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But—What About Africa?

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Overture

These days, a presentation of the arguments and evidence against the contagious/HIV hypothesis of AIDS (1, 2) is usually interrupted with the supposedly show-stopping question: "But—what about Africa?" A variant is: "But— aren't people living longer because of the drugs?" Before addressing these two questions, let's take a quick look at the 14 unproved assertions and unmet predictions that invariably lead to: "But—what about Africa?"

Predictions and assertions taken from the Durban Declaration (3)		
	Prediction	*Fact*
1	HIV is said to be abundant in AIDS patients.	But, only antibodies against HIV are ever found in patients.
2	HIV is said to cause immuno-deficiency by killing T-cells.	But, the T-cells that have been mass-producing HIV for the AIDS test are immortal!
3	Because of the vast majority of healthy HIV carriers, HIV is said to need 5-10 years to cause AIDS.	But, HIV replicates in 1 day, generating over 100 new HIVs. At this rate there would be enough HIV to infect all cells of a human body, and thus cause AIDS in 1 week.
4	AIDS is said to spread by infection with HIV.	But, in the USA, HIV infections have remained constant at 1 million since 1985, whereas AIDS increased from 1981 until a peak in 1992 and had been declining until 12 to 18 months after Highly Active Anti-Retroviral Therapy (HAART) became widely available late 1996.
5	HIV is said to spread through sexual contact.	But, for an uninfected American woman (resp. man) to get infected and spread an HIV epidemic there would need an average of 140,000 (resp. 4.4 million) random heterosexual contacts.
6	All sexually active people are said to be at risk for AIDS.	But, since 1981, AIDS in the USA and Europe has been restricted to intravenous drug users and male homosexual drug users.
7	Pathogenic viruses cause one specific disease, for which they are named (e.g. smallpox)	But, HIV is said to cause 26 diseases, of which none is specific for HIV.
8	All viral diseases are contagious to un-vaccinated people.	But, not one nurse or doctor has ever contracted AIDS from over 816,000 American AIDS patients in 24 years. And, not one of the thousands of HIV researchers has contracted AIDS from working with the "deadly virus".

9	Infectious viral epidemics form a bell-shaped chronological curve: rising exponentially with virus spread and declining with immunity within months.	But, AIDS increased in the USA slowly over 12 years (1981-1992) followed by a steady decline after a peak in 1992. The decline in AIDS and deaths abruptly stopped after the widespread use of HAART in late 1996.
10	Since 1798, researchers have made vaccines against viruses, e.g. polio.	But, 19 years of HIV-AIDS research has failed to come up with a vaccine.
11	Viral diseases result from the loss of many virus-infected cells.	But, even in dying AIDS patients only 1 in 500 T-cells is ever infected by HIV, which is completely dormant.
12	AIDS should be a pediatric epidemic, because HIV is transmitted "from mother to infant" at rates of 25-50%, and because "34.3 million", were said to be infected in 2000.	But <1% of AIDS in the US and Europe is pediatric.
13	"HIV is [said to be] the sole cause of the AIDS pandemic".	But, all AIDS diseases were known long before HIV was discovered, and over 4,621 HIV-free AIDS cases have been described in the AIDS literature, before the CDC insisted in 1993 that an AIDS case be HIV-positive.
14	"HIV recognizes no social, political or geographic borders."	But, the American/European and African epidemics differ both clinically, and epidemiologically.

I. "Can Africa be saved?"

"Can Africa be saved?" the cover of Newsweek asked as far back as 1984 (4), reflecting the old Western belief that Africa is doomed to starvation, terror, disaster and death. This was repeated two years later in an article in the same journal in a story about Aids in Africa. The title set the scene: "Africa in the Plague Years" (5). It continued: "Nowhere is the disease more rampant than in the Rakai region of south-west Uganda, where 30 percent of the people are estimated to be seropositive." The World Health Organisation (WHO) confirmed "by mid-1991 an estimated 1.5 million Ugandans, or about 9% of the general population and 20% of the sexually active population, had HIV infection" (6). Similar reports were repeatedly published during the last 15 years, declaring as much as 30% of the population doomed to premature death, with dire consequences for families and society as a whole? The predictions announced the practically inevitable collapse of the country in which the world-wide epidemic supposedly originated.

Today, however, one reads little about Aids in Uganda because all the prophesies have proved false, as evidenced in the ten-year census of September 2002 (7). Summing up, the Uganda Bureau of Statistics says, "Uganda's Population grew at an average annual rate of 3.4% between 1991 and 2002. The high rate

of population growth is mainly due to the persistently high fertility levels (about seven children per woman) that have been observed for the past four decades. The decline in mortality reflected by a decline in Infant and Childhood Mortality Rates as revealed by the Uganda Demographic and Health Surveys (UDHS) of 1995 and 2000-2001, have also contributed to the high population growth rate." In other words, the already very high population growth in Uganda has further increased over the past 10 years and is now among the highest in the world (8).

Even if Uganda has so far escaped the apocalypse that was predicted in 1984, the popular media continue to inform us that the whole of Sub-Saharan Africa has suffered massive devastation and depopulation as a result of two decades of AIDS. Notwithstanding the claims of the media, it is extremely difficult to document an Africa AIDS catastrophe that some have compared to the European plague of the Middle Ages.

A new AIDS epidemic was claimed to have emerged in Sub-Saharan Africa in 1984 (9-14). In sharp contrast to its America and European namesakes, the African AIDS epidemic is randomly distributed between the sexes and not restricted to behavioral risk groups (15-17). The African epidemic is also a collection of long-established, indigenous diseases, such as chronic fevers, weight loss (alias "slim disease"), diarrhea and tuberculosis (18-23). In addition, the African AIDS-defining diseases differ from the American/European AIDS diseases significantly in their prevalence among AIDS patients. For example, the predominant American/European AIDS disease, *Pneumocystis carinii* pneumonia, is almost never diagnosed in Africans (24, 25).

According to the WHO, the African epidemic increased from 1984 until the early 1990s, similar to the American/European epidemics, but has since leveled off to generate about 75,000 cases annually ((26) and back issues) (Fig. 1). (By way of comparison, the plague epidemic of London in 1665 had eliminated 1/3 of the population with plague-specific symptoms in a few weeks to months (Fig. 2) [29] and the flu epidemic of 1918 eliminated 20 million in one season (27).

By 2001, Africa had reportedly generated a cumulative total of 1,093,522 AIDS cases (26). But, during this period the population of Sub-Saharan Africa had grown (at an annual rate of about 2.6% per year) from 378 million in 1980 to 652 million in 2000 (28). Therefore, a possible, above-normal loss of 1 million lives to AIDS is statistically hard to verify for two reasons: 1) the loss would be dwarfed by the overwhelming, simultaneous gain of 274 million people (the equivalent of the population of the USA), and 2) the African AIDS-defining diseases are indistinguishable from conventional African morbidity and mortality (2).

Because of the many epidemiological and clinical differences between African AIDS and its American/European namesake, and because of the many uncertainties about the statistics on African AIDS (29), both the novelty of African AIDS and its relationship to American/European AIDS have recently been called into question (29-37). Indeed, all available data are compatible with a perennial African epidemic of poverty-associated diseases under the new name AIDS (19, 22).

Because the WHO decided in 1985 to accept AIDS diagnoses without an HIV-test, there is no reliable documentation for even an HIV epidemic in Africa (29, 38). Such presumptive diagnoses were approved because the cost of the HIV-antibody test is prohibitive for most Africans. As a result, there are huge discrepancies in African AIDS statistics. For instance, based on WHO information, the Durban Declaration claimed in 2000 that, "24.5 million...are living with HIV or AIDS in Sub-Saharan Africa". However, the WHO had reported no more than 81,565 new cases AIDS for the whole African continent in

that year (obtained by subtracting the cumulative total of 794,444 in 1999 from the cumulative total of 876,009 in 2000) (39, 40).

African AIDS is assumed to be sexually transmitted

The assumptions 1) that HIV is sexually transmitted, predominantly on an heterosexual basis, and 2) in 2000 there were "24.5 million...living with HIV or AIDS in Sub-Saharan Africa" (40) produce a sexual paradox. Mainstream HIV researchers have agreed that for a woman it takes on average 1000 unprotected sexual contacts with HIV-positive men to transmit HIV, and for a man an average of 8000 unprotected sexual contacts with HIV-positive women (36,41,42); incidentally, these are very low transmission rates: by way of comparison, it only takes 2-3 sexual contacts to spread syphilis. Clearly it is not possible to maintain such a constant 1:1 prevalence rate between the sexes over two decades with an 8-fold difference in per-contact susceptibility.

Notice that, according to the CDC's HIV/AIDS surveillance reports (checked for various years), the percent of children (under 15) in the USA who had AIDS was never over 1% in any given year. In recent years the number is below 1%. Getting a handle on number of HIV-positive children is more difficult. A lot of assumptions are involved but for 2004 the CDC estimated that about 0.2% (no error range is given) of HIV-positive Americans were under 15 years old. Numbers for Africans are wholly unreliable. They are all generated by computer models which have error rates of 50-100% and more, based on the frequent changes in the estimates for any given year among different models.

Based on the official UNAIDS Report on the Global HIV/AIDS Epidemic, published in June 2000, we shall assume that in the Sub-Saharian Africa there were about a million HIV-positive children. This means that AIDS was spread, according to official sources, mainly through sexual contacts. But what is the average frequency of sexual contacts in Africa?

In order to rely on fact, rather than on groundless fantasies of African sexual activity, notice that the figure for South Africa is 29 per year (0.6 per week, or once in 13 days). Now a survey by Durex, a leading a leading manufacturer of contraceptives, found the frequency of sexual interaction varies significantly from country to country and that the global average for frequency of sex is 109 times per year (2.1 times per week, or once every 3.3 days). The following summary shows how individual nations compare to the national average of frequency of sexual interaction per year.

Frequency By Country:
United States 135
Russia 133
France 128
Germany 127
Britain 124

People from Thailand had the lowest average sexual frequency at 64 times per year, half the frequency of Americans (source: 1997 Durex Global Sex Survey). The South African average, therefore, is less than half this minimum national frequency! And yet, notwithstanding the much higher frequency in Europe and USA with respect to Africa, the promised heterosexual AIDS epidemics never materialized (43).

It strains credulity to accept that poor, hungry Sub-Saharan Africans are engaging in particularly high levels of sexual activity and promiscuity. A recent thorough epidemiological study of sexual transmission of HIV in Africa found the same "low rates of heterosexual transmission [of HIV], as in developed countries [and] no correlation between the percent of adults...reporting non-regular sexual partners...and

HIV prevalence" (36). These and other anomalies led Brewer et al. to "propose that existing data can no longer be reconciled with the received wisdom about the exceptional role of sex in the African epidemic" (44). Thus, either the assumption of the Durban Declaration that HIV is sexually transmitted, or its claim that 24.5 million are HIV-positive, or both are flawed. Nevertheless, we continue to read in newspapers and hear on television that 25 million people have died of AIDS, and there are upwards of 40 million people infected with HIV—and most of these are said to be in Africa.

South Africa is the richest country in sub-Saharan Africa and has the most reliable statistics on the continent. Statistics South Africa (Stats SA) reports a constant growth in the population of South Africa from 38 million in 1994 to 43 million in 2001 (Fig. 3) (46, 47). Furthermore, the rise in the number of deaths from all causes during the same period was also constant, growing as the population grows—but no faster (Fig. 3).

The latest antenatal screening survey in South Africa (48) also failed to support the hypothesis that HIV is sexually transmitted but instead confirms the conclusion of Brewer et al. that, "HIV is not transmitted by 'sex'" (45). The survey included testing pregnant women for syphilis and antibodies to HIV in order to see how the two diseases were correlated by geographical location and over time. But, there was no correlation. On the contrary, KwaZulu-Natal, which is leading when it comes to HIV, has the lowest rate of syphilis in all provinces (Fig. 4). Western Cape, on the other hand, had the highest rate of syphilis in 2000 but the lowest HIV prevalence. Northern Cape had the highest rate of syphilis in 2001 but the third lowest prevalence of HIV antibodies in that year. Paradoxically, then, there is an inverse geographical correlation between syphilis and HIV (Fig. 4) although both are said to be transmitted by heterosexual intercourse. An even more extraordinary result is the divergence over time between an increasing prevalence of antibodies to HIV and a declining rate of syphilis (Fig. 5). This is also difficult to understand given the assumption that both are sexually transmitted.

A recent study in Uganda produced similar results. The intention of the study had been to reduce HIV incidence by mass treatment of STDs with conventional antibiotics. The rationale behind the study was that reducing STDs (which was assumed to be a co-factor in the transmission of HIV) should reduce the transmission of HIV. However, the result of the study was paradoxical. While the investigators were very successful in significantly reducing STDs, their intervention had "no [effect] on incidence of HIV-1 infection..." (49).

The data from Thailand show that these paradoxical results are not peculiar to Africa. Even though Thailand is said to be severely hit by a heterosexually transmitted HIV-epidemic, we find yet again the same scenario presented by South Africa and Uganda. Bangkok has the highest rate of STDs but low HIV prevalence. Conversely, the so called Golden Triangle of northern Thailand has the highest rate of HIV but the second lowest STD morbidity of all regions. And, even within the different provinces of the Northern Region there is a negative correlation between HIV and syphilis (50). The conclusion from these observations is obvious: HIV cannot be heterosexually transmitted.

African AIDS numbers are based on HIV-antibodies in pregnant women

Before 1998, two HIV-antibody tests had been performed for the South African surveys: one screening test and a confirmation test on the positive samples. The second test was skipped from 1998 onwards, except in Western Cape, even though generally it is the accepted standard to do at least two tests. Furthermore, the manufacturer of the HIV-antibody test that was used in the surveys specifically warns that, "non-specific reactions may be seen in samples from some people who, for example, due to prior pregnancy...have antibodies to the human cells or media in which HIV-1 is grown for manufacture of the EIA" (51). In other words the test, which may show false positive reactions in women with "prior

pregnancy", is being used in pregnant women without further confirmation or adjustment. The insert that comes with the antibody test also warns that, "at present there is no recognized standard for establishing the presence or absence of HIV-1 antibody in human blood." This probably explains why "Studies from seven African countries over the last 15 years show rates of HIV incidence during antenatal and/or post-partum periods exceeding what could be expected solely from sexual transmission" (52). Yet, these problematic, unconfirmed results from pregnant women are then used to estimate the frequency of HIV in the general population (53) and eventually the whole of Sub-Saharan Africa.

Thus, there is no evidence that HIV is spreading through sexual intercourse (or any other way) in Africa or anywhere else. Combined with the evidence that Africa is not currently being devastated and depopulated by an AIDS epidemic, the inability to document a sexually transmitted epidemic of HIV shows that a future HIV-caused AIDS apocalypse in Africa is unlikely.

AIDS Incorporated at war with South African President Thabo Mbeki

The inability to document massive devastation and depopulation of Africa due to AIDS plus the lack of evidence for a sexually transmitted epidemic of HIV has made Africa—especially South Africa—the biggest roadblock impeding the expansion of American-dominated AIDS Incorporated throughout the developing world. The most significant battle to determine the future of AIDS Inc. is being waged right now in South Africa.

South African President Thabo Mbeki continues to receive intense personal attacks because he included on his AIDS Advisory Panel in 2000 a number of scientists and physicians from around the world who question the mainstream dogma on AIDS. Having failed to silence Mbeki, the AIDS establishment has orchestrated an international campaign to undermine his presidency and neutralize his influence because he insists on getting answers to some very basic questions:

1) Why is AIDS in Africa so completely different from AIDS in the USA and Europe?

2) How does a virus know to cause different diseases on different continents?

3) How does a virus know if you are male or female, gay or straight, white or black, rich or poor, urban or rural?

4) Where is the evidence that AIDS is devastating and depopulating South Africa?

5) Why treat immune deficiency with highly immunosuppressive anti-HIV drugs?

Until satisfactory answers to these questions are provided, Thabo Mbeki's government is justifiably suspicious of the rush to get the highly toxic anti-HIV drugs into South African bodies.

AIDS Inc., in collusion with western media, regularly presents a false picture of South Africans pleading with their president to provide antiretroviral drugs. What the western media never discusses, however, is the reluctance of South Africans to take the anti-HIV drugs even when offered freely. As recently as October 15, 2003, Old Mutual Insurance Company disclosed in its Healthcare Survey 2003, that HIV-infected employees were not voluntarily coming forward to participate in the antiretroviral programs offered by South African companies (54). A chronically unreported story is the inability of AIDS researchers to recruit sufficient numbers of South Africans to participate in HIV drug and vaccine clinical trials. The South African government is currently conducting trials in 18 centers across the country to determine the safety and efficacy of administering the anti-HIV drug nevirapine to pregnant women and

their babies. The trial was to have been completed in December 2002 but not enough women have volunteered. In any event, AIDS Inc. cannot afford to let this trial go to completion for two reasons: 1) the results may show that the drug is neither safe nor efficacious, and 2) the government of South Africa cannot be permitted to set the example of acting independently of AIDS Inc. when it comes to AIDS.

As the 2004 presidential election in South Africa approached (which Mbeki won with 70% of the vote), the media escalated the attack on Mbeki. During an interview with the Washington Post in September 2003, President Mbeki said that he personally did not know anybody with AIDS. Given the almost daily pronouncements that four million South Africans have "HIV/AIDS", the media rushed to portray Mbeki as either a buffoon or liar. Rian Malan, a famous South African author, was angered that no journalist bothered to find out the truth behind Mbeki's statement. Malan had published a lengthy article in 2001 titled "AIDS in Africa: in search of the truth" (33), where he documented the lack of evidence behind claims that AIDS was devastating and depopulating Africa. To address the most recent lapse in mainstream journalism, Malan sent a letter (as yet unpublished) to the *Sunday Times* of South Africa arguing that it is not only likely that Mbeki does not know anybody with AIDS but is probably true for many South Africans.

> *Letters to the editor*
> *Sunday Times*
>
> *Dear Sir:*
>
> *I am somewhat perplexed by the AIDS debate presently raging in your letters column. As we recall, President Mbeki started it by telling the Washington Post that he personally knew nobody who had AIDS. Pieter Dirk-Uys openly accused the president of lying, whereupon Essop Pahad dismissed the satirist as an irritating gadfly and the whole affair degenerated into yet another orgy of name-calling.*
>
> *I submit that the real point has been missed entirely.*
>
> *Dirk-Uys's position is predicated on the assumption that Africa's AIDS pandemic has been accurately measured. If it is true, as Mr. Dirk-Uys believes, that upwards of four million South Africans carry the virus, and that one in four urban adults is walking dead, it would indeed seem wildly unlikely that Mr. Mbeki knows no one who is infected.*
>
> *But what if the AIDS statistics are wrong? I won't bore you with a disquisition on how AIDS estimates are arrived at, and there would be little point anyway, because in most of Africa, statistics are unreliable or non-existent. They are considerably better here in the RSA, however, and among South Africa's middle and upper classes, they are very good indeed.*
>
> *We therefore know that about seven million South Africans have medical aid. We also know that 450,000 of them are officially estimated to be HIV-infected. And finally, we know (because the Sunday Times reported as much on September 24) that only 22,500, or five percent, of these medically insured individuals have come forth to claim the free life-saving medications to which they are entitled by virtue of being on medical aid.*
>
> *AIDS experts attribute this staggering shortfall to fear of stigmatisation. In other words, they ask us to believe that 19 out of 20 medically insured South Africans are so sensitive*

about HIV that they would rather die than admit to their doctors that they have this disease. Since this is preposterous, let's assume for the sake of argument that the number of infections in this particular population has been drastically over-estimated.

It seems safe to assert that almost everyone with whom the president has daily dealings is on medical aid. His wife and brother are almost certainly thus priviledged. All parliamentarians have medical aid, as do Mbeki's support staff, the civil servants who do his bidding and the policemen who guard his various palaces. We know, thanks to the aforementioned Sunday Times report, that only three in a thousand of these medically-insured people are receiving anti-HIV treatment. Others may be infected, but we can be absolutely certain about only three. Is it really inconceivable that the president doesn't know any of them?

I don't claim to know the answer, but the accuracy of HIV statistics should be urgently interrogated, preferably by a presidential commission including at least two specialists whose salaries and status are not in any way dependent on present assumptions regarding the extent of the plague.

Rian Malan
Cape Town

On July 30, 2003, the government of South Africa sent a clear message that the people of South African will determine their own future, independent from outside pressures. The Medicines Control Council (MCC) rejected HIVNET012, the Ugandan clinical trial that is the sole basis for using nevirapine to prevent the transmission of HIV from mother to child. MCC gave Boehringer Ingelheim (the manufacturer of nevirapine) 90 days to provide "further evidence of nevirapine when used on its own in reducing the risk of mother-to-child transmission of HIV" (55). Responding to the criticism of the MCC action, president Mbeki said that, "This announcement illustrated the challenge we face, to ensure that even on this vexed question...(we refuse) to allow the never-ending search for scientific truth to be suffocated by self-serving beliefs. … We must free ourselves of the 'friends' who populate our ranks, originating from the world of the rich, who come to us, perhaps dressed in jeans and T-shirts, as advisers and consultants, while we end up as the voice that gives popular legitimacy to decisions we neither made, nor intended to make, which our 'friends' made for us, taking advantage of an admission that perhaps we are not sufficiently educated" (56).

Realizing that South Africa is crucial to its expansion, AIDS Inc. drafted former president Jimmy Carter and billionaire Bill Gates to do battle with Thabo Mbeki in March, 2002. Carter said he and Gates believed South Africa had not made "adequate progress" in preventing new cases of Aids, which were increasing "by leaps and bounds every day".

Jimmy Carter urged President Mbeki to learn the lessons from poorer African countries that have been much more effective in fighting AIDS—which translated means those African countries that have submitted to the hegemony of AIDS Inc. Former president Mandela joined Carter and the other drugs-into-bodies enthusiasts saying that, "We can't afford to be conducting debates while people are dying. We have to ensure that our people are given the drugs which are going to help them. This is a war." War, indeed! President Clinton declared AIDS a national security threat to the USA in 2000, right before Mbeki's State visit to the Whitehouse.

On March 10, 2002, the African National Congress (ANC) lashed out at Jimmy Carter's attempt to pressure Mbeki's government.

> *"We are also surprised at the comments made by the [Carter] delegation about anti-retrovirals drugs in general and Nevirapine in particular.*
>
> *We do not understand why US citizens urge this drug upon us when the health authorities in their own country do not allow its use for mother-to-child transmission [of HIV]. One of the reasons for this is that these health authorities say that there is insufficient data about issues of the safety of the drug.*
>
> *We find it alarming that President Carter is willing to treat our people as guinea pigs, in the interest of the pharmaceutical companies, which he would not do in his own country.*
>
> *The comments he and others made after meeting with President Mbeki indicate the true purpose of his visit to our country, which was arranged without the knowledge of the government.*
>
> *Once more, we would like to assure President Carter that our government is firmly committed to meet the health challenges facing our people, including AIDS, STD's, TB, cholera, malaria and others.*
>
> *For this, we do not need the interference and contemptuous attitude of President Carter or anybody else. As South Africans, we have the possibility to find solutions to our problems, as the people of the US have.*
>
> *We are not arrogant to presume that we know what the US should do to respond to its many domestic challenges. Nobody from elsewhere in the world should presume they have a superior right to tell us what to do with our own challenges."*

George W. Bush's $15 billion AIDS package and his recent trip to South Africa (among other stops) was just the latest attempt to either bribe or pressure Mbeki to toe the US line on AIDS. If AIDS Inc. can pry open the drugs-into-bodies floodgates in South Africa, then billions of dollars will pour through Africa, India, and China on their way to the bank accounts of American and other drug companies. The giant corporations will get richer beyond measure whether or not giving nevirapine to women and children (or anybody else for that matter) is a good idea as Jimmy Carter, Bill Gates, Nelson Mandela, and George Bush claim, or insane and criminal as the black box warning labels that come with nevirapine, AZT, 3TC, d4T, ddI, etc. makes clear.

Nelson Mandela used the recent death of his son Makgatho to embarrass Mbeki on AIDS. According to an article in the January 6, 2005, issue of the Washington Post (57), "Former South African president Nelson Mandela announced Thursday that his son, Makgatho Mandela, 54, had died that morning of illness related to AIDS, and he urged other families to speak openly about the toll of a disease that has ravaged South Africa but is still widely regarded as a taboo topic." However, the article is revealing about what actually killed former President Nelson Mandela's son. "A spokesman for the Mandela family, Isaac Amuah, said in a phone interview that the immediate cause of Makgatho's death was complications from a gall-bladder operation. But he said that Aids was a contributing factor and that Mandela was determined to portray the death as resulting from Aids to demystify the disease."

A gall-bladder operation implies liver problems. The leading cause of death among HIV-positive people

in the US is now liver failure (see below). Liver failure is not (yet) an Aids-defining disease. All anti-HIV drugs cause liver toxicity and “Makgatho ... had been receiving antiretroviral treatment for more than a year”.

II. But—people are living longer because of the drugs!

When confronted with the fact that the evidence from Africa actually refutes the predictions of the contagious/HIV hypothesis of AIDS, the mainstream quickly retorts: “but—people are living longer because of the drugs”. Speaking for AIDS Inc., Martin Delaney of Project Inform says that, “the multi-drug combinations have dramatically reduced death rates and greatly extended the lives of those [HIV-positive people] using such therapies” (58). This is a very common assertion made these days about the wonderful life-saving benefits of the admittedly highly toxic anti-HIV drugs. However, even a quick look at the evidence shows that Delaney's unrestrained enthusiasm for the anti-HIV drugs is not justified.

The CDC's HIV/AIDS Surveillance Reports document how AIDS has changed in the USA over the past two decades. The CDC data show that AIDS peaked in 1992 and has been going down steadily ever since (Fig. 6). The mortality from AIDS is dropping because AIDS has been declining in the USA since 1992, years before the introduction in 1996 of Highly Active AntiRetroviral multi-drug combinations (HAART) that Delaney touts. The apparent life-saving benefits of the HIV-protease inhibitor-containing cocktails is a consequence of the simple fact that these drugs have appeared on the scene long after AIDS peaked in the USA, during a period when the mortality due to AIDS was naturally in decline (59).

Another reason for the decline in AIDS deaths is the CDC's re-definition of what constitutes AIDS in the USA. As of 1993, all you needed to qualify as an AIDS case were results from two lab tests: be immune to HIV, that is have antibodies to the virus, and have fewer than 200 CD4 cells per microliter of blood or a CD4 percentage less than 14 (60). The CDC has a rule that an AIDS case is classified according to the earliest definition that applies. Consequently, in 1997, 36,634 people (61% of all new AIDS cases) were classified under this non-disease category (59). Because the majority of new AIDS cases in the USA are classified according to the non-disease criteria of the CDC’s 1993 definition change, they do not have any of the colossal list of AIDS diseases—from diarrhea to dementia, pneumonia to Kaposi’s sarcoma—required by earlier definitions. Thus, the majority of new AIDS cases since the mid 1990s are disease-free (healthy) people. However, we can no longer follow the nationwide trend of including healthy people as AIDS cases after 1997 because the CDC stopped listing the AIDS-indicator diseases and conditions (formerly Table 12 (59)) in its HIV/AIDS Surveillance Reports.

Nevertheless, San Francisco continues to report AIDS cases according to specific AIDS-defining diseases. The San Francisco Quarterly AIDS Surveillance Report for 2000 shows in Table 10 on page 8 that 47.7 percent of all AIDS cases from 1980 through 2000 were diagnosed with AIDS according to the two lab tests of the 1993 definition change (61). Since this is a cumulative number, which combines all AIDS cases under four different definitions of AIDS, well over half of all people (mostly gay men) in San Francisco that are currently being labeled as AIDS cases have no AIDS-defining disease. In spite of the 1993 definition change, with its inclusion of large numbers of healthy people as AIDS cases, the figure on page one of reference (61) reflects the national picture showing that the number of new AIDS cases in San Francisco has steadily declined since a peak of 760 in 1992 to below 50 in 2000, the same low level as in 1982. The new AIDS cases in San Francisco are now so few you could know them all by name.

As a consequence of the CDC's 1993 definition of AIDS, over half of the people now being treated with the anti-HIV drug cocktails since 1996 (the year the HIV protease inhibitor cocktails became available) were healthy when they started taking the drugs. Delaney, mainstream AIDS researchers and the AIDS

press are crediting HAART with prolonging the lives of these healthy people. Sadly, these healthy people taking HAART don't stay healthy long. They eventually get sick from the drugs and die if they stay on them long enough (1, 62-65). “Hepatoxicity…can occur with any antiretroviral regimen currently in use. Most remarkably, longitudinal surveys have not only reported an increased incidence of hepatic injury in HAART-treated patients but also identified life-threatening hepatotoxic events and end-stage liver disease in patients on antiretroviral treatment” (66, 67). Indeed, a recent study ”found that end-stage liver disease has become the leading cause of death of HIV-seropositive patients” in a Boston hospital (68).

Just before Christmas 2004, John Solomon of the Associated Press broke the story that the National Institutes of Health (NIH) in 2002 hid the fact that the toxicity of the anti-HIV drug nevirapine was much more serious than they had led everyone to believe (69). Newly hired Dr. Jonathan Fishbein was abruptly fired by the NIH after blowing the whistle on the NIH’s cover-up of nevirapine’s toxicity (http://www.honestdoctor.org/resume.html). Senator Charles E. Grassley, the Finance Committee chairman and an Iowa Republican, has asked the Justice Department to investigate NIH's conduct (69).

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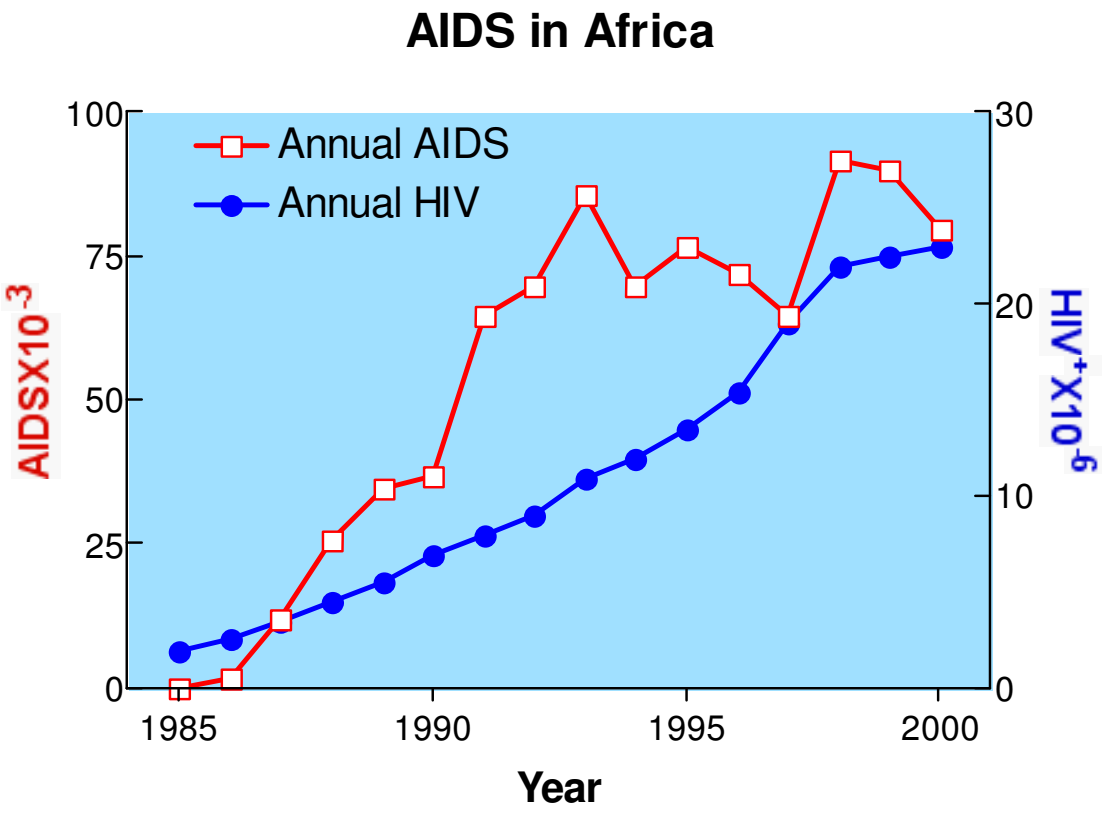

Figure 1. The incidence of AIDS cases and HIV antibody carriers in Africa according to the WHO (39, 40)

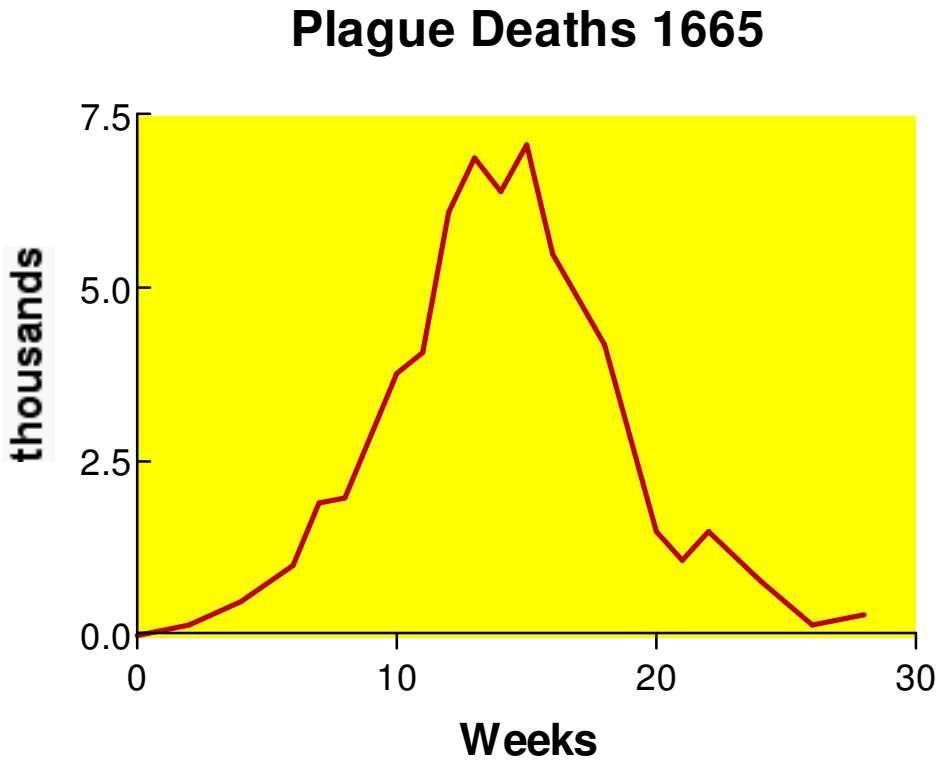

Figure 2. The plague in London of 1665 shows the classical bell-shape time-course (on the order of weeks) for a contagious epidemic (70).

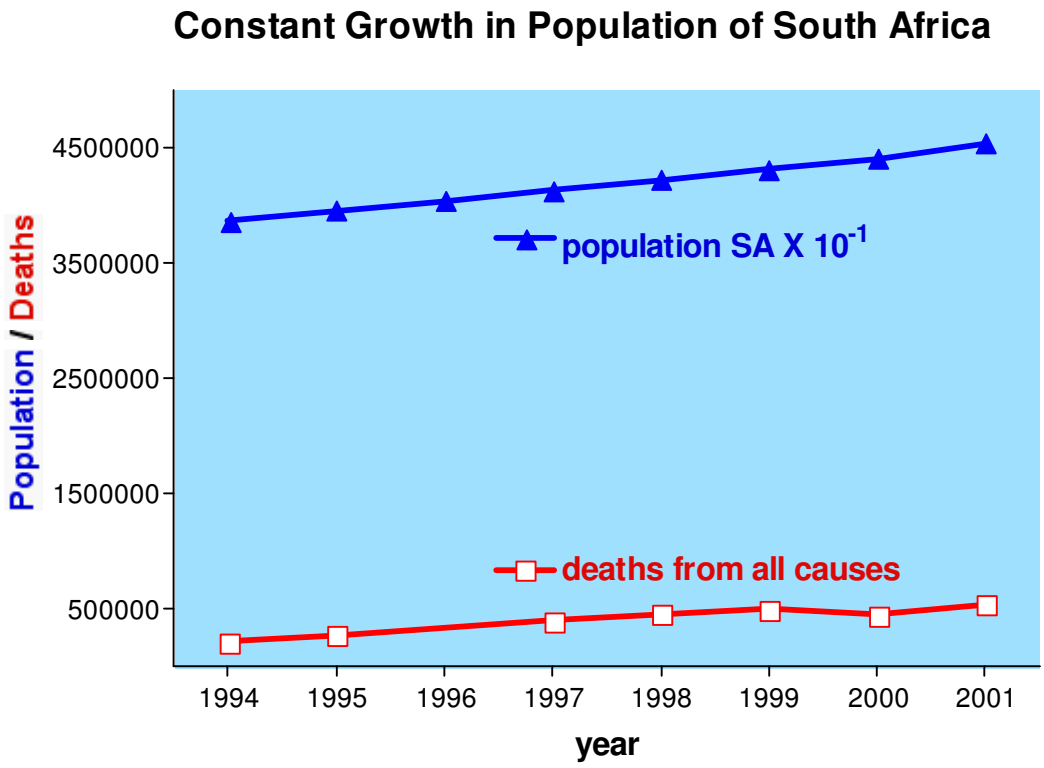

Figure 3. The increase in the number of deaths in South Africa parallels and is explained by the growth in the population (46, 47). There was even a slight drop in the number of deaths for 2000 and 2001. There is clearly no indication that AIDS (or anything else for that matter) is depopulating South Africa.

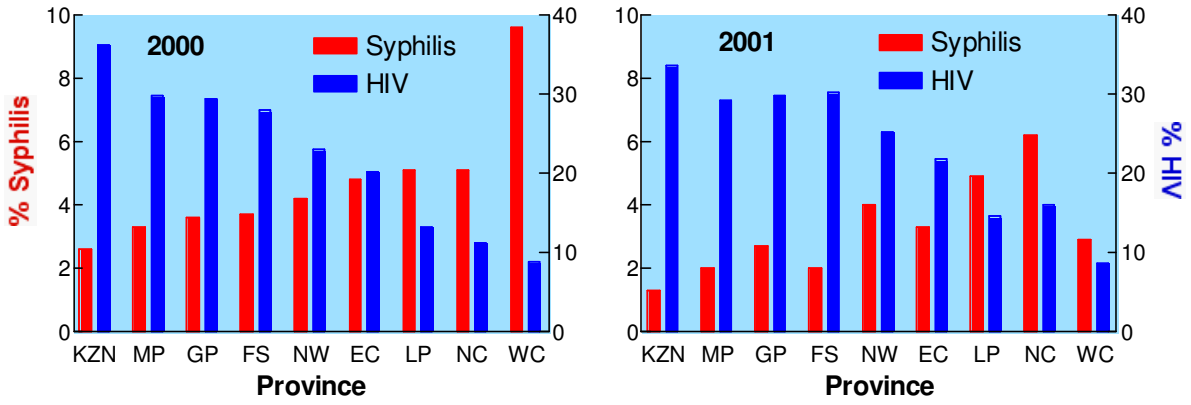

Figure 4. No correlation between syphilis & HIV prevalence among antenatal attendees in South African Provinces. KwaZulu-Natal (KZN), Mpumalanga (MP), Gauteng (GP), Free State (FS), North West (NW), Eastern Cape (EC), Limpopo province (LP), Northern Cape (NC), Western Cape (WC) (48).

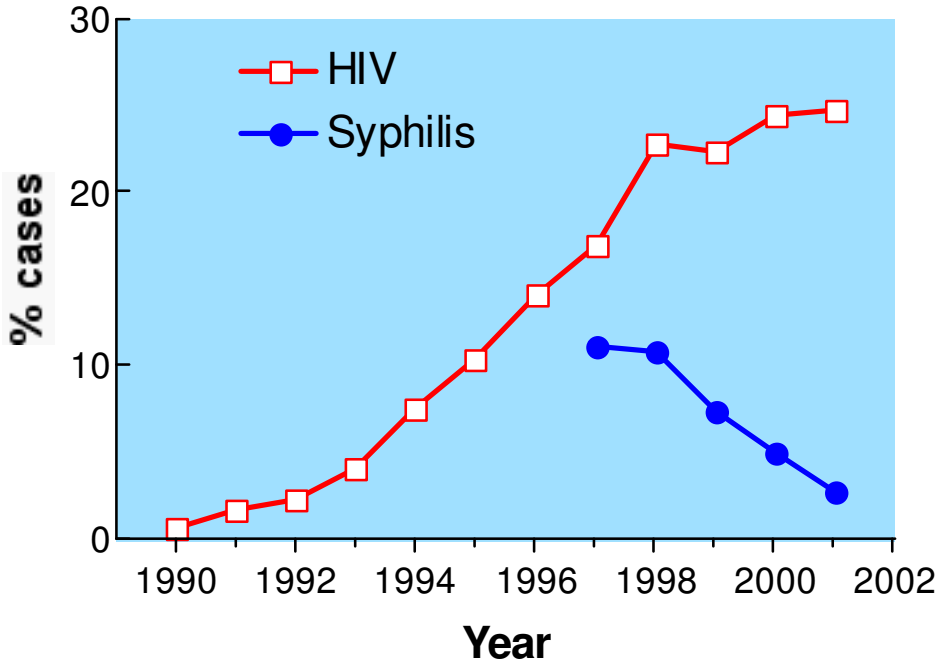

Figure 5. The divergence over time between an increasing prevalence of antibodies to HIV and a declining rate of syphilis in South Africa (48).

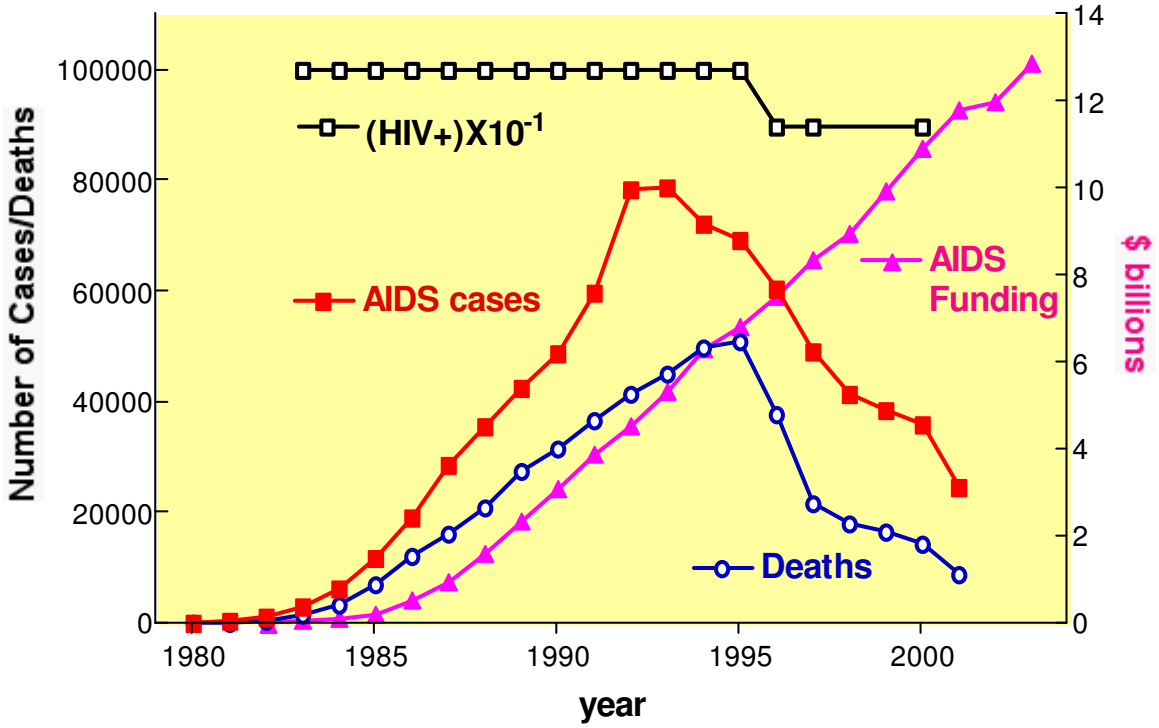

Figure 6. The CDC data show that AIDS peaked in 1992 and has been going down steadily ever since (59). The mortality rate from AIDS is dropping because AIDS has been declining in the USA since 1992, years before the introduction of Highly Active AntiRetroviral multi-drug combinations (HAART) in 1996. The apparent life-saving benefits of the HIV-protease inhibitor cocktails is a consequence of the simple fact that these drugs have appeared on the scene long after AIDS peaked in the USA, during a period when the mortality due to AIDS was naturally in decline. Note that US taxpayers continue to fund AIDS at ever increasing amounts for a total of $118 billion through 2003 (71, 72).

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