

Myths and Misconceptions of the Orthodox View of AIDS in Africa

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“Nothing in life is to be feared. It is only to be understood.”

Marie Curie

“To kill an error is as good a service as,
and sometimes even better than, establishing a new truth or fact.”

Charles Darwin

ABSTRACT

This article rebuts conventional claims that AIDS in Africa is a microbial problem to be controlled through sexual abstinence, behavior modification, condoms, and drugs. The orthodox view mistakenly attributes to sexual activities the common symptoms that define an AIDS case in Africa - diarrhea, high fever, weight loss and dry cough. What has really made Africans increasingly sick over the past 25 years are deteriorating political economies, not people's sexual behavior. The establishment view on AIDS turned poverty into a medical issue and made everyday life an obsession about safe sex. While the vast, self-perpetuating AIDS industry invented such aggressive phrases as “the war on AIDS” and “fighting stigma,” it viciously denounced any physician, scientist, journalist or citizen who exposed the inconsistencies, contradictions and errors in their campaigns. Thus, fighting AIDS in Africa degenerated into an intolerant religious crusade. Poverty and social inequality are the most potent co-factors for an AIDS diagnosis. In South Africa, racial inequalities rooted in *apartheid* mandated rigid segregation of health facilities and disproportionate spending on the health of whites, compared to blacks. *Apartheid* policies ignored the diseases that primarily afflicted Africans - malaria, tuberculosis, respiratory infections and protein anemia. Even after the end of *apartheid*, the absence of basic sanitation and clean water supplies still affects many Africans in the former homelands and townships. The article argues that the billions of dollars squandered on fighting AIDS should be diverted to poverty relief, job creation, the provision of better sanitation, better drinking water, and financial help for drought-stricken farmers. The cure for AIDS in Africa is as near at hand as an alternative explanation for what is making Africans sick in the first place.

The chief purpose of the historian, claims John Lukacs, “is the pursuit of truth through a reduction of ignorance, including untruths.”¹

The core characteristics of the historical method include the trait of curiosity, a willingness to hold up evidence from the past to a variety of angles, making connections between apparently disconnected events, and being prepared to modify deeply held views. For historians, there are neither sacred texts nor any sacred statistics. It matters more whether someone honestly considered ideas contrary to one’s own, and then took the time to identify the point at which significant lines of history converged. Logical coherence, relatedness to experience, openness to reasoned debate, and acceptance of sharp controversy are all indispensable for advancing historical knowledge.

Historical study “instills ways of thinking [which] include a respect for historical context and evidence, a greater awareness of the historical processes unfolding in our own time, and a deeper understanding of the varied traditions current today.”² Globalization refers to the closer integration of national economies into international markets through the increasingly unrestricted flow of trade, investment, objects, finance, and skills. Oceangoing ships transfer about 95 percent of the world’s trade in minerals, fuel, bulk commodities, foodstuffs and medicine whose estimated value for 2007 is at least \$6 trillion. In the modern era, the age of the so-called networked individual, human stories are increasingly connected as people in diverse parts of the world “form networks with distant and unknown others, readily engage in collective action, express ideas, broadcast values, and [can] be sure their voices are heard widely,” bound together by the consequences of science.³

Characterized by the rapid growth of transactions increasingly outside the framework of inter-state relations, globalization also involves the circulation of ideas and the claims of researchers often free of national regulation or scrutiny.⁴ If politics, economies and cultures have been merging in an increasingly integrated world for the past thirty years, then AIDS has become a key symbol of that globalization process.

¹ John Lukacs, *The End of an Age* (New Haven: Yale University Press, 2002), p. 77.

² Great Britain Quality Assurance Agency for Higher Education [<http://www.qaa.ac.uk/crntwork/benchmark/honouyrs.html>], cited in Jonathan Gorman, “Historians and Their Duties,” *History and Theory*, Vol. 43, #4 (December 2004), p. 110.

³ The term is from James Roseneau, “Illusions of Power and Empire,” *History and Theory*, Vol. 44, #4 (December 2005), pp. 73-87 who explains that “the internet and the cell phone are only the most conspicuous of several explosive technologies that have enabled people and their organizations to mobilize, demand, agree, yield, inform, coalesce, fragment or otherwise interact with each other on a global scale.”

⁴ Skeptics claim, of course, that freeing the international movement of capital, goods, services and skills increases the leverage of capitalists versus national governments, local communities, and workers, thereby weakening the national state’s capacity to impose equity-related costs on corporations. This is the cogent argument of Richard Sandbrook, Marc Edelman, Patrick Heller and Judith Teichman, *Social Democracy in the Global Periphery* (Cambridge: Cambridge University Press, 2006).

AIDS is too important, too vast and too scary to get its history wrong. Historians can investigate the ways in which people accept and implement the basic claims made about AIDS and explain how the core beliefs about AIDS spread effortlessly from the United States to Africa to become the basis for a global sexual health crusade.

Our knowledge and assumptions about AIDS are ultimately historical. They initially arose in the concrete circumstances of a particular place (California), at a specific time (early 1980s), and then extended quickly to Africa where AIDS became a dominant characteristic of the age of globalization. While doing field research in Somalia and Djibouti in the late 1980s and early 1990s, what was happening in Africa regarding AIDS came more clearly into focus to me – like a blinding flash of the obvious – as a manifestation of poverty and underdevelopment, *not* the product of some mutant virus spread by prostitutes, truck drivers and normal (or abnormal) sexual activities.

This article challenges the conventional assumptions that causally link sexual behavior to AIDS cases in Africa. It suggests that conceptual flaws, dubious statistics, western stereotypes, poorly designed research, an obliteration of history, and racist claims about African sexuality have created the untenable, often outrageous conclusions about AIDS now proliferating across Africa.

As a master narrative rooted in sexual fear, the AIDS in Africa discourse has had brilliant success as political theater, but is one of the great medical fallacies of our times. Discussions about AIDS in Africa often devolve into a series of rhetorical gimmicks and slogans, not a coherent strategy for public health improvements.⁵ It is time to develop a pluralist historiography that uses clarity, accessibility and precision to oppose the Soviet-style rigidity of the infectious viral theory of AIDS. For instance, despite somber insinuations that Africans are unwilling to discuss their sexual practices, in my experience every time I sought to critically review the literature on sexuality, it was the conventional AIDS researchers themselves who ended the conversation.⁶

⁵ These diffuse cultural forms are lavishly displayed at every biennial International AIDS Conference, dominated by therapeutic activism, pharmaceutical largesse, chronic victimhood, endless melodramas, and the songs, jingles, slogans and symbols of condom evangelicals and safe sex missionaries. On December 1, 2005 (World AIDS Day), the Kaiser Foundation placed a remarkable glossy insert in many American newspapers. Using 3-inch high letters, its first page proclaimed, “We All Have AIDS,” and the next page added, “If One of Us Does.”

⁶ Indispensable reading for any discussion about HIV and AIDS in Africa (especially given the barrage of ahistorical nonsense and statistical sophistry about South Africa) is a fine book by economist Eileen Stillwaggon, *AIDS and the Ecology of Poverty* (New York: Oxford University Press, 2006). One of its best parts is Chapter 7, “Racial Metaphors: Interpreting Sex and AIDS in Africa.” The thread of that chapter is Stillwaggon’s meticulous denouement of the errant and abhorrent research claims made by John and Pat Caldwell. Stillwaggon exposes as racist claptrap the utterly distorted observations that characterize the claims of those two, oft-cited mainstream AIDS researchers about African sexual behavior.

It made me wonder why historians of Africa, most of whom are critical thinkers on all other topics - Bush's policies against terrorism, the nature of Islamicist fundamentalism, the origins of *apartheid*, the impact of European colonialism, the roots of contemporary poverty - set aside their intellectual curiosity and submit so willingly to a set of claims organized around a sex panic.

A generation of researchers, policy-makers, pharmaceutical industry representatives, activists, rock stars and entertainers, all with a great stake in defending the infectious viral theory of AIDS, become unhinged at the prospect of new thinking. Even posing questions is deemed impermissible; anyone who raises them usually evokes dismissive vilification, delegitimizing, or worse. Mundane facts, the scientific method, second thoughts or even confidence in the powers of our own common sense matter little to social crusaders whose religious sense of certainty has them hunting for improper sexual behavior in order to save lives.⁷

AIDS researchers are comfortable speaking to audiences that seldom question their core beliefs. They rarely have their claims challenged as they cling to what amounts to a catechism. There is no topic where the suffocating atmosphere of political correctness remains so writ large. Evidently unable to make a historical argument, they respond with sputtering rage and a fusillade of hysterical abuse, outraged that a critic would scrutinize their agenda. Any historian who challenges the orthodox view of AIDS in Africa must be willing to stand up to a tidal wave of popular assumptions and to enter a morally righteous world where skeptics are as welcome as the Devil at a Christmas Mass demanding proof of Jesus' existence.

The master narrative about AIDS is rooted in 25 years of polemics bolstered by theatrical displays of red ribbons, candlelight vigils and quilts. For AIDS activists, moments like World AIDS Day, the biennial international conferences, announcing one's "HIV status," or citing gigantic numbers are central to their claims of justified fear-mongering. The more emotional and volatile one is, the more "real" he is believed to be. They systematically filter out any conclusions that do not toe the party line.

AIDS research has become the intellectual equivalent of an echo chamber where only the "right" ideas are heard with little diversity of perspectives. So many activists and researchers have such a stake in the infectious viral theory

⁷ One of the most comically rigid adherents to the orthodox view of AIDS is Nicoli Nattrass, an economist at the University of Cape Town. For a disorganized and quasi-hysterical attack on anyone who dares to question the conventional views on AIDS, see her "AIDS Denialism vs. Science," *Skeptical Inquirer* (September/October 2007) <http://www.csicop.org/si/2007-05/nattrass/html> (accessed December 15, 2007). For a lucid scientific rebuttal of Nattrass and similarly censorious AIDS true believers, see Henry H. Bauer, "Questioning HIV/AIDS: Morally Reprehensible or Scientifically Warranted?" *Journal of American Physicians and Surgeons*, Vol. 12, #4 (Winter 2007), pp. 116-120.

of AIDS that they must ignore all doubts or challenges. The ubiquitous hyping of the global “AIDS threat” aims to keep people in a state of fear about sexuality, nowhere more than in Africa. In closed loops, where critical thinking is anathema, the like-minded talk exclusively to other like-minded people and no one encourages new ideas.

The established paradigm about HIV and AIDS enjoys exemption from normal scrutiny and simple logic. Its defenders assume that no one should question whether the HIV antibody tests are remotely accurate, or why a case of AIDS (unlike any other known malady) is defined with such a decisive difference from one continent to another, or even what sexual behavior has to do with either one. With mind-numbing clichés, today’s AIDS orthodoxy aggressively censors any attempts to question the status quo of their specialization.⁸

According to psychologist Steven Pinker, some debates “get so entwined with people’s moral identity that one despairs that they can ever be resolved by reason and evidence.”⁹ He uses the term “the mentality of taboo” to describe the intellectual loop into which one enters, accepts its main propositions, then finds it difficult to escape. Within the mentality of taboo, “certain ideas are so dangerous that it is sinful even to think about them.”¹⁰ Adherents are shocked and outraged at even being asked to entertain a contrary thought. Not only do they refuse to consider such proposals, but one is not permitted to think about them because the very thought deserves only condemnation.

The mentality of taboo is widespread among AIDS researchers and activists who must show that their heart is in the right place and that they won’t betray those who trust them. Identifying sacred and tabooed beliefs serves as their membership badges. To believe something with a perfect faith, to be incapable of apostasy, is a sign of fidelity to the group and of loyalty to its cause. Breaking faith violates a sacred trust, which means betraying the oppressed and vulnerable. The defenders of the AIDS orthodoxy, to borrow Pinker’s phrase, can be seen as “intuitively certain they are correct and that their opponents have ugly ulterior motives.....[so that] when the facts tip over a sacred cow, people are tempted to suppress the facts and to clamp down on debate because the facts threaten everything they hold sacred.”¹¹

⁸ Upon arrival at Johannesburg International Airport in June 2000, one was greeted by a barrage of 6-foot high posters. One showed a photograph of a lithe white woman, seated on the ground, her head on her knees, a sad and forlorn look on her face with a caption at the bottom that announced, “Never has being positive, felt so negative.” Another poster depicted a gigantic condom, while the words at the bottom promised it was “cheap life insurance.” Buses in the conference city of Durban carried huge posters, which contained an admission on the far left, “I just had sex,” while the far right side posed the question, “will I die?”

⁹ Steven Pinker, *The Blank Slate: The Modern Denial of Human Nature* (New York: Viking Penguin, 2002), p. 281.

¹⁰ Steven Pinker, “The Science of Difference,” *The New Republic* (14 February 2005), p. 16.

¹¹ Pinker, *Blank Slate*, p. 281.

The mentality of taboo is incompatible with historical scholarship. When beliefs become sacred, that mentality is on a collision course with the findings of science and the spirit of free inquiry. “It is the job of scholars to think about things,” says Pinker, “even if only to make clear why they are wrong. Moralization and scholarship thus often find themselves on a collision course.”¹²

Whenever people moralize a scientific study of anything, they eventually follow up with indignant outrage, the castigation of heretics, and a refusal to consider the claims as actually stated, expressed through demonstrations, manifestos and public denunciations. The emotionalism with which people respond to any questions about the HIV hypothesis is a perfect example of this mentality of taboo. With many AIDS researchers and activists merely raising questions about the accuracy of their HIV-sex-AIDS-death theory is impermissible and must be greeted with censorship, scorn and punishment.

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

AIDS has become a great diversion. The belief that behavior modification will cure poverty overlooks the endemic conditions that cause the appearance of the “symptoms” in the first place. AIDS activists and researchers ignore the historical forces that propelled many parts of Africa into a downward economic spiral beginning in the late 1970s and set the stage for the appearance of “AIDS.”

During the Reagan Era, a “Washington Consensus” dominated official thinking about economic development in the U.S. government, the IMF, the World Bank and private banks and foundations. It called for sharp cutbacks in government spending, financial liberalization, privatization of state-owned enterprises, deregulation and the supremacy of the market over all other values, policies that contributed mightily to the demise of Africa. According to Joseph Stiglitz, an economist formerly with the World Bank, during the 1990s, the number of people living in extreme poverty (less than \$2 per day)

¹² Pinker, *op. cit.*, p. 279. This adherence to a “mentality of taboo” was in evidence after journalist Celia Farber published, in a mass circulation magazine, a scathing exposé of the flawed and sometimes fatal drug trials in Uganda, “Out of Control: AIDS and the Corruption of Medical Science,” *Harper’s* (March 2006), pp. 37-52. The readers’ response was so large that the magazine devoted the entire “Letters” section of its May 2006 issue to the feedback, where the staunch defenders of the orthodoxy and several of its leading critics were well represented.

increased by nearly 100 million, world-wide, with the disproportionate amount being found in Africa.

In his Presidential address at the 2005 meeting of the African Studies Association, historian Bruce Berman delineated distinctive African experiences with modernization to show how “the current epoch of globalization” had produced “profound immiseration, social decay, state failure and acute vulnerability...” Berman recalled how the “exhilarating days of independence in the 1960s and into the 1970s” gave way in the early 1980s to “extreme economic decline” whereby a “large proportion of the population of Africa [was] reduced, in the chilling Victorian word, to a social ‘residuum’ effectively expelled from the global market.”¹³

By the late 1970s, the post-colonial narrative of modernization, economic development, and nation-building began to collapse. Countries in eastern and southern Africa became so indebted to and dependent on international financial institutions that they were no longer free to make basic decisions about which goods and services could be allocated.¹⁴ Over the past 30 years, as world prices for key African agricultural exports stagnated, that continent was the only one where people became materially poorer.¹⁵ Beginning in the early 1980s, corruption and decay in the public health field, sharp decreases in the prices of exported commodities, severe restrictions on social services due to the IMF and World Bank strictures of “structural adjustment,” savage civil wars, declining rates of immunization, and crowded refugee camps were among the major forces afflicting Africa as the 20th century ended. None of these historical forces were related to sexual promiscuity.

The only African leader who ever seemed troubled by the many contentious aspects of the orthodox view of AIDS was South Africa’s President Thabo Mbeki, himself an economist. In early 2000, Mbeki appointed an AIDS Advisory Panel that consisted of 52 researchers, scholars and activists (including this author) who held widely opposing views on the definition, causation, prevention and treatment of AIDS cases. Mbeki sought evidence-based answers to three basic questions: 1) what causes the immune deficiency that leads to death from AIDS; 2) what is the most effective response to this cause or causes; and 3) why is HIV/AIDS in sub-Saharan Africa heterosexually transmitted while in the western world it is said to be largely homosexually transmitted?

¹³ Bruce Berman, “The Ordeal of Modernity in an Age of Terror,” Presidential Address, 48th Annual Meeting of the African Studies Association, November 18, 2005, Washington, D.C. Forthcoming in the April 2006 issue of *African Studies Quarterly*.

¹⁴ For thorough documentation, see Joseph E. Stiglitz, *Globalization and Its Discontents* (New York: Norton, 2002) and William K. Tabb, *Unequal Partners: A Primer on Globalization* (New York: New Press, 2002), especially Chapter Three, “Debt, AIDS, and Today’s Colonialism,” pp. 86-120.

¹⁵ This despair is abundantly shown in Martin Meredith, *The Fate of Africa: A History of Fifty Years of Independence* (New York: Free Press, 2005).

Science starts with careful observations of the natural world, and then constructs testable models to explain these data. It submits hypotheses to different perspectives and tests claims against the evidence. Mbeki applied the principle of “Occam’s razor” to AIDS, the scientific rule that the simplest of competing theories is preferred to the more complex, that explanations of unknown phenomena are to be sought first in terms of known quantities. The essence of the scientific method is to frame and operationalize a hypothesis “whose predictions comport with observable results in a consistent manner. If the hypothesis is valid and testable, its result should be generally reproducible, rather than unique to a particular experiment.”¹⁶ Developing a scientific culture is a matter of training critical minds that are able to judge things objectively, to understand the role of observation and measurement, and to comprehend the notion of proof. It also means placing the sciences in a broader historical context of political, economic, and cultural movements.

Mbeki questioned the authority of the international AIDS establishment because he was not convinced that sexual behavior, rather than poverty and malnutrition, were “at the root of his country’s medical woes.”¹⁷ As a head-of-state concerned about his nation’s well being, he sought credible explanations for how an alleged “disease” could be defined with such decisive difference from one continent to another. Mbeki felt that light could be shed on these issues in an open dialogue about public health, politics, and scientific accuracy.

Interested in academic risk-taking, Mbeki stirred up a hornet’s nest and furious international swarming began immediately. It became apparent that those intent on “fighting AIDS” had adopted a missionary-style crusade, evidently similar to “fighting *apartheid*” in the minds of many activists whose lives seemed devoted to a permanent campaign of some sort. Their reliance on military metaphors, apocalyptic visions, and withering scorn toward any disagreement reflected a zealotry that brooked no opposition. Outside the Durban Conference Center at the 2000 International AIDS Conference, enraged and bewildered demonstrators held signs that advocated, “one dissident, one bullet,” neatly capturing the anti-science demagoguery of AIDS activists.

The AIDS orthodoxy has long stifled what ought to have been a lively debate on issues ranging from statistics and epidemiology to science, economic

¹⁶ Nicholas Eberstadt and Sally Satel, “Health, Inequality and the Scholars,” *The Public Interest* (Fall 2004), p.116.

¹⁷ Harvey Bialy, *Oncogenes, Aneuploidy and AIDS* (Berkeley: North Atlantic Books, 2004), p. 180. A typically misguided attack on Mbeki’s queries is Virginia van der Vliet, “AIDS: Losing the ‘New Struggle?’” *Daedalus*, Vol. 130, #1 (Winter 2001), pp. 151-184. In his latest book, venerable South African journalist Allister Sparks resorts to an ill-informed mockery of Mbeki’s questions, fails to grasp the faux science of HIV statistics, ignores South African history before 1991, yet piously accepts the dubious, but errant epidemiology on which AIDS projections are based. Allister Sparks, *Beyond the Miracle: Inside the New South Africa* (Chicago: University of Chicago Press, 2003), Chapter 14, “An African Holocaust,” pp. 283-305.

history, and notions about African sexuality. Averse to second thoughts and unable to be self-critical, these messiahs-with-a-program contend that anyone who questions their core beliefs or challenges the infectious viral theory of AIDS is not merely an honorable scholar with different views, but is someone who commits great evil. This is not something they can prove or explain rationally - it is simply an article of faith.

Since the clinical symptoms that define an AIDS case are widespread in the general African population, if it transmits heterosexually it should also become widespread in other general populations, such as Americans, in which hundreds of thousands of heterosexuals annually contract venereal diseases. Instead, 25 years after it was first described in the medical literature in the United States, AIDS remains confined to special risk groups. Of the 40,000 annual new cases of HIV-positive Americans, over 95% are either drug users or homosexuals (or both) and fewer than 10,000 patients have ever been identified as heterosexual cases.¹⁸

For example, among the actors and actresses of the adult film industry (centered in Los Angeles) who perform prodigious amounts of condomless sex for money, between 1998-2004 approximately 81,000 HIV tests were administered to those pornographic stars. Of that amount (at \$50 per test), a grand total of *eleven* registered a positive result, or one in 8,000 in a cohort of 20-35 year olds that surely engages in more sex than almost anyone else in the USA.¹⁹

At my own university, California State University, Chico, America's former #1 Party School (according to *Playboy*, January 1987), a considerable amount of sexual activity occurs as demonstrated by the large number of cases of chlamydia, genital warts and herpes simplex seen at the Student Health Services Center. Yet, from 1989 to 2005, the Health Center administered 17,000 HIV tests; only *one* came back positive.²⁰

By dogmatic repetition, the notion has been pounded into the public's mind that HIV tests are reliable and empirically valid. Those who start with the concept of HIV as a transmissible retrovirus that causes AIDS seize on

¹⁸ Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report*, 1997, Vol. 9, #2, Tables #3-#5, pp. 10-12. For a trenchant actuarial analysis of the same data, see Peter Plumley, "An Actuarial Analysis of the AIDS Epidemic as it Affects Heterosexuals," *Transactions of the Society of Actuaries*, Vol. XLIV (1992), pp. 333-442; and "The Great HIV/AIDS Controversy: A Contrarian View," *Contingencies*, Vol. 7, #6 (November-December 1995), pp. 42-46.

¹⁹ Centers for Disease Control, "HIV Transmission in the Adult Film Industry: Los Angeles, California, 2004," *Mortality and Morbidity Weekly Report* (Vol. 54, #37), pp. 923-926; and Nick Madigan, "Voice of Health in a Pornographic World," *New York Times* (10 May 2004).

²⁰ Ari Cohn, "Cases of Genital Warts on the Rise at Chico State," *Chico Enterprise-Record* (20 October 2005); Diana Flannery, et. al., "Anal Intercourse and Sexual Risk Factors Among College Women, 1993-2000," *American Journal of Health Behavior*, Vol. 27, #3 (2003), pp. 228-234; Simona Gallegos, "Students Catch Infections from Unprotected Sex," *The Orion* (15 February 2006); and Nicole Pothier, "Statistics Show Unsafe Sex Scene," *The Orion* (29 March 2006). Moreover, about 1,400 U.S. college students die each year in alcohol-related incidents, such as fights, automobile accidents, and falls from balconies.

any decline or increase in HIV rates as evidence that AIDS cases are either receding or growing.

There is no evidence of widespread secondary or tertiary transmission of AIDS among heterosexuals in the West. “This is an important point to consider,” warns AIDS researcher Michelle Cochrane, “because the foundation of orthodox AIDS science and epidemiology rests upon the premise that HIV/AIDS is relatively frequently transmitted from an index AIDS case (the primary individual) to a secondary AIDS case either through an exchange of semen or blood. In turn, this secondarily ‘infected’ individual must be capable of transmitting HIV/AIDS to a third individual (tertiary transmission) by the same means, or an infectious disease epidemic cannot be sustained.”²¹

Cochrane juxtaposed the central tenets of orthodox AIDS research against actual San Francisco AIDS patients’ charts. She found that health officials over-estimated the risk of contracting AIDS through sexual activity, “while simultaneously under-estimating the proportion of the HIV/AIDS caseload that were attributable to intravenous drug use and/or socio-economic factors which condition access to healthcare and prevention services.”²²

Cochrane explained how the bureaucracy for AIDS surveillance in San Francisco played a key role in constructing a global consensus on AIDS historiography and science. This knowledge displays a remarkable coherence and internal consistency that is used to refute any criticism of its assumptions about the etiology, epidemiology and history of AIDS.

The AIDS Seroepidemiology and Surveillance Branch in San Francisco constitutes the world’s greatest repository for primary documentation on AIDS. It includes the medical charts and case files for every one of the 26,636 AIDS patients cumulatively reported since 1981 in the city.²³ Cochrane demonstrated how the vested interests of research institutions, AIDS organizations and activist groups perpetuated the conventional consensus that HIV causes AIDS, “a conclusion which persists despite the presence of multiple lacunae or anomalies that the theory has not resolved.”²⁴

Cochrane showed that health officials conspicuously *failed to investigate all risk factors* for immunological dysfunction among heterosexual adult females. In their surveillance studies, it was sufficient for such a woman “merely to claim that the source of her infection was sex with an IV drug user or another

²¹ Michelle Cochrane, “The Social Construction of Knowledge on HIV and AIDS: With a Case Study on the History and Practices of AIDS Surveillance Activities in San Francisco,” Ph.D. dissertation, Department of Geography, University of California, Berkeley, April 1997, p. 253. Cochrane’s dissertation was subsequently published as *When AIDS Began: San Francisco and the Making of an Epidemic* (New York: Routledge, 2004).

²² *Ibid.*, p. 7.

²³ San Francisco Department of Public Health, *Quarterly AIDS Surveillance Report; AIDS Cases Reported Through March 2006* (March 2006).

²⁴ Cochrane, *op. cit.*, pp. 322-24.

man at risk for HIV/AIDS...A percentage of the 187 [heterosexual] female AIDS cases [out of 25,221 cumulative cases in San Francisco] attributed to sexual transmission would, with proper investigation, be attributable to IV drug use. Epidemiological research in the United States and Europe has never proven that a female has sexually transmitted HIV to a man. [Because] heterosexual transmission of HIV from a male to a female happens with difficulty and very infrequently...all AIDS surveillance statistics on female AIDS cases have been gathered without rigorous scrutiny of the woman's risk for disease and with a bias towards including as many women as possible."²⁵

The *a priori* assumptions that directed AIDS surveillance activities in the United States sustained predictions about an exponential spread of the disease despite the lack of empirical data.²⁶ This may have reflected an unholy alliance between epidemiology, professional journals and the media. Harvard epidemiologist Alex Walker acknowledges that it only takes a handful of articles before a suspected association "springs into the general public consciousness in a way that does not happen in any other field of scientific endeavor."²⁷ According to a researcher from the National Institute of Environmental Health Sciences, "investigators who find an effect get support, and investigators who don't find an effect don't get support. When times are tough it becomes extremely difficult for researchers to be objective."²⁸

These are important points to consider when reviewing the epidemiological data on AIDS cases or HIV seroprevalence anywhere in Africa.²⁹ For instance, a study on Uganda alleged that "a reduction in births to HIV-infected mothers will affect demographic projections of the future numbers of AIDS orphans, as well as projections of the impact of HIV-1 on population

²⁵ *Ibid.*, pp. 259-60. The *Quarterly AIDS Surveillance Report* from the San Francisco Department of Public Health (March 2006), reports that over the past 25 years, a cumulative total of 254 heterosexual female AIDS cases have been reported out of 26,598 AIDS cases in San Francisco - or less than 1%.

²⁶ Robert T. Michael, John H. Gagnon, Edward Laumann and Gina Kolata, *Sex in America: A Definitive Survey* (Boston: Little, Brown and Company, 1994) reached similar conclusions. After fifteen years of dire warnings that everyone was at risk, few Americans changed their sexual behavior yet AIDS cases did not spread. The authors showed that "AIDS is, and is likely to remain, confined to exactly the risk groups where it began: gay men and intravenous drug users and their sexual partners." Convinced that "there is not and very unlikely ever will be a heterosexual AIDS epidemic in this country," they acknowledged that it could be "more difficult to raise research funds for a disease that is not a threat to most Americans," but insisted it was "better to tell the truth than to behave like scaremongers, telling the country that a disaster will soon strike us all, no matter what the data say." (pp. 216-18).

²⁷ Gary Taubes, "Epidemiology Faces its Limits," *Science*, Vol. 269 (July 14, 1995), p. 169.

²⁸ *Loc cit.*

²⁹ For instance, even though South Africa reported only 1,120 AIDS cases in 1995 but 90,292 cases of tuberculosis in 1994, AIDS was accorded a much higher national profile and larger budget so that it now dominates clinical practice across all medical fields ranging from pediatrics to neurology. *World Health Report 1996*, p. 130; "South Africa: Country Profile," *The Lancet*, Vol. 349 (May 24, 1997), p. 1542. The 1998 *World Health Report* indicated only 729 AIDS cases in South Africa for 1996 - a decrease of 35% from 1995!

growth.”³⁰ In 1987, the WHO estimated that 1 million Ugandans were HIV antibody-positive. Twelve years later, that number was unchanged yet the cumulative total of AIDS cases reported in Uganda since 1982 was 54,712.³¹ Researchers did not know the health status of the other 945,000 HIV-positive Ugandans who were not AIDS cases nor noticed the erroneous projections and discrepancies among articles published in the same journal.

The sociologist Joel Best has shown how statistics are supposed to be used to make social problems understandable (hence manageable) enabling people to make rational choices, especially when the topic elicits intense conflict, uncertainty or anxieties. Although the public may assume that tendentious waves of doomsday HIV or AIDS statistics are factually accurate, Best reminds us that “every piece of research contains limitations; researchers inevitably choose specific definitions, measures, designs, and analytic techniques. These choices are consequential; they shape every study’s results.”³² AIDS researchers wanted to quickly draw attention to an allegedly new social problem, to quantify it and to measure its scope. For over 25 years they have reduced a complex public health situation to a set of alleged “facts” upon which to base policies. But if their numbers were flawed from the outset, then they provided a deceptive and fruitless guide for making crucial public health decisions.

What exactly is HIV? The term “HIV” describes a collection of non-specific, cross-reactive cellular material. HIV tests are not standardized, but are arbitrarily interpreted by different laboratories. Because HIV tests are antibody tests, they produce many false-positive results. This is crucial to keep in mind whenever one reads about statistical rates or percentages of “HIV cases” in any population group.

All antibodies tend to cross-react. Humans constantly produce antibodies in response to stress, malnutrition, drug use, vaccination, certain foods, a cut, a cold, intestinal worms, tuberculosis, or even pregnancy. All of these antibodies are known to make HIV tests come up as positive.

The packet insert in an HIV/ELISA test from Abbott Laboratories contains this prudent disclaimer: “At present there is no recognized standard for establishing the presence or absence of antibodies to HIV-1 in human blood.” Yet the cornerstone surveillance study for HIV seroprevalence in Africa rests on administering a single ELISA test to pregnant women attending antenatal clinics, never acknowledging that the ELISA test is notoriously unreliable in

³⁰ Ronald H. Gray, et. al., “Population-Based Study of Fertility in Women with HIV-1 Infection in Uganda,” *The Lancet*, Vol. 351 (January 10, 1998), p. 102.

³¹ Dilys Morgan, et. al., “HIV-1 Disease Progression and AIDS-Defining Disorders in Rural Uganda,” *The Lancet*, Vol. 350 (July 26, 1997), p. 245.

³² Joel Best, *More Damned Lies and Statistics* (University of California Press, 2004), p. 154; and *Damned Lies and Statistics* (Berkeley: University of California Press, 2001).

those circumstances since pregnancy is one of numerous conditions known to elicit a “false positive” result.

The medical literature lists some *seventy preexisting conditions*, having nothing to do with sexual behavior, that are known to trigger an HIV-positive test result.³³ One study included “transfusions, transplantation, or pregnancy, autoimmune disorders, malignancies, alcoholic liver disease, or for reasons that are unclear...”³⁴ Another cited “liver diseases, parenteral substance abuse, hemodialysis, or vaccinations for hepatitis B, rabies, or influenza...”³⁵

Pregnancy is consistently listed as a cause of positive test results, even by the test manufacturers themselves: “[false positives can be caused by] prior pregnancy, blood transfusions... and other potential nonspecific reactions.” (Vironostika HIV Test, 2003).

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

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

Studies by Nancy Padian and her associates demonstrate that the infectivity rate for male-to-female transmission is extremely low.³⁶ An HIV-negative woman may convert to positive on average only after *one thousand* unprotected contacts with an HIV-positive man. An HIV-negative man may become positive on average only after *eight thousand* contacts with an HIV-positive woman. These data suggest two mutually exclusive conclusions. Either HIV is not a sexually transmitted microbe at all and other factors must account for HIV seroprevalence, or else African heterosexuals are far more promiscuous than American heterosexuals, an unproven assumption rooted

³³ Christine Johnson, “Factors Known to Cause False-Positive HIV Antibody Tests,” *Zenger’s Magazine* (September 1996), pp. 8-9; Neville Hodgkinson, “The World AIDS Conference,” *The European* (June 22, 1998).

³⁴ Terence I. Doran and Ernesto Parra, “False-Positive and Indeterminate Human Immunodeficiency Virus Test Results in Pregnant Women,” *Archives of Family Medicine*, Vol. 9 (September 2000), pp. 924-929.

³⁵ Eleftherios Mylonakis et. al., “Report of a False Positive HIV Test Result and the Potential Use of Additional Tests in Establishing HIV Serostatus,” *Archives of Internal Medicine*, Vol. 160 (August 2000), pp. 2386-2388.

³⁶ Nancy Padian et. al., “Heterosexual Transmission of Human Immunodeficiency Virus (HIV) in Northern California: Results from a Ten-Year Study,” *American Journal of Epidemiology*, Vol. 146, #4 (August 15, 1997), pp. 350-57.

in racist stereotypes.

With this in mind, why did so many public health professionals and officials come to view the diseases of poverty in Africa as sexually contagious? How can one virus cause twenty-nine heterogeneous AIDS indicator diseases almost entirely among males in Europe and America but afflict African men and women in nearly equal numbers?³⁷ The answer is that the World Health Organization uses a definition of AIDS in Africa that differs decisively from the one used in the West. The origins of this definition of African AIDS are quite illuminating.

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

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

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

The definition was reached by consensus, based mostly on the delegates’ experience in treating AIDS patients. It has proven a useful tool in determining the extent of the AIDS epidemic in Africa, especially in areas where no testing is available. Its major components were prolonged fevers (for a month

³⁷ Recent research among African populations suggests that a person with an over-active immune system that is constantly assaulted by various pathogens or burdened with chronic infections is more susceptible to a positive HIV antibody test result. Zvi Bentwich et. al., “Immune Activation is a Dominant Factor in the Pathogenesis of African AIDS,” *Immunology Today*, Vol. 16, #4 (1995), pp. 187-91.

or more), weight loss of 10 percent or greater, and prolonged diarrhea...”³⁸

The doctors recalled that:

“experts in STDs continued to regale us with tales of the excessive and often bizarre sexual practices associated with HIV in the West...we were also beginning to see a direct correlation between the number of sexual partners and the rate of infection...Compared to the West, heterosexual contacts in Africa are frequent, and relatively free of social constraints - at least for the men....There was every reason to believe that, having found heterosexually transmitted AIDS in Kinshasa, we were likely to find it everywhere else in the world.”³⁹

It was upon these unsubstantiated claims, clinical generalizations, western notions of sexual morality, and stereotypes about Africans that AIDS became a disease by definition. Africa was assigned a central role in the premise that *AIDS was everywhere* and everyone was at risk. By 1986, “people were falling over one another to get involved in AIDS research,” recalled the physicians. “They realized that AIDS represented an opportunity for grant money, training, and the possibility of professional advancement...A certain bandwagon mentality took hold. Careers and reputations were riding on the outcome.”⁴⁰

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

DeCock wanted to know what happened to those five people during the intervening ten years. According to McCormick and Fisher-Hoch:

“three of the five were dead. To determine if their deaths were attributable to AIDS, Kevin interviewed people who had known them. The friends and relatives of the deceased described an illness marked by severe weight loss and other ailments that *left little doubt* in Kevin’s mind that they had succumbed to AIDS [emphasis added].”⁴¹

DeCock concluded from these interviews that the subjects had died from AIDS, and that HIV had caused their death. He reached this conclusion without matching the five HIV-positive patients with peers from among the 595 HIV-negative subjects and without collecting mortality data and morbidity information about them. Had he done this, perhaps he would have discov-

³⁸ Joseph B. McCormick and Susan Fisher-Hoch, *Level 4: Virus Hunters of the CDC* (Atlanta: Turner Publishing, 1996), pp. 188-90.

³⁹ *Ibid.*, pp. 173-74.

⁴⁰ *Ibid.*, pp. 179-80.

⁴¹ *Ibid.*, p. 193.

ered that numerous HIV-negative Africans also die of severe weight loss and other so-called AIDS conditions.

DeCock further noted that antibody tests conducted in 1986 showed that the HIV prevalence in Yambuku had remained constant at 0.8% during the ten years since 1976. As far as he was concerned, this meant that HIV - and thus AIDS - really originated in Africa where it had existed for years in small numbers of rural inhabitants whom he imagined had contracted it from primates. He speculated that once some of those people in the late 1970s migrated to what he assumed were sexually promiscuous urban areas, an epidemic of HIV and AIDS exploded. DeCock did not consider that these same data could have been interpreted as indicating that HIV is a mild virus and difficult to transmit. Neither did McCormick and Fisher-Hoch.

The presumptive diagnosis employed by DeCock is known as a “verbal autopsy.” It is widely accepted in Africa, where “no country has a vital registration system that captures a sufficient number of deaths to provide meaningful death rates.”⁴² While medically certified information is available for less than 30% of the estimated 51 million deaths that occur each year worldwide, the Global Burden of Disease Study (GBD) found that sub-Saharan Africa had the greatest uncertainty for the causes of mortality and morbidity since its vital registration figures were the lowest of any region in the world - a microscopic 1.1%.⁴³

When the mainstream media use the term “AIDS-related illness,” they accept the sweepingly wide set of clinical symptoms that suddenly came to “define” an AIDS case anywhere in Africa in October 1985 and has remained in place ever since.

Whereas cases of acquired immune deficiency in the industrialized countries are almost exclusively a disease of a tiny percentage of homosexuals, intravenous drug users and recipients of tainted blood transfusions, AIDS cases in Africa are said to be as general and indiscriminate as such long-time African scourges as malaria, tuberculosis, schistosomiasis, and sleeping sickness (trypanosomiasis).

AIDS researchers and activists have created an image of sexual behavior in

⁴² Henry M. Kitange et. al., “Outlook for Survivors of Childhood in Sub-Saharan Africa: Adult Mortality in Tanzania,” *British Medical Journal*, Vol. 312 (January 27, 1997), pp. 216-17. The authors report that “a network of people was established in each of the [Tanzanian] study areas whose responsibility it was to inform a field supervisor of all deaths occurring in their areas. Locally known and respected people were selected...when a death was reported, the field supervisor in that area visited the home of the deceased and carried out a ‘verbal autopsy.’ This entailed interviewing the family by using a standard proforma with the aim of determining the cause of death.”

⁴³ Christopher Murray and Alan Lopez, “Mortality by Cause for Eight Regions of the World: Global Burden of Disease Study,” *The Lancet*, Vol. 349 (May 3, 1997), pp. 1269-1276. The authors advise that “the system of collecting cause of death data via ‘verbal autopsies’ needs to be assessed and improved to provide reliable data on broad categories of causes of death at low cost.” See also, “From What Will We Die in 2020?” *The Lancet*, Vol. 349 (May 3, 1997), p. 1263.

Africa to explain this heterosexual paradox of AIDS in Africa when compared to the United States or western Europe. Some researchers consider the paradox to be temporary. They speculate that HIV evolved or emerged first in Africa and that, in time, AIDS will be just as rampant in the West. However, they have said this for twenty-five years and nothing of the sort has occurred.⁴⁴

Other researchers account for a permanent paradox by suggesting that Africans are somehow different from Westerners, are substantially more promiscuous, and hence more likely to have genital ulcers. How else can they explain the widespread distribution of a virus whose transmission requires, for non-ulcerated genitals, a thousand heterosexual acts? Such insinuations warrant the closest scrutiny since generalizations about African sexual practices are analytically useless on an internally diversified continent of 670 million people.

At the 10th International AIDS Conference in Yokohama (August 1994), Dr. Yuichi Shiokawa claimed that AIDS would be brought under control only if Africans restrained their sexual cravings. Professor Nathan Clumeck of the Université Libre in Brussels was skeptical that Africans will ever do so. In an interview with *Le Monde*, Clumeck claimed that “sex, love, and disease do not mean the same thing to Africans as they do to West Europeans [because] the notion of guilt doesn't exist in the same way as it does in the Judeo-Christian culture of the West.”⁴⁵ AIDS educators try to counter this purported lack of guilt in African sexuality through conservative appeals to restraint, negotiating safe sex and a nearly evangelical insistence on condom use.

Many orthodox AIDS researchers perpetuate racist stereotypes of libidinous black men and women. The myths about the sexual excesses of Africans are old indeed. Early European travelers returned from the continent with tales of black men performing carnal feats with unbridled athleticism with black women who were themselves sexually insatiable. These affronts to Victorian sensibilities were cited, alongside ethnic conflicts and other “uncivilized” behavior, as justification for colonial social control.⁴⁶

⁴⁴ For instance, California has a population of nearly 36 million of whom at least 95% are heterosexuals. Between 1981 and 2003, a cumulative total of 134,852 cases of AIDS (approximately 6120 per year) were reported by county health departments. But only 5,956 cases (4.4% of the total or roughly **260 per year**) were attributed to heterosexual transmission.

⁴⁵ Jean-Yves Nau, “AIDS Epidemic Far Worse Than Expected,” *Le Monde* section in *Manchester Guardian Weekly* (December 14, 1993). Anthropologist Jack Goody claims that love is a consequence of modernity and a written culture. Thus, when literate people are separated by a social barrier or absence they write to each other using precise words that lead them to be analytical and reflexive, eventually coming to act as they write. Goody claims that African oral cultures had little elaboration of romantic love in art, discourse or actuality. Perhaps, AIDS researchers like Clumeck accept Goody's analysis to insinuate why Africans are more disposed to spread AIDS through heterosexual activity. Jack Goody, *Food and Love: A Cultural History of East and West* (London: Verso, 1999).

⁴⁶ A study investigated the history of Sarah (Saartjie) Bartmann, an early 19th century African woman from Cape Colony, whose unusually sized buttocks made her the object of popular caricatures in Britain and France. The book analyzed the centrality and paranoia that sexualized images of black people such as the “Hottentot Venus” played in 19th century European culture. T. Denean Sharpley-Whiting, *Black Venus*:

AIDS researchers added new twists to this old repertoire: stories of Zairians who rub monkeys' blood into cuts as an aphrodisiac or philandering truck drivers who get AIDS from prostitutes and then go home to infect their wives.⁴⁷ A facetious letter in *The Lancet* even cited a passage from Lili Palmer's memoirs as evidence for how a large male chimpanzee's "anatomically unmistakable signs of its passion for [Johnny] Weismuller" on the Tarzan set in 1946 "may provide an explanation for the inter-species jump" of HIV infection.⁴⁸

Some researchers assert that many African men prefer "dry sex" whereby women, particularly prostitutes, are said to "insert substances, such as household detergents or antiseptics, in their vagina prior to intercourse in order to prevent wetness." According to a study in *The Lancet*, this practice allegedly produces a "hot, tight, and dry" environment, which men find more pleasurable but which may "increase the risk of HIV-1 transmission, since the substances could cause the disruption of the membranes lining the vaginal and uterine wall."⁴⁹

Another theory attributed the origin of HIV to the "repeated radiation exposure of chimpanzees and mangabey monkeys in equatorial Africa" to strontium-90 from uranium mining in the former Belgian Congo and to radiation from atmospheric nuclear tests in the equatorial Pacific Ocean in the 1950s and 1960s after "radioactive fallout from them circled the globe around that latitude."⁵⁰

Recent speculation by Edward Hooper traced the origins of AIDS cases to oral polio vaccines that were accidentally contaminated in the Congo, allegedly with tissues from a primate version of HIV.⁵¹ As an example of how absurdly far-fetched this speculation has become, one reviewer of Hooper's book (biologist Helen Epstein writing in *New York Review of Books*) imagined that the subsequent linkages might have proceeded as follows:

"*Perhaps* a hunter or butcher carrying a benign monkey virus gave blood at a blood bank or had an injection. *Perhaps* someone was transfused with his blood, or *perhaps* the needle used to inject him was used to inject someone else without being sterilized. *Perhaps*, a few weeks later, the virus was transferred to a third person through another injection or transfusion. This *might*

Sexualized Savages, Primal Fears and Primitive Narratives (Durham: Duke University Press, 1999). See also, footnote #6 above in reference to Eileen Stillwaggon, *op. cit.*

⁴⁷ For an example of anecdotes and rumors presented as facts about East African truck drivers and AIDS, see Ted Conover, "Trucking Through the AIDS Belt," *The New Yorker* (August 16, 1993).

⁴⁸ Raul Sebastian, "Did AIDS Start in the Jungle?" *The Lancet*, Vol. 348 (November 16, 1996), p. 1392.

⁴⁹ Adele Baleta, "Concern Voiced Over 'Dry Sex' Practices in South Africa," *The Lancet*, Vol. 352, No. 9136 (October 17, 1998), p. 1292.

⁵⁰ Brandon P. Reines, "Radiation, Chimpanzees and the Origin of AIDS," *Perspectives in Biology and Medicine*, Vol. 39, #2 (Winter 1996), pp. 187-92.

⁵¹ Edward Hooper, *The River: A Journey to the Source of HIV and AIDS* (Boston: Little, Brown Publishers, 1999).

have been enough to 'kick-start' the virus. It *might* have evolved through such 'passaging' to become able to grow vigorously in human cells. It *might* have been able to infect new people through means other than needles or blood transfusions. It *might* have become sexually transmitted, and it *might* have become deadly. [all italics added]"⁵²

Aside from the lack of any verification to corroborate these claims, no one has ever shown that people in Rwanda, Uganda, Zaire, and Kenya - the so-called "AIDS belt" - are more sexually active than people in Nigeria which has reported a cumulative total of only 26,276 AIDS cases out of a population of 120 million or Cameroon which reported 18,986 cases in 14 million.⁵³ No continent-wide sex surveys have ever been carried out in Africa. Nevertheless, conventional researchers perpetuate stereotypes about insatiable sexual appetites and carnal exotica.⁵⁴ They assume that AIDS cases in Africa are driven by a sexual promiscuity similar to what produced - in combination with recreational drugs, sexual stimulants, venereal disease, and the over-use of antibiotics - the early epidemic of immunological dysfunction among a small sub-culture of urban gay men in the West.⁵⁵

⁵² Helen Epstein, "Something Happened," *New York Review of Books* (December 2, 1999), p. 18.

⁵³ World Health Organization, *Weekly Epidemiological Record*, Vol. 74, #48 (November 26, 1999), p. 401.

⁵⁴ For a compendium of these assumptions, see John C. Caldwell et. al. (eds.), *Resistances to Behavioural Change to Reduce HIV/AIDS Infection in Predominantly Heterosexual Epidemics in Third World Countries* (Canberra: National Centre for Epidemiology and Population Health, Australian National University, 1999). An investigation into the role of anal intercourse in Africa as a contributing factor to AIDS concluded that the "behaviors most relevant to [AIDS] transmission there (and probably in much of the Third World) seem less likely to be sexual than a consequence of unhygienic practices and medical care." Stuart Brody and John J. Potterat, "Assessing the Role of Anal Intercourse in the Epidemiology of AIDS in Africa," *International Journal of STD and AIDS*, Vol. 14 (July 2003), p. 434.

⁵⁵ In a review of *Sexual Ecology: AIDS and the Destiny of Gay Men* by Gabriel Rotello (New York: Dutton, 1997) and *Life Outside: The Signorile Report on Gay Men* by Michelangelo Signorile (New York: Harper-Collins, 1997), historian Daniel Kevles notes that with the advent of gay liberation, "bathhouses, while offering a communitarian haven from homophobia, also institutionalized part of the liberation movement, providing sexual opportunities in private cubicles, showers, hallways, and dimly lit 'orgy rooms' devoted to anonymous encounters...Tens of thousands were habitués of the 'circuit' - a series of large gay dance parties held in different places where they used one kind of drug to heighten their sexual energies and another to relax their sphincter muscles." Daniel J. Kevles, "A Culture of Risk," *New York Times Book Review* (May 25, 1997), p. 8. John Lauritsen and Dr. Joseph Sonnabend have described the unhealthy lifestyle of this very specific cohort of urban gay men in the United States who had unprecedented opportunities for sexual contacts with hundreds, even thousands of partners. It was a ghettoized sub-culture of promiscuous gay men who habitually abused alcohol and drugs that produced the epidemic levels of chronic infection and immunological breakdown that allowed opportunistic infections to take over bodies that had been repeatedly exposed to a wide range of microbes such as gonorrhea, cytomegalovirus, hepatitis, syphilis, non-specific viral infections, bacterial pathogens, and parasitic infections. Without addressing these underlying socio-economic and environmental causes, the commitment of researchers to lump together the diverse cases of immune-deficiency that began appearing in this small sub-culture led them uncritically to accept the unifying hypothesis of a single viral cause based on the similarities of the disease manifestations. See Joseph Sonnabend, "Fact and Speculation About the Cause of AIDS," *AIDS Forum*, Vol. 2, #1 (May 1989), pp. 2-12; John Lauritsen, *The AIDS War* (New York: Asklepios Press, 1993); and John Lauritsen and Ian Young (eds.) *The AIDS Cult: Essays on the Gay Health Crisis* (Provincetown, Massachusetts: Asklepios Press, 1997). Frank Bruni, "Drugs Taint Annual Gay Revels," *New York Times* (September 8, 1998) chronicled the abundant array of drugs like co-

Case studies from Africa suggest nothing of the sort. In 1991 researchers from Médecins Sans Frontières and the Harvard School of Public Health surveyed sexual behavior in Moyo district of northwest Uganda. Their findings revealed behavior that was not very different from that of the West. On average, women had their first sex at age 17, men at 19. Eighteen per cent of women and 50% of men reported premarital sex; 1.6% of the women and 4.1% of the men had casual sex in the month preceding the study, while 2% of women and 15% of men had done so in the preceding year.⁵⁶

The media misrepresentations that link sexuality to AIDS have spawned inordinate anxieties in regions of Africa already afflicted with extreme poverty, ravaged by war, and deprived of primary health care delivery systems. The disaster voyeurism of tabloid journalism enables the media to use AIDS to sell “more newspapers than any other disease in history. It is a sensational disease - with its elements of sex, blood and death it has proved irresistible to editors across the world.”⁵⁷ In recent years, western media have used unrelentingly melancholy metaphors to portray Africans as helpless wretches, which homogenize complex situations and contributes to public apathy and “compassion fatigue.”⁵⁸

In the age of globalization, public health seems to require more salesmanship than skepticism. The media’s appetite for scare tactics and its disdain for alternative perspectives enable them to treat Africa in apocalyptic terms.⁵⁹ Domsday scenarios compare AIDS in Africa to the great epidemics in history like the Black Death of the Middle Ages that killed 20 million people.⁶⁰ *USA Today* warned about “a time bomb ticking south of the Sahara” and UNICEF called AIDS “the modern incarnation of Dante’s Inferno.” U.S. Senator Diane Feinstein of California said, “I truly believe that the AIDS crisis is worse than the bubonic plague...this crisis can wipe out sub-Saharan Africa as we know it today. It is mega in its impact on the world...”⁶¹ In 2004, Professor Richard Feachem, Director of the Global Fund to Fight AIDS, TB, and

caine, Ecstasy, ketamine (“special K”) and a liquid anesthetic called gamma hydroxybutyrate (GHB) that were widely consumed at an August 1998 fund-raiser for AIDS at Fire Island, New York.

⁵⁶ Doris Schopper, Serge Doussantousse, and John Orav, “Sexual Behaviors Relevant to HIV Transmission in a Rural African Population,” *Social Science and Medicine*, Vol. 37, #3 (August 1993), pp. 401-12.

⁵⁷ James Deane, “The Role of the Media in the Fight Against AIDS,” *SIDAFrique*, #8/9 (1996), p. 29.

⁵⁸ Susan D. Moeller, *Compassion Fatigue: How the Media Sell Disease, Famine, War and Death* (New York: Routledge, 1998) and Jonathan Benthall, *Disasters, Relief and the Media* (New York: St. Martins Press, 1993). For a demonstration of how U.S. officials manipulated statistics and public fears to mobilize billions of dollars in a futile effort to halt the illicit international drug trade, see Mike Gray, *Drug Crazy* (New York: Random House, 1999).

⁵⁹ A typical example is Lawrence K. Altman, “Parts of Africa Showing HIV in 1 in 4 Adults,” *New York Times* (June 24, 1998).

⁶⁰ A scholarly attempt to analogize AIDS with the Black Death is David Herlihy, *The Black Death and the Transformation of the West* (Cambridge: Harvard University Press, 1997), pp. 5-6.

⁶¹ Zachary Coile, “Bill Would Enhance Access to AIDS Drugs,” *San Francisco Chronicle* (March 7, 2001), p. A7.

Malaria, somberly pronounced it “the worst disaster in recorded history.”⁶²

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

This marketing of anxiety intimidates and belittles Africans all in the name of promoting behavioral changes that will help “save Africa.” Some writers even admit that the manufacture of fear is a good way to increase social awareness. For conservatives who want to see “the notion of sexual responsibility [shake] off its puritanical image,” the subsequent “public anxiety about AIDS is seen as an important sentiment for popularizing a more restrictive and puritanical sexual ethos.”⁶³

Oblivious to the morbidity and mortality data from the *Global Burden of Disease Study*, journalists reflexively maintain that “AIDS is by far the most serious threat to life in Africa.”⁶⁴ Given the momentum behind this assumption, few scientists question the infectious AIDS hypothesis, thus leaving little reason for the media to scrutinize the reliability of AIDS research.⁶⁵ Scott Adams, the cartoonist who draws *Dilbert*, put it succinctly: “Reporters are faced with a daily choice. They can either painstakingly research stories or they can write whatever people tell them. Both approaches pay the same.”⁶⁶

The claims that millions of Africans are threatened by AIDS or are already HIV-positive make it politically acceptable to use the continent as a laboratory

⁶² Cited in Alex de Waal, “Sex in Summertown,” *Times Literary Supplement* (6 August 2004), p. 5.

⁶³ Frank Furedi, *Culture of Fear* (London: Cassell, 1997), p. 48. American novelist Philip Roth’s recent work, *The Human Stain* (New York: Houghton Mifflin, 2000), refers to the “ecstasy of sanctimony” that defines the current era of shrill moral hysteria about sexuality.

⁶⁴ “No End of Plagues,” *The Economist* (September 7, 1996), p. 38. One study found that 40% of American journalists rarely or never seek independent verification for a science story they are writing, and that 82% of the scientists polled felt that journalists did not understand statistics well enough to explain new findings. Jim Hartz and Rick Chappell, *Worlds Apart: How the Distance Between Science and Journalism Threatens America’s Future* (Nashville: First Amendment Center at Vanderbilt University, 1998). Media coverage of AIDS resembles the kind of writing that Australian journalist John Pilger describes as “repetitious, safe and limited by invisible boundaries.” Thus, as Will Rogers once quipped, it’s not ignorance that causes all the trouble in this world, “it’s the things people know that ain’t so.”

⁶⁵ The biennial “International AIDS Conference” resembles a pharmaceutical trade show for commodities of the AIDS industry. At the XII AIDS Conference (Geneva, June 1998), journalists and researchers referred to AIDS as a “runaway epidemic” and a “collective failure of the world,” demanding that it be made a “global public health priority.” Lawrence Altman, “At AIDS Conference, a Call to Arms Against ‘Runaway Epidemic,’” *New York Times* (June 29, 1998).

⁶⁶ Cited in Best, *Damned Lies*, p. 35.

for vaccine trials⁶⁷ and for the distribution of toxic drugs of disputed effectiveness like AZT.⁶⁸ For instance, AZT is a toxic chemical whose primary biochemical action is the random termination of DNA synthesis, the central molecule of life. It is frightening to recommend giving such a carcinogenic drug to pregnant women because fetuses cannot develop into babies without DNA synthesis.⁶⁹

Moreover, media claims that safe sex is the only way to avoid AIDS inadvertently scare Africans from visiting public health clinics for fear of receiving an AIDS diagnosis.⁷⁰ Even Africans “with treatable medical conditions (such as tuberculosis) who perceive themselves as having HIV infection fail to seek medical attention because they think that they have an untreatable disease.”⁷¹ Biomedical funds that used to fight malaria, tuberculosis and leprosy are now diverted into sex counseling and condom distribution, while social scientists shift their attention to behavior modification programs and AIDS awareness surveys.⁷²

One such initiative - the Summertown HIV-Prevention Project - lasted

⁶⁷ In a candid review of the fruitless vaccine trials, Richard Horton (editor of *The Lancet*) admitted that “until the gravity of this scientific failure is openly acknowledged, a serious debate about how to end HIV’s lethal grip...cannot take place.” Horton noted that many AIDS scientists fear that their inability to find a “single-dose, safe, affordable, oral vaccine that gives lifelong protection against all subtypes of HIV” will erode public confidence in other aspects of the “war on AIDS.” Their fears are justified. “AIDS: The Elusive Vaccine,” *New York Review of Books* (September 23, 2004), pp. 53-57. Several recent studies demonstrate how large numbers of people and many advocacy organizations profit from fear-mongering about dangers that are blown way out of proportion to their real risks. David Ropeik, *Risk: A Practical Guide for Deciding What’s Really Safe and Really Dangerous* (Harvard University Press, 2002); Barry Glassner, *The Culture of Fear* (New York: Basic Books, 1999); Frank Furedi, *Culture of Fear* (London: Cassell, 1997); Laura Lee, *100 Most Dangerous Things in Everyday Life and What You Can Do About Them* (New York: Broadway Books, 2004); and Marc Siegel, *False Alarm: The Truth About the Epidemic of Fear* (New York: John Wiley, 2005).

⁶⁸ In 1999-2000, several major companies offered to discount the cost of drugs to Africans. Glaxo Wellcome cut the price of AZT and 3TC to \$200 a month for sale in Uganda and Ivory Coast where the annual per capita income is less than the price of the drug. Urging African governments to subsidize the costs, UN official Joseph Saba said his agency had to “show them that AIDS justifies investing public funds.” Associated Press, “Firms Cut AIDS Drug Prices to 3rd World,” *San Francisco Chronicle* (June 24, 1998)

⁶⁹ An important analysis of AZT, its properties and effects, is Anthony Brink, *Debating AZT: Mbeki and the AIDS Drug Controversy* (Pietermaritzburg: Open Books, 2000).

⁷⁰ For instance, a 31-year old man in Kagera Province (Tanzania) was said to be dying of AIDS. Emaciated and despondent, he worked as a fisherman until he became sick in 1992 with diarrhea, chest pains, muscle weakness, and a severe cough. The man stayed with an aunt because his brother and sister refused to see him. “Since I became sick,” he told a reporter, “I have not made an effort to go to the hospital because I have no money and my aunt is not able to pay.” Susan Okie, “Tanzania Village Devastated by AIDS Deaths,” *Washington Post* (March 15, 1992).

⁷¹ “False-Positive Self-Reports of HIV Infection,” letter from Chifumbe Chintu et. al., *The Lancet*, Vol. 349 (March 1, 1997), p. 649.

⁷² Some Western scientists, including Dr. Luc Montagnier the French virologist who discovered HIV, claim that the practice of female circumcision facilitates the spread of AIDS. Yet Djibouti, Somalia, Egypt and Sudan, where female genital mutilation is the most widespread, are among the countries with the lowest incidence of AIDS cases. Thomas Bass, *Reinventing the Future: Conversations with the World’s Leading Scientists* (Reading, Massachusetts: Addison-Wesley, 1994), p. 40. See also the analysis by a Sudanese anthropologist, Rogaia Mustafa Abusharaf, “Unmasking Tradition,” *The Sciences* (March/April 1998), p. 24.

three years in an impoverished South African township. It was described as a “mixed bag of disappointments and achievements...[as] many proposed activities [were] yet to be implemented, consistent and widespread condom use remains low...and the most damning lack of Project success over the three-year research period is the lack of evidence for any reduction in STI [sexually transmitted infection] levels.”⁷³ The analysis by its Director uses such impenetrable prose that one is not surprised by the Project’s admitted lack of effect on either sexual behavior, HIV rates, or AIDS cases. As she states in her conclusion:

“In the interests of contributing to the development of a critical social psychology of sexuality, the research has illustrated the way in which sexual behaviour, and the possibility of sexual behaviour change, are determined by an interlocking series of multi-level processes, which are often not under the control of an individual person’s rational conscious choice. Sexualities are constructed and reconstructed at the intersection of a kaleidoscopic array of interlocking multi-level processes, ranging from the intra-psychological to the macro-social.”⁷⁴

The researchers of the Summertown Project honestly believed that sexual behavior changes would make people unsick and enable them to stay well. They never imagined that their project failed because its core construct was erroneous and incapable of correction. I doubt that they ever considered that the production of HIV antibodies was environmentally induced, and had little or nothing to do with sexuality. Their sincere interventions and complex proposals were wholly inadequate for the task of sexual behavior modification. The Project is a valuable example of how not to proceed with AIDS education and awareness.

In Africa, where women contract so-called “Slim Disease” in numbers roughly equal to males, there is no evidence to link the onset of immune deficiency with engagement in promiscuous homosexual intercourse. Intravenous drug use seems uncommon among villagers and city dwellers. Does this mean that in Africa heterosexual intercourse itself puts everyone at risk for AIDS? Does the “AIDS epidemic” in Africa portend the future of the developed world? Many scientists, bio-medical researchers and AIDS experts still believe this is the case.⁷⁵

⁷³ Catherine Campbell, *Letting Them Die: Why HIV/AIDS Prevention Programmes Fail* (Oxford: James Currey, 2003), p. 185.

⁷⁴ *Ibid.*, p. 183. Despite the stunning failures of the Project, one reviewer, who also was the Series Editor for its publisher, called it “the best book yet written on the struggle to control HIV.” De Waal, *op. cit.*, p. 5.

⁷⁵ By 2000, the theory that an infectious virus causes AIDS had become a “doctrinal system” whose adherents could dismiss impertinent historical facts by simply labeling them as “lies.” As Noam Chomsky once observed, “if you’re following the party line you don’t need to document anything; you can say anything you feel like...That’s one of the privileges you get for obedience. On the other hand, if you’re critical of received opinion, you have to document every phrase.” Cited in Donald Macedo (ed.), *Chomsky on Miseducation* (New

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

An important book by John Iliffe, *East African Doctors: A History of the Modern Profession* provides a case study in how recent African historiography is marred by an over-emphasis on HIV/AIDS.⁷⁶ Based on extensive archival research and a meticulous review of the vernacular press, this study by a leading historian of Africa explains how Africans became physicians in 20th century Uganda, Kenya and Tanzania. The writing is lucid and compelling, the arguments rich with personal anecdotes and insights.

At the outset, Iliffe states, “Not since the origins of mankind has East Africa been so important to the world as it is today. The special importance comes from the AIDS epidemic.”⁷⁷ Claiming that East African doctors have charted the “epidemiology of heterosexually transmitted AIDS” and devised control strategies, Iliffe eventually ends his book “as it began, with AIDS.”⁷⁸ His historical analysis is framed by assumptions about AIDS that warrant careful scrutiny.

Chapters two through nine of *East African Doctors* epitomize Iliffe’s cogent style of historical reconstruction. The chapters on post-colonial public health document how deteriorating political economies (not some rainforest virus) produced the classic symptoms of sickness - fever, persistent cough, diarrhea and weight loss - that American researchers re-defined as a new and distinct illness (AIDS) in the early 1980s, declaring it was caused by a single virus (HIV) which could be transmitted through sexual contact.

Under colonial education systems, an elite corps of African trainees dissected cadavers, learned precision in dosages and relied on microscopes “to embody rationality and enlightenment”⁷⁹ In the 1940s, Ugandan physician Sebastiano Kyewalyanga promoted hospitals and doctors for babies so Africans

York: Rowman and Littlefield, 2000), p. 173. And a Nobel laureate in economics, George Stigler agrees: “people demand much higher standards of evidence for unpopular or unexpected findings than for comfortably familiar findings.” George Stigler, *Memoirs of an Unregulated Economist* (Chicago: University of Chicago Press, 2003), p. 201.

⁷⁶ John Iliffe, *East African Doctors* (Cambridge: Cambridge University Press, 1998).

⁷⁷ *Ibid.* p. 1.

⁷⁸ *Ibid.*, p. 244.

⁷⁹ *Ibid.*, p. 49.

would achieve “better health, stressing regular breastfeeding, hygiene, nutrition, better housing, [and] the advantages of modern medical aid”⁸⁰ Bernard Omondi, a Kenyan doctor in the 1950s, diagnosed the causes of death at Kerugoya district hospital - pneumonia, gastroenteritis, tuberculosis and kwashiorkor - as a “syndrome with malnutrition at its root,” due primarily to socio-economic changes.⁸¹ The writings of these men impressed Iliffe “by how optimistic they were at this time of their ability to improve their societies.”⁸²

Chapters 7-9 provide the plausible context for the public health debacles that set the stage for AIDS: the violence and social chaos in Uganda, corruption and financial stringency that attended capitalist development in Kenya, and flawed attempts to transform the medical system in a socialist direction in Tanzania. After independence, public health was weakened throughout East Africa by fiscal constraints, population growth, the spread of tuberculosis, and such endemic environmental diseases as “malaria in the lowlands and respiratory infections in the highlands.”⁸³

During Idi Amin’s destructive regime (1971-79), per capita income in Uganda declined by 6.2% per year and the Ministry of Health’s real expenditure per person fell 85% while the country endured cholera and typhus epidemics, a major expansion of sleeping sickness and the worst measles epidemic in its history. At Mulago Hospital and Medical School, the water supply broke down for a decade, the mortuary’s refrigeration system collapsed, sewerage ceased to function, no X-ray units worked, and the food store was “full of rats and vermin.”⁸⁴

Insecurity persisted after Amin’s ouster. Immunization rates among Ugandan infants in 1985 were only 13% for polio, 17% for measles, and 37% for tuberculosis. The illicit sale of pharmaceuticals grew rampant as self-medication with illegal drugs was the “surrogate for a collapsing medical system” in a country whose GDP per capita in 1985 remained 43 per cent lower than in 1970. “The accumulated deterioration made the late 1980s the nadir of health services,” writes Iliffe, when “the pain and squalor of dilapidated hospitals” left them with little water, electricity, sewerage, equipment, transport or drugs.⁸⁵

A similar degeneration affected Kenya. The open selling of drugs, “apart from ...the possibility of poisoning,” alarmed doctors because “it bred drug resistance.” By 1992, “the dose of penicillin needed to cure gonococcal infection had increased over a hundredfold”⁸⁶

⁸⁰ *Ibid.*, p. 84.

⁸¹ *Ibid.*, p. 107.

⁸² *Ibid.*, p. 109.

⁸³ *Ibid.*, p. 133.

⁸⁴ *Ibid.*, p. 147.

⁸⁵ *Ibid.*, p. 155-56.

⁸⁶ *Ibid.*, pp. 190-91.

Tanzania shifted expenditures and doctors from urban hospitals to village health centers to cultivate *ujamaa* egalitarianism. Despite successful mass immunizations against measles, polio, and tetanus, public health worsened by the 1980s. Health facilities “were often dilapidated and the staff demoralized, chiefly for lack of money in a country whose real Gross National product per capita had fallen by an average of 0.5 per cent a year between 1965 and 1988.” According to Iliffe, “[P]overty-related conditions like malnutrition, malaria and diarrhoea were ... treated least effectively. Poverty explained why the main complaint against health facilities was lack of drugs, for poverty not only prevented their procurement and distribution but corrupted the medical staff who sold them for their own profit.”⁸⁷

In his concluding chapters, Iliffe appears undisturbed by the major role of pharmaceutical corporations in funding AIDS research, has no qualms about the zealotry of sexual behavior modification programs imported from the West, is not skeptical about the infectious viral theory of immuno-deficiency, and never questions whether “AIDS” really exists as a “new” disease.

Iliffe simply calls AIDS a “plague,” a “death sentence,” and a “general malaise” marked by sporadic fever, weight loss, persistent cough and periodic diarrhea. These are also the clinical symptoms of malaria, tuberculosis or malnutrition. He seems not to know that HIV tests do not detect a virus itself, only viral antibodies that are analyzed with an assortment of proteins not unique to HIV.

In contrast to the media’s doomsday scenarios, Iliffe quotes Dr. Anthony Lwegaba who wisely concedes that AIDS “might not be one disease, but a collection of diseases”⁸⁸ and Dr. Elly Katabira who sensibly observes that “many treatable conditions requiring hospitalization occur in AIDS patients.”⁸⁹ Iliffe even allows that “if properly treated, most AIDS patients improved before leaving hospital,” and that “although AIDS was incurable, chronic, infectious and widespread...it was also treatable, long-survived, [and] hard to transmit.”⁹⁰

John Iliffe wrote a superb historical treatment of the East African medical profession. Although it probably wasn’t his intention, his seminal book provided abundant data for scholars to begin a thorough reappraisal of the real origins of “AIDS” in Africa. Alas, instead Iliffe then expanded his orthodox interpretation of AIDS into a full-length study that contains not one dollop of skepticism. His latest text perpetuates the same spurious lumping of HIV rates with alleged AIDS cases and uncritically uses suspect statistics to medi-

⁸⁷ *Ibid.*, p. 212.

⁸⁸ *Ibid.*, p. 222.

⁸⁹ *Ibid.*, p. 241.

⁹⁰ *Ibid.*, pp. 241-42.

calize poverty and sexualize African life in the same fashion that marred his earlier study.⁹¹

A thorough historical treatment can yield demystifying results when examining AIDS in South Africa. Alert to the historical discontinuities in that country before and after 1989, that review must recognize that any comparative statistical analysis designed to show which illnesses now afflict South Africans and which ones formerly were the causes of death must be acutely sensitive to how the *definition* of what constituted “South Africa” dramatically changed between 1989 and 1999.

In 1989, South Africa was said, according to its official government terminology, to have a total population of about 21 million. But this figure consciously excluded the 6.1 million Africans who lived in the so-called TBVC states (Transkei, Bophuthatswana, Venda and Ciskei), which comprised 100,000 square kilometers. Furthermore, “South Africa” as defined in 1989 excluded another 8.2 million people who lived in the six “self-governing territories” (SGTs) that comprised a further 67,000 square kilometers.

The overwhelming majority of these 14.3 million Africans living in those fragmented territories were the most obvious victims of the white supremacist policy of *apartheid*. The huge rural slums of the TBVC countries were “urban” with respect to population density but were “rural” with regard to the absence of proper infrastructure or services, especially in terms of public health.

The 1989 study by Francis Wilson and Mamphela Ramphele, *Uprooting Poverty: The South African Challenge* analyzed the depths of poverty which they showed were caused by “insufficient labour, insufficient capital and the high risk of much toil yielding little fruit.” In many cases, they explained that “people are too poor to farm; they cannot afford protective fencing or even to buy seed and fertilizer. Tractors may be too expensive to hire and oxen too weak to plough.”⁹²

The statistical reporting for any aspect of health, employment and living conditions among those 14.3 million Africans was fragmented and systematically evasive. But no one disputed that mortality and morbidity rates were significantly higher in the TBVC countries and the SGTs than in the rest of South Africa. People in those areas suffered from far greater rates of protein anemia, malaria, tuberculosis, cholera and dysentery and that life expectancy was significantly lower there than in the rest of South Africa, as defined in 1989.

Imagine what happened when vital statistics on those 14.3 million people (who probably now number at least 17 million) were added for inclusion in post-*apartheid*, unitary South Africa? Today, the impoverished inhabitants of

⁹¹ John Iliffe, *The African AIDS Epidemic: A History* (Oxford: James Currey Ltd., 2006).

⁹² Francis Wilson and Mamphela Ramphele, *Uprooting Poverty: The South African Challenge* (New York: Norton, 1989), pp. 16-17.

those former rural slums are citizens of a single South Africa. Their addition to public health statistics reveals a great deal about the unhealthy living conditions that had long prevailed in the TBVC and SGT areas under the *apartheid* regime, not the transmissibility of a mutant retrovirus from the Congolese rainforest.⁹³

Many places in KwaZulu-Natal that corresponded to the former Bantustans or the Self-Governing Territory of KwaZulu were rural slums and cesspools of poverty, ignorance and disease in the pre-1991 period. Researchers who claim otherwise should provide mortality and morbidity statistics for KwaZulu, Transkei, Ciskei, and Venda for 1980 and 1985 to assure independent verification.

Even after the dismantling of the *apartheid* system, AIDS cases continued to afflict black South Africans. As a 1998 report for the American Association for the Advancement of Science and Physicians for Human Rights explained, “the epidemiology of the HIV/AIDS epidemic..... demonstrates the link between poverty, low status, and vulnerability to infection.”⁹⁴ It also concluded that the “rigid segregation of health facilities; grossly disproportionate spending on the health of whites as compared to blacks, resulting in world-class medical care for whites, while blacks were usually relegated to overcrowded and filthy facilities; public health policies that ignored disease primarily afflicting black people; and the denial of basic sanitation, clean water supply, and other components of public health to homelands and townships.”⁹⁵

At one session of Mbeki’s AIDS Advisory Panel, held a few days before the 2000 International AIDS Conference convened in Durban, Dr. William Malegaporu Makgoba of the South African Medical Research Council showed a slide that compared a large spike in registered deaths in South Africa in 1999 with those of 1990. Designed to “show” the devastating effect of the AIDS epidemic on the country’s mortality rate and based on statistics from the Department of Home Affairs, it studiously ignored the statistical discrepancy cited above.

Even more astonishing was the fact that the graph indicated the grand total of deaths by age and gender in South Africa for 1999 was 337,000. In a country of 42 million, that meant that the death rate for post-*apartheid* South Africa was 8/10 of 1%, *exactly* the death rate for the United States! When I queried Makgoba about this startling “good” news, he stared at me blankly, then

⁹³ This example of the historical continuity of socio-economic oppression from the *apartheid* regime to its multi-racial, democratic successor still eludes many commentators struggling to explain the novelty of “AIDS” in South Africa. See for example, Catherine Higgs, “Drugs, Sex, and HIV/AIDS in Contemporary South Africa,” *African Studies Review*, Vol. 47, #2 (September 2004), pp. 124-130.

⁹⁴ Andrew Chapman and Laurie Rubenstein (eds.), *Human Rights and Health: The Legacy of Apartheid* (Washington: AAAS, 1998), p. 20.

⁹⁵ *Ibid.*, p. xix, cited in Paul Farmer, *Pathologies of Power* (Berkeley: University of California Press, 2003), p. 275.

walked away in silence.⁹⁶

These historical discursions eventually take us back to Thabo Mbeki. After the distinguished Harvard physician Paul Farmer found himself at conferences where professional colleagues went “practically purple with rage discussing Mbeki,” even accusing him of genocide, he decided to look dispassionately at the controversy. Farmer concluded, quite sensibly, that Mbeki’s message was that “poverty and social inequality serve as HIV’s most potent cofactors, and any effort to address this disease in Africa must embrace a broader conception of disease causation.” Farmer acknowledged, “this is precisely the point many of us have tried to makeand we haven’t been branded as AIDS heretics.”⁹⁷

Unlike Farmer, however, Mbeki understood that any reappraisal of AIDS in Africa must recognize that HIV tests are notoriously unreliable among African populations where antibodies against conventional microbes cross-react to produce unacceptably high false results. For instance, a 1994 study in central Africa reported that the microbes responsible for tuberculosis and leprosy were so prevalent that over 70% of the HIV-positive test results were false. The study also showed that HIV antibody tests register positive in HIV-free people whose immune systems are compromised for a variety of reasons, including chronic parasitic infections and anemia brought on by malaria that are widespread in populations with the diseases of poverty.⁹⁸

By definition, all viruses that cause a disease infect over 30% of the cells they target, are present in the blood at concentrations in excess of 10,000 per milliliter, and are contagious. HIV is such a weak retrovirus that, when detected at all, it is present in such low concentrations (about one per milliliter) that only its antibodies can be detected. This explains why it is barely transmissible, requiring an average 1000 unprotected vaginal sex contacts with an antibody-positive person for someone to “acquire” HIV.⁹⁹

HIV tests (the ELISA and Western Blot) do not detect any virus itself but rather viral antibodies that are read with an assortment of proteins that are not

⁹⁶ These same statistics were featured prominently on the front page of the *Sunday Times* (Johannesburg), published the same day (July 2, 2000) that President Mbeki opened the XIII International AIDS Conference in Durban. The article by Laurice Taitz was entitled, “Young, Gifted and Dead.”

⁹⁷ Paul Farmer, “AIDS Heretic,” *New Internationalist*, #331 (January/February 2001), p. 15.

⁹⁸ Oscar Kashala et. al. “Infection with HIV-1 and Human T Cell Lymphotropic Viruses Among Leprosy Patients and Contacts...,” *Journal of Infectious Diseases*, Vol. 169, (February 1994), pp. 296-304. [“...ELISA and WB results should be interpreted with caution when screening individuals infected with *M. tuberculosis* or other mycobacterial species. ELISA and WB may not be sufficient for HIV diagnosis in AIDS-endemic areas of Central Africa where the prevalence of mycobacterial diseases is quite high.”].

⁹⁹ I. de Vicenza, “European Study Group on Heterosexual Transmission of HIV,” *New England Journal of Medicine*, Vol. 331, 1994, pp. 341-46. Moreover, recent research showing that male to female transmission of HIV was infrequent during natural conception was also “compatible with seroconversion rates in the order of 1 per 1000 episodes of unprotected intercourse reported in longitudinal studies of stable heterosexual couples as well as in studies of transmission through artificial insemination.” L. Mandelbrot, I. Heard, E. Henrion-Geant and R. Henrion, “Natural Conception in HIV-Negative Women with HIV-positive Partners,” *The Lancet*, Vol. 349 (March 22, 1997), pp. 885-89.

even unique to HIV. The tests detect antiviral immunity, which is a prognosis against, not for HIV. The tests fail three basic criteria: they are not specific, there is no standard interpretation of the results, and the results are not reproducible.

In a study that explained why there is no correlation between a positive HIV antibody test result and the isolation of HIV itself, the authors concluded “the use of HIV antibody tests as predictive, diagnostic and epidemiological tools for HIV infection needs to be carefully reappraised.”¹⁰⁰ Another investigation reported that even if HIV-1 is detected in the blood or cervical secretions of an HIV-positive woman, “the amount of HIV-1 excreted in the cervicovaginal fluid is independent of the quantity of virus present in the blood cells or plasma.”¹⁰¹ Richard Strohmman, Professor Emeritus of Molecular Biology at University of California (Berkeley), points out:

“HIV science has always been based not on detection of real infectious units (real virus) growing under some reasonable standard condition in living cells in the lab. Rather it is based upon a high tech series of assays constructed so that disappearingly small quantities of the virus, or some part of the virus, or some trace (aura) of viral presence may be measured. We have substituted the measurement for the real thing, like substituting the menu for the meal.”¹⁰²

The association of HIV antibody tests with ordinary infections does not mean that a positive result warrants a prognosis of death, an effect that would defy all classical experience with viruses, microbes and antibodies. Antibodies are proteins made by the immune system that react against microbes. The presence of antibodies is a near-perfect predictor of protection against a virus or microbe. It is unprecedented that antibodies would be predictive of a disease to come. Yet with HIV antibodies, the patient has never had one of the diseases, which is said to occur only after its detection.

According to Valendar Turner, M.D., of Royal Perth Hospital (Western Australia), the ELISA and Western Blot tests indicate that “*some* antibodies in patients react with *some* proteins in the culture of tissues from the same patients” but with “the total absence of proof of their specificity.”¹⁰³ In other

¹⁰⁰ Eleni Papadopulos-Eleopulos et. al., “Is A Positive Western Blot Proof of HIV Infection?” *Bio/Technology*, Vol 11 (June 1993), pp. 696-707; Eleni Papadopulos-Eleopulos et. al., “HIV Antibodies: Further Questions and a Plea for Clarification,” *Current Medical Research and Opinion*, Vol. 13, #10 (1997), pp. 627-34; Rosalind Harrison and Kevin Corbett, “Screening of Pregnant Women for HIV: The Case Against,” *The Practising Midwife*, Vol. 2, #7 (July/August 1999), pp. 24-29; and Eleni Papadopulos-Eleopulos et. al., “A Critique of the Montagnier Evidence for the HIV/AIDS Hypothesis,” *Medical Hypotheses*, Vol. X (2004), pp. 1-5.

¹⁰¹ Suraiya Rasheed et. al., “Presence of Cell-Free Human Immunodeficiency Virus in Cervicovaginal Secretions is Independent of Viral Load in the Blood of Human Immunodeficiency Virus-Infected Woman,” *American Journal of Obstetrics and Gynecology*, Vol. 175, #1 (July 1996), p. 123.

¹⁰² Richard Strohmman to Charles Geshekter, e-mail message, July 7, 1997.

¹⁰³ “Do Antibody Tests Prove HIV Infection? - Interview with Valendar F. Turner, M.D.,” *Continuum*, Vol. 5, #2 (Winter 1997), p. 13. See also, Eleni Papadopulos-Eleopulos et. al., “A Critical Analysis of the HIV-T4-cell-AIDS Hypothesis,” *Genetica*, Vol. 95, No. 1-3 (1995), pp. 5-24. Furthermore, a number of studies indicate little correlation between AIDS symptoms and either T-cell counts or viral load. In fact, no one can say

words, the tests detect proteins that are alleged to form the components of such an antibody but have never been shown to be unique to a virus. Yet the cornerstone surveillance study for HIV seroprevalence in South Africa rests on administering a single ELISA test to pregnant Africans attending antenatal clinics, never acknowledging that the ELISA is notoriously unreliable in these circumstances since pregnancy is one of 70 conditions known to trigger a “false positive” result.¹⁰⁴

Consider an investigation, reported in *The Lancet*, of 9,389 Ugandans with HIV antibody test results. Two years after enrolling in the study, 3% had died, 13% had left the area, and 84% remained. There had been 198 deaths among the seronegative people and 89 deaths in the seropositive ones. Medical assessments made prior to death were available for 64 of the HIV-positive adults. Of these, five (8%) had AIDS as defined by the WHO clinical case symptoms. The self-proclaimed “largest prospective study of its kind in sub-Saharan Africa” tested nearly 9400 people in Uganda, the former epicenter of AIDS in Africa. Yet of the 64 deaths recorded among those who tested positive for HIV antibodies, only *five* were diagnosed as AIDS-induced.¹⁰⁵

Turner explains that, according to the CDC, an African “with an AIDS defining diagnosis is counted as heterosexual AIDS simply by the fact that he or she comes from a country where heterosexual AIDS is claimed to be the ‘predominant’ mode of transmission. Knowledge of actual sexual contact is not a requirement.”¹⁰⁶

AIDS researchers in Africa assume there is a correlation between clinical symptoms (weight loss, chronic diarrhea, fever, a persistent dry cough) and sexual activity. Correlation - whether one phenomenon is found in tandem with another - is not causation. Proof of causation requires that we control all variables in order to isolate one variable as a cause, not merely as an associated factor. The clinical symptoms that define an AIDS case in Africa are expressed in roughly equal numbers among men and women, not because of al-

with certainty what these indicators mean. One report concluded that the accuracy of CD4 cell counts for AIDS was “as uninformative as a toss of a coin.” Thomas R. Fleming and David L. DeMets, “Surrogate End Points in Clinical Trials: Are We Being Misled?” *Annals of Internal Medicine*, Vol. 125, #7 (October 1, 1996), pp. 605-13.

¹⁰⁴ Department of Health, *Summary Report: 1998 National HIV Sero-prevalence Survey of Women Attending Public Antenatal Clinics in South Africa* (Pretoria: Health Systems Research and Epidemiology, February 1999). A perceptive critique of AIDS in Africa by South African journalist Rian Malan explained how the stories about AIDS “all originate in Africa, but the statistics that support them emanate from the suburbs of Geneva, where the World Health Organization has its headquarters.” Malan showed how blood is drawn to test for syphilis at antenatal clinics, and then tested for antibodies for HIV. “If a given number of pregnant women are HIV-positive, the [simple back-calculation] formula says, then a certain percentage of all adults and children are presumed to be infected too. And if that many people are infected, it follows that a percentage of them must have died.” Rian Malan, “AIDS in Africa: In Search of the Truth,” *Rolling Stone* (November 22, 2001), pp.70-82, 100-102.

¹⁰⁵ Daan W. Mulder, et. al., “Two-Year HIV-1-associated Mortality in a Ugandan Rural Population,” *The Lancet*, Vol. 343 (April 23, 1994), pp. 1021-23.

¹⁰⁶ “Interview with Dr. Valendar Turner,” *op. cit.*, p. 17.

leged heterosexual transmission, but because the socio-economic conditions that give rise to the gender equity in the distribution of these widespread symptoms are caused by environmental risk factors to which many Africans are regularly exposed.

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

To put it another way, the presentation of the clinical AIDS symptoms is likely to predict a positive HIV-antibody result on a single ELISA test. Thus, these AIDS symptoms could be said to “cause” a positive test result.¹⁰⁷

Poverty-stricken, malnourished subsistence farmers with malaria, tuberculosis or repeated attacks of dysentery are likely to have a considerable amount of cross-reacting antibodies in their systems. Dr. F.J.C. Millard, a physician at a small mission hospital in South Africa’s North Province (formerly Northern Transvaal), described the local conditions in which the incidence of tuberculosis and AIDS were rising: “the area had suffered from neglect during the *apartheid* years. There is poverty, malnutrition, violence, unemployment, overpopulation, and, most important of all, a lack of education.”¹⁰⁸

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

During the past twenty years, as the external financing of HIV-based AIDS programs in Africa dramatically increased, money for studying other health sectors remained static, even though deaths from malaria, tuberculosis, neo-

¹⁰⁷ Throughout my work as a member of Mbeki’s AIDS Advisory Panel, I sat next to Barry Schoub, a prominent virologist from the University of Witwatersrand. We chatted amiably about topics besides AIDS. During one casual conversation, when I suggested this reversal of the standard HIV=AIDS equation, Schoub agreed that the correlation between a person having those symptoms and then testing positive might exceed 99%. It was a classic reversal (or confusion) of the difference between causation and correlation. Having “AIDS” symptoms could easily predispose someone to test HIV-antibody positive, hence “having AIDS” could be said to cause “HIV.”

¹⁰⁸ F.J.C. Millard, “South Africa: A Physician’s View,” *The Lancet*, Vol. 351 (March 7, 1998), p. 748.

natal tetanus, respiratory diseases and diarrhea grew at alarming rates.¹⁰⁹

While western health leaders fixate on HIV, approximately 52% of sub-Saharan Africans lack access to safe water, 62% have no proper sanitation, almost half live on less than one dollar a day, and an estimated 50 million preschool children suffer from protein malnutrition.¹¹⁰ Poor harvests, rural poverty, migratory labor systems, urban crowding, ecological degradation, the collapse of state structures, and the sadistic violence of civil wars are the primary threats to African lives.¹¹¹ When essential services for water, power, and transport break down, public sanitation deteriorates and the risks of cholera, tuberculosis, dysentery, and respiratory infection increase.

Historian Randall Packard documented attempts made by the South African government to control the spread of tuberculosis and to lower its morbidity and mortality rates. Even though tuberculosis is curable and the available control measures are sufficient to combat it effectively with antitubercular drugs, the *apartheid* government made little impact on the overall prevalence of the disease. Packard showed that the South African government refused “to address the foundations of black poverty, malnutrition, and disease upon which the current [1980s] epidemic of tuberculosis is based...[and] placed their faith in the ability of medical science to solve health problems in the face of adverse social and economic conditions.”¹¹²

AIDS researchers and policy makers confuse correlation with causation as they conflate tuberculosis incidence and the reactivation of dormant TB with a person’s HIV-antibody status. This co-mingling enables conventional AIDS programs to link efforts to reduce the infectiousness and severity of tuberculo-

¹⁰⁹ World Health Organization, *Bridging the Gaps: The World Health Report 1995* (Geneva: WHO, 1995), Table 5 (p. 18) and Table A3 (p. 110); and World Health Organization, *Fighting Disease, Fostering Development: The World Health Report 1996* (Geneva: WHO, 1996), Table 4 (p. 24) and Table A3 (p. 127).

¹¹⁰ “A Good Turn for Africa, Please,” *The Lancet* (January 11, 1997), p. 69. The continent seems to grow poorer with every passing decade, leading some analysts to suggest that, “even if Africa’s aggregate growth doubles over the next nine years, its per capita income in 2006 would still be five percent lower than it was in 1974.” Dan Connell and Frank Smyth, “Africa’s New Bloc,” *Foreign Affairs*, Vol. 77, #2 (March/April 1998), p. 89. In Uganda, the expenditure on debt servicing (\$15 per head annually) is six times the spending on health and nearly one in two children is undernourished. Derek Summerfield, “The Politics of Apology,” *The Lancet*, Vol. 354 (July 31, 1999), p. 421.

¹¹¹ According to the *Global Burden of Disease Study*, 1.02 million Africans died of injuries (intentional and unintentional) in 1990. For South Africa, see Jeanelle de Gruchy and Laurel Baldwin-Ragaven, “Poverty and the South African Health Professions: A Commentary,” *Health Systems Trust Update* (#39, January 1999).

¹¹² Randall M. Packard, “Industrialization, Rural Poverty, and Tuberculosis in South Africa, 1850-1950,” in Steven Feierman and John M. Janzen (eds.), *The Social Basis of Health and Healing in Africa* (Berkeley: University of California Press, 1992), p. 129. In 1989, Packard observed that a “new resurgence of TB is surfacing in the urban areas of the country as thousands of workers and their families attempt to escape the poverty of the Bantustans. Once again, industrial capital and the state have combined to lay the groundwork for a major upsurge in urban-based TB... [will the state and local authorities] once again apply their time-honored policies of exclusion to solve this growing problem...[or] will they at long last recognize the futility of this policy and begin to deal with the underlying causes of TB?” Randall M. Packard, *White Plague, Black Labor: Tuberculosis and the Political Economy of Health and Disease in South Africa* (London: James Currey Publishers, 1989), pp. 318-19.

sis with family planning, safe sex messages and behavior modification proposals.¹¹³

In August 1998, the *New York Times* reported that Zimbabwe had become the center of the world's AIDS epidemic. It claimed that as many as 25 percent of all adult Zimbabweans were infected with HIV, the highest infection rate on earth. Although it provided no figures for previous years, the article acknowledged that the presumed increase in HIV incidence had occurred when increasing poverty, food shortages and instability had "begun to overcome the country. Tuberculosis, hepatitis, malaria, measles and cholera...have surged mercilessly. So have infant mortality, stillbirths and sexually transmitted diseases." Malarial deaths had risen from 100 in 1989 to 2,800 in 1997 and tuberculosis cases jumped from 5,000 in 1986 to 35,000 in 1997. The reporter admitted that all of these diseases indicated deepening social deprivation, with tuberculosis as "the sentinel illness of poverty and social decline."¹¹⁴

Subsequent reports showed that rural suffering in Zimbabwe was caused by government corruption, a savage drought and the breakdown of civil society under the harsh regime of Robert Mugabe. Zimbabwean misery over the past fifteen years was also the result of local mismanagement and gross inequities

¹¹³ For examples, see USAID/Bureau for Africa, *A Strategic Framework for Setting Priorities for Research, Analysis, and Information Dissemination on HIV/AIDS, STIs, and Tuberculosis in Africa* (Washington: USAID, June 1995).

¹¹⁴ Michael Specter, "Doctors Powerless as AIDS Rakes Africa," *The New York Times* (August 6, 1998). The article omitted any reference to the combined effects on Zimbabwe of the World Bank's structural adjustment programs in the 1990s coupled with poor harvests, drought, long-term food deficiencies, a 70% inflation, an unemployment rate of 50%, the cost of its 1998 military involvement in the Congo, and the murderous campaigns by the government against commercial agriculture that have resulted in an economic meltdown whereby the economy shrunk by 40% between 2000-2006, leaving the average Zimbabwean poorer by one-third than at independence in 1980. For a study of the serious economic degradation in rural and urban areas, see Leon Bijlmakers, Mary Basset and David Sanders, *Health and Structural Adjustment in Rural and Urban Zimbabwe* (Uppsala: Nordiska Afrikainstitutet Research Report, No. 101, 1996) which one reviewer termed, "an extensive survey of health, economic and demographic characteristics [that] monitored and documented the deterioration that occurred under the World Bank's structural adjustment program. It confirms what is widely believed, that charges for the use of health services, introduced at the behest of the Bank, deter the patients at greatest risk of disabling and fatal illnesses, the very patients for whom medicine has developed preventive, curative and cost effective interventions." Meredith Turshen in *African Studies Review*, Vol. 41, #1 (April 1998), p. 182. See also, Ken Owen, "Bloody Mugabe," *New Republic* (March 8, 1999), pp. 21-23 and R.W. Johnson, "Zimbabwe, Land of the Dying Children," *Sunday Times* /Johannesburg (January 7, 2007). In her latest study as part of an annual re-survey, Mary Bassett suggests that the impact of SAP on Zimbabwean households has been pernicious -- people are eating one meal a day, not seeking health care but saving money (for funerals?), there are more women headed households and hints of more child-headed households (orphans and children of a parent away at work). Stefano Ponte, "The World Bank and 'Adjustment in Africa'," *Review of African Political Economy*, #66 (December 1995), pp. 539-58 provides data showing that several countries which UNAIDS claims are threatened with a "plague of HIV (Tanzania, Uganda, Zambia and Zimbabwe) have been hard hit by Bank policies in terms of limited debt reduction and poor institutional capacity building." The enormous expansion of debt, the globalization of poverty and its impact on public health sectors since the 1980s are the context within which AIDS developed. See, Michel Chossudovsky, *The Globalisation of Poverty: Impacts of the IMF and World Bank Reforms* (New York: Zed Books, Inc., 1997).

in the region that were accelerated by strictures imposed by the World Bank's structural adjustment programs. In such dire straits, people were hurting because of food shortages and untreated illnesses, not because of sexual promiscuity. Once again, it was no accident that the clinical symptoms that define a case of AIDS in Zimbabwe (fever, diarrhea, weight loss, and persistent cough) were actually manifestations of protein anemia, unsanitary drinking water and parasitic infections in a country "with one of the fastest-shrinking economies on earth."¹¹⁵

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

Former WHO Director General Hiroshi Nakajima warned emphatically that "poverty is the world's deadliest disease."¹¹⁶ Indeed, the leading causes of immunodeficiency and the best predictors for clinical AIDS symptoms in Africa are impoverished living conditions, economic deprivation and protein anemia, *not* extraordinary sexual behavior or the trace measurements of antibodies for a retrovirus that has proved difficult to isolate directly.

The AIDS epidemic in Africa has been used to justify the medicalization of sub-Saharan poverty. Rather than treat the clinical symptoms of AIDS as the manifestations of impoverished living conditions, researchers like David Alnwick, UNICEF's health chief, invert this cause-and-effect relationship to allege that "all our efforts at providing safe water and other protections for children have been undermined, undone, by the AIDS epidemic."¹¹⁷

Western medical intervention has taken the form of vaccine trials, drug testing and demands for behavior modification.¹¹⁸ In 1997, the Division of AIDS at the National Institute of Allergy and Infectious Diseases concluded that there was "not enough evidence that a live attenuated HIV-1 vaccine [was]

¹¹⁵ Philip Gourevitch, "Wasteland: Letter From Zimbabwe," *The New Yorker* (June 3, 2002), p. 61. See also Michael Wines, "In Zimbabwe, Even the Farmers Are Going Hungry," *New York Times* (February 29, 2004), p. A6; Gabrielle Menezes, "Letter From Zimbabwe," *The Nation*, (May 12, 2003), pp. 12-14; and Samantha Power, "How to Kill a Country," *Atlantic Monthly* (December 2003), pp. 86-98.

¹¹⁶ WHO, *The World Health Report 1995*, v. Furthermore, the 1996 UNICEF report, *The Progress of Nations*, sensibly warns that "classifying deaths by disease hides the fact that death is not usually an event with one cause but a process with many causes. In particular, it is the conspiracy between malnutrition and infection which pulls many children into the downward spiral of poor growth and early death."

¹¹⁷ Quoted in David Perlman, "UN Moves to Prevent AIDS Babies," *San Francisco Chronicle* (June 30, 1998).

¹¹⁸ A steady stream of AIDS researchers from the United States and Europe has converged on Africa, convinced that their work is humane and benevolent just as 19th century missionaries came to cure and train. Jonathan Falla sees this impulse towards charity as another form of social control. "What Do They Think They Are Doing?," *Times Literary Supplement* (July 18, 1997).

safe - or effective.” Nonetheless, the International Association of Physicians in AIDS Care (IAPAC) insisted that a vaccine should not be required to meet U.S. safety and efficacy standards because the alleged number of AIDS cases rendered “further delay unethical.”¹¹⁹

AIDS scientists and public health planners should recognize the roles of malnutrition, poor sanitation, and parasitic and endemic infections in producing the clinical AIDS symptoms that are manifestations of non-HIV insults.¹²⁰ The data strongly suggest that socio-economic development, not sexual restraint, is the key to improving the health of Africans. Wherever one projects high rates of HIV-antibodies in Africans, one also finds high rates for all germs indicative of sanitation problems, which point towards abject poverty, destitution and a high disease burden.

Phillipe and Evelyn Krynen, medically trained charity workers employed by the French group Partage in Kagera Province (Tanzania), reported that when “appropriate treatment was given to villagers who became ill with complaints such as pneumonia and fungal infections that might have contributed to an AIDS diagnosis, they usually recovered.”¹²¹ Father Angelo D’Agostino, a former surgeon who founded Nyumbani, a hospice for abandoned and orphaned HIV-positive children in Kenya came to a similar conclusion:

“People think a positive test means no hope, so the children are relegated to the back wards of hospitals which have no resources and they die. They are very sick when they come to us. Usually they are depressed, withdrawn, and silent...But as a result of their care here, they put on weight, recover from their infections, and thrive. Hygiene is excellent [and] nutrition is very good; they get vitamin supplements, cod liver oil, greens every day, plenty of protein. They are really flourishing.”¹²²

Finally, a recent study of pregnant, HIV antibody-positive women in Tanzania showed that simply providing them with inexpensive micronutrient supplements produced beneficial effects and decreased adverse pregnancy outcomes. The researchers found that women who received prenatal multivitamins had heavier placentas, gave birth to healthier babies and showed a no-

¹¹⁹ Michael McCarthy, “AIDS Doctors Push for Live-Virus Vaccine Trails,” *The Lancet*, Vol. 350 (October 11, 1997), p. 1082.

¹²⁰ This is elaborated in Charles Gesheker, “Outbreak? AIDS, Africa, and the Medicalization of Poverty,” *Transition*, #67 (Fall 1995), pp. 4-14; Gesheker, “The Plague That Isn’t,” *Toronto Globe and Mail* (14 March 2000), and Cindy Patton, *Inventing AIDS* (New York: Routledge, 1990), especially Chapter 4, “Inventing African AIDS.” In 1997, Glaxo-Wellcome negotiated with the South African Department of Health to have the government subsidize the cost of importing AZT. As part of this “bouquet of assistance” to provide HIV positive women with AZT, the difference in cost between the actual and discounted price would be used to fund training for “AIDS counselors.” *The Weekly Mail and Guardian* (Johannesburg), August 22, 1997. Some pharmaceutical companies even urge pregnant African women who test HIV-antibody positive to take these powerful drugs and to stop breast-feeding their infants.

¹²¹ Cited in Neville Hodgkinson, “Cry, Beloved Country: How Africa Became the Victim of a Non-existent Epidemic of HIV/AIDS,” in P. H. Duesberg (ed.), *AIDS: Virus- or Drug-Induced?* (Dordrecht: Kluwer Academic Publishers, 1996), p. 353.

¹²² Hodgkinson, *op. cit.*, pp. 350-51.

ticeable “improvement in fetal nutritional status, enhancement of fetal immunity, and decreased risk of infections.” Their commitment to the belief that AIDS was caused by a viral infection obliged the researchers to conclude that “how the individual vitamins produce these effects is not fully understood.”¹²³

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

Nowadays, anywhere journalists look in Africa for telltale signs of poverty - inadequate libraries, poorly paved roads, a dearth of teachers, insufficient childhood immunizations, poor harvests, an excess of rinderpest or locusts, domestic abuse, awful public transportation systems, growing numbers of orphans, packs of wild dogs, disruptive regime transitions, or unwanted sexual advances - they will insist that HIV/AIDS is somehow, ultimately behind it.¹²⁴

Given the erratic and unreliable keeping of vital statistics across Africa and the vague symptomology that constitutes an “AIDS” case to begin with, it seems that unless an African was killed by gunshot wounds or had died from injuries sustained in a traffic accident, then almost any decedent can safely be alleged, without any death certificate or an autopsy, to have died from “AIDS” or an “AIDS-related illness.” Is any African child walking barefoot along a village path with a running nose, dirty clothes and no adult supervision now considered to be an “AIDS orphan?”

The 2005 meeting of the African Studies Association in the United States was organized around the general theme of “Health, Knowledge, and the Body Politic.” Yet almost no articles dealt with the real killers that afflict Africans or compromise their health: malaria, tuberculosis, protein anemia, respiratory diseases, childhood diarrhea, measles, tetanus or the immunosuppression that comes from malnutrition. But throughout the four-day conference, AIDS was everywhere.

If the term “panacea” refers to something that is a cure-all, then I propose the invention of a neologism to describe the all-encompassing power now attributed to HIV and AIDS in Africa.

The new hybrid term combines “pan” (all-inclusive) with “pathogen”(disease-causing agent) to form “panopathogen.” AIDS has become the African panopathogen, the cause of all that is debilitating or life-threatening.

Are these exaggerations? Perhaps. But a 2004 report, *Downward Spiral: HIV/AIDS, State Capacity, and Political Conflict in Zimbabwe* exemplifies

¹²³ Wafaie W. Fawzi et. al., “Randomized Trial of Effects of Vitamin Supplements on Pregnancy Outcomes and T Cell Counts in HIV-1 Infected Women in Tanzania,” *The Lancet*, Vol. 351 (May 16, 1998), pp. 1477-82. The absence of prenatal health care and adequate nutrition remain major factors in pediatric AIDS cases in the United States where 80% of HIV-infected babies are born to drug-addicted mothers who suffer from a host of vitamin deficiencies.

¹²⁴ See, Tamar Kahn, “Dogs Roam Wild as AIDS Kills Owners,” *Business Day* (4 February 2005).

the all-inclusive nature of the HIV/AIDS hypothesis.¹²⁵ One is astonished to learn about the diversity of economic maladies in Zimbabwe that the authors claim are either directly caused or indirectly induced by the HIV/AIDS epidemic and HIV disease, which they call “debilitation and mortality as the virus increasingly colonizes the work force.” These include:

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

It is deceptive rhetoric to assume that AIDS keeps Africa mired in poverty. Where there should be a vigorous historical debate to explain the causes of sickness and death, one inevitably finds the infectious viral theory of AIDS, a dogma with no time for questions or alternatives, just a rigid doctrine about behavior modification.

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

That money can purchase antibiotics to treat syphilis or gonorrhoea, rehydration tablets for diarrhea, directly observed therapy (DOTS) with anti-microbial medicine for tuberculosis sufferers, and micronutrients and vitamin supplements for pregnant women and breastfeeding mothers, regardless of their alleged HIV status. These measures may not be sexy, but they will save lives.¹²⁶

¹²⁵ Andrew T. Price-Smith and John L. Daly, *Downward Spiral: HIV/AIDS, State Capacity and Political Conflict in Zimbabwe* (Washington: U.S. Institute of Peace, #53, July 2004).

¹²⁶ For example, for about \$20, one can acquire a six-month supply of rifampin, isoniazid, pyrazinamide and ethambutol that will cure an African of tuberculosis. The regimen is a simple, proven, effective remedy for one of the real scourges of Africa.

Over the past century, infectious diseases have been controlled through such successful measures

as improved sanitation, cleaner drinking water, eradication of mosquitoes, isolation of genuinely contagious individuals, vaccinations, and the prudent use of antibiotics. Nowadays throughout

the AIDS community, the enemies of public health are said to come from within individuals

themselves, especially those given to inappropriate or promiscuous sexual behavior.

Multilateral institutions and African scientists should familiarize themselves with the body of literature that demonstrates the contradictions, anomalies and inconsistencies in the orthodox view that the symptoms of AIDS are caused by a single viral infection.¹²⁷ Once they consider the non-contagious

¹²⁷ Neville Hodgkinson, *AIDS: The Failure of Contemporary Science* (London: 4th Press, 1996); Elinor Burkett, *The Gravest Show on Earth* (Boston: Houghton Mifflin, 1995); Hiram Caton, *The AIDS Mirage* (Sydney: University of New South Wales Press, 1994); Robert Root-Bernstein, *Rethinking AIDS: The Tragic Cost of Premature Consensus* (New York: Free Press, 1993); Peter Duesberg, *Infectious AIDS: Have We Been Misled?* (Berkeley: North Atlantic Books, 1996); Joan Shenton, *Positively False: Exposing the Myths Around HIV and AIDS* (New York: St. Martins Press, 1998); Stuart Brody, *Sex at Risk: Lifetime Number of Partners, Frequency of Intercourse, and the Low AIDS Risk of Vaginal Intercourse* (New Brunswick: Transaction Publishers, 1997); Christine Maggiore, *What If Everything You Thought You Knew About AIDS Was Wrong?* (Los Angeles: American Foundation for AIDS Alternatives, 1999); Christian Fiala, "Dirty Tricks: How the WHO Gets Its AIDS Figures," *New African* (April 1998), pp. 36-38; Gordon Stewart, "A Paradigm Under Pressure," *Index on Censorship*, Vol. 28, #3 (May/June 1999), pp. 68-72; Huw Christie, "Rethinking AIDS," *Index on Censorship*, Vol. 28, #3 (May/June 1999), pp. 73-78; Peter Duesberg et. al., "The Chemical Bases of the Various AIDS Epidemics: Recreational Drugs, Anti-Viral Chemotherapy and Malnutrition," *Journal of the Biosciences*, Vol. 28, #4 (June 2003), pp. 383-412; John Crewdson, *Science Fictions: A Scientific Mystery, A Massive Cover-Up, and the Dark Legacy of Robert Gallo* (Boston: Back Bay Books, 2003); Eileen Stillwaggon, *AIDS and the Ecology of Poverty* (New York: Oxford University Press, 2006); Rebecca Culshaw, *Science Sold Out: Does HIV Really Cause AIDS?* (Berkeley: North Atlantic Books, 2007); and Henry H. Bauer, *The Origin, Persistence and Failings of HIV/AIDS Theory* (Jefferson, North Carolina: McFarland and Company, 2007).

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

There were similar distortions in Canadian reports:

From 1981 through December 31, 1998 there had been a **cumulative** total of 16,236 cases of AIDS reported in Canada.

In 1995 alone, 1637 adult cases of AIDS were reported of which 1491 (91%) were males and 146 (9%) females.

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

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

A fruitful methodological approach for enlightened skepticism about AIDS in Africa may be found in the scholarship that refutes comparably “self-evident” truths about environmental crises.¹²⁸ These studies show how scientists, development agencies and governments benefit from a crisis mentality by inventing, exaggerating and upholding assumptions (i.e., desertification, overgrazing, deforestation) long after the evidence for them had been overturned. As Bassett and Crummey explain, “the degree of urgency which accompanies so many calls for intervention is far too often directly proportional to the ignorance out of which it arises. Outsiders have been constructing Africa according to their own will for far too long.”¹²⁹

But for 1998, there were only 279 cases - 241 males (86.3%) and 38 females (13.7%), a total decrease of 75% in three years.

The actual number of adult female AIDS cases reported in Canada plummeted by 75% from 1995 to 1998. In a country of 32 million people, 15.1 million of them women, there were only 38 female AIDS cases in 1998.

Yet because the *percentage* of women with AIDS went up from 9% in 1995 to 13.7% in 1998 even though the actual number sharply went down, the *Annual HIV and AIDS in Canada Surveillance Report* (April 1999) from the Bureau of HIV/AIDS and STD at the Canadian Laboratory Centre for Disease Control issued an alarmist warning that the risk of AIDS among Canadian women had *dramatically increased* by 25% to now comprise nearly 14% of all diagnosed cases, “the highest proportion observed since monitoring of the epidemic began,” re-affirming how statistics are easily misrepresented to advance claims of an ever-expanding AIDS epidemic.

By 2004, the total number of AIDS cases annually reported in Canada had shrunk to 237, of whom 188 were males and 49 were females. Women account for 20% of all AIDS cases in Canada, but the latest report ignored the fact that the total number of female AIDS cases in Canada had actually **dropped 67%** from 1995 to 2004. *HIV and AIDS in Canada: Surveillance Report to December 31, 2004* (April 2005).

Finally, the same report noted with great alarm that while “the rising trend [rate of female AIDS] was seen in all age groups, it is most striking in the 15-29 year age group where the proportion of AIDS diagnoses attributed to females increased from 9.9% before 1994 to 45% in 2004.” It failed to mention that the **actual number** of female AIDS cases among all Canadian women, ages 15-29, had dropped 70%, from 30 cases in 1995 to **just 9** in 2004.

¹²⁸ Melissa Leach and Robin Mearns (eds.), *The Lie of the Land: Challenging Received Wisdom on the African Environment* (Oxford: James Currey, 1996); Thomas J. Bassett and Donald Crummey (eds.), *African Savannas: Global Narratives and Local Knowledge of Environmental Change* (Oxford: James Currey, 2003); and Vigdis Broch-Due and Richard Schroeder (eds.), *Producing Nature and Poverty in Africa* (Stockholm: Nordic African Institute, 2000).

¹²⁹ Bassett and Crummey, *op. cit.*, p. 30.

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

In fact, even the Executive Director of the UNAIDS Program, Peter Piot, seems to understand this:

“I was in Malawi [in 2003] and met with a group of women living with HIV. As I always do when I meet people with HIV/AIDS and other community groups, I asked them what their highest priority was. Their answer was clear and unanimous: food. Not care, not drugs for treatment, not relief from stigma, but food.”¹³⁰

¹³⁰ Peter Piot, *The First Line of Defence In World Food Program: Why Food and Nutrition Matter in the Fight against HIV/AIDS* (Rome: United Nations, 2003).