Aids in Africa

the Ugandan example

by Christian Fiala
translated by David Westacott
29. Mai 1998

Everyone does what they want
Nobody does what they should
But everyone joins in

To understand the present situation with HIV and Aids in Uganda, and to understand the reporting of it, a small excursion into the extremely tragic and turbulent history of the country is necessary.

"At the time of East African independence (in 1962), Uganda was hailed as a showpiece of British administration, far ahead of Kenya and Tanzania" and, for Winston Churchill, at the turn of the century the country was simply "the pearl of Africa", as the eminent historian Phares Mutibwa writes in his standard work on the history of Uganda. (1) "It was one of the most vigorous and promising economies in sub-Saharan Africa. It had a good climate and fertile soil: it was self-sufficient in food, and its agriculture, along with textiles and copper, earned enough foreign exchange to pay for imports and still show a surplus." (2)

The public health system, too, was exemplary for the conditions of the time. One sign of this is the introduction of an organised blood donor service as early as 1958. Within a short time, this form of medicine had become firmly established in the Ugandan public health system. This is explicable on the basis of the infectious diseases endemic to the region, which, among other things, cause anaemia in large sections of the population. If there is heavy loss of blood, the victim's life is

very quickly in acute danger and can only be saved by a rapid blood transfusion. This affects children, in particular in the frequent cases of malaria, and women who suffer blood loss after giving birth. But a blood transfusion is often also the only life-saver after accident injuries or armed conflicts. Thus, at the beginning of the 1970s, the blood bank for the hospitals in the capital, Kampala, alone was organising around 14,000 blood donations annually from 350,000 inhabitants. The majority of the donations came either from relatives of the patients or from paid blood donors, who were recruited either in front of the hospital gates or at well-known places like the bus station. In most cases the blood was not checked for pathogens. (2)
The organisation was autonomous and, under the prevailing conditions, exemplary. The blood bank used sterilised bottles and the needles were always re-sharpened when necessary.
There was not yet a central blood bank for the whole country, however, so outside Kampala every hospital was responsible for its own blood transfusions.

Another essential feature of European medicine is the administering of injections, either as therapy or as inoculation. This signified an essential advance, particularly in the treatment and prevention of widespread infectious diseases. Among the most common are diarrhoea, respiratory diseases, syphilis, gonorrhoea and other sexually transmitted diseases. Little account was then taken of the fact that unsterilised syringes can spread pathogens. Accurate analyses of the way syringes were sterilised at the time do not exist. Through anecdotal evidence alone, it is known that, in some cases, hundreds of people were vaccinated with the same needle, a practice which still continues in some parts. (22,23)
Today WHO confirms that "at minimum 12 billion injections are performed every year throughout the world" and "at least one-third are not being carried out in a safe manner and may be spreading disease". The situation is particularly dramatic in Africa, were "more than 80% of disposable single-use syringes are used more than once." (21) And a recent investigation in Tanzania found that 12 per cent of the syringes being prepared for use in health care facilities showed traces of the blood of the previous patient. (20)

Then came what are described in Uganda as "the two lost decades". This was the period under alternating dictators between 1966 and 1986, when there was a chain of economic mistakes, mass executions, civil war and war with neighbouring Tanzania. Some one million people met a violent death in this period. (in 1980, there were some 12.6 million inhabitants) (18) In addition, the country was so fundamentally destroyed that afterwards it was one of the poorest in the world. Thus, government expenditure on health at the end of this period was some nine per cent of the expenditure 20 years earlier. (2)

In 1986, as peace and political stability finally returned to a totally wrecked country, there was a another memorable event. The World Health Organisation published the following definition of Aids that was exclusively applicable to developing countries. (3)

Tab. 1: WHO Aids Definition (1986) for **adults** in developing countries (3):

Major signs:	Minor signs:
- weight loss ≥10% - chronic diarrhoea ≥ 1 month - fever ≥ 1 month (intermittent or constant)	- cough for > 1 month - generalized itching - recurrent herpes zoster - oro-pharyngeal candidiasis - chronic progressive and disseminated herpes simplex infection - generalized lymphadenopathy
exlusion criteria: - cancer - severe malnutrition - other recognized causes	
Aids is defined by the existance of: - at least 2 major signs **and** - at least 1 minor sign **and** - in absence of any exclusion criteria **or** - in a patient with generalized Kaposi's sarcoma **or** - in a patient with cryptococcal meningitis	

Under this, someone is declared to be suffering from Aids if they have had, for example, diarrhoea for more than a month, pronounced weight loss and coughing or general itching and no other cause can be ascertained with available means. On this definition an HIV test is expressly not necessary, and shortage of funds means that one is still only rarely carried out today. And on the Ugandan health ministry's registration form for people with Aids the possibility of an HIV test is not even mentioned. This means that Aids, the illness that in the words of Professor Luc Montagnier, the man who discovered HIV, "has no typical symptoms", is being diagnosed in developing countries exclusively on the basis of symptoms. (7) The symptoms called for are not exactly rare in a country with twenty years of systematic destruction behind it. So it is not really surprising that, as a result, Uganda has been declared as the country with the highest Aids rate.

Furthermore, as was the case in many other African countries, Uganda further redefined the WHO definition. Thus, having tuberculosis in Uganda can quite officially lead to an Aids diagnosis. As a result, the Aids statistics rise automatically. Initially, neighbouring Tanzania took the opposite route. There, criteria for an Aids diagnosis were at first set more narrowly. Two major and two minor criteria were necessary. This should actually have led to fewer cases of Aids than in Uganda.

However, not all the registered "Aids cases" actually fulfilled these criteria. Thus the Tanzanian health ministry writes in its report for August 1990, "Of the 1,987 new cases registered, only 667 (33.6%) fulfilled the above mentioned criteria. [...] Although1,320 cases would not strictly qualify to be called Aids cases, we have taken them as cases assuming that those who reported them just made an omission at the stage of compiling the forms." (6) Subsequently the definition of Aids was simply changed. The definition according to "single sign criteria" was added. This means that a sick person will be counted as an Aids case in Tanzania if they have one of the symptoms mentioned, and their doctor is convinced that it is Aids.

Both countries justify this procedure on the basis that the WHO definition is to imprecise and that it must be adapted to national circumstances. At the same time, it is totally absurd to assume that an infectious disease gives rise to different symptoms this side or that of an arbitrary political border.

In these circumstances, it is hardly surprising that Uganda suffered a sharp increase in "Aids cases" in the years after 1986. Thus, for example, half of the beds on the internal ward of the Makarere University Clinic in Kampala were occupied by Aids patients. That is to say, these patients were running high temperatures, had diarrhoea, or were suffering weight loss alongside one of the listed minory criteria, and had been declared to be Aids patients without an HIV test. It is also not surprising that there were many people suffering from such ailments in a country where the numerous infectious diseases and the poor hygiene mean that average life expectancy is about 50.

After this definition had been in use for some years, two other, equally internationally active health organisations wanted to raise their profiles and attempted to square the circle, namely to diagnose the "illness without sypmtoms" nevertheless on the basis of unspecific symptoms. The US American Centers for Disease Control and the Pan-American Health Organisation arrived independently of each other at the conclusion that the WHO definition "may not be adequate for clinical work" because "the potential inapplicability of that definition", and each declared its own new definition to be the only one that made sense. (4,5) These two definitions however, were not created in cooperation with each other or with the WHO, but in competition. Thus, since then, the developing countries have been able to pick and chose which of the three different definitions they would like to use in diagnosing Aids on the basis of clinical symptoms. They are also free to decide on one of the two different definitions used by the industrialised countries, the USA or Europe.

In international statistics, however, all the registrations of people with Aids are thrown into the same pot, although their numbers are based on different definitions and are thus not in the least bit comparable.

Interestingly, these important details are not known to the public or to many doctors. Actually, one could break off the whole discussion here, and describe all statements about Aids in Africa as speculation. But let's look at how reports from Africa are treated anyway. The WHO "believes" (15) that HIV in Africa is essentially sexually transmitted. This statement is remarkable in a number respects. Firstly, after more than 15 years it is clear that there is no epidemic in the heterosexual population in Europe. It is thus not understandable why this should happen in Africa of all places. Secondly, the supposedly specific sexual behaviour of Africans is frequently alluded to. Apart from the fact that even the first Christian missionaries held this belief, there is absolutely no scientific evidence for this view. On the contrary, Americans lead the world as far as changing partners is concerned, followed by France, Australia and Germany. South Africa, like Thailand, is well back in the middle of the field as one international study tells us. (8) But there is of course a long Christian tradition of fantasising about the supposedly licentious sex life of Africans.

With the help of the above-mentioned definition, the number of new Aids cases in Uganda and Tanzania increased every year up until 1991. Since then, the numbers have been dropping again.

Table 2. Registered Aids Cases in Uganda	
Year	new cases
up to1986	910
1987	2.914
1988	3.425
1989	6.090
1990	6.616
1991	10.235
1992	9.352
1993	4.641
1994	4.927
1995	2.192
1996	3.032

Source: Ministry of Health, Entebbe

All registered Aids cases are noted by the WHO in Geneva. As there is certainly an unknown number that are not registered, the WHO multiplies the registered cases in order to reach an estimate of the "actual" number. In which it becomes clear that this multiplication factor is higher every year. In 1996, the WHO multiplied registered Aids cases in Africa by 12. In 1997 this had jumped to 17. In the last one and a half years alone, 116,000 new cases of Aids in Africa have been registered with the WHO. In the same period, however, it has raised its statistics for the estimated cases by a whole 5.5 million thus multiplying the reported cases by 47. (18, 19)

If one starts from the number of Aids-cases registered on the basis of the above mentioned definitions, then there is only one thing to say: most people in Africa die from symptoms that arise from known and treatable infectious diseases like malaria, pneumonia or diarrhoea as a result of poor hygiene. The well-known horror scenarios about an epidemic of a new infectious disease exist exclusively in the heads of the statisticians through untenable and escalating multiplications.

On top of this, the statisticians have added together - that is, presented cumulatively - all Aids cases since the beginning of the 1980s. This form of presentation is extremely unusual in medicine as it produces useless results. The figures automatically rise, even if only a few new cases are still coming in each year. Thus the monthly publication of the German Medical Board (Deutsches Ärzteblatt) writes, under the headline "Cumulative Confusion": "Nobody thinks of adding up the case figures for mumps, tuberculosis or scarlet fever from the day the law on epidemics

was passed." Consequently, the only sense in such a form of presentation is that "Large figures bring in large amounts of public money." (11)

It is therefore not surprising that the WHO official reports always announce an imminent catastrophe. What is surprising is that almost all journalists and media dutifully spread the news without raising a single critical question.

Aids Orphans

The story of Aids orphans is certainly the most cynical since the discovery of HIV. And it sheds a characteristic light on the nature of reporting about Aids: obviously anything is allowed, without reservation, that makes people feel threatened.

"About 830,000 children are living with HIV/Aids. However, the impact of the HIV epidemic on children goes far beyond the large number of children already infected with the virus.
A study carried out by the Orphan Project (New York), estimated the number of children under 14 years old already orhaned by Aids to total more than 1 million in seven countries. Kenyan, Rwandan, Ugandan and Zambian orphans account for 95 % or these 1 million children. [...]
If, for example, we make the conservative guess that already orphaned children represent 10 % of the total number of children with HIV-infected mothers in Uganda, this means that more than 3 million children are alredy feeling the direct impact of the epidemic in this country alone." as the WHO's dramatic words in their press release of 28 November 1996 describe the situation. In Uganda, there are currently some eight million children under the age of 15. If three million of them are feeling the direct impact of Aids, then there is no doubt that Aids is now affecting innocent children to an unimaginable extent. Such a finding can only leave one speechless.

This speechlessness is only exceeded by astonishment at another WHO report on the same subject, with the unobtrusive title "The care and support of children of HIV-infected parents" On page two, one finds the following note: "The content of this restricted document may not be divulged to persons other than those to whom it has been originally addressed. It may not be further distributed nor reproduced in any manner and should not be referenced in bibliographical matter or cited." There then follow some facts about Aids orphans that one might actually have expected to see in the WHO press releases. "There is confusion as to what is meant by the term "orphan" [...] Projection studies carried out by WHO and studies done elsewhere have used different criteria." And, as it goes on, a few of these are further clarified:

"The UNICEF defines an orphan as a child whose mother has died, and WHO defines an orphan as a child who has lost both parents or only the mother. [...] In the Uganda enumeration study, an orphan is a child who has lost one or both parents (the standard Ugandan definition of an orphan)."
Lost, however, does not here mean dead, but simply absent, which is why the WHO also adds a far-reaching reservation: "One of the confusing aspects is the extent to which the absence of one parent is the norm in a given society."
What has been said so far should be more than enough to lead one to scrutinise all statements on this subject with the greatest scepticism.
Because of the large number of families with single parents, even the European countries would have a large number of "orphans" if one applied the Ugandan definition. But the authors obviously know the history of Uganda and therefore know of the important reservation already mentioned on interpreting figures from this country: "In the Uganda enumeration study, no distinction was made as to the cause of orphanhood, which in some areas included the effects of war." The authors are referring to the twenty-year rule of terror from 1966 until 1986, which also included periods of war and civil war. In this period, the country was not only fundamentally destroyed, but above all, some one million people were killed. It should not be necessary to mention that this also led to a large number of children being orphaned. In 1980, Uganda had some 12.6m inhabitants. (18)

People in Africa, and in Uganda in particular, need our help and support after this long period of suffering.
It is neither helpful nor effective if wrong data and absurd definitions are employed to mislead us and to divert attention from the country's real problems. The present situation is leading to large amounts of funds from the limited national budget and from foreign aid being invested in campaigns, among others, to promote faithfulness in relationships and the use of condoms. At the same time, it is clear that in Europe the two-thousand-year manipulation through Christian teaching on sex has brought about no lasting change in sexual behaviour. And our use of condoms has hardly changed in the last 10 years, despite the numerous campaigns. So it is not apparent why, of all things, the sexual behaviour of people in Africa should change as a result of campaigns.

In view of the poverty in most countries of Africa - more than half of the population has no access to clean drinking water (16) - the European fixation on a supposedly heterosexually transmitted Aids epidemic in Africa can only be regarded as cynical.

Furthermore, it is incomprehensible why in publications that are not generally accessible the WHO writes the opposite of what it publishes in its press releases.