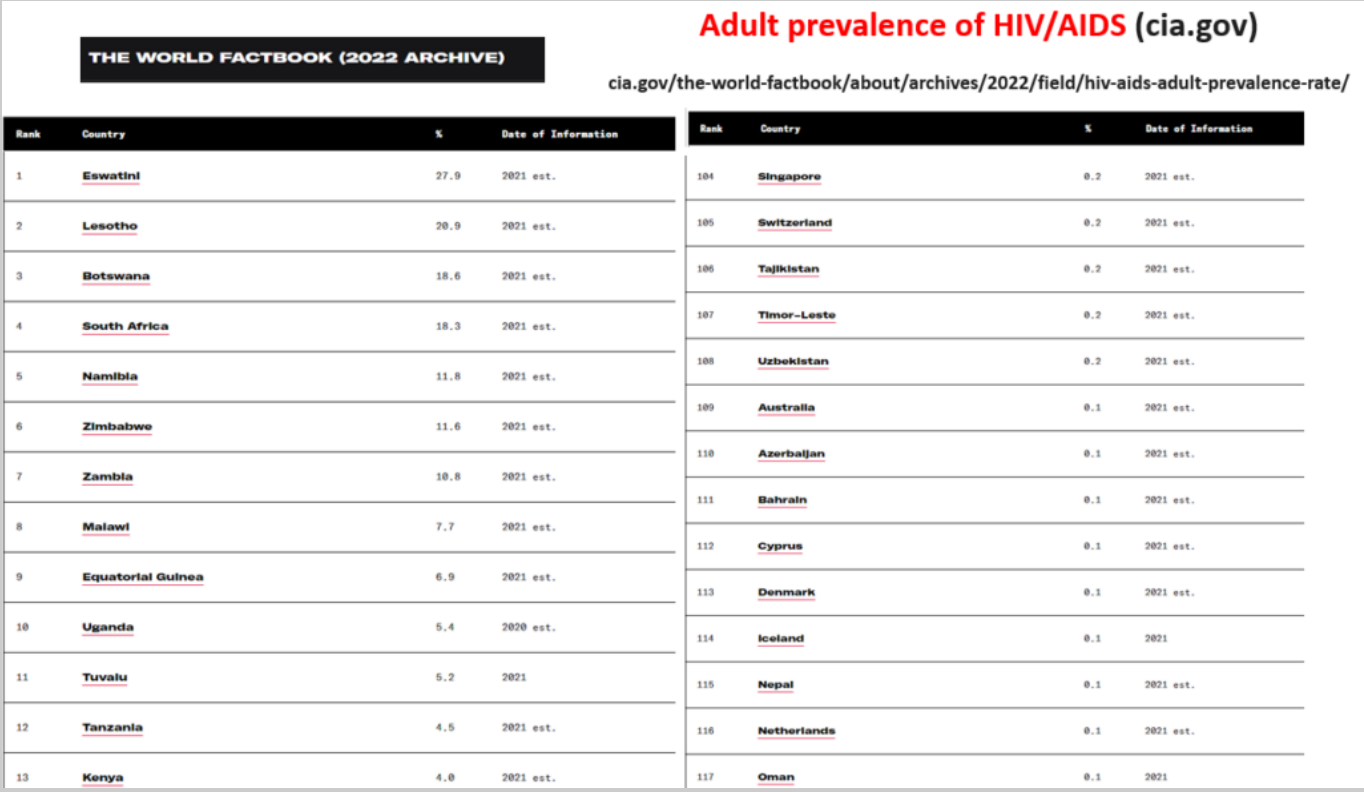
AIDS in Africa (engl)

The reporting figures for ‘HIV/AIDS’ for Lesotho and Eswatini (Swaziland) are more than 100 times higher than those in Singapore and Switzerland. In one region of the world, HIV/AIDS is one of the most common causes of death, while in the other, comparatively fewer people are affected.



THE WORLD FACTBOOK (2022 ARCHIVE)

Adult prevalence of HIV/AIDS (cia.gov)

cia.gov/the-world-factbook/about/archives/2022/field/hiv-aids-adult-prevalence-rate/

Rank	Country	%	Date of Information
1	Eswatini	27.9	2021 est.
2	Lesotho	20.9	2021 est.
3	Botswana	18.6	2021 est.
4	South Africa	18.3	2021 est.
5	Namibia	11.8	2021 est.
6	Zimbabwe	11.6	2021 est.
7	Zambia	10.8	2021 est.
8	Malawi	7.7	2021 est.
9	Equatorial Guinea	6.9	2021 est.
10	Uganda	5.4	2020 est.
11	Tuvalu	5.2	2021
12	Tanzania	4.5	2021 est.
13	Kenya	4.0	2021 est.

Rank	Country	%	Date of Information
104	Singapore	0.2	2021 est.
105	Switzerland	0.2	2021 est.
106	Tajikistan	0.2	2021 est.
107	Timor-Leste	0.2	2021 est.
108	Uzbekistan	0.2	2021 est.
109	Australia	0.1	2021 est.
110	Azerbaijan	0.1	2021 est.
111	Bahrain	0.1	2021 est.
112	Cyprus	0.1	2021 est.
113	Denmark	0.1	2021 est.
114	Iceland	0.1	2021
115	Nepal	0.1	2021 est.
116	Netherlands	0.1	2021 est.
117	Oman	0.1	2021

HIV/AIDS Prävalenz-Raten des CIA abgerufen am 02.06.2024. WHO-Daten: data.who.int/countries
Why?

HIV and AIDS are not the same thing. HIV is a virus that used to be found only in wild animals in (or north of) the equatorial region of Africa. It is detected by antibody tests or by gene sequencing. AIDS, on the other hand, refers to a clinically observed and medically defined disease or immunodeficiency syndrome in which (in addition to a positive test result) many other factors can also play a role. So, could it also be a testing or reporting epidemic in certain countries?
Is it due to different sexual behaviour?

The ‘cultural hypothesis’ has dominated the discourse on HIV and AIDS in Africa for over three decades. It has never been proven. Humans of all Homo sapiens cultures are capable of strong partner bonds with their cousins (chimpanzees or bonobos). They are driven by a strong desire for a ‘dopamine jackpot’ (Sapolsky 2023). From a biological perspective, cultural

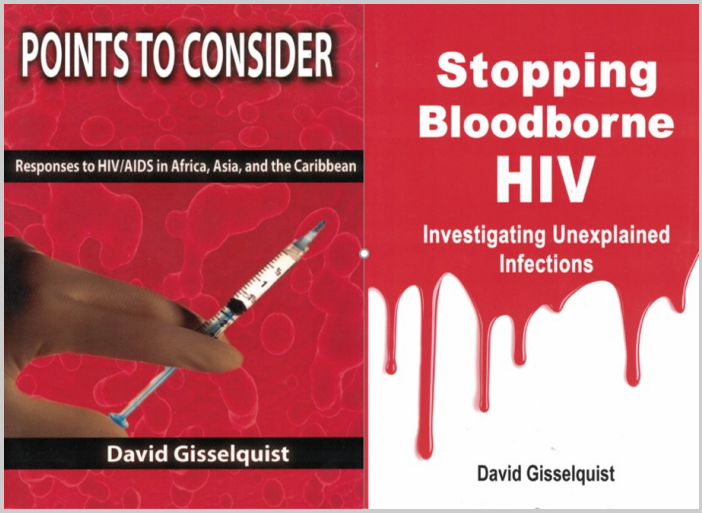
differences in sexual behaviour in humans are insignificant. They cannot explain regionally differing rates of sexually transmitted infections. Nevertheless, the racist explanation pattern still prevails today because it seems to illustrate the differences in prevalence as ‘natural’, confirming ideology, without having to ask about responsibilities.
How often is the HI virus (among other things) transmitted via needles, syringes and medical devices?

The extent of transmission of the HI virus through contamination during medical interventions has been investigated since 1985. The worrying results have since been confirmed many times over. The epidemics of the spread of the hepatitis C virus, which is not sexually transmitted, also show the risk of (‘nosocomial’) transmission of pathogens through the medical system. The outbreaks of Ebola, cholera and others are also typically linked to the inadequate quality of the medical facilities concerned.
The American scientist David Gisselquist has been working on the problem of nosocomial HIV transmission in Africa for decades. Like other colleagues who have come to similar conclusions, he has been largely ignored by the WHO and international organisations that like to inject a lot. One of the reasons for this could be fear of impending liability.

Unfortunately, the word liability (Acknowledgment: acceptance of the truth or existence of something) is largely unknown in development cooperation. (Another example)

Guest contribution: David Guisselquist: Africans get HIV from healthcare, May 2024

“Evidence from HIV se



quencing for blood-borne transmission in Africa Surveys and studies in sub-Saharan Afri

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We aim to show what phylogenetic analyses of HIV sequences from Africa say about the possible contribution of blood-borne transmission to Africa’s HIV epidemics. We searched PubMed and elsewhere for sources reporting phylogenetic analyses of at least 100 HIV from community-based studies in Africa. Within those sources, we searched for information relevant to assessing blood-borne transmission.

Sixteen reports met search criteria and provided information to assess blood-borne transmission. In five studies, similar sequences among couples (and household members presumed to be sex partners) identified a likely heterosexual source for 0.3% to 7.5% of community adults with sequenced HIV. In 10 studies, a median of 43% of sequence pairs linked two people of the same sex. Two studies report clusters of recent infections too large to be easily explained by sexual transmission. Phylogenetic analyses suggest blood-borne transmission makes a major contribution to Africa’s HIV epidemics.” David Gisselquist, May 2024).

A missing issue at the 2023 Global Summit on

Patient Safety

In late February 2023, I attended the 5th Global Ministerial Summit on Patient Safety in Montreux, Switzerland.[1] Because there was so much good mixed with bad, it's taken me more than a month to assemble these thoughts. Good: I believe that many people at the conference were fully committed to what they professed – better health, safer healthcare. Bad: I found few attendees – patient safety experts and advocates – aware of the decades-long and continuing failure to address nosocomial (from health care) HIV infections in sub-Sahara Africa.

The World Health Organization (WHO) helps to guide these summ

5th Global Ministerial Summit on Patient Safety in Montreux, Switzerland.

its. WHO’s attention to patient safety builds on a 2002 World Health Assembly resolution (W

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Background: investigations outside sub-Saharan Africa

If WHO staff and associated experts were serious about the plans and responsibilities laid out in these documents, they would be aware of unexplained HIV infections in Africa, and would recommend governments to investigate – the appropriate and proven strategy to protect patients. As demonstrated around the world, investigations of unexplained HIV infections: first identify the likely source clinics, next look for more victims by inviting others attending those clinics to come for tests; and from knowing who was infected find and fix dangerous procedures.

Beginning in 1986, investigations around the world – except in sub-Saharan Africa – have uncovered dozens of small to large outbreaks from medical procedures. In 11 countries in Asia, Europe, North Africa, and the Americas investigations uncovered 12 outbreaks with more than 100 to an estimated 100,000 infections.[5]

For example, in early 2019 a private doctor in Ratodero, Pakistan, sent a persistently sick 1-year old girl for an HIV test; she was HIV-positive, but her mother was not. Over the next several months, he found more infected children with HIV-negative mothers. After the media reported these infections in late April 2019, government arranged for widespread HIV tests on demand.[6] As of early 2023, government’s investigation had found more than 2,800 children along with hundreds of adults to be HIV-positive in and near Ratodero.[7] How did it happen? In June 2019, UNAIDS’ regional director reported: “Unsafe injection practices including reuse of syringes and IV [intravenous] drips, both by the doctors as well as quacks [unlicensed healthcare providers] in addition to poor infection control have emerged as the leading causes of HIV outbreak in Ratodero…”[8] According to Fatima Mir, a member of the investigating team, “To call [infection control] abysmal doesn’t even do justice to how bad it is… [T]here was a constant contamination of needles that were reused and reused and reused.”[9]

Investigations work: as of 2019, WHO estimated adult HIV prevalence of 0.2% or less in 9 of the 11 countries with large investigated outbreaks.[5]

Background: unexplained HIV infections in sub-Saharan Africa

From the mid-1980s and continuing, surveys and studies across sub-Saharan Africa have reported bunches of unexplained HIV infections. For example, during 2006-18, in national surveys in countries with at least 5% of adults HIV-positive, the percentage of self-declared virgins aged 15-24 years who tested HIV-positive ranged as high as 6.3% for men and 5.0% for women (Figure 4.1 in [5]). In seven national surveys during 2006-17 that tested mothers and children for HIV, the percentage of HIV-positive children with mothers testing HIV-negative ranged from 6% to 33% (Figure 4.2 in [5]); 33% was for children aged 6-23 months in Mozambique in 2015.

All along, studies in Africa looking for HIV infections and risks have reported bunches of unexplained infections. For example, a 2011-12 study among young women in Mpumalanga Province, South Africa, tested 2,533 high school women aged 13-20 years; 81 were HIV-positive, including 38 who reported never having vaginal or anal sex.[10] The study then followed and retested the women for 1-6 years during which time 190 got HIV, including 44 who reported no lifetime sex.[11]

Studies and surveys are only the tip of the iceberg of unexplained infections. With huge increases in HIV testing following the UN’s 2016 target for 90% of HIV-positive people to know their status by 2020,[12] hundreds of thousands of Africans now know they are infected despite no sexual or mother-to-child risks. In Eastern and Southern Africa, the region with the worst epidemics, 90% of those infected knew their status as of 2021, including 92%-94% in Botswana, eSwatini, Lesotho, and South Africa, the four countries with the worst epidemics, with 18.3%-27.9% adult HIV prevalence (WHO estimates for 2021[13]). Even so, not all unexplained infections have been recognized, because many HIV-positive people with no sex or mother-to-child risks have seen no need to test.

Not protecting patients in sub-Sahara Africa

from nosocomial HIV

As demonstrated in countries throughout the world, both the public and health experts have recognized unexplained infections as evidence patients are at risk unless and until investigations find and fix their source. In other words, government decisions to investigate have nothing to do with the percentages of HIV infections in a country or community from sex or blood-borne risks. Patient risk is the issue.

However, despite World Health Assembly resolutions charging governments and WHO to work together to protect patient safety, WHO, and governments have ignored the threat to patient safety represented by unexplained infections in sub-Saharan Africa. Continuing failure to investigate – or even to talk about and advocate investigations – makes a mockery of celebrated, meaningful, and articulated commitments to protect patients.

Letting go of the tiger's tail?

WHO and associated public health experts have a tiger by the tail. They grabbed the tail in the 1980s by not investigating recognized unexplained infections, and not warning Africans about unaddressed risks to get HIV from healthcare. At that time, Africa's HIV epidemics were not so large – as of 1988, WHO estimated 2.5 million infected in sub-Sahara Africa, about 0.6% of the population. But the tiger grew huge – as of end-2021, WHO estimates 28 million Africans had already died of AIDS and 25 million were living with HIV.

Recent HIV sequencing studies provide strong evidence that bloodborne, not sexual, transmission drives Africa's HIV epidemics. A 2022 review[14] of sequencing studies in Africa found five that sequenced HIV collected from large percentages of infected adults in geographically defined communities and then looked for similar viruses showing linked infections. These five studies identified sex partners with similar viruses to explain only 0.3% to 7.5% of HIV-positive adults with sequenced HIV in each study. Moreover, across eight studies that reported the sex of persons with similar infections, a median of 53% of sequence pairs linked persons of the same sex; in other words, a woman was equally likely to get HIV from a woman as from a man, which suggests that most HIV transmission had nothing to do with sex. If, as these studies suggest, bloodborne transmission drives Africa's epidemics, investigations that find and stop bloodborne risks

could not only protect patients but also mark the beginning of the end of Africa's HIV epidemics.

Will WHO let go of the tiger's tail? Based on what I saw at the Summit on Patient Safety in Montreux in February 2023, I am not hopeful WHO and associated experts will reconsider and revise their deadly silence about investigations as the standard response to unexplained infections.

After Montreux, here's what I expect: within not more than several years, the African public, made aware of unexplained infections by expanded HIV testing, will push their governments to investigate, as happened in Ratodero in 2019. That will take care of the issue, at least as far as Africans' patient safety and HIV epidemics are concerned. But once that's done, how will health professionals who ignored this disaster for decades – some misdirected the response, most trustingly accepted misdirection – respond when investigations discover nosocomial HIV outbreaks in Africa? Findings that are good for African's health may also be good for health professionals by helping them to come in from the cold; ignoring or denying commitments and ideals is not a good way to live.

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