Global health strategies on AIDS require evidence not emotions

By Andrew Maniotis and Charles Geshekter

Summary:

A Kenyan AIDS trial was interrupted because a 53 percent reduction in acquisition of "HIV" among circumcised men was observed. Out of 2,784 men studied in the trial, 69 men were “HIV” positive: 22 of these were circumcised, and 47 uncircumcised. Many, if not all 69 of them had received prior (or concurrent) treatment for penile infections, and 28 of the 69 had serologic syphilis at the outset. A year before, it was claimed that a trial of 4,996 HIV-negative men in Rakai, Uganda, showed that HIV acquisition was reduced by 48 percent in circumcised men. In the past, AIDS science by press release, like the Kenyan trial we question in this analysis, has led to horrible consequences for hundreds of thousands during the AIDS era who were experimented on with toxic "life saving" or "life extending" drugs.

Uncertainties exist because: data has been acquired at STD clinics or from trial participants with genital ulcer disease (GUD) or other infections, and the relative roles (if any) of biological versus cultural practices that influence "HIV" acquisition have been challenged by the WHO. Uncertainties regarding the damage done by microbicides also exist, which apparently increase the frequency of reported genital lesions and the feared spread of "HIV." The ability or inability to neutralize "HIV" by washing with mild or concentrated detergents is in question, and the transmission of "HIV" from human to human by providing evidence of seroconversion has yet to be provided in a form that constitutes as careful a study as the 10 year study that followed 175 serodiscordant couples for 10 years that found no conversions. Uncertainties also exist because of the vastly different rates and efficiency of transmission said to be associated with heterosexual, homosexual, and IV drug use in different regions, and, because of the ability of gamma globulin in neutralizing "HIV" among well-nourished and healthy individuals. Uncertainties also exist especially because of the validity (and invalidity) of different test kits to identify "HIV" positive participants, and the role (or non-role) of T-cells in progression to AIDS is also still in question.

The role of circumcision in preventing transmission of "HIV" and acquisition of AIDS in Africa is further complicated by compelling evidence from a series of recent studies that identified nosocomial (hospital and doctor-medicated) "HIV" transmission as the single most critically important factor for the spread of AIDS in Africa, which accounts for many anomalies and conundrums that cannot be explained by a sexual transmission hypothesis. From the 1950s into the 1980s, unsafe injections may have contributed to the silent spread of HIV in Africa in much the same way that other types of vaccination campaigns, including injections for schistosomiasis and other treatments in Egypt, established "hepatitis C" as a major blood-borne pathogen. While evidence for nosocomial transmission of "HIV" continues to accumulate since the long established fact that hepatitis B and flu vaccines cause "HIV" positive tests in some individuals, six

Bulgarian health care workers (The Tripoli Six) are currently about to be executed by firing squad in Libya for their alleged role in supposedly transmitting "HIV" to more than 400 Libyan children.

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

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

It is concluded that global health strategies for AIDS, like any other public health activities, should be based on evidence instead of racist notions regarding sexual behavior. Many of the basic assumptions regarding the probability that "HIV" leads to "AIDS" are clearly wrong, contradictory, and defy common sense, to the extent that the "HIV/AIDS" hypothesis should be retracted, and a full examination of where we went wrong, conducted, so we can learn from "mistakes." Although six health care workers in Libya are about to be executed due to mistaken notions regarding the association of immune suppressive syndromes with positive "HIV" testing, epidemiology, and toxic anti-retrovirals, it is perhaps the individuals in leadership roles in our own government who press release these kinds of distortions and propaganda, or who direct these trials and distort data, who must be held legally, and criminally responsible?

Introduction:

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

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

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

"The announcement yesterday about the results in two African studies of male circumcision may be the most important development in AIDS research since the debut of antiretroviral drugs more than a decade ago. The National Institutes of Health halted studies in Uganda and Kenya when it became overwhelmingly clear that circumcision significantly reduces men's chances of catching H.I.V."

*"The studies confirm the results of a trial that ended last year in South Africa, in which circumcision prevented **60 to 70** percent of new AIDS infections."*

"News of the South African results has already led to a surge in demand for the procedure across Africa, and clinics that now offer it have long waiting lists" [1].

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

*"Adult Male Circumcision Significantly Reduces Risk of Acquiring HIV Trials in Kenya and Uganda Stopped Early: The National Institute of Allergy and Infectious Diseases (NIAID), part of the National Institutes of Health (NIH), announced an early end to two clinical trials of adult male circumcision because an interim review of trial data revealed that medically performed circumcision significantly reduces a man's risk of acquiring HIV through heterosexual intercourse. The trial in Kisumu, Kenya, of 2,784 HIV-negative men showed a **53** percent reduction of HIV acquisition in circumcised men relative to uncircumcised men, while a trial of 4,996 HIV-negative men in Rakai, Uganda, showed that HIV acquisition was reduced by **48** percent in circumcised men. "These findings are of great interest to public health policy makers who are developing and implementing comprehensive HIV prevention programs,"says NIH Director Elias A. Zerhouni, M.D.* [2].

The results praised by this NIAIDS embargoed press are not yet published, nor are they soon going to be. Because the trial was stopped early, the Data Safety and Monitoring Board has blocked the publication of the work until it can complete its investigation. Dr.

R. C. Bailey, the Kenyan study's lead author, is certain that any journal will accept the results when they are written up and submitted (personal communication).

But science by press release can lead to horrible consequences, especially in the AIDS arena. The first Fischl 1987 AZT trial that obtained FDA approval for the drug also was stopped early in a record 4 months "out of compassionate reasons" [3]. The trial became unblinded on the part of both doctors and participants. Accusations of deception were leveled at the authors because patients were switched between arms. The Boston arm of the trial was supposed to be discarded due to sloppy record keeping but wasn't, and results later obtained in a longer, better designed, and much larger trial known as Concorde, were completely the opposite of the Fischl trial:

"The results of Concorde do not encourage the early use of zidovudine in symptom-free HIV-infected adults. They also call into question the uncritical use of CD4 cell counts as a surrogate endpoint for assessment of benefit from long-term antiretroviral therapy" [4].

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

1. What was the division in terms of actual numbers of cohort participants (Cps) among the 4996 enrolled in the two respective arms of the Ugandan trial – how many underwent circumcision and how many remained uncircumcised? According to the press release, of the 69 "HIV" positive men studied in the Kenyan trial, only 22 were considered circumcised out of the 2,784 men, while 47 were uncircumcised, and many, if not all of them had received prior (or concurrent) treatment for penile infections (R.C. Bialey, personal communication). Also according to Dr. Bailey, 28 of the 69 (CPs) had serologic syphilis at the outset. Is this a fair representation of how circumcision prevents the acquisition of an "HIV" positive test result when nearly half the cohort tested positive for syphilis?

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

3) How many of the CPs at the outset produced discordant EIAs for HIV status and hence required WB testing and did those who tested positive with ELISA's test consistently positive on WB's and PCR, or were these data fraught with inconsistent findings?

4) In its review of "behavioral disinhibitions" in Rakai District, the Protocols indicate that, before initiating the study, in terms of condom use, 17% were expected to use condoms inconsistently and 5% consistently, leaving 78% who were expected (presumably) not to use condoms at all. What did the researchers find were the actual percentages of such "behavior disinhibitions" between the two arms?

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

1). How does circumcision really prevent acquisition of "HIV/AIDS?"

2) Might there be other explanations for "AIDS" in Africa other than heterosexual transmission of "HIV?"

3). What is the background incidence of "HIV/AIDS" in the first place in Africa?

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

1. How does circumcision really prevent acquisition of "HIV/AIDS"?

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

*"Risk factors for HIV-2 infection in men attending Abidjan STD clinics were broadly similar to those for HIV-1 infection. HIV-1 infection was more strongly associated with current STD"[*5].

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

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

diagnosis found in this study. The development of rapid accurate tests for GUD is urgently required" [6].

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

"9.9% among circumcised men and 26.6% among uncircumcised men. After controlling for socio-demographic characteristics, sexual behaviour and other sexually transmitted infections, the protective effect of male circumcision remained with an adjusted odds ratio of 0.26 (95% confidence interval = 0.12-0.56). In Ndola, the prevalence of HIV infection was 25.0% in circumcised men and 26.0% in uncircumcised men. The power was insufficient to adjust for any differences in sexual behaviour" [7].

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

"Circumcised men have a lower risk of HIV-1 infection than uncircumcised men. Laboratory findings suggest that the foreskin is enriched with HIV-1 target cells…we noted no protective effect against herpes simplex virus type 2, syphilis, or gonorrhoea. The specificity of this relation suggests a biological rather than behavioural explanation for the protective effect of male circumcision against HIV-1" [8].

Are the penises of Indian men different than those of Africans, such that the acquisition of "HIV" among circumcised Indian men was less compared to uncircumcised men? Reynolds et al., would have us consider that there is a likely over-abundance of so-called "HIV" receptors present on the foreskin of Indian men, which isn't selective for herpes simplex, syphilis, or gonorrhea, "*or perhaps that the superficial Langerhans cells on the inner aspect of the foreskin and frenulum are "poorly protected by keratin," and thus [these cells] could play an important role in primary male infection*" [9].

However, in New Zealand, it was reported that:

"Results support a lack of association between circumcision status and HSV-2 acquisition, although a small effect cannot be ruled out" [10].

Despite theories regarding the distributions of "HIV" receptors on different cultural group's penises, the WHO comes to a different conclusion regarding biological differences based on cultural groups, as is presented in the WHO Manual for Male circumcision under local anaesthesia www.andrology.org/?download=WHO_MC_Manual%20v2.0.Oct%2006.pdf (Oct. 2006) where it is noted that:

"…of the 191 circumcised men (in the Reynold's et al. study [8]), 62.1% were Muslim. When non-Muslim men were assessed separately, the circumcised group was small and the same significance in protective effect was not found. This illustrates the difficulties in separating the effect of male circumcision from cultural factors."

What would be the effect of circumcision and “HIV” acquisition for men who have not acquired any other co-infections or who don’t have ulcers or GUD? And what about men who wash their privates with soap every so often?

It is known that *within one minute, a 0.5% solution of nonidet-P40*" inactivates “huge amounts” of artificially prepared "HIV" virus [11].

In addition, AIDS researchers who spent 10 years studying 1270 Kenyan female sex workers reported that:

"*…women who performed vaginal washing with **soap** or other substances were at higher risk for HIV-1 compared with those who used water alone (adjusted HR, 1.47; 95% CI, 1.02-2.13)*" [12].

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

"*…male circumcision was also strongly associated with lower HIV prevalence among countries with primarily heterosexual HIV transmission, but not among countries with primarily homosexual or injection drug use HIV transmission*"[13].

According to a recent report from South African AIDS researchers:

" *Women who had undergone FGC [female circumcision] had a significantly higher prevalence of bacterial vaginosis (BV) [adjusted odds ratio (OR)=1.66; 95% confidence interval (CI) 1.25-2.18] and a substantially higher prevalence of herpes simplex virus 2 (HSV2) [adjusted OR=4.71; 95% CI 3.46-6.42]. The higher prevalence of HSV2 suggests that cut women may be at increased risk of HIV infection*" [14].

Weather or not the sexual organs of African males or females is being studied in great detail by Western AIDS researchers, all of these data still do not explain why serodiscordant couple studies, in what is perhaps the most comprehensive study of "HIV" transmission to date, couldn’t demonstrate that "HIV" is transmissible from human to human by providing evidence of even one seroconversion among the 175 serodiscordant couples studied for 10 years:

“We observed no seroconversions after entry into the study *[nobody became HIV positive]…This evidence argues for* ***low infectivity*** (shouldn't it be no infectivity**?**) *in the absence of either needle sharing and/or other cofactors”* [15].

Massive amounts of money and effort have been directed toward smearing microbicides on the genitals of Africans, and the results of 16 or more "advanced" clinical trials funded by the NIH and other agencies are somewhat alarming. For instance, the decision was made to cancel the planned phase III trial of nonoxynol-9 (N-9) gel, a vaginal microbicide, on the genital mucosa of women from Malawi and Zimbabwe in preparation for a phase III efficacy study after it was learned that:

"N-9 gel 100 mg caused a significant increase in the rate of genital symptoms and epithelial disruptions compared with placebo" [16].

Microbicide studies in Africa that involved nearly 1,000 women found:

"59 of those who used the spermicide became infected with HIV, compared to 41 of those who used a dummy gel, and…The Centers for Disease Control and Prevention (CDC) said it was concerned by the findings because some groups advise people to use nonoxynol-9 to protect themselves from HIV if they cannot use a condom" [17].

Dr. Lynn Paxton, a microbicides expert at the CDC, said regarding the study:

"I think it's pretty clear we have to tell men who have sex with men not to use it'' [17].

Why doesn't Dr. Lynn Paxton tell everybody not to use it if the stuff causes genital lesions?

What if African males have microscopic cuts (not ulcers) on their penises (abrasions)? It has been known since 1985 that:

"Exposure to gamma-globulin alone inactivated about 99% of HTLV-III infectivity" [18].

Therefore, in normally nourished individuals who possess normal levels of gamma-globulin, circumcision couldn't likely account for a 60-70% or 48-53% reduction in inseminators acquiring "HIV" if the people followed in these trials had normal levels of gamma-globulins.

The ability of test kits for "HIV" to work or not to work are a serious issue in light of the fact that "HIV" test kits, especially the rapid ones, don't detect "HIV," but are believed to detect so-called markers of "HIV" in goats, cows [19], and "HIV-like" gene sequences in human, chimpanzee, and rhesus monkey DNAs from "normal uninfected individuals" [20]. In the culturing of "HIV," the so-called "HIV-specific" reverse transcriptase enzyme activity has been found in yeasts, insects and mammals of all kinds [21]. In this regard, in 1985, at the beginning of HIV testing among sperm donors, it was known that:

"68% to 89% of all repeatedly reactive ELISA (HIV antibody) tests were likely to represent false positive results" [22].

As for T-cells constituting the defining cell type attacked and diminished by "HIV" during progression to ARC and AIDS, only one year after the famous proclamation, again by press release, by Dr. Robert Gallo and Margaret Heckler:

*"HIV, **a variant of a known human cancer virus,** is the probable cause of AIDS,"*

Dr. Gallo, and his partner, Dr. Flossie Wong Stall published in no less a journal than Nature (Flosie Wong-Staal Robert C. Gallo, Nature Vol 317, 3 Oct 1985) that:

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

By this admission, should we therefore conclude that Africans, (and their descendents) and "the homosexuals" Gallo and Wong-Staal referred to, have different types of cells that are "*attacked*" by "HIV," followed by two different "AIDS-defining syndromes, Kaposi's sarcoma and the opportunistic infection, PC pneumonia (and other OI's-opportunistic infections)? This statement, somehow missed by the AIDS establishment, would be like saying that muscular dystrophy in Greeks is typically associated with muscle hypotrophy and demise, but in Germans who show no hypotrophy and demise in their muscles, with liver disease.

2. Might there be other explanations for "AIDS" in Africa other than heterosexual transmission of "HIV?"

Medical issues such as nosocomial transmission have become critically important to assess in light of the New York Times Rare Good News claim, and the claims of NIADS. For instance, some AIDS researchers such as Gisselquist et al. who have studied Africa and African AIDS extensively claim that "HIV/AIDS" is caused mostly by doctors! The reasons in support of the Gisselquist et al. claims published in the journal AIDS and elsewhere include:

"*An expanding body of evidence challenges the conventional hypothesis that sexual transmission is responsible for more than 90% of adult HIV infections in Africa. Differences in epidemic trajectories across Africa do not correspond to differences in sexual behavior. Studies among African couples find low rates of heterosexual transmission, as in developed countries. Many studies report HIV infections in African adults with no sexual exposure to HIV and in children with HIV-negative mothers. Unexplained high rates of HIV incidence have been observed in African women during antenatal and postpartum periods. Many studies show 20%-40% of HIV infections in African adults associated with injections (though direction of causation is unknown). These and other findings that challenge the conventional hypothesis point to the possibility that HIV transmission through unsafe medical care may be an important factor in Africa's HIV epidemic. More research is warranted to clarify risks for HIV*" [23].

"*The assumption that historic and continuing high rates of epidemic increases among African adults are almost exclusively due to sexual transmission requires much higher rates of heterosexual transmission in Africa than in the developed world. However, a recent study of HIV incidence in serodiscordant couples in Africa (only 1.2% reported consistent condom use) estimated a rate of transmission per coital act of only 0.0011, comparable to rates of 0.0003-0.0015 from similar studies in the US and Europe*" [23].

"A study in Kinshasa in 1985 found 39% (17 of 44) of HIV-positive inpatient and outpatient children 1-24 months old to have HIV-negative mothers; only five of 16 (with information) had been transfused... In a later report from Rwanda, 7.3% (54 of 704) of mothers of children with AIDS were HIV-negative; transfusions were identified as the risk factor for 22 of the 54 children… rates of unexplained incidence among African women are comparable to rates of maternal mortality from puerperal fever of 6% to 16% observed by Semmelweis during 1841-46 in the First Clinic at the University of Vienna's obstetric department." [23].

"Starting in the 1950s Africans experienced a massive increase in medical injections associated with mass injection campaigns targeted at yaws, with introduction and spread of parenteral therapies to treat other diseases, and with plummeting prices for antibiotics and injection equipment. For example, UNICEF administered 12 million injections for yaws in Central Africa alone during 1952-57. From the 1950s into the 1980s, unsafe injections may have contributed to the silent spread of HIV in Africa in much the same way that unsafe injections for schistosomiasis and other treatments in Egypt established hepatitis C as a major blood-borne pathogen, infecting about 15% to 20% of the general population at the end of the 1990s" [23].

"Our observations raise the serious possibility that an important portion of HIV transmission in Africa may occur through unsafe injections and other unsterile medical procedures" [23].

"More recently, nearly 400 children attending a single hospital in Libya apparently contracted HIV" [23].

Currently, there are 5 nurses and 1 doctor thought responsible for this transmission of "HIV" to these 400+ children (the Tripoli Six), and they are scheduled to be executed by firing squad in Libya.

The warnings by Gisselquist et al. regarding iatrogenic and nosocomial transmission of "HIV/AIDS" are reminiscent of those warnings by Dr, Anthony Fauci before the AIDS era. Doctors cause immune suppression, Dr. Fauci indicated, if they subject their patients to multiple transfusions, transplant surgery, or corticosteroid administration [24, 25]. It is now well established that these drugs and treatments can non-specifically induce "AIDS-specific" drops in T-cells with high frequency that is typically, but not always, reversible upon withdrawal of drugs, but transfusions may be another matter. This proclamation from the NIH's AIDS Czar of course was before he claimed that "HIV" doesn't always cause AIDS, and cemented this belief into a new disease category called Idiopathic CD4+ T-cell lymphocytopenia (ICL AIDS), which he said could explain “the mysterious AIDS cases.” The extraordinary feature of this patient ICL AIDS group is that they test negative for HIV.

Other evidence also suggests nosocomial or iatrogenic transmission of "HIV" positivity could largely account for "the African AIDS epidemic." A recent hepatitis B vaccine [26], or flu vaccine [27, 28], can cause “HIV” tests to show positive results.

Moreover, it is possible that physicians may misdiagnose a presumed case of AIDS. One example about misdiagnosing AIDS in the absence of “HIV” testing in resource poor countries here may be instructive:

*“The patient will complain of rashes, fever, itching, sore throat, headache, malaise, vertigo, sweating, insomnia, nausea, prostration, weight loss, loss of hair, or aching in the bones and joints. Some have hypertension, kidney disease, swollen liver, or swollen spleen; others have a subacute meningitis with cranial nerve involvement. This stage of syphilis is often confused with such conditions as infectious mononucleosis, iritis, neruoretinitis, lichen planus, cancer, nephritis, dementia, lymphomas, psoriasis and other skin eruptions, and even drug reaction…The thymus-dependent parts of the lymphatic system deteriorate, and there is consequent decrease in the numbers of “T-lymphocytes. The T-helper cells are particularly affected by this**: there is a decline in their number and the ratio with the T-suppressor cells is reversed.** Consequently, a long-term effect of syphilis is loss of, or decline in, the system of immunity, and lowering of the individuals capacity to defend himself against other infectious conditions For this reason secondary syphilis is called the great imitator”* [29].

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

3. What is the background incidence of "HIV/AIDS" in Africa?

Let us assume for a moment, in resource poor regions of Africa that do not have access to "HIV" test kits, that an AIDS doctor, supported by the makers of nevirapine or AZT on his humanitarian travels to Africa, can distinguish a case of syphilis, or malnutrition (which can be reversed simply with hydration and feeding [30, 31]), from "AIDS." Perhaps this doctor has a trusty microscope in the field with which T-cells can be counted. But if this physician was looking at T-cell counts, he/she would find that diminished and reversed CD4+ T lymphocyte counts (CD4 counts) along with many viral infections, bacterial infections, parasitic infections, sepsis, tuberculosis, coccidioidomycosis, burns, trauma, intravenous injections of foreign proteins, malnutrition, over-exercising, pregnancy, corticosteroid use, normal daily variation, psychological stress, and social isolation or simply for no apparent reason, as is generally known in immunology.

But what if this doctor had god-like differential diagnostic abilities, and he/she was aware that his patient hadn't previously received a recent hepatitis B, or flu vaccine, hemodialysis, multiple transfusions, or gamma globulin or immune globulin (as prophylaxis against infections), that his/her subject was free of TB or cryptic forms of that great imitator, syphilis, and that his patient was not malnourished, or suffering from herpes simplex I and II, arthritis, systemic lupus erythematosus, scleroderma, connective tissue disease, dermatomyostitis, tuberculosis, malaria, hemophilia, hepatitis, alcoholic

hepatitis, primary billiary cirrhosis, hyperbilirubinemia, hypergammaglobulinemia, leprocy, lipemic serum, malaria, malignant neoplasms, mycobacteriaum avium, Q-fever with associated hepatitis, primary sclerosing cholangitis, visceral leishmaniasis, renal failure, Stevens-Johnson syndrome, and was not merely presenting in the clinic with high levels of circulating immune complexes and ERS rates (erythrocyte sedimentation rates or “sticky blood” known to be high among Africans and other populations), free ribonucleoproteins, T-cell leukocyte antibodies, HLA antibodies (to Class I and II leukocyte antigens), p18, p24, p55, p12, p32, p51, p66, or gp160, gp41, gp120 antigens that may be present in fluids obtained from patients who have warts, or other known conditions/reasons for testing false positive for "HIV," and that he really had an "AIDS case," which he dutifully reported to the WHO or to UNICEF as such?

In this regard, we have been confounded by the fact that whenever we have requested the actual numbers of AIDS cases in selected African countries over an extended period of time, the AIDS orthodox establishment seems unable to provide such data, even after more than 20 years. Instead, we have been provided with estimates of projections of “HIV prevalence” in a given population.

To avoid harm, we feel that examination of both established and new AIDS policies that will affect millions of people should include the vital statistics generated by Africans themselves if they are available, as well as recommendations by physicians who have direct, empirical knowledge of African AIDS from their hospital or clinical setting.

In this context, a series of articles was published in the January 6, 2005 issue of the N.E.J.M. by Berkley et al. [32], and in the same issue, a pointed introductory commentary by Kim Mulholland and Richard Adegbola entitled, "Bacterial Infections-A Major Cause of Death among Children in Africa" claimed:

"*For the past 25 years, since the United Nations Children's Fund (UNICEF) has been publishing estimates of mortality among children worldwide, the international medical community has been aware of the appalling burden of early deaths among African children. Early studies indicated that, in the absence of any effective medical care, children born in a rural African village had a probability of death before the age of five years of 30 to 50%" [33] [which is from a period of time before the "AIDS era"] [33]. From the outset, it was understood that many of these deaths result from the combined effect of poverty and malnutrition. Since 1990, mortality rates have fallen but remain high by global standards. Twelve African countries still report official death rates for children under the age of five of more than 20 percent. Community-based studies of death among children have been able to attribute these deaths to a number of common causes, either syndromes or specific diseases* (see **Table I**)."

"***Table I.*** *Official Estimates of Mortality among Children under 5 years of Age According to Cause in Sub-saharan Africa and Globally in 2002.*

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

"In the study, 28 percent of children admitted to the hospital with bacteremia died. Even more important, 26 percent (308 of 1184) of hospital deaths were associated with bacteremia. This finding compares with 22 percent of the deaths that were associated with malaria, suggesting that bacterial disease may be responsible for more deaths in children than malaria in this area where malaria is endemic. Did the children who died at home die from a spectrum of causes similar to that among children who died after reaching the hospital? Both malaria and bacterial illness are amenable to relatively simple therapeutic approaches, but antimalarial drugs tend to be more widely available in African communities than are antibiotics. Therefore, in a rural community, bacteremia may be even more important as a cause of death among children than it is in a hospital setting, since the management of bacteremic illness in the community is likely to be less effective than the management of malaria" [32].

The article concluded:

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

But AIDS researchers count AIDS cases differently. For example, in one African study involving 8735 youths aged 15-24 years in 33 communities in South Africa:

"*HIV prevalence was reported to be* ***20.0%*** *among females and* ***7.5%*** *among males*" (OR 3.93 95% CI 2.51-6.15) [34].

The same group of AIDS researchers in 2003 reported a **15.5 %** prevalence among females and a **4.8%** prevalence among 15-24 year old males [35].

The same group of AIDS researchers reported that of 4393 15-35 year old women from Zimbabwe from whom complete data on sexual behaviors and HIV serostatus were obtained, that HIV prevalence in this sample was a breathtaking **40.1%** [36].

These numbers are in complete contrast to those published in the NEJM, and the vital statistics from the Republic of South Africa, which maintains the most reliable mortality and morbidity registry of any African country. We sought to determine how many cases of AIDS were officially reported in South Africa over the period 1995-2005, aggregated according to the country's nine provinces and perhaps listed by race, ethnicity, gender and age; instead, the available statistics only cover "HIV diseases."

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

An explanation for the nomenclature of the wards at Mseleni Hospital may be gleaned from the data available in the May 2006 publication by Statistics South Africa, entitled Mortality and Causes of Death in South Africa, 2003 and 2004: Findings From Death Notification which includes vital statistics back to 1997. [37].

This publication arranges data in a statistical category called "Leading Underlying Natural Causes of Death" for South Africa from 1997-2004, an important period in the political history of the country.

In 1999, the year that Thabo Mbeki succeeded Nelson Mandela as President of South Africa, there was a total of 9,782 deaths (in a country with a population then of 42 million) whose cause was officially listed as "HIV Diseases." That number represented 2.6% of all deaths in South Africa for 1999.

In the province of KwaZulu-Natal (whose northernmost district is Maputaland), in 1999 the total number of deaths attributed to "HIV Diseases" was 1,899, or 2.3% of all provincial deaths that year. Perhaps officials at Mseleni General Hospital had good reasons not to devote a special ward to "HIV diseases?"

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

So what really happened?

In 2004, the total number of South African deaths (in a country then of 47 million) whose cause was officially listed as "HIV Diseases" was 13,220. That number represented only 2.3% of ALL deaths in South Africa that year, a decrease from 2.6% five years earlier.

For both 2003 and 2004, "HIV diseases" were officially ranked #21 in the list of leading causes of death for South Africa.

We have no way of ascertaining from this data exactly how any attending physician, health care worker, or coroner knew for certain that so-called "HIV disease" was the underlying cause of death.

Meanwhile, in KwaZulu-Natal for 2004, the total number of deaths attributed to “HIV disease” that year was 3044 which corresponded exactly to the same 2.3% of all provincial deaths that were reported five years earlier.

It is our contention that statistics amassed on “HIV disease” and/or “AIDS” are littered with inconsistencies and absurd projections that invite criticism. For an example of how inflationary figures routinely characterize orthodox HIV and AIDS statistics, one need only consult the latest annual volume by S. Buhlungu, et. al. (eds.), State of the Nation: South Africa 2007 especially the chapter by H. Schneider, et. al., entitled, "The Promise and the Practice of Transformation in South Africa's Health System" [38].

That chapter utilizes a table that alleges that for 2000, HIV/AIDS was the #1 cause of death in South Africa, accounting for 30% of all the 410,000 deaths reported in the country, or 123,000 HIV/AIDS deaths.

Compare that alarmist data with the sober statistics given in mid-2006 by Statistics South Africa, which state that for 2000, HIV diseases numbered 10,321 or 2.5% of all deaths. In other words, even in 2007 Schneider and her associates retrospectively increased the number of HIV/AIDS deaths for 2000 in South Africa by 12 times!

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

1) In 1997 in KwaZulu-Natal Province, “HIV diseases” accounted for 2.2% of all its deaths; in 2004, it was 2.3%.

2) In 1997 in Mpumalanga Province, “HIV diseases” accounted for 2.3% of all its deaths; in 2004 it was >2.2%.

3) In 1997 in Limpopo Province, “HIV diseases” accounted for 2.3% of all its deaths; in 2004, it was >2.0%.

4) In 1997 in Free State Province, “HIV diseases” accounted for 3.9% of all its deaths; in 2004, it was >2.1%.

5) And even for South Africa as a whole, in 1997 “HIV disease” was said to account for 2.0% of all deaths; in 2004 it had risen to 2.3%, but that was down from 2.6% in 1999.

It appears that President Mbeki’s skepticism had some merit and was empirically based. This stands in sharp contrast to his critics, whose resort to personal vilification and vicious slurs, revealed the reflexively irrational and vindictive manner whereby HIV/AIDS mainstreamers respond to anyone who dares to challenge their assumptions.

As an African historian who has worked in various parts of Africa for 35 years, especially Somalia, Ethiopia, Kenya and Djibouti, Geshekter had observed an increasing number of Africans who appeared malnourished, or suffered from respiratory illness, or malaria over that period. None of those conditions had anything to do with sexual activities, but reflected the changing nature of African political economies since the late 1970s and its devastation on African lives.

For instance, when Geshekter visited northern Somalia (the Republic of Somaliland) in June-July 2001, he spoke at length with Dr. Ali Sheikh Ibrahim, a leading physician at the main hospital in the capital city of Hargeisa. Dr. Ali acknowledged that those were the same illnesses and medical problems that primarily afflicted northern Somalis, along with serious dental and gum diseases and mental breakdowns associated with the traumas of civil war violence.

Similar conclusions to Geshekter's were advanced by Stuart W. Dwyer, a district surgeon (forensic medical officer) in Grahams-town, South Africa who wrote to the British Medical Journal stating that:

"*As a prison medical officer in South Africa, I partly agree with President Mbeki's sceptical view of current statistical research into HIV infection and AIDS*" [39].

"*In South Africa's prisons there is a vast overcrowded (often 30 people per cell) population in which homosexuality is widespread and condom use practically non-existent. This is the perfect breeding ground for the rapid spread of HIV*" [39].

"*Prisoners with any other illnesses that do not resolve rapidly (within one to two weeks) are also tested for HIV. As a result, a large number of HIV tests are done every week. This prison, which holds 550 inmates and is always full or overfull, has an HIV infection rate of 2-4% and has had only two deaths from AIDS in the seven years I have been working there*" [39].

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

"Nutritional AIDS dominates the scene in South Africa today as indeed it did during Apartheid. In the middle 1950's and 1960's, 50 percent of black children were dead before the age of five. The causes of death were recorded as: pneumonia, high fever, dehydration, and intractable diarrhea due to protein deficiency. Today, these clinical features are called AIDS. Today in South Africa, TB is the leading cause of death and morbidity amongst Africans, but this is called AIDS" [40].

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

"There is no drop in the population. For the Kagera region, we see the same upward curve, with 53% growth between 1988 and 2002" [41].

"While the experts, with their statistics, would have one believe that there exists an extremely serious HIV/AIDS epidemic [in Africa], no trace of an epidemic is observable in the field. All that can be seen is a very poor, under-nourished population suffering from malaria, endemic immunodeficiency and common illnesses" [41].

"The so-called 'HIV' tests are unspecific; the positive results they may give are misleading and lead to the false belief in the existence of a viral epidemic. A positive test — and this applies especially to Africa — is not a sign of a specific viral infection. These so-called 'HIV' tests are deceptive, in that the positive results give the illusion that a precise diagnosis has been made" [41].

"And yet, it is these very same misleading [HIV test] results which constitute the basis of official statistics and which lead, first the experts, then the scientists, medical doctors, newspaper reporters, and finally the general public to believe that Africa is being ravaged by a specific viral infection called 'HIV/AIDS!' People speak of an epidemic of 'HIV/AIDS,' but the only thing which has the appearance of an epidemic is what I would call the 'epidemic of tests,' an artificial epidemic which is being actively promoted" [41].

"[The HIV tests] are also dangerous because they cause panic and stigmatization, they lead to the use of toxic anti-viral drugs and they draw attention away from the real sources of immune system deficiencies. Common sense and scientific reason dictate their abandonment" [41].

"To state that the priority, with respect to emergency humanitarian aid, should be given to the fight against 'HIV' and to giving those countries the possibility of buying cheap-priced anti-viral products is just as irrational as saying to someone suffering from acute vitamin C deficiency, 'Sir, I see that you are suffering from scurvy. You'd better go buy yourself some antibiotics and condoms" [41].

Earlier this year, Pali Lehohla, the statistician-general of South Africa and head of Statistics South Africa noted the "health of citizens is a concern in all countries, and understanding the causes of death is crucial for effective policy planning and intervention

to improve rates of survival," adding that "analysis of mortality trends underlies the development of programmes to reduce mortality" from all diseases [42].

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

"The historical development of statistics has been more akin to a stoneworker's construction of an arch without masonry. The arch is strong when finished, but it requires a supporting framework during construction and the removal of a single piece could cause the whole to fail." [43].

In conclusion regarding background AIDS incidence in Africa, one wonders if there might be some eerie correlation between the number of AIDS researchers, activists, and programs at work in a given African country, and the number of cases of "AIDS" or of "HIV disease" that get reported or must be reported?

A nugget from Schneider et. al.'s chapter offers a suggestive hint. The authors acknowledge that "a significant outcome of several generations [sic] of AIDS interventions has been the emergence of a very large body {60,000] of volunteer and semi-remunerated lay health workers functioning as counselors, treatment supporters, home-based caregivers and support group facilitators."

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

It has been little more than a year since the announcement that our government's chief of AIDS research, Dr. Edmond Tremont, rewrote a safety report on a U.S.-funded drug study to change its conclusions and delete negative information, and later, ordered the research resumed over the objections of his staff, so the profitable $500 million dollar plan to distribute nevirapine to African women would proceed, even though the drug's approval was withdrawn in the U.S. because of excessive toxicity [44]. It only has been a year or so since the Institute of Medicine covered up and trivialized Tremont's criminal behavior, according to Dr, Johnathan Fishbein. It should be noted that Dr. Fishbein had been hired to identify corruption within the NIH, but instead of a recognition plaque for his courage to risk career suicide, his reward for exposing corruption by Tremont (his boss at the time) was to be fired from his position as safety officer for the Nevaripine trials [45].

Virological failure or drug resistance are technical terms among "HIV-AIDS" proponents that simply means, that a drug has failed to do its job in suppressing an artificial "HIV" marker, viral load. This month (1/2007) in the New England Journal of Medicine, it was reported:

"*Nevirapine remains central to the prevention of mother-to-child transmission of human immunodeficiency virus type 1 (HIV-1) and to combination antiretroviral treatment*

throughout much of the developing world. Nevirapine administered as one dose to the mother and one to the newborn reduces mother-to-child transmission of HIV-1 by 41 to 47%, and well over ***875,000 women and infants*** *have received a single dose of nevirapine. A single dose of nevirapine is the cornerstone of the regimen recommended by the World Health Organization (WHO) to prevent mother-to-child transmission among women without access to antiretroviral treatment and among those not meeting treatment criteria. However, nevirapine resistance is detected (with the use of standard genotyping techniques)* ***in 20 to 69% of women and 33 to 87%*** *of infants after exposure to a single, peripartum dose of nevirapine.* ***Among 60 women starting antiretroviral treatment within 6 months after receiving placebo or a single dose of nevirapine, no women in the placebo group and 41.7% in the nevirapine group had virologic failure (P<0.001). Women who had received a single dose of nevirapine had significantly higher rates of virologic failure on subsequent nevirapine-based antiretroviral treatment than did women who had received placebo****. This apparently* ***deleterious*** *effect of a single dose of nevirapine was concentrated in women who initiated antiretroviral treatment within 6 months after receiving a single dose of nevirapine…****Among the 30 HIV-infected infants, a single dose of nevirapine (one each to mother and infant) as compared with placebo was associated with significantly higher rates of virologic failure and smaller CD4+percentage increases in response to subsequent nevirapine-based antiretroviral treatment"*** [46].

Because the NIH, and the IOM and other prestigious organizations consider it acceptable to fudge data when it suits political and economic interests, and because Nevirapine plus AZT failed to control "HIV" in 41.7% of women in the Nevirapine group compared to 0% in "the AZT plus placebo group, it is difficult to assess whether or not circumcision is the most important development in AIDS research since the debut of antiretroviral drugs. Moreover, one wouldn't want to administer more traditional "ARV's," such as AZT monotherapy because AZT and its class of drugs are known to increase morbidity and death amongst those designated as "HIV/AIDS" patients, especially people of African decent, as shown in the Veteran's Affairs Co-operative study:

"The Veterans Affairs Co-operative Study Group reported that, "AZT disproportionately harmed Blacks and Hispanics, and provided no benefit to the quelling of advancing immune suppression in Caucasians" [47].

In addition, with respect to children, it could be argued that giving AZT to infants and pregnant women by itself is a way to limit surplus population, especially with the implementation of George Bush's 3 by 5 plan (3 million on ARV's by 2005):

"de Martino et al. concluded that children born to ZDV-treated mothers "are more likely to have a rapid course of HIV-1 infection compared with children born to untreated mothers, as disease progression and immunological deterioration are significantly more rapid and the risk of death is actually increased during the first 3 years of life" [48].

Conclusions:

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

Just last month (December 2006), scientists admitted that:

"*viral load is only able to predict progression to disease in 4% to 6% of HIV-positives studied, challenging much of the basis for current AIDS science and treatment policy"* [50, 51].

An increasing number of scientists and researchers from many fields have been in agreement with South African President, Thabo Mbeki, for some time, and assert that there is no verifiable evidence to support the hypothesis that "HIV" causes "AIDS."

This conclusion eliminates the need to subject Africans to "anti-retroviral drugs," to any of the 15 failed "HIV" vaccines, to lurid and ludicrous circumcision campaigns, microbicides, or other unfounded treatments and dangerous medicines said to stave off or reverse the immune suppression characteristic of "AIDS." The horrible irony is that many key anti-"HIV/AIDS" drugs are themselves powerful immune suppressors or endogenous protease antagonists (principally developed for cancer chemotherapy to stop cells from dividing or interfere with normal cellular metabolism) with a long history of organ destroying side effects. Until recently, those effects were conflated within the AIDS death toll, further obscuring the true causes of death for the victims. The HIV=AIDS hypothesis has been the pretext for what can only be described as a public health genocide directed at the African continent and elsewhere.

It is not the Tripoli Six, the Bulgarian health-care workers accused of infecting hundreds of Libyan children who should be on trial for their lives as stated by Gisselquist.

Instead, perhaps it should be the international legions of "HIV=AIDS" strategists-opportunists at the NIH and elsewhere who have relentlessly pressed forward with their mistaken and crumbling "HIV=AIDS" paradigm with its "HIV=AIDS" death sentence that has **stigmatized and traumatized** hundreds of thousands of human guinea pigs. A generation of individuals in the mainstream AIDS establishment who have used skewed data to mislead corporate entities, manipulate generous non-profit funding institutions, and frighten the concerned public must be held accountable. This chapter of world medical history transpired under the careful watch of the NIH, IOM, CDC, and WHO,

and other institutions. It should be both a domestic and an international legal matter therefore, to assess the responsibility and determine an appropriate punishment for involvement and negligence in such a far-reaching crime against humanity.

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