Appendices

Unit 6

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UNIT 6
APPENDIX I

The political economics of medical research:
from searching for a cancer-causing virus to discovering the AIDS-virus:
by Joan Shenton[1]

How ever did HIV take off in the first place?

In order to understand how HIV ever came to be adopted as the cause of AIDS, it is not enough simply to run through the well rehearsed reasons advanced by the orthodoxy and then to list the points of disagreement offered by the scientists who challenge the established view. The history is far more interesting. It has to be told in context, carrying along the political and social climate surrounding the emergence of AIDS, and in particular the prevailing microclimates circling around the great virology laboratories of the times. This account of the history focuses on three men:

- Robert C Gallo and his circle of colleagues at the National Cancer Institute, part of the National Institutes of Health in Bethesda, Maryland.
- Luc Montagnier, a French scientist with his team at the Pasteur Institute in Paris first isolated LAV/HIV.
- Peter H. Duesberg, is a German molecular biologist with a previous reputation of having the best "lab hands" in the business. Based in Stanley Laboratory at the Berkeley campus of the University of California.

As the HIV bandwagon began to roll, Peter H. Duesberg, another retro-virologist based at the laboratories of University of California in Berkeley, began to write his discovered counter-evidence to the HIV causes AIDS hypothesis which Gallo upheld. Duesberg's first paper, critical of the HIV/AIDS hypothesis in the journal *Cancer Research*[2] had attracted a fair amount of attention amongst his peers and turned Gallo into a professional enemy. This was strange, because Gallo had once described Duesberg as the "guy who knows more about retroviruses than anyone else in the world." At a scientific conference in Germany in 1985 he introduced Duesberg as "brilliant and original, a scientist of extraordinary energy, unusual honesty, with an enormous sense of humour, and a rare critical sense which often makes us look twice, then a third time, at a conclusion many of us believed to be foregone."[3] But soon Gallo would be insinuating that Duesberg was not only wrong but mad, and that he hung around with unsavoury characters "in leather jackets." As far back as 1988 Gallo described Duesberg's ideas as "dangerous nonsense … He has now indicated to people that they can go out and fuck around and get infected by this virus and not worry.

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[1] This appendix is a continuation of UNIT 6's last section 5, written by Joan Shenton, adapted with the author's kind permission from Chapter 4 of *Positively False: Exposing the myths around HIV and AIDS* (1998) London: I.B. Tauris, pp. 32-46.

[2] Peter Duesberg (1987) "Retroviruses as carcinogens and pathogens: Expectations and Reality", *Cancer Research*, 47.5, CNREA 8, pp 1199-1220, 1 March 1987

[3] Robert Gallo (1985) "Introduction for P. H. Duesberg," *Haematology and Blood Transfusion,* vol. 29 in *Modern Trends in Human Leukemia* VI, (eds.) by Neth. Gallo, Greaves, Janka.

That's the part where I am mad at Peter."[4] Duesberg was once elected by his peers as Scientist of the Year three years running, academician of the US National Academy of Sciences and holder of an Outstanding Investigator's Grant from the US government. Then, for resisting the orthodox standpoint unquestionably, by maintaining scientific probity and critical distance, was henceforth unable to attract funding, shunned by his peers, and even prevented from teaching post-graduate students.

Duesberg was the inspiration behind the setting up of the Group for the Scientific Reappraisal of HIV, comprising now over 2,900 professionals internationally including scientists, academics and health professionals who challenge the virus/AIDS hypothesis.[5]

In a nutshell, Gallo became convinced that HIV is the cause of AIDS and that it is sufficient in itself to cause disease and death. In 1988 he told Anthony Liversidge in an interview for *Spin* Magazine that "HIV killed like a truck." and that talk of co-factors is "cock and horseshit … baloney."[6] He also said, in another interview "HIV would cause AIDS in Clark Kent [Superman] given the right dose and the right strain of the virus ... alone and of itself. No doubt in my mind."[7]

Montagnier was never quite so sure HIV could cause AIDS all on its own. In the very early days he was not sure if HIV was doing anything at all. As far back as 1983 at the Cold Spring Harbor Conference on human retroviruses, after describing his work on LAV-lymphadenopathy associated virus (which was later renamed HIV)—whilst emphasising that LAV *might* cause the lymph node abnormalities in AIDS patients, he said "many other retroviruses … might be causing AIDS." Seven years later he told us, "At first, we thought we had the best candidate for this virus to be the cause of AIDS. But after a while, even from the beginning actually, we thought for the activation of the virus in cells we need some co-factors." Montagnier believed that something else was needed—a co-factor or co-factors—in order to make HIV pathogenic (harmful). "So I would agree that HIV by itself, or some strains of HIV are not sufficient to cause AIDS."[8]

Duesberg believes HIV is not the cause of AIDS and that HIV is not biochemically active. It is simply a 'passenger', hitch-hiking retrovirus[9] that lives with us and is chronically dormant. It is barely detectable and consistently latent even in people with AIDS. He maintains that HIV and retroviruses in general, unlike ordinary viruses, do not kill cells. Indeed, it was for this reason that for ten years, retroviruses were wrongly suspected of causing cancer - a disease of uncontrolled cell growth. Paradoxically, this same type of virus was now blamed for causing AIDS, a disease where cells apparently disappear.

Retroviruses knit themselves into the DNA of their host cell and need to live with it. Anyone testing positive for HIV is demonstrating that the body's own immune system has done a good job by producing antibodies and neutralising the invader. Duesberg dismisses the co-factor theories by saying that introducing co-factors to bolster up a theory that is foundering is the sign of a bankrupt hypothesis.

In a 1994 interview for *Reappraising AIDS*, the journal produced by the Group for the Scientific Reappraisal of HIV Duesberg says, "In ten years of the most unprecedented

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[4] *New Scientist,* March 3, 1988.

[5] This statistic as of March 2013 is determined by signatories to Rethinking AIDS via electronic networking from Peru, Australia, Malaysia, Indonesia, United States, Europe, South Africa, Canada.

[6] Anthony Liversidge, *Spin* magazine, February 1988.

[7] Anthony Liversidge, *Spin* magazine, January 1988.

[8] "The AIDS Catch," *Dispatches*, Channel 4 (UK), Programme transcript, 1990.

[9] [In Unit 8, Köhnlein and Torsten Engelbrecht review briefly the meaning of 'retrovirus'—Ed.]

research effort we have no evidence that HIV is causing AIDS. The contrary is true. We have one million Americans who are HIV positive and are healthy, eight million Africans are HIV positive for eight years and are healthy, and half a million Europeans are healthy. 150 chimpanzees inoculated with HIV don't get AIDS and have these antibodies. How come no doctor ever in ten years picked up AIDS from a patient when they have treated them and we have no vaccine? How come 15,000 haemophiliacs live for ten years with HIV and don't die from it—instead their median lifespan doubles?"[10]

Duesberg and Gallo had been colleagues, but gradually they began to fall out in a big way. The duel between them is well known to those close to them. Duesberg's stories about Gallo are always accompanied by a generous helping of his wicked sense of humour. Perhaps the best documented account of their growing animosity is to be found in Gallo's section on Duesberg in his book *Virus Hunting* [11] and Duesberg's critique of the latter, "On Virus Hunting" in the *New York Native*.[12]

Gallo says, "One can only point out that Duesberg is a chemist, a molecular virologist. No physician, no epidemiologist, no health worker from any part of the world to my knowledge would agree with this (his) view."

Duesberg replies, "I wonder whether M.D. Gallo might not have been better cast using his medical training to treat AIDS patients than trying to resolve the 'molecular virology' of HIV and the 'chemistry' of AIDS."

Duesberg accuses Gallo of being so politically correct that he, "does not want to offend American homosexuals or central Africans and their microbes by assuring all of us that 'sexual transmission man to woman ... is probably the most common pathway to infection in the world and not man to man by sex, as we in the US tend to think. That, however," continues Duesberg, "leaves open the question as to why women represent less than ten percent of all AIDS cases in the US."

Gallo says, "... Duesberg's rush to the media has its dangerous side." To which Duesberg replies, "But Gallo, the father of science by press release, fails to explain why it is 'dangerous' for me, Montagnier, and others who question a hypothesis that in seven years of fierce research and annual investments that currently amount to 3 x 10 (to the tenth) dollars has yet to stop or contain AIDS, or even predict its spread."

Although this sparring might be regarded as entertaining, the key scientific differences of opinion between Duesberg, Gallo, and Montagnier, have never been properly reflected or reported. The consequences have been serious indeed. It is now apparent that people can live with HIV and never progress to AIDS, but for over a decade young men and women, on finding themselves antibody positive, have believed that they will die within ten years. The impact of this diagnosis, backed by the full weight of the medical orthodoxy, has led to countless psychological deaths.

Retrovirology—a catalogue of errors and mistaken assumptions

> "Some time after the War on Cancer, after discoveries became 'inventions' and researchers became entrepreneurs and Big Biology got too expensive to run without Big Business, biomedicine passed the point of being marshalled."
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> "The AIDS windfall," Barry Werth[13]

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[10] "Reappraising AIDS", recorded interview series, 1994.

[11] Robert Gallo, *Virus Hunting, AIDS cancer and the human retrovirus.* New York: Basic Books, 1991.

[12] Peter H. Duesberg, "On Virus Hunting," *New York Native*, April 29th, 1991.

[13] Barry Werh, "The AIDS Windfall," *New England Monthly*, June 1988.

When US President Richard Nixon declared 'war on cancer' in 1971 and the National Cancer Act was passed, the National Institutes of Health's National Cancer Institute was dominated by virologists. Robert Gallo, and colleagues like Howard Temin and David Baltimore and Myron (Max) Essex were there at the ready with millions of dollars at their disposal, ready to find a viral cause for cancer.

The intensity and enthusiasm encompassing the field of virology has to be seen in the context of the invention and use of the electron microscope. Its development in the 1940's led to a school of molecular biologists and virologists who were able to probe deeper and deeper into cells, eventually magnifying them up to 50,000 times. What they saw was all new territory, and what they mistakenly did was ascribe diseases to particles they subsequently identified as retroviruses - *because they were there*. But association has never been proof of causation and research in this field turned into scientific reductionism (ad absurdum) which in turn led to a series of monumental mistaken assumptions. Institutional arrogance, unaccountability and staggering displays of greed and vainglory cemented one mistaken hypothesis on to another to form an unassailable construct—the virus/AIDS hypothesis.

Interest in possible cancer-causing tumour viruses had been stirred at as far back as 1910 when Peyton Rous found he could induce tumours in healthy chickens by inoculating them with tumour tissue from chickens with sarcomas. But no one was able to duplicate Rous' results when they tried to repeat the experiments in other animals. It is Duesberg's view that retroviruses like the Rous sarcoma virus are of little clinical relevance to disease in animals or humans. "That (virus) has killed probably one chicken outside the laboratory" he says. "But there are two Nobel Prizes and twelve National Academy of Sciences members for that chicken alone. They don't ever say it that way, but it's true."[14]

In his book *Virus Hunting*, Gallo gives his own interpretation of what he saw as the noble search for a viral cause for disease. He takes us through the early days of animal retrovirus hunting. Key researchers in the field were Harvard scientist Max Essex, and William Haseltine, who, together with Gallo, led the search for cancer causing retroviruses during the heyday of the cancer campaign. Gallo then moves on to the discovery of oncogenes (incidentally it was Duesberg who identified the first one in his own lab).

It was thought that oncogenes might hold the key to all cancers. The oncogene is a special gene which when incorporated into the genetic material of a virus was thought to be able to convert a normal cellular gene into a cancer gene (or cellular oncogene). However, Duesberg, having tested the relationship between cellular and viral genes, pointed out that viral oncogenes are so rare and so artificial that they are not relevant to cancer in humans or wild animals,[15] thereby overturning the main premise of cancer research of the 1970s and 1980s and as a result, disinviting himself from any of the major scientific conferences on the subject. To date, there have been no major breakthroughs from the oncogene work and no virus has been found that can cause a conventional cancer tumour in humans. Most importantly, there is still no evidence that cancer is an infectious, transmissible disease.

At about the same time (1970) came the discovery of reverse transcriptase activity, which led to the identification of retroviruses. This enzyme enabled an RNA-based virus to knit itself into its host cell's DNA nucleus. No one had believed that this could happen. It was always thought that DNA converted to RNA but not vice versa. This led to the Nobel Prize being awarded to Howard Temin and David Baltimore in 1975. Many say Professor Harry Rubin at Berkeley did the important pioneering work on this and should have been

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[14] Stephen S. Hall, "Gadfly in the Ointment," *Hippocrates,* September/October 1988.

[15] "Haematology and Blood Transfusion," Vol 29, *Modern Trends in Human Leukemia* VI, (Eds.) R. Neth, R.C. Gallo, M.F. Greaves, G. Janka, 1985.

recognised for it.

All of this spurred Gallo on, he says, "to look for the first cancer-causing human retrovirus."[16] But here began a catalogue of calamitous errors that would make even the most dedicated follower of fashion in science shudder. It also lends us a clue as to the way in which other huge 'mistakes', like the mix-up between Montagnier's and Gallo's "AIDS virus" and what some argue to be the biggest mistake of all—attaching a single viral cause for AIDS—came to be made.

The first mistake came hard on the heels of Temin and Baltimore's discovery of reverse transcriptase. When reverse transcriptase was found it was thought to identify retroviral activity and hence infection because retroviruses were known to require reverse transcriptase in order to knit themselves into their host cell. Gallo swiftly announced finding evidence of retroviral infection in human leukaemias. It was described as a 'milestone discovery' because it was the first time evidence had been produced linking retroviruses with disease in humans. Scientists around the world desperately tried to reproduce his discovery but failed. Gallo's critics thought that by linking himself to the work of Temin and Baltimore, he (Gallo) might be heading for a Nobel Prize a few years hence,[17] but his 'milestone discovery' was found to be an uncontrolled artefact, in other words a false positive.

The signs of serious over-enthusiasm appeared in 1975 when Gallo announced that he had isolated the first human retrovirus from a leukaemia patient. He was all set to discuss his findings at the annual Virus Cancer Programme meeting in Hershey, Pennsylvania and in preparation had sent some samples for independent examination. To his dismay he heard at the meeting that his human retrovirus was no more than a laboratory contamination of not one, but three different animal retroviruses, from a monkey, a gibbon and a baboon!

Gallo was deeply hurt, and angry enough to suggest that there had been some 'monkey business'. "I mean, what could it be but sabotage? One contamination can occur, but three? In fifteen years I had had one contamination from a mouse. But three?"[18] This incident prefigures the vehemence with which Gallo initially denied the accusation that his HIV virus was a contaminant from Montagnier's lab.

Commenting on the Hershey incident Gallo said, "What surprised me is not the findings—as I say, I was already developing my own doubts—but the vehemence with which they were delivered. More than one speaker used our misfortune to ridicule the very idea of a human retrovirus. It seemed as if a special effort were being made not simply to point out our error but to put the final nails in the coffin of the study of human retroviruses."[19]

In 1977 The National Cancer Institute's Virus Cancer Programme was abruptly closed down. Duesberg's epitaph for the programme runs as follows, "When you're in the retrovirus business you can detect a retrovirus. When you look at disease, you can look for the retrovirus. We have done that before with multiple sclerosis, we have done it with sarcomas, and in almost all cases a virus was found sooner or later. What was not emphasised by many of these laboratories was that the same viruses were subsequently always found in healthy carriers and that's why the virus cancer programme is essentially a failure."[20]

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[16] Robert Gallo, *Virus Hunting*, op.cit.

[17] Abraham Karpas letter to Serge Lang, February 1993, *Why we will never win the war against AIDS*, Bryan J Ellison & P.H. Duesberg, Inside Story Communications, El Cerrito, California, 1994.

[18] Jad Adams, *AIDS—The HIV Myth*, New York: Macmillan, 1989, p. 43.

[19] Robert Gallo, *Virus Hunting*, op. cit.

[20] Peter Duesberg, "AIDS—the unheard voices," *Dispatches.* Channel 4 (public television broadcasting UK.) rushes transcript, 1987. [See in Unit 8 section 2 of this Course Reader, the

The development from cancer retro-virology to AIDS retro-virology

The researchers formerly occupied with investigation at the National Cancer Institute had tried to find a viral cause for cancers, then breast cancer, then multiple sclerosis and even Alzheimer's disease. All attempts had failed. There was no more funding available for this research trajectory.

Gallo needed a professional breakthrough and he finally had one. He took cells from patients with leukaemia, grew them in cell cultures and found reverse transcriptase activity. There had to be a retrovirus there, he reckoned. He called it Human T-cell Leukaemia Virus (HTLV). This became the first of a series of HTLVs (from HTLV-I to HTLV-V) that Gallo gathered together into a family of retroviruses, but not all of them were obedient children. One of them, HTLV-III, which he declared was the cause of AIDS, was particularly wayward.

But before we discuss Gallo's 'AIDS virus' we need to understand exactly how HTLV-I gained credence.

In Japan, in 1975, clusters of cases of leukaemia in elderly patients had been noted in the two southern islands. Kiyoshi Takatsuki of Kyoto University had called it Adult T-cell leukaemia (ATL) and wondered if there might be an infectious cause. Two other scientists, Yorio Hinuma and Isao Miyoshi were also on the trail, and had isolated a retrovirus which Gallo says was identical to his HTLV. Gallo claims he and his colleagues isolated the first examples of HTLV in 1978-1979, and the results were published in 1980. There was a rush of excitement as the same retrovirus was identified in black patients born in the USA and in people from Caribbean countries, South America, Africa and Japan. The leukaemia condition itself, Gallo said, could take from a few years to forty years to develop, and he began to speculate wildly about the origins of his discovery—that the retrovirus had come from Africa, where it had infected Old World primates and humans and had reached the Americas through the slave trade. He even suggested that Portuguese traders could have taken the retrovirus to Japan in the sixteenth century—via imported slaves and monkeys.[21]

Gallo clung fiercely to his hypothesis that HTLV-I was capable of causing disease and it is interesting to read the bullying tones he and his colleagues used whenever anyone dared to question his claims. One fellow scientist, Dr Carlo Croce in Philadelphia had been so bold as to say he thought HTLV-I was an *indirect* cause of leukaemia [author's emphasis]. A stern rap on the knuckles was fired off to Croce by Gallo in a letter dated February 10th, 1986. "Surely if you are aware enough to comment on HTLV-I disease you ought to do it with greater care. Obviously, you speak semantically when you say HTLV-I is an indirect cause of T-cell leukaemia.... What is most surprising to me is that your arguments sound straight out of a 'Duesberg performance' ... In short, Carlo, I was surprised by the rapidity and zest of making these conclusions. They appear self-serving and are not helpful to you or to the field."[22]

Gallo sent copies of the letter to William Haseltine and others. Haseltine's reply to Gallo is a fine example of how the "keepers of the received wisdom" stick together, exercising peer pressure to maintain the consensus. "Dear Bob", wrote Haseltine, "I was pleased that you wrote a note to Carlo... I hope that Carlo takes your advice to modify his

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significance of this remark emerges in light of J.S. Mill's second principle of causal reasoning labelled 'the method of difference'.—Ed.]

[21] Robert Gallo, *Virus Hunting*, op. cit.

[22] Robert Gallo, letter to Carlo Croce, February 10, 1986.

talks appropriately."[23] Always remembering that it was from the HTLV (human T-cell leukaemia virus) family that Gallo claimed the AIDS virus had sprung, it is interesting, with the benefit of hindsight, now to reassess the significance of this "first human retrovirus", HTLV-I, that had risen to fame so quickly.

The problem was, and even Gallo admits it, that the same retrovirus could be found in perfectly healthy people. In fact, he himself states that only 1% of people "infected" with HTLV-I ever developed leukaemia and the latency period could be as long as forty years.[24] A Japanese study put the incidence of Adult T-cell leukaemia in people with antibodies to the virus as low as 0.06 percent.[25]

As Gallo continued to gather his HTLV family around him—HTLV-II came next and then the infamous HTLV-III (later to be called HIV, much to Gallo's chagrin as it could no longer be included within his HTLV family)—Duesberg's doubts grew in a very big way. As he began to voice his disbelief about the role of retroviruses in disease, some of his colleagues began to listen and he was invited to write his pivotal paper for Cancer Research. This article, "Retroviruses as Carcinogens and Pathogens: Expectations and Reality" with its 280 references was published in March 1987[26] and was the first of a series of devastating attacks on the whole field of oncogenes and virus/cancer research, and also of the virus/AIDS hypothesis. Before we tackle Gallo's claims that his discovery, HTLV-III (i.e. HIV) was the cause of AIDS, we must record Duesberg's criticisms of Gallo's earlier assertions that a retrovirus like HTLV-I could cause cancer.

In his *Cancer Research* (1987) paper Duesberg describes retroviruses as the most common and benign passenger viruses of healthy animals and humans, probably because of the unique way they have of co-existing with their host cell without causing disease symptoms and also because of the way they can replicate without killing their host cell. He points to the very few cases of leukaemia in animals and humans infected with retroviruses—the risk being as low as 0.1 percent which is a low as the risk of leukaemia in animals and people without the virus. Duesberg goes on to explain that the only role the suspected retroviruses called oncogenes play in cancer is to cause abnormal cells to be made (hyperplasia) which are not necessarily malignant. The only way this abnormal accumulation of cells can occur is when the virus is forced into highly concentrated levels in "hothouse" laboratory conditions. Hardly ever has an animal outside the laboratory developed a malignant cancer from these viruses and never has there been a reported case of a human developing cancer from them. He concludes by saying that latent retroviruses are almost always involved in all natural infections but they do not, either directly or indirectly, cause cancer tumours. They are simply passengers and should not be regarded as targets for cancer prevention or cancer therapy.[27]

After publication of his article Duesberg was interviewed by author, John Lauritsen. Duesberg told him he did not think HTLV-I played any role at all in leukaemias. He emphasised his point that only in laboratories, where animals are forced by injecting high quantities of virus into them before they have properly developed their own immune system to resist this assault, do they produce abnormal cells.[28] Although most of the *Cancer*

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[23] William Heseltine, letter to Robert Gallo, Febrary 24, 1986.

[24] Robert Gallo, *Virus Hunting,* op.cit.

[25] K. Tajima and T. Kuroishi, Japan *J. Clin. Oncol*, 15: 423-430, 1985.

[26] Peter Duesberg, "Retroviruses as carcinogens and pathogens: Expectations and Reality", *Cancer Research*, Vol 47, No 5 CNREA 8, pp 1199-1220, 1 March 1987. [This paper appears as an appendix to Unit 8 of this Course Reader.—Ed.]

[27] Ibid.

[28] John Lauritsen, *The AIDS War*, Asklepios, New York, 1993, p 50-51, ISBN 0-943742-

Research article challenged the accepted view of the relationship between retroviruses and cancer, the last section led on to challenge the virus-AIDS hypothesis.

Duesberg's key points were that the level of HIV in the body, even in advanced AIDS was too low to cause disease; that a retrovirus like HIV was not capable of killing its host cell and going on to infect others; that the latency period did not make sense, because viruses cause infection when they enter the body and cannot wait five or ten years before they cause harm; and that the cases of AIDS without HIV and HIV without AIDS made a nonsense of infectious virus-causes-AIDS hypotheses.

These important points had never been put before yet here they were, published in 1987 by a prestigious scientific journal. After studying them carefully we became convinced that we should pursue these lines of argument further. It was this article, first spotted by my colleague Jad Adams, that changed the course of our lives, and set our small team off on a 10 year quest to document one of the most fascinating battles ever, at the leading edge of science.

Gallo links HTLV-III to AIDS

The idea that AIDS might be caused by a retrovirus was circulating as far back as 1981. All of the early cases of AIDS were identified by the fact that the young men with symptoms of AIDS shared a common factor, their T-cell count was very low. T-cells are a subset of white blood cells that are crucial to the immune system. By 1982, after hearing James Curran of the Centres for Disease Control describe cases of young men with a very low T-cell count and express the view that they might be looking at the first signs of a newly emerging and potentially epidemic disease, bells began to ring in Gallo's head. What could be affecting these T-cells, he wondered? "Intellectually, I began to play out one scenario. What if AIDS were due to a mutation of an HTLV, probably occurring in Africa, which had spread to Haiti, then to the United States.?"[29] Gallo's friend Max Essex had already been working on the idea that if HTLV-I could infect T-cells and cause leukaemia, why couldn't it also cause another disease during its [alleged] long period of latency? As AIDS reportedly affected T-cells, why couldn't HTLV-I also cause AIDS?

It was from then on that AIDS, which until then had been just a collection of disparate symptoms, began to be labeled as a single disease with a single infectious cause.

Once the word "infectious" was introduced all the epidemic-control alarm bells were set off at once. The problem was that if HTLV-I were supposed to cause infected cells to multiply and grow into cancers, how could it at the same time kill T-cells off? "Indeed," write Duesberg and Ellison, "retroviruses had seized the high ground of cancer research in the 1970s precisely because they did not kill infected cells, but rather integrated themselves into the cell's cancer-causing agents. Still, Essex's hypothesis, implicating HTLV-I appealed to Gallo—until he finally noticed the contradiction. Gallo then quietly changed the name of the virus; for Human T-cell Leukaemia Virus he substituted Human T-cell Lymphotropic Virus, meaning one that favours infecting T-cells [or T-Lymphocytes]. This new name implied neither cancer nor cell-killing, thereby maintaining an ambiguity that could allow the virus to cause both diseases at once."[30]

In other words Gallo, realising that HTLV-I had been associated with the cell proliferation necessary to cause a cancer like leukaemia, now had to explain how the

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08-04. [Chapter XXXIII of *The AIDS War* appears here in Unit 6 section 2—Ed.]

[29] Robert Gallo, *Virus Hunting,* op.cit.

[30] Bryan J. Ellison & P.H. Duesberg, "Why We Will Never Win the War on AIDS", Inside Story Communications, El Cerrito, California, 1994.

retrovirus he claimed to have discovered could work in an opposite way and kill cells off. He simply distanced HTLV-I from leukaemia by substituting the L for leukaemia in HTLV-I to L for Lymphotropic. 'Lymphotropic' means a preference for T-Lymphocytes, which allowed Gallo to cover all his options.

Together with his co-workers Gallo set about testing the blood of patients with AIDS, and after enormous efforts to find a cell line they could work with, as well as pooling ten different retroviruses into one brew (a technique that has been highly criticised by fellow scientists) Gallo came up with a new retrovirus which he duly kept in the family and named HTLV-III. It was now 1984.

In the meantime, at the Pasteur Institute in Paris, Montagnier and his co-workers had also been busy isolating a virus strain from a young man with swollen lymph nodes. They came up with a retrovirus they cautiously named LAV (Lymphadonopathy associated virus). Gallo encouraged them to write up their results and in April 1983 he sent Montagnier's paper to the journal Science. Montagnier had been in touch with Gallo, and Gallo had offered to look through the paper before its publication. Montagnier had not written an abstract for the paper, so Gallo offered to write it for him and read it to him over the telephone. Gallo had written the following lines, "We report here the isolation of a novel retrovirus from the lymph node of a homosexual patient with multiple lymphadenopathies. The virus appears to be a member of the human T-cell leukaemia virus (HTLV) family."[31]

This last sentence was to reverberate through history. Montagnier claimed later that he had not fully understood Gallo's English on the telephone and would never have accepted Gallo's linking LAV to his HTLV family.[32] However in July 1983 Montagnier brought Gallo samples of LAV together with photographs.

Oddly enough no one had taken much notice of Montagnier's 1983 paper in *Science*. Then in the spring of 1984 word got out that Gallo had finally tracked down the cause of AIDS. It was Gallo's own HTLV III. As a result a most unusual thing happened. Before the publication of any information about HTLV-III and AIDS to the scientific community, a press conference was called. Margaret Heckler, Secretary of the Department of Health and Human Services, with Gallo by her side declared, "The probable cause of AIDS has been found."

On the same day Gallo filed a US patent for the HIV blood test kit he had developed. Dr Kary Mullis, who was awarded the 1993 Nobel Prize for chemistry for inventing polymerase chain reaction, a method of DNA/RNA amplification, subsequently used to detect HIV in blood samples, shakes his head when he remembers that day. "Why they did it I cannot figure out. Nobody in their right mind would jump into this thing like they did. The secretary of health just announcing to the world like that that this man Robert Gallo, wearing those dark sunglasses, had found the cause of AIDS. It had nothing to do with any well-considered science. There were some people who had AIDS and some of them had HIV not even all of them. So they had a correlation. So what?"[33]

Mullis is equally scathing about Montagnier's labeling of his isolate, from the lymph node of a homosexual man, as the cause of AIDS. "Just because someone who needed to find a clinical connection with a virus belonging to the only type of virus he knew how to work with, found one of them in a patient who had a new disease that was beginning to play a role in medicine, he blamed it [the virus] as the cause ... Do you see how it works? ... Anyone looking into this would say this man had a personal interest in finding a link between his own virus and this disease. Did Montagnier investigate all known viruses, and then finally, for

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[31] Barre-Sinoussi, F. et al, Science, 220, 868-871, May 1983.
[32] Personal conversation with Peter Duesberg, 1989.
[33] Celia Farber, reporter "Fatal Distraction," *Spin* magazine, June 1992.

some good reason, home in on this one? Because, if he had looked for any other virus in that lymph node, he would have found it. And that was already in the literature."[34]

From the day of the Washington press conference, the virus AIDS hypothesis became gospel and the money started to flow. Gallo received $100,000 a year from the test patent. William Haseltine, one of Gallo's close working colleagues in the darker days of retrovirus-linked cancer research, had formed a biotechnology company called Cambridge Bioscience and invited Max Essex to join him. This suited Essex well, from his position at Harvard's School of Public Health. Although Harvard would own the patents on anything he discovered, Cambridge Bioscience would have the license which is where the real money was made. " Thus Harvard would have a vested interest in what research Essex chose to give priority to and how he assigned graduate students to experiments. It was a blurring of business and education ..." wrote Barry Werth in *New England Monthly*. Essex had connected HTLV with AIDS a year before the putative cause of AIDS was identified and he clung to his theory even after the discovery of HIV. "His reluctance to consider the doubts about his work raised concern over his role in AIDS from the start - and not only his role. Other researchers began suspecting Essex, Gallo and Haseltine of having their own agenda to promote the particular family of retroviruses first found by Gallo. This was said to explain Gallo's attempts to have the AIDS virus named HTLV-III."[35]

Needless to say, when HIV and AIDS became big business, Essex and Haseltine became millionaires, in spite of yet another monumental blunder on Essex's part. He was investigating two AIDS-related viruses, one in African monkeys, and one in apparently healthy prostitute women in Senegal. These 'new' virus isolates were, of course, quickly patented. But then a young Harvard scientist called Barry Mullins discovered that both of the much talked about 'new' AIDS-related viruses were no more than contaminants from domestic monkey viruses that were being worked on in an upstairs lab!

"Congratulations!" exclaimed my colleague Michael Verney-Elliott, "The people who did not bring you the cause of cancer have now not brought you the cause of AIDS."

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[34] "Repensar el SIDA - Lo Que No os Han Dicho", Interview in *Toledo* by Javier Manero Vargas and Miguel Albinana. Edited by Alfredo Embid-Madrid, 1994, ISBN 8488346O69.

[35] Barry Werth, "The AIDS Windfall," *New England Monthly*, June 1988

Appendix II
Unit 6

AIDS dissidents arrested, tortured, detained without trial in Uganda

by Ricci Davis

July, 2008

Alberta (Canada) Reappraising AIDS Society
http://aras.ab.ca/articles/popular/DissidentAbuse.htm

I was in Uganda for six months again until the beginning of June, 2008. My dissident efforts once again did not create a knock on effect. This is an account of the gruelling experience after my friend Mustafa and I were arrested in Kampala on 10th May:

On KFM Radio during April there was a huge campaign promoting AIDS. In March the AIC (AIDS Information Centre) announced via the media that door to door "HIV testing" would begin. I imagine this is what could have prompted Joint Clinical Research Council (JCRC) to compete by investing its USAID, PEPFAR (Presidential Emergency Foundation for AIDS Research) etc. funds into a similar theme.

The usual mixed messages were repeated: Testing positive is a death sentence and know your sero status. At the JCRC series of events held at a new location each week, its campaign specifically targeted children, especially children with generalised sickness. not so surprisingly the organisers sold the event on the basis that on–site testing of both children and their parents would be done free of charge. Moreover those found to be "infected" would be referred to the health clinic for free counselling and free treatment. All locations were deliberatly in slum areas.

Posters and banners on this day were attached to just about any fixed object, changing the atmosphere for the day. In general AIDS promoters openly refer to the poor as "ignorant"; inferring that they must be ignorant because they are poor. Today was no exception. The propaganda would have the near-destitute people believe that they could be "a tower of strength to their community", simply by bringing their children to be tested. In the centre of the field a stage would be set up and prepared for activists to drive their mantras home to the audience of children. Of course all the children in the area made a bee-line to the source of the noise out of curiosity, not usually being considered worthy of entertaining. No children would be tested without a guardian's consent, I was told.

Even so, with such a huge initiative, paid for by the American taxpayers, coming almost to the doorsteps of the poorest and most vulnerable; who among the adults would suspect that the free services offered might just be another Trojan Horse! Of the many activists I spoke to there that day proudly wearing their organisation's T shirt with a printed caption on, none seemed to have any medical background and all were convinced that services they were promoting must be good; because they were "free". The recorded interviews I made bore witness to who the ignorant folk really are. The question, do the tests really work? would be

answered thus: “Yes, when a drop of blood is placed on the strip and the client is HIV positive you can see a colour change”. To the question, do you know the names of the brands of tests being used might be answered thus: “No, but they do use three types of tests.”

Apart from orthodox AIDS researchers agreeing that rapid tests are all unreliable it seems plainly obvious to me that if there was even one reliable “HIV test” then that one would be the one used. Globally. Except that “false–positive results can be expected with any test kit” as according to the Abbott Laboratories test kit insert. The fact of the matter still is that there is no way of distinguishing between cross reactions and real reactions on non–specific antibody tests.

One activist I interviewed, ten minutes into the conversation on the subject of reliability of tests, readily described how he, as a child, happened to test positive and his councillor at the time told him not to worry about the result. Would that be the advice given today after the climate of fear has intensified? Years later he tested again and the result was negative. I asked him how they could promote something that he knew didn’t work correctly? He minimised his own experience.

In the middle of the afternoon the HIV worshippers used their drama skills to attract several hundred attentive children of all ages to listen to the life/death mantras. Some lucky young kids were invited on stage to sport JCRC T-shirts with a mantra printed on, while mimicking the dance of the leaders imagining themselves to be stars of the day.

Asked if the free anti–HIV drugs had proved to be a success with previous treated children, the young excited activist unwittingly answered that it was not known since the program to test and treat children was still relatively new. In a moment of glee, asked if he wanted everybody in Uganda to take anti–HIV drugs he replied, “yes”. He must not have known then that the main cause of death for American AIDS patients is liver failure according to the scientific research available. Of all those interviewed none had read any of the disclaimers printed on the inserts by the manufacturers of either the tests or the drugs being promoted.

My questioning created negative attention among some employees and they became suspicious. I was then ordered by security to move away from the area where people were being tested in order to maintain patient confidentiality. Yet actual testing was conducted in the open in the middle of a public field! I did as I was told and left as the atmosphere was becoming tense.

Two Weeks Later…

I arrived with my friend Mustafa at another location primarily to film the action on the stage and to have what was addressed to the 200 strong audience of minors translated and subtitles added. There would also be time to interview activists, members of the public and even lab folk and doctors if the opportunity arose. As we arrived by bus we soon realised that the event had not yet begun because employees were still setting up the stage and tents in the field just off the main road in Natete, near Kampala. My arrival was noticed by one or two members of staff who seemed to be smiling in my direction. I ignored them and suggested to Mustafa that we head for the restaurant across the road.

We had barely sat down when two men entered, announced that they were policemen and that we were under arrest. Something about filming without permission. There was no opportunity to protest and show them that the cameras remained inside the zipped bag or that there had been nothing to film since the event had not yet begun. We were directed back across the road to the police station next to the field. We were ordered inside an office and asked to sit ourselves down. Our property was taken from us. There were other people who were not policemen inside the room too. After some minutes curious and resentful looking JCRC members closed in to assure themselves that I was indeed out of arms reach and would remain so for the duration of their "compassionate" efforts to be delivered for the day. We were informally asked basic questions about ourselves. Soon a man I suspected to be posing as a policeman sat himself down, and while ready to write, began posing a series of questions: My names, age, profession, where I had travelled in Uganda and the motive etc. After a couple of minutes I insisted on being told what I was being charged with. As I got no reply I stopped answering questions. This man gave up, left the room and I didn't see him again.

Being denied any explanation, the hours seemed to be passing us by and I became concerned, despite reminding myself that I had done nothing illegal, my visa was still valid. Worried perhaps because of the atmosphere of concern from the JCRC employees who seemed to have more of a military aura about them than a medical one. What unnerved them all the more was my making a call from my phone to get a message to journalist Andrew Mwenda. I managed to speak to a friend of Mwenda and was told that Mwenda was interested in dropping by to investigate my misfortune.

Central Police Station

After about two hours and without warning we were taken out of the office and into a waiting police car accompanied by two CID officers and two uniformed policemen in the open back. It took us to CPS (Central Police Station) where we were taken up to the first floor and told to sit down in an office, occupied by a detective who hadn't much to say and continued working. Mustafa and I were allowed to communicate freely. After about half an hour the door opened and a policeman ordered Mustafa to follow him. After about one hour he returned distraught pleading to both the uninterested detective and I that it be noted that he had been slapped and abused. That he had not committed a crime did not matter, because he is African and has no rights.

Next it was my turn, I knew. The door opened, a policeman ordered me to follow, we went up a floor and I entered a huge room where almost three rows of chairs were taken up by policemen of various ranks. At the far end of the room was a row of desks and behind one sat what would be the interrogator. I was seated on a bench alongside the window and between the interrogator and the audience of policemen. I was asked the same basic questions as before and although it did seem as though this might be a deliberate attempt to intimidate me I decided to conform, but as the questions continued to delve into my professional and economical history I regrettably began to sound impatient and such apparent lack of respect

must only have humiliated the detective all the more. Since I knew that the questioning was going to lead them nowhere and that none of my answers would be considered acceptable it became uncomfortably clear to me that this process was going to last for some time to come. If only I had been in possession of my passport there would have been no problem, I kept being told. I was reluctant to disclose the whereabouts of it because it was at Mustafa's home and I didn't want to bring trouble and embarrassment to the home.

The 'Safe' House

Eventually it became evident that I had no choice. Maybe it would end the palaver, now that I seemed to be treated as a spy. At around 7pm, 8 hours after the initial arrest, we were taken out of the big building to a parked unmarked police car. It was twilight and what was to come next I dared not speculate. After a moment the rear door was opened and I was ordered to get in, lie down and keep my head down. A garment was thrown over my head and I was ordered not to remove it. Mustafa was put into the back of another car where he told me later he was lying on the floor with policemen's feet kept firmly against his head and body throughout the journey to the next place. After a fifteen minute journey, once the car I was in had stopped, I was able to look up and observe that we were inside a walled compound there were black painted vehicles with no markings on and soldiers patrolling around what seemed to be a normal house. As Mustafa left his vehicle he was clearly disorientated by his head being covered by the T shirt he was still wearing only it had been pulled up and tied at the top to prevent him from seeing anything. We were kept separated and directed by different military styled personnel to different parts of the house. I lost sight of Mustafa almost immediately and realised once again that he had more to fear than I simply for being Ugandan. I was led to a detention room that was bare and the door was then locked from the outside. Nothing was said, the fact that not even a reference to being charged was now far from my mind. I was apprehensive to say the least. I could be in here a long time and nobody would know where I was, I thought. Only Mustafa knew my whereabouts. Solitary confinement ended after only ten minutes and I was taken upstairs and entered a room where there was a frightful number of soldiers and policemen. About eight in all. All standing and all looking prepared for something exciting to come. Mustafa was also there. Not appearing to be distraught but he was. This became clear as he kept repeating the words, "tell them the truth, just tell them, tell them whatever they want to know… " I realised that what he was saying made sense and should not be questioned. The great admission had to be revealed before the squad.

"Where do you stay?", an authoritarian voice demanded to know. I replied that I lived in Zana in Mustafa's house and that that was where my passport was kept. among two of these standing nearby it appeared that they harboured violent tendencies and one had to be hindered from proceeding towards me. I dare not think what might have occurred had I been uncooperative. I was asked if together we could go to the home where I stayed and peruse my passport. I agreed. As if I had a choice anyway.

To Mustafa's House

About eight of us set off in two vehicles at around ten O'clock from what Mustafa would later refer to as a "safe house" in the direction of home, but only for a visit I knew. Prior to departure, obviously I was not going to be charged with anything, I was placed in handcuffs, which were deliberately clasped too tightly around the wrists and left me in constant discomfort. There was a short stop at Zana police station and I took the quiet moment as an opportunity to request to the policeman next to me to loosen the cuffs. He replied that he was unable to assist because the key was with a man in the front car. We arrived home after pulling up to the house this late and in two strange cars and entourage. Mustafa gave them access to the house and showed them into our room. In a moment everything will be over once my passport and visa were inspected. I unlocked the suitcase and produced the passport. The nearest policeman took it and without even showing any interest in opening it, he said, "we want to look in the case, bring it and put it on the bed where we can see it what you have." I did as was instructed and stepped aside. The many contents were sorted out into two piles. They would take the electronic gadgets, DVDs and printed sheets of A4 paper and leave the books, clothes and other things. Other members of the household began to appear and were questioning and being questioned while drawn to the realisation that I was in handcuffs.

Forms had to be signed by members of the household for possessions retained by the police. After which we returned to the cars and Mustafa was taken to the safe house in Kololo and I was taken to CPS and told that I would be spending the night in jail along with strangers, suspects of whom may also have committed no crimes.

A Night in Jail

At around midnight I was handed over to the station corporal at CPS called Okura. He politely asked if I had eaten anything to which I replied that I hadn't. I would of course have to pay, but at least food could be fetched from outside. I made the suggestion of snacks and milk tea and that the person being sent should buy enough to go round those on duty, since Okura was nice enough to list every single bank note I had in my possession without much of a complaint. He had said that it would not be safe to spend the night in the cell with money with me. There must have been over 50 notes in about 15 currencies and taken over 40 minutes to itemise. After the tea and chat were over he explained that he would be unable to allow me to remain in his office the whole night, because he would get into trouble with the superiors in the morning. I had confided in him my fear of being jailed with non–Western suspects for a while night. He had escorted me down and wanted to put me in the hands of a man in charge down there who neither resembled a policeman nor someone employed in my respectable position. He wore no uniform and even had the appearance of an alcoholic suspect. A delayed smile greeted me following the brief introduction as I looked back to PC Okura as a plea to provide an alternative. The only alternative was to sleep in a room nicknamed the "Sheraton", which to the uninitiated exists for the privileged who could afford to pay their way out of cleaning duties, sleeping on the hard floor and being shouted at 7am. Among the privileged in the "Sheraton" were about twelve

suspects including one South African and one Indian man. In the unprivileged section of the jail were about seventy suspects. There most certainly was commotion consisting of shouting, whining and shrieking while orders were given to the seventy unprivileged suspects to do their part in mopping and cleaning the floor and toilets on their knees. Members of the privileged seemed to take a discreet pleasure in looking on as duties were attended to. I was calculating on only being here for one night and my interrogators collecting me on time, around 9am.

Back to the Safe House

My calculation was correct. I was taken back to what I was later told by the Danish ambassador who lives next door, is the anti–terrorism detention building. There was no being reunited with Mustafa. Instead I was kept in the dark so to speak, periodically questioned along the same lines as before. All questions and answers leading nowhere. Later in the afternoon I witnessed large denomination bank notes exchanging hands twice and wondered where so much money could come from considering that policeman in Uganda typically earn so little officially. I was left sitting with my own thoughts for the most part but always with someone present. It was getting late in the day and I began to sense the possibility of spending a further night in the slammer. I resisted the depressing thought. I'm a dissident, not a terrorist, but I remember now that in the eyes of those who are obsessed with controlling the world, the two should be dealt with in the same way.

Ricci Released, Mustafa Still Imprisoned

After further ado I was indeed released, albeit quite late, and arrived home only to be disappointed and worried, that Mustafa had not been released. What was his supposed crime then? Since my passport and property including my cameras and gadgets were retained I was under obligation to report to the CID officer at Kibuye Police Station. At 10am the following morning, I had been informed. I took the liberty of first approaching the Home Office in Kamoja, near Kampala and reporting my experience to someone there. The man on duty called Barney who took a statement from me remembered me from 2005 facing a similar ordeal for being an active dissident.

First he took a detailed account of what had happened from me and wrote as much down as possible and then said that the embassy would be particularly concerned about my passport being returned, but Mustafa and my property would not be their concern. I then travelled to Kibuye Police Station and reported to CID officer Tweheyo Jackson with a view of having my property and passport returned. Little did I know but this would not happen for about three weeks and was going to be like being kept on the end of a piece of string. I was told to come back the following day.

Mustafa Released

Mustafa however was released finally after sixty hours of detention in total for no other reason than being in my company. On the Monday evening when he arrived home although there was a smile on his face when we saw each other, he soon gave an account of how he had been tortured by five soldiers while detained at the safe house. They had repeatedly beat his ankles, knees and stomach and hit his head against the floor sending him from one end of the room to another. They

had been torturing him for information and yet all the evidence, if it was dissident evidence they were after, was all printed in black and white in a book aptly entitled "What If Everything You Thought You Knew About AIDS Was Wrong?" by Christine Maggiore.

The Danish Ambassador and the Safe House

After my release I called in to The Daily Monitor newspaper and spoke to a reporter who wrote an account of what had happened to my friend and I. He was familiar with the "safe house" in Kololo. I also went bravely back to Kolola and knocked on the gate of the neighbour of the military occupants. The residents there are the Danish ambassador to Uganda, Stig Barlyng and his wife. I asked if anybody resident there realised that next door was a "safe house" and hadn't expected to speak to the ambassador. Although his wife was home. She came out onto the balcony after the guard had raised her attention. I began to speak in Danish and mentioned briefly what my enquiry was about. As I mentioned "safe house" she immediately interrupted and said that she would come down. She seemed to know what was what and almost insisted that I speak to her husband and without waiting for a response she let me know that she was on her way to the city and could drop me off at the gate of the Danish Embassy. Her husband, she assured me, was very interested in what goes on in the safe house next door and was active in the field of human rights.

We arrived at the gate and she called him from her mobile phone to let him know that a visitor was here to see him. I was soon escorted through security and up to the ambassador's office, where he was waiting to see me. He confirmed interest in advocating human rights, yet the slogan and "2015" logo on his T shirt, as well as the two meter high banners in the lobby,suggested otherwise, an international effort to reduce poverty, improve health and promote empowerment of women in Africa. 2015 is a Population Council sponsored ideology, known for its clandestine depopulation programs and always working closely with the Rockefeller Foundation. He told me he was known by government officials for his work on human rights and his deploring the use of "safe houses" in Uganda. He went on to say that, unlike me, he didn't fear his correspondences and phone calls being monitored, (as my phone calls were being) that he always expressed himself openly and therefore felt no reason to be secretive. I don't know if the one hour chat helped either of us in our different means to advocate human rights, but one thing will always stick in my mind. Since I wanted to get confirmation that the house next door was indeed being used as a "safe house" he drew a map using a page of a notepad and pen, which basically consisted of just a few lines. The name of the utility: Anti–Terrorism Task Force. I wrote this down on the same paper. I had told him that I wanted to take a photo of the entrance and he had advised me against it. Some moments later, as I was preparing to leave, I began to lean forward to reach for the paper and as I did so he reached forward to beat me to the piece of paper first, excusing that, just to be on the safe side, he would rather I didn't take it (the evidence, but evidence of what?)

Leaving Uganda

Taking advantage of my connections I managed to find out that i was actually suspected of being a spy, Interpol was involved who was liaising with the Home Office to collect information about me that might help them uncover a credible motive or undercover movement. That no information had been found to pass on seemed only to make the CID officers on the case all the more suspicious. My fear was confirmed, they intended to deport me it was revealed, even though it was known that I had an unchangeable flight home to UK on the 3rd June, less than ten days away. Sure enough CID Tweyeho Jackson told me on the phone on Friday that when I reported to the police station on Monday I should be prepared to leave. He didn't need to emphasise the word "leave". What inevitably comes before a deportation I calculated, was detention. I failed to report on the Monday. I thought, if I drag it out long enough they will allow me to fly home on the proper day and save themselves the expense of a ticket. I called Jackson on the Monday from Jinja to inform him of my whereabouts and it became clear to me that he was untroubled by the fact that I was not go in to be reporting back to him just yet. Although I knew he wasn't the one giving orders, but receiving them. As the days passed I couldn't decide what I feared most, being detained or losing my property consisting of valuable electronic equipment and recordings. On 30th May Mustafa and I arrived at CID headquarters but instead of going to Jackson's office we approached one of his superiors who helped us. We went with him to the block where Jackson's office was and he made enquiries with Jackson's colleagues and was told that Jackson was sick and would not be expected back until Monday, the day before my departure. I had already made my mind up that without my property being returned I would not be prepared to leave. The superior officer assured me that all would work out well, I would meet Jackson on Monday and my property returned. Mustafa and I came on Monday, we met Jackson who asked if I had confirmed my flight at the airline to which I replied that I would not do this until my property had been returned. He then informed me that my property would not be returned until proof of confirmation of flight had been submitted to him. Of course, although I didn't need to verbalise it, I knew that just because I had got flight confirmed would not necessarily mean that I would be on the flight. Because Jackson would only be on the premises until 3.30pm it meant that I had roughly two hours in which to walk to the city centre, wait my turn in the busy airline waiting room to see a member of staff, get the flight for the following day confirmed and a print out and return to CID headquarters in Kibuye. There were no further delays, because I discovered a way of jumping the queue and considered the situation to be an emergency. Except that when I got back to Jackson't office he excused himself to take a smoking break before we went to speak to a superior officer and get a form signed to release my property. Shortly afterwards I was shown my property which was in tact. The only disappointment was that all my recorded interviews had been deleted. This had to be expected considering the controversial admissions made by unsuspecting AIDS employees and experts. This however did not worry me too much since I had back up copies downloaded elsewhere.

In Summary

The superior officer I spoke to lastly wanted to know if I had any questions or complaints to make. I declined the invitation for the time being. I wanted first to have my property back. My friend had been tortured, we had been arrested without charge, had our property and passports taken from us, my trip to Rwanda to say farewell to my girlfriend and friends cancelled, my last three weeks in Uganda being full of stress, uncertainty and total disillusionment. And for what? Questioning the failed hypothesis, “HIV” = “AIDS” = Death paradigm among educators and experts!

UNIT 6
Appendix III

Challenging the Culture of Fear in Africa: Rethinking AIDS and Sexual Scares[1] by Charles L. Geshekter

"Nothing in life is to be feared. It is only to be understood."
Madam Marie Curie

This paper challenges the basic assumptions that causally link sexual behavior to AIDS cases in Africa. It suggests that conceptual flaws, dubious statistics, western stereotypes, poorly designed research, and racist claims about African sexuality have created untenable conclusions now proliferating across Africa. As a master narrative rooted in sexual fears, the AIDS in Africa discourse has been a brilliant success as political theater, but is one of the great medical fallacies of our times. Discussions about AIDS in Africa often devolve into a series of rhetorical gimmicks and political slogans, not a coherent strategy for public health improvements.

Why do African Studies academics, most of whom are critical thinkers on all other topics - Bush's policies against terrorism, the nature of Islamic fundamentalism, the origins of apartheid, the impact of colonialism, the roots of poverty – submit so willingly to a set of claims organized around a sex panic? A generation of researchers, policy-makers, activists and pharmaceutical industry representatives, with a great stake in defending the infectious viral theory of AIDS, become unhinged at the prospect of new thinking. Even posing questions is often deemed impermissible and anyone who raises them usually evokes dismissive name-calling, vilification, delegitimizing, or worse. Mundane facts, the scientific method, second thoughts or even confidence in the powers of our own common sense seem to matter little to social crusaders on the hunt for improper sexual behavior. In such a morally righteous world, critics deserve no voice.

The confusion that prevents us from thinking carefully about AIDS in Africa is borne of several factors: 1) racist claims regarding African sexuality and fanciful assumptions about truck drivers and prostitutes that have achieved the status of "urban legends;" 2) conjured up statistics that evaporate whenever one tries to pin them down specifically to a metropolitan area or the province of any country; 3) an inability to distinguish the unreliability of HIV antibody tests from the clinical symptoms of an "AIDS" case; and 4) an unfamiliarity with the nature of political economies of African states since the late 1970s.

In other ways, AIDS has become a great diversion. The belief that behavior modification will cure poverty disguises the endemic conditions that cause the appearance of the "symptoms" in the first place. Many AIDS activists and researchers ignore the historical forces that propelled parts of Africa into a downward economic spiral beginning in the late 1970s and set the stage for the appearance of "AIDS." In the Reagan Era,[2] a 'Washington

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[1] Charles L. Geshekter is Professor Emeritus of African History, Department of History, California State University, Chico, California 95929-0735 chollygee@earthlink.net Presented at the 48th Annual Meeting of the African Studies Association Washington, D.C. 18 November 2005. Included here for educational use with the consent of the author. Not for quotation without permission of the author. The paper titled "Myths and Misconceptions of the Orthodox View of AIDS in Africa" (2007) is available online < http://www2.units.it/etica/2007_2/GESHEKTER.pdf > published in *Ethics & Politics* IX(2): 330-370.

[2] [Ronald Reagan as the fortieth US president held office 1981-1989; ideologically and

Consensus' dominated official thinking about economic development in the U.S. government, the IMF, the World Bank and private banks and foundations. It called for sharp cutbacks in government spending, financial liberalization, privatization of state-owned enterprises, deregulation and the supremacy of the market over all other values, policies that contributed mightily to the demise of Africa. According to Joseph Stiglitz, an economist formerly with the World Bank, during the 1990s, the number of people living in extreme poverty (less than $2 per day) increased by nearly 100 million, world-wide, with the disproportionate amount being found in Africa.

Countries in east and southern Africa became so indebted to and dependent on international financial institutions that they were no longer free to make basic decisions about which goods and services could be allocated.[3] Beginning in the late 1970s, corruption and decay in the public health field, sharp decreases in the prices of exported commodities, severe restrictions on social services due to the IMF and World Bank strictures of "structural adjustment," savage civil wars, declining rates of immunization, and crowded refugee camps were among the major forces afflicting Africa as the twentieth century ended. None of these forces were related to sexual promiscuity.

In early 2000, President Thabo Mbeki appointed an AIDS Advisory Panel that consisted of 52 researchers, scholars and activists (including this author) who held widely opposing views on the definition, causation, prevention and treatment of AIDS cases. Mbeki sought evidence-based answers to three basic questions: 1) what causes the immune deficiency that leads to death from AIDS; 2) what is the most effective response to this cause or causes; and 3) why is HIV/AIDS in sub-Saharan Africa heterosexually transmitted while in the western world it is said to be largely homosexually transmitted? Mbeki applied the principle of Occam's razor[4] to AIDS, the scientific rule that the simplest of competing theories is preferred to the more complex, that explanations of unknown phenomena are to be sought first in terms of known quantities. The essence of the scientific method is to frame and operationalize a hypothesis "whose predictions comport with observable results in a consistent manner. If the hypothesis is valid and testable, its result should be generally reproducible, rather than unique to a particular experiment."[5]

The AIDS orthodoxy has long stifled what ought to have been a lively, inclusive debate on issues ranging from statistics and epidemiology to science, economic history, and notions about African sexuality. Averse to second thoughts and unable to be self-critical, they contend that anyone who questions their core beliefs or challenges the infectious viral theory of AIDS is not an honorable scholar with different views, but is someone who commits great evil. This is not something they can prove or explain rationally—it is simply an article of faith.

Since the clinical symptoms that define an AIDS case are widespread in the general African population, if it transmits heterosexually it should also become widespread in other general populations, such as Americans, in which hundreds of thousands of heterosexuals annually contract venereal diseases. Instead, 25 years after it was first described in the medical literature in the United States, AIDS remains confined to special risk groups. Of the 40,000 annual American AIDS patients, nearly 90% are either drug users or homosexuals and fewer than 10,000 have ever been

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contemporaneous and consistent with the UK prime minister Margaret Thatcher's philosophy and influence.—Ed.]

[3] This is amply demonstrated in Joseph E. Stiglitz, *Globalization and Its Discontents* (New York: Norton, 2002) and William K. Tabb, *Unequal Partners: A Primer on Globalization* (New York: New Press, 2002), especially Chapter Three, "Debt, AIDS, and Today's Colonialism," pp. 86-120.

[4] [The principle of theoretical parsimony known as Occam's Razor is explained in Unit 8 section 3 of this course reader.—Ed.]

[5] Nicholas Eberstadt and Sally Satel, "Health, Inequality and the Scholars," *The Public Interest* (Fall 2004), p. 116.

identified as heterosexual cases.[6]

For example, among the actors and actresses of the adult film industry (centered in Los Angeles) who perform prodigious amounts of condomless sex for money, between 1998-2004 approximately 81,000 HIV tests were administered to those pornographic stars. Of that amount (at $50 per test), a grand total of eleven registered a positive result, or one in 8,000 in a cohort of 20-35 year olds that surely engages in more sex than anyone else in the USA. Even at my own university, California State University, Chico, America's former #1 Party School (according to *Playboy*, January 1987) a considerable amount of sexual activity occurs as demonstrated by the large number of cases of chlamydia, genital warts and herpes simplex seen at the Student Health Services Center. Yet, from 1989 to 2004, the Health Center administered 17,000 HIV tests; only one came back positive.

By dogmatic repetition, the notion has been pounded into the public's mind that HIV tests are reliable and empirically valid. Those who start with the concept of HIV as a transmissible retrovirus that causes AIDS, seize on any decline or increase in HIV rates as evidence that AIDS cases are receding or growing.

The acronym 'HIV' describes a collection of non-specific, cross-reactive cellular material. HIV tests are not standardized, but are arbitrarily interpreted or "read" by different laboratories. Because HIV tests are antibody tests, they produce many false-positive results. This is crucial to keep in mind whenever one reads about 'rates' or percentages. All antibodies tend to cross-react. Humans constantly produce antibodies in response to stress, malnutrition, drug use, vaccination, certain foods, a cut, a cold, intestinal worms, tuberculosis, and even pregnancy. These antibodies are known to make HIV tests come up as positive.

The packet insert in an HIV/ELISA test from Abbott Laboratories contains this prudent disclaimer: "At present there is no recognized standard for establishing the presence or absence of antibodies to HIV-1 in human blood." Yet the cornerstone surveillance study for HIV seroprevalence in Africa rests on administering a single ELISA test to pregnant women attending antenatal clinics, never acknowledging that the ELISA test is notoriously unreliable in those circumstances since pregnancy is one of seventy conditions known to trigger a 'false positive' result.

The medical literature lists dozens of reasons for positive HIV test results. One study included "transfusions, transplantation, or pregnancy, autoimmune disorders, malignancies, alcoholic liver disease, or for reasons that are unclear..." [7] Another cited "liver diseases, parenteral substance abuse, hemodialysis, or vaccinations for hepatitis B, rabies, or influenza..."[8] Pregnancy is consistently listed as a cause of positive test results, even by the test manufacturers themselves." [False positives can be caused by] prior pregnancy, blood transfusions... and other potential nonspecific reactions." (Vironostika HIV Test, 2003).

These clarifications and disclaimers are critical for any discussion about alleged HIV rates in any African country, because HIV estimates are drawn almost exclusively from tests done on groups of pregnant women.

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[6] Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report*, 1997, Vol. 9, #2, Tables #3-#5, pp. 10-12.

[7] Terence I. Doran and Ernesto Parra, "False-Positive and Indeterminate Human Immunodeficiency Virus Test Results in Pregnant Women," *Archives of Family Medicine*, Vol. 9 (2000), pp. 924-929.

[8] Eleftherios Mylonakis, et. al., "Report of a False Positive HIV Test Result and the Potential Use of Additional Tests in Establishing HIV Serostatus," *Archives of Internal Medicine*, Vol. 160 (August 2000), pp. 2386-2388.

Sexual transmission cannot explain the differences in alleged rates of HIV positivity between African heterosexuals (about five per 100) and American ones (about one per 7000). When the HIV/AIDS paradigm debuted in 1984, its proponents assumed that HIV was easily transmitted coitally. When scientists actually tested this idea ten years later, they arrived at extremely low coital transmission frequencies. Researchers routinely classify HIV infection as a sexually transmitted disease (STD) without acknowledging the extraordinary difficulty of the sexual transmission of HIV.

Studies by Nancy Padian and her associates demonstrate that the infectivity rate for male-to-female transmission is extremely low.[9] An HIV-negative woman may convert to positive on average only after *one thousand* unprotected contacts with an HIV-positive man. An HIV-negative man may become positive on average only after *eight thousand* contacts with an HIV-positive woman. These data suggest two mutually exclusive conclusions. Either HIV is not a sexually transmitted microbe at all and other factors must account for HIV seroprevalence, or else African heterosexuals are more promiscuous than American heterosexuals, an unproven assumption rooted in hoary racist stereotypes.

With this in mind, why did so many public health professionals and officials come to view the diseases of poverty in Africa as sexually contagious? How can one virus cause twenty-nine heterogeneous AIDS indicator diseases almost entirely among males in Europe and America but afflict African men and women in nearly equal numbers?[10] The answer is that the World Health Organization uses a definition of AIDS in Africa that differs decisively from the one used in the West. The origins of this definition of African AIDS are quite illuminating.

Joseph McCormick and Susan Fisher-Hoch, physicians from the U.S. Centers for Disease Control (CDC), were instrumental in convening the WHO conference in the Central African Republic in 1985 that produced the "Bangui Definition" of AIDS in Africa. The CDC had just adopted the HIV/AIDS model to explain immune disorders found among American drug injectors, transfusion recipients, and a small cohort of promiscuous urban gay men. There was a tendency for HIV antibodies to react with plasma from some of these patients. The same was apparently true of blood from Africans afflicted with the diseases of poverty. The infectious viral model of AIDS assumed that immune deficiency would spread via HIV to a much larger faction of Africans than those who tested positive for the antibodies.

McCormick and Fisher-Hoch accepted this model. Here is how they explained their motivation for the Bangui Conference and the rationale behind the AIDS definition that resulted from it:

> "We still had an urgent need to begin to estimate the size of the AIDS problem in Africa....But we had a peculiar problem with AIDS. Few AIDS cases in Africa receive any medical care at all. No diagnostic tests, suited to widespread use, yet existed....In the absence of any of these markers [e.g., diagnostic T4/T8 white cell tests], we needed a clinical case definition....a set of guidelines a clinician could follow in order to decide whether a certain person had AIDS or not. [If we] could get everyone at the WHO meeting in Bangui to agree on a single, simple definition of what an AIDS case was in Africa, then, *imperfect as the*

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[9] Nancy Padian, et. al., "Heterosexual Transmission of Human Immunodeficiency Virus (HIV) in Northern California: Results from a Ten-Year Study," *American Journal of Epidemiology,* Vol. 146, #4 (August 15, 1997), pp. 350-57.

[10] Recent research among African populations suggests that a person with an over-active immune system that is constantly assaulted by various pathogens or burdened with chronic infections is more susceptible to a positive HIV antibody test result. Zvi Bentwich, et. al., "Immune Activation is a Dominant Factor in the Pathogenesis of African AIDS," *Immunology Today*, Vol. 16, #4 (1995), pp. 187-91.

> *definition might be*, we could actually start to count the cases, and we would all be counting roughly the same thing. [emphasis added]

The definition was reached by consensus, based mostly on the delegates' experience in treating AIDS patients. It has proven a useful tool in determining the extent of the AIDS epidemic in Africa, especially in areas where no testing is available. Its major components were prolonged fevers (for a month or more), weight loss of 10 percent or greater, and prolonged diarrhea..."[11]

The doctors recalled that:

> "experts in STDs continued to regale us with tales of the excessive and often bizarre sexual practices associated with HIV in the West...we were also beginning to see a direct correlation between the number of sexual partners and the rate of infection...Compared to the West, heterosexual contacts in Africa are frequent, and relatively free of social constraints - at least for the men....There was every reason to believe that, having found heterosexually transmitted AIDS in Kinshasa, we were likely to find it everywhere else in the world."[12]

It was upon these unsubstantiated claims, clinical generalizations, western notions of sexual morality, and stereotypes about Africans that AIDS became a disease by definition. Africa was assigned a central role in the premise that *AIDS was everywhere* and everyone was at risk. By 1986, "people were falling over one another to get involved in AIDS research," recalled the physicians. "They realized that AIDS represented an opportunity for grant money, training, and the possibility of professional advancement....A certain bandwagon mentality took hold. Careers and reputations were riding on the outcome."[13]

As proof that these AIDS symptoms were sexually transmitted, McCormick and Fisher-Hoch relied on a narrow survey conducted by Kevin DeCock, another CDC epidemiologist. DeCock examined stored blood samples taken in 1976 (for Ebola virus testing) from 600 residents of the small town of Yambuku, in northern Zaire. Samples from five patients (0.8%) tested positive for HIV antibodies. DeCock wanted to know what happened to those five people during the intervening ten years. According to McCormick and Fisher-Hoch:

> "three of the five were dead. To determine if their deaths were attributable to AIDS, Kevin interviewed people who had known them. The friends and relatives of the deceased described an illness marked by severe weight loss and other ailments that *left little doubt* in Kevin's mind that they had succumbed to AIDS [emphasis added]."[14]

DeCock concluded from these interviews that the subjects had died from AIDS, and that HIV had caused their death. He reached this conclusion without matching the five HIV-positive patients with peers from among the 595 HIV-negative subjects and without collecting mortality data and morbidity information about them. Had he done this, perhaps he would have discovered that numerous HIV-negative Africans also die of severe weight loss and other so-called AIDS conditions.

DeCock further noted that antibody tests conducted in 1986 showed that the HIV prevalence in Yambuku had remained constant at 0.8% during the ten years since 1976. As far as he was

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[11] Joseph B. McCormick and Susan Fisher-Hoch, *Level 4: Virus Hunters of the CDC* (Atlanta: Turner Publishing, 1996), pp. 188-90.
[12] Ibid., pp. 173-74.
[13] Ibid., pp. 179-80.
[14] Ibid., p. 193.

concerned, this meant that HIV - and thus AIDS - really originated in Africa where it had existed for years in small numbers of rural inhabitants whom he imagined had contracted it from primates. He speculated that once some of those people in the late 1970s migrated to what he assumed were sexually promiscuous urban areas, an epidemic of HIV and AIDS exploded. DeCock did not consider that these same data could have been interpreted as indicating that HIV is a mild virus and difficult to transmit. Neither did McCormick and Fisher-Hoch.

The presumptive diagnosis employed by DeCock is known as a 'verbal autopsy'. It is widely accepted in Africa, where "no country has a vital registration system that captures a sufficient number of deaths to provide meaningful death rates."[15] While medically certified information is available for less than 30% of the estimated 51 million deaths that occur each year worldwide, the Global Burden of Disease Study (GBD) found that sub-Saharan Africa had the greatest uncertainty for the causes of mortality and morbidity since its vital registration figures were the lowest of any region in the world - a microscopic *01.1%*.[16]

When the mainstream media use the term "AIDS-related illness," they accept the sweepingly wide set of clinical symptoms that suddenly came to "define" an AIDS case anywhere in Africa in October 1985 and has remained in place ever since. Whereas acquired immune deficiency in the industrialized countries is almost exclusively a disease of a tiny percentage of homosexuals, intravenous drug users and recipients of tainted blood transfusions, AIDS cases in Africa are said to be as general and indiscriminate as such long-time African scourges as malaria, tuberculosis, schistosomiasis, and sleeping sickness (trypanosomiasis).

AIDS researchers and activists have created an image of sexual behavior in Africa to explain this "heterosexual paradox" of AIDS in Africa when compared to the United States or western Europe. Some researchers consider the paradox to be temporary. They speculate that HIV evolved or emerged first in Africa and that, in time, AIDS will be just as rampant in the West. However, they have said this for twenty-five years and nothing of the sort has occurred.[17]

Other researchers account for a "permanent paradox" by suggesting that Africans are somehow different from Westerners, are substantially more promiscuous, and hence more likely to have genital ulcers. How else can they explain the widespread distribution of a virus whose transmission requires, for non-ulcerated genitals, a thousand heterosexual acts? Such insinuations warrant the closest scrutiny since generalizations about African sexual practices are analytically

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[15] Henry M. Kitange, et. al., "Outlook for Survivors of Childhood in Sub-Saharan Africa: Adult Mortality in Tanzania," *British Medical Journal*, Vol. 312 (January 27, 1997), pp. 216-17. The authors report that "a network of people was established in each of the [Tanzanian] study areas whose responsibility it was to inform a field supervisor of all deaths occurring in their areas. Locally known and respected people were selected...when a death was reported, the field supervisor in that area visited the home of the deceased and carried out a 'verbal autopsy.' This entailed interviewing the family by using a standard proforma with the aim of determining the cause of death."

[16] Christopher Murray and Alan Lopez, "Mortality by Cause for Eight Regions of the World: Global Burden of Disease Study," *The Lancet*, Vol. 349 (May 3, 1997), pp. 1269-1276. The authors advise that "the system of collecting cause of death data via 'verbal autopsies' needs to be assessed and improved to provide reliable data on broad categories of causes of death at low cost." See also, "From What Will We Die in 2020?" *The Lancet*, Vol. 349 (May 3, 1997), p. 1263.

[17] For instance, California has a population of nearly 34 million of whom at least 95% are heterosexuals. Between 1981 and 2003, a cumulative total of 134,852 cases of AIDS (approximately 6120 per year) were reported by county health departments. But only 5,956

useless on an internally diversified continent of 650 million people.

At the 10th International AIDS Conference in Yokohama (August 1994), Dr. Yuichi Shiokawa claimed that AIDS would be brought under control only if Africans restrained their sexual cravings. Professor Nathan Clumeck of the Université Libre in Brussels was skeptical that Africans will ever do so. In an interview with *Le Monde*, Clumeck claimed that "sex, love, and disease do not mean the same thing to Africans as they do to West Europeans [because] the notion of guilt doesn't exist in the same way as it does in the Judeo-Christian culture of the West."[18] AIDS educators try to counter this purported lack of guilt in African sexuality through conservative appeals to restraint, negotiating safe sex and a nearly evangelical insistence on condom use. Many orthodox AIDS researchers perpetuate racist stereotypes of libidinous black men and women. The myths about the sexual excesses of Africans are old indeed. Early European travelers returned from the continent with tales of black men performing carnal feats with unbridled athleticism with black women who were themselves sexually insatiable. These affronts to Victorian sensibilities were cited, alongside tribal conflicts and other "uncivilized" behavior, as justification for colonial social control.[19]

AIDS researchers added new twists to this old repertoire: stories of Zairians who rub monkeys' blood into cuts as an aphrodisiac or philandering truck drivers who get AIDS from prostitutes and then go home to infect their wives.[20] A facetious letter in *The Lancet* even cited a passage from Lili Palmer's memoirs as evidence for how a large male chimpanzee's "anatomically unmistakable signs of its passion for [Johnny] Weismuller" on the Tarzan set in 1946 "may provide an explanation for the inter-species jump" of HIV infection.[21] Some researchers assert that many African men prefer "dry sex" whereby women, particularly prostitutes, are said to "insert substances, such as household detergents or antiseptics, in their vagina prior to intercourse in order to prevent wetness." According to a study in *The Lancet*, this practice allegedly produces a "hot, tight, and dry" environment, which men find more pleasurable but which may "increase the risk of HIV-1 transmission, since the substances could cause the disruption of the membranes lining the vaginal and uterine wall."[22]

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[18] Jean-Yves Nau, "AIDS Epidemic Far Worse Than Expected," *Le Monde* section in *Manchester Guardian Weekly* (December 14, 1993). Anthropologist Jack Goody claims that love is a consequence of modernity and a written culture. Thus, when literate people are separated by a social barrier or absence they write to each other using precise words that lead them to be analytical and reflexive, eventually coming to act as they write. Goody claims that African oral cultures had little elaboration of romantic love in art, discourse or actuality. Perhaps, AIDS researchers like Klumeck accept Goody's analysis to insinuate why Africans are more disposed to spread AIDS through heterosexual activity. Jack Goody, *Food and Love: A Cultural History of East and West* (London: Verso, 1999).

[19] A recent study investigated the history of Sarah (Saartjie) Bartmann, an early 19th century African woman from Cape Colony whose unusually sized buttocks made her the object of popular caricatures in Britain and France. The book analyzed the centrality and paranoia that sexualized images of black people such as the "Hottentot Venus" played in 19th century European culture. T. Denean Sharpley-Whiting, *Black Venus: Sexualized Savages, Primal Fears and Primitive Narratives* (Durham: Duke University Press, 1999).

[20] For an example of anecdotes and impressionistic tales presented as facts about East African truck drivers and AIDS, see Ted Conover, "Trucking Through the AIDS Belt," *The New Yorker* (August 16, 1993).

[21] Raul Sebastian, "Did AIDS Start in the Jungle?" *The Lancet*, Vol. 348 (November 16, 1996), p. 1392.

[22] Adele Baleta, "Concern Voiced Over 'Dry Sex' Practices in South Africa," *The Lancet, Vol*. 352,

Another theory attributed the origin of HIV to the "repeated radiation exposure of chimpanzees and mangabey monkeys in equatorial Africa" to strontium-90 from uranium mining in the former Belgian Congo and to radiation from atmospheric nuclear tests in the equatorial Pacific Ocean in the 1950s and 1960s after "radioactive fallout from them circled the globe around that latitude."[23]

The latest speculation by Edward Hooper traced the origins of AIDS cases to oral polio vaccines that were accidentally contaminated in the Congo, allegedly with tissues from a primate version of HIV.[24] As an example of how absurdly far-fetched this speculation can become, one reviewer of Hooper's book (Helen Epstein in *New York Review of Books*) imagined that the subsequent linkages might have proceeded as follows: "*Perhaps* a hunter or butcher carrying a benign monkey virus gave blood at a blood bank or had an injection. *Perhaps* someone was transfused with his blood, or *perhaps* the needle used to inject him was used to inject someone else without being sterilized. *Perhaps*, a few weeks later, the virus was transferred to a third person through another injection or transfusion. This *might* have been enough to 'kick-start' the virus. It *might* have evolved through such 'passaging' to become able to grow vigorously in human cells. It *might* have been able to infect new people through means other than needles or blood transfusions. It *might* have become sexually transmitted, and it *might* have become deadly. [all italics added]"[25]

Aside from the lack of verification to corroborate these claims, no one has ever shown that people in Rwanda, Uganda, Zaire, and Kenya - the so-called "AIDS belt" - are more sexually active than people in Nigeria which has reported a cumulative total of only 26,276 AIDS cases out of a population of 120 million or Cameroon which reported 18,986 cases in 14 million.[26] No continent-wide sex surveys have ever been carried out in Africa. Nevertheless, conventional researchers perpetuate stereotypes about insatiable sexual appetites and carnal exotica.[27] They assume that AIDS cases in Africa are driven by a sexual promiscuity similar to what produced - in combination with recreational drugs, sexual stimulants, venereal disease, and the over-use of antibiotics - the early epidemic of immunological dysfunction among a small sub-culture of urban gay men in the

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[23] Brandon P. Reines, "Radiation, Chimpanzees and the Origin of AIDS," *Perspectives in Biology and Medicine*, Vol. 39, #2 (Winter 1996), pp. 187-192.

[24] Edward Hooper, *The River: A Journey to the Source of HIV and AIDS* (Boston: Little, Brown Publishers, 1999).

[25] Helen Epstein, "Something Happened," *New York Review of Books* (December 2, 1999), p. 18. [For a more thorough critique of this version of HIV as originating in African sexual perversion see a recent book review of Charles Geshekter, published in *New African* April 2013, which appears in this course reader in Unit 7 as Section 3.—Ed.]

[26] World Health Organization, *Weekly Epidemiological Record*, Vol. 74, #48 (Nov. 26, 1999), p. 401.

[27] For a compendium of these assumptions, see John C. Caldwell, et. al. (eds.), *Resistances to Behavioural Change to Reduce HIV/AIDS Infection in Predominantly Heterosexual Epidemics in Third World Countries* (Canberra: National Centre for Epidemiology and Population Health, Australian National University, 1999). A research effort to examine the role of anal intercourse in Africa as a contributing factor to AIDS concluded that the "behaviors most relevant to [AIDS] transmission there (and probably in much of the Third World) seem less likely to be sexual than a consequence of unhygienic practices and medical care." Stuart Brody and John J. Potterat, "Assessing the Role of Anal Intercourse in the Epidemiology of AIDS in Africa," *International Journal of STD and AIDS*, Vol. 14 (July 2003), p. 434. [An analysis of John Caldwell's assumptions and their impact on African epidemiology during the HIV-AIDS era of public

West.[28]

Case studies from Africa suggest nothing of the sort. In 1991 researchers from Médicins Sans Frontières and the Harvard School of Public Health surveyed sexual behavior in Moyo district of northwest Uganda. Their findings revealed behavior that was not very different from that of the West. On average, women had their first sex at age 17, men at 19. Eighteen per cent of women and 50% of men reported premarital sex; 1.6% of the women and 4.1% of the men had casual sex in the month preceding the study, while 2% of women and 15% of men had done so in the preceding year.[29]

The media misrepresentations that link sexuality to AIDS have spawned inordinate anxieties in regions of Africa already afflicted with extreme poverty, ravaged by war, and deprived of primary health care delivery systems. The disaster voyeurism of tabloid journalism enables the media to use AIDS to sell "more newspapers than any other disease in history. It is a sensational disease - with its elements of sex, blood and death it has proved irresistible to editors across the world."[30] In recent years, western media have used unrelentingly melancholy metaphors to portray Africans as helpless wretches, which may only homogenize complex situations and contribute to public apathy and

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[28] In a review of *Sexual Ecology*: *AIDS and the Destiny of Gay Men* by Gabriel Rotello (New York: Dutton, 1997) and *Life Outside: The Signorile Report on Gay Men* by Michelangelo Signorile (New York: HarperCollins, 1997), historian Daniel Kevles notes that with the advent of gay liberation, "bathhouses, while offering a communitarian haven from homophobia, also institutionalized part of the liberation movement, providing sexual opportunities in private cubicles, showers, hallways, and dimly lit 'orgy rooms' devoted to anonymous encounters...Tens of thousands were habitués of the 'circuit' - a series of large gay dance parties held in different places where they used one kind of drug to heighten their sexual energies and another to relax their sphincter muscles." Daniel J. Kevles, "A Culture of Risk," *New York Times Book Review* (May 25, 1997), p. 8. John Lauritsen and Dr. Joseph Sonnabend have described the unhealthy lifestyle of this very specific cohort of urban gay men in the United States who had unprecedented opportunities for sexual contacts with hundreds, even thousands of partners. It was a ghettoized sub-culture of promiscuous gay men who habitually abused alcohol and drugs that produced the epidemic levels of chronic infection and immunological breakdown that allowed opportunistic infections to take over bodies that had been repeatedly exposed to a wide range of microbes such as gonorrhea, cytomegalovirus, hepatitis, syphilis, non-specific viral infections, bacterial pathogens, and parasitic infections. Without addressing these underlying socio-economic and environmental causes, the commitment of researchers to lump together the diverse cases of immune-deficiency that began appearing in this small sub-culture led them uncritically to accept the unifying hypothesis of a single viral cause based on the similarities of the disease manifestations. See Joseph Sonnabend, "Fact and Speculation About the Cause of AIDS," *AIDS Forum*, Vol. 2, #1 (May 1989), pp. 2-12; John Lauritsen, *The AIDS War* (New York: Asklepios Press, 1993); and John Lauritsen and Ian Young (eds.) *The AIDS Cult: Essays on the Gay Health Crisis* (Provincetown, Massachusetts: Asklepios Press, 1997). Frank Bruni, "Drugs Taint Annual Gay Revels," *New York Times* (September 8, 1998) chronicled the abundant array of drugs like cocaine, Ecstasy, ketamine ("special K") and a liquid anesthetic called gamma hydroxybutyrate (GHB) that were widely consumed at an August 1998 fund-raiser for AIDS at Fire Island, New York, USA.

[29] Doris Schopper, Serge Doussantousse, and John Orav, "Sexual Behaviors Relevant to HIV Transmission in a Rural African Population," *Social Science and Medicine*, Vol. 37, #3 (August 1993), pp. 401-12.

[30] [illegible]

"compassion fatigue."[31]

In this age of globalization, public health seems to require more salesmanship than skepticism. The media's appetite for scare tactics and its disdain for alternative perspectives enable them to treat Africa in apocalyptic terms.[32] Doomsday scenarios compare AIDS in Africa to the great epidemics in history like the Black Death of the Middle Ages that killed 20 million people.[33] *USA Today* warned about "a time bomb ticking south of the Sahara" and UNICEF called AIDS "the modern incarnation of Dante's Inferno." U.S. Senator Diane Feinstein of California said, "I truly believe that the AIDS crisis is worse than the bubonic plague...this crisis can wipe out sub-Saharan Africa as we know it today. It is mega in its impact on the world..."[34] In 2004, Professor Richard Feachem, Director of the Global Fund to Fight AIDS, TB, and Malaria, somberly pronounced it "the worst disaster in recorded history."[35]

At the 15th International AIDS Conference in Bangkok (July 2004), these images of HIV/AIDS-ravaged Africa were taken as indisputable. Convinced that a strange mutant retrovirus was somehow unleashed on Africa from the Congo rainforest to cause AIDS, spread by promiscuous truck drivers and prostitutes, activists and researchers ignore the socio-economic history of modern Africa when waging war on AIDS. Their preferred weapons are the endless preaching of abstinence, sexual behavior modification schemes and condom use (the ABCs), and the prescribing of drugs of demonstrated toxicity.

The marketing of anxiety is supposed to promote the sexual behavior modification that will help "save Africa." Some writers even feel that the manufacture of fear is a good way to increase social awareness. For conservatives who want to see "the notion of sexual responsibility [shake] off its puritanical image," the subsequent "public anxiety about AIDS is seen as an important sentiment for popularizing a more restrictive and puritanical sexual ethos."[36] Oblivious to the morbidity and mortality data from the *Global Burden of Disease Study*, journalists reflexively maintain that "AIDS is by far the most serious threat to life in Africa."[37] Given the momentum behind this assumption,

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[31] Susan D. Moeller, *Compassion Fatigue: How the Media Sell Disease, Famine, War and Death* (New York: Routledge, 1998) and Jonathan Benthall, *Disasters, Relief and the Media* (New York: St. Martins Press, 1993). For a demonstration of how U.S. officials manipulated statistics and public fears to mobilize billions of dollars in a futile effort to halt the illicit international drug trade, see Mike Gray, *Drug Crazy* (New York: Random House, 1999).

[32] A typical example is Lawrence K. Altman, "Parts of Africa Showing HIV in 1 in 4 Adults," *New York Times* (June 24, 1998).

[33] A scholarly attempt to analogize AIDS with the Black Death is David Herlihy, *The Black Death and the Transformation of the West* (Cambridge: Harvard University Press, 1997), pp. 5-6.

[34] Zachary Coile, "Bill Would Enhance Access to AIDS Drugs," *San Francisco Chronicle* (March 7, 2001), p. A7.

[35] Cited in Alex de Waal, "Sex in Summertown," *Times Literary Supplement* (6 August 2004), p. 5.

[36] Frank Furedi, *Culture of Fear* (London: Cassell, 1997), p. 48. American novelist Philip Roth's recent work, *The Human Stain* (New York: Houghton Mifflin, 2000), refers to the "ecstasy of sanctimony" that defines the current epoch of shrill moral hysteria about sexuality.

[37] "No End of Plagues," *The Economist* (September 7, 1996), p. 38. A recent study found that 40% of American journalists rarely or never seek independent verification for a science story they are writing, and that 82% of the scientists polled felt that journalists did not understand statistics well enough to explain new findings. Jim Hartz and Rick Chappell, *Worlds Apart: How the Distance Between Science and Journalism Threatens America's Future* (Nashville: First Amendment Center at Vanderbilt University, 1998). Media coverage of AIDS resembles the kind of writing

few scientists question the infectious AIDS hypothesis, leaving little reason for the media to scrutinize the reliability of AIDS research.[38] Scott Adams, the cartoonist who draws *Dilbert*, put it succinctly: "Reporters are faced with a daily choice. They can either painstakingly research stories or they can write whatever people tell them. Both approaches pay the same."

The claims that millions of Africans are threatened by AIDS or are already HIV-positive make it politically acceptable to use the continent as a laboratory for vaccine trials[39] and for the distribution of toxic drugs of disputed effectiveness like AZT.[40] For instance, AZT is a toxic chemical whose primary biochemical action is the random termination of DNA synthesis, the central molecule of life. It is frightening to recommend giving such a carcinogenic drug to pregnant women because fetuses cannot develop into babies without DNA synthesis.[41]

Moreover, media claims that safe sex is the only way to avoid AIDS inadvertently scare Africans from visiting public health clinics for fear of receiving an AIDS diagnosis.[42] Even Africans

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boundaries." Thus, as Will Rogers once quipped, it's not ignorance that causes all the trouble in this world, "it's the things people know that ain't so."

[38] Nowhere is this more evident than at the biennial "International AIDS Conferences" which resemble pharmaceutical trade shows for commodities of the AIDS industry. At the XII AIDS Conference (Geneva, June 1998), journalists and researchers referred to AIDS as a "runaway epidemic" and a "collective failure of the world," demanding that it be made a "global public health priority." Lawrence Altman, "At AIDS Conference, a Call to Arms Against 'Runaway Epidemic'," *New York Times* (June 29, 1998).

[39] In a candid review of the fruitless vaccine trials, Richard Horton admits that "until the gravity of this scientific failure is openly acknowledged, a serious debate about how to end HIV's lethal grip…cannot take place." Horton notes that many AIDS scientists fear that their inability to find a "single-dose, safe, affordable, oral vaccine that gives lifelong protection against all subtypes of HIV" will erode public confidence in other aspects of the "war on AIDS." Their fears are justified. "AIDS: The Elusive Vaccine," *New York Review of Books* (September 23, 2004), pp. 53-57. Several recent studies demonstrate how large numbers of people and many advocacy organizations profit from fear-mongering about dangers that are blown way out of proportion to their real risks. David Ropeik, *Risk: A Practical Guide for Deciding What's Really Safe and Really Dangerous* (Harvard University Press, 2002); Barry Glassner, *The Culture of Fear* (New York: Basic Books, 1999); Frank Furedi, *Culture of Fear* (London: Cassell, 1997); Laura Lee, *100 Most Dangerous Things in Everyday Life and What You Can Do About Them* (New York: Broadway Books, 2004); and Marc Siegel, *False Alarm: The Truth About the Epidemic of Fear* (New York: John Wiley, 2005).

[40] In 1999-2000, several major companies offered to discount the cost of drugs to Africans. Glaxo Wellcome cut the price of AZT and 3TC to $200 a month for sale in Uganda and Ivory Coast where the annual per capita income is less than the price of the drug. Urging African governments to subsidize the costs, UN official Joseph Saba said his agency had to "show them that AIDS justifies investing public finds." Associated Press, "Firms Cut AIDS Drug Prices to 3rd World," *San Francisco Chronicle* (June 24, 1998)

[41] An important analysis of AZT, its properties and effects, is Anthony Brink, *Debating AZT: Mbeki and the AIDS Drug Controversy* (Pietermaritzburg: Open Books, 2000, ISBN #0-620-26177-3).

[42] For instance, a 31-year old man in Kagera Province (Tanzania) was said to be dying of AIDS. Emaciated and despondent, he worked as a fisherman until he became sick in 1992 with diarrhea, chest pains, muscle weakness, and a severe cough. The man stayed with an aunt because his

"with treatable medical conditions (such as tuberculosis) who perceive themselves as having HIV infection fail to seek medical attention because they think that they have an untreatable disease."[43] Biomedical funds that used to fight malaria, tuberculosis and leprosy are now diverted into sex counseling and condom distribution, while social scientists shift their attention to behavior modification programs and AIDS awareness surveys.[44]

One such initiative – the Summertown HIV-Prevention Project - lasted three years in an impoverished South African township. It was described as a "mixed bag of disappointments and achievements…[as] many proposed activities [were] yet to be implemented, consistent and widespread condom use remains low…and the most damning lack of Project success over the three-year research period is the lack of evidence for any reduction in STI [sexually transmitted infection] levels."[45] The analysis by its Director uses such impenetrable prose that one is not surprised by the Project's admitted lack of effect on either sexual behavior, HIV rates, or AIDS cases. As she states in her conclusion:

> "In the interests of contributing to the development of a critical social psychology of sexuality, the research has illustrated the way in which sexual behaviour, and the possibility of sexual behaviour change, are determined by an interlocking series of multi-level processes, which are often not under the control of an individual person's rational conscious choice. Sexualities are constructed and reconstructed at the intersection of a kaleidoscopic array of interlocking multi-level processes, ranging from the intra-psychological to the macro-social."[46]

The researchers of the Summertown project honestly believed that sexual behavior changes would make people unsick and enable them to stay well. They never imagined that their project failed because its core construct was erroneous and incapable of correction. Did they ever consider that the production of HIV antibodies was environmentally induced, and had little or nothing to do with sexuality?

In Africa, where women contract so-called "Slim Disease" in numbers roughly equal to males, there is no evidence to link the onset of immune deficiency with engagement in promiscuous homosexual intercourse. Intravenous drug use seems uncommon among villagers and city dwellers. Does this mean that in Africa heterosexual intercourse itself puts everyone at risk for AIDS? Does the "AIDS epidemic" in Africa portend the future of the developed world? Many scientists, bio-

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an effort to go to the hospital because I have no money and my aunt is not able to pay." Susan Okie, "Tanzania Village Devastated by AIDS Deaths," *Washington Post* (March 15, 1992).

[43] "False-Positive Self-Reports of HIV Infection," letter from Chifumbe Chintu, et. al., *The Lancet*, Vol. 349 (March 1, 1997), p. 649.

[44] Some Western scientists, including Dr. Luc Montagnier the French virologist who discovered HIV, claim that the practice of female circumcision facilitates the spread of AIDS. Yet Djibouti, Somalia, Egypt and Sudan, where female genital mutilation is the most widespread, are among the countries with the lowest incidence of AIDS cases. Thomas Bass, *Reinventing the Future: Conversations with the World's Leading Scientists* (Reading, Massachusetts: Addison-Wesley, 1994), p. 40. See also the analysis by a Sudanese anthropologist, Rogaia Mustafa Abusharaf, "Unmasking Tradition," *The Sciences* (March/April 1998), p. 24.

[45] Catherine Campbell, *'Letting Them Die:' Why HIV/AIDS Prevention Programmes Fail* (Oxford: James Currey, 2003), p. 185.

[46] *Ibid*., p. 183. Despite the stunning failures of the Project, one reviewer, who was also the Series Editor for its publisher, called it "the best book yet written on the struggle to control HIV." De

medical researchers and AIDS experts still believe this is the case.[47]

As anyone who attended the International AIDS Conference in South Africa (July 2000), can attest, there were more signs of an openly assertive "sexual culture" of surfers, casual drug users, semi-nudity, porn and sex shops, and beautiful prostitutes within one square mile of any hotel at South Beach in Durban than one ever sees in 1000 square miles of Zululand and Maputaland. If AIDS in South Africa is linked to heterosexual behavior or condomless sex, then its epicenter should be found amidst the white oceanfront culture of the north Durban coast, or the leafy suburbs of north Johannesburg, or the international swingers' scene around Sea Point in Cape Town. But those areas are, of course, the last places one finds AIDS cases in South Africa.

This takes us back to Thabo Mbeki. After the distinguished Harvard physician Paul Farmer found himself at conferences where professional colleagues went "practically purple with rage discussing Mbeki," even accusing him of genocide, he decided to look dispassionately at the controversy. Farmer concluded, quite sensibly, that Mbeki's message was that "poverty and social inequality serve as HIV's most potent co-factors, and any effort to address this disease in Africa must embrace a broader conception of disease causation." Farmer acknowledged, "this is precisely the point many of us have tried to make….and we haven't been branded as AIDS heretics."[48]

AIDS researchers in Africa assume there is a correlation between clinical symptoms (weight loss, chronic diarrhea, fever, a persistent dry cough) and sexual activity. Correlation - whether one phenomenon is found in tandem with another - is not causation. Proof of causation requires that we control all variables in order to isolate one variable as a cause, not merely as an associated factor. The clinical symptoms that define an AIDS case in Africa are expressed in roughly equal numbers among men and women, not because of alleged heterosexual transmission, but because the socio-economic conditions that give rise to the gender equity in the distribution of these widespread symptoms are caused by environmental risk factors to which many Africans are regularly exposed.

Moreover, there may be a correlation between having those clinical symptoms, which attest to an absence of good health, and the likelihood that the patient will generate a positive antibody test result. This does not prove that it was the antibodies (or "HIV") which caused those symptoms. Anyone who has those symptoms, which are due to environmental insults, may cause a positive test result, indicating simply that the patient is likely to be in poor health.

To put it another way, the presentation of the clinical AIDS symptoms is likely to predict a positive HIV-antibody result on a single ELISA test. Thus, these AIDS symptoms could be said to "cause" a positive test result.[49] Poverty-stricken, malnourished subsistence farmers with malaria, tuberculosis or repeated attacks of dysentery are likely to have a considerable amount of

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[47] By 2000, the theory that an infectious virus causes AIDS had become a "doctrinal system" whose adherents could dismiss impertinent historical facts by simply labeling them as "lies." As Noam Chomsky once observed, "if you're following the party line you don't need to document anything; you can say anything you feel like...That's one of the privileges you get for obedience. On the other hand, if you're critical of received opinion, you have to document every phrase." Cited in Donald Macedo (ed.), *Chomsky on Miseducation* (New York: Rowman and Littlefield, 2000), p. 173.

[48] Paul Farmer, "AIDS Heretic," *New Internationalist*, #331 (January/February 2001), p. 15.

[49] Throughout my work as a member of Mbeki's AIDS Advisory Panel, I sat next to Barry Schoub, a prominent virologist from the University of Witwatersrand. We chatted amiably about many things. During one casual conversation, when I suggested this reversal of the standard

cross-reacting antibodies in their systems. Dr. F.J.C. Millard, a physician at a small mission hospital in South Africa's North Province (formerly Northern Transvaal), described the local conditions in which the incidence of tuberculosis and AIDS were rising: "the area had suffered from neglect during the *apartheid* years. There is poverty, malnutrition, violence, unemployment, overpopulation, and, most important of all, a lack of education."[50]

Statistics on AIDS cases in Africa remain marred by the careless use of sources, questionable mathematics and a refusal by those who accept that data to engage in discussions with their critics. Throughout the July 2000 sessions of President Mbeki's AIDS Advisory Panel, purported AIDS cases in South Africa were routinely conflated with the results from a single ELISA HIV-antibody test derived from sentinel surveys performed on 18,000 pregnant (mostly African) women at antenatal clinics. This sleight-of-hand led adherents to the orthodox view on HIV/AIDS to accept "high counters" whose uncritical treatment of sources dismissed any attempt at verification and validation.

During the past twenty years, as the external financing of HIV-based AIDS programs in Africa dramatically increased, money for studying other health sectors remained static, even though deaths from malaria, tuberculosis, neo-natal tetanus, respiratory diseases and diarrhea grew at alarming rates.[51]

While western health leaders fixate on HIV, approximately 52% of sub-Saharan Africans lack access to safe water, 62% have no proper sanitation, almost half live on less than one dollar a day, and an estimated 50 million pre-school children suffer from protein malnutrition.[52] Poor harvests, rural poverty, migratory labor systems, urban crowding, ecological degradation, the collapse of state structures, and the sadistic violence of civil wars are the primary threats to African lives.[53] When essential services for water, power, and transport break down, public sanitation deteriorates and the risks of cholera, tuberculosis, dysentery, and respiratory infection increase.

Historian Randall Packard documented attempts made by the South African government to

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then testing positive might exceed 99%. It was a classic reversal (or confusion) of the difference between causation and correlation. Having "AIDS" symptoms could easily predispose someone to test HIV-antibody positive, hence "having AIDS" causes "HIV."

[50] F.J.C. Millard, "South Africa: A Physician's View," *The Lancet*, Vol. 351 (March 7, 1998), p. 748.

[51] World Health Organization, *Bridging the Gaps: The World Health Report 1995* (Geneva: WHO, 1995), Table 5 (p. 18) and Table A3 (p. 110); and World Health Organization, *Fighting Disease, Fostering Development: The World Health Report 1996* (Geneva: WHO, 1996), Table 4 (p. 24) and Table A3 (p. 127).

[52] "A Good Turn for Africa, Please," *The Lancet* (January 11, 1997), p. 69. The continent seems to grow poorer with every passing decade, leading some analysts to suggest that, "even if Africa's aggregate growth doubles over the next nine years, its per capita income in 2006 would still be five percent lower than it was in 1974." Dan Connell and Frank Smyth, "Africa's New Bloc," *Foreign Affairs*, Vol. 77, #2 (March/April 1998), p. 89. In Uganda, the expenditure on debt servicing ($15 per head annually) is six times the spending on health and nearly one in two children is undernourished. Derek Summerfield, "The Politics of Apology," *The Lancet*, Vol. 354 (July 31, 1999), p. 421.

[53] According to the *Global Burden of Disease Study*, 1.02 million Africans died of injuries (intentional and unintentional) in 1990. For South Africa, see Jeanelle de Gruchy and Laurel Baldwin-Ragaven, "Poverty and the South African Health Professions: A Commentary," *Health Systems Trust Update* (#39, January 1999).

control the spread of tuberculosis and to lower its morbidity and mortality rates. Even though tuberculosis is curable and the available control measures are sufficient to combat it effectively with antitubercular drugs, the *apartheid* government made little impact on the overall prevalence of the disease. Packard showed that the South African government refused "to address the foundations of black poverty, malnutrition, and disease upon which the current [1980s] epidemic of tuberculosis is based...[and] placed their faith in the ability of medical science to solve health problems in the face of adverse social and economic conditions."[54]

AIDS researchers and policy makers confuse correlation with causation as they conflate tuberculosis incidence and the reactivation of dormant TB with a person's HIV-antibody status. This co-mingling enables conventional AIDS programs to link efforts to reduce the infectiousness and severity of tuberculosis with family planning, safe sex messages and behavior modification proposals.[55]

In August 1998, the *New York Times* reported that Zimbabwe had become the center of the world's AIDS epidemic. It claimed that as many as 25 percent of all adult Zimbabweans were infected with HIV, the highest infection rate on earth. Although it provided no figures for previous years, the article acknowledged that the presumed increase in HIV incidence had occurred when increasing poverty, food shortages and instability had "begun to overcome the country. Tuberculosis, hepatitis, malaria, measles and cholera...have surged mercilessly. So have infant mortality, stillbirths and sexually transmitted diseases." Malarial deaths had risen from 100 in 1989 to 2,800 in 1997 and tuberculosis cases jumped from 5,000 in 1986 to 35,000 in 1997. The reporter admitted that all of these diseases indicated deepening social deprivation, with tuberculosis as "the sentinel illness of poverty and social decline."[56]

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[54] Randall M. Packard, "Industrialization, Rural Poverty, and Tuberculosis in South Africa, 1850-1950," in Steven Feierman and John M. Janzen (eds.), *The Social Basis of Health and Healing in Africa* (Berkeley: University of California Press, 1992), p. 129. In 1989, Packard observed that a "new resurgence of TB is surfacing in the urban areas of the country as thousands of workers and their families attempt to escape the poverty of the Bantustans. Once again, industrial capital and the state have combined to lay the groundwork for a major upsurge in urban-based TB... [will the state and local authorities] once again apply their time-honored policies of exclusion to solve this growing problem....[or] will they at long last recognize the futility of this policy and begin to deal with the underlying causes of TB?" Randall M. Packard, *White Plague, Black Labor: Tuberculosis and the Political Economy of Health and Disease in South Africa* (London: James Currey Publishers, 1989), pp. 318-319.

[55] For examples, see USAID/Bureau for Africa, *A Strategic Framework for Setting Priorities for Research, Analysis, and Information Dissemination on HIV/AIDS, STIs, and Tuberculosis in Africa* (Washington: USAID, June 1995).

[56] Michael Specter, "Doctors Powerless as AIDS Rakes Africa," *The New York Times* (August 6, 1998). The article omitted any reference to the combined effects on Zimbabwe of the World Bank's structural adjustment programs in the 1990s coupled with poor harvests, drought, long-term food deficiencies, a 70% inflation, an unemployment rate of 50%, and the cost of its 1998 military involvement in the Congo left the average Zimbabwean poorer by one-third than at independence in 1980. For a study of the serious economic degradation in rural and urban areas, see Leon Bijlmakers, Mary Basset and David Sanders, *Health and Structural Adjustment in Rural and Urban Zimbabwe* (Uppsala: Nordiska Afrikainstitutet Research Report, No. 101, 1996) which one reviewer termed, "an extensive survey of health, economic and demographic characteristics [that] monitored and documented the deterioration that occurred under the World Bank's structural adjustment program. It confirms what is widely believed, that charges for the

Subsequent reports showed that rural suffering in Zimbabwe was caused by government corruption, a savage drought and the breakdown of civil society under the harsh regime of Robert Mugabe. Zimbabwean misery over the past fifteen years was also the result of local mismanagement and gross inequities in the region that were accelerated by strictures imposed by the World Bank's structural adjustment programs. In such dire straits, people were hurting because of food shortages and untreated illnesses, not because of sexual promiscuity. Once again, it was no accident that the clinical symptoms that define a case of AIDS in Zimbabwe (fever, diarrhea, weight loss, and persistent cough) were actually manifestations of protein anemia, unsanitary drinking water and parasitic infections in a country "with one of the fastest-shrinking economies on earth."[57]

Other articles in the macabre series, entitled "Dead Zones," illustrated fundamental flaws in the HIV/AIDS model. Among sick or dying Africans, clinicians cannot distinguish which patients would test antibody-positive even if test kits were available. People were presumptively diagnosed as "having AIDS" simply by having the clinical conditions that HIV is *said to cause*, such as tuberculosis or the symptoms of malaria (persistent night sweats, fever, wasting) or that of cholera (diarrhea, fever, wasting).

Former WHO Director General Hiroshi Nakajima warned emphatically that "poverty is the world's deadliest disease."[58] Indeed, the leading causes of immunodeficiency and the best predictors for clinical AIDS symptoms in Africa are impoverished living conditions, economic deprivation and protein anemia, *not* extraordinary sexual behavior or the trace measurements of antibodies for a retrovirus that has proved difficult to isolate directly.

The AIDS epidemic in Africa has been used to justify the medicalization of sub-Saharan poverty. Rather than treat the clinical symptoms of AIDS as the manifestations of impoverished living conditions, researchers like Dr. David Alnwick, UNICEF's health chief, invert this cause-and-

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disabling and fatal illnesses, the very patients for whom medicine has developed preventive, curative and cost effective interventions." Meredith Turshen in *African Studies Review*, Vol. 41, #1 (April 1998), p. 182. See also, Ken Owen, "Bloody Mugabe," *New Republic* (March 8, 1999), pp. 21-23. In her latest study as part of an annual re-survey, Mary Bassett suggests that the impact of SAP on Zimbabwean households has been pernicious -- people are eating one meal a day, not seeking health care but saving money (for funerals?), there are more women headed households and hints of more child-headed households (orphans and children of a parent away at work). Stefano Ponte, "The World Bank and 'Adjustment in Africa'," *Review of African Political Economy*, #66 (December 1995), pp. 539-58 provides data showing that several countries which UNAIDS claims are threatened with a "plague of HIV (Tanzania, Uganda, Zambia and Zimbabwe) have been hard hit by Bank policies in terms of limited debt reduction and poor institutional capacity building." The enormous expansion of debt, the globalization of poverty and its impact on public health sectors since the 1980s are the context within which AIDS developed. See, Michel Chossudovsky, *The Globalisation of Poverty: Impacts of the IMF and World Bank Reforms* (New York: Zed Books, Inc., 1997).

[57] Philip Gourevitch, "Wasteland: Letter From Zimbabwe," *The New Yorker* (June 3, 2002), p. 61. See also Michael Wines, "In Zimbabwe, Even the Farmers Are Going Hungry," *New York Times* (February 29, 2004), p. A6; Gabrielle Menezes, "Letter From Zimbabwe," *The Nation*, (May 12, 2003), pp. 12-14; and Samantha Power, "How to Kill a Country," *Atlantic Monthly* (December 2003), pp. 86-98.

[58] WHO, *The World Health Report 1995*, v. Furthermore, the 1996 UNICEF report, *The Progress of Nations*, sensibly warns that "classifying deaths by disease hides the fact that death is not usually an event with one cause but a process with many causes. In particular, it is the conspiracy between malnutrition and infection which pulls many children into the downward spiral of poor

effect relationship to allege that "all our efforts at providing safe water and other protections for children have been undermined, undone, by the AIDS epidemic."[59]

Western medical intervention has taken the form of vaccine trials, drug testing and demands for behavior modification.[60] In 1997, the Division of AIDS at the National Institute of Allergy and Infectious Diseases concluded that there was "not enough evidence that a live attenuated HIV-1 vaccine [was] safe - or effective." Nonetheless, the International Association of Physicians in AIDS Care (IAPAC) insisted that a vaccine should not be required to meet U.S. safety and efficacy standards because the alleged number of AIDS cases rendered "further delay unethical."[61]

AIDS scientists and public health planners should recognize the roles of malnutrition, poor sanitation, and parasitic and endemic infections in producing the clinical AIDS symptoms that are manifestations of non-HIV insults.[62] The data strongly suggest that socio-economic development, not sexual restraint, is the key to improving the health of Africans. Wherever one projects high rates of HIV-antibodies in Africans, one also finds high rates for all germs indicative of sanitation problems which generally indicate abject poverty, destitution and a high disease burden.

Phillipe and Evelyn Krynen, medically trained charity workers employed by the French group Partage in Kagera Province (Tanzania), report that when "appropriate treatment was given to villagers who became ill with complaints such as pneumonia and fungal infections that might have contributed to an AIDS diagnosis, they usually recovered."[63] Father Angelo D'Agostino, a former surgeon who founded Nyumbani, a hospice for abandoned and orphaned HIV-positive children in Kenya came to a similar conclusion:

> "People think a positive test means no hope, so the children are relegated to the back wards of hospitals which have no resources and they die. They are very sick when they come to us. Usually they are depressed, withdrawn, and silent....But as a result of their care here, they put on weight, recover from their infections, and thrive. Hygiene is excellent [and] nutrition is very good; they get vitamin supplements, cod liver oil, greens every day, plenty of protein.

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[59] Quoted in David Perlman, "UN Moves to Prevent AIDS Babies," *San Francisco Chronicle* (June 30, 1998).

[60] A steady stream of AIDS researchers from the United State and Europe has converged on Africa, convinced that their work is humane and benevolent just as 19th century missionaries came to cure and train. Jonathan Falla sees this impulse towards charity as another form of social control. "What Do They Think They Are Doing?," *Times Literary Supplement* (July 18, 1997).

[61] Michael McCarthy, "AIDS Doctors Push for Live-Virus Vaccine Trails," *The Lancet*, Vol. 350 (October 11, 1997), p. 1082.

[62] This is elaborated in Charles Geshekter, "Outbreak? AIDS, Africa, and the Medicalization of Poverty," *Transition*, #67 (Fall 1995), pp. 4-14; Geshekter, "The Plague That Isn't," *Toronto Globe and Mail* (14 March 2000), and Cindy Patton, *Inventing AIDS* (New York: Routledge, 1990), especially Chapter 4, "Inventing African AIDS." In 1997, Glaxo-Wellcome negotiated with the South African Department of Health to have the government subsidize the cost of importing AZT. As part of this "bouquet of assistance" to provide HIV positive women with AZT, the difference in cost between the actual and discounted price would be used to fund training for "AIDS counselors." *The Weekly Mail and Guardian* (Johannesburg), August 22, 1997. Some pharmaceutical companies now urge pregnant African women who test HIV-antibody positive to take these powerful drugs and to stop breast-feeding their infants.

[63] Cited in Neville Hodgkinson, "Cry, Beloved Country: How Africa Became the Victim of a Non-existent Epidemic of HIV/AIDS," in P. H. Duesberg (ed.), *AIDS: Virus- or Drug-Induced?*

They are really flourishing."[64]

Finally, a 1998 study of pregnant, HIV antibody-positive women in Tanzania showed that simply providing them with inexpensive micronutrient supplements produced beneficial effects and decreased adverse pregnancy outcomes. The researchers found that women who received prenatal multivitamins had heavier placentas, gave birth to healthier babies and showed a noticeable "improvement in fetal nutritional status, enhancement of fetal immunity, and decreased risk of infections." Their commitment to the belief that AIDS was caused by a viral infection obliged the researchers to conclude that "how the individual vitamins produce these effects is not fully understood."[65]

Once scholars consider the non-contagious, indigenous-disease explanations for what are called AIDS, they may begin to see things differently. The problem is that dysentery and malaria do not yield headlines or fatten public-health budgets. 'Plagues' and infectious diseases do.

Inadequate libraries, poorly paved roads, a dearth of teachers, insufficient childhood immunizations, poor harvests, an excess of rinderpest or locusts, domestic abuse, awful public transportation systems, growing numbers of orphans, packs of wild dogs, disruptive regime transitions, unwanted sexual advances..... you name it and HIV/AIDS is somehow, ultimately behind it.[66]

Given the erratic and unreliable keeping of vital statistics across Africa (amply documented in the *Global Burden of Disease Study*), and the vague symptomology that constitutes an "AIDS" case to begin with, it sometimes seems that unless an African was killed by gunshot wounds or had died from injuries sustained in a traffic accident, then almost any decedent can safely be alleged, without any death certificate or an autopsy, to have died from "AIDS" or an "AIDS-related illness."

The 2005 meeting of the African Studies Association is organized around the general theme of "Health, Knowledge, and the Body Politic." Yet one finds almost no papers that deal with the real killers that afflict Africans or compromise their health: malaria, tuberculosis, protein anemia, respiratory diseases, childhood diarrhea, measles, tetanus or the immunosuppression that comes from malnutrition.

If the term "panacea" refers to something that is a "cure-all," then I propose a neologism to describe the all-encompassing power now attributed to HIV and AIDS in Africa. My new term combines "pan" (all-inclusive) with "pathogen"(disease-causing agent) to give us "panopathogen." AIDS has become the African panopathogen, the cause of all that is debilitating or life-threatening.

Is this an exaggeration? Perhaps. But a 2004 report, *Downward Spiral: HIV/AIDS, State Capacity, and Political Conflict in Zimbabwe* exemplifies the all-inclusive nature of the HIV/AIDS hypothesis.[67] One is astonished to learn about the diversity of economic maladies in Zimbabwe that

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[64] Hodgkinson, *op. cit.*, pp. 350-51.

[65] Wafaie W. Fawzi, et. al., "Randomized Trial of Effects of Vitamin Supplements on Pregnancy Outcomes and T Cell Counts in HIV-1 Infected Women in Tanzania," *The Lancet*, Vol. 351 (May 16, 1998), pp. 1477-82. The absence of prenatal health care and adequate nutrition remain major factors in pediatric AIDS cases in the United States where 80% of HIV-infected babies are born to drug-addicted mothers who suffer from a host of vitamin deficiencies.

[66] See, Tamar Kahn, "Dogs Roam Wild as AIDS Kills Owners," *Business Day* (4 February 2005). To describe the all-encompassing power now attributed to HIV and AIDS on African life, I propose the invention of the neologism "***panapathogen***," cobbled together from the Greek word ***pan*** (all inclusive) and the Greek term ***pathogen*** (disease-causing agent).

[67] Andrew T. Price-Smith and John L. Daly, *Downward Spiral: HIV/AIDS, State Capacity and*

the authors claim are either directly caused or indirectly induced by the HIV/AIDS epidemic and HIV disease, which they call "debilitation and mortality as the virus increasingly colonizes the work force." These include:

1) reduction of the labor supply
2) declining productivity of workers
3) decline in remittance income
4) current food shortage
5) decline in life expectancy
6) increased infant mortality
7) decline in personal savings
8) increased national debt
9) increased orphans
10) criminal behavior and general disenchantment
11) opportunities for terrorists
12) accentuated social class differences
13) reduction in the accumulation of knowledge and skills
14) increased violence against women
15) government collapse

People can be encouraged to behave thoughtfully in their sexual lives if they are provided with reliable information about contraception, family planning and venereal diseases. Rather than spend billions of dollars on behavior modification schemes or in pursuit of an illusory AIDS vaccine, multilateral aid should be earmarked to subsidize inexpensive but effective medicines to treat the specific symptoms of common illnesses that are a byproduct of impoverished living conditions.

That money can purchase antibiotics to treat syphilis or gonorrhea, rehydration tablets for diarrhea, directly observed therapy (DOTS) with anti-microbial medicine for tuberculosis sufferers, and micronutrients and vitamin supplements for pregnant women and breastfeeding mothers, regardless of their alleged HIV status. These measures may not be sexy, but they will save lives.[68]

Over the past century, infectious diseases have been controlled through such successful measures
as improved sanitation, cleaner drinking water, eradication of mosquitoes, isolation of genuinely contagious individuals, vaccinations, and the prudent use of antibiotics. Nowadays throughout the AIDS community, the enemies of public health are said to come from within individuals themselves, especially those with inappropriate or promiscuous sexual behavior.

Multilateral institutions and African scientists should familiarize themselves with the body of literature that demonstrates the contradictions, anomalies and inconsistencies in the orthodox view that the symptoms of AIDS are caused by a single viral infection.[69] Once they consider the non-

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[68] For example, for about $20, one can acquire a six-month supply of rifampin, isoniazid, pyrazinamide and ethambutol that will cure an African of tuberculosis. The regimen is a simple, proven, effective remedy for one of the real scourges of Africa.

[69] Neville Hodgkinson, *AIDS: The Failure of Contemporary Science* (London: 4th Press, 1996); Elinor Burkett, *The Gravest Show on Earth* (Boston: Houghton Mifflin, 1995); Hiram Caton, *The AIDS Mirage* (Sydney: University of New South Wales Press, 1994); Robert Root-Bernstein, *Rethinking AIDS: The Tragic Cost of Premature Consensus* (New York: Free Press, 1993); Peter Duesberg, *Infectious AIDS: Have We Been Misled?* (Berkeley: North Atlantic Books, 1996); Joan Shenton, *Positively False: Exposing the Myths Around HIV and AIDS* (New

Frequency of Intercourse, and the Low AIDS Risk of Vaginal Intercourse (New Brunswick: Transaction Publishers, 1997); Christine Maggiore, *What If Everything You Thought You Knew About AIDS Was Wrong?* ((Los Angeles: American Foundation for AIDS Alternatives, 1999); Christian Fiala, "Dirty Tricks: How the WHO Gets Its AIDS Figures," *New African* (April 1998), pp. 36-38; Gordon Stewart, "A Paradigm Under Pressure," *Index on Censorship*, Vol. 28, #3 (May/June1999), pp. 68-72; Huw Christie, "Rethinking AIDS," *Index on Censorship*, Vol. 28, #3 (May/June1999), pp. 73-78; Peter Duesberg, et. al., "The Chemical Bases of the Various AIDS Epidemics: Recreational Drugs, Anti-Viral Chemotherapy and Malnutrition," *Journal of the Biosciences*, Vol. 28, #4 (June 2003), pp. 383-412; and John Crewdson, *Science Fictions: A Scientific Mystery, A Massive Cover-Up, and the Dark Legacy of Robert Gallo* (Boston: Back Bay Books, 2003).

For an exposé of the CDC's misleading campaign in the United States, see Amanda Bennett and Anita Sharpe, "AIDS Fight is Skewed by Federal Campaign Exaggerating Risks," *Wall Street Journal* (May 1, 1996) and David R. Boldt, "Aiding AIDS: The Story of a Media Virus," *Forbes Media Critic* (Fall 1996). The CDC believed that exaggerating the risks to the American people was the only way to enlist widespread support for funds to combat AIDS. Thus, the theme of its public service ad campaign launched in 1987 was, "If I can get AIDS, anyone can." But from 1990 to 1992, the proportion of heterosexuals (aged 18-49) in high risk American cities who reported multiple sexual partners **increased** from 15% to 19%, while condom sales **decreased** by 1%, and 65% of respondents admitted they used condoms either sporadically or not all. Americans were not practicing safe sex and teen pregnancies and venereal diseases were on the rise. Yet AIDS cases continued to decrease sharply. Even the fraction of Americans assumed to be HIV-antibody positive declined from an estimated 1 million in 1985 to 700,000 in 1996. Joseph A. Catania, et. al., "Risk Factors for HIV and Other Sexually Transmitted Diseases and Prevention Practices Among U.S. Heterosexual Adults: Changes from 1990 to 1992," *American Journal of Public Health*, Vol. 85, #11 (November 1995), pp. 1492-99.

There were similar distortions in Canadian reports. By December 31, 1998 there had been a cumulative total of 16,236 cases of AIDS reported in Canada since 1981. In 1995 alone, 2009 adult cases of AIDS were reported. 1834 (91.2%) were males and 175 (8.8%) females. In 1996, there were 1385 adult cases of AIDS reported in Canada, a decrease of nearly 30% in one year. Of the 1385 adult cases, 1220 were males (88%) and 165 were females (12%). In 1997, there were just 573 adult cases, 485 males (84.6%) and 88 females (15.4%). In 1998, there were only 279 cases - 241 males (86.3%) and 38 females (13.7%), a total decrease of almost 90% in three years.

The actual number of adult female AIDS cases reported in Canada had decreased by 50% from 1995 to 1997. In a country of 32 million people, 15.1 million of them women, there were only 38 female AIDS cases in 1998. Yet because the ***percentage*** of women with AIDS went from 8.2% in 1995 to 13.7% in 1998 even though the actual number sharply decreased, the *Annual HIV and AIDS in Canada Surveillance Report* (April 1999) from the Bureau of HIV/AIDS and STD at the Canadian Laboratory Centre for Disease Control issued an alarmist warning that the risk of AIDS among Canadian women had ***dramatically increased*** by 25% to now comprise nearly 14% of all diagnosed cases, "the highest proportion observed since monitoring of the epidemic began," re-affirming how statistics are easily misrepresented to advance claims of an ever-expanding AIDS epidemic.

By 2003, the total number of AIDS cases annually reported in Canada had shrunk to 218, of whom 164 were males and 54 were females. Women now account for 25% of all AIDS cases in Canada, but the latest report drew little attention to the fact that the total number of female AIDS

contagious explanations for AIDS cases in Africa, they can help stop the proliferation of terrifying misinformation and tendentious projections that associate sexuality with death.

The inadequate empirical basis for the "ABCDs" of AIDS policies (abstinence, behavior modification, condoms, drugs) replicates policy errors made to justify environmental interventions thirty years ago. Both propose that western researchers, funding agencies and drug (or chemical) manufacturers provide a self-righteous service to rescue a helpless, ravaged continent. In the case of AIDS, it has meant the medicalization of poverty, the infantilization of African behavior, and the sexualization of everyday life.

A fruitful methodological approach for enlightened skepticism about AIDS in Africa may be found in the scholarship that refutes comparably "self-evident" truths about environmental crises.[70] These studies show how scientists, development agencies and governments benefit from a crisis mentality by inventing, exaggerating and upholding assumptions (i.e., desertification, overgrazing, deforestation) long after the evidence for them had been overturned. As Bassett and Crummey explain, "the degree of urgency which accompanies so many calls for intervention is far too often directly proportional to the ignorance out of which it arises. Outsiders have been constructing Africa according to their own will for far too long."

The value of local knowledge remains greater than ever as a basis for challenging external constructions about African reproductive health or ecological integrity. If we tap into that knowledge we may finally recognize that the "cure" for AIDS is as near at hand as an alternative explanation for what is making Africans sick in the first place.

Surveillance Report to December 31, 2003 (April 2004), pp. 28-30. [The fallacies mentioned here in the inferential analysis of HIV and AIDS statistics in Canadian published reports as explained by Charles Geshekter are presented more fully in Unit 3 section 5 of this course reader.—Ed.]

[70] Melissa Leach and Robin Mearns (eds.), *The Lie of the Land: Challenging Received Wisdom on the African Environment* (Oxford: James Currey, 1996); Thomas J. Bassett and Donald Crummey (eds.), *African Savannas: Global Narratives and Local Knowledge of Environmental Change* (Oxford: James Currey, 2003); and Vigdis Broch-Due and Richard Schroeder (eds.),

UNIT 6
Appendix IV

Death by Nevirapine
A case of unethical research practices in USA

by John Solomon, Associated Press (2005) and *Celia Farber* New York Press (2005)

Posted: May 5, 2005 11:00 am ET

(Washington) To gain access to hundreds of HIV-infected foster children, federally funded researchers promised in writing to provide an independent advocate to safeguard the kids' well-being as they tested potent AIDS drugs. But most of the time, that special protection never materialized, an Associated Press review has found.

The research funded by the National Institutes of Health spanned the country. It was most widespread in the 1990s as foster care agencies sought treatments for their HIV-infected children that weren't yet available in the marketplace.

The practice ensured that foster children - mostly poor or minority - received care from world-class researchers at government expense, slowing their rate of death and extending their lives. But it also exposed a vulnerable population to the risks of medical research and drugs that were known to have serious side effects in adults and for which the safety for children was unknown.

The research was conducted in at least seven states - Illinois, Louisiana, Maryland, New York, North Carolina, Colorado and Texas - and involved more than four dozen different studies. The foster children ranged from infants to late teens, according to interviews and government records.

Several studies that enlisted foster children reported that patients suffered side effects such as rashes, vomiting and sharp drops in infection-fighting blood cells, and one reported a "disturbing" higher death rate among children who took higher doses of a drug, records show.

The government provided special protections for child wards in 1983. They required researchers and their oversight boards to appoint independent advocates for any foster child enrolled in a narrow class of studies that involved greater than minimal risk and lacked the promise of direct benefit.

Some foster agencies, including those in Illinois and New York, required researchers to sign a document agreeing to provide the protection regardless of risks and benefits.

However, researchers and foster agencies told AP that foster children in AIDS drug trials often weren't given such advocates even though research institutions many times promised in writing to do so.

Illinois officials believe none of their nearly 200 foster children in AIDS studies got independent monitors. New York City could find records showing 142 - less than a third - of the 465 foster children in AIDS drug trials got such monitors even though city policy required them. The city has asked an outside firm to investigate.

Likewise, research facilities including Chicago's Children's Memorial Hospital and Johns Hopkins University in Baltimore said they concluded they didn't provide advocates for foster kids.

Some foster children died during studies, but state or city agencies said they could find no records that any deaths were directly caused by experimental treatments.

Researchers typically secured permission to enroll foster children through city or state agencies. And they frequently exempted themselves from appointing advocates by concluding the research carried minimal risk and the child would benefit directly because the drugs already had been tried in adults.

"Our position is that advocates weren't needed," said Marilyn Castaldi, spokeswoman for Columbia Presbyterian Medical Center in New York.

If they decline to appoint advocates under the federal law, researchers and their oversight boards must conclude that the experimental treatment affords the same or better risk-benefit possibilities than alternate treatments already in the marketplace. They also must abide by any additional protections required by state and local authorities.

Arthur Caplan, head of medical ethics at the University of Pennsylvania, said advocates should have been appointed for all foster children because researchers felt the pressure of a medical crisis and knew there was great uncertainty as to how children would react to AIDS medications that were often toxic for adults.

"It is exactly that set of circumstances that made it absolutely mandatory to get those kids those advocates," Caplan said. "It is inexcusable that they wouldn't have an advocate for each one of those children.

"When you have the most vulnerable subjects imaginable - kids without parents - you really do have to come in with someone independent, who doesn't have a dog in this fight," he said.

Those who made the decisions say the research gave foster kids access to drugs they otherwise couldn't get. And they say they protected the children's interest by carefully explaining risks and benefits to state guardians, foster parents and the children themselves.

"I understand the ethical dilemma surrounding the introduction of foster children into trials," said Dr. Mark Kline, a pediatric AIDS expert at Baylor College of Medicine. He enrolled some Texas foster kids in his studies, and doesn't recall appointing advocates for them.

"To say as a group that foster children should be excluded from clinical trials would have meant excluding these children from the best available therapies at the time," he said. "From an ethical perspective, I never thought that was a stand I could take."

Illinois officials directly credit the decision to enroll HIV-positive foster kids with bringing about a decline in deaths - from 40 between 1989 and 1995 to only 19 since.

Some states declined to participate in medical experiments. Tennessee said its foster care rules generally prohibit enlisting children in such trials. California requires a judge's order. And Wisconsin "has absolutely never allowed, nor would we even consider, any clinical experiments with the children in our foster care system," spokeswoman Stephanie Marquis said.

Officials estimated that 5 percent to 10 percent of the 13,878 children enrolled in pediatric AIDS studies funded by NIH since the late 1980s were in foster care. More than two dozen Illinois foster children remain in studies today.

NIH, the government health research agency that funded the studies, did not track researchers to determine whether they appointed advocates. Instead, the decision was left to medical review boards made up of volunteers at each study site.

A recent Institute of Medicine study concluded those Institutional Review Boards (IRBs) were often overwhelmed, dominated by scientists and not focused enough on patient protections.

The U.S. Office for Human Research Protections, created to protect research participants after the notorious Tuskegee syphilis studies on black men in the 1930s, is investigating the use of foster children in AIDS research. The office declined to discuss the probe.

AP's review found that if children were old enough - usually between 5 and 10 - they also were educated about the risks and asked to consent. Sometimes,

foster parents or biological parents were consulted; other times not.

Research and foster agencies declined to make foster parents or children in the drug trials available for interviews, or to provide information about individual drug dosages, side effects or deaths, citing medical privacy laws.

Other families who participated in the same drug trials told AP their children mostly benefited but parents needed to carefully monitor potential side effects. Foster children, they said, need the added protection of an independent advocate.

"If they did not fulfill that requirement, how can you be sure the community participant really got the benefit and the informed consent that is needed," said Michelle Lopez, a New Jersey woman whose daughter has participated in drug trials.

"I was very concerned about that because the argument we are getting is the kids are getting better and we are enhancing their lives, but none of these drugs save these kids lives," she said.

Many studies that enlisted foster children involved early Phase I and Phase II research - the riskiest - to determine side effects and safe dosages so children could begin taking adult "cocktails," the powerful drug combinations that suppress AIDS but can cause bad reactions like rashes and organ damage.

Some of those drugs were approved ultimately for children, such as stavudine and zidovudine. Other medicines were not.

Illinois officials confirmed two or three foster children were approved to participate in a mid-1990s study of dapsone. Researchers hoped the drug would prevent a pneumonia that afflicts AIDS patients.

Researchers reported some children had to be taken off the drug because of "serious toxicity," others developed rashes, and the rates of death and blood toxicity were significantly higher in children who took the medicine daily, rather than weekly.

At least 10 children died from a variety of causes, including four from blood poisoning, and researchers said they were unable to determine a safe, useful dosage. They said the deaths didn't appear to be "directly attributable" to dapsone but nonetheless were "disturbing."

"An unexpected finding in our study was that overall mortality while receiving the study drug was significantly higher in the daily dapsone group. This finding remains unexplained," the researchers concluded.

Another study involving foster children in the 1990s treated children with different combinations of adult antiretroviral drugs. Among 52 children, there were 26 moderate to severe reactions - nearly all in infants. The side effects included rash, fever and a major drop in infection-fighting white blood cells.

New York City officials defend the decision to enlist foster children en masse, saying there was a crisis in the early 1990s and research provided the best treatment possibilities. Nonetheless, they are changing their policy so they no longer give blanket permission to enroll children in preapproved studies.

"We learned some things from our experience," said Elizabeth Roberts, assistant commissioner for child and family health at the Administration for Children's Services. "It is a more individualized review we will be conducting."

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CELIA FARBER
NEWS & COLUMNS

After 20 years of hysteria, alarmism, misplaced recrimination and guilt, AIDS fatigue has beaten the newspaper-reading mind into a kind of blank. Citizens can't be faulted for not knowing how exactly to respond to last week's eruption of scandal from an NIH whistle-blower named Jonathan Fishbein, an AIDS researcher charged with overseeing clinical trials here and abroad. A reverberating language of bureaucracy and euphemism surrounds AIDS stories, making it impossible to know what has actually transpired. When people die from AIDS drugs, for instance, the word "death" is studiously avoided. I have seen medical articles documenting the fact that more people now die of toxicities from AIDS drugs than from the vanishingly opaque syndrome we once called AIDS. Death was referred to as a "grade four event," thus placing it eerily within the acceptable parameters of predictable phenomena in AIDS research‹not as a failure, a crisis or even something to lament.

John Solomon broke the first in a series of stories in the Associated Press on Dec. 14. The lead read:

Weeks before President Bush announced a plan to protect African babies from AIDS, top US health officials warned that research in Uganda on a key drug was flawed and may have underreported severe reactions, including deaths, government documents show.

The story held many shocking revelations, but was quickly spun upside-down and inside-out by the AIDS spin machine, which can take any horror and reduce it to banality, keeping the strict focus off of government malfeasance. What Fishbein disclosed was that NIH AIDS research chief Edmund Tramont had airbrushed and cooked damning clinical data from a large experimental trial in Uganda that tested a drug called Nevirapine against AZT, in pregnant HIV-antibody-positive women, intended to reduce HIV transmission. Tramont had censored reports of thousands of toxic reactions to the drug, and "at least 14 deaths," concealing from the White House the truth about the drug, just before Bush rolled out his $500 million plan to push Nevirapine across Africa.

Additional data not widely reported in the media revealed that there were 16 more deaths in babies on Nevirapine, bringing the total to 30, and 38 babies died on AZT (the other arm of the study). The ominous data coincided with findings from an aborted study in South Africa in the late 1990s (stopped due to toxicities and deaths); it was disturbing enough that the drug's manufacturer, Boehringer Ingelheim, withdrew its application to have the FDA approve the drug for use in pregnant women in all Western nations, including the U.S.

In 2000, the FDA put out a black-box label on the drug (which is approved for use in HIV-positive adults as part of a "cocktail therapy"), warning that it could cause fatal kidney damage and a syndrome that causes the flesh to blister and peel as though burned.

This is the drug that countless campaigners‹spanning the political spectrum from George Bush to Bono‹wish to give all Africans "free access" to. South African President Thabo Mbeki has been savagely pilloried for attempting to stop the drug's distribution to black South Africans. South African lawyer and journalist Anthony Brink's scathing report "The Trouble With Nevirapine" documented the long-known "problems" with the drug. The report was widely read by South Africa's leadership, and is the source of furious debate between black South Africans and the mostly white-run media, which still ridicules all criticism of U.S.-imported AIDS drugs

and protocols as being a symptom of not caring about AIDS victims.

Nevirapine is a cheap drug, believed to reduce the transmission of HIV antibodies from mother to child if given before and during birth, despite there being no reliable data to prove that Nevirapine "drastically reduce[s]" transmission." (On average, in women who are well nourished, about eight percent of babies born to HIV-positive mothers with no intervention wind up HIV-antibody-positive; of these, disease progression is not tied to HIV status but rather to the overall health of the mother.) Wild claims about reduction in transmission are based on outdated, flawed research and ignore critical facts. In Africa, for instance, the test used to detect for HIV antibodies cross-reacts with the very proteins of pregnancy, meaning the women may not be true positives to begin with. Furthermore, every baby carries ghost antibodies from its mother for up to 18 months, which it eventually sheds, so all data about HIV status prior to that window of time is useless‹but consistently cited anyway.

Nevirapine is a non-nucleoside reverse transcriptase inhibitor‹a class of drug designed in the hopes of being less toxic than AZT. This isn't asking much, since AZT is chemotherapy that simply terminates DNA synthesis.

"Of all the AIDS drugs, Nevirapine is the most acutely toxic," explained Dr. Dave Rasnick, a fierce critic of the government's AIDS research agenda, and a former drug developer. "It shows its toxic effects quickly. It has been documented in the medical literature for years that a *single* dose of Nevirapine can kill a person. People don't normally drop dead from taking a protease inhibitor, but that is what happens with Nevirapine. The rationale for this stuff is just as bizarre as it could be."

He continued: "Liver toxicity is the leading cause of death of HIV-positive people in America and Europe in the cocktail era."

Some months ago, I asked Rasnick to send me documentation of this seemingly unfathomable statement, which he did. The statement is in line with interviews I did with healthcare workers back in 2000, who reported that many more people are hospitalized from the effects of the AIDS drugs than from any of the 30-odd symptoms that originally constituted the definition of AIDS (i.e., a disintegration of the immune system).

This would seem to be a p.r. problem for the AIDS industry. But as we learned from the spin that followed the Fishbein revelations, death by AIDS drugs is not viewed as something that should get in the way of a well-intentioned research agenda‹either in the West or in Africa.

The high dudgeon, when it came, was directed not at the NIH for experimenting to lethal effect on pregnant Ugandan mothers, cooking and deleting data, stating openly that African research can't be held to the same standards as Western research, or any of the other disturbing things that came out of Tramontgate.

The ire was aimed at the Associated Press and its reporters for spreading alarm about Nevirapine in Africa, which raised "fears that many women there will stop taking the drug."

The *New York Times* led the Orwellian spin, in a December 21 article by Donald McNeil Jr. The lead went right to the heart of the matter: The dyspepsia of activists and public health experts.

A series of articles critical of past trials of an important AIDS drug has created a furor in Africa, causing many public health experts to worry that some countries will stop using the drug, which prevents mothers from infecting their babies with the virus that causes AIDS.

It went on: "On Friday, The National Institutes of Health for Allergy and Infectious Diseases, an arm of the National Institutes of Health, sharply criticized the articles, saying, 'It is conceivable that thousands of babies will become infected with HIV and die if single-dose Nevirapine for mother-to-infant HIV prevention is withheld because of misinformation.'"

Misinformation? The AP stories were specifically about the transmogrification of information into misinformation that Tramont engineered for his White House report. He cooked data. He deleted information about toxic reactions and death. In what kind of inverted universe is this not a gross violation of the entire premise of science and medicine?

Nature soon followed suit. From an article dated December 23, this dizzying opener:

Scientists and patient advocates this week united to defend an HIV treatment against allegations that a key clinical trial was flawed. A doctor from Global Strategies for HIV Prevention was quoted: 'This

is the most successful therapy in the entire AIDS epidemic. It should not be attacked.'

"We are now living in a time of psychotic science, or abnormal science as I call it," said former *New York Native* publisher Chuck Ortleb, who was boycotted by the activist group ACT UP for publishing scathing critiques of AZT in the 1980s‹a drug that was later proven to shorten rather than lengthen life. "That's why there are no controls in AIDS science, no dissent, why it's all science by press release. These self-appointed AIDS czars pretending to speak for the gay community, pretending to be revolutionaries, pretending to be anti-government when in fact they've always worked hand in hand with the government."

In recent years, Ortleb has turned to writing satirical novels, plays and a soon-to-be-released film called *The Last Lovers on Earth*, which is centered on a future dystopia in which AIDS research has been so successful that all gay men are dead.

"With their logic," Ortleb says, "this risk-benefit analysis, it doesn't matter if people die on the drugs, because they died so that the rest of the world could be saved."

His most recent send-up is a fictional press release for a new medical group called "Doctors Without Borders, Brains or Ethics," and focuses on protecting the AIDS establishment from criticism, "before the infection of skepticism spreads."

Let us not forget that Nevirapine is a drug that was pulled by its own manufacturer from use in the West, after an investment of many millions of dollars. It remains banned for use in pregnant first-world women.

Still, the NIH is using it on American women, in experimental trials you never heard about‹until now. Alongside the revelations about the Ugandan trial, the AP stories brought to light that Joyce Ann Hafford, a 33-year-old, perfectly healthy, eight-months pregnant HIV-positive woman from Tennessee died from liver failure in an NIH trial testing Nevirapine. Her liver counts had been way off for days, and still doctors didn't take her off the drug.

The doctors told her family, naturally, that she had died of AIDS. The trouble is, cocktail-drug deaths are easily distinguished from AIDS deaths. This was not the case with AZT, a drug that simply decimated the immune system. Cocktail deaths are caused

primarily by liver toxicity, heart attacks and strokes‹from the effects of the drugs on the body's fat metabolism.

Hafford's death crystallizes the raging conflict between the establishment point of view that HIV is deadly and drugs save lives and the "denialist" or dissident point of view that HIV is not deadly at all by itself, but AIDS drugs are. Hafford had no so-called AIDS symptoms; she was simply HIV positive. She also had an older healthy child, which suggests that HIV may not be as lethal as advertised. By refusing to lament her death, or even the scores of Ugandan deaths, and instead attacking the messenger, the AIDS establishment has shown itself to be lost, with a broken compass, on the map of medicinal ethics.

Once it becomes acceptable to kill patients in experimental clinical trials and cover it up, without consequence, you might argue that all is lost.

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