# Uncommon Questions:
## A Feminist Exploration of AIDS

*Women's Health Interaction*

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## *Uncommon Questions*: A Feminist Exploration of AIDS

*Research and writing:* WHI Collective: Donna Chiarelli, Julie Delahanty, Carla Marcelis, Rose Mary Murphy, Bibiana Nalwiindi Seaborn, Karen Seabrooke

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### Women's Health Interaction (WHI): Who are we?

Women's Health Interaction is a voluntary feminist health collective, started in 1983. We advocate for women's health in the context of social and economic justice. At WHI we develop and use feminist principles in working together, sharing responsibilities in the group and making decisions by building consensus.

WHI believes that the personal is political, and we link our own experiences to those of other women around the world. We analyze these experiences for common themes and build our education and advocacy work from this. We collaborate with women's and health organizations and networks in Canada and around the world.

# *Uncommon Questions:*
## A Feminist Exploration of AIDS

## Table of Contents

# *Uncommon Questions:*
# A Feminist Exploration of AIDS

## Preamble: Setting the Context

*Women's Health Interaction (WHI) has prepared this paper as a contribution to the ongoing discussion on AIDS. We are concerned about the suffering and death around the world that has been attributed to HIV/AIDS. At the same time, along with a growing number of people, we have come to question the links between HIV and AIDS, and the idea that HIV = AIDS = Death. Specifically because of the high human costs involved, it is important to understand the weaknesses in the dominant theory concerning the cause of AIDS, and to question the treatments that are being prescribed and, in some cases, imposed.*

*The focus on HIV and AIDS is relatively new to our group. In the past, WHI has worked on issues of women's reproductive rights and women and pharmaceuticals, promoting our feminist vision of holistic and integrated approaches to health care that increase women's control over our own bodies and health, and that focus on prevention of illness. We believe, together with many others, that women's health status is fundamentally linked to the position and power of women in society, and to the social and economic conditions in which we live. The medicalization and manipulation of women's health has led to programs and strategies that ignore the root causes of illness. Women are victimized and targeted for dangerous drugs, often bypassing the right to informed consent. Further, alternative health therapies and strategies are ignored. This focus on medical interventions by governments and the medical industry is based on a model that promotes and relies on a "pill for every ill" rather than the eradication of the social conditions that cause disease to flourish.*

*It is from our evolving understanding and critique of the medical model as applied to women's health that WHI has begun to take a look at the issue of AIDS. Our previous work on women's health has caused us to question "common knowledge" about issues, and challenge the assumptions that underpin popular beliefs. It has caused us to question in whose interest specific knowledge is constructed and disseminated. As we delved deeper into the literature and spoke with HIV-seropositive "dissidents", we began to question some of the assumptions about the relationship between HIV and AIDS. We learned that there were alternative theories about the causes of AIDS, and that the researchers and activists who questioned whether HIV = AIDS = Death, were often silenced and in other ways isolated and punished for challenging the dominant theory.*

*We became concerned that women diagnosed as HIV positive, particularly pregnant and breast-feeding women, are routinely advised and sometimes pressured to take extremely toxic drug therapies, such as AZT. Pregnant or nursing women who refuse retroviral drugs for themselves or their newborns, or who refuse to stop breastfeeding, have been threatened with having their children taken from them (Farber, 1998, 1999). We began to have concerns about the human rights and reproductive rights of HIV-positive women seeking treatment or having treatment imposed, in addition to many questions about the safety of the AIDS drugs, and the link between HIV and AIDS itself.*

*With the above in mind, WHI decided to engage in a deeper learning process, to educate ourselves about HIV and AIDS, to identify gaps in our knowledge and to seek to fill these gaps through research and consultation with others. We have written this paper as a first step in this learning and dialogue process.*

*We recognize that there are gaps in this discussion paper; for example, it was difficult to obtain alternative information on HIV/AIDS in the Third World. This is a priority for our future exploration.*

*While many women's health advocates have argued that women have been excluded from treatment and are discriminated against in programs that address HIV and AIDS, this critique has generally not extended to challenging prevailing HIV/AIDS orthodoxy itself. We feel that our own questioning in this regard is important and consistent with the history of our work. We realize that for many this paper will represent a great deal of unexplored territory and its content may be perceived as threatening to those living with an HIV-positive or AIDS diagnosis. We know that others in the women's health movement will respect our choice in asking these questions, and will engage with us in seeking answers.*

*Donna Chiarelli*
*Julie Delahanty*
*Carla Marcelis*
*Rose Mary Murphy*
*Bibiana Nalwiindi Seaborn*
*Karen Seabrooke*

**Women's Health Interaction**
**Ottawa, August, 1999**

# Introduction

Our involvement in AIDS is not an academic exercise. We fear that people are dying unnecessarily as a direct result of the way that AIDS has been conceptualized and treated. In this paper, we challenge common assumptions that are made about AIDS and HIV. We ask questions that focus on three basic injustices associated with the way that HIV and AIDS have come to be understood and addressed globally. The first injustice is the unequal power and marginalization of women. The second injustice arises when people are prevented from exercising their right to fully-informed consent in issues of testing and treatment. The third injustice arises when alternative viewpoints are discredited, or worse, silenced.

Part I of this paper identifies the feminist framework that has informed our analysis. The framework identifies principles associated with women's health that guided our elaboration of the issues. These include: 1) critiquing the medical model of disease; 2) defining women as experts in our own health; 3) enshrining principles of informed consent; and 4) challenging the current allocation of research funding.

In Part II, we ask specific questions about the AIDS paradigm. Each section begins with a set of common assumptions or "common knowledge" on a particular issue, followed by a series of "uncommon questions" – questions that are rarely asked, but ought to be. While we do not have all the answers ourselves, we believe that these questions have to be asked, and ultimately, they have to be answered. Identifying the "uncommon questions," and developing a discussion around them, began with reading extensively in the mainstream literature on AIDS, as well as literature by those dissenting from the popular understanding of AIDS. Our bibliography, and Appendix A, include many of these resources. We conclude this section by exploring how the AIDS paradigm has been constructed, with particular reference to the medical establishment and pharmaceutical companies which have had overwhelming control over the scientific information produced and disseminated publicly about AIDS.

Finally, in Part III, as a contribution to the dialogue we hope to promote, the paper outlines some of the policy implications which emerge from what we have learned in creating this discussion paper. A series of appendices is also attached to the discussion paper, which provide more detail on points raised throughout the document.

# I. A Feminist Framework

Women have unequal power in society, which results in less control over our lives and health, fewer choices, unequal treatment and, for many women, physical and psychological violence that critically affects our health. In addition, women's health and disease, and the research and treatment of women's disease, are defined by those who hold most power in society. It is in this context that women's health needs and problems have to be understood. The concepts valued by the women's health movement promote better lives and health care for women, and for all people.

The women's health movement has a powerful tool in feminist theory which, at base, includes a critique of male-dominated and hierarchical power structures that underlie poverty and powerlessness. A feminist analysis of women's health problems is based upon core principles with which to approach the phenomena of disease and health, as well as the related processes involved in the research, treatment and prevention of disease. The following principles are central to a feminist analysis of health.

## Critique of the Medical Model of Disease

The medical model of disease, including its preoccupation with the germ theory of disease, is a limited and often harmful model. The medical model assumes that illness is caused by a specific and identifiable agent, bacteria or virus, that invades the body. When the body cannot fight off the invader, a person succumbs to the attack and becomes ill. The physician identifies the agent through laboratory tests, and then prescribes specific drugs designed to repulse the invading organism. This model implies that the causes of disease lie within the (weak and imperfect) individual, and focuses therapeutic intervention on individuals, and on symptoms, while ignoring other variables and elements within the social and physical environment. The model defines the body in a mechanistic way and sees medicine quite literally in military terms as a "war" against hostile agents, requiring the use of an arsenal of drugs to combat the disease. Just as in war, the side effects of therapies are seen as unfortunate but necessary consequences of medicine, echoing the military notion of "collateral damage".

A feminist perspective attempts to de-medicalize disease and health by taking a broader, more holistic and comprehensive view of these processes. It takes into consideration the multi-factoral elements of disease, including the economic, social and political factors that have a direct impact on health. It recognizes that health is affected by a whole range of factors, including nutrition, stress, pollution and other contaminants. A feminist perspective emphasizes the need to recognize the complex way the *internal* environment, which is the body, interacts with the external environment.

We recognize the role and power of mind in maintaining health, as well as in healing, and the interactive effects of our social environment on our state of wellness (or illness). We advocate for improving peoples' social conditions and for preventing disease rather than treating people exclusively with powerful drugs. Confronting and resolving the causes of poverty, stress and addiction are central to dealing with disease.

## Women as Experts: Knowing our Bodies, Defining our Health

We advocate that women have the central role as experts in their own health and illness. Women need to be heard and their experiences validated. Fundamental to a feminist perspective is the recognition that consciousness-raising is a powerful tool to empower women, and that women's health depends on that empowerment. When we share our experiences and gain knowledge and authority to make decisions, we can prevent many harmful practices and promote alternative solutions. Consciousness-raising and political activism brought about the childbirth movement, identified violence against women as a major global problem, made visible and reduced the psychiatrizing and tranquilization of women, and built a movement for women to regain reproductive control of our bodies.

It is through discussion with other women that we have named our experience, identified the powerful forces that have kept us dependent on, and often harmed by, medical processes, and empowered us to find alternatives. This process has played an important role in "de-medicalizing"

disease and going beyond measures that focus on individuals and too often "blame" us for our own illness. Consciousness-raising, sharing experiences and becoming fully-informed, allows us to redefine problems and create healthy solutions.

Women need to be a central part of all processes dealing with disease and health. Our experiences and voices need to be included in every phase of research, treatment and prevention programs. Women's needs are different from men's needs, and our bodies react differently than men's. Women's reproductive and breastfeeding capacities place us in a critical and vulnerable position. What happens to a pregnant woman can directly affect her baby *in utero* and after birth. Further, the gender roles that women are ascribed by society may also create specific health problems that need to be addressed. For example, it is well documented that women are more likely to work in the unregulated sector of the economy where occupational health issues go unaddressed by formal regulations and where they are physically and psychologically vulnerable.

## Informed Consent

A central principle that has been promoted by the women's health movement is that every person has the right to control over her own body and to fully-informed choice and consent concerning medical interventions. This means that therapeutic alternatives should be presented with the full range of risks and benefits outlined. It means receiving full information on alternative therapies, as well as the consequences of refusing treatment.

The importance of informed choice extends to testing. No one should be coerced into being tested for a disease. For consent to be truly informed, information should be based on sound research conveyed accurately, honestly and objectively. It is also fundamental that the potential consequences of our choices should never be exaggerated.

## Funding Research

The women's health movement has questioned why women's health problems receive such a low proportion of funding in comparison to funding for male-identified diseases, and specifically in comparison to research on AIDS. Comparison with funding for breast cancer research is illustrative. In 1992, Health Canada pledged $25 million over five years to the Breast Cancer Initiative. At the same time, it allocated $203.5 million for a five year national AIDS strategy. And yet, in the fourteen years between 1982 and 1996, while 9,500 Canadians (565 women) had died of AIDS, more than 60,000 died of breast cancer. In other words, in this period for every person who died of AIDS, 6 women died of breast cancer, and for every woman who died of AIDS, 106 died of breast cancer (Mallet, 1996)[1].

This disproportionately low level of funding for research on women's specific health issues is a serious flaw in current research programs, but we must also question medical research priorities in general, regardless of their gender bias. Research funds are weighted heavily in favour of funding the medical/pharmacological approach to understanding and addressing disease, rather than emphasizing prevention and alternative therapies that take social and economic conditions into consideration.

The application of these four principles as a guide in our analysis of women's health issues has focused our concern that current research, testing, treatment and portrayals of AIDS are remote from a feminist understanding and approach and may be putting women and their children at risk. This process has led us to explore the very meaning and definition of AIDS, and the potential human rights questions arising from the testing and treatment of women.

1. Because AIDS is considered a relatively "new" health problem, funding might for a time justifiably have been higher than for a health problem with an already well established research program. However, the unprecedented investment in AIDS research and the rapid establishment of AIDS research facilities since the mid-Eighties – coupled with the fact of the failure of early predictions of AIDS developing as a widespread and deadly epidemic – confirm the conclusion that the present disproportionate levels of funding for AIDS research and prophylaxis cannot be justified.

# II. Common Knowledge/ Uncommon Questions

## 1. How is AIDS Defined?

### *Common Knowledge*

*HIV = AIDS = DEATH*

### *Uncommon Questions*

*Is HIV the cause of AIDS? Does HIV always lead to AIDS? Has the definition of AIDS changed over the years? Are there alternative theories? Is death inevitable? Do social, economic and political factors play a role in developing AIDS?*

***Is HIV the cause of AIDS, and does HIV always lead to AIDS?***

The relationship of HIV to AIDS is not an obvious and undisputed fact, but rather a theory constructed, advanced and defended by the scientific and medical community. The dominant medical model of AIDS (Acquired Immune-Deficiency Syndrome) states that AIDS is a condition directly linked to HIV, a virus that attacks the body's T-Cells and immune system, weakening the body's capacity to resist disease, thereby making it susceptible to a long (and rapidly lengthening) list of "opportunistic" infections. AIDS is a medical "construct", and integral to its definition and diagnosis is the presence of HIV. In the U.S. for example, according to the Centers for Disease Control's definition, a person cannot have AIDS, regardless of other symptoms, unless she has HIV, since HIV is considered the cause of AIDS and is part of its diagnosis. As Celia Farber reports, "it is the perfect circular definition, and has ensured the AIDS establishment a near perfect correlation between HIV and AIDS" (Farber, 1997: 99).

***Are there alternative theories?***

Even within the scientific community there is controversy over the cause and treatment of AIDS.[2] A number of established researchers have challenged the prevalent theory that HIV causes AIDS and have raised alternative explanations for the disease. Robert Root-Bernstein, Professor of Physiology at Michigan State University and author of *Rethinking AIDS: The Tragedy of Premature Consensus* (1993), was one of the first to publicly ask: "What if HIV doesn't cause AIDS?" Root-Bernstein – along with other scientists such as Peter Duesberg, a renowned microbiologist and virologist, member of the National Academy of Science, and a former candidate for the Nobel Prize, and Eleni Papadopulos-Eleopulos, biophysicist and chairwoman of the Board of the International Forum for Accessible Science – has pointed out many gaps in this simplistic virus-disease causation theory. They assert that even within the medical paradigm, HIV does not meet the criteria of a human retrovirus, nor does it follow the epidemiological course of an "epidemic" (Root-Bernstein, 1993). Nobel Laureate (Chemistry), Kary Mullis, asserts that "...we have not been able to discover any good reasons why most of the people on earth believe that AIDS is a disease caused by a virus called HIV. There is simply no scientific evidence demonstrating that this is true" ("Introduction" to Duesberg, 1996: xiii).

Despite strong resistance to their speculation and alternative theories, many members of the scientific establishment continue to raise questions about how "AIDS" functions. Root-Bernstein, for example, places emphasis on an immune system already weakened by any of a wide variety of possible "co-factors" (other than HIV) which allows the infections associated with AIDS to take hold. Others, such as Joseph Sonnabend, suggest that there are other, more specific, co-factors which play key roles in the onset of AIDS (Sonnabend, 1993). K. Shallenberger asserted in the journal *Medical Hypotheses* that the single HIV infectious pathogen model of AIDS, "just does not

2. See Appendix A: *Alternative Activists, Theories and Organizations.*

fit the bill" (Shallenberger, 1998: 67-80). Shallenberger has developed a theory of AIDS based on the immune system itself, rather than a single invasive virus. He does not question the existence of HIV, but argues that AIDS is a multifactoral condition based on a reversal of the traditional roles of the two principle arms of the immune system, "cell mediated immunity" (CMI) and "antibody mediated immunity" (AMI). Shallenberger suggests that AIDS is a disease event entirely separate from HIV, and found principally in people most subject to repeated antigenic exposure, including 1) people with multiple sexually-transmitted diseases, and viral, bacterial and parasitic infections; 2) drug addicts exposed to various hepatitis and other pathogens via dirty syringes and contaminated street drugs; and 3) hemophiliacs exposed to commercially-made clotting factor consisting of 99% alloantigenic impurities (Shallenberger, 1998: 67-80).

### *Do social, economic, and political factors play a role in developing AIDS?*

The greatest number of AIDS cases are reportedly among groups which are socially and economically marginalized. It is well known that social, economic and political conditions play integral roles in building, or in destroying, immunity. People living in poor social and economic conditions do not have access to good nutrition, safe water, or adequate health care. Their immune systems may be weakened and they are often much more susceptible to disease.

In Europe and North America, AIDS-defining diseases include over 30 conditions,[3] including tuberculosis and cervical cancer. In addition, an HIV-positive test and a T-cell count below 200 in the absence of other symptoms may be adequate for a confirmed diagnosis (Geshekter, 1994). Conversely, despite the official definitions and AIDS orthodoxy, in Africa and other developing countries the presence of HIV is not necessary for an AIDS diagnosis, and testing is rare. The World Health Organization's clinical-case definition for these countries is based on a list of symptoms that include chronic diarrhea, prolonged fever, ten percent body weight loss in two months and a persistent cough.[4]

These criteria for AIDS are disturbingly similar to endemic diseases such as dysentery, tuberculosis, cholera and malaria. Many experts, such as Dr. Harvey Bialy, eminent Science Editor of *Bio/Technology*, a sister publication of the journal *Science*, argue that AIDS is simply a new name for old diseases that result from inadequate health care, widespread malnutrition, endemic infections and unsanitary water supplies (Shenton, 1998; Murphy, 1994). In this case, it would be very easy for widespread, and counterproductive, misdiagnosis of AIDS. For those who do undergo testing for HIV, the tests have been proven remarkably unreliable, particularly in developing countries (Johnson, 1996: 5). The potential for false positives is very high partly due to anomalies in the tests themselves, but also because – as is now well-documented – people who live in areas where leprosy, malaria, and TB are prevalent, routinely produce false positive HIV test results since the test reacts to the proteins of the antibodies for these diseases" (Harrison, 1996:9).

A growing number of scientists and researchers argue that, to be effective, AIDS research and prevention has to address structural poverty, unhealthy living conditions and the lack of primary health care, rather than simply attempting to change peoples' sexual behaviour (Murphy, 1994; Geshekter, 1997). Shenton reports that in Uganda, "As a result of the redefined AIDS problem, coping with malaria, a curable disease, has become seriously neglected with cutbacks in funding for malaria control and medication" (Shenton, 1998: 168).

The focus on the HIV virus as the cause of AIDS and the key to its prevention means that research and treatment programs continue to search solely for pharmaceutical cures. Financial and human resources are diverted away from addressing the underlying social and economic causes of the chronic immune suppression that blights the lives of hundreds of millions who live in grinding poverty.

3. See Appendix B: *Chronology of CDC's AIDS Definitions.*
4. See Appendix C: *Provisional WHO Clinical Case Definition for AIDS (Bangui).* In Africa there are upwards of 2,200 documented cases of people who met the WHO definition of AIDS and who are HIV-free. At a leading African centre for AIDS research in Abidjan, the researchers found that, "over one-third of cases not qualifying as AIDS under [the] Bangui definition of symptoms were HIV-positive, and one-third of cases that did quality as AIDS were HIV negative" (Shenton, 1998: 13 ).

***Has the changing definition of AIDS affected women?***

The list of AIDS-defining diseases is being continually changed, and from year-to-year diseases are added to or deleted from the list. Recently, more attention has been given to women's specific conditions related to AIDS. In the beginning of 1993, the Centers for Disease Control (CDC) in the United States added cervical cancer and pelvic inflammatory disease (PID) to the list of AIDS-related conditions. Notably, and not surprisingly, at the same time that these diseases were added, the number of women diagnosed with AIDS and HIV increased rapidly, and often retroactively. However, many researchers believe that there is in fact no causal link between HIV and cervical cancer, and that the potential for misdiagnosis is very high (Ratcliffe, 1995: 15). In both cervical cancer and PID, researchers claim that the conditions themselves may cause a woman to test positively, but falsely, for HIV antibodies. It is important to note that no other kind of cancer, with the exception of kaposi sarcoma, has been linked to AIDS or to other immune suppression conditions.

***Is death inevitable?***

It is the standard assumption that there is no cure for AIDS. We are told that if we contract HIV we will eventually develop AIDS and ultimately die from its effects. When a person is diagnosed as HIV-positive, she is pressured to take whatever drug treatments she can afford, regardless of whether she has symptoms of disease. Even when asymptomatic, she is forced to struggle with the presumed fatality of her condition, and the rapidly debilitating side effects of the drugs. However, the number of healthy long-term HIV-positive people – particularly seropositive women, men and children who have not initiated drug treatments – is an increasingly identifiable group, and more and more we are hearing dissenting and concerned voices pose the question: is AIDS really the fatal disease and epidemic that we have been led to believe? (Doherty, 1999; see also HEAL Website www.epcnet.com; and Appendix A attached).

## 2. AIDS as an Epidemic : Reviewing the Statistics

### Common Knowledge

*AIDS spreads rapidly and has now reached epidemic proportions. AIDS is not just a gay disease. Everyone is at risk. More and more women are getting AIDS, and the fastest growing risk group is heterosexual women.*

### Uncommon Questions

*Does AIDS follow the pattern of an epidemic? Is there an AIDS explosion? Are heterosexual women really at high risk? Have we been manipulated by AIDS statistics? Do we need to re-assess this "epidemic?"*

***Does AIDS follow the usual pattern of epidemics?***

As Celia Farber asks, "If the HIV-spreads-like-wildfire-kills-like-a-truck model of disease were true, then why wouldn't there be a heterosexual explosion by now?" (Farber, 1996: 87). One of the reasons why AIDS is assumed to have reached "epidemic" proportions is because of the mainstream belief that AIDS is caused by an infectious agent, HIV, which is transmitted through the blood and other bodily fluids, such as semen or breast milk. While these routes of transmission would actually make it more *difficult* to contract HIV than, for example, a flu or a virus transmitted through the air, the assumption persists that the general population is at high risk of contracting HIV, particularly men and women who are sexually active, people who come into contact with infected blood products, and infants born to HIV-positive women. Because of these assumptions about how AIDS is spread and the high risk associated with the routes of transmission, AIDS is (quite understandably) believed to be spreading rapidly and evenly across the general population.

Following this logic, if we assume that AIDS works like a typical infectious disease, then we would expect that it would follow the five characteristics of an infectious disorder (Horton, 1996: 14), that is:

1. It would spread randomly between sexes;
2. It would rapidly appear, at least within months;
3. It would be possible to identify "active and abundant (HIV) microbes in all cases";
4. Cells would die or be impaired, beyond the ability of the body to replace them;
5. There would be a consistent pattern of symptoms in those infected.

In the case of AIDS, most of these characteristics have not been met. In the U.S. and Europe, men are affected far more commonly than women, particularly homosexual men. In 1988, Toronto-based epidemiologist, Eric Mintz, already questioned the epidemic hypothesis: "...if the median time between HIV seropositivity and full-blown AIDS is at least 7 years (or 15 years, as has been recently claimed), then this epidemic is about 20 years old. Since it has begun to plateau, it is most likely in middle age. If there has been no widespread heterosexual spread, why would one expect it to occur now, as the reservoir in most of the high-risk groups is diminishing?" (Mintz, 1988: 28).

The disease does not appear rapidly; in fact, for most it has *never* appeared even many years after the original diagnosis. This is evident by the fact that only 1 percent of HIV-positive people in the USA develop AIDS per year (Duesberg, 1987). Further, it is not possible to identify active and abundant HIV microbes in all cases. The CDC has shown that 10 percent of cases diagnosed with AIDS have no sign of antibodies to HIV (Shenton, 1998: 11). Cells do not die out in the numbers necessary to cause disease and death. Finally, in Africa, the symptoms associated with AIDS are very different from those seen in North America and Europe, although this can be partially explained by the fact that immune deficiency will make people more vulnerable to the infections endemic in their specific locale, which may differ from place to place.

In fact, figures published by the U.S. Centers for Disease Control for the year ending 1997 show total U.S. HIV/AIDS diagnoses declined from 68,808 in 1996 to 60,634 in 1997 in a population of 272,000,000. In 1996, heterosexual contact was ascribed to 14 percent of all cases; in 1997, 13 percent. In absolute numbers, heterosexual-contact cases declined from 9,526 in 1996, to 8,112 in 1997. Female adult diagnoses declined from 13,767 to 13,105. Pediatric diagnoses declined from 671 to 473, of which all but 63 were among those defined as "racial/ethnic minorities".

***Is there an AIDS explosion?***

According to Health Canada the global figure of all reported AIDS cases, living or dead, as of December, 1996, was 1,393,638. North America accounted for 555,321 of these cases. The remaining cases were distributed among all the countries of Europe (167,571) and the other continents, including the Third World. Africa accounted for 499,035 cases, with all other regions combined reporting the remaining cases. All of Asia accounted for only 29,705 cases. These statistics are from the World Health Organization (WHO) for the diagnosed incidence of AIDS to December 1996 (Health Canada, 1996: 5).

The totals in these statistical updates from the WHO are *cumulative* since 1979, and reflect not merely cases diagnosed in a particular year, but *all* cases ever reported worldwide, living and dead. There is no other endemic or epidemic disease for which such cumulative statistics are maintained (Murphy, 1995: 39-46).

Even at that, these numbers are far lower than the predictions made about the scale of the problem. The frequent explanation for the differential between the predicted incidence of HIV/AIDS and the more modest figures that are actually reported is that: 1) very few countries have the capacity to diagnose AIDS; and 2) they resist reporting the true incidence because they do not want to admit to the problem. While some countries may not have the capacity, or inclination, to do wide-scale testing for HIV, these countries are still diagnosing AIDS in the absence of the test. As a result, given the potential for mis-diagnosis based on common symptoms, actual cases of AIDS may well be much *lower* than reported, rather than higher.

In any case, the idea that governments resist reporting AIDS has little credence, given the pressure on governments to bow to the agenda of the WHO and other international institutions, and the funds made available to governments willing to accept AIDS as a priority. In many cases virtually the only international health money available is for AIDS research and treatment so there is a great incentive to diagnose AIDS wherever possible, and to focus on sexual/reproductive behaviours in treatment and education programs. A common complaint of Third World NGOs is that if they do not give priority to AIDS, there is little international funding available for their health activities. Given this pressure, together with the tremendous interest in tracking down and reporting AIDS by the multilateral and non-governmental humanitarian sector – not to mention the lucrative pharmaceutical industry and its associates in the medical training and research field – we can have some confidence that the numbers reported above are not significantly below actual incidences. The idea that the incidence of AIDS is worse by a factor of five, ten, or twenty has no basis. In many countries, NGOs are hard-pressed to find AIDS sufferers (Health Canada, 1996: 4).

Many activists are concerned about the effect of claims that AIDS has reached epidemic proportions in Africa and other developing countries. These claims have been used to justify the use of Third World populations, particularly in Africa, but also in South-East Asia and the Americas, for vaccine trials and drug tests that are not permitted in Europe and North America. Poor countries in the South – desperately seeking health care funding and drugs to curtail the reported "epidemic" – employ much less strict regulations over testing of drugs and vaccines, and are under extreme pressure to acquiesce to sponsoring such experimental trials. When governments in the South make decisions that run counter to prevailing orthodoxy on AIDS, as was recently the case in South Africa, they come under extreme attack from AIDS advocates (Mickleburgh, 1999; Murphy, 1999).

It is the theoretical premise that the cause of AIDS is primarily viral, together with the social-sexual theories about the spread of AIDS, that leads to a prediction of an epidemic, not the observable facts. If a deadly virus was indeed spreading widely and rapidly throughout the globe through sexual transmission, the present modest numbers would be much higher. Indeed there would be no controversy, because the numbers in Canada and the United States themselves, where diagnosis and reporting is aggressive and rigorous, would already be astronomical, which they are not. The facts simply do not back up the theory.

One explanation given for the present low numbers in North America is that the figures are in part due to the increased use of more effective anti-retroviral drugs which are prolonging the onset of full blown AIDS in those with HIV. Yet there is serious debate about the positive and negative impact of AZT and the so-called "drug cocktails", with many critics challenging the claims of their effectiveness in preventing the onset of disease in HIV-positive people. The recent use of these drugs cannot explain the failure of the prediction made in the mid-1980s that North America and Europe would experience a major catastrophic epidemic by the early nineties. Indeed, research compiled by Kevin Doherty (1999) indicates that the three most common characteristics of long-term "HIV-positive survivors" are:

1. They avoided taking chemotherapy/anti-retroviral drugs such as AZT, ddI, ddC, d4T, and 3TC;
2. On learning of their HIV status (HIV-positive), they stopped all high-risk activities such as drug use and unprotected sex;
3. They began taking charge of their lives, including their nutrition, exercise, and health.

Clearly, more research is required that carefully accounts for these factors.

***Are heterosexual women really at high risk?***

In hard numbers, relatively few women are diagnosed with AIDS even with the inclusion in recent years of specific women's diseases such as cervical cancer. As Celia Farber reports, fewer women are becoming infected, and "the bulk of heterosexual transmission is taking place within a disenfranchised community that is marked by poverty, poor health care, sexually-transmitted diseases and drug use" (Farber, 1996). This conclusion is not new.

Stephen Strauss, a science editor for the *Globe and Mail*, years ago asked the critical question, "If AIDS is caused solely by HIV, and spread via sexual intercourse, then why is it not spreading along sexual lines so much as along sociological lines, with poverty and drug use being central co-factors?...prostitutes have no higher incidence of either HIV or AIDS than any non-risk groups – unless they are IV-drug users" (Strauss, 1993). The work of Eric Mintz (1988) discussed earlier also undermined the conclusion that women were at significant risk of contracting HIV through sexual contact.

***Have we been manipulated by AIDS statistics?***

It appears that AIDS statistics are often manipulated to give the illusion of an increase in AIDS cases, when there has actually been a decrease. In a very revealing example, Christine Maggiore (1997) reports that:

> In Canada, a nation with an extremely low incidence of AIDS, AIDS groups and reporters play up the few cases they can find and often perform their own magic with the numbers. For example, new Canadian AIDS cases for 1995 were 1,369 and of these, 111 or 8% were among women. In 1996, when the number of new AIDS cases dropped by almost 50% to a total of 712, the media and AIDS organizations not only ignored the good news, but devised a way to make it appear bad. Since 67 of the 712 AIDS cases for 1996 were among women (a decrease of 44 from the year before), the lower number of cases among women was now part of a smaller total. This provided an opportunity to express a *decrease* of 44 as an *increase* of 1.4% (emphasis added).

Maggiore provides the following chart to illustrate:

| *Year Reported* | *Total New AIDS Cases* | *Number of Women* | *% of Cases of Women* | |
|---|---|---|---|---|
| 1995 | 1369 | 111 | 8% | What makes the News? Rise of AIDS among Women by 1.4% |
| 1996 | 712 | 67 | 9.4% | |

[From: *What if everything you thought you knew about AIDS was wrong?* by Christine Maggiore, 1997: 37]

What is key here is that in 1996, only a miniscule total of 67 women – among a population of over 15 million women – were diagnosed with AIDS in Canada; and although this itself was an almost 50 percent *reduction* in new cases, we read about it as a major and continuing *increase*. We can only ask why, and in whose interest, are statistics reported this way?

In addition, unlike other statistics on disease which are reported on an annual basis, AIDS statistics in Canada and around the world are calculated *cumulatively*. This means that statistics report the cumulative total of people who have AIDS or have died from AIDS since it was first defined as a category in the late seventies. Thus, of the total number of AIDS cases ever reported in Canada between 1979 and December 1998 (that is, 16,236 cases), 71 percent (11,525) are deceased. Since 1995, the number of AIDS deaths each year has significantly declined, with an 89.5 percent drop in deaths in 1998 as compared with 1995. Deaths peaked at 1,420 in 1995, and fell to just above 100 in 1998. Similar trends are visible in the incidence of positive HIV tests, which have declined 23.3 percent between 1995 and the end of 1998 (Health Canada, 1999:5). This is precisely the kind of plateau and decline in figures predicted by people like Eric Mintz over ten years earlier.

Since numbers on their own are difficult to interpret, especially given the differing ways numbers are presented, it is important that these figures are contextualized. Well over 100 women and children are murdered across Canada every year. In Quebec alone, between December 6, 1989, when 14 women in Montreal were killed by a gun-wielding anti-feminist, and December 6, 1998, 501 women and children were killed by men (Montreal Men Against Sexism, 1998).

The generalized confusion and fear about AIDS is caused not by direct experience, but by speculation out

of proportion with the scale of events in the real world. Prevailing preoccupation about AIDS among most Canadians, for example, could not be based on direct personal experience since, according to the official Government of Canada cumulative statistics as of December, 1998, reported above, there has been a total of 16,236 cases of AIDS reported in the almost twenty years since records have been kept, of which 1,218 were women. As in the United States, most of the increase in diagnosis in Canada in the past several years has been due to the retroactive inclusion of new diseases within the diagnostic definition of AIDS, rather than the discovery of new cases. As Brian Murphy emphasizes, "...compared to other deadly conditions, such as breast cancer and heart disease, for example, which are far more prevalent, or the horrendous incidence of traffic deaths and occupational accident and disease, this number of cases in and of themselves would have relatively little direct impact on 30 million Canadians, very few of whom have ever met a person with AIDS" (Murphy, 1995).

Another poignant example is the alarming statistic that iatrogenic death (death from medical treatment) is now one of the largest causes of death in the United States. A recent ground-breaking study by Pomeranz, Lararou & Corey (1998) documents the very serious adverse effects of both prescription and over-the-counter drugs, revealing that adverse drug effects are one of the leading causes of death worldwide. The side effects of drugs are between the 4th and 6th leading cause of death after heart disease, cancer and lung disease. Following analysis of thousands of hospital patients in 39 U.S. cities, the researchers found that adverse reactions – which didn't include prescribing errors or drug abuse – kill 100,000 Americans every year and seriously injure 2.1 million more (Pomeranz, Lararou & Corey, 1998: 1200-1205)!

In 1995, 12 times more Americans died of cancer (538,455) and 17 times more of heart disease (737,563) than died of AIDS (43,115). Yet today at the U.S. National Institute of Health, funding for AIDS research (US$1.5-billion) is second only to cancer research ($2.2-billion) and exceeds the $1.4-billion spent on heart disease (Bailey, 1995). As Celia Farber notes, "because AIDS is perceived as 'everybody's disease', funds that might have saved lives had the education campaigns been better targeted were instead squandered across a broad population, most of whom were never at risk" (Farber, 1996).

Joan Shenton argues that money is at the root of the alarming AIDS figures put out by the UN system. "In the early 1990s, the WHO's Global Programme on AIDS [later to be taken over by UNAIDS] was employing between 2,000 – 3,000 people. They continually fed highly inflated figures to the press, and officials at public meetings began to quote their estimated cases for AIDS in order to drum up funding, quietly dropping the actual reported figures. When they were challenged there was acknowledgment that the figures they were using as fact were no more than guesswork" (Shenton, 1998: 59). By 1995, the WHO AIDS program dismissed 750 of its workers because none of the pandemic predictions had come true.

***Do we need to re-assess this "epidemic" ?***

The fact is, the number of people with AIDS is not astronomical; the numbers are not increasing but decreasing, and they reveal none of the mathematical characteristics of an epidemic. The projections issued by the UN and other bodies concerning "estimated" cases worldwide are just that – projections based on estimates, specifically estimates of infection with HIV – all based on a theory that itself is highly suspect, and in direct contradiction with the actual diagnosed incidence of AIDS. And increasingly we are seeing this question being asked even in the popular media, when only a few years ago headlines predicted only apocalypse.

A challenge to the epidemiology of AIDS must be made, because such extravagant numbers are used to justify the preoccupation with AIDS. In an open letter from the Secretary General of the International Forum for Accessible Science (IFAS), Michael Baumgartner advocates a full reappraisal of the HIV-AIDS hypothesis by an international independent scientific committee. He asserts that, "Epidemiological data does not support the predictions made in 1984 that the conditions labeled AIDS were caused by a new specific retrovirus, transmissible by sexual intercourse, inevitably fatal and spreading uncontrollably in the general population, culminating in a global pandemic. Independent epidemiological research together with the passage of time has since shown that this hypothesis and the ensuing predictions are wrong" (Baumgartner, 1998: 11).

# 3. AIDS and Testing

## Common Knowledge

*Everyone should be tested for HIV. The tests designed to determine a person's HIV status are accurate and reliable. If you test positive for HIV you will eventually get AIDS. Pregnant women should have an HIV test as part of their routine testing.*

## Uncommon Questions

*Does HIV even exist? What do HIV tests actually measure? How reliable are HIV tests, and what are the chances of getting a false test result? Should pregnant women be subject to routine or mandatory HIV tests? What are the effects of being diagnosed with HIV? What are the human rights implications of such a diagnosis? How might someone be discriminated against having tested positive or been diagnosed with AIDS?*

### *Does HIV exist?*

Eleni Papadopulos-Eleopulos and a group of HIV/AIDS dissident scientists at the University of Western Australia, known as the 'Perth Group', maintain that HIV has never truly been isolated, that the proteins alleged to be specific to HIV are actually stress proteins released in response to a severe disease condition. The various indirect molecular, biochemical and genetic findings have been interpreted as meaning HIV isolation, but none have offered conclusive direct evidence of HIV – that is, HIV has not been isolated as an independent, stable particle – and therefore, according to Papadopulos-Eleopulos, HIV may not exist at all (Papadopulos-Eleopulos, 1993 and 1995; Ankomah, 1996).

### *What do HIV tests actually measure?*

Current HIV tests do not test for the HIV virus itself, but for its antibodies. In fact, tests look for any antibody whose "key" fits the "lock" of the proteins in the mixture. The most commonly used test world-wide for the detection of HIV antibodies is called ELISA – the Enzyme Linked Immunosorbent Assay. The proteins reacting with the antigens of the ELISA test are supposed to be exclusive to HIV. According to the Canadian Medical Association, "A positive test result indicates that the person has been infected with HIV and can transmit the infection to others" (CMA Guidelines, 1995: 12). However, the ELISA test is known to produce false positive results because the solution reacts to many different antibodies, not just HIV antigens. CMA guidelines therefore recommend that all positive test results be verified by repeat ELISA tests and a second independent assay, usually the Western Blot immunoblot or radioimmune precipitation.

The Western Blot test demonstrates antibodies to specific viral proteins. The different proteins are separated and a person's serum is placed over each of the antigens. If the antibodies are present in the serum, they will bind to the test antigens causing a colour change or dark band. The formations of various bands of the viral proteins is considered a positive result because the bands are said to confirm the presence of specific HIV antibodies in the person's blood. The Western blot is technically difficult and expensive (Malarkey, 1996:158). When a person has a negative or indeterminate result, it is recommended that she be tested again in 6 weeks.

According to many AIDS experts, the Western blot is more specific than ELISA, but neither is accurate enough to be used as a benchmark for measuring HIV status. Notably, the criteria for a positive Western Blot test varies widely around the world. The number of bands of proteins needed to react before considering the Western Blot positive depends on where and by whom the test is done, reflecting a lack of standardization globally. "Around the world different combinations of two or three or four of the ten possible bands are deemed proof of infection. In Africa you need two bands but in France, the United Kingdom and Australia you need four and under the U.S. FDA and Red Cross rules you need three" (Turner, 1998, as quoted by Christie, 1998: 14). The number of bands

is set according to the prevalence of HIV infection. In theory, by emigrating from New York to Australia, an HIV-positive status can become negative.

***How reliable are HIV tests, and what are the chances of getting a false test result?***

Several AIDS experts critique the HIV tests because they are unreliable. HIV antibody tests lack what are technically known as *specificity* and *sensitivity*,[5] and according to Peter Duesberg, "the [ELISA] test can be wrong over 50% of the time" (Guccione, 1996: 9).

Antibodies are known to be non-specific and they cross-react with many conditions and proteins. Valendar Turner of the Perth Group says that "all the (antibody) test indicates is that some antibodies in patients react to some proteins present in cultures of tissues from the same patients. But, given that information, what a scientist is obliged to do next is make the comparison with the virus gold standard, before pronouncing the test highly specific for diagnosing HIV infection" (Christie, 1998:18). In other words, scientists must be able to find the virus itself to determine the presence of HIV. Without this "gold standard" there is no way to interpret test results accurately. Turner suggests that it is incorrect for scientists to claim that HIV antibody tests are better nowadays because they use purer proteins, because the gold standard comparison has not been used (because HIV itself has never been independently isolated in the lab). He goes on to say that it is a "tragedy that these tests were introduced in the total absence of proof of their specificity" (Turner, cited in Christie, 1998: 18).

Further, "In 1988 the U.S. Army tested over a million soldiers and found that even in healthy military recruits, half of all the 12,000 first positive ELISA's were negative second time around. And after a second positive ELISA two thirds failed to react on a first Western Blot. And some first Western Blots failed to react on a second Western Blot" (Turner, cited in Christie, 1998: 18).

The potential for false positive test results escalates when the population tested is likely to have infections such as those frequently seen in the Third World or among immigrants from these countries. There are more than 70 conditions and proteins that can cause false positive HIV tests, including hepatitis, TB, malaria, leprosy and even certain types of influenza which produce similar antibody proteins as the so-called HIV antibodies.[6] Both the ELISA and Western Blot tests have difficulty detecting the difference (Burkett, 1995: 13; Christie, 1998; Johnson, 1996). Pregnancy can itself cause an antibody reaction. Repeating the test is only likely to repeat the same cross-reaction to non-HIV antibodies. Furthermore, new cross-reactions are being discovered all the time.

In spite of these serious and well documented limitations, kits for the rapid and simple testing of the presence of HIV advertise that they can provide a person with a definite negative or preliminary positive result in 10 minutes or less. As of April 1995, none of these tests had been approved for sale in Canada. However, the CMA Guidelines suggest that these tests have advantages over current protocols (for example, they do not require complex laboratory equipment or technical training to perform) in specific settings, such as remote areas, or developing countries, even though in their own document they admit that these tests raise "significant scientific, technical, epidemiological, cost and ethical issues" (CMA Guidelines, 1995: 19). Given the probability of errors, widespread use of these kits can have serious and dangerous consequences.

In addition to some of these technical factors in generating unreliability in various tests, Root-Bernstein explains the statistical error (known as Bayes Law) involved with reliability of diagnostic tests in general. When testing is done on a random or a screening basis for people who are not at specific risk for AIDS due to other factors (usually socio-economic), the number of false positives escalates. Under laboratory conditions tests are reliable about 97 percent of the time. This sounds good on the surface, but it actually means in random testing under laboratory conditions, "...about eight false positives for every true positive. [And] if the test kit were 90 percent reliable, a home test for HIV would yield between twenty-five and several hundred false positives for every true positive" (Root-Bernstein, 1990: 7). This high probability of error is one of the reasons tests should be re-confirmed and administered only to people who belong to an identified

5. *Specificity* is essential for reliability and is usually indicated as a percentage. Specificity is a measure of how often a positive test turns up when it is known that HIV is absent; this is called a false positive result. A test should not react unless the HIV antibody is actually present. If the test is negative 100 times in 100 people with no HIV, then it is considered 100% specific. *Sensitivity*, on the other hand, is a measure of how often a test is positive when you know HIV is present. If you get a negative result when HIV is present, this is commonly called a false negative (Christie, 1998: 18).
6. See Appendix D, *Factors Known to Cause False Positives.*

risk group or who already display other symptoms of AIDS, such as opportunistic infections, and therefore have a much higher than average probability of being infected. "Accuracy begins to approximate reliability only when an appreciable fraction of the population is afflicted – say 10 percent – or if the test is limited to [people] who display symptoms suggesting a high probability of being infected – that is, when testing is not random" (Root-Bernstein, 1990: 7).

***Should pregnant women be subject to routine or mandatory HIV tests?***

While HIV testing of pregnant women is theoretically done only with the consent of the woman, some provinces have recently made routine HIV testing and counselling the norm. In 1998, the Ontario Ministry of Health announced that the provincial screening program was being expanded to include voluntary prenatal HIV testing for all pregnant women, regardless of other risk factors. Under the new program, approximately 150,000 prenatal HIV screening tests will be performed annually (Government of Ontario, 1998). According to the Health Ministry, the primary goal of the new program is "to assist women in accessing appropriate treatment for HIV as early as possible. Anti-retroviral treatment will help to maintain the health of the woman as well as reduce the risk of passing the virus to the baby" (Government of Ontario, 1998). According to the Ontario Government, "many women with HIV do not have obvious risk factors – most are diagnosed only after their children are found to have the virus" (Government of Ontario, 1998). The test is also being recommended to all women considering becoming pregnant.

Elsewhere in Canada other provinces are making changes. The Quebec Ministry of Health and Social Services has initiated a new program recommending that all pregnant women, and women contemplating pregnancy, be offered an HIV test. Since 1993, the Northwest Territories' Maternal and Perinatal Committee, which has representation from the Department of Health and Social Services and the Northwest Territories Medical Association, has recommended that all pregnant women be tested for HIV. This is now considered routine, although technically women may "opt out" (Health Canada, 1998; Samson, 1998).

There are real concerns about routine HIV testing of pregnant women. First, pregnancy is a condition that is known to cause cross-reactions with HIV tests, leading to higher rates of false positive test results. The Alberta Reappraising AIDS Society (ARAS) asserts that testing this low-risk population will likely result in many false positives, with dangerous consequences. They maintain that the health of every pregnant woman who is branded HIV-positive, as well as that of her baby, will be damaged by both toxic AZT therapy (used to fight HIV) and the prohibition against breastfeeding. ARAS suggests that people have forgotten some of the lessons history has taught us about the dangers of certain drugs in pregnancy. For example, they wonder, "Does anybody remember Thalidomide?" (ARAS press release, February 23, 1999).

***What are the effects of an HIV-positive diagnosis?***

One of the problems of consenting to an HIV test in the first place, especially in the case of asymptomatic persons, is that a positive test causes profound psychological distress and immediately moves a person into the medical system and treatment with toxic drugs. In the case of a pregnant woman, she will be given information on terminating her pregnancy and if she continues with the pregnancy, drug treatments will be recommended in the belief that AZT administered to the pregnant woman reduces mother-to-child transmission of HIV. She often will be advised to have her birth by cesarean section. Furthermore, breastfeeding will be strongly discouraged, and possibly prohibited, because it is believed that uninfected infants breast-fed by HIV-positive women can become infected (CMA, 1995: 17-18). All of these drastic measures are based on the assumptions that HIV is accurately detected by the tests, that HIV causes AIDS, that drugs such as AZT effectively treat and prevent AIDS, and that it is justifiable to use AZT in the presence of positive HIV tests, even in asymptomatic infants and their mothers. We, along with many others, question each of these assumptions and point out the serious impacts – physical, mental, emotional, economical, social and legal – that can result.

The implications of testing include real physical, psychological and economic concerns. When people are diagnosed as HIV-positive, their doctors often suggest that

they begin to take chemotherapeutic drugs to treat their condition. The medical model of disease and treatment cultivates this response. People who are misdiagnosed, or are in any case asymptomatic, are still treated with potent drugs, such as AZT, which have hazardous effects; indeed, effects that precisely parallel the defined symptoms of AIDS itself, since these chemotherapies destroy virtually all growing cells and critically undermine the immune system along with much else in the body. In this case, testing – which leads to treatment – jeopardizes a person's health.

The Canadian Medical Association (CMA) recommends that testing only be carried out with the consent of the patient and when the patient considers the advantages to be greater than the disadvantages, and that the person be counselled pre- and post-testing. However, even though the CMA promotes "informed consent", the underlying assumptions are that 1) tests actually identify the presence of HIV; 2) HIV will lead to the development of AIDS; and 3) an HIV-positive test should be followed by medical treatment (CMA, 1995: 10).

Meanwhile, beyond all of these risks to health, there is the risk of alienation and social isolation. The public continues to stigmatize people who are identified as HIV-positive or diagnosed with AIDS. A person is blamed for her condition – it is her fault because she is "promiscuous"; it is his fault because he is gay; it is their fault because they are drug addicts. In many people's eyes, it is "wrongful" behaviour that has led to this condition. The responsibility for contracting the disease is placed on the sufferer; she is made to feel guilty and shameful for her condition, in addition to being pressured into making choices of testing and treatment.

***What are the human rights implications of an HIV-positive diagnosis? How might someone be discriminated against having tested positive or been diagnosed with AIDS?***

In the United States there have already been cases where HIV-positive women have had their babies removed by child welfare authorities, and then been ordered by the courts to give their newborns AZT and to stop breastfeeding, under threat of losing custody of their children. This is happening even though, as Farber points out, the U.S. Centers for Disease Control and Prevention specifies in their recommendations that: "Discussion of treatment options should be non-coercive, and the final decision to accept or reject AZT treatment recommended for herself and her child is the right and responsibility of the woman. A decision not to accept treatment should not result in punitive action" (Farber, 1999).

It is these kinds of actions that concern us because, despite the right of women to informed consent, the wide acceptance of the assumption that HIV causes AIDS and can be transmitted by breastfeeding poses very real potential for human rights violations, over and above health implications. It is already happening, in the United States, and in Canada.

Yet there continue to be calls for mandatory testing and treatment for HIV in North America. Already in some cases, employers or health insurance companies will not consider applicants without proof of HIV-free status. The potential for discrimination is clear: people may lose their jobs or be prevented from access to employment, may not be granted health care, and may not be able to visit or immigrate to some countries. According to a recent report, "Canada is considering whether it should routinely screen would-be immigrants for HIV, the deadly virus that causes AIDS, as it does for communicable diseases such as tuberculosis and syphilis. The government says that it is the first time it has raised the possibility of testing and excluding carriers of the virus. The review is linked to proposed changes to immigration policy..." (*The Ottawa Citizen*, January 9, 1999: A4).

Another serious implication of HIV-positive status is the possibility of being denied treatment for other illnesses. For example, at a clinic in Haiti where patients come for treatment for TB and other infectious diseases, those identified as HIV-positive have been refused treatment on the assumption that they "will definitely die of AIDS" and that the clinic "cannot afford to give HIV-positive patients medication" (Shenton, 1996: 12-14). There is considerable anecdotal evidence among Canadian aid workers and their Third World counterparts, that this reaction is very common in poor areas of the world where they work.

# 4. AIDS and Breastfeeding

## Common Knowledge

*Although breastfeeding is normally the best infant care possible, women with HIV should not breastfeed because the baby can get AIDS from breastmilk.*

## Uncommon Questions

*Can a mother pass on the HIV virus through breastmilk? Do infants develop AIDS through this kind of transmission? Should HIV-positive pregnant women be discouraged from breastfeeding, especially where conditions are known to be unsafe for formula feeding?*

***Can a mother pass on the HIV virus through breastmilk, and do infants develop AIDS through this kind of transmission?***

A number of reports claim that HIV infection rates increase with breastfeeding. UNAIDS states that more than one third of infants infected through "vertical transmission" (mother-to-child transmission) are infected through breastfeeding. In a recent report, UNICEF announced that a child stands a 20 percent risk of vertical transmission of the virus in late pregnancy and childbirth and is at an additional 14 percent risk of infection through breastmilk. Obviously, these conclusions are controversial, and the policy dilemmas enormous, given the staggering implications for breastfeeding practices worldwide. Yet despite the potentially disastrous consequences, in 1998 the UN released a statement warning HIV-positive women not to breastfeed their children, but rather resort to infant formula.

There are a number of points that need to be raised in connection to AIDS and breastfeeding. The first question is whether the studies which indicate that breastfeeding increases the rate of HIV transmission are valid. In fact, these are speculative statements, projections from models of prevailing AIDS theory – like all projections on AIDS issued by the UN. The hypothesis that AIDS can be contracted from mother to child in this way has not yet been proven. Some of the studies simply compared the chance of vertical transmission in developing countries, where women generally breastfeed, and developed countries, where the rate of breastfeeding is much lower, and showed the risk to be higher in the developing countries, and extrapolated breastfeeding as the determining variable in the difference (Goldfarb, 1993). Obviously, without looking at control samples, such studies are not conclusive.

The American Academy of Pediatrics, while presently holding that breastfeeding can be a source of HIV infection, does state that, "currently no randomized clinical trials are available that accurately document the incremental risk of HIV transmission through breastfeeding over that occurring during the intrauterine and intrapartum periods. Evaluation of populations that vary only by method of infant feeding have been limited to date, due to the homogeneity of feeding practices in current cohorts, with breastfeeding the norm in developing countries and formula feeding the norm in industrialized countries" (AAP Policy Statement on Human Milk, Breastfeeding and Transmission of HIV in the US, 1997).

Secondly, while some accept that HIV can be present in breast milk and conclude that it is the source of some infants testing positive for HIV antibodies, there is as yet no study done on the number of those infants developing AIDS. In fact, some studies have shown that breastfeeding slows the progression of the disease in babies who are born HIV-positive. A 1995 study showed that human milk contains a factor that inhibits the binding of HIV to specific receptor sites on human T-cells (La Leche League, 1995). It is important to note also that there have been multiple anti-infectious, protective substances which have been identified in human milk (Jelliffe & Jelliffe, 1978; La Leche League International, 1995; Radetsky, 1999).

Another issue that has significant policy implications derives from the fact that world-wide, most pregnant women are not aware of their HIV status. There is no reliable test that guarantees against false positives and it is highly unlikely – and in any case, undesirable – that all pregnant women could be tested for HIV antibodies,

particularly given the cost and the reality that most women the world over do not have access even to basic prenatal care. As such, the policy of discouraging breastfeeding is absurd, and any significant shift from breastfeeding to bottle-feeding as a result of such a policy will generate child mortality figures several times higher than the best estimate of those dying as a result of HIV transmission.

***Should pregnant women who are HIV-positive be discouraged from breastfeeding, especially when conditions are known to be unsafe for formula feeding?***

In the absence of appropriate information, discouraging breastfeeding due to its purported connection with HIV is truly frightening. It is imperative that policy-makers not lose sight of the importance of breastfeeding to maternal and infant health. For decades health advocates have been able to say without hesitation that breastfeeding is the best thing for both the mother and the baby. Besides being an excellent source of nutrition, a mother's milk protects her child against morbidity and mortality from infectious diseases of bacterial, viral, and parasitic origin, while the act of breastfeeding establishes a bond between mother and infant. As a spokesperson from UNAIDS states, "In 90% of the developing world, the protection that is afforded by breastfeeding against the diseases of the Third World is higher than the rate of HIV transmission" (Meier, 1997).

Over the years, the campaign to restrict manufacturers from marketing and selling infant formula to women who are unable to use it safely, or who do not have appropriate information about its negative health effects, has been an uphill struggle. Despite an international code of conduct for the sale and marketing of breastmilk substitutes, infant formula manufacturers have continued to flaunt these codes, continuing to put profits over maternal and child health (Delahanty, 1994). The efforts by health care workers and advocates, including earlier important efforts of UNICEF, to improve infant health through breastfeeding have saved the lives of countless children – and improved their long-term health and life expectancies even more. Breastfeeding also confers significant and well documented benefits to women's health (Jelliffe and Jelliffe, 1978; Palmer, 1988; Van Esterik, 1989; Minchin, 1989; La Leche League, 1995).

## 5. Treatment

### Common Knowledge

*There is no known cure for AIDS but life can be prolonged through drug therapy. People with HIV-positive status should begin treatment early to prevent the onset of the disease. An HIV-positive pregnant woman should begin treatment early and have a cesarean section to avoid transmission to her child. HIV-positive infants should begin treatment at birth.*

### Uncommon Questions

*What are the effects of these highly toxic drugs, and how have they been tested before being administered? Could these drugs in fact be making some people sick, and even killing them, who would otherwise not be seriously ill at all? Who is benefiting from the emphasis on drug treatment? Are there any alternatives?*

***What are the effects of these highly toxic drugs, and how have they been tested before being administered?***

When we hear in the media about people who are living with HIV and AIDS, the discussion is most frequently centered around treatment. Those who have been diagnosed as being HIV-positive are advised immediately to take chemotherapeutic drugs such as AZT or drug cocktails known as protease inhibitors. These incredibly expensive drugs involve a highly regimented schedule. We often hear about people who are struggling to gain access to these drugs to "save" their lives. We have been told that these drugs offer the only prospect for survival and that everyone who has HIV or AIDS needs these drugs. Yet these drugs do not cure AIDS – the research

literature does not even pretend they do – and they have severe adverse effects, many of which are similar to the symptoms ascribed to AIDS itself.

What generally goes unquestioned is the safety and value of these drugs. How have they been tested before being marketed? There is conclusive documentation that the trials for AZT contain flawed data and that the trials were cut short before long-term effects could be known (Lauritsen, 1993: 381-398). Beyond this, the *known* toxicity of AZT is of real concern, for any human being, but especially when its use is proposed for pregnant women. We know the vulnerability of the mother and her developing fetus, and as a result pregnant women are discouraged from smoking, drinking and even therapeutic use of patent medicines and prescription drugs – all to protect her own health and that of her unborn child and infant. Yet now we would force powerful toxins like AZT on the mother and baby as a prophylaxis?

This seems absurd, and even more so since scientific studies have pointed towards a similarity between AZT and DES – diethylstilbestrol (Avicenne 1996: 86-102). DES is a synthetic estrogen that was used in Canada for prevention of miscarriage between 1941 and 1971. When it was withdrawn from the market in 1971, scientists knew that it had direct health impacts, including a risk for vaginal cancer, on the daughters whose mothers had taken DES during pregnancy. We question why this information about the link between DES and AZT compounds has not meant a radical re-examination of the therapeutic value of AZT use in pregnant women and their children.

Many women's groups have sought the inclusion of more women in clinical trials for HIV drugs, emphasizing that the side-effects appear to be very different for women than for men. Perhaps we should instead question why clinical trials should be done with women or men at all, when the research thus far has not attempted to determine the long-term effects of these drugs in any systematic way, and to the extent that their effects are known, they are known to be deleterious, and potentially deadly.

A good example of these problems was highlighted recently in *The Ottawa Citizen*. The article pointed to our flawed system of approving and administering HIV drugs before the adverse side effects, particularly for women, are known. Maggie Atkinson, an HIV-positive woman who was offered a new drug cocktail, reported that her body began to change after taking the drugs: "her arms and legs started wasting away; her breasts became enlarged; her body fat got redistributed; her period came twice a month" (Foot, 1998: A5). Ms. Atkinson and a group of women with the Canadian AIDS Society criticized Health Canada for allowing the drugs to enter the market before the side effects were documented. They noted that there is no system in Canada that ensures that long-term studies of the drugs are carried out to determine their adverse effects.

Once a drug is licensed and marketed, pharmaceutical companies monitor the effects of drugs only on an ad hoc basis through sporadic reports from physicians and on-going clinical trials. Often doctors don't report unexpected side effects, either because they are not sure that the cause of the side-effect is due to a specific drug, or because the reporting process is too time-consuming.

In any case, there has not been much discussion on the long-term effects of drug treatments on AIDS itself. We know that misuse or overuse of antibiotics leads to drug resistance, the development of virulent strains which cannot be treated, and to severely compromised immune systems. How will AIDS treatment affect the "opportunistic" diseases from which people with an AIDS diagnosis actually suffer? The side effects of the drugs cause many to end treatment – side effects such as metabolic disorders, body changes like swollen abdomen and breasts, severe weight loss, soaring cholesterol levels and diabetes. Doctors have noted that many patients rationally end treatment, largely, in the words of one patient, because "sometimes battle fatigue just comes along" (Picard, July, 1998: A6).

### *Could these drugs be killing people?*

The problems with the main anti-viral drug therapy, AZT, are massive. AZT is, in fact, a cause of death in HIV-positive people (Lauritsen, 1993: 71-86). As Christine Maggiore reports:

> AZT is not a new drug. It was not created for the treatment of AIDS and is not an anti-viral. AZT is a chemical compound that was developed – and abandoned – over 30 years ago as a chemotherapy treatment for cancer.

> As we know, chemotherapy works by killing all growing cells in the body. Many cancer patients do not survive chemotherapy due to its destructive effects on the immune system... AZT was designed to prevent formation of new cells by blocking the development of DNA chains. In 1964, experiments with AZT on mice with cancer showed that AZT was so effective in destroying healthy growing cells that the mice died of extreme toxicity. As a result, AZT was shelved and no patent was ever filed. Twenty years later, the pharmaceutical company Burroughs Wellcome (now Glaxo Wellcome) [took out a patent and] began a campaign to re-market AZT as an anti-viral (anti-HIV) drug and won FDA approval for its use as an AIDS treatment after one highly flawed study of only four months duration... In addition to destroying T Cells, B Cells and the red blood cells that carry oxygen throughout the body, AZT and other nucleoside analog drugs destroy the kidneys, liver, intestines, muscle tissue, and the central nervous system (Maggiore, 1997: 14-15).

1984

The lack of efficacy of available AIDS drugs has led researchers to the widespread belief that, "...a safe and effective vaccine remains the single most important scientific goal in AIDS research, for it offers the only realistic strategy for stopping the worldwide epidemic" (*Montreal Gazette*, July 3, 1998: B7). However, the same report suggests that research on AIDS vaccines to date have shown them to be both unsafe and ineffective. Given the many questions that exist in the scientific community about the way HIV is transmitted and the factors underlying the onset of disease, the drive towards finding a vaccine appears premature and potentially unfounded (Verey-Elliott, 1997: 6-7). Who would be the target groups for receiving such a vaccine if it existed? Would a vaccine be appropriate for the general population? Would certain marginalized groups be pressured to use the vaccine against their will? We know that already the prime targets for testing are people in Africa and Asia, where some trials have already been allowed to proceed.

***Who is benefiting from the emphasis on drug treatment?***

How much is the drive for profit a factor in advocating drug therapy? Pharmaceutical companies have much invested in marketing their treatments for AIDS. Inevitably, and often unwittingly, the medical profession itself is a primary vehicle to improved pharmaceutical sales, since advice to patients for earlier or increased use of pharmaceutical treatments – even without adequate testing – increases sales and profit for the companies that produce these agents. And despite the toxicity of AIDS drugs, HIV-positive people, including those with no symptoms of disease, are increasingly being told to begin early drug treatment.

Joan Shenton reveals astonishing figures in her book, *Positively False – Exposing the Myths around HIV and AIDS*. She describes how governments have spent thousands of millions of dollars on AIDS since 1984 – some US$40 billion of public money. "With $40 billion spent in 14 years in the U.S. alone, it is the biggest industry next to the defense department" (Shenton, 1998: 31, 246).

Shenton believes the AIDS establishment is at least partly driven by money. The sale of HIV test kits has become a source of immense revenue. Each time blood is tested, it means about Cdn$1.00 for the company producing the kit. "Many scientists researching the AIDS virus themselves had companies selling test kits and owned millions of dollars in company shares. AIDS for these individuals was a very profitable business" (Shenton, 1998: 15). Gallo and Montagnier, the two scientists who claimed discovery of the HIV virus, worked out a settlement where they agreed to "split the royalties from the blood test kits. By 1994, those royalties had amounted to $35 million" (Shenton, 1998: 47). Gallo holds thirteen U.S. patents and has applied for twenty-nine others. He will split the profits 50-50 with his employers, the University of Maryland. The royalties from HIV test kits were providing Montagnier's employer, the Pasteur Institute, with a steady 5 percent of its funding. The sales of diagnostic and monitoring kits totaled more at $186 million in 1995 in the U.S. alone and were predicted to rise by 50 per cent within five years (Hodgkinson, 1998: 2).

The greatest profit is made by the pharmaceutical companies which produce drug therapies for not only those people diagnosed with AIDS, but also those who have merely tested positive for HIV but remain symptom-free. By 1997, cumulative worldwide sales of Glaxo Wellcome's AZT, the first "anti-HIV drug", had exceeded $2.5 billion

(Hodgkinson, 1998:2). Canadian researchers have calculated that providing drug cocktails to everyone in the world with HIV-AIDS who would supposedly benefit from treatment would cost US$36 billion annually. A three-drug cocktail would cost US$24 billion to distribute to patients in Africa, another $7 billion in Asia, $4 billion in the Americas and almost $1 billion in Europe (Picard, May 4, 1998: A5). The three-drug cocktail costs one person about Cdn$11,000 per year. Ontario residents following these regimes have to cover many of these high drug costs themselves (see Box 1).

***Are there alternatives?***

Little attention is given to the underlying factors of poverty and poor social and economic conditions that have a direct and dramatic impact on health conditions and on people's immune systems, or to the social justice measures that could radically reduce people's vulnerability to immuno-suppression and easily-preventable diseases (Murphy, 1994, 1995). Most money that goes into AIDS research is focused on the biomedical link between HIV and AIDS, rather than on examining the socio-economic causes of chronic immuno-deficiency, whether in the industrialized North or in the nations of the South. In the South, where pervasive poverty increases the likelihood of the breakdown of already weakened immune systems, the use of toxic drugs like AZT to treat HIV – rather than employing other remedial public health and economic measures – is even more questionable than it is in the industrial nations of the North. But increased use of AZT is exactly what is transpiring, as Glaxco Wellcome makes the drug available at a much lower cost – often reduced by 50 to 75 percent – through subsidized programs with local governments in developing countries. In any other case this would be called drug dumping (Marais, 1999: 1).

Box 1

**The cost of AIDS treatment in Ontario**

According to a study published by the Globe and Mail (May 4, 1998), it costs $18,140 to treat a person living with HIV or AIDS in Ontario. About half goes to drugs, and one-quarter each to formal care (doctors, hospitals) and community care (mostly home care). Even though Canadians are supposed to enjoy universal health care, only about half the costs are covered by these programs. Sunnybrook research found that average out-of-pocket expenses for people with HIV-AIDS are close to $5,000 annually. Much of that is spent on drugs as well as supplements (many necessitated by the side effects of the cocktails) as well as physical therapy and home care.

# 6. Reflections on the Construction of Knowledge about AIDS

## Common Knowledge

*The medical profession and the media provide the public with all the information about AIDS that is available.*

## Uncommon Questions

*Does the public have access to alternative information about AIDS? Who controls how we understand AIDS? What if they are wrong?*

### *Does the public have access to alternative information about AIDS?*

Those people who have claimed that HIV does not cause AIDS or is not the sole cause of AIDS – and the numbers within the medical community are growing – have been vilified by both the medical establishment and the media. The most famous "heretics" in the HIV=AIDS theory – experts such as Root-Bernstein, Duesberg, Papadopulos-Eleopulos and the Perth Group, Mullis – all have impeccable credentials. Despite their record of excellence and scientific rigour, these scientists face severe criticism and are ostracized by the scientific establishment. Efforts to silence these and other scientists have been intense. They have lost funding and the respect of their peers and they find it difficult to publish in mainstream scientific and medical journals (Duesberg, 1996: 396; Horton, 1996).

Given the repercussions to outstanding scientists who have questioned AIDS orthodoxy, it is no wonder that others are nervous about making similar claims. When we at WHI began to think about some of these issues, we were very apprehensive about delving into this area, and particularly to entertain critiques of the HIV=AIDS connection. Grappling with these questions has not been easy, particularly in an environment where to ask a question, to express doubt, is tantamount to heresy. Still, even though at times we have felt insecure in our own course, we continue to ask the questions that need to be asked and seek answers that can increase our understanding. We believe that debate and the investigation of alternative views of AIDS, its causes, treatment and prevention, are essential. It is through healthy debate that the most appropriate health policies are promoted, particularly where treatment involves toxic and experimental drugs.

### *Who controls how we understand AIDS?*

The medical-pharmaceutical industry is a powerful force rarely questioned by the media, or other institutions in society or the public. Healthy debate and adherence to accepted scientific protocols is often considered unnecessary, redundant, and even a threat to public health. This is particularly evident with AIDS. Because powerful scientific institutions and individuals believe they already have an acceptable answer, alternative investigation of AIDS is seen as diversionary and discredited. For the most part, the media uncritically perpetuate many of the myths surrounding AIDS and are reluctant to publish alternative views. As a result, mainstream media coverage of critical voices is rare.

### *What if they are wrong?*

While examining the reality of AIDS is necessary, we have not asked these questions simply to determine the truth. We would not have had the courage to do that.

What has kept us going in this inquiry is the simple question, "What if they are wrong?" We realize that if the common definitions, assumptions and solutions to AIDS are wrong, or even distorted, the life and death consequences are enormous. If prevailing AIDS theory is wrong, then resources are being diverted from real needs. More importantly, the conventional solution, AZT and other drugs, are harming people, not healing them. For us, then, this investigation is about social justice and human rights. We are asking these difficult questions because silence is no longer an acceptable alternative.

# III. Policy Implications

While we ask questions about the causes of and solutions to AIDS as it is currently defined, we also know that people are dying – whatever the causes – and that solutions need to be found. Our research has led us to the conclusion that current approaches are inadequate, and we advocate for greater attention to the root causes of immune deficiency. From a public health perspective there needs to be a re-focusing of attention on issues of poverty, empowerment, drug use, social infrastructure and other determinants of health. All health problems, including AIDS, will remain a problem as long as communities face problems of poverty, malnutrition, drug abuse, and lowered health status. Governments, health authorities, and communities themselves need to address long-term solutions to health problems as a first line of action. A number of policy recommendations are implicit in our analysis. They include:

- Government and private sector research funds should be directed towards alternative theories and treatments for AIDS, including the multi-factor causation theory. Research into alternative and holistic interventions should be supported. Research on specific anti-viral therapies, including vaccines, should cease until the role of HIV in AIDS is understood.
- Research should be conducted on the toxic effects of AIDS drugs and the effects on the immune system from multiple infection, IV drug use, blood transfusions and malnutrition.
- All testing should be voluntary, and involve intensive counselling. Under no circumstances should mandatory testing be introduced, or testing be imposed on an individual or a group. Such testing increases the probability of discrimination, forced treatment and other human rights violations. In the context of highly unreliable testing, and questions concerning the relationship between HIV and AIDS, such violations can never be justified on public health grounds.
- There should be no screening for HIV, particularly for pregnant women or for immigration purposes, until problems of accuracy, reliability, standardization and specificity are addressed.
- HIV self-testing kits should be banned. These kits are extremely unreliable and the consequence of receiving a positive diagnosis can result in severe psychological and physical consequences.
- True informed consent should be promoted by requiring that alternative treatment be presented as well as full disclosure of the toxic and long-term effects of drug therapy for AIDS, as well as the consequences of refusing treatment.
- Pregnant women, including those identified as HIV-positive, should have fully-informed choice regarding drug therapy and method of delivering their child.
- The Canadian health protection system should be strengthened and actively enforced to protect the safety of Canadians, particularly with respect to drug approval processes.
- Reporting by physicians and pharmaceutical companies of adverse drug effects should be systematic and mandatory, not voluntary, and criminal sanctions for liability in cases of injuries through negligence and corruption must be maintained.
- Direct-to-consumer advertising of prescription drugs should be prohibited.
- Breastfeeding should be encouraged for all women. The risk of transmission of HIV compared to the risks of not breastfeeding should be fairly portrayed. Women should have access to all information regarding the consequences of having a positive test for HIV, including the material provided in this paper. The World Health Organization (WHO) Code of Marketing for Breastmilk Substitutes should be monitored and enforced in all countries.
- Official Development Assistance (ODA) should prioritize eradication of poverty. Budgets for health should be reflective of the true needs identified by the recipients and current levels of funding for AIDS should be reassessed in light of this information. In particular, ODA money should not be diverted from primary health programming to AIDS work.

- Public education programs and medical practitioners should impart a broad view of health and the multiple factors that affect the immune system so that prevention of immune deficiency can be enhanced.
- Governments and international organizations should critically examine the statistics on AIDS reported in Canada and worldwide. Existing contradictory statistics bring into question the reliability of these numbers and highlight the problem of formulating policies based on these figures. Governments should re-assess whether AIDS is an epidemic in their countries, and globally, and revise their policies accordingly.

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# Appendix A

## Alternative Activists, Theories and Organizations

*Bialy, Harvey*, a molecular biologist, worked for many years as a tropical disease expert and is now the science editor of *Bio/Technology*. He believes that "AIDS death" in Africa is caused by poverty-linked diseases like TB, whose deadliness is exacerbated when people mistakenly diagnosed HIV-positive are denied proven conventional treatment for their already well-known diseases – TB, malaria, parasitic infections; and that much needed funding is being diverted to AIDS and away from treating these conventional diseases (Shenton, 1998: 155-160).

*Duesberg, Peter*, a professor of molecular and cell biology at the University of California, and a renowned pioneer in retrovirus research, challenges the HIV-causes-AIDS hypothesis and advocates for research funds into other explanations for AIDS. Duesberg argues that HIV is a harmless hitch-hiker unable to cause AIDS because: there are very low levels of HIV in the body, which never rise, even in advanced AIDS; there are too few infected cells in the body for HIV to cause disease; the latency period, from infection with HIV to full-blown AIDS, is unprecedented in any viral disease, is inexplicable within prevailing viral theory, and inconsistent with what is known of viral behaviour and effects; there are many cases of HIV infection with no AIDS; and 10 percent of diagnosed AIDS cases have no sign of antibodies to HIV (Duesberg, 1996; Shenton, 1998:11). Duesberg also does not believe that AIDS is an infectious disease, because it does not adhere to Koch's 4 postulates for infectious diseases. Instead he believes that AIDS results from toxic agents. He believes that the immune system is weakened by co-factors including the recreational use of amyl nitrates, intravenous drug abuse, repeated infections, and malnutrition. Once the immune system is deficient, opportunistic infections invade the body. His book, *Inventing the AIDS Virus* (1996) and the following articles explain these arguments. See:

Duesberg, Peter, "Retroviruses as carcinogens and pathogens: expectations and reality" in *Cancer Research*, Vol. 47, no. 5, CNREA 8, 1 March 1987, pp. 1199-1220.

Duesberg, Peter, "AIDS epidemiology: inconsistencies with human immunodeficiency virus and with infectious disease", in PNAS, Vol. 88, February 1991, pp. 1575-9.

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A very useful summary of Duesberg's perspective on the causal relationship between AIDS and drug use can be found in Duesberg, Peter, and David Rasnick, "The Drug-AIDS Hypothesis", a supplement insert to *Continuum*, Vol. 4, No. 5, February/March, 1997, pp. 1-24.

More information about Dr. Duesberg's research can be found at: www.duesberg.com

*Farber, Celia* is a journalist who has researched and written many articles challenging the AIDS orthodoxy which were, for many years, published in *Spin* magazine. She now writes for several periodicals, including a regular column in the webzine, *Impression*. In an article written for *Mothering*, Farber comprehensively outlines the flawed process for adopting AZT for the treatment of AIDS and pregnant women who are HIV positive. Farber clearly documents the toxic effects of AZT therapy and the potential dangers to pregnant women. She also reviews the critique that HIV causes AIDS and the research that demonstrates that HIV tests are inaccurate. Farber's regular column in *Impression* can be found at: www.impressionmag.com/aids.html. See:

Farber, Celia, "AZT Roulette. The Impossible Choices Facing HIV-Positive Women", in *Mothering*, September-October, 1998, pp. 53-65.

*Griffiths, Mark*, a musician, tested HIV-positive in 1986 while staying at a detoxification centre in Switzerland. He relates his positive test result to a decade of alcohol and heroine addiction and his self-destructive life as a rock musician. Since his diagnosis he has transformed his life, improved his nutrition and his general emotional health. When in 1990 he found out about Duesberg and other scientists confronting the HIV/AIDS paradigm, he was confirmed in what he intuitively knew all along. He remains in good health and works at making alternative AIDS theories known in France. His story can be read on the web site: perso.wanadoo.fr/sidasante/temoigna/temmarkg.html

*Lanka, Stefan*, is a member of a group of retired scientists who formed a Study Group on Nutrition & Immunity, to study emerging fields of science, and they challenge the virus – AIDS hypothesis. Lanka's article, "HIV: reality or artifact?" (*Continuum*, Vol. 3, no. 1, April/May, 1995) presents the Alfred Hassig (Berne) group's opinion on the cause of AIDS. They say that AIDS is the result of a persistent stress response, shifting the metabolism of the body into a state of assault on the immune system which the body cannot sustain, resulting in chronic whole body inflammation, causing antibodies to be formed against proteins from the body's own cells. These are the antibodies that have become interpreted as HIV antibodies. They say the inflammatory response involves the neuroendocrine system much like other autoimmune disease such as SLE (lupus), and isn't viral at all. They are opposed to drug treatment and suggest practical ways of helping people with this phenomena – reducing stress, controlling inflammatory response, ensuring good nutrition and avoiding recreational/street drugs (Shenton, 1998: 225). See:

Conlan, Mark G., "Interview with Stefan Lanka, Challenging both Mainstream and Alternative AIDS Views", *Newsmagazine*, December 1998. This article about the virologist, biochemist and evolutionary biologist, describes Lanka's discoveries and viewpoints about HIV in easily understandable terms. It explains why Lanka believes that all so-called retroviruses are actually the body's own creations; that hepatitis is an autoimmune disorder rather than a viral disease; that AIDS has nothing to do with immune suppression and that it should actually be called Acquired Energy Deficiency Syndrome – AEDS – because its true cause is a breakdown of the immune system itself. This interview can be found on the Rethinking AIDS homepage at: www.virus-myth.com/aids/data/mgglanka.htm

Also see: A. Hassig, et. al., "Errors on pathogenesis, prevention and treatment of AIDS", *Continuum*, Vol. 5, No. 4, Summer 1998, pp. 28-29.

*Passi, Siro*, is a biochemist, presently Scientific Director of the Pathophysiology Laboratory of the St. Gallicano Research Institute (Rome). Over the past two decades he has published many papers on oxidative stress and its adverse consequences in different pathologies. On the basis of his studies on HIV positive and AIDS patients, he asserts that HIV phenomena are the outcome of oxidative stress, and not vice versa. He says there are multiple factors capable of inducing oxidative stress and leading to immunosuppression: recreational drugs including amphetamines, nitrates, heroin, cocaine, alcohol, cigarette smoke, etc.; medication drugs, including antiviral, antimicotic, antibiotic, chemotherapeutic, and other drugs. He argues that malnutrition/denutrition, poor sanitation, and parasitic infections represent the main causes of African AIDS. See:

Passi, Siro, "Progressive Increase of Oxidative Stress in Advancing Human Immunodeficiency", *Continuum*, Vol. 5, No. 4, Summer, 1998, pp. 20-26.
Passi, Siro, and Chiara de Luca, "Dietic Advice for immunodeficiency", in *Continuum*, Vol. 5, no. 5, Winter, 1998-99.

*Papadopulos-Eleopulos, Eleni*, is a bio-physicist from the University of Western Australia,and the Chairperson of IFAS (International Forum for Accessible Science). She leads a research team that argues for a reappraisal of HIV and its role in AIDS. The Perth group contends that antibody proteins are not specific to HIV and are probably endogenous (part of the body itself) and may increase when the body is under

severe immunological stress. They argue that because HIV has never been isolated according to the Pasteur Institute's criteria of 1973, it may not exist at all. See:

Papadopulos-Eleopulos, Eleni, V. F. Turner, J.M. Papadimitriou et al. "HIV Antibodies: Further Questions and a Plea for Clarification", in *Medical Research and Opinion*,Vol. 13, 1997, pp. 627-634.

Papadopulos-Eleopulos, Eleni, "Factor VIII, HIV and AIDS in haemophiliacs: an analysis of their relationship", in *Genetica*, Vol. 95, 1995, pp. 25-50.

Papadopulos-Eleopulos, Eleni, "Is a positive Western blot proof of HIV infection?", in *Bio/Technology*, Vol. 11, June, 1993.

Papadopulos-Eleopulos' views on the false link between HIV and haemophilia are reviewed by Christine Johnson, in "Bad blood or bad science: are haemophiliacs with AIDS diagnoses really infected with HIV?", in *Continuum*, Vol. 5, No. 4, Summer 1998, pp. 32-36. The same issue contains an essay by Papadopulos-Eleopulos and her Perth colleagues on "Oxidative stress, HIV and AIDS", reprinted from *Research in Immunology*, No. 143: 145-148, Paris 1992. See also:

"Is HIV the cause of AIDS?", an interview by Christine Johnson with Eleni Papadopulos-Eleopulos, in *Continuum*, Vol. 5, No. 1, 1997.

More information and references can be found at: www.virusmyth.com/aids/perthgroup.index.html

*Root-Bernstein, Robert*, held the MacArthur Prize fellowship (known as the MacArthur "genius" award) from 1981-1986, and is associate professor of physiology at Michigan State University. In his book, *Rethinking AIDS. The Tragic Cost of Premature Consensus* (1993), Root-Bernstein reviewed the entire existing body of AIDS research to that point. Root-Bernstein believes that HIV cannot be the sole cause of the immune-suppression found in AIDS patients. He argues that co-factors are necessary for AIDS, and that they alter its course (1993: 337). He shows that many people infected with HIV remain healthy and sometimes HIV positive people even rid themselves of the virus; that sexual transmission is extremely difficult and rare – female prostitutes virtually never contact HIV unless they also use drugs; and that the predicted heterosexual epidemic has not come about. Root-Bernstein presents a "multi-factorial" model of AIDS, which views the disease as resulting from numerous insults to the immune system itself. He identifies co-factors such as illicit and prescription drug use, sexual promiscuity, anal exposure to semen, transfusions, malnutrition, or multiple infections (1993: 338). He argues that a person's life-circumstances (socio-economic) and behaviours are a much more important factor in determining a person's susceptibility to developing AIDS than is commonly accepted in the medical community. Thus he focuses on specific controllable factors that increase risk of AIDS. He advocates for more research into the various co-factors and their effects on our health. See:

Root-Bernstein, Robert, *Rethinking AIDS. The Tragic Cost of Premature Consensus*, The Free Press, New York, 1993.

Root-Bernstein, Robert, "Misleading Reliability", in *The Sciences*, The New York Academy of Sciences, March/April 1990, pp. 6-8.

*The Group for the Scientific Reappraisal of HIV/AIDS Hypothesis* is a group of 500 scientists and health professionals, whose purpose is to study and challenge the AIDS orthodoxy, founded by Dr. Charles Thomas and Dr. Peter Duesberg and includes Dr. Kary Mullis, Chemistry Nobel Prize winner (Shenton, 1998: 12, 33). This group produces a monthly newsletter called *Reappraising Aids*.

Articles by many of the members of the group and other interesting information challenging the HIV=AIDS paradigm can be found on the group's Rethinking AIDS homepage at www.virusmyth.com/aids. Subscription information as well as an index of issues can be found at:

www.virusmyth.com/aids/reappraising/index.html.

*Health Education AIDS Liaison* (HEAL) is a non-profit education network committed to increasing public awareness of important information not made available by AIDS service agencies and unacknowledged by most media. HEAL's mission is to inform people of the evidence that the HIV=AIDS Hypothesis is false. HEAL asserts that "anti-viral" drugs, claimed to eradicate HIV, are harmful and dangerous. HEAL supports people who have been labeled HIV-positive by assuring them that their diagnosis is not a death sentence. HEAL encourages people to EXPECT HEALTH and pursue holistic, non-toxic approaches to the prevention and treatment of disease.

The HEAL Los Angeles homepage with lots of information can be found at: www.epcnet.com/heal

There is also a dynamic HEAL chapter in Toronto. HEAL Toronto's pamphlet is available from tel/fax 416-406-4325; email: endaids@hotmail.com. The HEAL Toronto homepage is at: www.geocities.com

The French HEAL affiliate, called A.M.G. can be found at: perso.wanadoo.fr/sidasante

The *International Coalition for Medical Justice* fights for the rights of consumers and parents to reclaim responsibility for their own health without government intrusion into the decision making. They insist on accountable scientific and medical research and try to help people make "true" informed decisions rather than simply trust the hypotheses set forth by the CDC and NIH. The ICMJ Legal Defense Fund offers patients, families and parents legal information, advice and funding, and the Fund will also establish an initiative in the United States to hold all health departments and medical practitioners to standards as they relate to testing, the toxic effects of conventional treatment and the "true" cause of AIDS and other diseases and conditions. ICMJ can be reached at 540-829-9350, or by e-mail at icmjustice@yahoo.com; their websites are www.icmj.org or www.tripod.members/ICMJ/

*International Forum for Accessible Science* (IFAS) is an umbrella group which has brought together scientists, gay health activists and human rights workers to highlight radical challenges to current AIDS research, diagnosis, and treatment strategies.

*International Long Term Survivors Network (HIV/AIDS)* has been established to link and support people living with HIV for seven years and longer without recourse to anti-HIV pharmaceutical drugs, and to do research on alternative measures to maintain health. The Network is currently conducting what it has called the International Community Collaborative Long Term Survivor Survey. People wanting information about the network or to participate in the survey, can contact Clair Walton, the Network coordinator, through *Continuum*.

*The Alberta Reappraising AIDS Society* (ARAS) was "formed to challenge the myth that HIV is the cause of AIDS and to provide information to Albertans that will ensure that they realize that HIV tests are inaccurate, that AIDS is caused by exposure to toxic or immune-suppressive substances, and that anti-HIV drugs are extremely toxic, can cause AIDS, and may be fatal." ARAS President, David Crowe can be reached at crowed@cadvision.com or (403) 289-6609.

*Continuum* is A UK-based magazine edited by Huw Christie, which promotes an open discussion of a wide variety of views on the causes of AIDS, and the consequences of orthodox views and treatments, as well as news of alternatives. The address for subscriptions is *Continuum*, Rear Unit 4, IA Hollybush Place, London E2 9QX, phone 44-171-613-3909, fax 613-3312, email continu@dircon.co.uk. An index o issues and subscription information can be found at www.continuum.org or www.virusmyth.com/aids/continuum/index.html

*Médecines Nouvelles* is a French critical alternative health quarterly with articles on a wide range of studies and criticisms of the conventional medical system, including toxicity of vaccines, death and illness caused by pharmaceuticals, and alternative approaches to different diseases. Every issue contains one or more articles on AIDS, ranging from French translations of articles by Duesberg and Lanka, to a critique of AZT toxicity by Dr J. Avicenne, a physician and *conseiller médical* with "Positifs", an organization of "angry HIV-positive people" (as they call themselves).

*Médecines Nouvelles* can be contacted at: www.positifs.org. The magazine, *Médecines Nouvelles*, can be obtained from: B.P. 2, 14130 Blangy-le-Chateau, France, tel: 31.64.63.00.

A French alternative AIDS activist website can be found at: perso.wanadoo.fr/sidasante

*IDEAS About AIDS* is an extensive series of excellent radio documentaries on AIDS dissent and alternative AIDS theories broadcast by the Canadian Broadcasting Corporation (CBC) program "CBC Ideas" between 1987 and 1999. The series, which has won awards from the Canadian Science Writers Association, has been produced by a brilliant and courageous team of journalists led by Max Allen and Colman Jones. All transcripts, including extensive bibliographies, are available from CBC Radio at: Ideas Transcripts, CBC, Box 500, Stn. A, Toronto, Canada, M5W 1E6, or by email from ideastran@toronto.cbc.ca. For more information and extensive resource lists, see: www.radio.cbc.ca/ programs/ideas/Aids/index/html.

# Appendix B

## Chronology of Centres for Disease Control's AIDS Definitions

(Duesberg, *Inventing the AIDS Virus*, pp. 210-211)

| Year | Diseases | HIV Antibody |
|---|---|---|
| 1983 | **Protozoal and helminthic infections** | |
| | 1. Cryptosporidiosis, intestinal, causing diarrhea for more than a month | |
| | 2. Pneumocystis carinii pneumonia | |
| | 3. Strongyloidosis, causing pneumonia, central nervous system (CNS) infection or disseminated infection | |
| | 4. Toxoplasmosis, causing pneumonia or CNS infection | |
| | **Fungal infections** | |
| | 5. Candidiasis, causing esophagitis | |
| | 6. Crytococcosis, causing CNS or disseminated infection | not required |
| | **Bacterial infection** | |
| | 7. "Atypical" mycobacteriosis, causing disseminated infection | |
| | **Viral infection** | |
| | 8. Cytomegalovirus, causing pulmonary, gastrointestinal tract, or central nervous system infection | |
| | 9. Herpes simplex virus, causing chronic mucocutaneous infection with ulcers persisting more than a month or pulmonary, gastrointestinal tract, or disseminated infection | |
| | 10. Progressive multifocal leukoencephalopathy (presumed to be caused by a papovavirus) | |
| | **Cancer** | |
| | 11. Kaposi's sarcoma in persons less than 60 years of age | |
| | 12. Lymphoma, primary of the brain | |
| 1985 | 13. Histoplasmosis | |
| | 14. Isosporiasis, chronic intestinal | |
| | 15. Lymphoma, Burkitt's | |
| | 16. Lymphoma, immunoblastic | required |
| | 17. Bronchial or pulmonary candidiasis | |
| | 18. Chronic lymphoid interstitial pnemonitis (under 13 years of age) | |
| 1987 | 19. Encephalopathy, dementia, HIV-related | |
| | 20. Mycobacterium, tuberculosis any site extrapulmonary | |
| | 21. Wasting syndrome, HIV-related | required |
| | 22. Coccidiomycosis, disseminated or extrapulmonary | |
| | 23. Crytococcosis, extrapulmonary | |
| | 24. Cytomegalovirus, other than liver, spleen, or nodes | |
| | 25. Cytomegalovirus retinitis | |
| | 26. Salmonella septicemia, recurrent | |
| 1993 | 27. Recurrent bacterial pneumonia | |
| | 28. Mycobacterium tuberculosis any site (pneumonia) | |
| | 29. Pneumonia, recurrent | |
| | 30. Invasive cervical cancer | required |
| | 31. T-cell count less than 200 cells per microliter or less than 14 percent of the expected level. | |

# Appendix C

## Provisional World Heath Organization Clinical Case Definition for AIDS (Bangui)

(The following information is quoted from Chirimuuta, Richard and Rosalind, pp. 171-172, who referenced WHO's *Weekly Epidemiological Record* No. 10, March 7, 1986, page 71.)

A *clinical* case definition is needed in countries where diagnostic resources are limited. A provisional clinical case definition was developed at a WHO Workshop on AIDS held in Bangui, Central African Republic, 22-24 October, 1985. This definition was reviewed and slightly adapted at the Second Meeting of the WHO Collaborating Centres on AIDS as follows:

### Adults

AIDS in an adult is defined by the existence of at least 2 of the major signs associated with at least 1 minor sign, in the absence of known causes of immunosuppression such as cancer or severe malnutrition or other recognized etiologies.

1. *Major signs*
   (a) weight loss > 10% of body weight;
   (b) chronic diarrhoea > 1 month;
   (c) prolonged fever > 1 month (intermittent or constant).

2. *Minor signs*
   (a) persistent cough for > 1 month;
   (b) generalized pruritic dermatitis;
   (c) recurrent herpes zoster;
   (d) oro-pharygeal candidiasis;
   (e) chronic progressive and disseminated herpes simplex infection;
   (f) generalized lymphadenopathy.

The presence of generalized Kaposi's sarcoma or cryptococcal meningitis are sufficient for the diagnosis of AIDS.

### Children

Paediatric AIDS is suspected in an infant or child presenting with at least 2 of the following major signs associated with at least 2 of the following minor signs in the absence of known causes of immunosuppression such as cancer or severe malnutrition or other recognized etiologies.

1. *Major signs*
   (a) weight loss or abnormal slow growth;
   (b) chronic diarrhoea > 1 month;
   (c) prolonged fever > 1 month.

2. *Minor signs*
   (a) generalized lymphadenopathy;
   (b) oro-pharygeal candidiasis;
   (c) repeated common infections (otitis, pharyngitis, etc.);
   (d) persistent cough;
   (e) generalized dermatitis;
   (f) confirmed maternal LAV/HTLV-III infection.

# Appendix D

## Factors Known to Cause False-Positive HIV Antibody Tests Results

Anti-carbohydrate antibodies[52, 19,13]
Naturally-occurring antibodies[5,19]
Passive immunization: receipt of gamma globulin or immune globulin (as prophylaxis against infection which contains antibodies)[18, 26, 60, 4, 22, 42, 43, 13]
Leprosy[2, 25]
Tuberculosis[25]
Mycobacterium avium[25]
Systemic lupus erythematosus[15, 23]
Renal (kidney) failure[48, 23, 13]
Hemodialysis/renal failure[56, 16, 41, 10, 49]
Alpha interferon therapy in hemodialysis patients[54]
Flu[36]
Flu vaccination[30, 11, 3, 20, 13, 43]
Herpes simplex I[27]
Herpes simplex II[11]
Upper respiratory tract infection (cold or flu)[11]
Recent viral infection or exposure to viral vaccines[11]
Pregnancy in multiparous women[58, 53, 13, 43, 36]
Malaria[6, 12]
High levels of circulating immune complexes[6, 33]
Hypergammaglobulinemia (high levels of antibodies)[40, 33]
False positives on other tests, including RPR (rapid plasma reagent) test for syphilis[17, 48, 33, 10, 49]
Rheumatoid arthritis[36]
Hepatitis B vaccination[28, 21, 40, 43]
Tetanus vaccination[40]
Organ transplantation[1, 36]
Renal transplantation[35, 9, 48, 13, 56]
Anti-lymphocyte antibodies[56, 31]
Anti-collagen antibodies (found in gay men, haemophiliacs, Africans of both sexes and people with leprosy)[31]
Serum-positive for rheumatoid factor, antinuclear antibody (both found in rheumatoid arthritis and other autoantibodies)[14, 62, 53]
Autoimmune diseases:[44, 29, 10, 40, 49, 43] Systemic lupus erythematosus, scleroderma, connective tissue disease, dermatomyositis
Acute viral infections, DNA viral infections[59, 48, 43, 53, 40, 13]
Malignant neoplasms (cancers)[40]
Alcoholic hepatitis/alcoholic liver disease[32, 48, 40, 10, 13, 49, 43, 53]
Primary sclerosing cholangitis[48, 53]
Hepatitis [54]
"Sticky" blood (in Africans)[38, 34, 40]
Antibodies with a high affinity for polystyrene (used in the test kits)[62, 40, 3]
Blood transfusions, multiple blood transfusions[63, 36, 13, 49, 43, 41]
Multiple myeloma[10, 43, 53]
HLA antibodies (to Class I and II leukocyte antigens)[7, 46, 63, 48, 10, 13, 49, 43, 53]
Anti-smooth muscle antibody[48]
Anti-parietal cell antibody[48]
Anti-hepatitis A IgM (antibody)[48]
Anti-Hbc IgM[48]
Administration of human immunoglobulin preparations pooled before 1985[10]
Haemophilia[10, 49]
Haematologic malignant disorders/lymphoma[43, 53, 9, 48, 13]
Primary biliary cirrhosis[43, 53, 13, 48]
Stevens-Johnson syndrome[9, 48, 13]
Q-fever with associated hepatitis[61]
Heat-treated specimens[51, 57, 24, 49, 48]
Lipemic serum (blood with high levels of fat or lipids)[49]
Haemolyzed serum (blood where haemoglobin is separated from the red cells)[49]
Hyperbilirubinemia[10, 13]
Globulins produced during polyclonal gammopathies (which are seen in AIDS risk groups)[10, 13, 48]
Healthy individuals as a result of poorly-understood cross-reactions[10]
Normal human ribonucleoproteins[48,13]
Other retroviruses[8, 55, 14, 48, 13]
Anti-mitochondrial antibodies[48, 13]
Anti-nuclear antibodies[48, 13, 53]
Anti-microsomal antibodies[34]
T-cell leukocyte antigen antibodies[48, 13]
Proteins on the filter paper[13]
Epstein-Barr virus[37]
Visceral leishmaniasis[45]
Receptive anal sex[39, 64]



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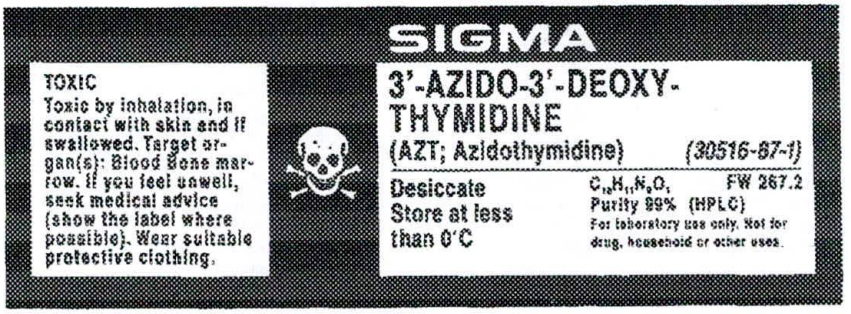
(Johnson, 1996: 5)

# Appendix E

## AZT LABEL




ACTUAL COPY OF AN AZT LABEL

This label has appeared on bottles containing as little as 25 milligrams, a small fraction (1/20-1/50) of a patient's daily prescribed dose*

(*Reference: Physicians Desk Reference 1994, pp. 324)

DIS-2M.2

**Questions and Answers which come to mind regarding the HIV theory of AIDS**

**Q = Question A = Answer**

**Q 1. How is infection with HIV diagnosed?**

**A 1.** By an antibody test. Several proteins, claimed to HIV proteins by HIV experts, are positioned on a narrow cellulose strip, which then is reacted with the patient's blood. If there is a reaction, the reacting proteins appear as a series of horizontal bands. The number and combination of bands necessary to proclaim the patient is infected varies from country to country and even from laboratory to laboratory (see attached Table 1).

**Q 2. What is the proof that the proteins claimed to be HIV are indeed HIV?**

**A 2.** None. In 1983 Luc Montagnier and his team[1], and in 1984 Robert Gallo and his team[2], claimed to have proven the existence of HIV proteins by purifying the virus particles. That is, by obtaining the particles separated/isolated from everything else. In 1997 Montagnier admitted that he had not purified (isolated) HIV and in his view neither did Gallo[3]. By this time there was ample evidence that HIV proteins were proteins of normal cells. The fact that these proteins are cellular proteins found in all of us was proven beyond reasonable doubt in 1997 by some of the best HIV experts[4].

**Q 3. Why do these cellular proteins react with antibodies, which are present in patient sera? (Blood)**

**A 3.** Because people who are in the AIDS risk groups such as gay men, haemophiliacs, drug users as well as people who are infected with different non-HIV agents including mycobacteria have antibodies to their own proteins, that is, auto-antibodies[5, 6,7]. Even if they were unquestionably HIV proteins it doesn't follow the reacting antibodies are also HIV. That's because antibodies meant for one thing regularly latch on to proteins belonging to other things. Sometimes they latch on even harder to other things. So these reacting antibodies could be antibodies that appeared in response to something else. For example, it's been proven that antibodies which appear in response to mycobacterial (such as leprosy and TB) infection and fungal organisms, which between them infect 90% of AIDS patients, react with the proteins in the HIV antibody test[8]. In fact AIDS patients are full of antibodies and react with just about anything you can think of, even laboratory chemicals[5]. But no one says AIDS patients are infected with laboratory chemicals.

**Q 4. Does this mean that a positive antibody test does not prove HIV infection?**

**A 4.** Yes. In fact the manufacturers of the antibody test are telling us exactly this. For example, Abbott Laboratories in their packet inserts state: "At present there is no recognized standard for establishing the presence or absence of HIV-1 antibody in human blood". [9,10]

**Q 5. Why then is everybody with a positive antibody test told that they are infected with HIV, especially when such news is so devastating for both patient and his or her family?**

**A 5.** The HIV experts have never given a valid reason. Perhaps they are so focussed in explaining everything in terms of HIV they cannot see the alternatives.

**Q 6. Is there a way to determine if anyone who has a positive antibody test is indeed infected with HIV?**

**A 6.** Yes. It can be done by determining what relationship exists between a positive antibody and the presence of HIV itself. That is, by simultaneously performing an HIV antibody test and HIV isolation

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purification. This has never been done and could not be done so far because HIV isolation/purification has not been achieved.[11] Although many claims have been made for HIV isolation the correct procedure has never been followed. What the experts call HIV isolation is not distinct from the HIV antibody test. In fact it's an HIV antibody test "done backwards". The difference is that instead of the patient supplying the antibodies (in their blood), and the test manufacturers the proteins (in the test kit): in the "HIV isolation" procedure the protein are present in the cell culture and the test manufacturers supply the antibodies.[12,13] Or rather just one commercially manufactured antibody. So all that's different is the source of the reagents. The purported HIV isolation is still a reaction between a protein and an antibody. And that's an antibody test.

**Q 7. If HIV has not been isolated then what is the proof for its existence?**

**A 7.** There is no proof. It may or may not exist.

**Q 8. What are the pictures purporting to show HIV particles?**

**A 8.** The vast majority of these pictures originate from cell cultures which have been exposed to numerous chemicals.[1, 2] In such cultures these types of particles are commonplace and the HIV experts are fully aware of this.[11] As far as the pictures taken from fresh human tissue are concerned, it is sufficient to mention that particles identical to that called HIV are found as frequently in people who don't have AIDS and are not at risk of getting AIDS as in those who have AIDS.[14] HIV is said to be a specific kind of virus, a retrovirus. Yet all the pictures published so far of "HIV" particles, no particle has bo main characteristics of retroviruses, that is, a diameter of 100 to 120 nm and spikes on their surface.[15]

**Q 9. If there is no proof for the existence of HIV, then what are mothers transmitting to their babies?**

**A 9.** Mothers with "HIV" antibodies have babies that also are found to have "HIV" antibodies. In fact, at birth all their babies have "HIV" antibodies but these are the mother's, not the baby's antibodies. They get into to the baby by crossing the placenta not long before birth. By approximately 2 years of age, only about 15% are left with such antibodies and these are said to be babies who have been infected. That's what the experts lead us to believe and they say those 15% now have their own antibodies, which they made because HIV took hold in that proportion of babies. They're not the mother's antibodies because by then they've all disappeared. But their conclusion creates a very large problem. And it's this: Sure it's true that in the babies the mothers antibodies gradually disappear. That's because the babies metabolise them. Not just the "HIV" variety of antibodies but all the different varieties of antibodies mothers pass to their children before they are born. In fact the disappearance of mother's antibodies is why babies are most susceptible to infections around 3-4 months of age because by this time nearly all the mother's antibodies have gone but the baby still hasn't built up enough of its own. Before the AIDS era it was known that all of the mother's antibodies disappear by nine months of age. And we mean all. At nine months they're zero.[16] And there's no way the body can selectively get rid of the "HIV" variety. The biochemica machinery can't say "You're a measles antibody, I'll get rid of you but you're an HIV antibody, I'll keep you twice as long". To the body an antibody molecule is just another protein (antibodies are all proteins by the way). But the way the "HIV" variety is lost after birth reveals something that doesn't fit. And it's this: If you follow the disappearance of the "HIV" antibodies from birth, it drops from 100% at birth to 75% at 9 months. Then to about 15% at 22 months, which the experts say, is the proof that 15% of babies are infected by their mothers. This means that 60% of children lose the "HIV" antibodies and test negative in an antibody test between 9 and 22 months. So what are the antibodies, which have been lost? Where did they come from? They can't be the mother's because they've all been metabolised by 9 months. They can't be caused by HIV infecting the babies because, according to the experts, if that happens, the antibodies remain for life. So how do you explain it? You can only explain it by saying they're not HIV antibodies at all but other antibodies that reacted in the test. But if that's true for 60% it could be true for all the babies including the 15% left with antibodies at 22 months. And if the tests are false in the babies they are also false in their mothers. And their fathers.[17]

**Q 10. Since the HIV experts admit that the antibody test cannot be used in babies what methods do they use to prove mother-to-child transmission of HIV?**

**A 10.** Two methods are used, namely death and a test that detects "HIV RNA" or "HIV DNA" known as the PCR. When a baby is born to an HIV positive mother, if that baby dies before they can use an antibody test, the baby is said to have died from AIDS caused by HIV transmitted from the mother. PCR is used in many of the studies, which attempt to prove mother-to-child transmission. This test has at least as many drawbacks as the antibody test. For example, a PCR test can revert from a positive to a negative for which the HIV experts have no explanation. Also the specificity of the PCR has never been determined accurately. Even the DNA-PCR, which is said to be more specific than the RNA-PCR, varies from 0 to 100%. [18] For babies, the RNA-PCR is used in an attempt to prove mother-to-child transmission of HIV. However, according to the manufacturer (Roche) of this test, "The Amplicor HIV-1 [RNA] Monitor test is not intended to be used as a screening test for HIV-1 or as a diagnostic test to confirm the presence of HIV-1 infection". [19] And that means in anyone. According to the latest CDC AIDS definition, "In adults, adolescents, and children infected by other than perinatal exposure, plasma viral RNA nucleic acid tests [PCR] should **NOT** be used in lieu of licensed HIV screening tests (e.g., repeatedly reactive enzyme immunoassay)". [20] But surely a test that can NOT be used to prove infection of adults, adolescents and even children (for example, by blood transfusion) will also be invalid to prove mother-to-child transmission of HIV. After all, the experts tell us it's all the same virus.

**Q 11. But doesn't AZT and nevirapine reduce mother-to-child transmission of HIV?**

**A 11.** There is no proof for this. Most of the studies which claim proof that AZT reduce transmission are not randomised, or double-blind and do not have controls.[17] Even the best of them, the ACTG076 has so many drawbacks that no valid conclusions can be drawn.[21] As far as nevirapine is concerned, so far there has been only one study, HIVNET012. [22] Given its design, execution and analysis, it is impossible to draw any valid conclusions.[23] Since all the HIV experts claim that AZT and nevirapine reduce mother-to-child transmission of HIV by reducing viral load, and since neither AZT nor nevirapine have any effect on viral load, then it follows these drugs cannot decrease mother-to-child transmission of HIV.[17, 23] No matter what the reported findings from these studies are, no physician or government can make decisions regarding the use of these drugs for reducing mother-to-child transmission of HIV unless and until the tests used to prove infection are guaranteed to be HIV specific. Including by the manufacturers.

**Q 12. Is HIV sexually transmitted?**

**A 12.** No. Regarding AIDS since 1982, and regarding "HIV" since 1984, evidence existed from studies in gay men that a positive test and AIDS is limited to the passive partner. The active partner does not get "HIV" or AIDS.[24, 25,26] Not from sex. So we have the spectacle of an infectious disease going one way. From active to passive partner. Like pregnancy. But that's impossible because microbes rely on person-to-person contact to spread. If they don't spread they're dead.

**Q 13. What about heterosexual transmission of HIV?**

**A 13.** The heterosexual transmission of HIV was one of the main predictions of the HIV theory of AIDS. Now, in the 3rd decade of AIDS, data from the largest, longest based design and executed prospective study in heterosexuals clearly proves there is no heterosexual transmission in North America, Europe and Australia.[27]

**Q 14. Then how is it possible for HIV be transmitted heterosexually in Africa?**

**A 14.** Unless HIV discriminates between people on the basis of race or colour, it is not possible. In fact, the best available data proves that "HIV" is no more heterosexually transmitted in Africa than in either North America, Europe or Australia. In table 2 the evidence from the best two non-prospective studies performed in the USA and in Africa are presented.[27, 28] Take a look at this table. See how long it takes for an "infected" man or woman, having sex every three days, no holidays, to "infect" their partner. Contrast this with gonorrhoea where you'd be infected in a week.

**Q 15. Why then do such a high percentage of Africans (for example, 10% of South Africans) test positive but this is not seen in the rest of the world?**

**A 15.** Firstly, there is no proof that 10% of South Africans test positive for HIV. This figure has been derived as follows: Pregnant women are tested with the ELISA antibody test. (HIV experts accept that the ELISA antibody test is non-specific in all individuals especially pregnant women). The findings for pregnant women are then extrapolated to the general population.[29] That is, it is assumed that since 10% of pregnant women test positive, then 10% of the whole population test positive. This high percentage of positive tests is not even found in the crowded South African prisons where the reported "HIV infection" is approximately 2.3%.[29] Secondly, due to poverty, South Africans frequently suffer from infectious diseases, which lead to the appearance of antibodies that will give a positive "HIV" antibody test.

**Q 16. But how can AIDS in Africa be explained? Isn't AIDS a new disease?**

**A 16.** AIDS stands for Acquired Immune Deficiency (AID) Syndrome (S). AID is nothing new, nor is it caused by a single factor such as HIV. Some of the best experts of "HIV/AIDS" in Africa such as Piot, Clumeck, Essex, Quinn were aware of this and admit that immune deficiency in Africa has existed for a considerable time and this has not been due to HIV. "Tuberculosis, protein calorie malnutrition, and various parasitic diseases can all be associated with depression of cellular immunity".[30] "A wide range of prevalent [in Africa] protozoal and helminthic infections have been reported to induc immunodeficiency".[31] "Africans are frequently exposed, due to hygienic conditions and other factors, to a wide variety of viruses, including CMV, EBV, hepatitis B virus, and HSV, all of which are known to modulate the immune system...Furthermore, the Africans in the present study are at an additional risk for immunologic alterations since they are frequently afflicted with a wide variety of diseases, such as malaria, trypanosomiasis, and filariasis, that are also known to have a major effect on the immune system" [CMV=cytomegalovirus; EBV=Epstein-Barr virus; HSV=herpes simplex virus].[32]

If AIDS in Africa is the same condition with the same cause as anywhere else in the world then AIDS in Africa and AIDS in the West should be identical. This is not the case and what is called AIDS in Africa is almost unrecognisably different from AIDS in the West, so much so that if African patients suddenly switched continents, very few Africans would remain AIDS cases. This is due to the existence of multiple AIDS definitions, one for Africa (the Bangui definition which separately lists adults and children), one for adults in North America, Europe and Australia, one for children in these countries and one for Latin America. None of the definitions of AIDS includes a new disease. All the diseases existed long before the AIDS era. In fact, the African definition (the Bangui definition) does not require a specific disease diagnosis but consists largely of symptoms such as weight loss, diarrhoea, cough and fever.[33] For example, an African with diarrhoea, fever and persistent cough for longer than one month is, by definition, an AIDS case. The symptoms listed in the Bangui definition are common and non-specific manifestations of many diseases, which are endemic in Africa and were so long before the AIDS era. This is accepted by some of the best-known experts on AIDS in Africa such as Mann, Fauci, Essex. For example, "...recognition of paediatric AIDS is particularly difficult in Kinshasha [Zaire], since many children have severe infant and childhood diseases with similar manifestations (eg, weight loss, chronic diarrhoea)".[34] "Well, of course it [the Bangui definition of AIDS] will be less reliable (than that used in non-Third-World countries). One typical example is what we call 'slim disease'. It's a wasting syndrome seen in Africa. Now that wouldn't fall under any categorization of AIDS by the standard empiric definition, but nevertheless, (slim disease) is being considered AIDS in Africa".[35] Also "malnutrition and general lack of medical services contributed to diarrhoea, tuberculosis, and other common African diseases that signify AIDS".[36] The diseases most frequently reported as signifying AIDS in Africa are Kaposi's sarcoma and TB. In fact, 90% of AIDS cases in developing countries are TB cases.[37] Kaposi's sarcoma existed in Africa in high frequency long before the AIDS era. Its cause was proven to be not an infectious agent.[38] At the beginning of the AIDS era Kaposi's sarcoma was one of the main reasons for the introduction of the HIV theory of AIDS. The overwhelming evidence which accumulated forced all the HIV experts to admit that HIV is not the cause of this disease.[38] Yet even today an African with Kaposi's sarcoma is an AIDS patient even if not tested for

HIV.[33] Up to 1987 TB was not considered to be an AIDS indicator disease. The 1987 CDC definition of AIDS considered extra-pulmonary TB but not pulmonary TB as indicating AIDS.[39] Thus, from 1987 to 1993 there were two causes of TB. One for extra-pulmonary TB (HIV) and another for pulmonary TB. According to the 1993 definition of AIDS, both pulmonary and extra-pulmonary TB are AIDS indicator diseases.[40] Since 1993, if an African patient (Australian TB patients are not tested for HIV) has TB and a negative antibody test, then the patient has TB and is treated accordingly. A patient with TB and a positive antibody test is not a TB patient but an AIDS patient and is treated accordingly. Although ample evidence exists which shows:

(i) that the antibodies which appear as a result of infection with the mycobacterial organism which causes TB react with the proteins in the "HIV" antibody test. That is a patient with TB would test positive for HIV even if not infected with such a virus;[7]

(ii) other things being equal, "AIDS" patients get better with anti-TB drugs just as fast as "non-AIDS" TB patients;[41]

(iii) TB is not a new disease and existed in Africa long before the AIDS era. The only thing, which is new, is an antibody test, which, so far nobody has shown to prove HIV infection. The notion that since 1993 a high percentage of TB cases in Africa are caused by HIV implies that all the traditional causes of TB in Africa vanished overnight in 1993 to make a way for a new cause, "HIV".

In other words, although the best known researchers of African AIDS clearly accepted that both AID and the AID syndrome (S) existed in Africa long before the AIDS era, and that they were caused by agents other than HIV, the same researchers expect the world to accept that in Africa there is a new disease, AIDS, caused by a new virus, HIV.

**Q.17 With AIDS representing over 35 diseases all traceable to a single HIV, what treatment must be given?**

**A.17** Modern medicine never had had any genuine antiretroviral drug, or antiviral drug for that matter. Modern medicine's "treatment" of heart attack, high blood pressure, diabetes, cancer, stroke for arthritis is always been symptom –oriented, without in any way understanding the cause / course / cure of any of the foregoing maladies. Granting that there is HIV end that it causes AIDS, all that the five star health care should do is to treat whatsoever the manifest illness, without wanting to attack the alleged root cause, namely, the HIV, for any treatment of HIV itself is illogical, counter productive, and even lethal.

**Q.18 What is the real nature of antiviral drugs?**

**A.18** In reality, there is no antiviral drug. AZT was synthesized as a hope against cancer, but its sheer toxicity forced its withdrawal. Now it is the same cell poison wearing the new ART garb. A thorn by any other name pricks as deep. AZT and all other ART drugs are indiscriminate cell poisons that devastate the body and the galaxy of side effects get ascribed to HIV AIDS. A flash back in to the history of syphilis is relevant here. In the 16th century, mercury therapy of syphilis came to the fore with much the same bravado as ART against HIV today. And it was Jean Fernel who pointed out in 1579 that " nearly all the late symptoms of syphilis were really due to mercury poisoning." HIV is no problem. ART/HAART are big problems however.

**Q.19 What is the epistemology of HIV AIDS?**

**A.19** Epistemology is recently recognised science that evaluates any knowledge to scientifically declare its scope & limitations. It is of interest to note that whereas medical men know an oceanic lot on cancer cell, coronary artery or the carotid, they can do nothing to control these entities.

The summary intellectual bankruptcy of the HIV AIDS establishment on the virus itself, the sheer unreliability of all the tests and the blindly toxic nature of all therapies allows one to epistemologically declare that HIV AIDS is a dogma but no science.

Joseph Hixson has written an account of the greatest scientific scandal of the 20th century perpetrated at the famous SKI. Newyork. (Hixson, J; The Patchwork Mouse, Anchor press, Newyork, 1976). Two statements from his book are relevant here.

a) "The American Public known to the rest of the world as the originator of fads and fetishes, suffers from time to time with a preoccupation over a single disease. "
b) "I have some advice for young researchers in biology. Stay out of cancer reasearch because it's full of money and just about out of science."

HIV –AIDS is an enemy that the USA has invented. The establishment now find it hard to dismount the tiger it has created. HIV AIDS is an obsession, a lot of money but no science nor sense.

**Q.20 How would you reread HIV AIDS?**

**A.20** Highly Imagined Virus and Allopathy Induced Deficiency Syndromes.

**Q.21 Can HIV AIDS be prevented?**

**A.21** When the virus itself is in the realm of imagination, how do we avoid it? Harvey Cushing, the famed American neurosurgeon, complained in the early part of the 20th century that prevention is an over work ed term. In the current medical scene, prevention is the predictable refuge of the therapeutically impotent, intellectually bankrupt and epistemologically arrogant modern medicine. HIV AIDS prevention is no exception.

**Eleni Papadopulos-Eleopulos** Biophysicist, Department of Medical Physics, Royal Perth Hospital, Perth, Western Australia

**Valendar F. Turner** Consultant Emergency Physician, Department of Emergency Medicine, Royal Perth Hospital, Perth, Western Australia

**John M Papadimitriou** Professor of Pathology, University of Western Australia, Perth, Western Australia

**Helman Alfonso** Department of Research, Universidad Metropolitana Barranquilla, Colombia

**Barry A. P. Page** Physicist, Department of Medical Physics, Royal Perth Hospital, Perth, Western Australia

**David Causer** Physicist, Department of Medical Physics, Royal Perth Hospital, Perth, Western Australia

**Sam Mhlongo** Head & Chief Family Practitioner, Family Medicine & Primary Health Care, Medical University of South Africa, Johannesberg, South Africa

**Todd Miller** Assistant Scientist, Department of Molecular and Cellular Pharmacology, University of Miami School of Medicine, Florida, United States of America

**Christian Fiala** Gynaecologist, Department of Obstetrics and Gynaecology, General Public Hospital, Korneuburg, Austria

**Anthony Brink** Advocate of the High Court of South Africa

**Neville Hodgkinson** Science Writer, Oxford, England

**Manu Kothari** Consultant Oncologist and Naturopathist, 14/B, S.V.Rd., Santacruz(W), Mumbai 400 054, INDIA.

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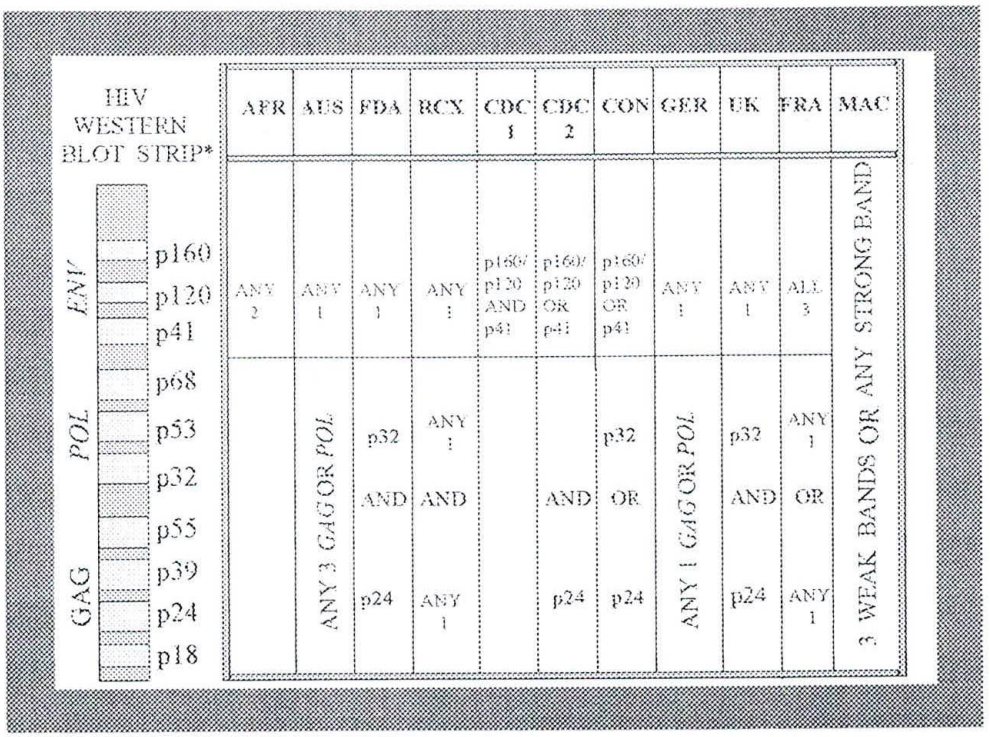
Table 1 **Criteria defining a positive HIV Western blot**




| AFR | AUS | FDA | RCX | CDC 1 | CDC 2 | CON | GER | UK | FRA | MAC |
|---|---|---|---|---|---|---|---|---|---|---|
| ANY 2 | ANY 1 | ANY 1 | ANY 1 | p160/ p120 AND p41 | p160/ p120 OR p41 | p160/ p120 OR p41 | ANY 1 | ANY 1 | ALL 3 | 3 WEAK BANDS OR ANY STRONG BAND |
| | ANY 3 *GAG* OR *POL* | p32 AND p24 | ANY 1 AND ANY 1 | | AND p24 | p32 OR p24 | ANY 1 *GAG* OR *POL* | p32 AND p24 | ANY 1 OR ANY 1 | |

AFR=AFRICA;[1] AUS=AUSTRALIA;[2] FDA=US FOOD AND DRUG ADMINISTRATION;[3] RCX=US RED CROSS;[3] CDC=US CENTER FOR DISEASE CONTROL;[3] CON=US CONSORTIUM FOR RETROVIRUS SEROLOGY STANDARDIZATION;[3] GER=GERMANY; UK=UNITED KINGDOM; FRA=FRANCE; MACS= US MULTICENTER AIDS COHORT STUDY 1983-1992. * Bands not in electrophoretic order

NOTES:

I. "The Association of Public Health Laboratories now recommends that patients who have minimal positive results on the WB, eg p24 and gp160 only, or gp41 and gp160 only, be told that these patterns have been seen in persons who are not infected with HIV and that follow-up testing is required to determine actual infective status". [4]

II. In February 1993 the US Food and Drug Administration relaxed their criteria in order to "reduce th number of HIV-1 seroindeterminate Western blot interpretations", that is, to increase the number of HIV positive individuals.[5]

1. WHO. (1990). Acquired Immunodeficiency Syndrome (AIDS). Proposed criteria for interpreting results from Western blot assays for HIV-1, HIV-2 and HTLV-I/HTLV-II. *Weekly Epidemiological Record* 65:281-298.

2. Healy DS, Maskill WJ, Howard TS, et al. (1992). HIV-1 Western blot: development and assessment of testing to resolve indeterminate reactivity. *AIDS* 6:629-633.

3. Lundberg GD. (1988). Serological Diagnosis of Human Immunodeficiency Virus Infection by Western Blot Testing. *Journal of the American Medical Association* 260:674-679. (Data presented in

this paper reveal that when the FDA criteria are used to interpret the HIV Western blot less than 50% of US AIDS patients are HIV positive whereas 10% of persons not at risk of AIDS are also positive).

4. Mylonakis E, Paliou M, Greenbough TC, Flaningan TP, Letvin NL, Rich JD. Report of a false-positive HIV test result and the potential use of additional tests in establishing HIV serostatus. *Archives of Internal Medicine* 2000;160:2386-8.

5. Kleinman S, Busch MP, Hall L, et al. (1998). False-positive HIV-1 test results in a low -risk screening setting of voluntary blood donation. *Journal of the American Medical Association* 280:1080-1083.

Table 2. Number of years to attain 50% and 95% probabilities transmission of HIV assuming sexual contact once every three days

| STUDY | DIRECTION OF TRANSMISSION | Per contact PROBABILITY | Years for 50% PROBABILITY | Years for 95% PROBABILITY |
|---|---|---|---|---|
| USA | M to F | 0.0009 | 6.3 | 27.4 |
| | F to M | 0.0001125 | 51 | 222 |
| Uganda | M to F | 0.0009 | 6.3 | 27.4 |
| | F to M | 0.0013 | 4.4 | 19.5 |

DIS-2M.3

# THE HIV DISBELIEVERS

By David France

*Newsweek* 19 August 2000

*Christine Maggiore is a different kind of AIDS activist -- one who tells people to forget safe sex and stop taking their lifesaving drugs. Why?*

One sweltering California afternoon a few weeks ago, Christine Maggiore was sitting in her cramped office, still jet-lagged from the long flight home from South Africa, where she'd attended the International AIDS Conference.

She hadn't yet found time to answer the "hundreds and hundreds, perhaps literally thousands" of e-mail messages she'd received from people she'd met there who were looking for AIDS literature or doctor referrals, or simply wanting to pat her on the back. "All your work and dedication is appreciated!!!" a typical message declared. She doesn't know when she'll find time to catch up -- her whole life is behind schedule because of her AIDS work. "My fiancé and I have been trying to find time to get married for years!" she says.

But Maggiore, who heads Alive & Well AIDS Alternatives in Burbank, Calif., is not your typical AIDS activist. In South Africa, some scientists spit nasty epithets at her. Protesters marching outside the meeting hall threatened to plug her and her galvanized followers with bullets. Why? Because Maggiore takes the strange contrarian stance that HIV, which has been blamed in the deaths of 18.8 million people worldwide, doesn't cause AIDS at all. She exhorts people to stop taking their medications and stop worrying about spreading their virus.

But Maggiore's influence here and abroad is swelling. The singer Nina Hagen wrote a song for her, and Esai Morales, the actor, is a big funder. The platinum-selling alternative rock band Foo Fighters promotes Maggiore's ideas on its Web site. And in South Africa, Maggiore met privately with South African President Thabo Mbeki, who endorses many of her beliefs. Mbeki's call for more research into whether HIV causes AIDS dominated headlines from the important biennial meeting. In response, 5,000 flabbergasted scientists signed a declaration calling the laboratory evidence "clear-cut, exhaustive, and unambiguous."

Such consensus doesn't impress Maggiore, a bright and compelling former garment executive with no scientific training or college degree. Through emotional newspaper columns, e-mail postings and lectures in such disparate places as the University of Miami School of Medicine and the Rev. Al Sharpton's National Action Network in Harlem, she continues to try to pick apart the scientific literature, a strategy that especially appeals to people with a beef against the establishment. "We're not saying that anybody is 100

percent correct or incorrect on this issue," Foo Fighters bassist Nate Mendel told Newsweek. "Simply, there's information out there that is being blocked out."

Maggiore is convinced that the HIV doesn't cause AIDS. No medical journal has ever proved to her it is dangerous. She calls standard HIV antibody tests so oversensitive that they can show positive "if you've had a flu shot or if you've ever been pregnant" (the Centers for Disease Control and Prevention disagree), and she cobbles together reams of footnotes, anecdotes and package inserts to prove it.

Then how does she explain all the deaths that have marked the pandemic? Here's where her argument takes a conspiratorial turn. In Africa, despite what health authorities say, people are simply not dying more than before, she asserts. And she thinks the 420,000 Americans who have died of AIDS are victims of the prescription drugs they hoped would save them. Or perhaps they died from recreational drugs. Or maybe they succumbed to "a profound fear of AIDS" itself. "We're not saying people haven't died of what is called 'AIDS'," Maggiore explained one afternoon in the sunny Burbank home she shares with her fiancé, a 31-year-old video editor named Robin Scovill, and her son. "We're just asking what is at the core of this incredible human tragedy. And by looking at other avenues, might we better resolve this?"

There is no way to know how many patients she has persuaded to abandon their medications or condoms, but Maggiore's detractors can barely contain their anger. "Many people will die because they will go untreated," says Dr. Luc Montagnier, the co-discoverer of HIV. White House AIDS policy director Sandra Thurman says bluntly, "Christine is putting lives in jeopardy."

Disbelievers -- "flat earth" types who fervently doubt the conclusions of science -- have been around since the Enlightenment. But they are staging a resurgence today, partly in reaction to the unparalleled role science plays in society. Disbelievers fear Big Science the way millennialists feared Y2K. Fragments of contrarian evidence are enough to shake their faith in everything from water fluoridation to global-warming statistics, childhood vaccine programs to the artificial sweetener aspartame, the Holocaust to evolution. Huge parcels of the World Wide Web are devoted to such exposes. "We're at a moment for a lot of things where skepticism becomes a dogma," says Michael Shermer, author of a book about the antiscience backlash, "Why People Believe Weird Things."

But what's in it for them? "The basis of denial is a need to escape something that is terribly uncomfortable," says Boston College psychology professor Joseph Tecce, who has studied Holocaust deniers and AIDS dissenters. "If something is horrific, I might want to pretend it doesn't exist."

Christine Maggiore's horrific event came on Feb. 24, 1992, when, she says, a routine blood test came back positive for HIV. She was 36 years old, single and a partner in a successful clothing wholesaler. A former boyfriend also tested positive. "I was mortified," she says. "According to the conventional wisdom, I had just foolishly and irrevocably ruined my entire life."

Maggiore was not immediately a disbeliever. Initially, the oldest child of a Los Angeles advertising executive sought the advice of doctors and planned to start treatment. But some scientific principles of the disease never added up to her. For one thing, she felt fine -- and still does. How could she have a killer virus? "There was this empirical data from my own body," she says. "I was ridiculously healthy."

Ultimately she discovered the work of Berkeley virologist Peter Duesberg, whose belief that AIDS is caused by lifestyle choices like promiscuity and drug use rather than infectious agents have long been dismissed by his peers. One spring evening in 1994, as she was sitting on a panel discussing AIDS prevention, it finally struck Maggiore that she no longer believed in the epidemic. "Being a practical person, it didn't seem to me after investigating this that there were good reasons for me to live my life as if I were dying," she says.

Now, nothing can dissuade her. Take the 1999 CDC report detailing the wild successes of protease inhibitors, the new class of AIDS drugs introduced in 1996. The study correlates a huge drop-off in classic AIDS-related infections with data on how many of the new drugs were prescribed. "Prescriptions don't mean people are actually taking the drugs," she objected. "Do you know how many people flush their drugs down the toilet?" (In fact, she says, the wholesale return to health is a direct result of that protest, in bathrooms across America.)

Today Maggiore is the most prominent foe of what she calls "the HIV equals AIDS equals death paradigm," having sold or given away 28,500 copies of her self-published booklet since 1995, in addition to the copies in French, German, Italian, Spanish, Portuguese and Japanese. She founded Alive & Well, which has spun off chapters around the globe and is affiliated with dozens of like-minded groups representing perhaps tens of thousands of followers.

Their message has resonated among a number of gay men who, exhausted by 20 years of medical vigilance and daily toxic drug regimens, are increasingly receptive to Maggiore's exhortation to "live in wellness...without fear of AIDS." And they have reinvigorated long-simmering AIDS conspiracy theories. According to a 1995 survey of 1,000 African-American churchgoers, one third believed HIV was concocted by the government for racial genocide. When she spoke before a crowded room in Harlem in 1998, spellbound members of the audience likened her to the abolitionists, interrupting her with cries of "John Brown lives!"

"If you told me five years ago I would be promoting the notion that HIV does not cause AIDS, I would have said you were nuts. I believed adamantly that HIV was a killer and these drugs were saving lives," says Michael Bellefountaine, 34, a friend of Maggiore's who decided against taking anti-HIV medication years ago. Now he attributes his survival to being drug-free. Last month he attended a protest in San Francisco and chanted, "HIV is a lie! It's toxic pills that made them die!"

AIDS educators already hold Maggiore and her acolytes responsible for an upswing in new infections. San Francisco authorities just announced that new HIV cases in 1999 were nearly twice as high as in 1997. "People are focusing on the wrong thing. They're focusing on conspiracies rather than protecting themselves, rather than getting tested and seeking out appropriate care and treatment," says Stephen Thomas, who directs the University of Pittsburgh's Center for Minority Health.

HIV renegades sometimes seem as if their main goal is mayhem, not constructive discourse. For instance, the San Francisco chapter of ACT UP, once a major force lobbying for more money for AIDS research, is now run by dissenters who stage protests against other AIDS leaders -- regularly bathing them in cat-box litter or spit. On Aug. 9, police charged two ACT UP members with assault and battery for allegedly striking city health department director Mitchell H. Katz and covering him with Silly String during a public meeting. Similar antics now prevail among a half-dozen ACT UP branches. "They're crazy," says Larry Kramer, who founded ACT UP in 1987. "They're undoing all we've fought for."

Picking over a black-bean wrap at her kitchen counter recently, Maggiore described herself simply as a person who asks questions others are overlooking. The fact that she provokes hostility only emboldens her. She sees only intolerance and recalcitrance among her detractors -- they "smack of parental authority and religious authority," she said. Her brother Steven, 41, calls her a modern-day Copernicus.

But she soon made it clear that her disregard for HIV is not just an intellectual gambit when her talkative 3-year-old son, Charlie, wandered into the kitchen after a midday nap. She talked about how she conceived him naturally and gave birth without drugs routinely given to prevent transmission. She continues to breast-feed him today, according to the family's pediatrician. Her family supports her in this, even though HIV can be transmitted through breast milk and judges have charged mothers in similar cases with child endangerment.

Maggiore and Scovill, Charlie's father, say they've never been curious to test the child for HIV (Scovill does not know his own status). Their pediatrician is not as sanguine. "I would not be opposed to testing his blood," admits Dr. Paul Fleiss, who says the boy has been very healthy. "But she is."

"He's a perfectly healthy little boy," says Scovill, bending to offer his son a macaroon. Charlie was skeptical. "They're really good," the father insisted patiently. "And for some reason they decrease viral load!" With that, both parents had a good laugh at the silly AIDS goblin. Such is the power of belief.

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**The Extremists versus the AIDS Experts**

How Maggiore's book "What If Everything You Thought You Knew About AIDS Was Wrong?" conflicts with information on HIV from the National Institutes of Health:

** Issue: Are HIV tests accurate? **

The Fringe: No. More than 70 conditions can cause false positives, from malaria to alcoholism. And people can revert to negative.

The Scientists: Yes. "Virtually 100 percent," experts say. In 20 years, just five adults and 27 kids have mysteriously reverted to negative.

** Issue: Is HIV a deadly virus? **

The Fringe: No. Many people who test HIV-positive live "in wellness" for years. Some say AIDS results from other factors.

The Scientists: Yes. Why some cases never progress is a puzzle, but all researchers agree: HIV is sufficient to kill.

** Issue: Do AIDS drugs work? **

The Fringe: No. Their side effects are suspiciously similar to AIDS symptoms, and the drugs are said to be lethal poisons.

The Scientists: Yes. They're toxic, but proven, life-prolongers -- many people have taken them prophylactically without damage.

** The Issue: Can you forget the condoms? **

The Fringe: Yes. If your partner is not in a risk group, you're more likely to be struck by lightning than HIV after one encounter.

The Scientists: No. That would be Russian roulette. HIV can be passed in a single encounter. Why take that risk?

DIS-2715

# AIDS COCKTAIL

By Rupa Chinai

*Times of India (Bombay)* 29 May & 4 Jun 2001

Mumbai -- Now that the AIDS 'cocktail therapy' is being offered at a lower price by Indian pharmaceutical companies, developing countries like South Africa and India are under increasing social pressure to distribute these drugs free through their public health system. However, before jumping into this decision, other dimensions need to be considered.

It is a fact that anti-retroviral drugs offer no cure for AIDS. In fact, the US federal health authorities issued new guidelines in February this year, backtracking on its long-held policy of "hit hard and early" for AIDS treatment. It now recommends that treatment for HIV should be delayed as long as possible for people without symptoms.

This US move is a result of growing concern over toxic effects of the therapies, reported The New York Times recently. "These toxic effects include nerve damage, weakened bones, unusual accumulation of fat in the neck and abdomen and diabetes. Many people have developed dangerously high levels of cholesterol and other lipids in the blood, raising concern that HIV positive persons might face another epidemic of heart disease," the report states.

"Studies show that the drug cocktail does not destroy the HIV virus, When infected people stop the therapy, the virus rebounds, making lifetime therapy a necessity" the report adds.

Meanwhile, a wholly new dimension to this debate is brought by a strong body of Western scientists, which include Nobel Prize winners. They believe that attacking the virus (HIV) will not deal with the underlying causes of immune suppression. AIDS is the consequence of a suppressed immune system, which has been subjected to repeated onslaughts by four factors that build up toxins and deficiencies in the body. These are: antibiotic abuse, recreational drug abuse, anal sex and nutritional stress.

The fact that these factors have appeared in combination over the past two decades, could explain the emergence of AIDS, claim the alternative thinkers. HIV, if it exists, is a marker of a suppressed immune system, they say.

While closely following the 'AIDS story' over the past six years, this reporter found the emergence of two clear trends:

* A large number of people from within the general population -- that is, those not part of the 'high-risk group' -- enjoy good health despite testing 'HIV positive' a decade ago. In Mumbai, the "AIDS capital of India", counselling groups such as Salvation Army and CASA (Counselling and Allied Services), who attend to HIV-positive people from this segment of

the population, say there is strong evidence to show that the damage caused to the immune system can be reversed.

"This happens when people change their habits of substance abuse, eat nutritious food, involve themselves in community service, practice discipline and hygiene, receive regular counselling, family and social support. Such persons emerge stronger and healthy," says Arun Meitram, a counselor at the Salvation Army clinic.

Incidentally, Salvation Army counselors recall only 15 deaths have occurred among the 900 patients they have been following over the past decade. In most cases the cause of death is related to malnutrition or TB.

Says Nagesh Shirgoppikar, a medical consultant to Salvation Army; "Our experience in treating 'HIV positive' persons over the past decade shows that all the components of comprehensive psychological, emotional, physical and conventional medical treatment are very important. If a person is treated wholly, he is fine. Our patients have remained asymptomatic for up to ten years, and enjoy perfect health without anti-retroviral drugs."

* However, a disturbing trend noticed among the 'gay community' and those indulging in drug abuse is the rapid progression into full-blown AIDS. This downslide confirms what the 'alternative thinkers' on AIDS are also saying -- chemical drugs (both recreational and antibiotic abuse) cause immune suppression. So does anal sex, which causes toxic shock to the 'receiving partner'.

Some evidence emerging from India substantiate this thinking. Rapid progression into AIDS is evident, for instance in Manipur. At a recent workshop on AIDS in the North-East region, officials from the Manipur State AIDS Society, said that rampant drug abuse has made AIDS a visible phenomenon.

In Manipur the intervention programme emphasises 'clean needle exchange', without simultaneous support for detoxification and rehabilitation. Evidence from Sankalp, an NGO working amongst drug addicts in Mumbai shows that when addicts are offered clean needles, it helps create a sense of acceptance of their problem without any prejudice. But they also need simultaneous detoxification facilities, with access to buprenorphine, (a 'partial opiate agonist' that enables an addict to stop hard drugs and taper off the craving for a 'chemical kick'), along with rehabilitation. Both facets receive mere 'lip service' in Mumbai and Manipur, which has a sizeable population of drug addicts.

Meanwhile, studies amongst Mumbai's gay community reveal that anal sex is a dominant pattern of sexual behaviour. More studies are required to establish whether this practice is linked to the progression of AIDS, and whether a combination of other factors like alcohol abuse, lack of proper nutrition and sanitation contributes to their vulnerability to AIDS. India's STD clinics and health centers make no effort to address these issues.

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Emerging evidence, both internationally and within India, is presenting a wholly new dimension of AIDS. It suggests that repeated assaults on the body's immune system by the build-up of toxins and nutritional deficiencies leads to AIDS. And, for many, the damage could be reversible even without drugs.

This new demension puts to doubt the accepted belief that a virus, HIV, is responsible for causing AIDS. In consequence, a question mark looms over the credibility of the HIV test and its ability to identify a person who is vulnerable to AIDS.

Questions over the validity of the HIV test are coming from Mumbai, the 'AIDS capital of India'. Evidence shows that the rampant use of HIV tests on asymptomatic persons is resulting in a large number of false 'HIV positive' results. Nobody knows the true extent of such incidents because the health authorities have no system of monitoring privately run laboratories and hospitals.

Alka Gogate, director of the Mumbai AIDS Society acknowledges the problem. She attributes it to the many private laboratories in the city that lack accreditation and technical expertise to assure standardised testing.

Mumbai's corporation hospitals no longer insist on an HIV test on admission. It is prescribed only when a patient shows symptoms such as repeated bouts of diarrhea, fever, loss of body weight or TB -- the common symptoms of AIDS-associated illnesses in India.

Private hospitals in Mumbai insist on a routine HIV test before admission. Several newspaper reports have documented the havoc false 'HIV positive' tests have caused in the lives of patients. According to Dr. Gogate their insistence on rampant HIV testing in the absence of clinical symptoms of AIDS, needs to be challenged.

Fear of social stigma has prevented many patients from making their complaint public. Widely reported however, is the case of a young man who tested HIV positive when he was undergoing a compulsory medical examination, required for getting a work permit in the Gulf. Subsequent negative tests at reputed laboratories did not change the decision of the Gulf Board to reject him.

Yet another reported case is that of two pregnant women who initially tested HIV positive, and their babies were subjected to a course of AZT, a toxic and controversial anti-AIDS drug. Thereafter, a second HIV test showed negative results.

The AIDS establishment now officially concede that reliance on a single HIV test is not acceptable in labeling a person as 'HIV positive'. At least three confirmatory tests are required to eliminate the possibility of picking up other infection markers. However, for most poor patients a single test remains the norm.

The unreliability of the HIV test confirms what 'alternate thinkers' on AIDS have maintained since long -- there is evidence to show that the HIV tests, Elisa and Western Blot, can show false results when there is cross-reactivity with a host of viral and bacterial species.

Their evidence holds there are at least 70 different conditions in a person being tested for HIV that can show false positive results. These conditions include influenza, herpes simplex, hepatitis, all mycobacterium bacterial species (including leprosy and tuberculosis), malaria, and even pregnancy and malnutrition.

The substance of this argument goes back to the 1980s when Robert Gallo and Luc Montagnier, American and French scientists respectively, first claimed to have isolated HIV. Review of the published literature by an Australian scientist group shows that viral particles claimed to be HIV, were taken from unpurified cell cultures and unspecific density gradients. The standard norm for isolation of a retrovirus requires that it must be purified from the presence of other "cellular debris", analysed and proven to be able to replicate.

The isolated particles in the Gallo-Montagnier experiment contained 'cellular debris' which also resembles retrovirus particles, and can react in an 'HIV antibody test'. Despite the faulty methodology, their research was unquestioningly accepted to set subsequent standards of an HIV test kit.

The fact that the HIV test is not specific for the detection of the virus is clearly stated in the literature accompanying the Eliza test kits (from Abbott Laboratories, for instance).

In the light of this evidence questions arise about whether bombarding the virus does any good to the body. Overwhelming research evidence from the fields of AIDS, cancer and heart disease, points to the dramatic difference in disease prevention, made through access to right nutrition, exercise and changed lifestyle.

Africa is cited as the example of a continent in the throes of AIDS. Health historians say that AIDS here, is a consequence of the depletion of the body's nutrition pool over generations, and the destruction of the immune system. As sub-Saharan Africa plunged deeper into the cycle of poverty, malnutrition and civil war, it also suffered epidemics of Ebola, Marburg or Lhassa fever that stayed with them for decades. AIDS they say is the logical conclusion of this onslaught.

The deepening economic crisis of India's poor will see more people testing 'HIV positive' because of their depleting nutrition status, stress and compromised immunity. This implies that the Indian population as a whole need more than condoms, sex education and a cocktail therapy of questionable value

DIS-2M.4

# 13TH INTERNATIONAL AIDS CONFERENCE
# DURBAN

***Speech of the President of South Africa at the Opening Session of the Conference By Thabo Mbeki***

*Office of the Presidency* 9 July 2000

Chairperson, Participants at the 13th International AIDS Conference; Comrades, ladies and gentlemen:

On behalf of our government and the people of South Africa, I am happy to welcome you to Durban and to our country.

You are in Africa for the first time in the history of the International AIDS Conferences. We are pleased that you are here because we count you as a critical component part of the global forces mobilised to engage in struggle against the AIDS epidemic confronting our Continent. The peoples of our Continent will therefore be closely interested in your work. They expect that out of this extraordinary gathering will come a message and a programme of action that will assist them to disperse the menacing and frightening clouds that hang over all of us as a result of the AIDS epidemic.

You meet in a country to whose citizens freedom and democracy are but very new gifts. For us, freedom and democracy are only six years old. The certainty that we will achieve a better life for all our people, whatever the difficulties, is only half-a-dozen years old. Because the possibility to determine our own future together, both black and white, is such a fresh and vibrant reality, perhaps we often overestimate what can be achieved within each passing day. Perhaps, in thinking that your Conference will help us to overcome our problems as Africans, we overestimate what the 13th International AIDS Conference can do. Nevertheless, that overestimation must also convey a message to you. That message is that we are a country and a Continent driven by hope, and not despair and resignation to a cruel fate.

Those who have nothing would perish if the forces that govern our universe deprived them of the capacity to hope for a better tomorrow. Once more I welcome you all, delegates at the 13th International AIDS Conference, to Durban, to South Africa and to Africa, convinced that you would not have come here, unless you were to us, messengers of hope, deployed against the specter of the death of millions from disease. You will spend a few days among a people that has a deep understanding of human and international solidarity.

I am certain that there are many among you who joined in the international struggle for the destruction of the anti-human apartheid system. You are therefore as much midwives of the new, democratic, non-racial and non-sexist South Africa as are the millions of our people who fought for the emancipation of all humanity from the racist yoke of the

apartheid crime against humanity. We welcome you warmly to South Africa also for this reason.

Let me tell you a story that the World Health Organisation told the world in 1995. I will tell this story in the words used by the World Health Organisation.

This is the story:

" The world's biggest killer and the greatest cause of ill-health and suffering across the globe is listed almost at the end of the International Classification of Diseases. It is given the code Z59.5 - extreme poverty.
"Poverty is the main reason why babies are not vaccinated, why clean water and sanitation are not provided, why curative drugs and other treatments are unavailable and why mothers die in childbirth. It is the underlying cause of reduced life expectancy, handicap, disability and starvation. Poverty is a major contributor to mental illness, stress, suicide, family disintegration and substance abuse. Every year in the developing world 12.2 million children under 5 years die, most of them from causes, which could be prevented for just a few US cents per child. They die largely because of world indifference, but most of all they die because they are poor...

"Beneath the heartening facts about decreased mortality and increasing life expectancy, and many other undoubted health advances, lie unacceptable disparities in wealth. The gaps between rich and poor, between one population group and another, between ages and between sexes, are widening. For most people in the world today every step of life, from infancy to old age, is taken under the twin shadows of poverty and inequity, and under the double burden of suffering and disease.

"For many, the prospect of longer life may seem more like a punishment than a gift. Yet by the end of the century we could be living in a world without poliomyelitis, a world without new cases of leprosy, a world without deaths from neonatal tetanus and measles. But today the money that some developing countries have to spend per person on health care over an entire year is just US $4 - less than the amount of small change carried in the pockets and purses of many people in the developed countries.

"A person in one of the least developed countries in the world has a life expectancy of 43 years according to 1993 calculations. A person in one of the most developed countries has a life expectancy of 78 - a difference of more than a third of a century. This means a rich, healthy man can live twice as long as a poor, sick man.

"That inequity alone should stir the conscience of the world - but in some of the poorest countries the life expectancy picture is getting worse. In five countries life expectancy at birth is expected to decrease by the year 2000, whereas everywhere else it is increasing. In the richest countries life expectancy in the year 2000 will reach 79 years. In some of the poorest it will go backwards to 42 years. Thus the gap continues to widen between rich and poor, and by the year 2000 at least 45 countries are expected to have a life expectancy at birth of under 60 years.

"In the space of a day passengers flying from Japan to Uganda leave the country with the world's highest life expectancy - almost 79 years - and land in one with the world's lowest - barely 42 years. A day away by plane, but half a lifetime's difference on the ground. A flight between France and Cote d'Ivoire takes only a few hours, but it spans almost 26 years of life expectancy. A short air trip between Florida in the USA and Haiti represents a life expectancy gap of over 19 years...

"HIV and AIDS are having a devastating effect on young people. In many countries in the developing world, up to two-thirds of all new infections are among people aged 15-24. Overall it is estimated that half the global HIV infections have been in people under 25 years - with 60% of infections of females occurring by the age of 20. Thus the hopes and lives of a generation, the breadwinners, providers and parents of the future, are in jeopardy. Many of the most talented and industrious citizens, who could build a better world and shape the destinies of the countries they live in, face tragically early death as a result of HIV infection."
(World Health Report 1995: Executive Summary, WHO.)
This is part of the story that the World Health Organisation told in its World Health Report in 1995. Five years later, the essential elements of this story have not changed. In some cases, the situation will have become worse.

You will have noticed that when the WHO used air travel to illustrate the import of the message of the story it told, it spoke of a journey from Japan to Uganda, another from France to the Cote d'Ivoire and yet another from the United States to Haiti.
From developed Asia, Europe and North America, two of these journeys were to Africa and the third to the African Diaspora.

Once again, I welcome you to Africa, recognizing the fact that the majority of the delegates to the 13th International AIDS Conference come from outside our Continent.
Because of your heavy programme and the limited time you will spend with us, what you will see of this city, and therefore of our country, is the more developed world of which the WHO spoke when it told the story of world health in 1995. You will not see the South African and African world of the poverty of which the WHO spoke, in which AIDS thrives - a partner with poverty, suffering, social disadvantage and inequity.

As an African, speaking at a Conference such as this, convened to discuss a grave human problem such as the acquired human deficiency syndrome, I believe that we should speak to one another honestly and frankly, with sufficient tolerance to respect everybody's point of view, with sufficient tolerance to allow all voices to be heard. Had we, as a people, turned our backs on these basic civilised precepts, we would never have achieved the much-acclaimed South African miracle of which all humanity is justly proud.

Some in our common world consider the questions I and the rest of our government have raised around the HIV-AIDS issue, the subject of the Conference you are attending, as akin to grave criminal and genocidal misconduct. What I hear being said repeatedly, stridently, angrily, is - do not ask any questions!

The particular twists of South African history and the will of the great majority of our people, freely expressed, have placed me in the situation in which I carry the title of President of the Republic of South Africa. As I sat in this position, I listened attentively to the story that was told by the World Health Organisation. What I heard as that story was told, was that extreme poverty is the world's biggest killer and the greatest cause of ill health and suffering across the globe. As I listened longer, I heard stories being told about malaria, tuberculosis, hepatitis B, HIV-AIDS and other diseases.

I heard also about micro-nutrient malnutrition, iodine and vitamin A deficiency. I heard of syphilis, gonorrhoea, genital herpes and other sexually transmitted diseases as well as teenage pregnancies.,. I also heard of cholera, respiratory infections, anaemia, bilharzia, river blindness, guinea worms and other illnesses with complicated Latin names.

As I listened even longer to this tale of human woe, I heard the name recur with frightening frequency - Africa, Africa, Africa! And so, in the end, I came to the conclusion that as Africans we are confronted by a health crisis of enormous proportions. One of the consequences of this crisis is the deeply disturbing phenomenon of the collapse of immune systems among millions of our people, such that their bodies have no natural defence against attack by many viruses and bacteria. Clearly, if we, as African countries, had the level of development to enable us to gather accurate statistics about our own countries, our morbidity and mortality figures would tell a story that would truly be too frightening to contemplate.

As I listened and heard the whole story told about our own country, it seemed to me that we could not blame everything on a single virus. It seemed to me also that every living African, whether in good or ill health, is prey to many enemies of health that would interact one upon the other in many ways, within one human body. And thus I came to conclude that we have a desperate and pressing need to wage a war on all fronts to guarantee and realise the human right of all our people to good health. And so, being insufficiently educated, and therefore ill prepared to answer this question, I started to ask the question, expecting an answer from others - what is to be done, particularly about HIV-AIDS!

One of the questions I have asked is - are safe sex, condoms and anti-retroviral drugs a sufficient response to the health catastrophe we face! I am pleased to inform you that some eminent scientists decided to respond to our humble request to use their expertise to provide us with answers to certain questions. Some of these have specialised on the issue of HIV-AIDS for many years and differed bitterly among themselves about various matters. Yet, they graciously agreed to join together to help us find answers to some outstanding questions. I thank them most sincerely for their positive response, inspired by a common resolve more effectively to confront the AIDS epidemic.

They have agreed to report back by the end of this year having worked together, among other things, on the reliability of and the information communicated by our current HIV tests and the improvement of our disease surveillance system. We look forward to the results of this important work, which will help us to ensure that we achieve better results

in terms of saving the lives of our people and improving the lives of millions. In the meantime, we will continue to intensify our own campaign against AIDS, including:
A sustained public awareness campaign encouraging safe sex and the use of condoms;
A better-focused programme targeted at the reduction and elimination of poverty and the improvement of the nutritional standards of our people;
A concerted fight against the so-called opportunistic diseases, including TB and all sexually transmitted diseases;
A humane response to people living with HIV and AIDS as well as the orphans in our society;
Contributing to the international effort to develop an AIDS vaccine; and, further research on anti-retroviral drugs.

You will find all of this in our country's AIDS action plan, which I hope has been or will be distributed among you. You will see from that plan, together with the work that has been going on, that there is no substance to the allegation that there is any hesitation on the part of our government to confront the challenge of HIV-AIDS.

However, we remain convinced of the need for us better to understand the essence of what would constitute a comprehensive response in a context such as ours which is characterized by the high levels of poverty and disease to which I have referred. As I visit the areas of this city and country that most of you will not see because of your heavy programme and your time limitations, areas that are representative of the conditions of life of the overwhelming majority of the people of our common world, the story told by the World Health Organisation always forces itself back into my consciousness. The world's biggest killer and the greatest cause of ill health and suffering across the globe, including South Africa, is extreme poverty.

Is there more that all of us should do together, assuming that in a world driven by a value system based on financial profit and individual material reward, the notion of human solidarity remains a valid precept governing human behaviour! On behalf of our government and people, I wish the 13th International AIDS Conference success, confident that you have come to these African shores as messengers of hope and hopeful that when you conclude your important work, we, as Africans, will be able to say that you who came to this city, which occupies a fond place in our hearts, came here because you care. Thank you for your attention.

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*Enquiries: Tasneem Carrim 083 650 7119*