

Ebola Outbreak Threatens Global Biological Holocaust

by Douglas DeGroot

Aug. 16—On Aug. 8, Dr. Margaret Chan, director general of the World Health Organization (WHO), declared the West African Ebola outbreak an international health emergency:

“This is the largest, most severe, most complex outbreak in the nearly four-decade history of the disease. I am declaring the current outbreak of the Ebola virus disease a public health emergency of international concern. Countries affected to date simply don’t have the capacity to manage an outbreak on this scale on their own.”

The day before, an emergency hearing was held in the U.S. House of Representatives—despite Congress being in August recess—where lawmakers heard testimony from disease experts, who gave chilling first-hand accounts of the situation in West Africa, backing up their assessment that the epidemic is “out of control.” The stark reality of their testimony flew in the face of the official line that the crisis could still be contained, which was otherwise presented to the lawmakers by top officials of the CDC (Centers for Disease Control and Prevention) and USAID (U.S. Agency for International Development), who repeated the story that the disease can be “contained” in Africa, even though no proper international mass-mobilization of resources to combat and control one of the most virulent viral diseases known to man is being undertaken.



In Sierra Leone, 32 nurses, and an unspecified number of doctors, died from Ebola between May 24 and Aug. 13. Shown: an Ebola patient being treated in Sierra Leone.

Among notable cases of failure to act against this emergency is President Barack Obama, who, in the midst of his grandstanding at his Africa Summit Aug. 4-6, made only passing reference to the disaster—at a conference which should have been the basis for mapping out emergency action to save lives.

For example, Dr. Thomas Frieden, Director of the CDC, averred that there is a significant crisis, but that it could be contained in Africa, and that there was no danger of it spreading to the United States. The same view was given by the representatives of the State Department.

What is involved in this crisis, simply, are two basic features:

- First, the microbe—filovirus genus (which has

five varieties) in the filoviridae family—is virulent, and has been known for 38 years, but there is no vaccine against it and no known cure. Ebola has never been prioritized for vaccine development;

- Second, to contain the outbreak—whose prior occurrences were predominantly in less-populated areas in central Africa that were not near larger cities—in-depth public-health measures such as quarantine, tracking of contacts, haz-mat handling equipment and treatment, are required. None of this equipment is readily available on the scale required in West Africa.

As of today, 1,145 people have died of Ebola in West Africa, three in Nigeria, and the rest in the three main victim countries—Guinea, Liberia, and Sierra Leone. The official infection case roster is 2,127.

Biological Holocaust

The Ebola outbreak poses the reality of impending biological holocaust, as a result of enforced primitive economic conditions, such as the austerity imposed by the IMF and World Bank’s Structural Adjustment programs. The countries being hit are among the poorest in the world, with no public-health systems and minimal modern infrastructure. Under the breakdown of the world economy, Africa-style conditions are spreading—and disease will follow.

Lyndon LaRouche forewarned of the genocidal results of these policies beginning in 1974, when he set up a task force to study the worldwide biological-ecological breakdown, and emergence of new diseases that would ensue if the “zero-growth” economic policies then being imposed upon Africa, were maintained and came to prevail more widely. As of the 1980s, such consequences were already unfolding. A report of the task force was published in 1974.

On July 1, 1985, LaRouche’s Biological Holocaust Task Force released an “EIR Special Report: Economic Breakdown and the Threat of Global Pandemics,” presenting handbook-style documentation of microbial disease threats. It detailed the scenario of a potential “biological holocaust,” of new and re-emerging human, animal, and plant diseases, if economic growth policies were not restored. HIV/AIDS, newly identified, was in the forefront. Seventy percent of the world’s HIV/AIDS victims are now in Africa.

Emergency in Action

On Aug. 15, the WHO released its second statement on Ebola in less than a week. It stated that the magni-

tude of the outbreak has been vastly underestimated, and that “extraordinary measures” are needed if the disease is to be contained.

Already, in a press briefing Aug. 13 in Geneva, WHO Director Chan had said that 1 million people are affected by the disease, and need help, including food, on a daily basis. The efforts to contain the hotspots with high numbers of infected people, by isolating them from the non-infected areas, by means of *cordons sanitaires*, has further disrupted the economies of the victim countries, resulting in lack of food supplies in infected and non-infected areas. WHO is also working with other agencies, including the World Food Program, to feed about 1 million people quarantined in villages in Guinea, Liberia, and Sierra Leone. She emphasized:

“There is no early end in sight. This is an extraordinary outbreak that requires extraordinary measures for containment. This is a severe health crisis, and it can rapidly become a humanitarian crisis if we do not do more to stop transmission.”

Chan added that “the outbreak is unprecedented in its size, severity, and complexity. Cases are occurring in remote rural areas that are difficult to access, but also in capital cities.” She also said that every city with an international airport has been placed at risk of an imported case.

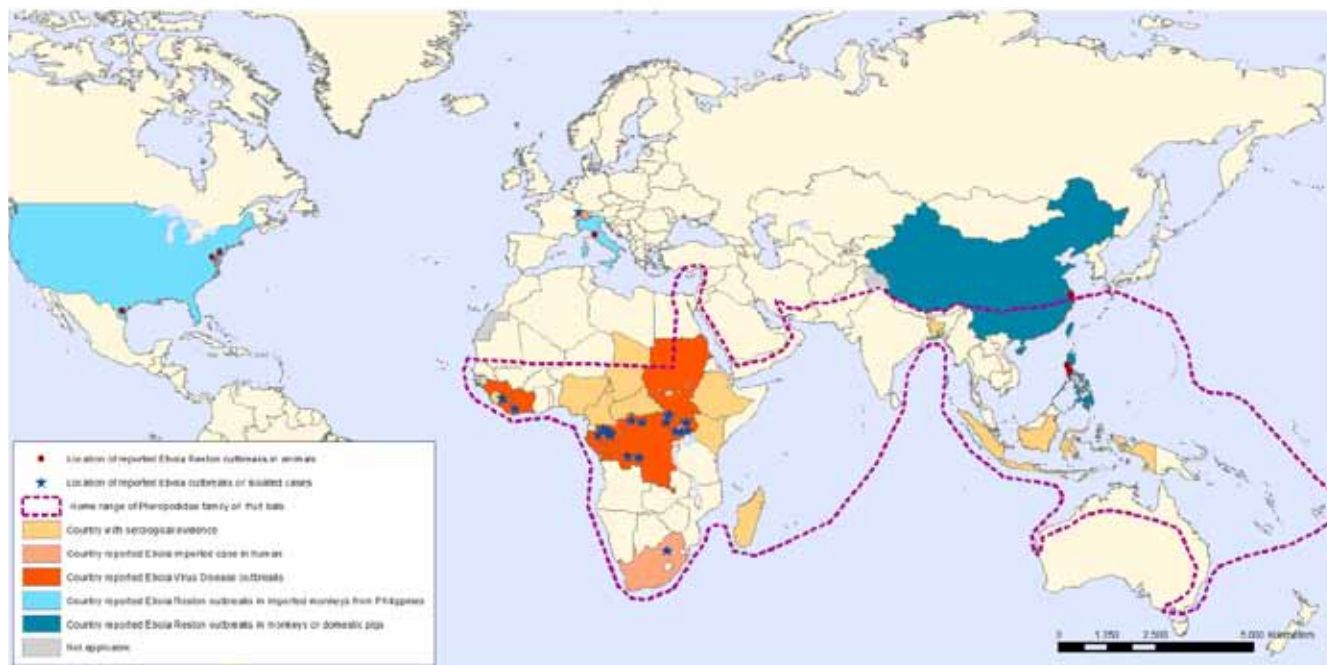
A Doctors Without Borders (Médecins Sans Frontières, MSF) spokesman said the disease is now spreading faster than they can keep up with. MSF is the only international institution that is providing patient care services in Liberia at this point. Samaritan’s Purse, which had previously been there, intends to return. People who have been involved in the efforts of containment report that the atmosphere in the affected areas is dominated by fear, like a war zone—you don’t know where it will strike next.

In reality, it’s impossible to know what the actual toll of the rampaging disease is. The actual death rates are higher than those official counts announced by health officials and caregivers because people living in the countryside or small villages away from towns, are not able to get to a health-care facility, or they avoid the tiny part of the health-care system that still functions, because everybody they have heard about who went, has died. The fatality rate is much higher in these areas because if people do get treatment, it is so late in the infection process, that their chances of surviving are small.

After the Aug. 7 hearing of the U.S. House Foreign

FIGURE 1

Geographic Distribution of Ebola Virus Disease Outbreaks in Humans and Animals



Affairs Subcommittee on Africa, Global Health, Global Human Rights and International Organizations, Chairman Rep. Chris Smith (R-N.J.), said simply, that at this point, delay in dealing with the situation is denial.

The Virus and the Outbreak

Ebola kills 50-90% of its victims. There is no cure, but the earlier an infected person gets treatment, the better are his chances of survival. A majority of the higher death rates occur when people die in place, often infecting family members who care for them, and who then suffer the same fate. Two Liberians who emigrated and live in the United States have reported that their entire families of eight and nine people back in Liberia died from Ebola in this manner. This is just an example of a process that has repeated itself many times.

The virus is transmitted by means of contact with the bodily fluids of an infected person. This is a relatively less effective vector than through droplets in the air, but still very dangerous. Health-care workers, both doctors and nurses, have been especially victimized by Ebola. Sierra Leone disclosed Aug. 15 that 32 nurses died from Ebola while performing their duties between May 24 to Aug. 13. The doctor leading the fight against Ebola there, Sheik Umar Khan, died of the disease, as did another leading Sierra Leone doctor.

The present Ebola epidemic is thought to have started with the death of a boy in Guinea in December 2013, which was not recognized as being caused by Ebola at the time. The number of deaths started increasing in February, and the virus was identified as Ebola in March.

Ebola hemorrhagic fever begins with flu-like symptoms, which can quickly become internal hemorrhaging. The incubation period before symptoms appear is usually 6-12 days, though it can vary from 2-21 days. Before symptoms appear, the virus spreads rapidly in the body, without the victim being aware that he or she is infected. Once a person is symptomatic, he or she is contagious.

The media are twisting the fact that since the virus is transmitted through direct contact with bodily fluids—blood, sweat, urine, etc.—and not through air droplets, this means it is hard to transmit. In reality, it’s only *relatively* hard, as compared with aerosol transmission. If you are in direct contact with bodily fluids, you will almost certainly get the virus.

The disease, which is a level-four pathogenic disease, requires the highest-level containment facilities, which also makes it harder to study.

The microbe—Zaire Ebolavirus—is a single-stranded type of RNA virus, which creates more possi-

bilities of mutation, and therefore makes it more difficult to make a vaccine. There are five strains of the Ebola virus, four of which have caused disease in humans. The Zaire Ebolavirus strain now running rampant in West Africa was discovered in 1976 in the Democratic Republic of Congo (then called Zaire) and Sudan. In the Zaire case, 280 died near a river named Ebola in Zaire.

In the Zaire case, the virus was discovered, and later identified, after an uncontrollably bleeding trader arrived at Yambuku Hospital, run by Belgian nuns, near the Ebola River. In a matter of days, 40% of the nurses had an unknown infection; 150 of the staff ultimately died. One infected nurse went to a hospital in the capital, Kinshasa, where doctors found the disease to be similar to the Marburg virus, which originated in eastern Kenya, which led to its identification as a hemorrhagic fever virus.

Since then, there have also been 20 lesser outbreaks of Ebola virus elsewhere in the DRC and Sudan, as well as Uganda, Congo Republic, Gabon, and Ivory Coast.

Expert Testimony

The two expert witnesses gave an on-the-ground picture of the horror to Congress on Aug. 8: Ken Isaacs, who works with the NGO Samaritan's Purse, which is active in the West Africa crisis zone, and Dr. Frank Glover, Jr., a Johns Hopkins-trained M.D., who also has a doctorate in public health.

Glover, who has been in and out of Africa for 20 years, said that the situation was already out of control, that there would be an untold number of victims, and decisively brought home the reality of the catastrophic potential for a biological holocaust. Isaacs had previously had a long career in USAID's Office for Disaster Assistance and has worked in disasters in many countries. He and Glover reported that death rates from the Ebola outbreak will be at an unimaginable level. Whole families are dying.

Isaacs testified that from 1976, when the disease was discovered, to outbreaks in 2008, there had only been 2,232 infections, in various outbreaks in central Africa, and a little more than 1,500 killed.

The present outbreak, he noted, is in densely populated areas, in the cities of Liberia, Guinea, and Sierra Leone, and has arrived in Lagos, Nigeria, with a population of 25 million. It is spreading rapidly. He said that the infection and death rates of this present outbreak

will quickly surpass the combined total of all previous outbreaks.

Isaacs said, "We believe the reported numbers only show 25-50% of the cases."

He pointed out that the Ministries of Health in Liberia, Guinea, and Sierra Leone do not have the capacity to deal with these crises in their countries. He also said that developing countries could be destabilized by the effects of the epidemic, which could lead to further global complications. If a mechanism is not found for the international community to become directly involved, "then the world will be relegating the containment of this disease that threatens Africa and other countries to three of the poorest nations in the world." Attention only began to be paid to the epidemic, he noted, after the American doctor and nurse of his NGO contracted the disease.

Isaacs emphasized that local doctors and health-care workers didn't realize the deadly character of the disease, and didn't have the equipment to determine who was infected and who was not, so they themselves got infected while treating people they didn't know had Ebola. The infected health workers then inadvertently spread the Ebola virus to patients who were seeking care for other diseases; this then led to the infection and death of those patients, as well as to the caregivers themselves. The virus presents with symptoms that are similar to 50% of the other diseases the caregivers normally come into contact with (fever, joint pain, diarrhea, and vomiting). Isaacs said that more medical labs are urgently needed, and called for a coordinated international response. He characterized the international response thus far as a failure.

Liberian Medical System Has Collapsed

Dr. Glover has spent four months a year in Liberia over the last few years, and presented chilling first-hand evidence. He testified that he had visited most of the health facilities in the country of 4.2 million, noting that they are all under-staffed and under-equipped. Fewer than 200 doctors existed prior to the epidemic. After the outbreak, the number of doctors involved in clinical care went down to 50. This was the result of the exodus of 95% of the expatriate doctors.

After the outbreak, the epidemic began claiming the lives of nurses, who did not have adequate protective gear, not even gloves. As a result, they fled the hospitals. Once a few doctors died of Ebola, all of the gov-

FIGURE 2
Confirmed Cases of Ebola



ernment hospitals essentially closed. Even patients refused to go into the hospitals. Nurses say they will return when they get protective gear, such as gloves, goggles, and gowns.

Glover’s shocking report showed that, in the middle of this enormous medical crisis, there is hardly any medical care available in Liberia. At the only hospital in Monrovia which treats Ebola, and which has five African doctors, there is only space for 25 patients; others are turned away. The emergency room at this hospital has been shut down because there is no protective gear. Yesterday the government began to expand this Ebola treatment center, which is one of only two in the country.

Glover noted that most patients with Ebola are dying in their communities, and when family members care for them, they also get the infection. To make things worse, people are dying of treatable diseases, such as malaria, typhoid, pneumonia, and surgical illnesses, because no facilities are functioning because of health-care workers’ fear of being infected by a person seeking treatment.

Glover said that many people die within 24 hours of presentation of symptoms, and that there is no way to count all the people who are dying. Conditions for spread of disease have been magnified due to the fact that many rural people who have moved to the cities seeking employment live in extremely crowded conditions, and travel in public transport that is packed with

people who may be infected.

He said that the only way to contain any infectious disease is to reach every person that an infected person has come into contact with, a number which may be in the hundreds, but Liberia does not have the capabilities to do this. Thus, victims’ contacts are not being tracked down. He reported that, to work in these conditions, health workers need to have their skin entirely covered, and such equipment is just beginning to trickle in.

Glover also said the death rates are going to be at a level nobody can imagine.

Isaacs reported that burial practices in Liberia have contributed to the spread, because of veneration of the dead. This includes kissing and washing of the deceased, in which family members contact body fluids which transmit the virus.

PTSD: A Further Complication

In addition to the effects of poverty in Liberia and Sierra Leone, the situation has been significantly worsened by 14 years of protracted internal conflict in Liberia, and 11 years in Sierra Leone, wars which made the states ungovernable. As a result, as the witnesses pointed out, for that period, there was no education, which is greatly complicating the efforts to inform the populations about the nature of the disease, and what has to be done to prevent it from spreading. Seventy-five percent of the Liberian population is illiterate as a result of the internal war.

As a result, the two nations are ready-made petri dishes where epidemics can easily develop.

The witnesses also said that a great part of the population of Liberia (and the same holds for Sierra Leone) suffers from Post-Traumatic Stress Disorder (PTSD) because of horrible things they saw, or that happened to them, during that period. In Sierra Leone, for example, a significant number of adults and children had limbs hacked off.

Set Up To Spread

The danger is that the conditions created by the wars in Liberia and Sierra Leone have turned them into incubators from which Ebola can spread elsewhere in West Africa, and beyond. Nigeria, the most heavily populated country in Africa, is setting up a special hospital 200 km north of its largest city, Lagos, in hopes of preventing a serious outbreak there. A traveler from Liberia died of Ebola there, one of his hospital caregivers has subsequently died, and other hospital workers have been infected or are in quarantine.

The UN estimates that by 2015, Lagos, which presently has a population of over 25 million, will be the world's third-largest megacity, after Tokyo and Mumbai. A serious insurgency in northeastern Nigeria would also make it more difficult for Nigeria to deal with the infection, if it gets out of control.

WHO warned that Kenya is also at high risk for the disease, because it is a transport hub. Seventy flights a day arrive there from West Africa. British Airways has suspended flights to Liberia and Sierra Leone, and regional airlines have begun suspending flights from the three main hotspots. Chad has suspended flights from Lagos.

Other continents are not immune. Serbia already has 14 people under observation as potentially having the disease. Southern Europe is also extremely vulnerable, since there is massive migration from Africa, on the order of 75,000 refugees since the beginning of this year. Although most come from countries not yet known to have Ebola, the danger is clear—and concern is spreading.

International Resources Needed

While any real solution requires crash programs to build infrastructure and economies, an immediate mobilization is also needed on the health-care front. Epidemiologist and public-health expert Dr. Michael T. Osterholm is calling for a broad international mobilization



EG/ECHO

Despite the valiant efforts of in-country health providers, educators, Doctors Without Borders (MSF), WHO-organized public-health agencies, and Red Cross and Red Crescent, the geographic spread of the disease and shortage of personnel make it impossible to implement an effective control strategy. Here, health workers prepare to aid Ebola patients, April 2014.

because there are not enough front-line providers of medical care. He says that despite the valiant efforts of country health providers and community educators, Doctors Without Borders, WHO-organized public-health agencies, and the Red Cross and Red Crescent, who are dedicated and heroic, and have helped stop outbreaks in the past, an MSF spokesman told him, the geographic spread of the disease and shortage of personnel will make it impossible to implement an effective control strategy.

Osterholm notes that the three countries that make up the center of the outbreak, have a population of 22 million people in a 165,000-square-mile area. Given that the victim countries do not have the capabilities now, the small number of personnel that the WHO can mobilize is not sufficient.

As he put forward in an opinion piece Aug. 3, Osterholm advocates a two-pronged approach for the immediate period: a mobilization by the United States, Canada, Germany, Britain, France, Italy, and Japan to deploy hundreds of infectious disease experts, in addition to medical and technical assets to map the epidemic. In addition, hundreds more personnel will be

needed to establish treatment centers, as well as to work with local leaders and educators to help people learn how to stop virus transmission.

In addition, there needs to be a strong commitment from the three governments to stop the epidemic. The three leaders—Presidents Ellen Johnson Sirleaf (Liberia), Alpha Condé (Guinea), and Ernest Bai Koroma (Sierra Leone)—have declared states of emergency, but their efforts have to be coordinated with the WHO and the NGOs. This is crucial to stop the fear and panic.

Osterholm warns that if such an all-out mobilization is not made, West Africa could be further politically and economically destabilized. Already some crops are not being harvested, he reports, because of unrest resulting from the outbreak. His assessment is that the situation is at a critical point, and if the international community doesn't respond adequately, there could be a dramatic and dangerous shift in West Africa's future.

The world paradigm-shift represented by the BRICS offers the real promise for Africa as well as for the planet. But problems such as Ebola, which has gotten out of hand because Africa has been prevented from

being able to develop; and the anti-government warfare being conducted by proxy British financial empire-steered militias, are being used to sabotage the BRICS Africa initiative.

LaRouche Warned

In LaRouche's 1974 warning of a potential biological-ecological holocaust, he accused the IMF and other international financial institutions of carrying out an intentional policy of genocide through the imposition of austerity aimed at depopulating the planet.

As of the 1980s, such consequences were already unfolding, as was especially evident in the AIDS pandemic, which devastated the African continent.

In 1983, LaRouche wrote of "the threatened resurgence of epidemics and perhaps even pandemics now that endemic potentials are arising from collapsing economies in both the industrialized and developing nations." *EIR's* 1985 Special Report detailed the scenario of a potential "biological holocaust"; in February 1986, an updated report was published, "An Emergency War Plan To Fight AIDS and Other Pandemics."

In a presentation on Aug. 30, 1997, LaRouche stated: "With the [Rwandan and Ugandan] invasions around the Ebola districts in Africa, we're in danger of an Ebola breakout internationally, as well as other diseases, which turn up from obscure places, and can tend to become pandemic—epidemic and pandemic—for which humanity has no present immune potential; can kill off whole masses of people in very short periods of time, under these kinds of Four Horsemen of the Apocalypse conditions."

To prevent the danger of pandemics, he advocated for Africa in particular, as well as the rest of the world, water, power, and infrastructure so that productive economies could be built, and modern, in-depth public health, and sanitation systems installed, and medical care established. Such developments would prevent the continent from being turned into a breeding ground for and victim of pandemics.

An estimated 1 billion persons today lack safe drinking water, and 2.5 billion—a third of the planet's population—lack water for sanitation. Considered on the crudest basis of volume of water available per capita, ratios in many parts of the world are below that needed for minimal personal use, and far below per-capita requirements that would reflect levels of water usage consistent with modern economic activities of industry, agriculture, power production, and public health.

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—Lyndon LaRouche, Feb. 11, 2013