Appendices

Unit 11

I: *The Silent Revolution in Cancer and AIDS Medicine (excerpts)* by Heinrich Kremer

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APPENDIX I
UNIT 11

The Silent Revolution in Cancer and AIDS Medicine
By Heinrich Kremer, MD (2001)
Excerpts from Chapter XI **The lifesaving knowledge on healing**[1]

There is no reason for panic should a patient find himself stigmatized as "HIV positive" as a result of the "HIV test". Death prognoses are an expression of limited medical knowledge rather than justified in biological fact. A careful anamnesis of the patient is necessary; the determination of the immune cell status and antibody status are obligatory. In healthy people the T4 cell counts can even drop below 200 per microliter without a serious loss of cellular immunity functions.

Valid information can be obtained through the DTH recall antigen test (antigen recall test of the skin, delayed type hypersensitivity. A weak or anergic (ineffective) DTH skin test reaction indicates the probability of a prevalent shift to type-2 cytokine status and the danger of opportunistic infections.

Preventing and treating systemic illnesses with glutathione/cysteine compensation

The organism's need for thiol is often underestimated or neglected. After the predominant scenarios in the "thioester-iron world" one of the essential conditions for the origin of life in the prebiotic world before the creation of cellular organisms, was the capacity of sulfur to generate bonds and exchanges between protons of the sulfhydryl groups through "weak interactions", (De Duve 1991). Saltwater contains naturally an elevated sulfur concentration, but for terrestrial life forms there is a consistent danger of latent deficiencies of non-protein thiols and sulfates. Both are indispensable because they are responsible for the regulation of the redox milieu, the functioning of cell symbiosis in immune and non-immune cells and innumerable biosyntheses and biochemical reactions (Wrong 1993, Hässig 1999).

At least 2 grams of glutathione and simultaneously 5 to 10 grams of N-acetyl cysteine must be orally administered per day for 2 to 4 weeks at the beginning of compensation therapy. Lack of glutathione in the lung secretion layer is an important conditioning factor for cellular immune deficiency against the pneumocystis carinii fungi, the pathogens of the most common AIDS indicator disease, PCP of the lungs.

Rigorously administered compensatory therapy, in cases of pre-AIDS or AIDS, during a well-monitored treatment phase produces better and more cost effective results than the counterproductive prescription of chemotherapeutic agents (AZT etc., "cocktail therapy", HAART) and permanent prophylaxis with chemo-antibiotics (Bactrim etc.) which may bring short-term results, but have been proven to aggravate symptoms.

The other important family of natural liver protecting agents are polyphenols. Antioxidative protection of cell symbioses of liver cells and other cell systems including the immune cells, by polyphenols is of particular importance in the highly acute AIDS state, if intracellular opportunists can proliferate without inhibition, due to the failure of the cytotoxic NO-gas producing Th1 helper cells.

In this precarious situation…[t]he use of micronutrients (vitamins, minerals and trace elements) must be considered in a differentiated way regarding compensation and regulation therapies for the prevention of pre-AIDS and AIDS as well as for other systemic diseases. "Deficiencies of single micronutrients are known to adversely affect the immune system by

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[1] The full text of this chapter can be accessed online at:
http://ummafrapp.de/skandal/heinrich/kremer_the_lifesaving_knowledge_on_healing.pdf

depression of cellular and humoral immunity. The basic extracellular matrix, which embeds all tissues and organs, functions as filter for all the bioenergetic, substantial, hormonal and sensory inputs and outputs of cellular symbiosis.

Direct activation of the mitochondrial cell symbiosis can be stimulated by coenzyme Q10 (Folkers 1986) and L-carnitine (Bremer 1990). C Q10 plays an important role in the electron transfer in the mitochondrial respiratory chain. Reduced mitochondrial performance as consequence of chemotherapeutics, caused by damage to mitochondrial DNA after the intake of AZT etc. and Bactrim etc., can additionally be compensated by the daily dose of 600 mg lipoic acid (alpha-lipoic acid) plus 300 mg thiamine (vitamin B1) for a month or longer. These counter-regulations must, sooner or later, lead to clinical full-blown AIDS, if the primary stress factors can not be minimized, the proton demand deficiencies are not balanced and the dysregulation of the cell symbiosis is aggravated additionally by the use of 'chemo-tactical' weapons.

The preventive and therapeutic aim must be to balance the redox milieu, to improve the fluidity of the micro-Gaia milieu, to reconstruct the cytokine balance. The use of AZT and analogous virucidal medication as recommended by the responsible authorities, is based on the antibiotic paradigm, which means the toxicological extinction of microbial inflammation germs. Man lives, however, in an ongoing symbiosis with a whole range of microorganisms, hence the question is justifiable if it would not be more sensible to support the probiotic, physiological mechanisms of self-healing to support organisms" (Hässig 1993). The variety of the effective and non-toxic intervention options demonstrates a possible change within medical practice "from antibiosis to symbiosis". Therefore, it is the overriding task of physicians to reduce the paralyzing and destructive fear of death and instead encourage people affected by systemic cell dys-symbiosis by reinforcing their natural will to survive by clarification of the actual state of knowledge. The most effective protection against the abuse of "violent medicine" (Albonico 1997) as a modern instrument of terror and fear is the rational knowledge, that every kind of risk for and any targeted attack on, the cell symbiosis of immune cells and nonimmune cells is answered according to the laws of evolutionary biology.

The profound change in 'natural' verifiable knowledge of the sciences progresses from antibiosis (from the Greek: anti = against + bios = life) to symbiosis (from the Greek: sym = with, together). The foreseeable end of lethal virus hunting and of one-sided aggressive cancer expunging represents, both for those concerned and for medical therapists as well as for general population, a self-critical liberation from the staging of a collective and exploitive terrorism of fear.

Humans in preindustrial times were not exposed to the oxidative stressors in the environment, food, and medicine now present in modern civilization. In addition, the modern practice of vaccination also leads to more aggressive Type-2 switching. Today, these additional stress burdens flip the Type-2 switch too easily. The net result is a population-wide increase in chronic immunological deceases such as allergies, asthma, autoimmune conditions and cancer.

Immunological observations of AIDS patients demonstrate a Type-2 cytokine dominance. In 1989 it was observed that asymptomatic "HIV"-seropositive individuals are systemically deficient in glutathione. One of the safest ways to boost systemic glutathione is oral N-acetylcysteine (NAC)…Clinical trials have proved astounding results and NAC is universally recommended for seropositive patients.

Reverse transcription is a well-known factor in the repair of oxidatively damaged nuclear DNA. Cell cultures of HIV are necessarily subjected to unusual oxidative and mitogenic stressors in order to express the "HIV proteins." The genetic expression of pathological proteins is just another symptom of systemic imbalance.

A widely overlooked fact by AIDS researchers is that everyone has "HIV proteins" in small amounts; those stigmatized as "HIV+" simply have higher amounts than the arbitrary threshold of the "HIV antibody" ELISA test kit.

Gilles St. Pierre gave a presentation about the tragic death of his wife, Maria, who had been on the retroviral therapies for several years and then decided to go off them, cold turkey. She was fine for a while, but then went into decline and died. Felix de Fries, a specialist on AIDS therapies from Zurich, advised that one thing he has learned over his many years of advising AIDS patients is to go off the medications slowly. Felix proved to be a valuable contribution to the conference on the subject of how to heal a damaged immune system. Here is a review of some of the references Felix offered us.

How to Heal a Weakened Immune System

The glutathione deficiencies that cause the inhibition of nitric oxide synthesis also lead to the dissolution of the mitochondrial symbiosis. It is imperative to focus on restoring the mitochondrial symbiosis as a primary goal of AIDS therapy.

Mitochondrial dysfunction is also tied to cancer…a breakdown of oxidative cell respiration and increase of lactic acid fermentation is a precursor to cancer. … [T]he decline of T-cells seen in the peripheral blood is not due to any postulated "HIV-mediated cell killing" but rather is another consequence of the thiol-mediated cytokine shift (Th-1 to Th-2). The Th2 cells reside primarily in the bone marrow and out of view from peripheral blood counts. An analogy cited by Kremer: "the 'police officers' of the bloodstream are missing from the streets, not because gangsters have killed them, but instead because they have taken desk jobs."

HAART therapy causes the Th-2 cells to return to the bloodstream causing a transient increase in CD4+ blood count, but this is misleading because the Th-2 cells cannot produce cytotoxic NO gas and are therefore lame against preventing infections.

There is no 'magic bullet' solution to the immune dysfunction seen in AIDS, as explained by the shift to Th2 dominance, because there is no HI-Virus to be eradicated. The process of reversing the Th2 dominance is complex and highly individual; it requires time, patience, and the help of a truly knowledgeable physician. There is still much to be discovered regarding the healing powers of orthomolecular cell-symbiosis compensation therapy for AIDS.

However, the therapy's scientific basis is solid…The final nail in the coffin for the HIV theory is that the cell types used to derive "HIV proteins" (Gallo used cancer cells, and Montagnier used embryonic cells) all have altered mitochondrial bioenergetics that predispose them for Type-2 counter-regulation.

UNIT 11
APPENDIX II

HEALTH STRATEGIES TO FIGHT AIDS IN AFRICA REQUIRE RELIABLE EVIDENCE NOT EMOTIONAL EXCESS

by
Andrew J. Maniotis and Charles L. Geshekter[1]

Introduction

A Kenyan AIDS trial was interrupted because a fifty-three percent reduction in acquisition of 'HIV' among circumcised men was observed. Out of 2,784 men studied in the trial, sixty-nine men were 'HIV' positive: twenty-two of these were circumcised, and forty-seven were uncircumcised. Many, if not all, sixty-nine of them had received prior (or concurrent) treatment for penile infections, and twenty-eight of the sixty-nine had serologic syphilis at the outset. A year before, it was claimed that a trial of 4,996 HIV-negative men in Rakai, Uganda, showed that HIV acquisition was reduced by forty-eight percent in circumcised men. During this era of AIDS, previous episodes of conducting AIDS science-by-press-release, like the Kenyan trial we question in this analysis, have led to horrible consequences for hundreds of thousands who have been experimented upon with toxic 'life saving' or 'life extending' drugs.[2]

Uncertainties exist because: data has been acquired at STD clinics or from trial participants with genital ulcer disease (GUD) or other infections; while the relative roles (if any) of biological pathogens versus cultural practices that influence 'HIV' acquisition have been challenged by the World Health Organisation (WHO). Uncertainties regarding the damage done by microbicides also exist; for, according to reported incidents, these apparently increase the frequency of genital lesions and the feared spread of 'HIV'. The ability or inability to neutralise 'HIV' by washing with mild or concentrated detergents is in question, and the transmission of 'HIV' from human to human by providing evidence of sero-conversion has yet to be provided in a form that constitutes as careful a study as the ten-year study that followed 175 sero-discordant couples for ten years and found no conversions whatsoever.[3] Uncertainties also exist because of the vastly different rates and efficiency of transmission said to be associated with heterosexual, homosexual, and IV (intravenous) drug use in different regions, and, because of the ability of gamma globulin to neutralise 'HIV' among well-nourished and healthy individuals. Uncertainties also exist especially because of the validity (and the invalidity) of different test kits to identify 'HIV' positive participants, and because the actual role (or non-role) of T-cells in progression to AIDS is also still in question.

The role of circumcision in preventing transmission of 'HIV' and acquisition of AIDS in Africa is further complicated by compelling evidence from a series of recent studies that identified nosocomial (hospital and doctor-medicated) 'HIV' transmission as the single most critically important factor for the spread of AIDS in Africa, which accounts for many anomalies and conundrums that cannot be explained by a sexual transmission hypothesis.

The references for these citations are listed at the end of this appendix.

[1] This is a reprint of Chapter 36 in Volume I of *Reclaiming the Human Sciences and Humanities through African Perspectives* eds. H. Lauer & K. Anyidoho (2012) Accra: Sub Saharan Publishers, pp. 587-610.

[2] [Regarding the ethicality of anti-retroviral therapy see Unit 5 in the course reader.–Ed.]

[3] N. Padian et al. (1997).

From the 1950s into the 1980s, unsafe injections may have contributed to the silent spread of HIV in Africa in much the same way that other types of vaccination campaigns, including injections for schistosomiasis and other treatments in Egypt, established 'hepatitis C' as a major blood-borne pathogen. While evidence for nosocomial[4] transmission of 'HIV' continues to accumulate since the long established fact that hepatitis B and flu vaccines cause 'HIV' positive tests in some individuals, six Bulgarian health care workers (The Tripoli Six)[5] that came near to being executed by firing squad in Libya for their alleged role in supposedly transmitting 'HIV' to more than 400 Libyan children.

In an interview with co-author A. J. Maniotis, published in a Greek newspaper *Paraskevi+13* December 7, 2007, and currently undergoing translation into several languages by an European Union official, the oncologist Maniotis remarked:

> [The case of the 'Tripoli Six'] is a good example of [the] question: 'Is HIV a Black disease or an African disease?' because it wasn't only the President of France and his wife who helped in freeing these health care workers, but it was the recommendations of Luc Montagnier and other people in the 'AIDS establishment' to release these people . . .. . .
>
> First of all, it is impossible to get a cluster of [so] many nosocomial (that is to say hospital-induced) 'HIV' infections in a single place over such a short period of time. So, the AIDS establishment did what they always do; they pinned it on the presence of Black people in the hospital. When asked to explain 426 cases of children's deaths, Luc Montagnier said—if I am not mistaken—'Well, it probably has to do with the infusion of health care workers from sub-Saharan Africa'—which makes no sense medically. It makes no sense scientifically. And certainly, it's a racist thing to say, and at best it impugns the sub-Saharan health care workers who have come to Libya and elsewhere to try and find jobs; and it also punishes the Africans and African-Americans wherever they live in the world because it is assumed that because of their skin colour and culture, that they have a higher incidence of AIDS. . . [T]he populations of Africa have been increasing during the last 20 years, not decreasing because of some killer viral epidemic, despite the fraudulent and downright politically and economically motivated statements to the contrary by the World Health Organization, the Bush Administration, and others. African statistics for AIDS in all forms come to an astonishing 2.3 percent of the population will typically test positive. It has been reported, in addition, that prison populations in South Africa, have a 'HIV-positive' testing rate of about 2.3 percent, and one prison official I quoted in this article said he'd only seen one or two cases of full blown "AIDS" in 7 years in his prison." [See A.J. Maniotis (2007: 43) interviewed by Lambrous Papantoniou, Washington DC.—Ed.]

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[4] ['Nosocomial' means originating or taking place or acquired in a hospital, particularly with reference to an infection. Iatrogenic' describes ailments, symptoms, illness or disease induced through the action, method, therapy or intervention of a doctor or one due to an action or procedure which has been medically prescribed. –Ed.]

[5] [This widely publicised series of trials, sentencings, and appeals began in 1998, involving the defence of a Palestinian medical intern and five Bulgarian nurses. They were first sentenced to death, the case was then remanded by Libya's highest court, and they were sentenced to death again, with the decision upheld by Libya's highest court early in July, 2007. The six accused then had this sentence commuted to life imprisonment by a Libyan government panel. They were released following a deal (on terms that remain controversial in the international arena) which was reached through negotiations with EU representatives on humanitarian issues. On July 24, 2007 the five nurses and the doctor were extradited to Bulgaria, where their sentences were commuted by the Bulgarian President and they were freed.–Ed.]

To examine the potential value of circumcision versus the possibility of nosocomial transmission, misdiagnosis, and other possibilities regarding the acquisition of AIDS in Africa, we reasoned that examination of both hypotheses must be well established before conclusions are drawn. And new AIDS policies that will affect millions of people should include the vital statistics generated by Africans themselves if they are available, as well as recommendations by physicians who have direct, empirical knowledge of African AIDS from their hospital or clinical setting. A wealth of data obtained directly from Statistics South Africa and other sources, which reported for both 2003 and 2004, that 'HIV diseases' were officially ranked number 21 in the list of leading causes of death for South Africa, and constituted between two and three percent (2-3%) of all deaths throughout most regions. These statistics, reported by Africans themselves, are supported by historical, sociological, and cultural considerations, and by the accounts of prison officials, as well as by both African and foreign doctors who have written about how delivery of medical care to Africans has changed or not changed over the period of several decades. These observations further suggest that the state of affairs regarding 'HIV/AIDS' in Africa has nothing to do with sexual activities, but reflects the changing nature of African political economies since the late 1970s, its devastation on African lives, in some regions, because of the traumas of civil war violence, and the damage to African culture and society due to a proliferation of 'HIV' testing, and the flood of 'HIV/AIDS' health care opportunism.

Drug studies to date have not been properly evaluated in order to compare with circumcision statistics from Kenya, regardless of what the complete data from the Kenyan study will show, if they ever are published. It has been admitted unabashedly that more than 875,000 African mother-infant pairs have been experimented on in this fashion.

The analysis of AIDS statistics and the research results presented in this chapter demonstrate that global health strategies for AIDS, like any other public health activities, should be based on evidence instead of racist notions regarding sexual behaviour. Many of the basic assumptions regarding the probability that 'HIV' leads to "AIDS" are clearly wrong, contradictory, and defy common sense, to the extent that the 'HIV/AIDS' hypothesis should be retracted, and a full examination of where we went wrong, conducted, so we can learn from 'mistakes'. Although six health care workers in Libya narrowly escaped execution due to mistaken notions regarding the association of immune suppressive syndromes with positive 'HIV' testing, epidemiology, and toxic anti-retrovirals, it is perhaps the individuals in leadership roles in Western governments (in particular the US through National Institutes of Health (NIH) and Centres for Disease Control (CDC) who press release these kinds of distortions and propaganda, and who direct these trials and distort data, who must be held legally, and criminally responsible?

Science-by-press-release

Numerical precision is widely considered a sign of scientific rigour. The provision of data which is verifiable is especially important when discussing public health policy.

One must also determine how accumulated data may fit into a preconceived conceptual framework of a disease's aetiology in order to generate meaningful hypotheses that may (or may not) offer reliable predictions. If epidemiological projections actually materialize, they can guide interventionist policies. But if the actual results deviate significantly from the initial projections, it may signal that the original premises of the conceptual framework were flawed.

For these reasons, a December 14, 2006 *New York Times* newspaper editorial article entitled, "Rare Good News About AIDS," came as a shock:

> The announcement yesterday about the results in two African studies of male circumcision may be the most important development in AIDS research since the debut of antiretroviral drugs more than a decade ago. The National Institutes of Health halted studies in Uganda and Kenya when it became overwhelmingly clear that circumcision significantly reduces men's chances of catching HIV. The studies confirm the results of a trial that ended last year in South Africa, in which circumcision prevented sixty to seventy percent of new AIDS infections. News of the South African results has already led to a surge in demand for the procedure across Africa, and clinics that now offer it have long waiting lists.[6]

Shortly thereafter, NIADS (National Institute of Allergy and Infectious Diseases) claimed:

> Adult Male Circumcision Significantly Reduces Risk of Acquiring HIV Trials in Kenya and Uganda Stopped Early: The National Institute of Allergy and Infectious Diseases (NIAID), part of the National Institutes of Health (NIH), announced an early end to two clinical trials of adult male circumcision because an interim review of trial data revealed that medically performed circumcision significantly reduces a man's risk of acquiring HIV through heterosexual intercourse. The trial in Kisumu, Kenya, of 2,784 HIV-negative men showed a fifty-three percent reduction of HIV acquisition in circumcised men relative to uncircumcised men, while a trial of 4,996 HIV-negative men in Rakai, Uganda, showed that HIV acquisition was reduced by forty-eight percent in circumcised men. "These findings are of great interest to public health policy makers who are developing and implementing comprehensive HIV prevention programs," says NIH Director Elias A. Zerhouni, M.D.[7]

The results praised by this NIAIDS embargoed press are not yet published, nor are they soon going to be. Because the 2006 Kenyan trial was stopped early, the Data Safety and Monitoring Board has blocked the publication of the work until it can complete its investigation. Dr. R. C. Bailey, the Kenyan study's lead author, is certain that any journal will accept the results when they are written up and submitted (personal communication).

But science by press release can lead to public atrocities, especially in the AIDS arena. The first Fischl 1987 AZT trial that obtained FDA approval for the drug also was stopped early in a record 4 months "out of compassionate reasons."[8] The trial became unblinded on the part of both doctors and participants. Accusations of deception were levelled at the authors because patients were switched between arms. The Boston arm of the trial was supposed to be discarded due to sloppy record keeping but wasn't, and results later obtained in a longer, better designed, and much larger trial known as Concorde, were completely the opposite of the Fischl trial:

> The results of Concorde do not encourage the early use of zidovudine in symptom-free HIV-infected adults. They also call into question the uncritical use of CD4 cell counts as a surrogate endpoint for assessment of benefit from long-term antiretroviral therapy.[9]

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[6] Editorial "Rare Good News About AIDS," *The New York Times.* Section A, December 14, 2006: 40.

[7] US Dept. of Health and Human Services NIH News, National Institute of Allergy and Infectious Diseases (NIAID) EMBARGOED FOR RELEASE Wednesday, December 13, 2006, 12:00 Noon ET Contact: NIAID News Office +01-301-402-1663.

[8] Fischl, M. A. et al. (1987).

[9] Seligmann, M., et al (1994).

Certain issues are somewhat alarming regarding the information made available about the Kenyan and Ugandan trial protocols:

i) What was the division in terms of actual numbers of cohort participants (CPs) among the 4,996 enrolled in the two respective arms of the Ugandan trial—how many underwent circumcision and how many remained uncircumcised? According to the press release summarised in the introduction to this chapter—to repeat the details which warrant careful consideration—of the sixty-nine 'HIV' positive men studied in the Kenyan trial, only twenty-two were considered circumcised out of the 2,784 men, while forty-seven were uncircumcised, and many, if not all of them, had received prior (or concurrent) treatment for penile infections (R.C. Bailey, personal communication). Also according to Dr. Bailey, twenty-eight of the sixty-nine cohort participants had serologic syphilis at the outset. Is this a *realistic* representation of how circumcision prevents the acquisition of an 'HIV' positive test result when nearly half the cohort tested positive for syphilis?

ii) In each arm of the studies, at the outset and at termination, how many of the cohort participants suffered from anaemia, malaria, common parasitic infections, STD's or any respiratory illness like TB or pneumonia?

iii) How many of the CPs at the outset produced discordant ELISA[10] test results for HIV status and hence required Western Blot testing? And did those who tested positive with ELISA's test consistently positive on Western Blot's and PCR (polymerase chain reaction), or were these data fraught with inconsistent findings?

iv) In its review of 'behavioural disinhibitions' in Rakai District, the research protocols indicate that, before initiating the study, in terms of condom use, seventeen percent were expected to use condoms inconsistently and five percent consistently, leaving seventy-eight percent who were expected (presumably) not to use condoms at all. What did the researchers find were the actual percentages of such 'behavioural disinhibitions' between the two arms?

Until we see the data, and can become as optimistic as these agencies and media regarding the benefits of circumcising every black man in Africa, we will try to answer four different questions that the embargoed trial data will hopefully address, one day when it becomes available.

1) How does circumcision really prevent acquisition of 'HIV/AIDS'?
2) Might there be other explanations for 'AIDS' in Africa other than heterosexual transmission of 'HIV'?
3) What is the background incidence of 'HIV/AIDS' in Africa the first place?
4) Is circumcision the most important development in AIDS research since the debut of antiretroviral drugs?

[10] [ELISA or Enzyme-Linked Immunosorbent Assay, also known as the 'rapid test', legally (in the UK and the USA) requires back-up corroboration with Western Blot anti-body test result before a positive diagnosis on ELISA is regarded as definitive. See Rodney Richards (2001a) and (2001b) concerning the contested application of these kits designed for general blood screening to clinical diagnosis of individual patients. PCR denotes the polymerase chain reaction method of tracking HIV, developed by Nobel prize winning chemist Kary Mullis who was among the earliest to oppose the application of his technique in 'HIV/AIDS' diagnosis. —Ed.]

How does circumcision really prevent acquisition of 'HIV/AIDS'?

Many studies including the Ugandan and Kenyan studies, have been conducted from statistics collected at STD clinics, or with men who have 'penile ulcers' or STD's. For example, on Cote d'Ivoire:

> Risk factors for HIV-2 infection in men attending Abidjan STD clinics were broadly similar to those for HIV-1 infection. HIV-1 infection was more strongly associated with current STD.[11]

Ulceration of the external genitalia has been studied in both men and women in South Africa exhibiting genital ulcer disease (GUD):

> The accuracy of a clinical diagnosis was, in men: lymphogranuloma venereum (LGV) 66%, donovanosis 63%, chancroid 42%, genital herpes 39%, primary syphilis 32%, mixed infections 8%, and in women; secondary syphilis 94%, donovanosis 83%, genital herpes 60%, primary syphilis 58%, chancroid 57%, LGV 40%, mixed infections 14%. Overall, diagnostic efficiency was greater in women than in men. When compared with other causes of GUD, donovanosis ulcers bled to the touch and were larger and not usually associated with inguinal lymphadenopathy. In women, extensive vulval condylomata lata were readily differentiated from all other causes of GUD. A clinical diagnosis in genital ulceration was less accurate in men than in women. The diagnostic accuracies for donovanosis and secondary syphilis were relatively high but for most other conditions were low. Differences between clinical and laboratory diagnostic accuracies may reflect similarities between the clinical appearances of the various causes of GUD, the presence of mixed infections, atypical ulceration due to longstanding disease, and insensitive laboratory tests. In this community all large ulcers should be treated empirically for syphilis and donovanosis. Uncircumcised men with GUD are an important HIV core or 'super-spreader' group locally, and prevention strategies should include counselling and health education in the light of the inaccuracy of clinical diagnosis found in this study. The development of rapid accurate tests for GUD is urgently required."[12]

Another group reported that in Kisumu, the prevalence of HIV infection was:

> 9.9% among circumcised men and 26.6% among uncircumcised men. After controlling for socio-demographic characteristics, sexual behaviour and other sexually transmitted infections, the protective effect of male circumcision remained with an adjusted odds ratio of 0.26 (95% confidence interval = 0.12-0.56). In Ndola, the prevalence of HIV infection was 25.0% in circumcised men and 26.0% in uncircumcised men. The power was insufficient to adjust for any differences in sexual behaviour.[13]

However, in India, it was reported by Reynolds et al., that:

> Circumcised men have a lower risk of HIV-1 infection than uncircumcised men. Laboratory findings suggest that the foreskin is enriched with HIV-1 target cells . . . we noted no protective effect against herpes simplex virus type 2, syphilis, or gonorrhoea. The specificity of this relation suggests a biological rather than behavioural explanation for the protective effect of male circumcision against HIV-1.[14]

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[11] M.O. Diallo, et al. (1992).
[12] N. O'Farrell, et al. (1994).
[13] B. Auvert, et al. (2001).
[14] S.J. Reynolds, et al (2004).

Are the penises of Indian men different than those of Africans, such that the acquisition of 'HIV' among circumcised Indian men was less compared to uncircumcised men? S.J. Reynolds et al quoted above would have us consider that there is a likely over-abundance of so-called 'HIV' receptors present on the foreskin of Indian men, which isn't selective for herpes simplex, syphilis, or gonorrhoea,

> . . . or perhaps that the superficial Langerhans cells on the inner aspect of the foreskin and frenulum are "poorly protected by keratin," and thus [these cells] could play an important role in primary male infection.[15]

However, in New Zealand, it was reported that:

> Results support a lack of association between circumcision status and HSV-2 acquisition, although a small effect cannot be ruled out.[16]

Despite theories regarding the distributions of 'HIV' receptors on different cultural groups' penises, the WHO comes to a different conclusion regarding biological differences based on cultural groups, as is presented in the *WHO Manual for Male circumcision under local anaesthesia*[17] wherein it is noted that:

> . . . the 191 circumcised men (in the S.J. Reynold's et al 2004 study), 62.1% were Muslim. When non-Muslim men were assessed separately, the circumcised group was small and the same significance in protective effect was not found. This illustrates the difficulties in separating the effect of male circumcision from cultural factors.

What would be the effect of circumcision and 'HIV' acquisition for men who have not acquired any other co-infections or who don't have ulcers or genital ulcer disease? And what about men who wash their private parts with soap every so often?

It is known that "*within one minute*, a 0.5% solution of nonidet-P40" inactivates "huge amounts" of artificially prepared 'HIV' virus.[18] In addition, AIDS researchers who spent ten years studying 1270 Kenyan female sex workers reported that:

> . . . women who performed vaginal washing with *soap* or other substances were at higher risk for HIV-1 compared with those who used water alone (adjusted HR, 1.47; 95% CI, 1.02-2.13).[19]

Maybe boys are different than girls with respect to circumcision and 'HIV' acquisition? From a recent analysis of 118 countries it was concluded that:

> . . . male circumcision was also strongly associated with lower HIV prevalence among countries with primarily heterosexual HIV transmission, but not among countries with primarily homosexual or injection drug use HIV transmission.[20]

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[15] S.G. McCoombe, et al (2006).
[16] N. Dickson, et al (2005).
[17] <www.andrology.org/?download=WHO_MC_Manual%20v2.0.Oct%2006.pdf> Accessed October 2006.
[18] L. Resnick, et al (1986).
[19] R.S. McClelland, et al (2006).
[20] P.K. Drain, et al (2006).

According to a recent report from South African AIDS researchers:

> Women who had undergone FGC [female genital circumcision] had a significantly higher prevalence of bacterial vaginosis (BV) [adjusted odds ratio (OR) = 1.66; 95% confidence interval (CI) 1.25-2.18] and a substantially higher prevalence of herpes simplex virus 2 (HSV2) [adjusted OR = 4.71; 95% CI 3.46-6.42]. The higher prevalence of HSV2 suggests that cut women may be at increased risk of HIV infection.[21]

Whether or not the sexual organs of African males or females are being studied in great detail by Western AIDS researchers, all of these data still do not explain why serodiscordant[22] couple studies could not demonstrate that 'HIV' is transmissible from human to human in a ten year study. In what might be the most comprehensive study of 'HIV' transmission to date, there was no evidence of even one seroconversion among the 175 serodiscordant couples studied:

> We observed no seroconversions after entry into the study [i.e. nobody became HIV positive] . . . This evidence argues for low infectivity [arguably no infectivity] in the absence of either needle sharing and/or other cofactors . . .[23]

Massive amounts of money and effort have been directed toward smearing microbicides on the genitals of Africans. The results of sixteen or more 'advanced' clinical trials funded by the NIH and other agencies are somewhat alarming. For instance, the decision was made to cancel the planned phase III trial of nonoxynol-9 (N-9) gel, a vaginal microbicide, on the genital mucosa of women from Malawi and Zimbabwe in preparation for a phase III efficacy study after it was learned that:

> N-9 gel 100 mg caused a significant increase in the rate of genital symptoms and epithelial disruptions compared with placebo.[24]

Dr. Lynn Paxton, a microbicides expert at the CDC, commented on the results and implications of studies in Africa that involved nearly 1,000 women:

> 59 of those who used the spermicide became infected with HIV, compared to 41 of those who used a dummy gel, and . . . The Centers for Disease Control and Prevention (CDC) said it was concerned by the findings because some groups advise people to use nonoxynol-9 to protect themselves from HIV if they cannot use a condom.
>
> I think it's pretty clear we have to tell men who have sex with men not to use it.[25]

It is not clear why Dr. Paxton doesn't advise everybody not to use the preparation since the study reveals that it causes genital lesions.

What if African males have microscopic cuts (abrasions, not ulcers) on their penises? It has been known since 1985 that "exposure to gamma-globulin alone inactivated about 99%

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[21] Linda Morison, et al (2001).

[22] [Serodiscordant couple refers to partners accorded opposite HIV status. Seroconversion refers to a patient's status shifting on the basis of test results. –Ed.]

[23] N. Padian, et al (1997).

[24] I.F. Hoffman, et al (2004).

[25] Maggie Fox, "Spermicide worsens HIV risk, study finds," *Reuters* July 12, 2000.

of HTLV-III infectivity."[26] Therefore, in normally nourished individuals who possess normal levels of gamma-globulin, circumcision is not likely to account for a sixty to seventy percent or forty-eight to fifty-three percent reduction in inseminators acquiring 'HIV', if the people followed in these trials had normal levels of gamma-globulin.[27]

The ability of test kits for 'HIV' to work or not to work is a serious issue in light of the fact that 'HIV' test kits, especially the rapid ones, don't detect 'HIV', but are believed to detect so-called markers of 'HIV'[28] in goats, cows,[29] and 'HIV-like' gene sequences in human, chimpanzee, and rhesus monkey DNAs from 'normal uninfected individuals'.[30] In the culturing of 'HIV', the so-called 'HIV-specific' reverse transcriptase enzyme activity has been found in yeasts, insects and mammals of all kinds.[31] In this regard, in 1985, at the beginning of HIV testing among sperm donors, it was known that "68% to 89% of all repeatedly reactive ELISA (HIV antibody) tests were likely to represent false positive results."[32]

As for T-cells constituting the defining cell type attacked and diminished by 'HIV' during progression to ARC and AIDS, this too is not clearly established by the data nor by Dr. Robert Gallo and Margaret Heckler those who initially declared that: "HIV, *a variant of a known human cancer virus,* is the probable cause of AIDS" [emphasis added]. Only one year after this famous proclamation, again by press release, Dr. Robert Gallo and his research partner Dr. Flossie Wong-Stall published in no less prestigious a journal than *Nature*,[33] that:

> The association of Kaposi's sarcoma with AIDS deserves special mention. This otherwise extremely rare malignancy occurs predominantly in a restricted group, that is, **the homosexuals**, and **can occur *in the absence* of any T-cell defect in the patients** [emphasis added].

By this analysis, should we therefore conclude that Africans, (and their descendents) and "the homosexuals" that Gallo and Wong-Staal referred to, have different types of cells that are "*attacked*" by 'HIV', followed by two different "AIDS-defining syndromes, Kaposi's sarcoma and the opportunistic infection, PC pneumonia (and other opportunistic infections)"? The Gallo/Wong-Stall observation and its implications, somehow missed by the AIDS establishment, are comparable to claiming that muscular dystrophy in *Greeks* is typically associated with muscle hypotrophy and demise; but in *Germans*, who show no hypotrophy and demise in their muscles, muscular dystrophy is causally associated with liver disease.

Might there be other explanations for 'AIDS' in Africa other than heterosexual transmission of 'HIV'?

Medical issues such as nosocomial transmission have become critically important to assess in light of the *New York Times* "Rare Good News" claim, and the claims of NIADS. For instance, some AIDS researchers who have studied Africa and African AIDS extensively,

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[26] A.M. Prince, et al (1985).

[27] [Gamma-globulin is a type of protein found in the blood which contains many types of antibodies. —Ed.]

[28] [See Rodney Richards (2001) in Unit 4 section 1 in the course reader, and in this supplement, Unit 4 Appendix I for explanatory interviewing accessible to a general audience.—Ed.]

[29] Joseph H. Willman, et al (1999).

[30] M.S. Horwitz, et al (1992).

[31] H. Varmus (1987).

[32] I. Schiff, et al (1985).

[33] Flossie Wong-Staal and Robert C. Gallo (1985).

claim that 'HIV/AIDS' is caused mostly by doctors, substandard hospital conditions, and the population subjected to non-sterile medical procedures and unsafe medical care.

The warnings by AIDS researchers in Africa regarding iatrogenic and nosocomial transmission of 'HIV/AIDS' are reminiscent of those warnings by the current Director of the U.S. National Institute of Allergy and Infectious Disease (NIAID) Dr. Anthony Fauci, before the AIDS era. Dr. Fauci indicated that doctors cause immune suppression if they subject their patients to multiple transfusions, transplant surgery, or corticosteroid administration.[34] It is now well established that these drugs and treatments can non-specifically induce 'AIDS-specific' drops in T-cell counts with high frequency that is typically, but not always, reversible upon withdrawal of drugs; but transfusions may be another matter. This proclamation from the was made before he claimed that 'HIV' doesn't always cause AIDS, and before he cemented this conclusion into a new disease category called Idiopathic CD4+ T-cell lymphocytopenia (ICL AIDS), which he said could explain "the mysterious AIDS cases." The extraordinary feature of this patient ICL AIDS group is that they test negative for HIV.

Other evidence also suggests nosocomial or iatrogenic transmission of 'HIV' positivity could largely account for 'the African AIDS epidemic'. A recent hepatitis B vaccine,[35] or flu vaccine,[36] can cause 'HIV' tests to show positive results. Moreover, it is possible that physicians may misdiagnose a presumed case of AIDS. One example about misdiagnosing AIDS in the absence of 'HIV' testing in resource poor countries here may be instructive:

> The patient will complain of rashes, fever, itching, sore throat, headache, malaise, vertigo, sweating, insomnia, nausea, prostration, weight loss, loss of hair, or aching in the bones and joints. Some have hypertension, kidney disease, swollen liver, or swollen spleen; others have a subacute meningitis with cranial nerve involvement. This stage of syphilis is often confused with such conditions as infectious mononucleosis, iritis, neruoretinitis, lichen planus, cancer, nephritis, dementia, lymphomas, psoriasis and other skin eruptions, and even drug reaction . . . The thymus-dependent parts of the lymphatic system deteriorate, and there is consequent decrease in the numbers of T-lymphocytes. The T-helper cells are particularly affected by this: **there is a decline in their number and the ratio with the T-suppressor cells is reversed.** Consequently, a long-term effect of syphilis is loss of, or decline in, the system of immunity, and lowering of the individual's capacity to defend himself against other infectious conditions For this reason secondary syphilis is called the great imitator.[37]

Would this classic description of syphilis have been called an AIDS case?

What is the background incidence and reportage of 'HIV/AIDS' in Africa?

Let us assume for a moment, in resource poor regions of Africa that do not have access to 'HIV' test kits, that an AIDS doctor, supported by the makers of nevirapine or AZT on his humanitarian travels to Africa, can distinguish a case of syphilis, or malnutrition (which can be reversed simply with hydration and feeding,[38] from 'AIDS'. Perhaps this doctor has a trusty microscope in the field with which T-cells can be counted. But if this physician was looking at T-cell counts, he/she would find that diminished and reversed CD4+

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[34] A.S. Fauci (1975); A.S. Fauci, et al (1976).
[35] D. Lee, et al (1992).
[36] L. Simonsen, et al (1995); P. Christian, et al (2006).
[37] Harris L. Coulter (1987).
[38] G. Parent, et al (1994); P. Chevalier, et al (1998).

T lymphocyte counts (CD4 counts) along with many viral infections, bacterial infections, parasitic infections, sepsis, tuberculosis, coccidioidomycosis, burns, trauma, intravenous injections of foreign proteins, malnutrition, over-exercising, pregnancy, corticosteroid use, normal daily variation, psychological stress, and social isolation or simply for no apparent reason, as is generally known in immunology.

If this doctor had god-like differential diagnostic abilities, and was aware that the patient had not previously received a recent hepatitis B, or flu vaccine, hemodialysis, multiple transfusions, or gamma globulin or immune globulin (as prophylaxis against infections), that the patient was free of TB or cryptic forms of syphilis (the 'great imitator), and that the patient was not malnourished, or suffering from herpes simplex I or II, arthritis, systemic lupus erythematosus, scleroderma, connective tissue disease, dermatomyostitis, tuberculosis, malaria, hemophilia, hepatitis, alcoholic hepatitis, primary billiary cirrhosis, hyperbilirubinemia, hypergammaglobulinemia, leprosy, lipemic serum, malaria, malignant neoplasms, mycobacteriaum avium, Q-fever with associated hepatitis, primary sclerosing cholangitis, visceral leishmaniasis, renal failure, Stevens-Johnson syndrome, and was not merely presenting in the clinic with high levels of circulating immune complexes and ERS rates (erythrocyte sedimentation rates or 'sticky blood' known to be high among Africans and other populations), free ribonucleoproteins, T-cell leukocyte antibodies, HLA antibodies (to Class I and II leukocyte antigens), nor that the evidence of antigens p18, p24, p55, p12, p32, p51, p66, or gp160, gp41, gp120 present in fluids had been obtained from the patient's having warts, or other known conditions or reasons for yielding a false positive when tested for 'HIV', *then* only could the doctor be certain that the patient really was an 'AIDS case'. Then let us suppose the doctor dutifully reported the case to the WHO or to UNICEF.

Even if such ideal conditions were the norm, it does not follow that accurate statistics would be available from which to extrapolate conclusions about incidence or trends of incidence of AIDS in Africa. We have been confounded by the fact that whenever we have requested the actual numbers of AIDS cases in selected African countries over an extended period of time, the AIDS orthodox establishment seems unable to provide such data, even after more than twenty years. Instead, we have been provided with estimates of projections of 'HIV prevalence' in a given population.

To avoid harm, the assessment of both established and newly proposed AIDS policies that will affect millions of people should include the vital statistics generated by Africans themselves if they are available, as well as recommendations by physicians who have direct, empirical knowledge of African AIDS from their hospital or clinical settings. With this aim, a series of articles was published in the January 6, 2005 issue of the *New England Journal of Medicine* by J.A. Berkeley et al. In the same issue, a pointed introductory commentary by Kim Mulholland and Richard Adegbola (2005) entitled "Bacterial Infections-A Major Cause of Death among Children in Africa" claimed:

> For the past 25 years, since the United Nations Children's Fund (UNICEF) has been publishing estimates of mortality among children worldwide, the international medical community has been aware of the appalling burden of early deaths among African children. Early studies indicated that, in the absence of any effective medical care, children born in a rural African village had a probability of death before the age of five years of 30 to 50% [which is from a period of time before the 'AIDS era'].[39] From the outset, it was understood that many of these deaths result from the combined effect of poverty and malnutrition. Since 1990, mortality rates have fallen but remain high by global standards. Twelve African countries still report official death rates for children under the age of five of more than 20 percent. Community-

[39] W. H. Mosley (1983).

based studies of death among children have been able to attribute these deaths to a number of common causes, either syndromes or specific diseases (see Table I) [below].

Table I. Official Estimates of Mortality among Children under 5 years of Age According to Cause in sub-Saharan Africa and Globally in 2002.

Cause of Death	Africa	Global
Acute respiratory infection	16	18
Diarrhoeal disease	14	15
Malaria	22	10
Measles	8	5
HIV or AIDS	8	4
Neonatal deaths	13	23
Other causes	19	25
All causes	4.5 million	10.9 million

In the study, 28 percent of children admitted to the hospital with bacteraemia died. Even more important, 26 percent (308 of 1184) of hospital deaths were associated with bacteraemia. This finding compares with 22 percent of the deaths that were associated with malaria, suggesting that bacterial disease may be responsible for more deaths in children than malaria in this area where malaria is endemic. Did the children who died at home die from a spectrum of causes similar to that among children who died after reaching the hospital? Both malaria and bacterial illness are amenable to relatively simple therapeutic approaches, but anti-malarial drugs tend to be more widely available in African communities than are antibiotics. Therefore, in a rural community, bacteraemia may be even more important as a cause of death among children than it is in a hospital setting, since the management of bacteraemic illness in the community is likely to be less effective than the management of malaria.[40]

The article concluded:

Only 18 percent of children admitted with bacteraemic illness were infected with HIV, whereas severe malnutrition was present in 37 percent, suggesting that the latter is a more important co-factor. During the past six years, the world of international health care has been dominated by high-profile efforts to control HIV infection, malaria, and tuberculosis. Of these, malaria is seen as the most important contributor to death among children in Africa. This study (Berkeley, et al) gives us [Kim Mulholland and Richard Adegbola] cause to question whether this very narrow, disease-based approach is indeed appropriate and whether the most important causes of death among children have been appropriately targeted. Even in an area of rural Kenya with high rates of HIV infection and malaria, there appear to be more deaths of children associated with bacterial infection than with malaria, with malnutrition still the main cofactor. **Global health strategies, like any other public health activities, should be based on evidence** [emphasis added].

AIDS researchers do not count AIDS cases following any uniform standard. For example, in one African study involving 8,735 youths aged 15-24 years in 33 communities in South Africa:

[40] J.A. Berkeley, et al (2005). Available <https://content.nejm.org/cgi/content/short/352/1/75?ck=nck> accessed December 27, 2007.

> HIV prevalence was reported to be 20.0% among females and 7.5% among males (OR 3.93 95% CI 2.51-6.15).[41]

That result was published in 2005, from "a baseline survey in 2002" according to the methods described from the outset in the report. The same group of AIDS researchers published in the same year their results based on "a nationwide survey conducted from March to August in 2003" and reported a 15.5 % prevalence among females and a 4.8% prevalence among 15-24 year old males.[42] The same group of AIDS researchers reported from their work "in and around Harare" studying 4,393 "urban Zimbabwean" women aged 15-35 years old, from whom complete data on sexual behaviours and HIV serostatus were obtained over the period "September 1999 to November 2002." They reported that HIV prevalence in this sample was a breathtaking 40.1%.[43]

These percentages stand in complete contrast with those published in the *New England Journal of Medicine*, and they diverge from the vital statistics provided by the Republic of South Africa which maintains the most reliable mortality and morbidity registry of any African country. We sought to determine how many cases of AIDS were officially reported in South Africa over the period 1995-2005, aggregated according to the country's nine provinces and perhaps listed by race, ethnicity, gender and age. Instead, the available statistics only cover "HIV diseases."

By way of background, in July 2000 Geshekter visited Mseleni General Hospital in the Maputaland area of South Africa (within KwaZulu-Natal province), one of the poorest regions of the country. When he asked the nurses' supervisor to identify the hospital's wards she identified them as follows: 1) ob-gyn, 2) childhood maladies, 3) accidents and personal injury trauma, 4) mental illnesses, and 5) tuberculosis. Not one word about AIDS or HIV. Perhaps all five wards implicitly incorporated HIV or AIDS? She never said.

An explanation for the nomenclature of the wards at Mseleni Hospital may be gleaned from the data available in the May 2006 publication by *Statistics South Africa*, entitled "Mortality and Causes of Death in South Africa, 2003 and 2004: Findings From Death Notification" which includes vital statistics back to 1997.[44] This publication arranges data in a statistical category called "Leading Underlying Natural Causes of Death" for South Africa from 1997-2004, an important period in the political history of the country. In 1999, the year that Thabo Mbeki succeeded Nelson Mandela as president of South Africa, there was a total of 9,782 deaths (in a country with a population then of 42 million) whose cause was officially listed as "HIV Diseases." That number represented 2.6% of all deaths in South Africa for 1999. In the province of KwaZulu-Natal (whose northernmost district is Maputaland), in 1999 the total number of deaths attributed to 'HIV diseases' was 1,899, or 2.3% of all provincial deaths that year. Perhaps officials at Mseleni General Hospital had good reasons not to devote a special ward to 'HIV diseases'.

For the next five years there ensued bruising scientific debates (which the AIDS orthodoxy scorned as 'denialism') in which a constant questioning of the efficacy of HAART and ARVs was juxtaposed against the scare-monger predictions of a looming 'HIV/AIDS' holocaust about to engulf South Africa. So what really happened?

In 2004, the total number of South African deaths (in a country then of 47 million) whose cause was officially listed as 'HIV diseases' was 13,220. That number represented only 2.3% of *all* deaths in South Africa that year, a decrease from 2.6% five years earlier. For both 2003 and 2004, 'HIV diseases' were officially ranked number 21 in the list of leading

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41 A.E. Pettifor, et al (2005a).
42 A.E. Pettifor, et al (2005b).
43 A.E. Pettifor, et al (2004).
44 Statistics South Africa (2005).

causes of death for South Africa. We have no way of ascertaining from this data exactly how any attending physician, health care worker, or coroner knew for certain that so-called 'HIV disease' was the underlying cause of death. Meanwhile, in KwaZulu-Natal for 2004, the total number of deaths attributed to 'HIV disease' that year was 3,044 which corresponded exactly to the same 2.3% of all provincial deaths that were reported five years earlier.

It is our contention that statistics amassed on 'HIV disease' and/or 'AIDS' are littered with inconsistencies and absurd projections that invite criticism. For an example of how inflationary figures routinely characterize orthodox HIV and AIDS statistics, we analyse a chapter in the latest annual volume State of the Nation: South Africa 2007, entitled "The Promise and the Practice of Transformation in South Africa's Health System."[45] That chapter utilises a table that alleges that for the year 2000, HIV/AIDS was the number one cause of death in South Africa, accounting for 30% of all the 410,000 deaths reported in the country, or 123,000 HIV/AIDS deaths. Compare that alarmist claim and data quotation with the sober statistics given in mid-2006 by Statistics South Africa, which state that for the year 2000, HIV diseases numbered 10,321 or 2.5% of all deaths. In other words, even in 2007, Schneider and her associates retrospectively increased the number of HIV/AIDS deaths for 2000 in South Africa twelve times.

The data on death rates from 'HIV diseases' from 1997 to 2004 in South Africa reveals other interesting anomalies from select provinces:

i) In 1997 in KwaZulu-Natal Province, 'HIV diseases' accounted for 2.2% of all its deaths; in 2004, it was 2.3%.
ii) In 1997 in Mpumalanga Province, 'HIV diseases' accounted for 2.3% of all its deaths; in 2004 it was >2.2%.
iii) In 1997 in Limpopo Province, 'HIV diseases' accounted for 2.3% of all its deaths; in 2004, it was >2.0%.
iv) In 1997 in Free State Province, 'HIV diseases' accounted for 3.9% of all its deaths; in 2004, it was >2.1%.
v) And even for South Africa as a whole, in 1997 'HIV disease' was said to account for 2.0% of all deaths; in 2004 it had risen to 2.3%, but that was down from 2.6% in 1999.

Concerning the declarations about an HIV cataclysm threatening to destroy the very fabric of civilisation on the continent with its epicentre in South Africa, it appears that President Mbeki's scepticism has had some merit and has been empirically based. This cautious assessment stands in sharp contrast to his critics, whose resort to personal vilification and vicious slurs have revealed the reflexively irrational and vindictive manner whereby HIV/AIDS mainstreamers respond to anyone who dares challenge their assumptions.

In December 2006, scientists admitted in print, using high profile medical journals that as their medium, that:

> viral load is only able to predict progression to disease in 4% to 6% of HIV-positives studied, challenging much of the basis for current AIDS science and treatment policy.[46]

[45] S. Buhlungu, et. al. (eds) (2007) especially the chapter by H. Schneider.
[46] B. Rodriquez, et al. (2006) in *JAMA* (*Journal of the American Medical Association*); J. Cohen (2006) in *Science.*

As an African historian who has worked in various parts of Africa for thirty-five years, especially Somalia, Ethiopia, Kenya and Djibouti, co-author Geshekter has observed an increasing number of Africans who appeared malnourished, or suffered from respiratory illness, or malaria over that period. None of those conditions had anything to do with sexual activities. Rather, these ailments reflected the changing nature of African political economies since the late 1970s and the devastation that this economic deterioration has wrought upon African lives. For instance, when Geshekter visited northern Somalia (the Republic of Somaliland) in June-July 2001, he spoke at length with Dr. Ali Sheikh Ibrahim, a leading physician at the main hospital in the capital city of Hargeisa. Dr. Ali acknowledged that malnourishment, upper respiratory disease, and malaria were the same illnesses and medical problems that primarily afflicted northern Somalis, along with serious dental and gum diseases and mental breakdowns associated with the traumas of civil war violence. Similar conclusions to Geshekter's were advanced by Stuart W. Dwyer, a district surgeon (forensic medical officer) in Grahamstown, South Africa, when in 2002 he wrote a letter to the editors of the *British Medical Journal*:

> As a prison medical officer in South Africa, I partly agree with President Mbeki's sceptical view of current statistical research into HIV infection and AIDS . . .
>
> In South Africa's prisons there is a vast overcrowded (often 30 people per cell) population in which homosexuality is widespread and condom use practically non-existent. This is the perfect breeding ground for the rapid spread of HIV.
>
> Prisoners with any other illnesses that do not resolve rapidly (within one to two weeks) are also tested for HIV. As a result, a large number of HIV tests are done every week. This prison, which holds 550 inmates and is always full or overfull, has an HIV infection rate of 2-4% and has had only two deaths from AIDS in the seven years I have been working there.[47]

Sam Mhlongo, M.D., Head of the Department of Family Medicine and Primary Health Care at the Medical University of South Africa, Johannesburg claimed that:

> Nutritional AIDS dominates the scene in South Africa today as indeed it did during Apartheid. In the middle 1950's and 1960's, 50 percent of black children were dead before the age of five. The causes of death were recorded as: pneumonia, high fever, dehydration, and intractable diarrhoea due to protein deficiency. Today, these clinical features are called AIDS. Today in South Africa, TB is the leading cause of death and morbidity amongst Africans, but this is called AIDS.[48]

Dr. Marc Deru, a Belgian physician who has also worked extensively in Africa, noted that official census results in Tanzania showed a regular *upward* curve in the size of the country's population for the period 1967 to 2002, with a population growth of 49% between 1988 and 2002:

> There is no drop in the population. For the Kagera region, we see the same upward curve, with 53% growth between 1988 and 2002.
>
> While the experts, with their statistics, would have one believe that there exists an extremely serious HIV/AIDS epidemic [in Africa], no trace of an epidemic is observable in the field. All that can be seen is a very poor, under-

[47] Stuart W Dwyer (2002: 237).

[48] Sam Mhlongo (2003) Address to European Parliament Conference on AIDS in Africa, Brussels, December 8.

> nourished population suffering from malaria, endemic immunodeficiency and common illnesses.
>
> The so-called 'HIV' tests are unspecific; the positive results they may give are misleading and lead to the false belief in the existence of a viral epidemic. A positive test—and this applies especially to Africa—is not a sign of a specific viral infection. These so-called 'HIV' tests are deceptive, in that the positive results give the illusion that a precise diagnosis has been made.
>
> And yet, it is these very same misleading [HIV test] results which constitute the basis of official statistics and which lead, first the experts, then the scientists, medical doctors, newspaper reporters, and finally the general public to believe that Africa is being ravaged by a specific viral infection called 'HIV/AIDS!' People speak of an epidemic of 'HIV/AIDS,' but the only thing which has the appearance of an epidemic is what I would call the 'epidemic of tests,' an artificial epidemic which is being actively promoted.
>
> [The HIV tests] are also dangerous because they cause panic and stigmatization, they lead to the use of toxic anti-viral drugs and they draw attention away from the real sources of immune system deficiencies. Common sense and scientific reason dictate their abandonment.
>
> To state that the priority, with respect to emergency humanitarian aid, should be given to the fight against 'HIV' and to giving those countries the possibility of buying cheap-priced anti-viral products is just as irrational as saying to someone suffering from acute vitamin C deficiency, 'Sir, I see that you are suffering from scurvy. You'd better go buy yourself some antibiotics and condoms.[49]

Earlier this year, Pali Lehohla, the statistician-general of South Africa and head of Statistics South Africa noted the "health of citizens is a concern in all countries, and understanding the causes of death is crucial for effective policy planning and intervention to improve rates of survival," adding that "analysis of mortality trends underlies the development of programmes to reduce mortality" from all diseases.[50]

Considering the importance of having reliable epidemiological data when dealing with 'HIV diseases' or 'AIDS' in Africa, this observation by statistician Stephen Stigler is especially salutary:

> The historical development of statistics has been more akin to a stoneworker's construction of an arch without masonry. The arch is strong when finished, but it requires a supporting framework during construction and the removal of a single piece could cause the whole to fail.[51]

Finally, when regarding the background of incidence of AIDS in Africa, one wonders if there might be an eerie correlation between the number of AIDS researchers, activists, and programs at work in a given African country, and the number of cases of 'AIDS' or of 'HIV disease' that get reported? A brief quote from Schneider's chapter in the 2007 report of South Africa's Human Science Research Council offers a suggestive hint. The authors (S. Buhlungu, et al 2007) acknowledge that "a significant outcome of several generations [sic] of AIDS interventions has been the emergence of a very large body [60,000] of volunteer and semi-remunerated lay health workers functioning as counsellors, treatment supporters, home-based caregivers and support group facilitators."

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[49] Marc Deru (2003) Address to European Parliament Conference on AIDS in Africa, Brussels December 8.

[50] Pali Lehohla (2006) Knowing Causes of Death is Crucial for Planning, Business Report, September 14.

[51] Stephen M. Stigler (1999: 9).

Is circumcision the most important development in AIDS research since the debut of antiretroviral drugs?

It was 2004 when the announcement was made in the public domain that the United States government's chief of AIDS research, Dr. Edmond Tremont, had rewritten0 a safety report on a US-funded drug study which changed its conclusions and deleted negative information *post hoc.* Subsequently he ordered the research to be resumed, over the objections of his staff, so the profitable five hundred million dollar plan to distribute nevirapine to African women would proceed, even though the drug's approval had been withdrawn in the US because of its excessive toxicity and dubious efficacy.[52] The US Institute of Medicine covered up and trivialised Tremont's criminal behaviour, according to Dr. Johnathan Fishbein, who had been hired to identify corruption within the US National Institutes of Health; but instead of a recognition plaque for his courage to risk career suicide, his reward for exposing corruption by Tremont (his boss at the time) was to be fired from his position as safety officer for the nevirapine trials.[53]

Virological failure or drug resistance are technical terms among 'HIV-AIDS proponents which simply mean that a drug has failed to do its job in suppressing what some experts regard as an artificial 'HIV' marker: 'viral load'. January 2007, in the *New England Journal of Medicine*, it was reported:

> Nevirapine remains central to the prevention of mother-to-child transmission of human immunodeficiency virus type 1 (HIV-1) and to combination antiretroviral treatment throughout much of the developing world. Nevirapine administered as one dose to the mother and one to the newborn reduces mother-to-child transmission of HIV-1 by 41 to 47%, and well over **875,000 women and infants** have received a single dose of nevirapine. A single dose of nevirapine is the cornerstone of the regimen recommended by the World Health Organization (WHO) to prevent mother-to-child transmission among women without access to antiretroviral treatment and among those not meeting treatment criteria. However, nevirapine resistance is detected (with the use of standard genotyping techniques) **in 20% to 69% of women and 33% to 87% of infants** after exposure to a single, peripartum dose of nevirapine. **Among 60 women starting antiretroviral treatment within 6 months after receiving placebo or a single dose of nevirapine, no women in the placebo group and 41.7% in the nevirapine group had virologic failure (P<0.001). Women who had received a single dose of nevirapine had significantly higher rates of virologic failure on subsequent nevirapine-based antiretroviral treatment than did women who had received placebo**. This apparently **deleterious** effect of a single dose of nevirapine was concentrated in women who initiated antiretroviral treatment within 6 months after receiving a single dose of nevirapine . . . **Among the 30 HIV-infected infants, a single dose of nevirapine (one each to mother and infant) as compared with placebo was associated with significantly higher rates of virologic failure and smaller CD4+percentage increases in response to subsequent nevirapine-based antiretroviral treatment** [emphasis added].[54]

There is no clear means of providing a definitive answer to the fourth of our questions which was posed at the beginning of this section. At this point in time the overall value of antiretroviral drugs is impossible to assess, despite the tremendous amount of time and money put into their research and development, because the US National Institutes of Health

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[52] John Solomon (2004) Associated Press Writer. <http://www.ahrp.org/infomail/04/12/15b.php>

[53] John Solomon (2005).

[54] S. Lockman, et al (2007: 356).

and the US Institute of Medicine, as well as other prestigious organisations responsible for monitoring the quality of research, setting policy and standards that reach worldwide, collectively consider it acceptable to fudge data when it suits political and economic interests of a controlling elite with investment in pharmaceutical industrial profits. In latest studies, nevirapine plus AZT have failed to control 'HIV' in 41.7% of women in the nevirapine group compared to 0% in "the AZT plus placebo group." So perhaps it is appropriate to conclude that, after all, circumcision is the most important development in AIDS research since the debut of antiretroviral drugs. Moreover, of the options currently available, certainly circumcision does the least damage. One would not want to administer more traditional 'antiretrovirals' such as AZT as a monotherapy, because despite anecdotal and isolated successes in prolonging life of terminally ill patients, AZT and its class of drugs are known to *increase* morbidity and death amongst those designated as 'HIV/AIDS' patients, especially among people of African decent, as shown in a Veteran's Affairs Co-operative study. The Veterans Affairs Co-operative Study Group reported that AZT disproportionately harmed Blacks and Hispanics, and provided no benefit to the quelling of advancing immune suppression in Caucasians.[55]

In addition, with respect to children, it has been realised for nearly a decade that giving AZT to infants and pregnant women by itself is a way to limit surplus population, especially with the implementation of George Bush's '3 by 5 plan' (three million people on ARVs by the year 2005):

> Maurizio de Martino, et al [who constitute the Writing Committee for the Italian Register of HIV Infection in Children] concluded that children born to ZDV-treated mothers "are more likely to have a rapid course of HIV-1 infection compared with children born to untreated mothers, as disease progression and immunological deterioration [of infants to the ZDV-treated mothers] are significantly more rapid and the risk of death is actually increased during the first 3 years of life."[56]

Conclusions

AIDS strategies, like other public health activities, must be based on verifiable evidence, not press releases or racist assumptions. A growing body of data support the inescapable conclusion that 'HIV' cannot be the principle cause, nor even a weak marker, of immune-related illnesses in Africa or anywhere else. What is commonly called one's 'HIV status' may only mask or confuse the actual, clinical health status of an individual, leading to misdiagnosis, stigmatisation, mistreatment, and even medical malpractice. Considerable scientific evidence documents that a lack of sanitation, clean drinking water and nutritional support [30, 31, 49] form the basis for infectious, bacterial and other diseases including immune suppression and all of the current 'AIDS defining' conditions. Approaches to epidemics which mandate providing adequate food and clean water to people, are not unethical—are they?

An increasing number of scientists and researchers from many fields have been in agreement with the former South African President Thabo Mbeki, for some time, and assert that there is no verifiable evidence conclusively supporting the hypothesis that 'HIV' causes 'AIDS'.[57] This realisation eliminates the need to subject Africans to (i) 'anti-retroviral

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[55] J.D. Hamilton, et al (1992).

[56] Maruizio de Martino, et al. (1999). ZDV stands for Zudovudine, another generic name for AZT, the abbreviation for azidothymidine, having the trade name Retrovir®. For more details about the largely disappointing track record of these and other anti-retrovirals, and their distribution in Africa as wonder drugs, see Unit 5.—Ed.].

[57] See Henry H. Bauer (2007) for a lengthy overview.

drugs', (ii) any of the fifteen failed 'HIV' vaccines, (iii) lurid and ludicrous circumcision campaigns, (iv) microbicides, (v) other unfounded treatments and dangerous medicines said to stave off or reverse the immune suppression characteristic of 'AIDS', or (vi) unreliable and misleading 'HIV status' disclosure.

The horrible irony is that many key anti-'HIV/AIDS' drugs are themselves powerful immune suppressors or endogenous protease antagonists (principally developed for cancer chemotherapy to stop cells from dividing or interfere with normal cellular metabolism) with a long history of organ destroying side effects. Until recently, those effects were conflated within the AIDS death toll, further obscuring the true causes of death for the victims. The HIV=AIDS hypothesis has been the pretext for what can be described as a public health genocide directed at the African continent and elsewhere.

This opens a new page in the lengthy book of ethical concerns surrounding chronic failures to address the barriers to enjoyment of robust health and longevity in Africa, now bracketed and camouflaged under the dubbing 'HIV/AIDS'. The evidence throws into question the moral status of those international legions of 'HIV=AIDS' strategic opportunists who relentlessly press forward with a mistaken and crumbling 'HIV=AIDS' paradigm—an ideology which remains nonetheless lucrative and strategic, career-wise, to sustain at present. The slogan 'HIV=AIDS' constitutes a multi-faceted death sentence in Africa insofar as it continues to stigmatise and traumatise hundreds of thousands of people who remain exploitable as human guinea pigs by the pharmaceutical research and development industry.

A generation of individuals in the mainstream AIDS establishment who have used skewed data to mislead corporate entities, who manipulate generous non-profit funding institutions, and who frighten the concerned public must be held accountable. This chapter of world medical history transpired under the careful watch of the US National Institutes of Health (NIH), the US Institute of Medicine (IOM), the US Centers for Disease Control and Prevention (CDC), the UN World Health Organisation (WHO), and other institutions. It should be both a domestic and an international legal matter therefore, to assess the responsibility and determine an appropriate punishment for involvement and negligence in such a far-reaching crime against humanity.

References to Unit 11, Appendix II

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