

# Omicron's Message for the Year of LaRouche

by David Shavin

## *The anti-vaxxer on Omicron:*

*See, vaccines don't work. They are only 35% effective against Omicron. More vaccines, fewer results. Anyhow, Omicron is about like the flu. So, I'm not going to panic. And, when you think about it, influenza really just takes out some of the weakest in the population. This is how nature works. So, maybe we should stop fighting it, and spend a fraction of the money to make terminal victims of the flu and of COVID as comfortable as possible. The do-gooders get in the way of God's work.*

## *The pro-vaxxer on Omicron:*

*This is a pandemic of the anti-vaxxers. If stupid, selfish people would have just taken their vaccines in this country, this COVID would be a thing of the past. I've gotten my vaccination, so I'm part of the solution, not the problem. Other parts of the world can fend for themselves. Selfish people get in the way of God's work.*

Jan. 7—It is not hard to hear the messages of frustration. But perhaps, as COVID-19 enters its third year, the Omicron variant has come to deliver a new type of message—one that was delivered a long time before COVID ever appeared upon the scene. This article hopes to address that message, so that the ears of the deaf might be unstopped.

Certainly, the infectiousness is unlike anything seen before. On Dec. 27, the world recorded over 1,000,000 new cases in a day for the first time ever. On Jan. 3, one week later, the United States *alone* recorded over 1,000,000 new cases in a day. And the positivity level



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*U.S. hospitals could be within days of being overwhelmed again, as in January 2021.*

has skyrocketed upwards from 6.7% on Dec. 14 to over 25% three weeks later—indicating that the infection has spread significantly more than the official numbers of cases indicate. Genomic sequencing samples for the last week of December indicate that Omicron, as of Jan. 1, accounts for an estimated 95% of the new cases in America. In four successive weeks, it went from less than 1% to 8%, then to 38%, to 77%, and finally to 95%.

Prior to any consideration of the severity of illnesses, the mere magnitude of infections is certain to strain, and likely to break, the supply chain of goods and services—simply from the days missed by nurses, doctors, transportation workers, firemen, policemen, sanitation workers, etc. However, even if Omicron cases prove to be less severe than previous variants, they are more than enough to bury the hospitals with moderate to severe cases.

In the United States, COVID-19 hospitalizations are climbing at around 4,000 per day, and have now reached the all-time peak levels of January 2021 of around 130,000. While some percentage are patients admitted for other causes who then tested positive, the pressure on the hospital system is very real. COVID patients in ICUs grew by over 15% last week, and are now over 80% of the historic peak.

Worse, the veterans of the COVID war, led by the nurses, have found their valiant efforts rewarded by careless national policies, guaranteeing a perpetual no-win battle—and resulting demoralization and despair. Many hospitals are now severely understaffed, as trained professionals have departed. Twelve states report critical staffing shortages at over 30% of their hospitals, with Vermont (58.8%), New Mexico (50.9%) and Rhode Island (50%) presently in the worst shape. And since the shortages have been increasing day by day, these 7-day averages understate the actual situation.

The Omicron variant has been ripping through the so-called advanced sector of Europe and North America, led by the United Kingdom, the United States and now also France. As of the writing of this article, it is now breaking out in India, with the 7-day average more than six times its level a week ago, going from 18,500 (Jan. 2) to 112,100 (Jan. 9). Detected cases on Jan. 9 were 179,700, and positivity levels have jumped from less than 2% to over 13%. Previously, India, a nation of 1.4 billion people, had maintained a level below 10,000 cases per day for five weeks. (This is a “U.S.-equivalent” of less than 2,500 cases/day.) This week’s eruption is not a welcome development.

### **Omicron: Mutation Madness**

The Omicron variant, though much more infectious than Delta, seems to be markedly less fatal. Early results indicate that it appears to attack the nose and throat areas more often than the lungs. Omicron appeared on the scene no later than mid-November and was first identified by Dr. Tulio de Oliveira’s genomic sequencing team in South Africa. Particularly



*Prof. Tulio de Oliveira, who identified the new Omicron variant of COVID-19 in South Africa.*

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notable was the massive increase in mutations found in Omicron, four-to-five times the mutations in the previous variants. While Alpha had 10, Beta 11, Gamma 12 and Delta 9, Omicron weighed in at 50—and with 36 of them in the crucial protein-spike area.

One of the mutations, the infamous E484K has been associated—previously, in the Beta and Gamma variants—with an alteration in the shape of the spike, making it more challenging for antibodies to recognize the invader. This would contribute to a lowering of a vaccine’s efficacy in preventing infection (or, for that matter, the efficacy of a post-infection immunity). Omicron

has another well-known nasty mutation, N501Y, one associated with what is called the “receptor binding domain.” It has previously appeared in Alpha, Beta and Gamma, where it achieves a tighter binding of the virus to the cell. The neutralizing antibodies fail to hold their ground or to shake the virus’ grip. This results in a more efficient transmission for the virus.

However, beyond these two, whose history has provided some clues to their activity, Omicron has many more mutations in both areas, not well understood. Further, in the furin cleavage site, where the enzyme furin activates the virus, Omicron has another advantage with mutations H655Y, N679K and P681H, which appear to increase the virus’s mobility.

### **The HIV ‘Mutation Factory’**

The leader of the team that first detected and identified Omicron, Tulio de Oliveira, the head of the Genomics Program at the Africa Centre of Epidemic Response and Innovation (CERI), had been studying various infectious diseases in Africa for a number of years: chikungunya, dengue fever, hepatitis B and C, yellow fever, Zika, and HIV. In 2017, he founded South Africa’s KwaZulu-Natal Research Innovation and Sequencing Platform (KRISP), and in 2020 it successfully detected COVID’s Beta variant. De Oliveira focused recently upon HIV, or human immunodeficiency virus, which is rampant in South Africa.

It has been known that HIV/AIDS patients were at

least 30-50% more likely to die from COVID-19—not surprising, as there is a systemic incapacity of the body’s ability to mount a successful immune defense. There are 27.5 million HIV/AIDS cases concentrated in sub-Saharan Africa, about 73% of the world’s total.

On Aug. 30, 2021, at an immunology conference, de Oliveira presented the evidence that the continued toleration of HIV was a recipe for disaster:

There is good evidence that prolonged infection in immune-compromised individuals is one of the mechanisms for the emergence of SARS COVID-2 variants.... South Africa really risks becoming one of the mutation factories of the world.

De Oliveira described his study of patients with HIV and COVID-19. He had five patients who had trouble clearing the coronavirus out of their systems. One, a 36-year-old woman, tested positive repeatedly for SARS-CoV-9, incubating the virus for 216 days. In the process, her virus went through 32 mutations, with 13 of them on the spike protein—including E484K and N510Y. He reported that a “handful” of the mutations were “known to strengthen the virus’ ability to resist the vaccines and drugs” used against COVID-19. “You have this massive virus evolution, really the virus accumulating over 30 mutations.” (Healthy immune systems clear SARS-CoV-9 in a couple of weeks.)

It appears that the intensity of mutations in this one woman is only a special case of what happens when the virus can occupy a specific area for an extended time. De Oliveira put forward the proper, hopeful approach: “This could be a golden opportunity to control the HIV epidemic and protect the world from variants.”

About seven weeks after de Oliveira spoke those words, Omicron was identified in Johannesburg.

Dr. Jonathan Li, a Harvard infectious-diseases specialist, was the first to detail extensive coronavirus mutations in an immune-suppressed patient. He commented on de Oliveira’s work, saying that the T-cells are under attack by HIV and are not able to support the effort of the immune system’s B-cells to clear the infection. Said Li:

The sheer number of mutations that arose all of a sudden here is really reminiscent of what we’ve seen. If I had to guess, I would say this is likely how Omicron came about. This is a syndemic.

By “syndemic,” Li meant the combination of two epidemics with the potential for worse results than would have occurred from either one separately.



*The Omicron variant was initially detected in samples collected Nov. 12-20 in and around Johannesburg, South Africa, where as much as 20% of the country’s 8 million people with HIV live.*

### **South Africa: One of Every Seven HIV-Infected**

The initial Omicron cases were detected in samples collected Nov. 12-20 in and around Johannesburg, South Africa, where as much as 20% of the country’s eight million HIV cases are found. There are about 37.7 million HIV cases in the world, of which about 27.5 million are in sub-Saharan Africa. Of those, about 8 million are not getting anti-retroviral medicines to boost their immune systems. In South Africa, an astounding one out of every seven people is infected with HIV, and of its 8 million cases, about a third lack the benefit of therapeutics. Those 2.5 to 3 million people represent a fragile concentration of immune-compromised individuals, part of what de Oliveira described as their “mutation factory.” This appellation applies, even taking into account his caveat that Johannesburg—an airline hub that he compared to Atlanta, Georgia—could have imported an Omicron case. In that case, it would have been “amplified” by the immuno-suppressed, virus-welcoming region.

Earlier, in 2020, the Beta variant of COVID had first

been identified in the Nelson Mandela Bay area, an area on the southern Indian Ocean coast with the highest concentration of untreated HIV cases in South Africa. De Oliveira's team had good reason to be investigating a link between concentrations of immuno-suppressed populations, an increased rate of coronavirus mutations, and the production of new variants in the population.

South Africa went on to fight the coronavirus invasion with very little support. The country has an official unemployment level of over 30%. Over 1,300 health-care workers have died so far in the battle, greatly crippling the country's capacity. A shortage of vaccine doses vectored the limited supply toward the elderly, leaving younger populations completely uncovered. In 2020, Great Britain cut aid that resulted in such programs as the Joint United Nations Program on HIV/AIDS losing 80% of its funding. Testing for HIV has decreased by 22%.

Officially, there have been about 91,500 COVID-19 deaths in a country of almost 60 million. However, the 250,000 or so "excess deaths"—that is, deaths beyond what occurred in each of the years prior to 2020—indicate the official count may be less than half of the actual figure.

After Omicron got the attention of the West, de Oliveira's article, "Africa: tackle HIV and COVID-19 together"—co-authored with Nokukhanya Msomi, Richard Lessells and Koleka Mlisana—[appeared](#) in *Nature* (Dec. 1, 2021). It reviewed some of the above points and argued that leaving Africa behind in HIV/AIDS and COVID-19 will surely undermine vaccination efforts elsewhere. There must be full vaccination of Africa, the authors wrote, "to reduce transmission rates globally, limit the emergence of new variants and accelerate global control of the pandemic." The large immuno-compromised population must receive boosters promptly and on time. And the remaining diseases, besides HIV, must be conquered, including malaria and tuberculosis.

### The Sin of Omission

At about the same time that de Oliveira addressed the immunology conference, *EIR*'s last review of the COVID-19 fight included the following:

[T]he issue is the toleration of endemic diseases that weaken the human immune system. The human immune-deficiency virus (HIV) is still



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*Africa must be fully vaccinated "to reduce global transmission rates, limit emergence of new variants, and accelerate global control of the pandemic." —Dr. Tulio de Oliveira*

killing about 750,000 people per year in Africa, as are lower respiratory tract infections—each at about six times the COVID-19 level. Besides HIV, there are: the Ebola, Zika, Nipah (NiV) and Chikungunya viruses that are active and problematic; outbreaks of plague; and new organisms, such as *Rickettsia felis* and *Tropheryma whipplei*, that enter into the fray.

Beside what has already been mentioned, Africa has seen over the last twenty years outbreaks of measles, yellow fever, monkey pox, Rift Valley Fever (RVF), Tick-Borne Relapsing Fever, and a new genetic variant of *Mansonella*. There is every indication that prolonged conditions of economic deprivation weaken the collective immune systems of mankind, allowing for an increased rate of mutational activity of infectious agents.

The analysis appeared in the Sept. 3, 2021 *EIR*, "Beyond Pandemic: Biological Holocaust." The [piece](#) also included a summary of Lyndon LaRouche's interventions over decades in defense of public health.

The world figured out quite a while ago how to deal with unclean water and mosquitos. Given that the toleration of such conditions, directly causing deaths many times greater than those lost to the coronavirus, has gone on as long as it has, it is not a big surprise that the callous habits of thought in the so-called advanced sector have left parts of the world, at best, an afterthought in the current vaccine effort. But the virus doesn't operate that way.

Putting matters into proper perspective, it is simply pathetic to send to Africa COVID-19 vaccines that arrive too few, too late. (And it is adding insult to injury when they do arrive, that some are near their expiration dates and must be destroyed.) Further, though it must be done, it is not even a favor to Africa to send two to three billion doses of fresh vaccines. Other completely conquerable diseases have been, and still are, killing Africans at a much faster level than the new guy on the block, COVID. Rather, sending such vaccines would be a favor *to the vaccinated world*, to improve the chances that their own populations are protected.

What would be a favor to Africa, along with a salvation for the developed nations themselves, would be to mobilize our factories, our workforce, our scientists, our youth around a mission of permanently ending underdevelopment. The nuclear-based electricity, the massive water projects for hydroelectric power, transportation and clean water, the hospital and health care facilities, the mobilization of the talents of the vast African youth population—all of this and more has been long overdue. In its own way, it is the first sane and safe step away from a global financial blowout, and possibly from the recent nuclear saber-rattling.

### **Listen to What Omicron Is Telling You**

So, what does Omicron bring to a world where not taking vaccines doesn't work and, now, simply taking vaccines doesn't work either? Vaccines are one important tool in an epidemiologist's war chest to defeat the coronavirus; but, clearly, vaccines get outflanked when slowly and incompletely deployed. Delta already showed that the new variants move faster than a slow deployment of vaccines. (Vaccine efficacies against infection dropped from the 90-95% range down to the 50-70% range.) Omicron rubs it in everybody's faces, that you may not be able to jab new vaccines into your arms fast enough to keep Omicron, or its cousins Pi and Rho, waiting in the wings, away from your doorstep.

Governments have to mobilize science and industry in crash programs to stay ahead of the mutation process, but they have to mobilize their own populations to join the battle. These are populations that have grown deeply cynical of decades of their governments defending financial speculation above all, while selling out home mortgages, industrial and agricultural production, education, the hospital system built up under the Hill-Burton Act, and your pet cat. Is there any surprise that large portions of the population think government

defends Wall Street against their living standards and future?

### **Mr. Omicron on the LaRouche Year**

Admittedly, the one recent crash program in America that worked, Operation Warp Speed, initiated in April 2020 to rapidly develop vaccines, might have triggered a healthy memory of how the country had acted in its better moments—e.g., Project Apollo or the defeat of polio—when it had a mission, one for the benefit of humanity. But that didn't happen. Instead, the moment was lost in the mindless partisanship and narrow-minded, one-issue, “my-team-vs-your-team” fantasy games of American so-called politics. That was a few Greek letters ago.

Now, LaRouche's physical economy approach—reflected in his [Four Laws](#), and the [program](#) published in *EIR* for 1.5 billion jobs rebuilding modern, basic health care capacities worldwide—is alive and well, when all the attempts to step around it have failed. At core, it means simply addressing what should have been done all along, which undone brings malnourishment, compromised immune systems, and the breeding grounds for viruses, bacteria, fungi—and possibly things we know not of.

Hospitals, a trained health care workforce, nutritious food, and clean water require, as a start, modular nuclear electricity capacity, major water and irrigation projects, and nothing short of 15- to 30-year investments in the workforce.

The seeming inability of the financial system to even consider such things simply means that it is bankrupt—morally, conceptually and, yes, even financially. What else could it mean, when financial arrangements are so dysfunctional that clearly-defined projects, both necessary for present survival and key for maintaining and expanding productive potential, are deemed unprofitable?

Lyndon LaRouche, born in 1922, was that rare soul exemplifying Friedrich Schiller's aphorism, “Live with your century, but do not be its creature.” He relentlessly brought into the century in which he lived, that which was necessary for the future century.

This year, 2022, the centennial of his birth, is the year of LaRouche. It is, indeed, as Mexican President José López Portillo famously intoned, “time to listen to the wise words of Lyndon LaRouche.” Omicron, in its own blunt fashion, makes that clear.

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