a river's journey away from the Uganda hotbeds, and yet WHO reports a demure cumulative total of 215 cases

in Egypt (pop. 65 million) since AIDS began.

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