Reappraising
AIDS
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Under Development & Racial Stereotypes
RETHINKING AIDS IN AFRICA

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The problem with the truth is that it is mainly uncomfortable and often dull . — H.L. Mencken

Millions of Africans have long suffered from severe weight loss, chronic diarrhea, fever, and persistent coughs. In 1985 Western researchers suddenly defined this cluster of symptoms as a distinct syndrome, AIDS, and declared that it was caused by a single virus, HIV, which they considered to be sexually contagious.[1]

American health officials universally accept this HIV-AIDS model to explain what used to be considered the diseases of rampant poverty in Africa. There are at least three reasons why this view needs careful reconsideration.

First is the fact that many of the Africans who qualify for AIDS diagnoses — perhaps as many as 70% — turn out to be negative when tested for HIV.

Second is the failure of the African HIV-AIDS model to predict the course of AIDS in the United States. Since AIDS symptoms are widespread in the general African population,[2] 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, 16 years after it was first described in the medical literature, in the United States AIDS has remained rigidly confined to special risk groups. Of the 70,000 annual American AIDS patients, at least 90% are drug users (including nearly all the gay patients), and fewer than 10,000 are designated as heterosexual cases.

Third, sexual transmission can't explain the differences in rates of HIV positivity between African (about five per 100) and American (about one per 7,000) heterosexuals. When the HIV-AIDS paradigm made its debut in 1984, its proponents assumed that HIV was easily transmitted coitally. Scientists tested this idea only years later, though, when they arrived at extremely low coital transmission frequencies. The latest study shows that an HIV-negative woman converts to positive on average only after *one thousand* unprotected contacts with a positive man, and a negative man becomes positive on average only after *eight thousand* contacts with a positive woman.[3] These data suggest two mutually exclusive conclusions. Either HIV isn't a sexually transmitted microbe after all, and other factors account for HIV prevalence; or African heterosexuals are wildly more promiscuous than American heterosexuals, a scenario that surely is not true.

With all of this in mind, why do so many health professionals consider it useful or necessary to view the diseases of poverty in Africa as sexually contagious? And why did they ever believe it?

Defining AIDS in Africa

CDC physicians Joseph McCormick and Susan Fisher-Hoch convened 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 the diseases of American drug injectors, a cohort of promiscuous urban gays in the party drug scene, and transfusion recipients. HIV turned out to be one of the many viruses that tended to react with blood from these patients. The same was true of blood from Africans afflicted with the diseases of poverty. The HIV-AIDS model assumed that AIDS would "spread" via HIV to a much larger fraction of Africans than those who currently suffered from it.

McCormick and Fisher-Hoch accepted this model. They recently explained their motivation for the 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 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.4

The doctors wanted to refute the ugly moralism of the 1980s that AIDS was a "gay plague" by convincing the American government that "AIDS was a plague all right, but that no one was immune."[5] McCormick and Fisher-Hoch 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.[6]

It was upon these grossly unscientific claims, inaccurate clinical generalizations, western notions of sexual morality, and 19th-century racist stereotypes about Africans that AIDS became a "disease by definition." Africa was assigned a central role in promoting 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 couple. "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."[7]

As proof that these "AIDS symptoms" were sexually transmitted, McCormick and Fisher-Hoch point to a narrow survey conducted by Kevin DeCock, another CDC epidemiologist. In 1986, DeCock examined stored blood samples taken in 1976 (for Ebola virus testing) of 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 [60%] 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 [emphases added]."[8]

DeCock concluded from these interviews that the dead subjects died from AIDS, and that HIV had caused it. He reached this conclusion without properly 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 as well. Had he done this, perhaps he would have discovered that even HIV-negative Africans 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 has he was concerned, this meant that HIV — and thus AIDS — really did originate in Africa. HIV (AIDS) existed for years in small numbers of rural inhabitants (who had contracted the HIV from primates, he imagined). He speculated that once some of those people in the late '70s migrated to what DeCock falsely assumed were sex-crazed cities, 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 sort of 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."[9] 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 *1.1%*.[10]

These findings prompted *The Lancet* to acknowledge editorially that "current strategies to improve the world's health may need to be reassessed" and to ponder "how much more money is spent on research into HIV infection [the 30th cause of death] than into the causes of suicide [#12] or the prevention of road-traffic accidents [#9] and why should this be."[11]

Racism and African Sexuality

Whereas AIDS in the industrialized countries almost exclusively confines itself to a tiny percentage of homosexuals, drug injectors, and transfusion patients, AIDS afflicts the same general African population that faces such ancient scourges as malaria, schistosomiasis, and sleeping sickness (trypanosomiasis).

This is known as the "heterosexual paradox" of AIDS. Champions of the HIV model attempt to explain it in two contradictory ways. Some simply declare that the paradox is temporary. They speculate that HIV arrived first in Africa and, in time, AIDS will be just as rampant in the West. However, they've been saying this now for over ten years.

Others recognize the permanence of the paradox. They account for it by declaring that Africans are just different from Westerners. They are substantially more promiscuous and more likely to have genital ulcers. How else to explain the widespread distribution of a virus that requires, for non-ulcerated genitals, a thousand heterosexual acts?

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 Universite 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."[12]

Such racist 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.

AIDS researchers added new twists to an old repertoire: stories of Zairians who rub monkeys' blood into cuts as an aphrodisiac, of ulcerated genitals, and of philandering East African truck drivers who get AIDS from prostitutes and then go home to infect their wives.[13] 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.[14]

No one has ever shown that people in Rwanda, Uganda, Zaire, and Kenya — the so-called "AIDS belt" — are more active sexually than people in Nigeria, which has reported only 3,002 cumulative AIDS cases out of a population of 100 million, or Cameroon, which reported only 8,141 cases in 10 million.[15] No continent-wide sex surveys have ever been carried out in Africa. Nevertheless, conventional researchers perpetuate racist stereotypes about insatiable sexual appetites and carnal exotica. 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 over-use of antibiotics — the early epidemic of immunological dysfunction among a small sub-culture of gay men in the West.[16]

The research from Africa suggests nothing of the sort. In 1991 researchers from Medicins Sans Frontieres and the Harvard School of Public Health did a survey of sexual behavior in the Moyo district of northwest Uganda. Their findings revealed behavior that was generally 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 did so in the preceding year.[17]

52% of sub-Saharan Africans lack access to safe water, 62% lack proper sanitation, and 50 million pre-school children suffer from protein-energy malnutrition.

The media misrepresentations that link sexuality to AIDS have spawned inordinate anxieties and moral panics 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 them 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."[18]

Public health seems to require salesmanship, not skepticism. The media's appetite for scary scenarios and its disdain for alternative perspectives enables it to treat Africa in apocalyptic terms. This marketing of anxiety helps to promote behavior modification programs to "save Africa." 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."[19]

The serious consequences of claiming that millions of Africans are threatened by infectious AIDS makes it politically acceptable to use the continent as a laboratory for vaccine trials and the distribution of toxic drugs of disputed effectiveness like ddI and AZT. On the other hand, campaigns that advocate monogamy or abstinence and ubiquitous media claims that "safe sex" is the only way to avoid AIDS inadvertently scare Africans from visiting a public health clinic for fear of receiving a "fatal" AIDS diagnosis. Even Africans "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."[20]

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.[21] Yet Djibouti, Somalia, Egypt, and Sudan, where female genital mutilation is the most widespread, are among the countries with the lowest incidence of AIDS.

Does the "AIDS epidemic" in Africa portend the future of the developed world? The scientific establishment certainly thinks so. Biomedical funds that had been earmarked to fight African malaria, tuberculosis, and leprosy are now diverted into sex counseling and condom distribution, while social scientists have shifted their attention to behavior modification programs and AIDS awareness surveys.

Good Intentions, Bad Science: HIV Tests and Disease

A reappraisal of AIDS in Africa must recognize that HIV tests are notoriously unreliable among African populations where antibodies against endemic conventional viruses and microbes cross-react to produce ludicrously high false-positive results. For instance, a 1994 study on central Africa reported that the microbes responsible for tuberculosis and leprosy were so prevalent that over 70% of the HIV-positive test results there are false.[22] The study also showed that HIV antibody tests register positive in HIV-free people whose immune systems are compromised for a wide variety of reasons, including chronic parasitic infections and anemia brought on by malaria.

The very low frequency of vaginal transmission of HIV makes it hard to imagine that heterosexual transmission can be responsible for high rates of HIV prevalence observed in some regions.[23] So what is responsible?

Perhaps the tests used to determine HIV infection in Africa overstate the prevalence. Some HIV tests detect entities believed to be part of HIV itself, such as certain proteins or genetic sequences. But in Africa HIV prevalence is determined by testing for antibodies, which are components of the host immune system, not the virus. The fact that these tests react with antibodies triggered by ordinary African microbes suggests an explanation for HIV prevalence in Africa that is more plausible than sexual transmission.[24]

Even the association of HIV antibody tests with ordinary infections does not mean that positive results warrant a prognosis of death. Consider an investigation, reported in *The Lancet*, of 9,389 Ugandans with unequivocal HIV antibody test results.[25] Two years after enrolling in the study, 3% had died, 13% had left the area, and 84% remained. There had been 198 deaths among the seronegative people and 89 deaths in the seropositive ones. Medical assessments made prior to death were available for 64 of the HIV-positive adults. Of these, five (8%) had AIDS as defined by the WHO clinical case symptoms. The self-proclaimed "largest prospective study of its kind in sub-Saharan Africa" had tested nearly 9400 people in Uganda, the so-called epicenter of AIDS in Africa. Yet of the 64 deaths recorded among those who tested positive for HIV antibodies, only *five* were diagnosed as AIDS-induced.

99.95% of all Africans do not have AIDS, including 97% of those who test HIV-positive.

If it is not sexual transmission of HIV, then what causes the widespread appearance of AIDS symptoms throughout Africa? The evidence strongly implicates the ordinary, widespread socio-economic conditions that give rise to AIDS symptoms even among HIV-negative Africans.[26]

In her meticulous 1997 doctoral dissertation, Michelle Cochrane juxtaposed the central tenets of AIDS orthodoxy against the material record of San Francisco AIDS patients' charts. She found that public health officials persistently over-estimated the risk of contracting HIV/AIDS through sexual activity, "while simultaneously under-estimating the proportion of the HIV/AIDS caseload that were attributable to intravenous drug use and/or socio-economic factors which condition access to health care and prevention services."[27]

Cochrane showed that health officials conspicuously failed to investigate all risk factors for immunological dysfunction among heterosexual adult females.In their surveillance studies, it was considered sufficient for

> *a heterosexual female merely to claim that the source of her infection was sex with an IV-drug user or another man at risk for HIV/AIDS... A percentage of the 187 female AIDS cases [out of 24,371 cumulative cases in San Francisco] attributed to sexual transmission could, with proper investigation, be attributable to IV-drug use. Epidemiological research in the United States and Europe has never proven that a female has sexually transmitted HIV to a man. [Because] heterosexual transmission of HIV from a male to a female happens with difficulty and very infrequently... all AIDS surveillance statistics on female AIDS cases have been gathered without rigorous scrutiny of the woman's risk for disease and with a bias towards including as many women as possible [emphasis added].*[28]

The a priori assumptions that directed AIDS surveillance activities in the United States subsequently allowed predictions about an exponential spread of the disease to survive as "common knowledge," despite the lack of empirical data. These are critical points to consider when reviewing any epidemiological data on "AIDS" cases in Africa.

For the period 1984-95, the WHO compared estimates of HIV seropositivity with the actual numbers of AIDS cases in its *Weekly Epidemiological Reports.* The cumulative result is that 99.95% of all Africans do not have AIDS — including 97% of those who test HIV-positive. These facts strikingly contradict the popular view of an Africa overrun by fatal HIV infections.[29]

AIDS and the Medicalization of Poverty

Primary health care systems in Africa will remain hampered until public health planners systematically gather statistics on morbidity and mortality to accurately show what causes sickness and death in specific African countries. During the past ten years, as the external financing of HIV-based AIDS programs in Africa dramatically increased, money for studying other health problems remained static, even though deaths from malaria, tuberculosis, neo-natal tetanus, respiratory diseases, and diarrhea grew at alarming rates.[30]

While Western health leaders fixate on HIV, 52% of sub-Saharan Africans lack access to safe water, 62% lack proper sanitation, and an estimated 50 million pre-school children suffer from protein-calorie malnutrition.[31] Poor harvests, rural poverty, migratory labor systems, urban crowding, ecological degradation, social mayhem, the collapse of state structures, and the sadistic violence of civil wars constitute the primary threats to African lives.[32] When essential services for water, power, and transport break down, public sanitation deteriorates, and the risks of cholera, tuberculosis, dysentery, and respiratory infection increase.

WHO Director General Hiroshi Nakajima warns emphatically that "poverty is the world's deadliest disease."[33] Indeed, the leading causes of immunodeficiency and the best predictors for clinical AIDS symptoms in Africa are impoverished living conditions, economic deprivation, and protein malnutrition, not extraordinary sexual behavior or antibodies against HIV, a virus that has proved difficult or impossible to isolate directly, even from AIDS patients.

The so-called "AIDS epidemic" in Africa has been used to justify the medicalization of sub-Saharan poverty. Thus, Western medical intervention takes the form of vaccine trials, drug testing, and almost evangelistic demands for behavior modification.

AIDS scientists and public health planners should recognize the role of malnutrition, poor sanitation, anemia, and ordinary infections in producing clinical AIDS symptoms in the absence of HIV.[34] The data strongly suggest that socio-economic development, not sexual restraint, is the key to improving the health of Africans.

Medically trained charity workers Phillipe and Evelyn Krynen, employed by the French group Partage, in Kagera Province of 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."[35]

A similar observation comes from Father Angelo D'Agostino, a former surgeon who founded Nyumbani, a hospice for abandoned and orphaned HIV-positive children in Kenya:

"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. They are really flourishing."[36]

Conclusion

People can be encouraged to behave thoughtfully in their sexual lives if they are provided with reliable information about condom use, contraception, family planning, and venereal diseases. Multilateral institutions and African AIDS educators should familiarize themselves with the scientific literature that demonstrates the contradictions, anomalies, and inconsistencies in the HIV/AIDS orthodoxy.[37] They have a major responsibility to consider the non-contagious explanations for "AIDS" cases in Africa and to stop the proliferation of terrifying misinformation that equates sexuality with death.

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Why Africa?

According to the HIV-AIDS model, AIDS is new, and is caused by a new virus, HIV. Supporters of this view imagine that HIV was introduced to the human population in sub-Saharan Africa, and spread from there to the West. Why?

When Robert Gallo introduced this model in 1984, AIDS conditions (tuberculosis, pneumonia, wasting, etc.) were very rare among young American adults, except in three special groups: gay consumers of party drugs, drug injectors (irrespective of sexual orientation), and blood recipients. Gallo found that the distribution of HIV also fit this pattern. Of 164 healthy, risk-free Americans he examined for HIV antibodies, only one (0.6%) tested positive. But of 15 healthy gay Americans, four (27%) tested positive, as did three of five (60%) AIDS-free drug injectors (*Science* 224:497-508, May 4, 1984).

For people assuming that HIV really was a new virus, these data meant that HIV was more prevalent among the risk groups than among the general population because the virus had been among the risk groups longer. Surely this virus would spread outside those groups, and it would find its natural "endemic" level in the general American population.

But just how high would this level be? And how did gays and drug injectors get this virus?

In 1985, Anthony Fauci examined the HIV-antibody rates of healthy American and African heterosexuals. In his group of 100 Americans, none tested positive. In his group of 100 Africans, though, six tested positive (*JAMA* 254[18]:2599-2602, Nov. 8, 1985).

Since these groups apparently shared the same modes of transmission (heterosexual contact), one logical interpretation of these data — assuming HIV really was a new virus — was that HIV had existed longer in Africa than in the USA. And in time the HIV level in the USA's general population would approach that of Africa's.

Two other factors helped convince Western scientists that "AIDS came from Africa." One was that unlike in America's general population, AIDS conditions were at the time rampant across Africa. The second factor helping this idea along was the imagination of Western scientists, who were apparently agreeable to suggestions of intimacy between African people and jungle animals. This provided an explanation for a source of this supposedly new virus.

But this is not the best explanation of the data.

For one thing, HIV rates have never increased for risk-free Americans in the 12 years that have passed since HIV testing became generally available in 1985. This is powerful evidence that HIV has existed among Americans for just as long as any other virus.

Fauci's data showed that rates for *all* viruses are very high among both American risk groups and Africans. For example, 3% of his healthy American heterosexuals were positive for Hepatitis B, whereas 85% of his AIDS-free homosexual Americans were positive. And where he found cytomegalovirus antibodies in 42% of his healthy American subjects, he found them in *100%* of his healthy African subjects. So the rate of HIV should be higher among the AIDS-risk populations, even if HIV is just as old as those other viruses.

What factors, then, cause so many viruses to infect so many members of the AIDS risk groups? And do those factors play causative roles in the development of AIDS conditions? The people who blame HIV for AIDS seem to have asked neither question.

— Paul Philpott

Protecting the Young, Proclaiming the Truth, Smiting the Wicked

by Paul Philpott

One of the most adamant promoters of the infectious AIDS model has always been Donald Francis, the physician whose involvement in the early days of the AIDS era was dramatized in the popular Randy Shilts book *And the Band Played On*, which was made into an HBO film starring Mathew Modine as Francis and Alan Alda as Robert Gallo.

Today, Francis is the president of a bio-technology firm, Genenvax, Inc., in California. In 1996, a local teenager interning with Francis, Gwen Shen, happened to be a student of high school physics teacher Tom Woosnam, who openly admires UC-Berkeley retrovirologist Peter Duesberg, author of numerous scientific papers and two books (*Inventing the AIDS Virus* and *Infectious AIDS: Have We Been Misled?*) characterizing HIV as harmless, and AIDS as non-contagious.

When Shen questioned Francis about the dissident AIDS view that she learned about from talking with Woosnam and reading an article Woosnam published in the student paper, Francis wrote her the following letter:

2 February, 1996
Dear Gwen:

Thank you for your questions regarding Dr. Peter Duesberg's hypothesis that HIV-1 doesn't cause AIDS.

When he first proposed this hypothesis several years ago, Dr. Warren Winkelstein, former Dean of the School of Public Health at Berkeley and an expert on AIDS, and I had lunch with Dr. Duesberg in an attempt to stop his ludicrous claims. It was evident from that lunch and clear thereafter that Peter has lost his ability to judge scientific findings.

Peter Duesberg's claims that HIV-1 does not cause AIDS is nonsense. There is no data on his side of the argument and a library of data on the other side. I have enclosed a few summary articles that deal with the issue.

If a teacher claims to students that HIV-1 doesn't cause AIDS, then that teacher is violating both his/her responsibilities as a science teacher dedicated to seeking truth and his/her trusting relationship as a guide and advisor to students.

To publish an article in a school newspaper discussing the controversy is fine. But there should be clear additions to the article which point out how ridiculous the claim is so that students are not left unguided.

Sincerely,
Donald P. Francis, M.D., D.Sc.
President, Genenvax, Inc.

Consider the five articles that Francis included as representative of the "library of data" supporting his infectious AIDS view. One was the almost-forgotten May 20, 1983 *Science* paper by HIV discoverer Luc Montagnier of the Pasteur Institute in Paris, "Isolation of a T-lymphotropic retrovirus from a patient at risk for AIDS." This article hardly established AIDS as a contagious syndrome caused by HIV. It contained data from only a single patient, a gay man with lymphodenopathy (persistently swollen lymph nodes), who had not even qualified for an AIDS diagnosis.

The movie depicted this paper as influencing young Dr. Francis, a CDC field soldier heroically struggling to solve the AIDS riddle: Why were "healthy" gay drug addicts with long STD histories wasting away and dying of opportunistic infections? Montagnier's paper pointed to the probable answer, Francis felt.

But only one person in the world had the resources to demonstrate conclusively that Montagnier's virus was the cause of AIDS, develop antibody tests for it, *and* push into motion a massive government program devoted to combating it: Robert Gallo, director of the world's most sophisticated retrovirus lab, at the National Institutes of Health. Gallo was busy looking for his *own* AIDS virus to present to the world. Could he admit that Montagnier had beat him to the punch? Could he bring himself to exalt someone else's virus?

In the movie's climax, young Dr. Francis convinced Gallo to consider Montagnier's virus.

Which brings us to the other four papers sent to Gwen Shen by Francis, now fifteen years older and enjoying professional prominence for having played a stellar role in winning hegemony for the infectious AIDS model.

The four articles consisted of the famous set of May 4, 1984 *Science* papers by Gallo, who had followed up on Francis' urgings. It was those papers that Gallo advertised in his notorious live-broadcast, pre-publication press conference with Margaret Heckler, who was then the Secretary of Health and Human Services. In the movie, a mortified Francis watched on TV as Gallo claimed for himself — with no acknowledgment to Francis or Montagnier — the "discovery" of HIV (then called HTLV-III) and its role as "the probable cause of AIDS."

Not revealed at the press conference was the data contained in those four articles: of 72 patients diagnosed with AIDS, 12% were *negative* for HIV and 64% had no active HIV infection.

Based on those scientific findings, we can think of no reason to judge AIDS as a contagious syndrome caused by HIV. That Francis still does suggests that it is he who suffers from an inability to logically "judge scientific findings."

But we would not go so far as to call Francis a "twisted fellow," as he called Duesberg in an attached note inviting Shen to "feel free to share [the letter] with anyone."

Although Francis wishes to protect students from Duesberg's view, we do not think that students should be protected from *any* scientific view, even Francis' "ludicrous" hypothesis that AIDS is infectious and caused by HIV. Although we agree with him that guidance is a proper role for teachers, we do not believe that this duty includes banning students from reaching independent conclusions. Furthermore, we insist that Tom Woosnam's responsibility as "a science teacher seeking truth" obligates him to share with his students his scientific conclusions, however "ridiculous" someone else may find them.

We have limitless faith that students will find truth so long as they receive good information and diverse opinions.— *P. P.*

"Partying turkeys to preach Brazil AIDS awareness"

That's verbatim from a January 24 Reuters headline announcing that "turkeys in party dress will be the symbol of Brazil's AIDS campaign during Carnival because of the turkey's long-standing association, in local slang, with the male genital organ."

We didn't make this up, folks. It gets even more fun.

"By opting to feature an animal," the story continues, "the campaign's creators hoped to avoid a repeat of last year's outcry when a government television advertisement featured a man conversing with his irrepressible penis called Braulio." That particular campaign was called off when "men named Braulio complained they were being ridiculed."

This is all too believable to anyone who's witnessed an "AIDS education" seminar conducted by certified "AIDS educators" in American classrooms. The "educators" often perform spectacular tricks with condoms, fitting them over watermelons, or even their own heads — and then inflating the balloons with their noses.

This accompanies the CDC comic books (literally, comic books) they distribute (in place of referenced documentation) to support their view. — *Paul Philpott*

ACT-UP CO-OPTED?

A March 21 *New York Times* article describes the current state of affairs at ACT-UP, the organization responsible more than any other for promoting the diseases of drug-using gay men as a single condition of infectious immune deficiency (section B, page 1).

"Back in its heyday... 700 activists would show up" at the New York meetings, the article says, "but at the most recent gathering... only 50 people attended."

It's no wonder. It seems all the old ACT-UP volunteers have now "fashioned actual careers" in the AIDS industry, according to the article. These are the people who used to march in front of the White House demanding that President Reagan direct Congress to build with tax dollars an empire of HIV programs.

They got their empire, which now employs them to do things like pull condoms over their heads and inflate them with their noses, or manage those who do.

The transformation of shrieking ACT-UP agitators into ersatz "professionals" has created some very interesting alliances that reveal the nature of the HIV empire. Take for example ACT-UP founder Larry Kramer and NIH official Anthony Fauci. The article reminds us that Kramer once branded Fauci "a murderer" for not constructing a gargantuan enough HIV research budget. Now the two are such good pals that they regularly exchange phone calls and dine together.

Then there's Peter Staley and the executives of Glaxo-Wellcome (then Burroughs-Wellcome), the manufacturer of AZT. Staley once barricaded himself with other ACT-UP volunteers in the headquarters of Burroughs-Wellcome to protest the high cost of "anti-HIV" drugs. Now the company periodically flies him to its offices for consultation.

How did everyone become such great friends?

Everyone got what they wanted, thanks to American tax payers. ACT-UP's message that "everyone is at risk" took hold both with their politically correct sympathizers (who wanted to help them) and their conservative adversaries (who wanted to bolster their attacks on promiscuity). Politicians of all stripes urgently constructed a multi-billion dollar annual HIV budget, largely based on testimony from ACT-UP representatives and their then-adversaries: Fauci and Burroughs-Wellcome officials. They all asked for the same things: more money for research (to Fauci for distribution to various government and university laboratories), drug subsidies (to Burroughs-Wellcome and other pharmaceutical companies), and "community education" (to support groups and activist organizations, including ACT-UP).

Today, political groups like ACT-UP receive "AIDS education" money not just from direct tax funding, but also from the drug companies and government agencies for which they now effectively lobby. In some industries these contributions would be considered kick-backs. The flow of money begins with average American taxpayers, scared by government-sponsored "AIDS education" efforts into thinking that "everyone is at risk." Accurate AIDS education would eliminate that fear... and the flow of money. —*P.P.*

Portland Reappraiser Ann Frye

"I find it distressing that so many health care practitioners, especially holistic physicians and midwives, unquestioningly accept the HIV hypothesis," says Ann Frye, a certified professional midwife in Portland who called in to express her support for *Reappraising AIDS*. "The HIV hypothesis just doesn't hold any water."

"I think Peter Duesberg has a good handle on the history" of AIDS and the social and scientific phenomenon surrounding it, she continues. But she wonders if Duesberg may have overlooked the pathological effects of some non-drug factors prevalent among the risk groups.

Frye is particularly impressed by the prevalence of STDs among the original gay AIDS patients. She concludes that repeated exposure to syphilis, and incomplete and repeated treatment of it with toxic drugs, might play an important role in many cases diagnosed as "AIDS."

Fry has written three textbooks on the subject of midwifery, and can be contacted at 503/255-3378.

NOTES FROM MEDICAL SCHOOL

While working as a phlebotomist at the university's hospital in 1996, I became friends with a fellow student, who was also employed drawing blood. She told me that before I came to work there, she experienced an accidental needle prick that led to a frightening experience with prophylactic AZT therapy.

The incident involved a needle that my friend had just used to draw blood from a patient. When a quick check of the patient's records showed that he was HIV-positive, panic set in, as did waves off nausea, which lasted about an hour. When the nausea passed, she was rushed to the hospital's Employee Health Department. The attendants drew blood for HIV testing (to confirm that my friend was HIV-negataive at the time of her exposure) and initiated AZT therapy, to be be continued for about six weeks— the time it takes for an HIV infection to show up on an antibody test.

We are taught that upon initial exposure, HIV replicates furiously for some time — weeks to months, but generally six weeks, we are told — before the immune system generates enough antibodies to show up in HIV tests. So when medical personnel are exposed to HIV-positive blood, they are immediately prescribed a dose of AZT to be taken every day for six weeks. Then they are tested for HIV. If they test negative, they are taken off the AZT.

Within days of beginning her prophylactic AZT treatment, my friend began to display alarming symptoms: severe nausea, weight loss, blackouts, and hair loss. She had to stop working, and was unable even to run errands. She assumed that her symptoms resulted from the AZT. And although she believed in the HIV model and subscribed to the logic of AZT propylaxis, she decided to stop taking AZT even at the risk of developing AIDS.

This action contradicted the urgent orders of her physician, who did not inform her that in the absence of AZT prophylaxis, 999 of 1,000 people who get pricked by HIV-tainted needles never become positive. Within days her symptoms disappeared and she returned to work feeling like her old self.

After the allotted time, she tested negative for HIV. It seems to me that she should have learned a personal lesson from this. Fear of HIV can cause acute, debilitating nausea, weight loss, blackouts, and hair loss, conditions that I believe physicians blame on HIV in patients who test positive.

I did not feel close enough to this fellow medical student to share my true understanding of this topic, due to fear about how my unpopular view might affect me with my peers. At the time, I did not know that 99.9% of all people in her position end up negative even without AZT. I wonder if she will ever learn that fact during her medical studies. And I wonder if she will ever notice that the symptoms she experienced while taking AZT are some of the same symptoms officially attributed to HIV.

And I wonder how this experience will affect the way she feels about her chosen profession, given that her physician insisted she take an (apparently) AIDS-causing drug to prevent the one-in-a-thousand chance that she would become infected with a virus that *supposedly* causes AIDS.

The author is a second-year student at a large American medical school. He requests that RA *withhold his name to prevent academic and professional reprisals.*

New!

Reappraising Web Site

http://www.wwnet.com/~philpott/ReappraisingAIDS

Featuring an archive of *RA* articles, links to other sites and articles, plus additional information.

HEAL (Health Education AIDS Liaison)

HEAL is an international network of independent groups challenging the validity of the HIV/AIDS hypothesis, the accuracy of HIV tests and the efficacy of HIV-based protocols as treatments or preventions for AIDS.

To obtain an information catalog, a complete list of HEAL chapters in 20 North American cities and three countries around the world, local seminar schedules or other information, call:

HEAL-LA	HEAL-New York	HEAL-Seattle
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For a copy of the new expanded and revised edition of *What If Everything You Thought You Knew About AIDS Was Wrong?*, a concise and compelling introduction to the HIV/AIDS debate, send $7.95 plus $1.00 shipping to:

HEAL 11684 Ventura Blvd., Studio City, CA 91604.

Reappraising AIDS

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