War, famine and now pestilence

Sleeping sickness ravages Central Africa

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Large areas of Central Africa could be depopulated in the near future due to a massive death toll from West African trypanosomiasis, commonly known as sleeping sickness. The disease is spreading exponentially and is virtually out of control. In some provinces of tropical Africa sleeping sickness has become the number one cause of mortality. One report says that an entire village in the Central African Republic was completely wiped out.

In the Democratic Republic of Congo 20,000 cases were reported in 1995, but the World Health Organization (WHO) estimates the figure is closer to 250,000. In the Congo they report more people die from sleeping sickness now than from AIDS. Similarly in 1995 in Angola, 2,478 cases were reported, but probably 100,000 people have been infected. 30,000 new cases were reported from among the 55 to 60 million people in equatorial Africa that are exposed to the risk of a bite from the tsetse fly. Since only 4 million of the people at risk are under active surveillance, or have access to health centers where reliable diagnosis is available, WHO says the true estimate is closer to 300,000 and perhaps as high as 500,000.

A total of 36 countries in equatorial Africa could be affected, including 22 of the world's most underdeveloped countries. These include countries currently embroiled in civil war and countries where forces have recently become involved in the escalation of the war in the Congo. Along with the Democratic Republic of Congo and Angola, Uganda and Sudan also report epidemic rates.

The rate of infection is climbing rapidly. In Sudan, where WHO estimated 5,000 cases, actual surveillance was carried out in late 1997 in Tambura County in southern Sudan. Doctors from the US Centers for Disease Control (CDC), working with others international medical aid groups, arrived at the figure of between 9,000 and 12,000 people infected in that one county alone. In 16 villages, 19.3 percent of the 1,400 screened had contracted the disease. In one area it was as high as 45 percent. In 1988 the prevalence in this area was only .3 or .5 percent, but now every village surveyed showed evidence of infection. It is possible that the disease was still at a relatively low level in these areas in 1994, but has become epidemic in less than three years.

African sleeping sickness is caused by T. brucei gambiense, a parasite transmitted by the bite of the tsetse fly. Death inevitably claims the untreated victims, usually within two years. According to the CDC the parasite slowly wears down the victim's immune system. 'Symptoms such as fever and swollen lymph nodes begin to appear. Eventually, after a few months to a few years, the parasite invades the central nervous system (stage II), resulting in personality changes, disturbance of sleep patterns, progressive confusion, and difficulty walking and talking. Death usually occurs within a few months of central nervous system involvement.'

Each infected person is a source of parasites for new tsetse fly hosts, who go on to infect more humans and cattle. With sickness and death affecting all age groups, further impoverishment will affect villages, as workers are unable to take care of crops. Since the parasite is fatal to cattle used to power farming, famine also threatens to spread.

Although it costs about a thousand dollars to treat a victim of the parasite, there is not even enough money for proper surveillance. In southern Sudan a 10-year Belgian-funded eradication program was ended in 1989 because of the civil war. Only recently have the UN and private medical relief agencies intervened in limited control efforts.

The incidence rate in large areas of the continent is simply unknown. African countries where barely 1 percent of the at-risk population is under surveillance are reporting cases of sleeping sickness to the World Health Organization.

Even during the first half of this century, when the notorious outbreaks occurred in the area, surveillance of the at-risk population was generally maintained. Cases of African sleeping sickness were practically eliminated during the years 1960 to 1965, and it was thought the disease was on the verge of total eradication. It began to reemerge progressively from 1970 onwards. Still, through surveillance and treatment, outbreaks had largely been controlled even in the '70s. However, disease levels in some countries are estimated to be as high as those reported in the record years

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of 1925-30.

In the August issue of *Discover* science writer Karl Zimmer explains the processes that allow the parasite to wear down the immune system of its human host. He also points out that trypanosomes have infected people for thousands of years, but probably rarely became epidemic until the past few thousand years, most likely because Africans began farming in tsetse fly country. Before Africa was carved up by the imperialist powers, the farming populations were able to move more freely, away from the areas infested by tsetse flies that had become infected with T. brucei gambiense.

'And when the European capitalists forced them to work in places loaded with the tsetse flies sleeping sickness became the biggest health threat in Africa,' Zimmer writes. 'In 1906, Colonial Undersecretary Winston Churchill reported to the British House of Commons that the disease had reduced the population of Uganda from 6.5 million to 2.5 million.'

As far as aid from outside is concerned, there is little. The $4 million worth of Pentamadine, the stage I treatment medication donated by Schein Bayer Pharma Inc. for the effort in Sudan, is more than offset by a recent tenfold increase in the cost of the drug. Because it is also used to treat infections endemic to AIDS patients, the demand for stage I medicine has skyrocketed in the last 10 years.

Cost to care for stage II patients is higher. They require therapy with the drug Melarsoprol. In addition, patients need weeks of secondary care to survive the rigors of this drug, which contains 20 percent arsenic. A two-year follow-up is required to make sure the patient does not become reinfected. Screening must be done of all residents to be effective, requiring a blood test after several months and, if infection is found, a spinal tap to determine whether the parasite has reached the brain.

WHO estimates $30 million a year would be required to fight the disease in the at-risk countries. When the IMC requested $3 million from the US agency for international development (USAID) for its limited effort in Tambura County, it was provided only $1 million to be divided between the IMC and CARE. These agencies report their effort has to date saved only about 500 lives.

The reemergence of sleeping sickness in Africa since the early 1970s roughly parallels the drive by the United States and European capitalist countries to extract billions of dollars from Africa in debt repayments, plunging the continent into deeper and deeper poverty. The regimes and military cliques who promote ethnic conflict and civil war, while maneuvering with the imperialist powers, gravely hamper efforts needed to deal with this threat to the civilian population.

When considering the figures presented by aid agencies for the diagnosis and treatment of this infectious disease, among many, plaguing the people of Central Africa, it is obvious that the $75 million spent by the US to bomb Afghanistan and Sudan could have saved countless lives had the money instead been devoted to health care. Under circumstances where malaria, tuberculosis, river blindness and sleeping sickness are resurging to levels not seen in this half-century, to say nothing of the AIDS crisis in Africa, medical resources could have been funded to save the lives of millions.

But the choice of the target for the US bombing in Sudan rivals the worst acts of the turn-of-the century imperialist pillagers. The destruction of a $100 million pharmaceutical factory in one of the most impoverished countries of the world is an unspeakable war crime. Evidence is now conclusive that the factory produced only pharmaceuticals, including anti-parasitic drugs for livestock and antibiotics for human consumption. These are precisely the drugs needed to dealing with the uncontrolled rise of parasites and infectious diseases, which are leading killers throughout Central Africa and most of the underdeveloped world. This bombing could better be described as an act of genocide.

For a fact sheet on West African trypanosomiasis and a map showing the disease-endemic region see: http://www.cdc.gov/ncidod/diseases/trypan/fswaftry.htm

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