Conference Report

Tuberculosis, in link with AIDS, is now number-one killer

by G. Phau

At an international conference on lung disease held in Boston, Massachusetts May 20-24, experts presented a shocking picture of how tuberculosis is making a spectacular comeback worldwide, in alliance with the AIDS pandemic. Here are the facts:

- There are an estimated 20 million cases of clinical tuberculosis in the world today, according to the World Health Organization (WHO)—which is notorious for underestimating the health crisis.
- Of all contagious diseases, tuberculosis is the number-one killer. Now that the AIDS virus, HIV, has struck heaviest among the underprivileged, especially black Africans, TB has become the first manifestation of AIDS, and both TB and HIV reinforce one another dramatically, to spread ever more quickly.
- There are at least 8 million new cases of TB per year, with over 95% of them in developing countries. Half of these cases are highly contagious.
- TB is up 20% and more in Central Africa, as among America's black and Hispanic minorities. In developing countries, and among U.S. blacks and Hispanics, over 80% of cases occur in the 15-49 age group—i.e., among those of child-bearing age.
- Tuberculosis causes at least 3 million deaths a year, two-thirds of them in black sub-Saharan Africa.

"TB in the Era of HIV Infection" was the topic which opened and closed the conference that drew 1,100 physicians and was organized by the American Lung Association, the American Thoracic Union, and the International Union Against Tuberculosis and Lung Diseases (IUATLD). Specialists in lung disease from all over the world showed how TB screening and control programs had either been abandoned in the past 15 years (as the WHO admitted in its own document), or had been maintained at a level insufficient to deal with the disease.

The conference ended with a powerful resolution calling upon governments, non-governmental organizations, and the WHO to assist developing nations where both pandemics are hitting hardest. *At least 30 million people, mostly young adults, will die of TB in the next 10 years,* the resolution states. HIV has made the situation worse. In developing countries, TB is often the way patients learn they have AIDS. The resolution demands:

- high-quality care for HIV and TB patients, regardless of ability to pay;
- measures to contain the spread of both diseases;
- support for health programs in developing countries where HIV and TB pandemics are striking;
- training of more people for screening and treatment;
- an information campaign on both diseases;
- funding of basic research;
- research funding for a vaccine against HIV and better vaccines against TB.

TB stalks U.S. cities

Dr. William E. Braun, of the Centers for Disease Control (CDC) in Atlanta, Georgia, reported 14,768 cases of TB in the United States during the latter part of the 1980s, most of them among minorities. He showed a graph of TB declining steadily until 1985, when it shot upward suddenly, with the onset of the HIV virus. This, he said, indicates that TB is spreading as a result of HIV; riding along the AIDS disease, it has found a new life. In short, a person infected with the TB bacillus, having contracted HIV, will develop the clinical form of tuberculosis, and transmit it to the next person who may or may not be HIV-infected.

Dr. Braun gave the example of Belle Glade, Florida, to show what is happening in communities across the United States. We see there, he said, a great increase in pediatric tuberculosis, and a good number of cases of pediatric HIV and TB combined.

In 1985, when the medical establishment was hysterically denying the AIDS-TB link, *EIR* published an interview with Dr. Mark Whiteside of the Institute of Tropical Medicine in Miami, on the Belle Glade situation (" 'We have a public health emergency': the real story of AIDS in Florida," *EIR*, Sept. 27, 1985). The economically depressed community of Belle Glade had an unusually high per capita incidence of AIDS, along with TB, parasitic diseases, and viral and tropical diseases—and a high incidence of AIDS among those not

considered members of a "high-risk" category according to the CDC's scientifically incompetent criteria. Dr. Whiteside's warnings at that time were ignored by the CDC and the rest of the medical establishment, who insisted that the only way a person could get AIDS was by sex, blood transfusion, or dirty needles.

But today, the CDC is changing its tune, and there is talk among the experts now to the effect that plain pulmonary TB is an indicator for AIDS, and not just extrapulmonary TB—meaning that the disease is much more widespread than previously admitted. But looking at cases of pulmonary TB might force the medical establishment to jack up their figures for AIDS cases by 30%, so this may not happen for a long time.

Dr. Jeffrey Starke, from Baylor College of Medicine in Houston, Texas, told the conference that the rate of TB among U.S. blacks and Hispanics is the highest in 30 or even 40 years, "though TB is a preventable and curable disease, and, at least in the well-to-do-nations, the TB problem ought not to exist." He documented that 1) TB is most prevalent in the United States among minorities; 2) TB is most prevalent among young adults, particularly blacks (among whites, the higher rates are among the elderly); 3) HIV affects the same people; 4) among those infected, there is little medical treatment, due to poverty, drug addiction, homelessness, and the inability to pay; 5) there is a lack of screening, notably for high-risk infants; 6) the drugs "crack" cocaine and "ice" are making the problem worse; and 7) there are great delays in tracing people with whom the patients have had close contact. Dr. Starke explained that the need to identify contacts can be a life-or-death matter: If there is a several-week or -month delay between the detection of TB in a young adult, and the screening of children in the household, this gives plenty of time for the children to become infected (1-3 months) and develop meningeal TB.

The African tragedy

The dramatic nature of the combined TB and HIV pandemic on the African continent is shown by the official projection of 2 million orphans in the next 10 years. In reality, there could be 10 times that number—children whose mothers will have died of TB and or HIV.

Two-thirds of all TB deaths occur in Africa today. As for AIDS, the rate of contamination is continuing to increase, with an average of 25% of young adults infected in Central African cities. The estimates of the IUATLD and WHO are that 50% of TB patients today in Africa are also seropositive for HIV—and the figures often reach 70%.

Even the reluctant WHO, in a 1990 report, demands action: "If no efficient program is carried out, tuberculosis will spread far and wide, because the additional cases of TB caused by HIV infection will progressively infect more and more people, among the HIV positive population, as among the HIV negative population. The situation in Africa is really alarming and calls for immediate and energetic action. It is as urgent and perhaps even more so, to achieve improvements in the struggle against TB in Asia, where HIV hasn't yet had time to spread."

Dr. Braun, from the CDC, indicated that serological testing in Abidjan, Ivory Coast, on 2,580 ambulatory TB patients, resulted in figures of 41% seropositive for HIV-1 and HIV-2, the highest number of them in the 20- to 40-year age group, those of child-bearing age, and thus likely to infect their children with HIV and/or TB.

Fully one-third of TB cases in Africa are estimated due to HIV, and of the present 2 million deaths annually from TB, 1.5 million are Africans (the IUATLD puts the death figure at 3 million). It is impossible to give accurate figures,

Disease in the ghetto: Who will pay the bill?

A nurse from the Atlanta Centers for Disease Control presented the very fancy TB-control program which the Centers for Disease Control (CDC) has set up, called "Healthy lungs for all by the year 2000." This writer asked: "You have presented a rosy picture of the CDC's past and future TB-control program. However, if TB is still under control in the white community, this is not the case among minorities, where, according to the CDC itself, it is raging out of control with a 22.4% increase just from 1987 to 1988. The fact is that the increased poverty and homelessness in this country mean that both HIV and TB will increase in the ghettos. Several physicians have come up to me during this conference, to tell me that they are concerned at the lack of screening, that this lack of screening is not just a big problem in developing nations, but also in U.S. cities."

The nurse could only acknowledge the problem and say that a bill would be presented to Congress to seek financing for some additional programs.

Several participants came up to this writer after the session to express agreement with the question—among them a nurse member of the Massachusetts Thoracic Society, who reported that the CDC has failed to deal with the problem of all those denied medical care because of inability to pay: poor members of minorities, drug addicts, and homosexual AIDS victims who have lost their jobs.

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since so many patients in rural areas die from TB and/or AIDS and are never identified, never having gone through specialized care—or any care. A pneumologist from Malawi pointed out that besides screening, it is also important to make sure that the TB patients take their medicine until they are cured, and to increase the efficiency and compliance rate, patients with TB are automatically hospitalized for a month once they are identified. He said the problem was that the World Bank wanted to start forcing Malawi to end government subsidies and institute payment by patients for medical care, but hardly anyone could afford payment.

The World Bank's genocidal approach is starkly seen in its 1989 report "Sub-Saharan Africa," which recommends "a shift away from curative medicine into more efficient forms of Primary Health Care" in Africa. Since under the PHC system set up by the WHO in 1978, there no longer exist trained physicians or medics in most of rural Africa (where 90% of the population lives). With the recommendation coming in the midst of the worse health crisis since the 1920s, one can only conclude that the WHO policymakers are concerned not with curing disease, but with reducing "overpopulation"—especially when it comes to black people.

WHO officials meeting in May in Geneva agreed that the world organization had to "soften up" the programs of the International Monetary Fund and the World Bank, so that health care would not be the first thing to be cut in the Structural Adjustment Plans—the draconian austerity measures—as "transition" measures. Few have asked, "Transition to what?"

What must be done

In the case of TB, the necessary treatment and public health methods are long established. As Dr. Karl Styblo, head of the scientific committee of the IUATLD, said, "For TB, the screening/treatment duo is, of all health interventions, the most efficient in the world." After giving the figures on the TB/HIV pandemic, Dr. Styblo said: "What can we do? We cannot influence the move from infection to disease, but we can act on the risk of infection. That highlights the necessity to find patients in the early stages." That is because, as most speakers said, TB is a preventable, transmissible, and curable disease.

And what about AIDS? The French-based IUATLD, under the leadership of Prof. Jacques Chretien and Dr. Annick Rouillon, has sought to steer the reluctant WHO bureaucracy toward a much sounder approach to HIV prevention by reviving screening for TB, and there is now a TB specialist as part of the AIDS groups in each region of the world. But will that lead to real changes in policy on the part of the WHO?

Dr. Gary Slutkin, of the WHO AIDS committee in Geneva, in his passive account of the reality of TB today, was indicative of the problem. Slutkin was among the first to ring the alarm bell on the TB and HIV problem, at the 1988 international AIDS conference in Stockholm. But in Boston, his competent picture of the TB problem was followed by an absurd account of how Jonathan Mann, former director of the AIDS program at WHO, had gone from one secretary and $6 million to over 200 staff members and a budget over $100 million—and how he was using this to send teams of specialists to poor countries to promote educational campaigns about "safe sex" and the use of condoms, much to the ire of "old-fashioned" governments! Dr. Slutkin compared the AIDS effort to the successful WHO effort to eradicate smallpox, which comparison is fundamentally wrong, since in the latter case there was a vaccine and a massive screening program, whereas in the case of HIV, there are no vaccines and the WHO strenuously opposes screening, against the will and better judgment of many practitioners.

Slutkin said in conclusion that the WHO's efforts will lead to the distribution of 140 million condoms this year. Some naive listener could ask: What about antibiotics for TB? What about syringes? What about microscopes and X-ray machines for detection of lung problems? What about the money and the facilities to train hundreds of thousands of new mobile medical teams for screening and treatment to face this emergency?

The WHO's head of tuberculosis treatment, Dr. Arata Kochi, told the conference, "We have to shift from a silent emergency to a very loud one. We are all ears—but so far, we hear mostly the muteness of rubber."