AIDS FROM AFRICA: SCIENCE OR SCIENCE FICTION

by Richard and Rosalind Chirimuuta

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The Acquired Immune Deficiency Syndrome (AIDS) was first recognised as a clinical entity in 1981 in the United States, and although the majority of cases even today have been reported from the United States, the Western scientific community has convinced the world that it is primarily an African disease and an African problem. To explain how a disease originating in one continent was yet disseminated to the rest of the world from another, the scientist have argued that there was a remote central African "lost tribe" in whom the virus has been present for centuries, or alternatively who acquired the infection from monkeys 30 or so years ago. Haitians (but no-one else) working in central Africa then became infected (presumably heterosexually) and, on returning home, spread the disease to homosexual American tourist. By this circuitous route the virus reached the United States and from there spread to the rest of the world.

Whilst this scenario seems quite fantastic to many Africans, the underlying themes are all too familiar. Primitive, isolated and disease ridden peoples in darkest Africa living with monkeys and using their blood for fertility rites, perhaps even having sexual intercourse with them, are all staple ingredients of racist mythology. Because we suspected a racist motivation for the "science" that was arguing for AIDS from Africa we decided to review the scientific literature. When questioning the African hypothesis we anticipated a difficult task, as the research was conducted by reputable scientists and was subjected to peer review prior to publication. As our study progressed it became increasingly clear to us that the racist preconceptions of the researchers led them to conclusions that had no scientific foundation.

The first black people diagnosed as suffering from AIDS in any number were Haitians living in the United States. The possibility that they may have caught the infection from Americans in the United States or in Haiti was not given serious consideration and Haiti was immediately accused of being the source of the epidemic. Soon Haitians with AIDS were being reported from all over the Western world and the Centers for Disease Control (CDC) in Atlanta, Georgia, in-

cluding Haitians as a group at risk for AIDS along with homosexuals, intra- venous drug users and haemophiliacs. It was only in 1985 that CDC, faced with overwhelming evidence that Haitians per se were no more risk for AIDS than anyone else, removed them from the high risk classifications, but not before Haitians en masse were dismissed from their jobs, evicted from their homes, and even housed in separate prisons. Abandoning Haiti, the researchers then turned their attention to Africa.

Out of Africa

One of the reasons given by scientists for this turn to Africa was the high incidence of Kaposi's sarcoma (KS) in Africa, although it was clear from the beginning that the benign clinical course of African KS was very different from the aggressive, disseminated form of KS in AIDS patients. A number of AIDS-like cases were reported retrospectively, the most cited being a Danish surgeon who worked in Zaire and died in 1977. This patient was given prominence in Randy Shilt's book *And The Band Played On* as the first documented Western case of AIDS, and Jonathan Mann, director of the AIDS program for the World Health Organisation (WHO) and even medical text books are now citing the case as evidence that AIDS originated in central Africa. It was claimed that she acquired the infection from her patients, at least on of whom had KS, but there was no firm evidence that she died of AIDS, and other diagnostic possibilities were not considered. In 1988, five years after the case was published, we learned that her serum had been tested and found human immunodeficiency virus (HIV) enzyme linked immunosorbent assay (ELISA) negative, but the author of the original paper has not published this information in the scientific literature.

Although such AIDS-like cases are presented as evidence that the human immunodeficiency virus existed in Africa prior to the American epidemic, they raise more questions than they resolve. The documentation of retrospective cases is inevitably incomplete, and, as the case of the Danish surgeon demonstrates, an illness can be clinically similar to AIDS without evidence of HIV infection. More generally, such cases can only support an African origin if they only occurred in Africa, but AIDS-like cases have been well documented in Europe and America. Indeed, on the opposite page to the report of the Danish surgeon in the same issue of the Lancet was an account of an AIDS-like illness in a young German homosexual, but whilst non-AIDS in a Danish surgeon heads the citation index proving an African origin, the German case has been completely ignored.

From America to Europe

The other difficulty associated with restrospective cases is their relationship to the AIDS epidemic. If the sporadic AIDS-like cases were genuine cases of AIDS, one would expect some evidence for contact between early American cases and Africans, or at least some cases of AIDS in the large expatriate African population in the United States. Again, if AIDS had first appeared in Africa, it would surely have spread from there to Europe and America at the same time, yet it has been established beyond question that the epidemic initially spread to Europe from America and not Africa. To explain this epidemiological conundrum AIDS researchers have proposed that Haitians were the vehicle for transmission from Africa to the United States, but singularly fail to explain why a negligible number of expatriate Haitians became infected with HIV whilst the far more numerous Belgians, French, English, Portuguese and, particularly in Zaire since the 1950's many Americans, were so fortunately spared. There is also ample evidence, from African medical records, seroepidemiological studies and medical records of Africans treated in Europe that the African epidemic began in the early 1980's, after the American and even the European epidemics. If sporadic cases prior to the epidemic were truly AIDS, why should an endemic disease cause and epidemic in another country and only later cause and epidemic in the country of origin?

False Positive

The next source of support for the African hypothesis came from the seroepidemiological studies undertaken in Africa or on African serum stored in the West. This research, more than any other, has been at the foundation of all the fantastic stories of millions dying in Africa. Using and enzyme linked immunosorbent assay seropositive figures at 25% of patients attending a clinic in rural Zaire in 1984, (28) 50% of the Turkanas in Kenya from 1980-1984, and 66% of children in Uganda in 1972 were reported. As AIDS was rare or unknown in the areas where the serum was collected, one would expect the authors to have had serious doubts about the reliability of the tests, but sadly scientific scepticism has never been a feature of AIDS research in Africa. One of the most cited studies was undertaken on serum collected in Zaire in 1959. Using a number of tests in addition to ELISA, only one of 1213 plasmas was positive, but the identity of the donor, described as "rural Bantu", was no longer known. As with the sporadic AIDS-like cases, only seroepidemiology in Africa is considered relevant to the question of the origin of HIV. A study using the same tests was undertaken on stored serum taken from "aboriginal" Amazonian Indians in Venezuela in 1968/69, and 9 of 224 samples were positive on all the tests. The results were challenged by other researchers as probable false positivity, but the single positive sample from Zaire continues to be cited as evidence that the world AIDS epidemic began in Zaire 30 years ago.

In an interview shown on British television Professor Hunsmann, head of virology and immunology section and professor of medicine at the German Centre of Primate Research at Gottingen, discussed the problems of seroepidemiology:

> We had conducted quite extensive experiments in respect to the epidemiology... of the first human retro-virus... HTLV (Human T-Lymphotropic Virus) -1... For this reason we had several thousand serum samples frozen and saved in our refrigerated stock. When the news came that there was another and new human retrovirus discovered, the AIDS virus... we could immediately search among our stock and probe for an earlier presence of this virus in Africa... These tests quickly and clearly gave results, namely, that the first "positive" probes which we could find among our more than 7,000 serum samples are dated only after the beginning of the 'eighties, from the years 1982-83; and that among samples from before that date - and we had quite a lot of that earlier time in our stock - not a single one proved positive. We have concluded from all this that most other researchers had probably fallen victim to the technical difficulties connected with the conservation and analysis of older serum samples. And the American authors who originally had produced those high percentage data had to correct them - but certainly, once some wrong information like that has been put into circulation it continues to go on. This has lead to quite a lot of friction between some African states and the United States.

Later in the same interview when asked why AIDS is not considered to have originated in the United States, Professor Hunsmann made the following comment:

> Testing of the kind being done in Africa and to that volume has never been done by anyone in America. Nobody has looked at the stocked blood serum in the USA and there certainly is much more there than in Africa. Nor has anyone asked what happened to the general population. Only one single group, the homosexual community in San Francisco, has been analysed and the results showed a high percentage of HIV positivity already by the mid 1970's. But no other samples have been tested to the extent done in Africa. I think this should be clearly said.

Slaves and Monkeys

Researchers had originally proposed that AIDS was an "old disease of Africa" that had reached the West via recent intercontinental travel, a rather curious notion given the enforced intercontinental travel of up to 100 million Africans in previous centuries. As this hypothesis became increasingly untenable attention was diverted to the possi-

racist notions that Africans are evolutionarily closer to sub-human primates

bility of a monkey origin of the virus. Such ideas cohabit easily with racist notions that Africans are evolutionarily closer to sub-human primates. Dr. Robert Gallo and his co-workers were among the pioneers of this line of research, both for HTLV-1 and HTLV-111 (later renamed HIV). Two of Gallo's colleagues, Kanki and Essex, reported the isolation of a virus similar to HTLV-111 in macaque monkeys who were suffering from an AIDS-like illness, and labelled it simian T-lymphotrope virus type 111 (STLV-111) of macaques. For those who were arguing an African origin of the AIDS virus, an Asian monkey like the macaque was not a suitable source but less than six months later the same researchers reported finding the virus in "wild-caught" African green monkeys from Kenya and Ethiopia. This research, like most other research on AIDS in Africa, was motivated only by a desire to prove an African origin of the disease, and was greeted with enthusiasm by the Western scientific community. Discussion quickly moved on to the question of how the virus crossed the species barrier, and two AIDS "experts" from St Mary's Hospital in London even offered this explanation:

> Monkeys are often hunted for food in Africa. It may be that a hunting accident of some sort, or an accident in preparation for cooking, brought people in contact with infected blood. Once caught, monkeys are often kept in huts for some time before they are eaten. Dead monkeys are sometimes used as toys by African children.

Are we seriously to believe that African parents are so desperate for toys for their children that they give them putrefying carcasses of dead animals? More fantastic suggestions were published in the *Lancet*:

> Sir:- The isolation from monkeys of retroviruses closely related to HIV strongly suggests a simian origin for this virus... Several unlikely hypothesis have been put forward... In his book on the sexual life of people of the Great Lakes area of Africa Kashamura writes: "pour stimuler intense, on leur inocule dans les cuisses, la region du pubis et le dos du sang preleve sur un singe, pour un homme, sur une guenon, pour ne femme" (to stimulate a man or a woman and induce them to intense sexual activity, monkey blood (for a man) or she-monkey blood (for a woman) was directly inoculated in the pubic area and also the thighs and back). These magic practices would therefore constitute an efficient experimental transmission model and could be responsible for the emergence of AIDS in man.

It is hardly surprising that western AIDS researchers have become persona non grata in many African countries.

... amongst those who hunt monkeys AIDS is notable for its absence

Most Africans, in fact, have little contact with monkeys, and amongst those who regularly hunt monkeys, for example the pygmies of the equatorial rain forests, AIDS is notable for its absence. On the other hand, in recent years there has been a marked increase in contact between man

and monkeys not in Africa but in the West. Monkeys have been used widely for scientific research, and with the discovery that their kidneys provide excellent tissue culture material for virus isolation, propagation and vaccine production, hundreds of thousands have been caught and transported from their native haunts. If there is any truth in the hypothesis that HIV originated in monkeys (and African monkeys are not the only candidates) it would seem more appropriate to investigate modern medical research than speculate about the customs and behaviour of Africans.

Although the African green monkey hypothesis was widely accepted, it came under increasing scientific challenge. Attempts to repeat the Essex and Kanki experiments on other wild African green monkeys were unsuccessful, and the genetic sequences of the virus isolated from laboratory macaque monkeys, the virus Essex and Kanki claimed to have isolated from "wild-caught" green monkeys and another supposedly human virus called HTLV-1V, were found to be identical. Essex and Kanki were then obliged to admit that their green monkey virus was a laboratory contaminant. A retrovirus was eventually isolated from African green monkeys, but it bore little resemblance either to the macaque virus or the human AIDS viruses, and could not have originated from African green monkeys in recent times. It is difficult to understand why this virus has been called simian immunodeficiency virus of African green monkeys (SIVagm) as it does not cause immune deficiency. In all this confusion of viruses one question surely needs to be asked: What is the origin of the virus that caused AIDS-like illnesses in laboratory macaque monkeys? This virus does not occur in wild macaque monkeys, but does have some similarity with the human AIDS viruses. Had these monkeys been subjected to experiments with retroviruses, and did the appearance of AIDS-like illnesses in the monkeys predate the human AIDS epidemic?

Public Retraction

It is instructive for anyone who still has illusions in the objectivity of science or the integrity of some AIDS researchers to read the October 1988 edition edition of the *Scientific American*. The issue was devoted to AIDS, and the section titled "The Origins of the AIDS Virus" was written by Essex and Kanki and was illustrated by a full page colour picture of an African green monkey. Eight months after admitting that the African green monkey virus was a laboratory contaminant, Essex and Kanki have the audacity to state:

> Why SIV is endemic in these wild African monkeys but seems to do them no harm, and is also found in the captive Asian macaques, where it causes disease, was (and still is) an enigma...

Does this re-presentation of discredited data signal the abandonment of any pretence of scientific integrity in order to promote conscious and deliberate propaganda?

Other attempts to implicate Africa in the AIDS epidemic also came to grief. Dr. Anthony Pinching and his team from St Mary's Hospital, London, claimed that a particular genetic variant, the Gc1f allele, predisposed the person to infection with HIV, and that this variant was common in central Africa. The Gc1f allele had, in fact, been found to be common in the Bi Aka pygmies of the Central African Republic and the Peuhl Fula of Senegal, ethnically distinct groups in whom AIDS was either rare or notable for its absence, but it would seem to European minds all Africans are the same. This research was reported in the media as a major breakthrough in the search for a cure for AIDS, but a year later, after a number of other laboratories failed to confirm the findings, Dr Pinching admitted that their original data were erroneous. At least Dr Pinching unlike Dr Bygbjerg and so many other AIDS researchers, had the courtesy to admit his error publicly and apologise to his fellow scientists for the extra work he had caused, although his apologies were not extended to the many Africans whom he had offended.

If so much of the scientific evidence for an African origin for AIDS is found to be wanting, what, then, is the scale of the African epidemic? Whilst doctors from the West claim there are tens of thousands of Africans dying from AIDS, the experience of African doctors and ordinary people is very different. One Zimbabwean woman who in 1988 had not seen or heard of anyone with AIDS said that it was like being asked to believe in the Holy Ghost. A Ghanaian physician, Dr Konotey-Ahulu described the AIDS epidemic in the following way:

> ... The African does not speak of Africa as if it was 'a little country somewhere in Timbuktu'. Africa is a massive continent with 600 million people in 2,300 tribes distributed in 53 different, sometimes very different, countries. For example, the difference between Ghana and next-door Ivory Coast vis à vis the sex trade is the difference between Ghana's ex-colonial master Britain and Côte d'Ivoire's France. Scientific and media descriptions of Africa's 'AIDS elephant', with its 53 body parts, have sometimes been like those of the proverbial blind men surveying the elephant. Most researchers concentrate on the tusk and not surprisingly, come out with 'the AIDS problem in Africa is very sharp and pointed; the whole continent is like that'. Even when experts from Nigeria, the large body-part of the elephant, confirm with seropositivity studies that there is not yet an AIDS problem in their country, they are shouted down with "Under-reporting! Under-reporting! The whole beast has a sharp profile." To these safari experts, Tanzania and Sierra Leone, Uganda and Gabon, Zaire and Ghana, Rwanda and Gambia, are all the same...

Dr Konotey-Ahulu toured all the AIDS affected African countries (except Zaire, where he was refused entry, although US government sponsored AIDS researchers appear to have no such difficulties) and reported his findings in the *British Medical Journal* and the *Lancet*:

> In February and March of this year (1987) I made a six-week tour of twenty-six cities and towns in sixteen sub-Saharan countries, including those most afflicted by AIDS, did ward rounds with doctors and nurses, met ministers of health, directors of medical services, and research workers (native and expatriate)...
>
> If one judges the extent of AIDS in Africa on an arbitrary scale from grade 1 (not much of a problem) to grade V (a catastrophe), in my assessment AIDS is a problem (grade 11) in only five, (possibly six, since I was unable to obtain a visa for Zaire) of the countries where AIDS has occurred... In no country is the AIDS problem consistently grade 111 (a great problem), or ever grade 1V (and extremely great problem), and in none can it be called a catastrophe (grade V). In Kenya, for instance, contrary to widespread reports I would rate AIDS in 1987 as grade 1...
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> Before the days of AIDS in Ghana there was a death a day... on my ward alone thirty-four beds...
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> They died from one or another of the following: cerebrovascular accident from malignant hypertension, hepatoma, ruptured amoebic abcess, haematemesis, chronic renal failure, sickle-cell crisis, septicaemia, perforated typhoid gut, hepatic coma, haemoptysis from tubercolosis, brain tumour, Hodgkins disease... Today, because of AIDS, it seems that Africans are not allowed to die from these conditions any longer. If tens of thousands are dying from AIDS (and Africans do not cremate their dead) where are the graves?...
>
> "Why do the world's media appear to have conspired with some scientists to become so gratuitously extravagant with the untruth?"- that was the question uppermost in the minds of intelligent Africans and Europeans I met on my tour.

Dr Konotey-Ahulu was particularly critical of Western researchers who, with no experience of tropical medicine, used seroepidemiology as a substitute for, rather than an adjunct to clinical epidemiology, and described the difficulties faced by doctors working in Africa who sought funding from external research agencies to increase their clinical epidemiological research base.

Although African governments have repeatedly been accused of under-reporting and the number of AIDS cases notified to the World Health Organisation (WHO) from African countries have never reached the expectations of the Western AIDS establishments, it is important to appreciate how even these relatively modest figures are derived. In the West AIDS is diagnosed and hence reported when a patient develops an opportunistic infection or AIDS dementia. The diagnosis is confirmed with at least two and often more different types of tests, e.g. ELISA, Western blot, radioimmunoprecipitation assay. Thus the great majority of patients with symptoms and signs of HIV infection, i.e. those with persistent generalised lymphadenopathy or AIDS related complex (now called symptomatic HIV infection) do not reach the official statistics until they

develop opportunistic infections or dementia. There is a degree of under-reporting (up to 20 percent in the United States) but virtually no over reporting. Because of the expense of laboratory tests for HIV infection and opportunistic diseases physicians and health workers in most African states have been encouraged to use the WHO clinical criteria for AIDS, confirmed with ELISA when available. The WHO clinical criteria do not distinguish AIDS and symptomatic HIV infection, and in Africa both are therefore reported as AIDS cases. Nor do they differentiate AIDS from other clinically similar wasting diseases and a number of studies have shown that between 26 and 50 percent of patients who fulfil clinical criteria are seronegative for HIV infection. Diagnostic pitfalls include infections particularly tuberculosis, parasitic infestation, lymphomas and occult carcinomas, and endocrine disorders such as diabetes mellitis, thyrotoxicosis and Addison's disease. Confirmatory testing with ELISA, if available, also presents difficulties, given the high rate of false positivity with this test. In this context it is curious to note that the proportion of African AIDS patients who have died is much lower than that in the West, where it is consistently 50 to 60 percent. It is most unlikely that Africans with AIDS live longer than their Western counterparts, and far more probable that reported African cases include patients at an early stage of the disease and patients with clinically similar but less deadly diseases.

If the criteria used to diagnose AIDS in Africa were used in the West the number of Western AIDS cases would increase manyfold

If the criteria used to diagnose AIDS in Africa were used in the West the number of Western AIDS cases would increase manyfold, and therefore comparisons between the incidence of AIDS in Africa and the West are meaningless. Such difficulties are usually dismissed on the assumption of enormous under-reporting of AIDS in Africa, but if this were so, what happens to these patients? Do they die, or do they somehow fade away unmourned, unburied and unrecorded. In Africa as in the West AIDS is predominantly afflicting the young, sexually active section of the population and a change in the pattern of disease and death in this group would be reflected in official statistics even if not reported as due to AIDS. Yet Western researchers seem incapable of believing that African countries gather such statistical information although it is often readily available in the libraries of their own institutions. When comparing the incidence of AIDS in different countries it is also important to consider the rate of progression from HIV infection to 'full blown' AIDS. It is probable this will be more rapid in countries with a high rate of infectious and parasitic disease, and consequently the proportion of AIDS patients to the number with HIV infection will be higher. Even if African states were using the same criteria to diagnose AIDS as in the West, assumptions about the prevalence of HIV infection based on Western experience would be misleading.

Expatriate Africans - Low Risk

Even if one chooses to ignore the information provided by various African Ministries of Health some assessment of the scale of the African epidemic can be made by studying expatriate Africans. Many Africans in Europe and America are temporary residents, or travel home frequently, and AIDS in this group should mirror the epidemic in their countries of origin. Whilst there was much excitement about the incidence of AIDS in expatriate Africans in Europe in the early 1980's, the number of Africans diagnosed in Europe actually declined between 1984 and 1986, perhaps because reliable tests for AIDS became available, and only in 1987 showed a modest increase. Africans with AIDS in Europe are no longer reported separately by the WHO, perhaps because they have ceased to be a significant proportion of the total European cases. Although there was much talk of the risks of transmission of HIV-2 by West Africans in Britain, more than 6.500 patients with West African connections were tested and all were found negative for this virus. It is curious that expatriate Africans in the United States have never featured in discussions about the supposed African origin of AIDS, nor have they been reported as suffering from AIDS in any number.

Cheap USA Blood - Contaminated

Sound scientific methodology surely dictates that evidence contrary to a proposed hypothesis should be sought as vigorously as evidence for the hypothesis. In the case of AIDS from Africa contrary evidence has not been sought at all, but this singular deficiency in effort is then presented as a lack of result. If scientists did wish to explore the possibility that HIV was introduced to Africa from the United Stares and Europe we would mention two possible areas for research. The first is the export of infected American blood products. Discussion in the scientific literature about Africa and transmission of HIV by blood products inevitably concentrated on the possible importation of infected plasma to America from Africa (an unsubstantiated hypothesis that died quickly), or the spread of HIV in Africa by local blood transfusions. We could find only one reference to the export of infected American blood to third world countries, in a WHO working paper where it was said that contaminated plasma pools may have been sold at discount prices in developing countries since they could not check the products. Western countries outside the USA are for the most part self sufficient in whole blood and plasma, and the only significant group infected from America were haemophiliacs who were given imported American clotting factors. Poor countries often cannot afford a blood transfusion service, and wealthy patients with blood loss may be transfused with imported blood whilst the poor at best receive an immediate transfusion from a relative or friend. If imported whole blood was responsible for introducing AIDS into Africa, this would be consistent with the initial appearance of AIDS in the urban-based elite in countries like Zaire which are particularly dependant on America. It would also account for the development of AIDS in expatriate Europeans, such

as the French woman who developed AIDS after a blood transfusion in the Cameroons, as it is unlikely that she was transfused with locally obtained blood.

Sex Tourism: Blame the Blacks

A second, and we suspect far more important route by which AIDS may have been introduced into Africa is sex tourism. AIDS researchers, who seem unable to contemplate that white men can infect African women, have presented AIDS in Africa as a disease transmitted by promiscuous men (and to racist minds all Africans are promiscuous) to prostitutes who then infect foreign clients. Prostitution in Africa countries tends to occur at two levels: with younger and prettier women seeking valuable foreign exchange who work in the large hotels and night spots which attract foreign tourists and wealthy Africans, and with older and less attractive women whose clientele is predominantly poor and local. If African realities agreed with the researchers suppositions, older African women and their local clientele would be bearing the brunt of the epidemic, but to the contrary it is the young women frequenting the tourist centres and foreign military and naval establishments who are developing AIDS and are transmitting it to their African sexual partners: husbands, boyfriend and wealthy African clients. This too would explain why AIDS is particularly affecting the African elite. By adopting a Western life-style they may be acquiring a Western disease.

AIDS introduced into Africa by sex tourism

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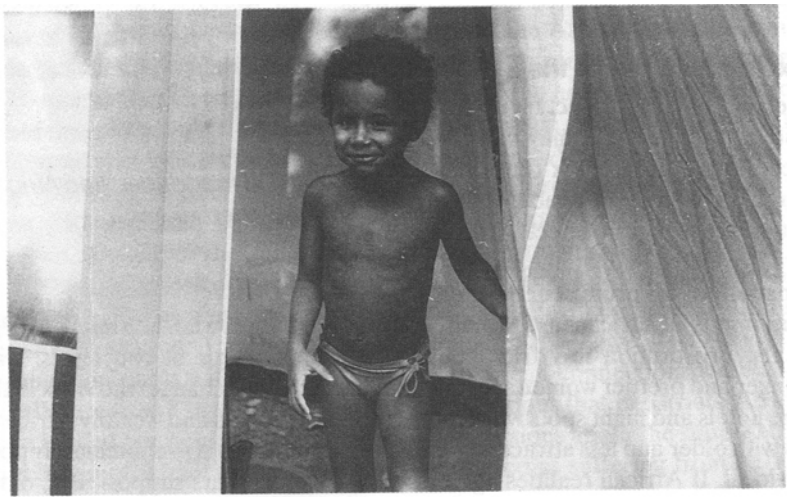
When discussing the issue of the origin of AIDS we are frequently asked by well meaning people "Does it really matter where AIDS came from, shouldn't we forget about the origin and concentrate on dealing with the epidemic". Certainly we agree that every effort should be made to contain the epidemic, in Africa as elsewhere in the world, but for a number of reasons we believe that the issue of the origin cannot be brushed under the carpet and ignored.

Firstly, if AIDS did not originate in Africa, where did it come from? There is abundant evidence that in nature retroviruses do not cross the species barrier, but with the development of techniques for viral culture, and the experimental growth of cocktails of viruses in cell cultures of various species, an artificial origin for HIV would seem a distinct possibility. Over and above the accidental production of HIV in the laboratory is the prospect of deliberate production of the virus, and the funding was allocated to the US military for just such



a purpose. We do wonder if it is any coincidence that those such as Robert Gallo and Max Essex who are the most active proponents of the African hypothesis have the most to lose in any investigation of a possible laboratory origin for HIV. If HIV is an artificial and not a natural product, then we must surely ensure that it is the last such virus to emerge in that manner.

Secondly, by claiming, without any solid scientific foundation, that Africa is the origin of HIV and that Africa is facing an AIDS holocaust scientists are abetting racism already rampant in the West. Africans are now considered an AIDS risk irrespective of their behaviour or life style, and this not only increases the personal experience of racism, but governments are less constrained when wishing to incorporate restrictions based on race into national policy.

Thirdly, by promoting the idea that AIDS is spreading from Africa to the rest of the world, scientists are ignoring the very real possibility that AIDS is being spread in Africa by sex tourism from the West. Where resources are limited, health education should be directed to those most at risk. There is abundant evidence from Ghana, for example, that sex tourism in the Ivory Coast is the route by which AIDS is being introduced into Ghana, and endeavours to halt the spread should include a reduction of the economic pressures on young Ghanaian women that lead them work as prostitutes, and advice about how to reduce the risk of infection if they do.

Fourthly, by placing such emphasis on the African epidemic, the scale of the epidemic elsewhere and measures needed to control it are diminished in importance. Asians, with limited contact with Africans, have been considered little risk for AIDS. Only now the consequences of widespread European sex tourism in Asia are being discussed. Intervention at an earlier stage may have saved many lives.

Although racism in its various manifestations has come under increasing challenge in recent years it remains a potent influence, and it is naive to believe that medical science is immune to this particular poison. With the emergence of a new and deadly sexually transmitted disease it was perhaps almost inevitable that Black people would be attributed with its origin and transmission, whatever the evidence. Racism is an irrational system of beliefs without scientific foundation, and much of the confused, contradictory and simply nonsensical conclusions reached by the scientists about AIDS and Africa can be attributed to their attempts to square their research findings with their racist preconceptions, rather than objective scientific reality. The determined pursuit of the African origin has been of little scientific or practical merit, but instead has escalated racism, created conflict between African and Western countries, diverted resources away from areas where they are much needed, and has wasted time. Let us hope we can learn from our mistakes, otherwise we will be doomed to repeat them.

scientists' racist preconceptions

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