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Briefings

AIDS IN AFRICA

Carol Barker and Meredith Turshen

AIDS, a fatal disease that was originally identified in Africa in the 1970s, is now a public health problem in central Africa and is spreading to southern and western Africa. The incidence of AIDS may be ten to twenty times higher in Zaire than in the USA. Neither homosexuality, nor intravenous drug abuse, nor haemophilia — characteristics of the groups labelled 'at risk' in Europe and North America — appears to be a factor in Africa where AIDS occurs as frequently among women as men.

AIDS is a syndrome, not a single infection like smallpox. Common symptoms of AIDS in Africa are chronic diarrhoea, weight loss, and fever of unknown origin; in North America and Europe, pulmonary problems and central nervous system disorders are common symptoms. The cause of death may be meningitis, tuberculosis, or fungal infection in Africa, pneumonia or certain forms of cancer in North America and Europe.

What causes AIDS? There are two theories, which are not mutually exclusive. One is that AIDS is caused by the LAV/HTLV-III virus, which breaks down the body's defence system. The other is that the virus is the causative agent but that its presence in the body may be important only if the immune system is already weakened. The immune system may weaken as a result of malnutrition and poor diet, poor sanitation, frequent infection, overuse of antibiotics, and a synergistic interaction of malnutrition and infection. This state is known as 'immune overload', which is a deficient immune response or failure of the immune response. The important question is, In what conditions does the AIDS virus give rise to symptoms of AIDS?

The first theory holds that risk factors are race (40 per cent of US cases are Black and Hispanic), intravenous drug use (perhaps as many as 80 per cent of US cases), and sexual preference (73 per cent of US cases are classified as gay or bisexual men, but 70 per cent of AIDS patients in New Jersey are heterosexual). These categories overlap because the assignment of an individual with two or more characteristics is arbitrary. According to the second theory, risk factors are poverty, malnutrition, frequent infection, lack of sanitation, and the indiscriminate use of antibiotics. Although these theories are not scientifically antagonistic, their political implications are very different.

In this briefing, we wish to argue that official reporting of AIDS in Africa has been suppressed because of Western attitudes to the disease, which embrace the first theory. It is one thing to have it put about that a disease is rampant because of conditions such as homosexuality and drug-taking, which can be blamed on the victim, and quite another to ascribe disease to conditions of deprivation. The groups likely to be prey to the second category of risk factors — poverty, malnutrition, and infection — in the US are Blacks, Hispanics, and intravenous drug users. In order to examine the response of African governments, we have first to analyse the attitudes taken towards AIDS in North America and Europe, where the epidemic was first reported.

The first theory stigmatises and stereotypes certain groups of people who are at risk socially — homosexuals for the threat they supposedly pose to family life, heroin addicts who are mostly very poor and often Black inner-city residents, and refugees from the Duvalier regime in Haiti who received a racist reception in the USA, a response quite different from that given to Cuban refugees. Haemophiliacs are singled out as innocent victims because AIDS was transmitted to them by contaminated blood products traced to centres that purchased blood from infected donors, until new screening procedures were introduced in 1985.

The AIDS epidemic in North America and Europe is being used as an excuse to discipline the homosexual community, to punish drug addicts severely, and to expel Haitian refugees from the US. AIDS has been added to the list of diseases that are grounds for exclusion of people seeking immigrant visas to the US. This assault is motivated in part by unwillingness to pay for the long-term hospital care needed by AIDS victims (the cost of the first 9,000 AIDS-related deaths in the US is \$1,200 million, and health insurance companies are now refusing policies to single men between 30 and 55 years of age who have never married).

In Sweden the government announced in January 1985 that two-year prison sentences would be meted out to AIDS victims (should they live that long) if they were found to have sexual relations with someone free of AIDS. As of that date there were eight deaths from AIDS in Sweden and 200 cases were identified. In March of 1985, the government of the UK announced new regulations giving magistrates broad authority to hospitalise AIDS patients even against their will, explicitly to keep them from spreading the disease.

The press is sensationalising AIDS as the 'gay plague' and comparing it to the bubonic plague of the fourteenth century in which 25-50 million people died. The result of course has been a wave of hostility against homosexuals, gay men being dragged out of their cars and beaten on the streets. As of the end of 1985 there were 275 cases in the UK, which has a population of 56 million. The response would seem to be out of proportion to the public health danger.

AIDS is still a rare disease: 4,000 people died of AIDS in the US in 1985 whereas 462,000 died from cancer, which is not the leading cause of death in the US (heart disease is). Apparently the AIDS virus may be carried by individuals who never become ill but may be a source of infection to others. As only one in fifty or one hundred infected people develops symptoms of AIDS, the panicky reaction may be explained not by any medical criterion but by a conjunction of social fears and taboos — the combination of homosexuality, contagiousness, and cancer.

We have dwelt at some length on the reactions to AIDS in the US and Europe in order to put into perspective what is happening in Africa. AIDS did not become a

news item when it was first identified in Africa among heterosexual Africans, but Africa is now being labelled as the source of the epidemic. The angry response of African governments is to withhold data for fear of jeopardising tourism. If they buy the victim-blaming analysis of European and North American virologists, as the South African government is certain to do, then there is little hope that the disease will be treated or that the root causes will vanish.

Recent research findings and epidemiological data collected world-wide by WHO show that AIDS has spread to every continent, though relatively few cases are reported from Asia and the Western Pacific (other than Australia). Haitians were removed from the US list of groups at risk following intense political pressure. When it was revealed that the sex ratio of AIDS patients was roughly equal in Zaire, the US reviewed early medical diagnoses, which had given the impression that AIDS was a male disease: it appears that there were cases in women but they were classified as heroin addicts, Haitians, or the partners of bisexual men. Heterosexual transmission is now acknowledged to be as probable as homosexual transmission.

The high proportion of female AIDS patients in Africa raises another problem. Recently the UK Royal College of Obstetricians and Gynaecologist released a report on the transmission of AIDS during pregnancy: studies show that infected women can transmit the virus to the fetus and that half of infected babies develop symptoms with 6-8 months of birth. Given poor sanitary environments and high levels of infection in most African countries, we can expect rising rates of infant and child mortality as the AIDS epidemic spreads.

Is AIDS a sexually transmitted disease? If the main mechanism of transmission is the mixing of infected blood with healthy blood, AIDS may be misclassified as a venereal disease. AIDS is a very difficult disease to catch: infection results from direct insertion of the virus into the bloodstream. In Africa, where health service budgets are always inadequate, hypodermic needles are routinely reused and potentially a source of infection. Injections given by unlicensed practitioners using unsterilised needles are another potential source. Cultural practices such as ritual scarification and clitoridectomy, in which there is bleeding and the reuse of possibly infected instruments, may also play a part in the spread of AIDS.

Whatever the mode of transmission, AIDS seems to be a class-based disease that arises when synergies of malnutrition and infection are common in deprived populations. We do not know the prevalence of AIDS-virus carriers in the general population of Europe or North America because those being screened are Black, African, or labelled as homosexuals, prostitutes, or drug-users. Other potential carriers may, by virtue of their superior social status, avoid public scrutiny or avoid expression of the disease in terms of the symptoms categorised as important in the USA.

The problem is even greater in Africa, where AIDS is much more difficult to identify without blood tests than it is in the US or Europe because its symptoms (diarrhoea, fever, weight loss) are so common. As Cliff, Kanji, and Muller point out in this issue, aid agencies and international organisations are putting considerable pressure on African governments to screen for AIDS. Screening of what is perceived to be a minority health problem is expensive and it is confounded by outsiders coming into an African country with ill-founded prejudices as to who are at-risk groups (e.g. 'prostitutes'). Furthermore, so long as the victim-blaming labels for AIDS-sufferers

— homosexuals, drug addicts, etc. — linger, no African government is likely to be happy about screening. Tourism alone is a good reason for keeping quiet.

Meanwhile the IMF is forcing African governments to cut back the social services, including public health and clinical care, that might mitigate the impact of the economic crisis. Health levels are deteriorating rapidly, malnutrition is spreading across the continent in the wake of the current drought, and Africans are more vulnerable to infections — now including AIDS — than ever before.

Bibliographic Note

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PRIMARY HEALTH CARE IN ZAIRE

Brooke Grundfest Schoepf

This briefing is based on unpublished research conducted while the author was Chief of the Medical Anthropology Seminar, Centre International de Semiologie, National University of Zaire, 1975-78, and during subsequent brief visits. The term 'biomedicine' refers to diagnosis and treatment based on scientific biological research. As practised in Zaire, however, western-style medicine may involve very little scientific method, and equipment and training bear little resemblance to modern standards of biomedicine. 'Folk practitioners' are herbalists, diviners and religious healers, empirical midwives and others. Traditional medicine, a term with ideological overtones, is avoided.

The attempt to institute a national primary health care (PHC) system in Zaire bears the imprint of both the colonial past and contemporary socio-political contradictions. In 1973, the Zaire government, in response to foreign advice, issued a 'Health Rights Manifesto,' established a National Health Council, and began discussing primary health care. At a 1975 rural health conference, the government acknowledged that the missions still played a major role as providers of rural health services. In 1979 the National Health Council had yet to meet in the six years since its founding. Today health services remain heavily class and urban biased. The government hospital in Kinshasa still absorbs more than half of the health budget. Companies provide health services to employees and their families. Adequate routine biomedical care is available mainly to the bourgeoisie, many of whom seek specialist services in Europe.

Zaire's economy has been in crisis since 1975; as a result, living conditions of the vast majority have deteriorated. The full effects of grinding poverty upon those who have abandoned all hope of betterment in the present system remain undocumented. One response has been religious revivalism. Both the rural and urban poor suffer from endemic infections and parasitic diseases, often without benefit of modern treatment; malnutrition and related conditions are the major cause of death.

PHC is not inexpensive, but Zaire has not lacked foreign funding. PHC requires substantial resources to train, support and supervise peripheral health workers and to improve referral hospitals. It also requires a conducive institutional context.