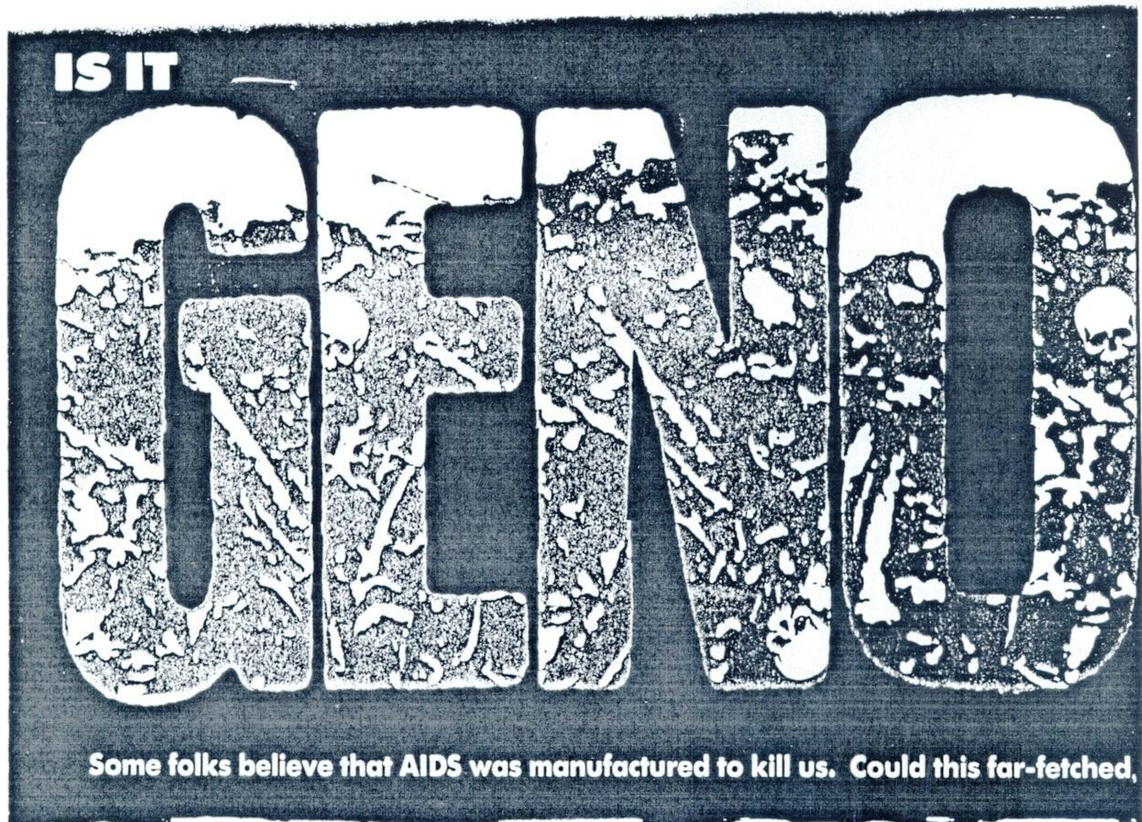
ESSENCE, September 1990



The time: the late 1970's. In a well-guarded laboratory complex in an American suburb, an elite conference of biologists, demographers and political scientists listen closely to the report of an epidemiologist. This physician, who studies the origins and progress of diseases, is telling the group that he has created a virus that will render the human immune system powerless. A simple cold that would leave a healthy person miserable will kill people who have been exposed to this virus. There is no cure. It is always, always fatal. "We can use this virus to eliminate certain populations," he explains. "We thought we'd try homosexuals first—nobody cares what happens to them, anyway, there'll be little outcry. And if the virus proves effective—we can move on to other populations. Like the Black underclass. That'll help cut down on the dollars you have to spend on welfare." The room chortles in agreement. The meeting is adjourned.

A few years later, in San Francisco, New York, Miami and Los Angeles, gay men begin to sicken and die. A few years after that, poor Blacks also succumb to the same puzzling symptoms. The genocide project has begun.

It may sound far-fetched, but a growing number of African-Americans believe in some variation of that scenario—which was, by the way, utterly a product of this writer's imagination. From pulpits, in colleges and on street corners, the idea of an AIDS conspiracy keeps popping up. James Small, Ph.D., a Black-studies instructor at the City College of New York (CCNY), lectures on it regularly, as do Nation of Islam leader Louis Farrakhan and Frances C. Welsing, M.D., a Washington, D.C., psychiatrist. *Tony Brown's Journal* featured a discussion of the genocide conspiracy.

As an increasing number of African-Americans continue to sicken and die and as no cure for AIDS has been found, some of us are beginning to think the unthinkable: *Could AIDS be a virus that was manufactured to erase large numbers of us? Are they trying to kill us with this disease?*

WHAT THE CONSPIRACY THEORISTS BELIEVE

Although scientists know what AIDS is and how it is spread, no one is quite sure where this virulent virus came from. That question mark has encouraged the

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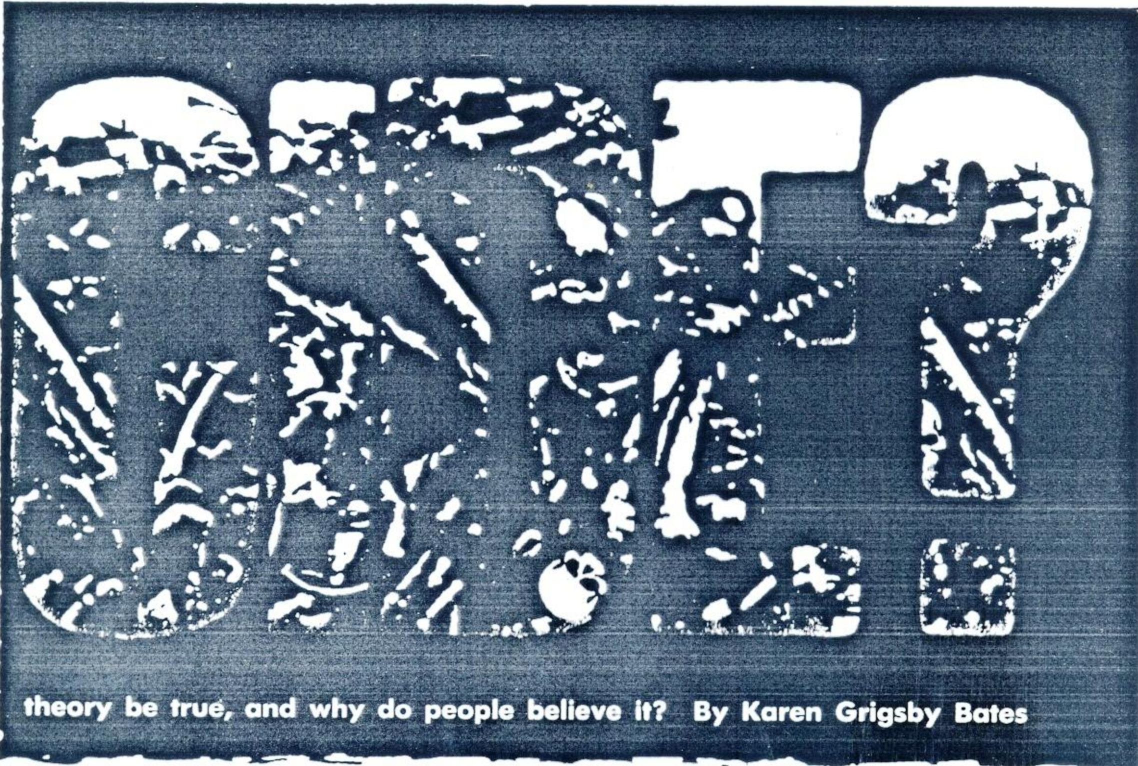


spread of a conspiracy theory.

"It's unclear where or how the AIDS virus originated," says Helene Gayle, M.D., a medical epidemiologist at the Centers for Disease Control in Atlanta. There are, she says, "several speculations as to AIDS origins."

A popular one centers on the African green monkey, which is supposed to have transmitted the virus to residents of Central Africa, who began, according to theory, the worldwide contamination. (This hypothesis has received wide circulation in the scientific community, although many experts, including Gayle, discount it.)

While scientists remain unclear as to the virus's origins, there are some who claim to have a concrete theory about exactly where the virus began: in a laboratory.

Robert Strecker, M.D., Ph.D., a white physician trained in pharmacology and gastroenterology who practices in Los Angeles, puts it bluntly: "AIDS was a disease that was requested, manufactured and deployed and does exactly what it was intended to do." In a nutshell, he believes that sometime around 1972, scientists (with government approval, he insinuates) contaminated cows with the bovine visna virus, which he calls the "mother and father of AIDS." He hypothesizes that the disease spread to humans in Africa when they were injected with the smallpox vaccine, which was produced from viral lesions of the infected cattle. When injected into humans, says Strecker, this new recombined virus was capable of producing a new disease—AIDS.

With a battery of articles and scientific studies in tow (including a May 11, 1987, *London Times* front-page story entitled "Smallpox vaccine triggered Aids [sic] virus"), Strecker has called for a congressional investigation into the origins of AIDS. "It's not a problem seeing where the virus came from," he insists. "It's a question of whether we're going to do anything about it."

He and others believe the virus was created as a tool for biological warfare and repeatedly cite scientific sources to back up their theories. In a videotape distributed by *The New American*, a New York Black newspaper (and produced, ironically enough, by the American Quack Association), Strecker insists that in a 1972 issue of the *Bulletin of the World Health Organization* (Vol. 47, p. 259) scientists requested that a virus that infects the immune system be produced.

Other conspiracy theorists cite a 1969 issue of the *Congressional Record* (July 1, p. 129), in which a physician referred to a government-sponsored research project that would create a "synthetic biological agent . . . *for which no natural immunity could have been acquired.*" (Italics ours.)

In his book *AIDS and the Doctors of Death*, Alan Cantwell, Jr., M.D., a Los Angeles dermatologist, theorizes (with Strecker's help) that the AIDS virus was introduced into the United States via a 1978 program to test the hepatitis B vaccine in more than a thousand gay males. "Newly 'liberated' homosexuals were anxious to cooperate with the government in matters of gay health," writes Cantwell. "Within a decade, most of the men in the experiment would be doomed to die."

Various other conspiracy theories suggest that the Russians created AIDS, that it was manufactured at a U.S. Army biological research center in Fort Detrick, Maryland, or that it is associated with Agent Orange. [CONTINUED ON NEXT PAGE]

IS IT GENOCIDE?

"There is a possibility that the virus was produced to limit the [number] of African people and people of color in the world."
Barbara Justice, M.D.

"It's dangerous to be preoccupied with theories [of an AIDS conspiracy] when we need to work on containing the disease."
Wayne Greaves, M.D.

(Various political groups such as Lyndon LaRouche's racist National Democratic Policy Committee use these theories to support their call for a quarantine of people with AIDS.)

Strecker, Cantwell and others haven't pointed to AIDS as a genocidal plot to rid the planet of Black folks, but some have. "There is a possibility that the virus was produced to limit the number of African people and people of color in the world who are no longer needed," says Barbara J. Justice, M.D., a New York City physician who is researching AIDS. She also believes there is a possibility that the melanin in our skin may make us more susceptible to AIDS. "All of a sudden here comes this raging virus that seems to have a propensity for Black people. If you stand back and look at it and you also look at the history of this country, at the very least you have to be suspicious."

James Small at CCNY agrees. He firmly believes that AIDS was manufactured in a laboratory, with government backing. (He, too, cites the *Congressional Record* to buttress this argument.) He thinks that the thousands of whites who have died so far—mostly gay men—were merely a test batch, the practice run for the real target: us. Frances Welsing asserts that "any army that moves against an enemy people calculates that it will lose some of its own." Gay white men's deaths, then, were merely a planned distraction employing what some view as "an expendable part of the white population." The Reverend Cecil Williams, pastor of Glide Memorial United Methodist Church in San Francisco, is sure that the introduction of crack (and the AIDS that crack-addicted prostitutes often contract) was conceived expressly to prevent the Black community's functioning. "It's happened before," he insists. "Look at the FBI's program [Cointelpro] in the 1960's, when the mandate was to discredit our leadership and to destroy any political opposition in our communities."

Given the realities of racism and the nation's seeming inability to control AIDS or crack, the concept of AIDS as a useful tool in population control doesn't much shock Professor Small. "Our whole *relationship* to [whites] has been that of [their] practicing genocidal conspiratorial behavior on us," says Small, "from the whole slave encounter right up to the Tuskegee study." Small refers to the infamous Tuskegee Syphilis Experiment in Macon County, Alabama, where, from 1932 to 1972, 600 Black males with syphilis were intentionally *not* given treatment so researchers could track the disease's progress. "People make it sound nice, by saying the Tuskegee 'study,' " says Small, "but do you know how many thousands and thousands of our people *died* of syphilis because of that?"

But even Justice admits that conspiracy theories are based largely on conjecture. "Everything we're talking about is a result of deductive reasoning," she says. "What else do we have to go on? We don't have access to the secret archives of WHO [the World Health Organization], the U.S. and the western world-war machines."

THE OPPOSING VIEW

Most experts have short patience with such suppositions. When told of Strecker's theory, Steve Tronick, Ph.D., chief of the gene-structure section of the Laboratory of Cellular and Molecular Biology of the National Cancer Institute, whose work Strecker uses in his presentations, laughed. "He's got a great imagination. Even though the visna virus and HIV [human immunodeficiency virus, which causes AIDS] are genetically related, for the visna virus to have mutated to such a degree that it would've changed into the AIDS virus is virtually impossible given the time frame," explains Tronick. "Anyone who knows anything about virology knows that the theory is absurd."

Phyllis Kanki, D.V.M. and Ph.D., an assistant professor in the department of cancer biology at the Harvard AIDS Institute and a veterinarian who has studied both animal viruses and HIV, had this to say: "There is no evidence whatsoever that I know of for his theories. [A human] most likely could not be infected with the bovine visna virus. Even if somehow you were, there is no evidence that either the bovine leukemia virus or visna causes a disease like AIDS."

What about melanin? Does it make us more susceptible to the virus? "I can't think of any effect melanin would have that would make any difference," she says. "There are no data to support this idea. It sounds crazy."

Wayne Greaves, M.D., chief of infectious diseases at Howard University Hospital, is annoyed by theories of an AIDS conspiracy. "It's dangerous to be preoccupied with these theories when we need to work on containing the disease," he says. "I'm too busy worrying about caring for sick patients and educating people about AIDS to get caught up in this kind of inane rhetoric."

"If we say that AIDS is a conspiracy to kill us off," adds Dr. Alvin F. Poussaint, associate professor of psychiatry at Harvard Medical School, "it relieves us of any responsibility for helping to stop the disease's spread."

Stephen B. Thomas, codirector of the Minority Health Research Laboratory at the University of Maryland in College Park, calls the AIDS conspiracy theory a "disaster myth," an idea developed in an attempt to make sense of something catastrophic that has happened. These myths are useful psychic security blankets—*to a point*—because they allow us to continue functioning after disaster has struck, says Thomas. But he draws the line when myths, like that of genocide conspiracy, impede treatment and educational outreach, such as the advocacy of safe sex through, among other things, the use of condoms.

"There are Black professionals with Ph.D.'s and M.D.'s behind their names who say safe sex [with condoms] equals a lower Black birth rate, which equals Black genocide. This," he snorts, "is ridiculous."

WHY ALL THIS TALK OF GENOCIDE?

Even as the conspiracists continue to explore the origin of the disease and the majority of experts in the field dismiss their claims, a larger question remains: What is going on in our collective psyche that allows conspiracy theories of AIDS or drugs to take hold?

Since slavery, there have always been those who thought that white America has targeted us for extinction, just as soon as we outlive our collective usefulness. Harvard's Poussaint says those suspicions are valid. "We were brought here as slaves, abused, oppressed and segregated," he says. "The feeling is that some white people would just like to see us disappear. If we recognize that we are unwanted, it's easier to take the next step and say 'They're trying to kill us.' "

An increase in racism has also led us to feel suspicious, even paranoid. "Right now it seems to be okay to hate Black folks," explains Courtland Milloy, a *Washington Post* columnist who often writes about D.C.'s Black community. Milloy says the shots fired during the Reagan years left us bleeding, badly. "With violent racism on the rise and unemployment for Black men—especially young Black men—being what it is, some folks wonder why nobody seems to care enough to do anything about it."

And, as Stephen Thomas points out, Tuskegee still haunts us: "There has been historical precedent for experimentation on Blacks."

Thomas adds that when health authorities—especially from the government—attempt to educate the Black community on AIDS origins and transmission, Tuskegee is never very far from anyone's mind. "Although everyone may not know the *specifics* of the Tuskegee experiment, they have enough residual knowledge of it so that they mistrust government-sponsored programs, and this results in a lack of participation in risk-reduction efforts," Thomas says.

CONFRONTING REALITY

However AIDS managed to invade our community, we bear the primary responsibility for halting its spread, and our collective work has been cut out for us. It is imperative that we put aside our personal prejudices about homosexuality and realize that gay and bisexual men must engage in safe sex if they are to halt the disease's spread. In addition, says Thomas, "we must recognize as a community that homosexuality exists and stop being so judgmental about it.

"Because we have traditionally been so uncomfortable with homosexuality, it may take the death of a very famous African-American to shake us up. We don't have the equivalent of a Rock Hudson yet." Thomas refers to the 1950's screen idol whose AIDS death in 1985 galvanized mainstream society to take action against the disease. "Max Robinson was the closest thing and, to his credit, he wanted people to know he'd died of AIDS, so Blacks could become more aware of the disease." (The late news correspondent admitted to being promiscuous and is assumed to have contracted AIDS through sexual intercourse.)

The contempt directed at homosexuals is so great that the obituaries of some of our most famous Black men have listed causes of death such as bone-marrow disease, pneumonia complicated by shigella, and a rare blood disease; all are standard AIDS-related secondary opportunistic infections that even nonphysicians now recognize immediately. Even though it was widely assumed that these luminaries were gay, it was too painful to admit that their deaths were AIDS-related.

We must also own up to the drug problems in our communities—IV drugs and crack—and try to come up with creative ways to control the spread of AIDS in users and their partners. "People who are still denying their addictions," says Eugene Givens, III, Ph.D., a clinical psychologist who directs Boston's addiction-services department located at the city's department of health and hospitals, "are disinclined to believe that what's spreading AIDS is unsafe sexual practices and the careless and thoughtless sharing of needles." Those people would rather point their fingers and cry genocide, Givens says, "because if that were true, then there's no point in modifying their behavior—which they don't want to do."

Better-off Blacks must begin to take some responsibility for AIDS and drugs—which they perceive to be a grass-roots problem. "Because most of the people who are suffering from AIDS are in the so-called underclass, the middle class won't get involved in a political agenda until it's too late," says Thomas.

We must also urge our political organizations to agitate for more funds, not just for AIDS research but also for psychological support systems for people diagnosed as HIV-positive, and medical and economic aid for people with AIDS—especially because statistics indicate that Black AIDS deaths will skyrocket during this decade.

These steps may decrease the numbers of women who are contracting AIDS (via needles or infected partners) and subsequently passing it on to their children. Acting now could save our next generation. And that salvation is the best antidote to a genocidal conspiracy—imagined or real. ◆

Karen Grigsby Bates, of Los Angeles, covers a variety of topics for ESSENCE. *Senior editor Linda Villarosa contributed major reporting to this article.*

THE NEW YORK TIMES, 28 August 1990

The Spread Of AIDS: A Mystery Unravels

Scientists begin to figure out why some heterosexuals are at higher risk.

By ELISABETH ROSENTHAL

RESEARCHERS are finally finding answers to one of the biggest mysteries surrounding the heterosexual spread of AIDS: why some people contract the virus after a single act of intercourse while others have sex with an infected partner for years without using condoms and are not infected.

"There seems to be a wide variation" in the ease with which the virus spreads among heterosexual couples, said Dr. Thomas O'Brien, an epidemiologist at the Federal Centers for Disease Control. "We're starting to have a sense of the factors that are important."

In a series of small studies carried out in Africa, Europe and the United States, the scientists have zeroed in on several conditions that seem to make some people more proficient at spreading the AIDS virus and others more vulnerable to acquiring the disease. The factors include previously unsuspected venereal diseases, variations in the amount of virus that infected people have in semen or vaginal secretions and possibly the use of intrauterine devices.

"There's no clear relationship between the number of episodes of unprotected sex and whether someone gets infected," said Dr. John N. Krieger, a urologist at the University of Washington. "It's not a simple equation. We're trying to figure out what's going on at a biological level."

Transmission of the AIDS virus can occur either from man to woman or from woman to man, but most studies have shown that the virus spreads far more readily from male to female. Although they are still relatively few, female partners of men infected with the human immunodeficiency virus, which causes AIDS, are one of the fastest growing group of patients with the disease in the country.

Although experts consider the virus difficult to spread through vaginal intercourse, some AIDS patients have spread the disease widely. Several months ago The New England Journal of Medicine reported the case of a man in Belgium who transmitted the disease to at least 11 women before he died, despite having had only one known sexual encounter in a few of the cases.

Certain conditions seem to increase the likelihood of transmission. For several years, doctors

have known that venereal diseases that cause genital ulcers, like syphilis or herpes, increase the risk, presumably by increasing the likelihood that AIDS virus in the blood, semen or vaginal secretions will gain access to the partner's bloodstream. And, as among homosexual men, transmission of the virus among heterosexual couples by anal intercourse seems to be particularly frequent.

But a plethora of small studies have implicated numerous other factors as promoting the spread of the AIDS virus by heterosexual intercourse, including these:

¶Lack of circumcision puts men at higher risk of contracting AIDS, at least in part because uncircumcised men have more genital ulcers than their circumcised counterparts. In Africa, the number of AIDS cases is generally lower in regions where men are routinely circumcised.

¶A handful of sexually transmitted diseases that do not cause genital ulcers, including gonorrhea, chlamydia, trichomonas and human papilloma virus. These cause an inflammation of the genital region, which may facilitate the transfer of the virus during sex.

¶A benign condition of the cervix, called ectopy, in which unusually delicate tissue covers part of the vagina. Cervical ectopy is common in women in their teens and 20's but tends to disappear as women age.

¶Use of an intrauterine device for contraception. In an Italian study, women who used IUD's were three to four times more likely to contract AIDS from an infected partner than women who used no contraception.

¶Intercourse during menses. This practice increases the risk of transmission from women to men.

Apart from these conditions, important new research by Dr. Krieger and others suggests that the amount of virus infected patients can transmit varies from person to person and from time to time. Studies of semen specimens from men with AIDS have shown that 10 to 30 percent contain the virus. Many experts say that people who carry the virus go through cycles of infectiousness, which peak both early and late in the course of the disease.

'The Findings Are Plausible'

All the new studies involved relatively small numbers of people, and many were conducted in Africa, where heterosexual transmission is common. Experts caution that more work is needed to define the force of these risks in the United States. "These are not easy studies to do," said Dr. O'Brien. "The findings are plausible but we need more data."

Most studies examined couples in which only one member was infected and sought to determine the characteristics of the partners who later acquired the disease. Surprisingly few couples used condoms.

Experts emphasize that the now-convincing links between venereal disease and AIDS lend a new urgency to treating sexually transmitted diseases aggressively. Public health experts say programs to control infections like gonorrhea and syphilis have been eclipsed by the focus on AIDS in recent years, and these diseases are on the rise.

Heterosexual transmission of the AIDS virus, the primary route of spread in Africa, is increasing rapidly in the United States, particularly among women whose partners are intravenous drug users. In a 12-month period ending in June, about 6 percent of the 39,000 new AIDS cases reported were attributed to heterosexual contact, with about two-thirds of the cases among women.

Dr. Nancy Padian at the University of California at San Francisco studied couples in which only one member was infected and found that the spread from man to woman was over 10 times more frequent than the spread from woman to man. A Brazilian study of 11 couples in which the wife carried the AIDS virus found not a single man infected after an average of four years of unprotected sex.

Studies emphasize the need to treat venereal disease.

Many scientists cautioned that the perception that men are far better at giving than receiving the virus may be, in part, an illusion. They said that the original high risk groups in the United States were entirely or predominantly male, including gay and bisexual men, hemophiliacs, intravenous drugs users, so the first wave of spread into the heterosexual population would have had to involve men infecting women. In Africa, female prostitutes have proved quite able to transmit the disease.

Scientists are not sure exactly how each suspect factor increases the probability of a person's spreading AIDS, but most probably act to erode barriers of membranes and skin during vaginal intercourse.

The sexually transmitted diseases, as well as ectopy, make the vaginal and cervical tissue more fragile and increase the risk that sexual intercourse will produce tiny cuts and bleeding. These cuts could serve as a way of entry, or exit, for the virus.

The IUD, which sits in the uterus, has a string that dangles through the cervix into the vagina. This string, Dr. Minkoff said, could cause abrasions to the cervix and even traumatize the penis during intercourse, again promoting viral spread. In addition, experts say, the IUD as well as the string are irritants that increase the number of white cells in the uterus and vagina; these are the cells that the AIDS virus infects.

Perhaps the most intriguing work has been on cervical ectopy, done by Dr. Gregory Moss, senior fellow in the Department of Infectious Diseases at the University of Washington. Dr. Moss studied 90 couples in Nairobi, Kenya, in which at least one member carried the AIDS virus. He found that if women had ectopy, they were more likely to have contracted the virus.

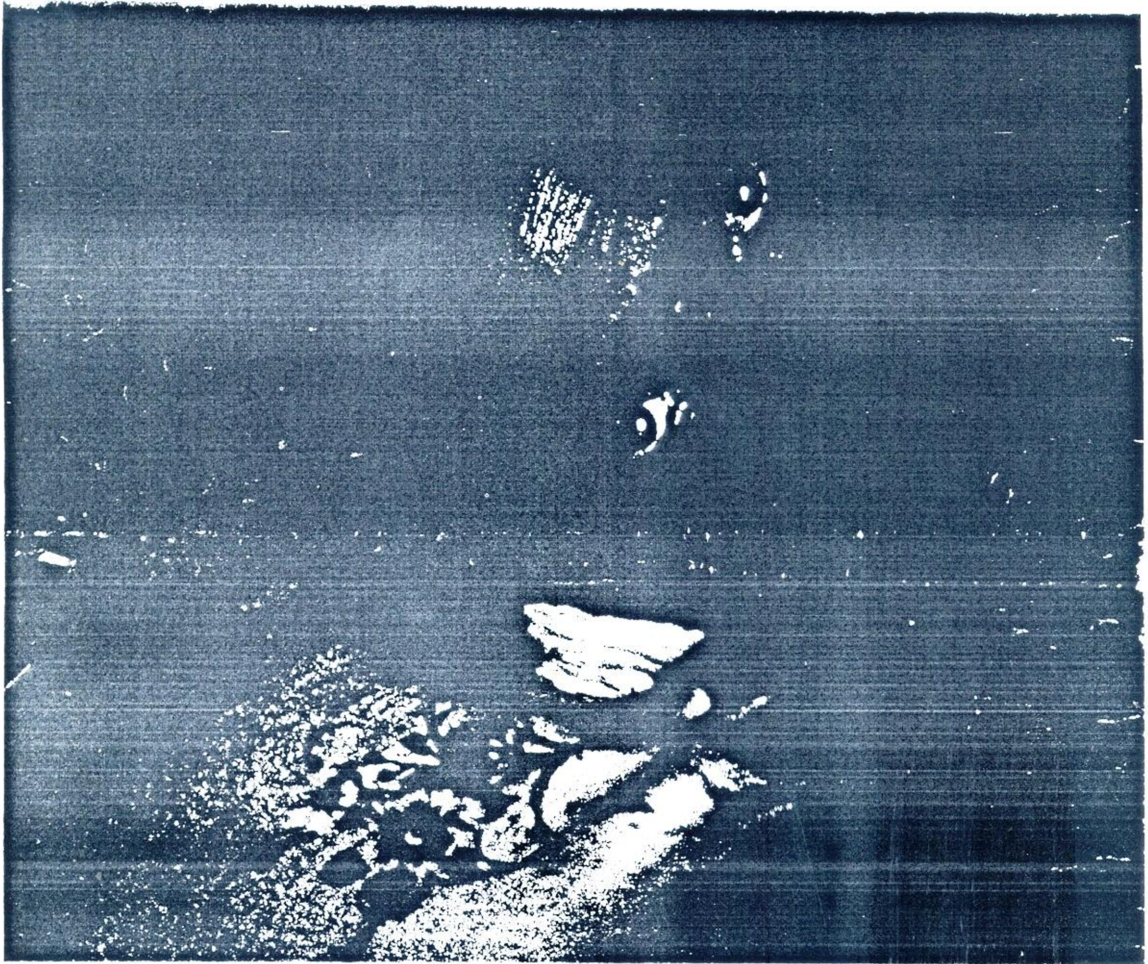
Dr. Moss said a woman with cervical ectopy has only a fragile one-cell-thick outer shell covering her cervix and that this contains a high number of blood vessels, making it predisposed to bleeding. The normal cervix is covered with a tougher skin-like tissue. Some groups of women are known to have a high incidence of ectopy, including pregnant women and women on birth-control pills.

In addition, about 80 percent of teen-agers have the condition, Dr. Moss said, adding that the number decreases steadily with age and is nearly absent by menopause.

The notion that ectopy might promote the spread of AIDS may help explain the distribution of the AIDS in the United States. While over 90 percent of patients over 30 years old infected with the AIDS virus are male, that percentage decreases in younger groups, and among teenagers nearly equal numbers of men and women are afflicted.

Although scientists are striving to understand the factors that make certain people more capable of giving or receiving the AIDS virus, they stress that their conclusions should not leave patients with a false sense of security. Even people not subject to any of the known or suspected risks can still contract AIDS, and all the new studies reinforced the finding that the best way to avoid the disease was still to use condoms.

THE NEW YORK TIMES MAGAZINE, 12 August 1990



PHOTOGRAPHS BY JOANNA PINNEO/FOREIGN MISSION BOARD/SBC

SCENES FROM A NIGHTMARE

In Uganda, where AIDS has devastated a society, young African doctors battle the scourge with little more than dedication.

BY KATHLEEN HUNT

KAMPALA'S MULAGO HOSPITAL STIRS IN the early morning like a great lumbering monster, sloshing and swishing as cleaning women hurl buckets of water onto the floor and rhythmically scrub away the memories of the previous night. On the dusty road outside, streams of people hobble up to the ponderous six-story complex. Inside, barefoot young children scurry through the dark, slippery corridors, carrying blankets and plastic basins to their ailing elders. On October mornings, chilled by the thunderous nocturnal rains, stiletto winds rush through the shattered windows.

Once a week, dozens of young men and women huddle in the hallway outside the stark room where a 37-year-old doctor named Elly Katabira runs Mulago's AIDS clinic. Katabira refers many of them to the teeming 300-bed adult medical ward, where 40 to 70 percent of the patients have infections and cancers related to AIDS, ranging from tuberculosis and severe diarrhea to herpes zoster and Kaposi's sarcoma.

With the explosion of the AIDS epidemic in central and eastern Africa, dilapidated Government hospitals like Mulago are increasingly swamped with young men and women with illnesses related to the AIDS virus, HIV. According to a national survey released last December, at least 10,000 Ugandans have developed AIDS — mainly through heterosexual contact — and nearly 800,000 of its roughly 17 million citizens are believed to be infected with the virus.

Katabira, like many of the young physicians working at Mulago, studied medicine at Uganda's Makerere University, once the flagship of sub-Saharan Africa, and went on to learn advanced clinical procedures in Britain. Like many of his colleagues, he turned down the opportunity for a comfortable career abroad to put his skills to use back home. Now, defying chronic shortages of sterile needles, rubber gloves, HIV test kits and even the most basic medicines, he is in the vanguard of a new generation of African physicians, battling the AIDS epidemic from the trenches.

LONG-LEGGED AND SLIGHTLY STOOPED, Elly Katabira dashes from the clinic to the wards like a spider on the run. His clipped, reedy voice rises above the din of the crowds in the corridors. His clothes are neat but threadbare, and his manner is as unvarnished as his modest beginnings. The son of a hospital medical assistant, Katabira was the first in his family to become a physician. "I felt I wanted to do better than my father," he recalls, "so I decided to become a doctor."

As dozens of patients slouch on benches in the hall outside the clinic, Katabira listens intently to a fresh-faced young woman and her mother, both wearing the traditional long Buganda dress with puffy butterfly sleeves. His thick, steel-framed glasses slip down his narrow nose as he leans over to examine the Kaposi's sarcoma lesions on the young woman's arm, almost certainly a sign of HIV infection. As he gently explains in Luganda, the local language, that he is going to do a blood test for the AIDS virus, the young woman silently wipes a tear from her eye.

The women leave to speak with the volunteer counselors in the hall, and Katabira sighs. "Here is a typical case of the serious social consequences we face," he says. "Three months ago, the girl's husband died from HIV, and she's also lost one child to it. She now has Kaposi's sarcoma herself, and has five more kids. Her mother is caring for those kids, along with a grandchild from a son who recently died from HIV." Inserting her record into the bulging file of the patients he has seen in the AIDS clinic (in two and a half years, they total 2,200), he mourns, "The social impact; it's terrible."

In the dilapidated hospitals, shortages of basics like rubber gloves and antibiotics are chronic. At left, one of Uganda's 10,000 AIDS victims. Above, Dr. Elly Katabira at his clinic.

Uganda's orphans — a rapidly growing population — are the latest victims in the chain of crippling effects the AIDS epidemic is having on the nation's society and economy. Ugandan health officials report that in the southwestern district of Rakai, which has suffered the worst ravages of the disease, 14 percent of the children — possibly as many as 23,000 — have lost a parent to AIDS. Neither the traditional extended families nor the financially strapped Government can afford to support and school the orphans.

Unlike in the United States and Europe, AIDS in Africa is mainly spread heterosexually. Scientists point to a multitude of "risk factors" that may account for the alarming rate of transmission —

Kathleen Hunt is a Paris-based journalist who recently spent two years in Africa.

JOANNA PINNEO/FOREIGN MISSION BOARD/SBC

In Uganda's Rakai district, one of the areas hardest hit by AIDS, 14 percent of the children have lost a parent to the disease. Here, a Rakai farmer who died of AIDS is buried a month after one of his sons, also a victim.

tabulating it all by hand." Katabira jumped at Berkley's offer to lend him his laptop computer.

"He was like a born-again data analyzer," Berkley muses, recalling the endless evenings and weekends Katabira spent hovering over the keyboard, typing with two spindly fingers, recording his cases.

WHEN KATABIRA HAS A heavy turnout in the clinic, the entrance to the inpatient ward looks like the Gates of Hell. The hallway is knee-deep in people languishing on foam mattresses and straw mats, all gazing up with imploring eyes. It is hard to tell the patients from their relatives, who — surrounded by bedrolls and burlap sacks of food and toiletries — camp alongside them to give the basic nursing care that the overwhelmed staff cannot provide.

One of the senior residents in charge when I visited the ward last fall was 32-year-old Dr. David Serwadda. His deep, resonant voice was showing signs of strain. "The number of patients is so overwhelming," he said, "and we can't even get simple antibiotics, antidiarrheal, antifungal drugs to treat their opportunistic infections and prolong their life."

including the widespread presence of other sexually transmitted diseases and the fact that in the central African nations many men are uncircumcised. Increasingly, the disease is also being spread by infected pregnant women to their newborns. Thirty to 50 percent of the infants delivered by these women are born with the virus.

In Uganda, no district has remained untouched. But the affliction is heaviest in the capital, where about one in five adults has the virus, and in the southwestern districts along Lake Victoria, including Rakai, where in some of the trading centers as many as half of the women between 20 and 29 years of age are infected. Eventually, if they can cobble together the bus fare, many of them end up at Mulago's clinic.

KATABIRA LEFT MAKERERE MEDICAL school in 1975, in the twilight of its glory. In 1978 he began working at Central Middlesex Hospital in London, specializing in cardiology, and continued at British hospitals for six years. From a distance, he followed the news of Idi Amin's final years of terror, and the further waves of war and plunder that engulfed Uganda under the regime of Milton Obote.

Despite the upheaval in Uganda, Katabira says that when he became eligible for promotion to full attending physician in 1984, he was feeling the urge to go home. "Mainly," he recalls, "I didn't want my children to grow up where life was so easy. I wanted them to experience what I did as a child. You couldn't do that in England. I guess it's really a matter of what you value. Do you just want to enjoy the good life? To me, my family mattered the most, and to be with my people."

But in July 1985, just before the family was to leave England, a military coup toppled the embattled Obote Government. Katabira's friends told him he was crazy to go back in the middle of a civil war. His wife, he says, was "really scared."

"But I'd already put in my resignation," he says with a shrug, "and as of July 31 I was going to be without a job. We had already packed. We had to go." They arrived on the first commercial flight into Uganda following the coup. Four days later, Katabira reported for work at Mulago.

He found the hospital in shambles, the result of years of neglect and the civil war. He says he had to adjust his British-formed work habits to survive. He also had to contend with a new epidemic: a fatal wasting disease Ugandans were calling "slim." Scores of men and women had fallen ill since the first known concentration of AIDS in Uganda was reported in 1982 among smugglers in the fishing villages along Lake Victoria's southwestern shore. Many victims were ostracized, believed to be bewitched or sexually immoral.

Katabira argued with his colleagues that the patients needed a clinic where they could be treated and counseled without discrimination. Eventually, on his own, he located a vacant room in the outpatient wing, where, with a table and a couple of chairs for furnishings, he and two others set up the Immunosuppressive Syndrome Clinic. After the others dropped out, he kept the clinic running by himself for several months.

Dr. Seth Berkley, a medical epidemiologist from the Atlanta-based Carter Presidential Center's Task Force for Child Survival, worked regularly with Katabira during a two-year assignment with the Ugandan Ministry of Health. "First there were no drugs in Mulago, so Elly scraped together donations from private aid organizations, carrying them around in plastic bags like a shopping-bag man," Berkley recalls. "Then there were no protocols for treating AIDS in Africa, so he put together a textbook, which is now used all over the country."

Katabira's commitment to patient care is rivaled only by his enthusiasm for research, despite the fact that promotions in Uganda's medical establishment are based solely on seniority and not scientific publications. "He was so determined to understand this new epidemic unfolding in front of him," Berkley says. "I found him coding detailed clinical information on every one of his cases, and

Serwadda's frustration on the wards was deepening as the epidemic continued to grind through the remote villages of southwestern Uganda. One of the principal investigators of a health-education study in the hard-hit district of Rakai, he was beginning to consider community-based public health programs and prevention as the only hope for stemming the spread of the deadly disease.

As Serwadda stooped over a 40-year-old man with HIV symptoms — fever, cough and oral thrush — two men arrived to transfer a patient with raging AIDS-related diarrhea, whose corner bed stood in a fulvous pool. Arms stiffened and faces rigid with terror, they hoisted the mattress like a sagging stretcher. The sick man slid down into the soiled center as they staggered out the door.

Like a surrealistic backdrop, this scene went on noiselessly behind Serwadda, who was listening with his stethoscope as his patient stared blankly, sucking short breaths through his mouth. Holding a chest X-ray up to the window, Serwadda instructed his junior resident to run tests for tuberculosis, and prescribed an antifungal for the thrush.

"I'm afraid of going home with cholera, meningococci or other bacteria on my hands," Serwadda confessed at the end of his morning rounds, heading for the sink in the tiny on-call room. A stinging, sour smell came from a sputtering autoclave, ostensibly boiling used needles, metal clamps and the scant pairs of rubber gloves the nurses shared.

Serwadda heaved a sigh. "I've told the medical superintendent about the health risk to the hospital staff. But if the doctors agitated for even the most minimal things — like gloves, or masks to protect your face from blood splattering, even soap — the ministry couldn't afford it."

Uganda's economic crisis has crushed expectations of importing adequate medical supplies, let alone antiviral drugs like AZT. For the cost of treating one patient with AZT for a year ($7,000 in the United States), more than 2,000 HIV-related chest infections could be treated with basic antibiotics in Uganda — but

even these are not always available. The Government, though dedicated to fighting the AIDS epidemic openly and aggressively, cannot afford to stock Mulago with imports like codeine, or even Lomotil for the relentless diarrhea that eventually dehydrates HIV patients.

The availability of the most common antibiotics rises and falls monthly, depending on foreign-exchange reserves and import delays. An AIDS-related abscess might first be treated with ampicillin, then tetracycline when the ampicillin runs out. When medicines are completely exhausted, the doctor writes a prescription and hopes the patient's family can find the money to have it filled at a private pharmacy in Kampala, where entrepreneurs import and sell drugs at a premium. Finally, if a family has no resources to go beyond the hospital, patients have to settle for aspirin and the clinic's homemade rehydration solutions of water, salt and sugar. With luck, the hospital will have calamine lotion to soothe their herpes blisters.

Uganda's economic crisis has also had a paralyzing impact on the staff's productivity, because everyone is out trying to make ends meet. Katabira — a university lecturer in medicine and neurology, whose duties include ward rounds at other clinics as well as at his own, AIDS counseling, home visits and service on the National AIDS Prevention Committee — earns a Government salary of $7.50 a week. This is enough to buy half a loaf of bread, one glass of milk, half a stalk of green bananas and a half-gallon of gasoline. His wife, working as a nurse in a private clinic, brings home an additional $5 weekly. Their children's education, which the Government cannot afford to provide free, costs them $338 a year.

Such calculations defy reason, but this has been the reality for Ugandans since the economy began its downward spiral in the mid-1970's. From dawn to dusk, life is a never-ending choreography of odd jobs and side businesses. Elly Katabira raises chickens.

"I have around 300 right now, but only 80 are laying," he told me in his light-bulb-heated chicken shed one day, as a mob of chicks cheeped madly around our feet. "We get about two trays — 60 eggs — a day, and when I have a big enough catch, I take them to a dealer in town." Crinkling his nose at the ammonia fumes wafting up from the litter shavings, he turned to me and nodded. "This is really how I survive!"

WITH THEIR FAR-FLUNG side jobs, hospital schedules, research projects and obligations to extended families, Uganda's dozen or so AIDS specialists barely have time to catch up with one another, much less develop the sort of team approach used in many American hospitals. Likewise, they are basically on their own in coping with the stress, which can build to a crescendo on days when the ward seems to be pulsating with new "syndrome" patients. On one such day, Serwadda ran into a medical school classmate named Dorothy, who asked him to look at the 22-year-old daughter of a friend of hers. A thick, charcoal-like crust covered the inner side of the young woman's right thigh.

"Touch it," Dorothy whispered. "It's so hard." Serwadda's fingertips made a knocking sound on the leg. "Have you ever seen Kaposi's sarcoma like that?" she asked. Gently tilting the woman's head, he shone his penlight on her palate.

As he straightened up, he took Dorothy's arm. "We should step over here and talk for a bit," he said softly, leading her away.

"Is the girl married?" Serwadda asked.

"No," Dorothy answered, "but she has a fiancé, and they were to be married soon." She paused, then added that earlier, when the woman had a major outbreak of herpes zoster — which in Uganda is a near-perfect indicator of HIV infection — her boyfriend had apparently tried to comfort her by telling her it was just like blisters he had gotten, which eventually went away. Dorothy gazed at Serwadda. "Now he seems to have abandoned her."

They agreed that they should call in a specialist from the Cancer Institute, and Dorothy spoke with the young woman's mother. But Serwadda was shaken. He strode out of the ward, back down the corridors toward the residents' office. Suddenly he blurted, "I've got to get out of clinical medicine. It's too depressing." He turned to me angrily. "I told you before, if I'm ever going to make any difference, I have to go into public health — not just sit here waiting for people like that woman. What can you do?" he demanded, glaring back at the ward. "You try to be truthful, tell her she has 'immunosuppression,' and there really isn't very much we can do for her."

Serwadda's voice thickened. "Ninety percent of the patients I treated last year in the department of medicine were terminal. And young: 20, 22, 26 years old. It's so depressing. So depressing."

Reaching the office, he flopped down onto a hard wooden chair. We talked about the particularly pernicious nature of the AIDS epidemic, which is cutting down Uganda's young, working adults just as they are emerging from a long, dark passage of economic and social breakdown.

"In our system, you could-

n't have gotten a more devastating disease," he began. "It kills your father. It kills your mother. And your sister. It leaves you a nonstarter, and yet," he broke off, arching his eyebrows, "you've already started in life. And in the absence of any welfare system, you've had it." His voice trailed off as he turned away. "You have had it."

We had lost track of the time, and the moon now cast a soft light through the window onto his face. "If I had a hundred million shillings and were chief of medical services for Uganda, I'd invest a big part of that in community-based programs, training local health educators," he declared. "Because even when we immunize, and reduce infant mortality, the death rate among infants of HIV-positive mothers is now negating the effects of immunization. Unless we put a lot into primary health education on AIDS, there's no way to win against it."

This summer Serwadda did what he said he would: He began a master's program in the United States, planning to return to Uganda armed with new skills in public health.

Meanwhile, worlds away in the equatorial haze of Kampala, Katabira will continue to rumble over the dusty dirt roads, visiting patients languishing in their mud huts. For a short period this summer, he too is out of the country — a World AIDS Foundation International Scholar at San Francisco General Hospital, studying different approaches to clinical trials in AIDS research — but he will be back home next month. In addition to his clinics and teaching, he'll continue to work with TASO (The AIDS Support Organization), the nationwide volunteer network that he and Noerine Kaleeba, an indomitable young physical therapist who lost her husband to AIDS, founded in 1987.

Such spontaneous efforts to confront the deadly epidemic exemplify the resourcefulness Ugandans have repeatedly summoned forth over the years. "The AIDS epidemic is not the only challenge we've had in this country," insists the national AIDS Control Program director, Dr. Samuel Okware. "We've had sleeping sickness, which swept thousands of people, and several plagues. And we've had ups and downs in the security situation for the last 20 years. This is another such problem which I think we'll be able to handle."

But for the foreseeable future, Uganda's doctors face formidable obstacles. Katabira's textbook on AIDS care opens with a practical, if prophetic, word of advice: "Good care can be achieved with almost no diagnostic tests and few therapeutic modalities. Do not be discouraged by what is not available. Use what you have." ■

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Jane Perlez/The New York Times

In Mutikula South, Uganda, Josephine Senyonga cares for her 12 grandchildren orphaned by AIDS.

In AIDS-Stricken Uganda Area, The Orphans Struggle to Survive

By JANE PERLEZ

Special to The New York Times

MUTIKULA SOUTH, Uganda — Josephine Senyonga, a diminutive woman with decades of hard farm labor etched into her face, sat on the floor of her one-room house, surrounded by 12 grandchildren.

What in normal circumstances should have been a tableau of warmth was one of tragedy, repeated in thousands of houses and huts in a 30-mile swath from this village in Rakai County to Lake Victoria.

Mrs. Senyonga's three sons and three daughters-in-law died of AIDS last year and left her, a struggling 69-year-old widow, to care for their children.

A Disease Crueler Than War

In a grove of banana trees in her backyard, heaps of red pebbles, dappled with sunlight, mark the graves.

In another village closer to the lake, 70-year-old Salongo Mawawu looks after his 12 orphaned grandchildren. Six graves, five of them freshly dug, are at the side of his house, reminders to his grandchildren that their parents — teachers and traders — had died of AIDS. His last daughter, who is also a mother, is expected to die soon.

The AIDS epidemic here is perhaps more haunting, more depressing than Africa's hard-case wars and famines. In war, the women and children are often spared. In famine, only segments of the population, the very young and the elderly, seem vulnerable.

In Rakai, a county of about 300,000, AIDS kills the breadwinners and leaves behind the most helpless: children.

From all the thousands of AIDS deaths of mothers and fathers, up to 40,000 children in the county have been are orphaned by a disease they understand to mean continual and uncurable sickness, uninterrupted mourning, daily funerals and impoverishment.

In many villages of Rakai, rows of houses stand silent, shuttered and abandoned, the parents dead and the children taken to usually less prosperous and aging grandparents.

"We are losing everyone," Mr.

Continued ...

Jane Perlez/The New Yor

Kasensero, a trading post on the shore of Lake Victoria where the first AIDS cases in Uganda were reported during the civil war in 1982.

Mawawu said., after showing a visitor the graves in his garden.

Doctors here say that the transmission rate of AIDS from infected mother to baby — during pregnancy or while giving birth — is 30 to 50 percent, about the same as in the United States.

But since they have no measure of when mothers died or how old their children were when they died they cannot estimate, they say, how many of the surviving children in Rakai are infected with the virus.

The people of Rakai have always thought that AIDS, commonly known as "Slims Disease," was different from malaria. For a long time they believed that AIDS afflicted those who stole or were "bewitched" by relatives.

Now They Know the Cause

Many now say they know it is caused by heterosexual transmission but seem unprepared to accept it. Elizabeth Nakabago, whose 52-year-old husband died of AIDS last year, appeared very thin. She felt well, she insisted. But a visitor from Kampala, the capital, said he had watched her deteriorate.

Scientists are studying why heterosexual transmission of the virus is such an important factor in Africa but have not yet reached any conclusions.

AIDS testing is virtually impossible for men and women deep in the villages. And as one man argued: "Why should we have tests if you have no medicines to cure us."

A member of Parliament from Rakai, Manuel Pinto, who organized a house-to-house survey recently, says there are about 40,000 children in Rakai who have lost one or both parents through AIDS.

An American statistician with the United Nations Children's Fund, Susan Hunter, reports 25,000 such children as of last fall but cautions that her figure was conservative even at the time.

In Uganda, an orphan is defined as a child who has lost one or both parents. In families where one parent has died, the grandparents commonly take charge of the children, particularly when the remaining parent moves away to try to remarry.

It is the question of how to lift the morale of these orphans in a country bereft of social services that Mr. Pinto and others are trying to grapple with.

The Background

War's Ravages And Now Disease's

The Rakai district, an area of greenery and red soil, ravaged in the 1970's and early 1980's during the civil war, was the first place in Uganda to report cases of AIDS. Once a flourishing region of the Baganda Kingdom, railroads used to run to the lake shore. Crumbled milestones poking out of papyrus reeds attest to a road, now a potholed track barely suitable for bicycles, that once was alive with buses.

The area was neglected after independence from Britain. But during the 20-year civil war, the traders of Rakai prospered, buying soap, tires and beer from across the water in Tanzania and selling them to the capital, Kampala.

It was those who profited and led a high life who became the AIDS carriers and casualties, says Juvenalis W. Kibira, the deputy chairman of the orphans' organization of Rakai, which was founded last year by Mr. Pinto.

AIDS Spread From Area

After the first AIDS cases were reported in 1982 around Kasensero — the first known concentration of AIDS in Africa — the disease moved through Rakai county and then spread north to the entire country.

In Uganda as a whole, the figures are dramatic. Last December, the Minister of Health, Zak Kaheru, reported that 790,522 Ugandans had tested positive for the HIV virus and of these, at least 10,000 had developed the disease. The figures compiled for 1988 showed that, discounting children, about 1 in 8 Ugandans was infected.

In Kampala, the Health Ministry reported that 1 in 4 was infected. And in Rakai, new figures from a survey by the Centers for Disease Control in Atlanta show that half the women at the trading posts are HIV positive.

The infection rate compares to a rate of 1 in 200 in the United States and 1 in 500 to a thousand in Britain, said Martin Foreman, director of the AIDS unit of the Panos Institute, a London-based group specializing in development issues.

The New York Times

In Rakai, AIDS kills breadwinners and leaves many orphans.

Rakai remains the region in Uganda most affected by AIDS, with the death toll steadily rising after 1986. While the total number of deaths apparently leveled off last year, deaths among women are inexplicably increasing, according to Miss Hunter's figures. There are no precise figures on the total number of AIDS deaths.

The Despair

Parentless Children Survive on Own

The despair in Rakai is evident in the almost universally sullen expressions of children almost uniformly dressed in ragged clothing. In some cases there are no guardians and they must fend for themselves. In one case, Mr. Pinto's group found five sisters and brothers cared for by the eldest, a 17-year-old. They cooked in an old paint can.

Even in Rakai households where one parent has survived, there is no escape from the disease. In Kimote, a village along the road that rises from Lake Victoria, the chief, Leo Muddu, died of AIDS just before Easter.

On a recent Saturday afternoon, a visitor found one of the chief's sons, Munyumya, a vigorous boy of 14, at home. A 26-year-old sister died of AIDS two years ago. His mother and four brothers were away at an AIDS burial.

In a side room of the house lay his dying 26-year-old brother. When a European face appeared in the doorway, the young man, Tofa, pleaded in a scratchy voice for medicine. His left leg had a large sore, he was suffering from diarrhea and he had been unable to walk for a month. "We are all dying. We are all dying," he whispered.

"I bring him water and juice," explained Munyumya.

Widow Cares for 9 Children

Up the track, Elizabeth Nakabago, a 49-year-old widow, was walking home from the burial rites of a girl of 17 who had died in childbirth, probably of complications arising from AIDS.Mrs. Nakabago's 52-year-old husband, partowner of a bus in Kampala, came home to die last year, leaving her seven children aged 5 to 17. She also cares for two grandchildren left her by three of four grown sons and daughters who died of AIDS.

As in many homes, the inside of Mrs. Nakabago's one room showed remnants of a better past. A faded photograph of a fancy wedding, probably in the 1940's, hung on one wall. But now Mrs. Nakabago can only afford the $3 yearly school fees for two of the seven children. The rest stay home.

Medical Help

Basic Dispensary Almost Inaccessible

Rakai County's medical services consist of a derelict dispensary and an overworked medical center on the most northern edge and thus inaccessible to most. The only two doctors in the county are posted there.

During an inspection of the dispensary one night, Mr. Pinto found the place in darkness because there were not even candles. Patients, women with young babies, sat on the veranda and three unattended babies slept inside. The senior officer, known as a medical assistant, who is trained in hygiene and no more, had left for home three days earlier.

The dispensary is supposed to receive four cartons of essential drugs a month from a Danish medical program but receives two — the contents of which are usually sold for profit by the staff, Mr. Pinto said.

AIDS has hit Rakai and the rest of Uganda at a time when the Government of President Yoweri Museveni, trying to recover from 20 years of war, is strapped for cash. About 50 percent of the national budget is spent to fight rebels in the north. Most of the meager revenues that come from coffee are spent on repaying debts.

A tight economic reform program from the World Bank allows no room for social services: $1 a year per person is a generous estimate of the amount spent on medical services, some economists say.

Inadequate medical services and traditional inclinations not to trust them anyway, makes many AIDS sufferers in Rakai seek other means of treatment. Last year, thousands of AIDS patients flocked to a woman in neighboring Masaka County after she asserted that soil from a certain place, drunk with water, would cure AIDS. The government put an end to her practices but not before vast quantities of soil had been consumed.

More enduring is Brother Anatoli Wasswa, a Roman Catholic priest of Kyotera in Rakai who dispenses herbal medicine — bark, roots and leaves — to AIDS patients. On a recent day, a 24-year-old woman who had been diagnosed as being HIV positive a year ago, arrived for her first treatment.

"We treat each symptom differently, so you can give a person up to five different herbs," he said. He doesn't promise cure. "But a person can live longer, to six months longer," he said.

The Future

Surveys Conducted But Not Much Else

The future of the children in Rakai has caught the attention of various international aid groups. But so far, little other than surveys of the numbers of orphans has been accomplished.

This irritates the energetic Mr. Pinto who, like his wife, Marie, was born in Baloole, a village not far from the lake. A former manager of the Esso Oil Company, before he fled from Idi Amin into exile in Kenya for 10 years, he has founded the association to help the orphans, as well as the Rakai Development Association. The main challenge, says Mr. Pinto, is to show people hope.

"We have to persuade people to do something for themselves," he says. He believes it is paramount that the children stay in the area with relatives and not be transplanted to orphanages, as has been proposed by some groups.

In Ugandan culture, all adult members of a clan are responsible for the clan's children. "Everyone in your clan

Continued ...

is a mother or father," said Mr. Kibira. "That's why we believe the orphans can be looked after in our homes. If you don't take an orphan then the spirit of a dead mother or dead father will come and curse. This strong force will make sure orphans are taken in."

Already Mr. Pinto's association is paying the school fees — compulsory for Government schools in Uganda — of orphans who are doing well in school but whose guardians cannot afford the outlay. New classrooms have been added to Lugonza Primary School in the district; one day-care center for 30 children has been started.

Mr. Pinto plans to turn an overgrown plantation into plots for the unemployed young men who remain idle and set a depressing tone for the children. A clay brick-making factory to be run by women is also in the works.

And he is going to ask the multinational corportions that have remained in Uganda to pitch in. It would cost about $125,000 for 40,000 orphans to go to school for a year, he said.

"We need help now because a child of 8 will be 12 in four years time and a real social outcast if he hasn't been to school," Mr. Pinto said.