

**CASTRO HLONGWANE,
CARAVANS, CATS, GEESE ,
FOOT & MOUTH AND
STATISTICS.**

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**HIV/AIDS
and the Struggle
for the Humanisation of the African.**

PRELUDE

“ And Conrad’s stand-in, Marlow, (in *Heart of Darkness*), muses on how ‘the conquest of the earth, which mostly means the taking it away from those who have a different complexion or slightly flatter noses than ourselves, is not a pretty thing when you look into it too much.’”

(*King Leopold’s Ghost* by Adam Hochschild, Houghton Mifflin Company, New York, 1998.)

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“ All the human race loves a lord – that is, it loves to look upon or to be noticed by the possessor of Power or Conspicuousness; and sometimes animals, born to better things and higher ideals, descend to man’s level in this matter. In the Jardin des Plantes I have seen a cat that was so vain of being the personal friend of an elephant that I was ashamed of her.”

(*Does the Race of Man love a Lord?*, by Mark Twain, April 1902: *Mark Twain*, The Library of America, 1976.)

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“ The failure of American AIDS to ‘explode’ into the general population led the authorities to look for the phenomenon elsewhere. New AIDS cases in the U.S. began falling before the introduction of ‘protease inhibitor’ therapy, and from 1997 to 1998 dropped from about 60, 000 to 48, 000. Of teenagers diagnosed in 1998, only 68 were classified as ‘heterosexual contact.’ Among women, AIDS diagnoses fell from 13, 000 in 1997 to 11, 000 in 1998...If the very high AIDS spending by the U.S. government is to be sustained, the emergency would have to be drummed up elsewhere...so Africa beckoned.”

(Inventing an Epidemic, The American Spectator, 2000, by Tom Bethell, Washington Editor.)

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“ In money terms, first there is the pharmaceutical industry. If AIDS in Africa is now a national security threat, as President Clinton has declared, American money will be appropriated for the very expensive drugs to spend in Africa – billions of dollars of potential profits. If Washington doesn’t appropriate funds, there’s the fear that African nations might buy generic, foreign-made copies of U.S. drugs. Then there is the public health establishment. More billions can go for salaries, offices, staffing, travel and long reports. The World Health Organisation budget has skyrocketed along with African AIDS statistics. Many public health officials are well meaning, seeing AIDS fears as the only way to get money to help the misery afflicting so much of Africa. In America, government AIDS money is spreading far and wide. Federal spending now tops \$10 billion and is increasing yearly even as case loads fall.”

(AIDS Hype in Africa? No HIV Test Required, Disease Defined Differently Than in U.S., by Jon Basil Utley, Robert A. Taft Fellow at the Ludwig von Mises Institute, USA, April 30, 2000.)

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“Africa Can’t Just Take a Pill for AIDS”; New York Times (www.nytimes.com) (07/06/00) P. A27; Goldyn, Lawrence.

“Lawrence Goldyn, a doctor who treats HIV-positive patients, writes in an editorial that South African President Thabo Mbeki has frustrated AIDS researchers with his decision not to promote the use of the drug AZT and his consideration that HIV may not cause AIDS. However, in the light of the country’s poor infrastructure, these decisions are rational. South Africa lacks the resources and pharmaceuticals to treat its growing HIV-infected population. Cocktail drugs cost up to \$15,000 a year, not affordable for most, and unavailable without the social, economic, and medical structures needed to administer drug therapies. The complicated treatments for HIV require full adherence and stability, and getting South Africans to follow a drug schedule could be impossible, based on the past failure of tuberculosis treatments. Transmission of HIV to newborns is also an issue, but in a country where breast-feeding is the only option, the infection rate is 30 per cent for infants born to an infected mother. The best solution is an AIDS vaccine, but without research funds that turn profits, it is years away. Mbeki is right to say that the Western way of fighting AIDS will not transfer to Africa.”

Current TB News: Week of July 10, 2000: Johns Hopkins Center for Tuberculosis Research.

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“As my journey through the pharmaceutical jungle progressed, (in which a number of people were murdered, others killed with experimental drugs, and governments and universities corrupted), I came to realise that, by comparison with the reality, my story was as tame as a holiday postcard.”

“The Constant Gardener” by John le Carre. (Author’s Note): Coronet Books, Hodder and Stoughton, London. 2001.

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PREFACE

This monograph discusses the vexed question of HIV/AIDS.

It is based on the assumption that to understand this matter, it is necessary to study it.

It does not accept the assertion that only scientists and medical doctors are capable of understanding this medical condition. Written essentially by non-scientists, it nevertheless seeks to understand the scientific logic of the thesis of HIV/AIDS.

It accepts that there are many unanswered scientific questions about the HIV/AIDS thesis and many hypotheses about this matter that are falsely presented as facts.

It recognises the reality that there are many people and institutions across the world that have a vested interest in the propagation of the HIV/AIDS thesis, because they have too much to lose if any important element of this thesis is proved to be false.

It accepts that these include the pharmaceutical companies, which are marketing anti-retroviral drugs that can only be sold, and therefore generate profits, on the basis of the universal acceptance of the assertion that “HIV causes AIDS”.

It also accepts that among those that share the vested interests of these companies are governments and official health institutions, inter-governmental organisations, official medical licensing and registration institutions, scientists and academics, media organisations, non-governmental organisations and individuals.

It recognises that there are many well-meaning institutions and individuals in our country and the rest of the world who have innocently accepted and propagate the positions advanced by those who share these vested interests.

It accepts that these have to be exposed to the truth, in the conviction that their consciences will enable them to side with the truth against the untruth, provided that they are informed of the truth.

It also accepts that the HIV/AIDS thesis as it has affected and affects Africans and black people in general, is also informed by deeply entrenched and centuries-old white racist beliefs and concepts about Africans and black people. At the same time as this thesis is based on these racist beliefs and concepts, it makes a powerful contribution to the further entrenchment and popularisation of racism.

It further recognises the reality that, driven by fear of their destruction as a people because of an allegedly unstoppable plague, Africans and black people themselves have been persuaded to join and support a campaign whose result is further to entrench their dehumanisation.

In this context, **it recognises the reality** that in our own country, the unstated assumption about everything to do with HIV/AIDS is that, as a so-called “pandemic”, HIV/AIDS is exclusively a problem manifested among the African people.

It recognises the fact that for the whole truth to emerge, and nothing but the truth, a difficult struggle will have to be waged to overcome the determined resistance of those who have a vested interest in the perpetuation and entrenchment of the currently dominant HIV/AIDS propositions.

It also recognises the frightening and dangerous reality that some of those who share this vested interest are ready and willing to do everything in their power to ensure that their view prevails, globally. This includes the use of any means and measures whatsoever, with no holds barred, to destroy and remove all those who oppose them.

It therefore warns that those who open their minds to what is contained in this document as a whole should understand that they expose themselves to many hazards and dangers that may pose a threat to their careers, their future and their lives.

The monograph accepts that our people, and others elsewhere in Africa and the rest of the world, face a serious problem of AIDS.

It accepts the determination that AIDS stands for Acquired Immunodeficiency Syndrome.

It accepts that a Syndrome is a collection of diseases. It proceeds from the assumption that the collection of diseases generally described as belonging to the AIDS syndrome have known causes.

It rejects as illogical the proposition that AIDS is a single disease caused by a singular virus, HIV.

In other words, **it accepts** that AIDS is either a syndrome or a disease. It cannot be both. Its acronym correctly describes it as a syndrome. For this reason, it is not described as AIDD.

It accepts that an essential part of AIDS is immune deficiency. This constitutes the ID in AIDS.

It accepts that this immune deficiency may be acquired, accounting for the A in AIDS.

It asserts that there are many conditions that cause **acquired** immune deficiency, including malnutrition and disease.

It therefore argues that, in our situation, many and varied interventions have to be made to protect and strengthen the immune systems of our people.

It accepts that these include attention to our nutrition and the eradication of the diseases of poverty that afflict millions of our people.

It accepts that a vaccine should be developed to strengthen the immune system so as to reduce its exposure to the possibility of deficiency.

It accepts that HIV may be one of the causes of this immune deficiency, but cannot be the only cause.

It accepts the proposition that currently existing kits used to check the existence or otherwise of HIV give a “positive” result in response to a variety of medical conditions.

Accordingly, it accepts the assertion that these kits do not establish the presence or absence in the human body of HIV.

It accepts the proposition that these kits detect the presence of antibodies produced by the immune system to fight conditions in the human body that the immune system identifies as a threat to good health.

It rejects as baseless and self-serving the assertion that millions of our people are HIV positive.

It supports the proposition that correct medical practice demands that each person should be treated for any illness identified through clinical examination, regardless of their “HIV status”.

It therefore rejects the condemnation of people to a slow death on the basis that they are HIV infected, which condition cannot be reversed.

It accepts the proposition that anti-retroviral drugs can neither cure AIDS nor destroy the HI virus.

It therefore rejects the suggestion that the challenge of AIDS in our country can be solved by resort to anti-retroviral drugs.

It rejects the assertion that, among the nations, we have the highest incidence of HIV infection and AIDS deaths, caused by sexual immorality among our people.

It rejects the claim that AIDS is the single largest cause of death in our country.

It argues that we must understand properly and comprehensively the burden of disease and death in our country and ensure that we follow appropriate health and other policies to address this burden, including treatment.

It accepts that the pursuit of the objective of health for all must continue to be one of the central objectives of our government and society.

It argues that while those who have commercial and political interests in the promotion of anti-retroviral drugs, and insulting our people, pursue an agenda aimed at minimising and denying the real causes of illness and death in our country, we have a responsibility to understand these real causes of illness and death.

It rejects the argument to “break the silence” about AIDS by imposing the silence of the grave about diseases of poverty.

It is opposed to the medicalisation of poverty.

It argues that an all-round approach should be adopted to deal with AIDS, focusing in particular on prevention of any infection or condition that might lead to immune deficiency, including sexually transmitted diseases.

It argues that an all-round approach should be adopted to deal with all diseases that affect our people.

It is based on the proposition that each one of our citizens has a responsibility to take all necessary measures to protect his or her health.

It rejects as fundamentally incorrect and anti-democratic the attempt to transfer the responsibility to look after oneself to the state, which seeks to turn the state into an omnipotent apparatus that must even police the sexual activities of every individual South African.

It asserts that it is important that the government and society as a whole should ensure that the citizen has all the necessary information to be able to discharge the responsibility to conduct himself or herself in a responsible manner.

The monograph accepts the responsibility of the state to do everything it can to provide adequate and affordable health care for all our citizens. This must include treatment of the so-called opportunistic diseases, including TB and STD's.

It argues for loyalty to the truth and a refusal on the part of the government and the people to succumb to pressures that are directed at serving particular commercial and political interests at the expense of the health of our people.

It rejects the assertion that, as Africans, we are prone to rape and abuse of women and that we uphold a value system that belongs to the world of wild animals, and that this accounts for the alleged “high incidence” of “HIV infection” in our country.

It enjoins all our people to think for themselves, refusing to be intimidated or terrorised by those who have powerful voices and the backing of the fabulous wealth we do not have, because we are poor.

It recognises that the effort it took to produce this monograph will only be meaningful to the extent that we, as Africans, have the courage, integrity and self-confidence to think and act independently and correctly, in our own interest.

It accepts that ours are a courageous, principled and confident people, who have demonstrated these qualities over many centuries.

The monograph is based on the recognition of the fact that the HIV/AIDS issue is both scientific/medical and profoundly political.

It accepts the proposition that despite the reality that our world is driven by a value system based on financial profit and individual material reward, the notion of human solidarity remains a valid precept governing human behaviour.

The monograph seeks to advance the cause both of better health for all our people and the recovery of our dignity as black people and human beings. These are fundamental to our very being as a movement and a people and therefore do not permit of any compromise.

Chapter I

As the 19th century came to a close, in 1900, the great pan-Africanist, W.E.B. du Bois, said that the problem of the 20th century was the problem of the colour line. During the last year of this 20th century, 2000, our President, Thabo Mbeki, was asked to open the Durban 13th International AIDS Conference, which he did.

On reporting this event, the media said that hundreds of delegates walked out of this opening session both because of what the President said and what he did not say. Let us quote what he said.

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

“ This is the story: **The world’s biggest killer and the greatest cause of ill-health and suffering across the globe is listed almost at the end of the International Classification of Diseases. It is given the code Z59.5 - extreme poverty.**

“ Poverty is the main reason why babies are not vaccinated, why clean water and sanitation are not provided, why curative drugs and other treatments are unavailable and why mothers die in childbirth. It is the underlying cause of reduced life expectancy, handicap, disability and starvation. Poverty is a major contributor to mental illness, stress, suicide, family disintegration and substance abuse. Every year in the developing world 12.2 million children under 5 years die, most of them from causes which could be prevented for just a few US cents per child. They die largely because of world indifference, but most of all they die because they are poor.

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

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

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

“HIV and AIDS are having a devastating effect on young people.

“ In many countries in the developing world, up to two-thirds of all new infections are among people aged 15-24. Overall it is estimated that half the global HIV infections have been in people under 25 years with 60% of infections of females occurring by the age of 20. Thus the hopes and lives of a generation, the breadwinners, providers and parents of the future, are in jeopardy.”

Because he said all these things, it was said that hundreds of delegates walked out on President Mbeki!

They also walked out because there were two things he did not say. **One** of these was that he did not say that HIV causes AIDS! **The other** was that he did not say that HIV/AIDS is the single greatest threat to the survival of the peoples of sub-Saharan Africa! Instead, he concluded his address with the words:

“ The world’s biggest killer and the greatest cause of ill health and suffering across the globe, including South Africa, is extreme poverty.

“ Is there more that all of us should do together, assuming that in a world driven by a value system based on financial profit and individual material reward, the notion of human solidarity remains a

valid precept governing human behaviour! On behalf of our government and people, I wish the 13th International AIDS Conference success, confident that you have come to these African shores as messengers of hope and hopeful that when you conclude your important work, we, as Africans, will be able to say that you who came to this city, which occupies a fond place in our hearts, came here because you care. Thank you for your attention.”

Offended both by what he said and what he did not say, reportedly hundreds of delegates who undoubtedly consider themselves to be friends of the Africans, walked out on the President.

The great puzzle is why these friends of the Africans found the truth, as told by the WHO, so unpalatable. Medical science everywhere in the world recognises the central importance of diseases of poverty.

As we will demonstrate later, even the most highly developed countries in the world are themselves involved in a struggle against diseases of poverty within their own borders.

For some strange reason, Africa, among the poorest continents of the world, is not supposed to talk about these diseases of poverty and to focus on their eradication. **We are urged from all sides to break the silence about HIV/AIDS and maintain perfect silence about the diseases of poverty.**

To what do we owe these strange goings-on!
The war to defeat AIDS is also a war to defeat the humiliation and dehumanisation of the African people.

This humiliation and dehumanisation ‘is not a pretty thing when you look into it too much.’

When the humiliated and dehumanised speak of it too much, some friends of the African judge such conversation as not being a pretty thing. Discussion then becomes impossible.

The war to defeat AIDS is a difficult struggle because it is not only a struggle against the conditions that produce ill health and

unnecessary death among millions of Africans, challenging as this struggle is.

It is a difficult struggle also because it has to be waged against some friends of the African, who find that the truth is not a pretty thing.

Asserting that they stand on irrefutable scientific knowledge, these particular friends of the Africans, and the Africans themselves, are horrified beyond measure that the Africans will perish, consumed by an HIV/AIDS pandemic which is sweeping across the face of Sub-Saharan Africa.

Statistics are produced regularly to show rapidly growing HIV infections and rapidly growing deaths from HIV/AIDS on our continent.

Our friends claim that millions of Africans, in increasing numbers, are infected with a highly mutant and indestructible Human Immunodeficiency Virus. They say that this HI Virus is communicated from person to person through heterosexual intercourse and from mother to child.

To stop the spread of the Virus, they say that the Africans should abstain from sexual intercourse or use condoms.

They also say that HIV-positive mothers should be given drugs to stop the transmission of the Virus. Their babies, too, should be given the same drugs, presumably to kill the Virus if the mother has nevertheless transmitted it.

They urge that in the event of rape, the victims should also be given drugs, in case the rapist/s is or are carriers of the HI Virus.

They argue that all the above conforms, unequivocally, to the best available scientific knowledge. It is therefore unquestionable. Diagnosis, prevention and treatment are all based on immutable scientific truths that were agreed by the global scientific community 20 years ago.

It is then said that to question any of the above, or to ask any questions whatsoever, is to commit the sacrilege of questioning science itself and take on the guilt of the perpetration of the high crime of genocide.

The message is simple to understand and communicate. If it moves – clothe it in a condom! If it was naked – destroy its diseased emission with drugs!

The message is also simple in another way. The assertion is made that scientific discoveries about HIV and AIDS were proclaimed two decades ago. At the moment of the proclamation, the science of AIDS came to a standstill. It was frozen at this particular moment into an unquestionable and unchangeable monument to scientific thought.

Accordingly, further scientific inquiry into this matter is impermissible.

Such scientific knowledge as was possible two decades ago must be supported by all and sundry, including scientists, as part of a religious dogma. Accordingly, to establish his or her credentials, everybody must answer the ballad question – do you **believe** that HIV causes AIDS! **Belief** about a scientific matter, and not empirical evidence, thus becomes the criterion of truth.

In his book, “*Eros & Civilisation*”, (Sphere Books, London: 1970), Herbert Marcuse wrote of our epoch as “ a period when the omnipotent apparatus punishes real non-conformity with ridicule and defeat...”

And so it has come to pass that anybody who has dared to question any of the above allegedly established scientific truths, has been confronted by this omnipotent apparatus. Accordingly, it has punished non-conformity with ridicule, defeat and worse.

Elsewhere in the same book, Marcuse writes:

“ The primal father, as the archetype of domination, initiates the chain reaction of enslavement, rebellion, and reinforced domination which marks the history of civilisation. But ever since the first, prehistoric restoration of domination following the first rebellion, repression from

without has been supported by **repression from within**, the unfree individual introjects his masters and their commands into his own mental apparatus. The struggle against freedom reproduces itself in the psyche of man, as the **self-repression of the repressed individual**, and his self-repression in turn sustains his masters and their institutions.” (Our emphases).

In our case, it would seem that this is precisely what the “omnipotent apparatus” has achieved. The defeat and repression of the non-conformists is sustained by repression from within. The unfree individuals, the Africans, have introjected their masters and the commands of the masters into their own mental apparatus. Thus do they sustain their masters, their ideas and their institutions.

In his ‘*Political Preface 1966*’ to this book, Herbert Marcuse says:

“ The people, efficiently manipulated and organised, are free; ignorance and impotence, introjected heteronomy (the internalisation by the ‘unfree’ as the true exercise of individual autonomy of the practice of seeming to make an independent determination of choices, which are, in reality, pre-determined by another – *Our annotation*) is the price of their freedom.”

He goes on to say:

“ What started as subjection by force soon became ‘voluntary servitude’, collaboration in reproducing a society which made servitude increasingly rewarding and palatable...Today, this union of freedom and servitude has become ‘natural’ and a vehicle of progress.”

Mark Twain put this differently when he said the ‘all the human race loves a lord...In the Jardin des Plantes I have seen a cat that was so vain of being the personal friend of an elephant that I was ashamed of her.’

Chapter II

Perhaps in citing these passages, especially from “*Eros & Civilisation*”, we have moved forward far too quickly in terms of the presentation of our narrative, which the omnipotent apparatus views and denounces as non-conformist.

Let us therefore retrace our steps and, as it were, begin from the beginning.

The *Book of Genesis* in the *Holy Bible*, says:

“And God said, ‘Let there be light,’ and there was light. God saw that the light was good, and he separated the light from the darkness.”

Taking example from this, though disadvantaged by the fact that we do not have the power of the Creator, we trust that what we present in this brief discourse will help all of us to separate the light from the darkness with regard to the issue of AIDS. This may be difficult. It is, nevertheless, critically important.

Given that our minds on this matter have become thoroughly clogged by the information communicated by the omnipotent apparatus, a miracle will have to be achieved to get all our people to use their brains, rather than perish on emotional responses based on greatly heightened levels of fear.

In reality, as will become clear, what we are about is the cleaning of the Augean stables that constrain the African mind. Let us present our first scientific fact.

The first report on the incidence of HIV in South and Southern Africa was published in the “*New England Journal of Medicine*” and the “*South African Medical Journal*”, both in 1985.

Two of the most important findings in this report were that in our country and region:

- HIV infection was confined to male homosexuals; and,
- HIV was not endemic in this region of the world.

To quote this report, it said:

“ The only positive subjects were in the group comprising male homosexuals. The majority of these positive subjects had either recently been to the United States or had had sexual contact with other homosexuals who had visited the United States...Our preliminary data show that the agent implicated in causing AIDS, HTLV-III (later named HIV), is not endemic in this part of Africa.”

During the same year, October 1985, German researchers had an article published in the British medical journal, *The Lancet*. They stated that:

“ the data suggest that HTLV-III was rare in Africa until recently, and still is rare in much of the continent.”

Some of our friends, the friends of the Africans, say that five years later, this situation had changed completely. They say that now, in our region and country, the HI Virus was transmitted heterosexually and that it had become endemic.

The point made in the 1985 report about male homosexuals and HIV coincided with what science said about the incidence of HIV in the United States and Western Europe at the time.

To all intents and purposes, 15 years later, this situation has not changed both in the US and in Western Europe. But, as we have said, and as is generally known, our own situation has changed radically, resulting also in it being said that we now have the highest incidence of HIV or the spread of HIV in the world.

The question that arises from this is – why! Why does the same Virus behave differently in the US and Western Europe from the way it behaves in Southern Africa!

It would seem obvious that this question must be asked. If we are interested in the advance of scientific knowledge, the better to understand the African human condition, it is imperative that an answer be found.

It would seem equally obvious that for us successfully to deal with the HI Virus as it affects us, we need to understand what induces it to behave differently in different parts of the world.

In answer to these questions, some of our friends, the friends of the Africans, say that we are affected by a particular type or variant of the HI Virus, which is unique to ourselves and which also mutates at a high frequency rate.

However, this answer throws up new questions. Why is this special type of HI Virus confined only to our region of the world! Why does it not spread to other areas, even within Africa! What happened to the 1985 South African HI Virus which behaved in the same way as the US and West European HI Virus! If it mutated into what it is today, why did it not mutate in the same way in the US and Western Europe!

Once more, scientifically substantiated answers to these questions are necessary to enable us to defeat the HI Virus as it affects us. It would seem only logical, once the assertion was made that ours is a unique HI Virus, that, consequently, unique solutions have to be found to respond to this distinct situation.

Up to now, no answers have been provided to any of the questions that have been posed. Instead, in the name of science and friendship with the Africans, the omnipotent apparatus of which Marcuse wrote, has sought to present honest questions as a manifestation of unacceptable non-conformity.

It has done everything it could, and continues to act, to punish those who dare to ask questions. It uses its might, sustained by the self-repression of the Africans, to ensure the permanent repression of those who inquire.

In 1995 three scientists, Zvi Bentwich, Alexander Kalinkovich & Ziva Weisman, sought to provide answers to some of these questions in a 'Viewpoint' published in "*Immunology Today*" (Vol 16 No 4). They wrote:

“ Several features of the AIDS epidemic in Africa mark it as a distinct entity from the disease that is present in North America and Europe: it

is primarily a heterosexually transmitted disease with a male-to-female ratio of 1:1, and lacks the known 'classical' risk groups of male homosexuals and intravenous (i.v.) drug users; it is probably transmitted more easily; the progression of infection and disease is faster – the time from infection to onset of clinical manifestations and overall survival may be shorter; and the clinical manifestations are different, particularly the main opportunistic infections and the main organ systems involved...

“ Our view is that **profound changes in the host immune response** may account for the dramatic differences in the behaviour of the AIDS epidemic in Africa and in other developing countries. Such changes make the host more susceptible to HIV infection and less capable of controlling the infection once it is acquired. Infectious diseases, mostly helminth (intestinal worm) infections endemic in Africa and the developing countries, activate the immune system and alter its balance in such a way that makes the host more receptive to HIV and more vulnerable to its effects. This altered 'background' immune response must be taken into consideration when designing vaccines and devising new therapies for HIV in Africa and other developing countries. (Our emphasis).

“ **The average African host is exposed to a huge number of infectious diseases from early childhood onwards.** These include various bacterial, viral and parasitic infections. Noteworthy is the wide prevalence of helminth infections, malaria and tuberculosis in most parts of Africa: especially in Sub-Saharan Africa, and in East and West Africa. Also of central importance is the very high prevalence of STDs, particularly genital ulcer diseases (GUDs), which play an important role in facilitating the dissemination of HIV infection into the general population...(Our emphasis).

“ In addition to the central role of STDs, important cofactors such as the cultural habit of scarification, as well as transfusion, hygiene and nutrition, may facilitate HIV transmission and infection.”

On February 27, 2002, the British newspaper “*The Guardian*” carried two articles, one entitled: “*Sex diseases soar among generation no longer in fear of Aids epidemic*”, and the other: “*Scourge of syphilis returns as gays fail to heed safe sex message*”.

The latter article on syphilis says:

“ Within the past year there have been outbreaks of syphilis in Manchester, North London and Brighton. The disease, which had almost disappeared from Britain, can lead to brain damage, disability and even death if untreated...

“ Around three quarters of the Manchester cases have been in young gay or bisexual men, typically in their twenties or early thirties. The heterosexual cases were thought to be a separate cluster with links abroad. About a quarter had another sexually transmitted infection as well as syphilis and around a fifth knew they were HIV positive...

“ A Manchester health authority report said the men told of heavy use of alcohol, and drugs ‘with aphrodisiac and disinhibitory effects’... Further research is needed into why people seem not to be heeding safer sex advice, particularly in relation to unprotected anal sex. Reasons could include boredom with the messages, people feeling (inaccurately) that HIV is curable...”

The other article says:

“ Sexually transmitted diseases are rampaging through the UK unchecked as a new generation of young people, who missed the Aids scare of the 1980s, fail to protect themselves by practising safe sex.

“ According to a report published yesterday by the British Medical Association, (BMA), sexually transmitted infections, which include HIV/Aids, gonorrhoea and syphilis, have soared by almost 300, 000 cases between 1995 and 2000. The consequences can be devastating. Those who become HIV positive may not die but are condemned to a lifetime on toxic drugs, while thousands of women who unknowingly contract chlamydia, which often has no symptoms, risk infertility...

“ Says the BMA, the group most at risk now – aged 18-24 – are too young to have seen the (1980s Aids) adverts or been impressed by (their) dire message...

“ Paul Martin, sexual health programme manager in Brighton, where gay men have been encouraged to go for six monthly sexual health ‘MOTs’ because of an outbreak of syphilis, said their clinics were now ‘bursting at the seams’.”

“*The Daily Telegraph*” also of February 27, 2002 reported that:

“ From 1995 to 2000 the figures for new cases (of) gonorrhoea were up by 102 per cent..., chlamydia up by 107 per cent..., and syphilis up by 145 per cent...Thousands of cases of at least 22 other sexually transmitted infections provide the new total.

“ Dr James Bingham, consultant in genito-urinary medicine at Guy’s and St Thomas’ Hospitals in London, said syphilis was reaching the level seen when Second World War troops came home and gonorrhoea was at levels seen before the Aids campaigns.”

The same edition of “*The Daily Telegraph*” carries a letter by Robert Whelan of “*Civitas*” which comments on the BMA report. It is entitled “*The results of Aids scaremongering*”. The letter says:

“ The spread of STDs, which is particularly concentrated among teenagers and the early twenties, can truly be described as having reached epidemic proportions, and the consequences of some of these conditions can be both serious and long lasting.

“ However, the false sense of security that young people have about STDs is partly due to the hysterical promotion of Aids as a major public health issue in the late 1980s and early 1990s. The Aids “epidemic” never materialised and, partly as a result, people now treat all warnings about the consequences of sexual activity as scaremongering. (Our emphasis.)

“ The question is: what do we do about it now? Unfortunately, the leaders of the medical profession appear to have few ideas.”

The issues raised by Robert Whelan apply directly and immediately to us. We are the latest victim of the scare mongering that visited the people of the US, the UK and the rest of the western world “in the late

1980s and early 1990s.” We too are already harvesting the bitter fruits of the sustained campaign of which Robert Whelan complains.

Had he spoken out against this scare mongering in the 1980s and 1990s, Robert Whelan would have been denounced by the omnipotent apparatus as engaging in a “denial” that would condemn millions of Britons to death.

But, as in the UK, it is precisely this scare mongering that is condemning millions of our own people to ill-health, disability and death because of a refusal to recognise the critical importance of the diseases of poverty and other illnesses that afflict our people, including STDs. **This is done to sustain a massive political-commercial campaign to promote anti-retroviral drugs.**

The British Medical Association was reporting on the situation in the UK as at year 2000. We are talking here of a country that has a very well developed health infrastructure and a population that is not generally affected by diseases of poverty or exceedingly low levels of education.

The article we quoted earlier, published in 1995 by “*Immunology Today*” and written by Zvi Bentwich et al, which pointed to “the central role” of sexually transmitted diseases in contributing to immune deficiency, referred especially to Africa and the rest of the developing world.

In that case we were talking of countries that have a very weak health infrastructure, endemic diseases of poverty and widespread ignorance, which results in many taboos and superstitions. If it can be said now of a country as developed as the UK, that a crisis of STDs is emerging, we can only imagine what is happening in the countries of which Bentwich wrote!

Research from the MRC Maternal and Perinatal Research Unit at Kalafong Hospital in Tshwane indicates that between 2,8% and 11% of stillbirths and perinatal deaths were attributed to syphilis in 1993. (Delport, De Jong, Pattinson & Odendaal).

Since then, the prevalence of active syphilis infection in mothers in antenatal care has been reduced by more than half. This success is due to improved primary health care, antenatal care, supply of penicillin, etc.

It is estimated that a 20% reduction in STD's in South Africa over the next 15 years would result in HIV sero prevalence of below 1% in 2015 rather than the projected 16% (Wasserheit 1992). There are 11 million episodes of STD's being treated annually in South Africa, often unsatisfactorily (Reddy, 1999), with 12% of men report symptoms suggestive of STI in the previous 12 months. (*South African Demographic Health Survey, 2000*).

Because of these prevalence levels, our government is paying particular attention to the prevention and treatment of STD's. For the reasons we have already stated, this will make an important contribution to the fight against acquired immune deficiency.

But for the omnipotent apparatus the most important thing is the marketing of the anti-retroviral drugs. The issues raised by Bentwich and others, of the importance of STDs with regard to immune deficiency have been buried by the imposition of a blanket silence about the incidence and prevalence of these diseases. At the same time, it is demanded of all of us that we must break the silence!

Hopefully, the report of the British Medical Association will become better known to alert even us, who, as Marcuse said, may be suffering from the self-repression of the repressed individual. We should be alerted to the fact that if STDs in a country as developed as the UK are "rampaging through the (country) unchecked", then the situation in our countries must be catastrophic.

Two or three years ago, the South African Medical Research Council (MRC) prepared a report for Eskom on "the incidence of HIV" among the staff of the company. In this report the MRC drew attention to two disturbing matters.

One of these was the high incidence of STDs among our people, as noted by Bentwich et al. The second was the very shoddy medical treatment of these diseases by general practitioners in our country,

which leaves many infected people continuing to incubate these diseases because of incomplete and incompetent treatment by our doctors. The article by Bentwich et al draws attention to the serious threat this poses with regard to our immune systems.

Devoted as it is to the propagation of the faith about HIV/AIDS and the marketing of anti-retroviral drugs, the MRC - a state institution supposedly dedicated to serve the people of South Africa – says virtually nothing in its public communications about STDs in our country and what we should do about them.

We know why the pharmaceutical companies pay little attention to the overwhelming majority of diseases that afflict the poor. The simple reason is that the treatment of these diseases does not offer big profits.

The public servants working at the MRC have still to explain why they seem so little interested in the overwhelming majority of diseases that afflict the poor. Could it be the same reasons as those influencing the behaviour of the commercial enterprises!

In a year 2000 letter to a WHO Task Force on STDs, Dr John B. Scythes of Canada wrote:

“ Our basic concept is that by stopping syphilis, or at least slowing it down, far fewer people will get HIV-infected and/or develop AIDS – but not just because of fewer opportunities for transmission of the virus. I respectfully suggest that syphilis represents more than simply an ulcerative or focal activation phenomenon in HIV acquisition/AIDS. Syphilis may also turn out to be an important immunologic co-factor for susceptibility to active viral expression and progression to AIDS...

“ I am suggesting you consider the problem of latent syphilis, when the disease has gone **untreated or inadequately treated for some highly variable period of time**, a phenomenon which has simply not been investigated in modern times in terms of its immunologic consequences.” (Our emphasis).

Chapter III

Other scientists have also addressed the issues raised above, that “profound changes in the host immune response may account for the dramatic differences in the behaviour of the AIDS epidemic in Africa and in other developing countries.”

In an article in the *World Journal of Microbiology & Biotechnology* 11, 135-143, E. Papadopoulos-Eleopolus et al, wrote:

“ AIDS researchers in Africa, including those from the CDC and WHO, admit that immune deficiency in Africa has existed for a considerable period of time and this has not been due to HIV.

“ ‘Tuberculosis, protein calorie malnutrition, and various parasitic diseases can all be associated with depression of cellular immunity’ (Pearce, R.B. 1986 Heterosexual transmission of AIDS. *Journal of the American Medical Association* 256, 590-591. Piot, P. et al.)’

“ ‘A wide range of prevalent (in Africa) protozoal and helminthic infections have been reported to induce immunodeficiency. (Clumeck, N. et al: *Journal of the American Medical Association* 254; *New England Journal of Medicine* 310.’

“ ‘Among healthy Africans resident in a non-AIDS area, the numbers of helper and suppressor lymphocytes were the same in HTLV-III/LAV seropositive and seronegative subjects...(Biggar, R.J. et al: *The Lancet II*, 520-523.)’

“ ‘Africans are frequently exposed, due to hygienic conditions and other factors, to a wide variety of viruses, including CMV, EBV, hepatitis B virus, and HSV, all of which are known to modulate the immune system...Furthermore, the Africans in the present study are at an additional risk for immunologic alterations since they are frequently afflicted with a wide variety of diseases, such as malaria, trypanosomiasis, and filariasis, that are also known to have a major effect on the immune system...(CMV=cytomegalovirus; EBV=Epstein-Barr virus; HSV=herpes simplex virus). (Quinn, T.C. et al: *Journal of the American Medical Association*, 257, 2617-2621.)’ “

When “*The New Encyclopaedia Britannica*” (15th Edition), discusses “immune deficiencies” it says:

“ There are several ways in which the protective mechanisms (of the immune system) outlined above may fail. Some are inborn, due to genetic defects in the development of one or more of the cells involved in immune responses. Others result from infectious agents that damage essential immune cells. Still others are due to poisons or to drugs administered accidentally or with the intention of curing or ameliorating other diseases. In yet other cases, the immune deficiency stems from inadequate nutrition...

“ Severe infections by certain parasites, such as trypanosomes, also cause immune deficiency, as do forms of cancer, but it is uncertain how this comes about...

“ In countries where the diet, especially that of growing children is grossly inadequate in respect to protein intake, severe malnutrition ranks as an important cause of immune deficiency. Antibody responses and cell-mediated immunity are seriously impaired, probably due to atrophy of the thymus and the consequent deficiency of helper T cells. This renders the children particularly susceptible to measles and diarrheal diseases. Fortunately, they thymus and the rest of the immune system can recover completely if adequate nutrition is restored.”

In its discussion of “sleeping sickness”, “*The Oxford English Dictionary*”, Second Edition, says:

“ Any of several similar diseases caused by protozoans of the genus *Trypanosoma* and transmitted by flies of the genus *Glossina*, prevalent in tropical Africa, and characterised by the proliferation of the trypanosomes in the blood and changes in the central nervous system leading to apathy, coma, and death.”

(We have inserted this definition to explain to the reader some of the diseases caused by the *trypanosomes* referred to in the medical texts.)

Pacifici et al describe the effects of 100mg of the “recreational” drug Ecstasy used by young people at “rave parties”. The 17 volunteers received one or two doses in a 24 hour period, resulting in a 30% decline in blood concentration of CD4+ cells within hours of the single dose. The CD4+ levels recovered to their former levels within the subsequent 24 hours.

Among subjects who received two doses of the drug four hours apart, the decline of CD4+ cells was even more serious, reaching a level of 40% below normal. Although a day later T cell levels rose, they did not return to normal.

(Pacifici R, et al: *“Effects of repeated doses of MDMA (‘Ecstasy’) on cell-mediated immune response in humans”*. *Life Sciences* 2001; 69: 2 931 – 2 941.)

Furthermore, the report claims that the effect of Ecstasy can rise to deadly levels among people living with AIDS who take protease inhibitors and non-nucleoside reverse transcriptase inhibitors such as nevirapine.

In another study, Pacifici et al report on the effect on the immune system of the combination of Ecstasy and alcohol, for which they used six healthy volunteers.

There was a decline in CD4/CD8 cell ratio due to a decrease in both percentage and absolute terms of CD4 T-helper cells and a simultaneous increase in natural killer cells. Alcohol consumption produced a decrease in T-helper cells and B lymphocytes. The combination of MDMA and alcohol (ethanol) had the greatest suppressive effect on T cells. Drug treatment also produced also produced a large increase of immunosuppressive cytokines.

(Pacifici R, et al: *“Acute effects of 3,4 methylendioxyamphetamine alone and in combination with ethanol on the immune system in humans”*. *J Pharmacol Exp Ther*, 2001; 296(1): 207-215.)

Put simply, what all this means is that the drug Ecstasy on its own and in combination with alcohol suppresses the immune system. It is

not difficult to see from this that, as with intravenous drug users, prolonged abuse of this drug alone and together with alcohol, can lead to acquired immune deficiency. This has nothing to do with HIV!

All the scientific texts we have cited assert that there are many conditions that cause changes to the immune system, including **malnutrition and various tropical diseases**, themselves a manifestation and consequence of poverty and underdevelopment. To our knowledge, no serious scientist has or would question these known and provable scientific truths.

Unfortunately for us, and the scientists, the omnipotent apparatus denounces these views as being non-conformist and therefore totally unacceptable. It condemns them as belonging to a school of thought categorised as “dissident” and genocidal. They must therefore be suppressed.

This must be done, so they say, to save us, the Africans, from the HIV/AIDS pandemic and, according to them, the sole cause of immune deficiency, HIV.

Honest medical science recognises the disastrous impact of malnutrition on us as Africans and the rest of the developing countries.

An Indian article (*aidscareindia.com*) says: (See also: the World Health Report, 1998):

“ Some 40% of the 10 million deaths among under-five children each year in the developing world are associated with malnutrition...

“ Maternal malnutrition is the major determinant of IUGR (intrauterine growth retardation) in developing countries...

“ In Africa...the actual number of malnourished children has, in fact, risen. In addition, natural disasters, wars, civil disturbances, and population displacement have all contributed to continuing high rates of malnutrition...

“ Iodine deficiency disorders (IDD) constitute the single greatest cause of preventable brain damage in the fetus and infant, and of

retarded psychomotor development in young children. It remains a major threat to the health and development of populations the world over, but particularly among preschool children and pregnant women in low-income countries...

“ Vitamin A deficiency (VAD) is a major public health problem, and again the most vulnerable are preschool children and pregnant women in low-income countries. In children, VAD is the leading cause of preventable visual impairment and blindness...In addition, VAD significantly increases the risk of severe illness and death from common child infections, particularly diarrhoeal diseases and measles...In VAD-prevalent countries, pregnant women often experience deficiency symptoms, such as night blindness, that continue into the early period of lactation...

“ Iron deficiency is the world’s most widespread nutritional disorder, affecting both industrialised and developing countries. In the former, iron deficiency is the main cause of anaemia. In developing countries, it is also associated with other nutrient deficiencies (folic acid, vitamin A, B12), malaria, intestinal parasitic infestations (especially hookworm, schistosomiasis and amoebiasis), and chronic infections such as HIV...

“ Zinc deficiency causes growth retardation or failure, diarrhoea, immune deficiencies, skin and eye lesions, delayed sexual maturation, night blindness and behavioural changes...

“ Inadequate dietary calcium intake is associated with a number of common, chronic medical disorders worldwide, including osteoporosis, osteoarthritis, cardiovascular disease (hypertension and stroke), diabetes, dyslipidaemias, hypertensive disorders of pregnancy, obesity, and cancer of the colon...

“ Outbreaks of beriberi, pellagra and scurvy still occur among the extremely poor and underprivileged and, not infrequently, in large refugee populations...

“ Between 30% and 40% of all cases of cancer are preventable by feasible and appropriate diets, physical activity and maintenance of appropriate body weight.”

The same applies to heart disease and stroke, which accounted for 22% of deaths in South Africa in 1996.

One third of the annual 55.7 million deaths in 2001 globally, were caused by heart disease and stroke, with the majority occurring in developing countries. This is a true “pandemic”, propagated by the ‘globalisation’ of risk factors such as cigarette smoking, salty high saturated fat foods, obesity and lack of exercise.

(**NB:** in many parts of our country, our soil suffers from zinc deficiency. This affects the plants grown in such soils, which are part of the national food supply. In addition, the staple maize meal consumed by the majority of our people comes out of the milling process completely denuded of its nutritional value. Nevertheless, because the religious faith demanded of us prescribes that we attribute all ill health to the HI Virus, it is prohibited that any of the foregoing should either be known or discussed. Any discussion focused on eliminating the zinc deficiency mentioned above falls victim to the accusation of ‘fiddling while Rome burns.’ Terrified of bad publicity, and keen to demonstrate that we are not fiddlers, energetically and with smiles on our faces, we fan and feed the fires that are consuming Rome!)

A US-trained physician from Haiti, Paul Farmer, has written in his book “*AIDS and Accusation*”: (University of California Press, 1993):

“ Although repeatedly termed a ‘complete mystery’ by North American academics, the epidemiology of AIDS and its silently transmitted precursor, HIV, is only superficially random. Careful review of existing data and critical assessment of the validity of certain studies allow us to conclude that the Haitian epidemic is a tragic but unsurprising component of **a much larger pandemic**. In the various theaters of this international scourge, whether New York or Port-au-Prince, HIV has become what Sabatier (1988) has termed a ‘misery-seeking missile’. It has spread along the path of least resistance, rapidly becoming **a disorder disproportionately striking the poor and vulnerable**...AIDS is far more likely to join a host of other sexually transmitted diseases – including gonorrhoea, syphilis, genital herpes, chlamydia, hepatitis B, lymphogranuloma venereum, and even

cervical cancer – that have already become **entrenched among the poor.**” (Our emphases.)

Not surprisingly, “*the Harvard University Gazette*” of March 19, 1998 carried an article entitled – “*AIDS Epidemic Called Crisis Among Blacks*”. The article, written by William J. Cromie said:

“Once considered a white epidemic in the United States, AIDS has now changed colour.

“From 1985 until 1996, whites accounted for the highest percentage of AIDS infections, but the line was crossed in 1996. Cases among whites dropped from 60 percent of the total in 1985 to about 35 percent in 1997. Among blacks, cases have almost doubled, from about 25 percent to 45 percent, in the same period...

“Henry Louis Gates Jr...summed up the situation this way: ‘While blacks make up only 12 percent of the U.S. population they account for almost half of the cases of AIDS’...

“The numbers are especially bleak for black women and children...Black women represent the highest percentage (56 percent) of all AIDS cases reported among women, and an increasing proportion of new cases (60 percent). Fifty-five percent of new infections with the AIDS virus among 20 to 24-year-olds occurs among blacks.

“Among those between the ages of 24 and 44 years, three times as many black as white men died of AIDS in 1996. Five young black women died for every white woman in the same year...

“The CDC also reported that black children currently account for 58 percent of the AIDS cases among newborns, compared to 18 percent for whites, and 23 percent for Hispanics.

“Most women, black and white, have contracted AIDS either through illegal drug use (about 45 percent) or heterosexual contact (about 38 percent). Many of the latter cases are due to having sex with men who have gotten the disease from contaminated needles.

“CDC statistics show that 22 percent of all AIDS infections among men were caused by dirty needles. Black males account for 36 percent of such cases...

“One in every two blacks has been tested for infection with HIV – the AIDS virus – compared with 38 percent of all Americans. Among blacks younger than 30 years the testing rate is 65 percent. Most of the testing was done during the past 12 to 18 months.”

As Dr Farmer of Haiti had said, five years before the Harvard article appeared, whether in New York or Port-au-Prince, HIV has spread along the path of least resistance, rapidly becoming **a disorder disproportionately striking the poor and vulnerable.**

All of this tells us, the Africans, that poverty and underdevelopment are a major cause of premature mortality and disability among us. We are confronted by ‘the larger pandemic’ of poverty and underdevelopment. But the omnipotent apparatus is intent that we should not know all this. If we do, we should discount it as being of no major consequence.

And yet there is a large volume of literature that addresses the critically important issue of health, poverty and underdevelopment, some of which we will now proceed to cite.

The “*African Institute for Scientific Research and Development*” has written:

“ In rural Africa agriculture, health and the environment are like three sides of a triangle. As the sides define and determine the triangle, so do agriculture, health and the environment both define and determine rural development. For socio-economic development to occur attention must be paid to all the three aspects...

“ Despite national and international efforts to improve health for all, many communities in East Africa are still plagued with communicable and other preventable diseases such as tuberculosis, immunisable childhood diseases, nutritional disorders, maternal deaths, eye infections, injuries, and problems related to alcohol and narcotic drug abuse.

“ Common infections such as acute respiratory tract infections, diarrhoea, malaria and sexually transmitted diseases (including HIV/AIDS) are responsible for most of the morbidity and mortality in rural communities. The incidence of many of these diseases can be drastically reduced through community based health education, immunization, improved mother and child health care and enhanced nutrition.”

The University of Glasgow Department of General Practice, International primary health care, has published the following article:

"Health in Zambia and the UN AIDS Conference in Lusaka"

Dr DOROTHY LOGIE, GP Adviser to Borders Health Board
(*Report on a meeting held on 09/02/00*) in which she writes:

“ At a recent conference in Lusaka the staggering proportions of the AIDS epidemic in Sub-Saharan Africa was thrown into relief. With 10% of the world's population and two thirds of the world's cases of HIV, the burden of what is arguably the worst epidemic to hit mankind since the 'black death' has fallen primarily on the world's poorest nations.

“ With Zambia as an example, Dr Logie set the HIV epidemic in its context. The fall in life expectancy to 43 years has not only followed on from an ever increasing incidence of HIV but has been in the context of a 30% cut in spending on education and a 50% cut in spending on health. In a country which 20 years ago had a well developed schooling and health care service, diseases of poverty such as TB, waterborne diseases and malaria are on the increase, as are maternal and infant mortality indicators. One quarter of children are undernourished and one half of the country has no access to safe water. Three quarters of girls and a half of all children do not now complete primary education. Four fifths of the population live on less than 60p a day.

“ Zambia owes the rest of the world, primarily the World Bank and the IMF, \$6.5 Billion, more than twice the country's gross national product. The debt must be serviced at \$200 million per annum,

regardless of the cost to health, education or nutrition. This amounts to one half of all export earnings. Seven times as much is spent on servicing its debt as it can afford to spend on health care. The cuts in education and health care spending have been driven by structural re-adjustments demanded by the World Bank. These have included introducing user fees for health and education and placing a limit on state responsibilities. (see Table 1)...

“ There is urgent need for action to challenge the selective blindness of a global economic system incapable of taking the radical steps necessary to provide stability and hope in an entire continent facing a bleak future. The positive first steps of the British government to cancel the debts of the world's 25 poorest countries, albeit with heavy pre-conditions, are to be supported and more drastic steps urged. As health professionals we have a duty to research and highlight the damaging impact on health of imposed Western economic re-adjustments and to unequivocally condemn the intolerable burden of unsustainable debt.”

For its part, the “*African Journal of Food and Nutritional Sciences*”, Volume 1 No. 1 August 2001, Abstracts, published the article:

CO-EXISTENCE OF OVER- AND UNDERNUTRITION RELATED DISEASES IN LOW INCOME, HIGH-BURDEN COUNTRIES: A contribution towards the 17th IUNS congress of nutrition, Vienna, Austria 2001

Rutengwe R., Oldewage-Theron W, Oniang'o R & Vorster H.H.
Abstract

“ About one third of the world's population suffer from micronutrient deficiencies and hundreds of millions suffer from chronic diseases of lifestyle. Prevalence rates, particularly low birth weight, stunting and underweight, remain high particularly in Eastern Africa and South Central Asia. More than a third of all children in developing countries remain constrained in their physical growth and cognitive development. The 1990 ambitious goal of halving childhood underweight prevalence by the year 2000 has not been achieved by most countries. Global progress in fighting malnutrition is slow and crippled by rapid increase of both communicable and non-

communicable diseases, the so-called “double burden of disease”. About 115 million people suffered from obesity related diseases in the year 2000. Overweight and obesity (globesity) prevalence is advancing rapidly in developing countries.

“ Cardiovascular diseases (CVD), myocardial infarction, angina pectoris and stroke as one of the most important causes of mortality and morbidity globally, will continue to be first and second leading causes of death in the world. **Most developing countries, including South Africa, currently are in the process of transition** and experiencing **the double burden** of both communicable and non-communicable diseases in which **chronic diseases of lifestyle such as CVD have emerged while the battle against infectious diseases has not been won.** In the last few years the HIV/AIDS epidemic has spread extremely rapidly and is likely to double overall mortality rates, undermine child survival and halve the life expectancy over the next five years.” (Our emphases).

The US Environmental Research Foundation published an article on February 5, 1998, entitled:

“Poverty Makes You Sick”

“ Numerous studies in England and the U.S. have shown consistently that a person’s place in the social order strongly affects health and longevity. It now seems well-established that poverty and social rank are the most important factors determining health – more important even than smoking...

“ George Kaplan and his colleagues at the University of California at Berkeley measured inequality in the 50 (US) states as the percentage of total household income received by the less well of 50% of households. (*British Medical Journal*, Vol 312, April 20, 1996: 999-1003.) It ranged from 17% in Louisiana and Mississippi to 23% in Utah and New Hampshire. In other words, by this measure, Utah and New Hampshire have the most EQUAL distribution of income, while Louisiana and Mississippi have the most UNEQUAL distribution of income.

“ This measure of income inequality was then compared to the age-adjusted death rate for all causes of death, and a pattern emerged: the more unequal the distribution of income, the greater the death rate. For example in Louisiana and Mississippi the age-adjusted death rate is about 960 per 100,000 people, while in New Hampshire it is about 780 per 100,000 and in Utah it is about 710 per 100,000 people. Adjusting these results for average income in each state did not change the picture: in other words, it is the gap between rich and poor within each state, and not the average income of each state, that best predicts the death rate...

“ Isn't it time that the public health community – physicians, public health specialists, and environmentalists – recognised that **poverty, inequality and racism cause sickness and death?** Given what science now tells us, medical policy – including medical training – should aim to combat and eliminate poverty, inequality, and racism just as it now aims to combat and eliminate infectious diseases and cancer. With U.S. health care costs now exceeding \$1 trillion each year, anti-poverty and anti-racism initiatives would be economically efficient as well as humane.” (Our emphasis).

A British medical journal aimed at medical students, *Student BMJ* Vol 9, June 2001, published:

“ *Poverty and Health*” by Mike Rowson in which he says:

“ **Poverty is the number one killer in the world today**, outranking smoking as the leading cause of death...(Our emphasis).

“ Health professionals need to promote interdepartmental cooperation and action by governments to promote better education, water, and sanitation and other services which improve the lives of the poor. The diseases of poverty cannot be tackled without concerted economic and political action.”

The series, *Current Infectious Disease Reports* 3:1-3, 2001, published an article:

“The Unacceptable Costs of the Diseases of Poverty” by Richard L. Guerrant, M.D., University of Virginia School of Medicine, USA, in which he writes:

“ Poverty and lack of sanitation result in high-risk behaviours and malabsorption-inducing enteric infections. Thus the complex interactions of such societal issues as poverty and lack of basic sanitation in areas where only suboptimal therapeutic regimens are affordable may drive the resistant microbes that threaten us all...

“ The most important medical/health advance of our century will be the discovery and realisation of the true costs of the diseases of poverty... (Guerrant’s emphasis.)

“ The lessons of tropical and resistant infectious diseases are that only with a recognition of their root causes linked to poverty will we apply readily available technologies and develop new tools for their control. Only this recognition will determine whether we shall or shall not chart a secure future for ourselves and those who follow.”

The campaign US *“World Hunger Year”* said:

“ In the last 50 years, almost 400 million people worldwide have died from hunger, hunger-related diseases and poor sanitation. That’s three times the number of people killed in all wars fought in the entire 20th century. (Above information provided by Bread for the World Institute)...

“ Each day in the developing world, 30, 500 children die from preventable diseases such as diarrhoea, acute respiratory infections or malaria. Malnutrition is associated with over half of those deaths. (Above information provided by UNICEF, World Health Organisation).”

Naturally, the story is the same with regard to specific instances. On July 24, 2000, Johns Hopkins University issued the following statement:

“ The Bill & Melinda Gates Foundation has awarded the Johns Hopkins School of Public Health \$20 million to find the precise

combination of vitamins and other micronutrients that will be most effectively save lives and prevent illness among impoverished mothers and children in the developing world...

“ ‘The results of these studies are likely to prove crucial to the well-being and survival of millions of women and children a year,’ said William R. Brodie, president of the Johns Hopkins University...

“ In the developing world, an estimated one in four children dies before reaching age 5. Worldwide, some 11 million children and 7 million adults die each year from diseases associated with poverty.”

The Hookworm Vaccine Initiative reports:

“ Hookworm infection is one of the most prevalent and devastating infections of humans - more than one billion individuals harbor hookworms in their intestine (1,2). Some tropical clinical investigators rank hookworm as the second most important parasitic infection of humans, next to malaria (3). Within developing economies hookworm is a leading cause of anemia and malnutrition. In China reliable estimates based on diagnostic testing of almost 1.5 million individuals indicate that 194 million individuals harbor hookworms (4,5), making hookworm one of China’s most significant public health problems. Similar numbers of cases of hookworm occur on the Indian subcontinent, in Sub-Saharan Africa (6), and in Central and South America (7) (Fig. 1).

“ The World Bank estimates that more than 20% of the disability-adjusted life years (DALYs) lost from communicable diseases among children living in developing economies are a direct result of intestinal nematode infections like hookworm (9). In its 1993 World Development Report, the World Bank ranked intestinal helminths first as the main cause of disease burden in children aged 5 to 14 years.

“ Estimates of hookworm infection in pregnancy conducted jointly by the Wellcome Centre for the Epidemiology of Infectious Diseases (Oxford University) and the WHO indicate that some 44 million women are simultaneously pregnant and infected with hookworm (10). An estimated 3-5 million of these pregnant women harbor heavy hookworm infections that adversely influence intrauterine growth rates, prematurity and birth weight.

“ Overall, hookworms are central to the downward spiral of malnutrition and rural poverty in less developed countries. Recently, hookworm has also been identified in some populations as an important medical problem among the elderly living in poor rural areas (11).

“ In this decade, new information has reawakened the international community to the importance of hookworm-associated chronic blood loss and the resulting protein malnutrition, negative nitrogen balance, iron deficiency and anemia. These features have again been linked to devastating consequences for both children and mothers (8-10,15-20). It is now well recognized that moderate and heavy hookworm infections during childhood cause stunting of linear growth, reduced physical fitness and physical activity, as well as intellectual and cognitive retardation in children (15,17-21).

“ Many of these clinical features are directly attributable to the chronic effects of iron deficiency (22-24); in some instances these deficits are irreversible (24). Plasma protein losses also contribute to hookworm-associated malnutrition. As a consequence, children are also rendered susceptible to intercurrent viral and bacterial infections (15). Chronic hookworm infection prevents children from achieving their full potential to become productive individuals in later life. During pregnancy more than 10 percent of hookworm-infected women suffer worm burdens heavy enough to adversely affect intrauterine growth, prematurity, and birthweight (10).

“ Together, these consequences devastate maternal and child health. When accurately accounted for, such as in the World Bank study mentioned above, these features place hookworm infection at the top of the list in terms of their impact on childhood and maternal health ”

Global estimates of hookworm prevalence by region (1).

Region	Population	Hookworm Infections	%Prevalence
Sub-Saharan Africa	512 million	140 million	27%
Latin America	441 million	135 million	31%
Middle East	503 million	96 million	19%
India	850 million	319 million	38%
China	1160 million	358 million	31%
Other Asia/Islands	654 million	250 million	38%
Total	4120 million	1297 million	31%

We should keep this in mind that hookworm is one of the conditions that produces a ‘false-positive’ when people are tested for the HIV status.

In 2000, the health authorities in Seattle, Washington, USA, carried out an interesting study entitled:

“ The Health Status of American Indians (AI) and Alaska Natives (AN) living in King County” (2000).

The report included: Mortality rates for American Indians and Alaska Natives (AI/AN) living in King County compared with all King County resident by age group and cause of death, three year averages, 1996-1998, as follows:

Age	AI/AN Rate/100,000	Rate/100,000 Persons Total King County	Relative difference
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<1 year	1,272.5	547.9	+132%
1-14	54.8	16.8	+226%
15-24	90.9	68.5	-
25-44	337.1	132.8	+154%
Unintentional injury	91.1	30.6	+198%
45-64	622.0	489.7	+27%
65-84	3847.5	3495.6	-
85 and older	10493.8	14785.7	-

It also dealt with other matters as indicated below.

Water,
food-borne
disease

Hepatitis A	40.5	25.2	+61%
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Blood,
sex-borne
disease

Hepatitis B	3.7	3.1	-
Chlamydia	366.9	200.1	+83%
Gonorrhoea	86.1	57.0	+51%
Syphilis	6.5	3.9	-

AIDS	45.5	18.4	+147%
All causes	572.9	407.2	+41%

All Mortality by poverty areas

>20% FPL	888.6	540.6	+64%
5-20% FPL	528.6	424.9	+24%
<5% FPL	421.6	754.5	-

(N.B. FPL = Federal poverty level. >20% FPL represents those areas in King County where more than 20% of the population lived below the federal poverty level, etc.)

Total infant mortality	12.5	5.2	+140%
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Primary cause of infant death: SIDS

8.0	0.8	+900%
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(N.B. SIDS = Sudden Infant Death Syndrome.)

The WTO is also involved in this debate and struggle, which is about health, poverty and underdevelopment. During 2000, WTO DDG Rodriguez addressed the European Commission and said, among other things:

“ Intellectual property rights are a necessary part of finding that balance (between providing adequate incentives for research and development and ensuring affordable access to new drugs.) They have an essential role to play in providing incentives for research and

development. No company will invest the resources required for research and development without a promise of some degree of exclusivity in exploiting the results of its efforts. **At the same time, it is also clear that the intellectual property system itself will not be sufficient to provide incentives for research and development into the diseases which mainly afflict the poor in developing countries, with limited purchasing power.** We thus very much welcome the growing worldwide recognition of this and the initiatives being taken to fill this gap, involving as they do intergovernmental agencies, national governments and private foundations as well as the industry itself. The Commission's Communication is an important contribution in this connection...(Our emphasis).

“ In this sense, let me say that we, at the WTO, are fully convinced that there is a very strong relationship between trade, poverty and health. We fully acknowledge that efforts to promote basic public health as well as public education have a vital role to play in facilitating development. But, by the same token, **development and the increased resources that it provides are vital for promoting public health.** And an open trading system is a key component of development efforts.” (Our emphasis).

The US economist, Dean Baker, has addressed some of the issues of concern to the WTO, as they affect the United States. He has written:

“Consumers pay more than three and a half dollars to the drug industry for every dollar of research induced by patent protection. Another two and a half dollars goes to industry profits and marketing – and to the legal costs, campaign contributions, and political lobbying needed to protect and extend the industry's patent monopolies.”

In his article: “*Drug Prices in Crisis: The Case Against Protectionism*”, (“*Dollars and Sense Magazine*”, May/June 2001), Dean Baker writes:

“The costs of patent protection to consumers are enormous. The industry, which includes such giants as GlaxoSmithKline, Pfizer, and Bristol-Myers Squibb, estimates that it sold \$106 billion worth of drugs in 2000. If eliminating patent protection had reduced the price of

these drugs by 75%, then consumers would have saved \$79 billion. This figure, to put it in perspective, is 30% more than what the (US) federal government spends on education each year. It's more than ten times the amount that the federal government spends on Head Start. And it roughly equals the nation's annual bill for foreign oil.

“What do we get for this money? Last year, the pharmaceutical industry, according to its own figures, spent \$22.5 billion on domestic drug research (and another \$4 billion on research elsewhere). For tax purposes, the industry claimed research expenditures of just \$16 billion. Since these expenditures qualify for a 20% tax credit, the federal government directly covered \$3.2 billion of the industry's research spending (20% of the \$16 billion reported on tax returns.) Even if we accept the \$22.5 billion figure as accurate, this still means that the industry, after deducting the government contribution, spent just over \$19 billion of its own money on drug research.

“In other words, consumers (and the government, through Medicaid and other programs) spent an extra \$79 billion on drugs because of patent protection, in order to get the industry to spend \$19 billion of its own money on research. This comes out more than four dollars in additional spending on drugs for every dollar that the industry spent on research. The rest of the money went mainly to:

- marketing...
- protecting patent monopolies...
- profits...

“If spending an extra four dollars on drugs in order to persuade the industry to spend one dollar on research doesn't sound like a good deal, don't worry. It gets worse...

“Last summer, the *New York Times* cited data showing that drugs, when tested by researchers who were supported by the drug's manufacturer, were found to be significantly more effective than existing drugs 89% of the time. By contrast, drugs tested by neutral researchers were found to be significantly more effective only 61% of the time...

“By creating incentives to misrepresent, falsify, or conceal research

findings, patent monopolies are harmful to our pocketbooks as well as our health...For example, a recent study estimated that consumers were spending \$6 billion a year on patented medication for patients with heart disease, which was no more effective than generic alternatives in preventing heart problems. As a result of industry propaganda, consumers might also spend money on drugs that could be less effective than cheaper alternatives – or on drugs that could even be hazardous to their health...

“At the top of the list (of measures to counter the negative effects of protectionism with regard to drugs), the U.S. government should not be working with the pharmaceutical industry to impose its patents on developing countries. This is especially important in the case of AIDS drugs, since patent protection in sub-Saharan Africa may effectively be sentencing tens of millions of people to death.”

In another article “*Dying for Patients*” (Center for Economic and Policy Research, October 29, 2001), Dean Baker writes:

“(The pharmaceutical industry) argue that the patent monopolies allow them to earn enough money to fund the research that produces these drugs in the first place.

“This claim is at best half true. Much of the most important research was funded with our tax dollars by the National Institutes of Health (NIH). In many cases, the industry just came along in the final phases of testing in order to claim the patent rights. In fact, according to the industry’s own numbers, more research is actually supported by the government and private foundations and charities, than by the pharmaceutical companies.”

Alan Story of Kent Law School has written (2001):

“From a recent *New York Times* article: replying to critics of the drug industry who say it would rather find a cure for a bald American than a dying African, Francois Gros, a spokesman for Aventis, the French-German pharmaceutical company that makes three of the four sleeping sickness drugs, ruefully acknowledged: ‘That’s not completely wrong. We know what’s happening in the third world, but we don’t act.’ He went on to explain: ‘We can’t deny that we try to

focus on top markets – cardiovascular, metabolism, anti-infection, etc. But we're an industry in a competitive environment – we have a commitment to deliver performance for shareholders...

“And again from the *New York Times*: drug companies which last year spent \$40 billion on research, have in two decades, come up with only four medicines specifically for tropical diseases.”

All the foregoing, relating to health, poverty and underdevelopment should, in reality, be a matter of common sense. Spoken and published in many other parts of the world, it does not cause any consternation. But clearly, when these obvious truths are spoken here in our own country, they assume a more menacing meaning.

The omnipotent apparatus denounces them as constituting a “denial”. When we seek to act within the parameters of the very health paradigm contained in the paragraphs we have quoted, this is condemned as “fiddling while Rome burns.”

Our struggle for drugs and medicines that would be affordable to the millions of our poor people, was repudiated as a betrayal of the sacred principle of property rights, and a disastrous slap in the face of foreign investors.

The failure to ascribe the entire burden of disease that afflicts our people exclusively to the HI Virus earned our leaders the characterisation that they are *genocidaires*.

Stridently and openly, the omnipotent apparatus disapproves of our effort seriously to deal with the serious challenge in our country of health, poverty and underdevelopment. It is determined that it will stop at nothing until its objectives are achieved. What it seeks is that we should do its bidding, in its interests.

In this respect, all of us are obliged to chant that HIV=AIDS=Death! We are obliged to abide by the faith, and no other, that our immune systems are being destroyed solely and exclusively by the HI Virus. We must repeat the catechism that sickness and death among us are primarily caused by a heterosexually transmitted HI Virus. Then our

government must ensure that it makes anti-retroviral drugs available throughout our public health system.

But first of all, we have to repeat in unison – HIV causes AIDS causes Death!

According to this argument, necessarily, therefore, the two principal and decisive responses open to us, to respond to Africa's health challenges, are the use of condoms and the consumption of anti-retroviral drugs. Everything else that causes ill health and death among us, the omnipotent apparatus argues, is of peripheral importance.

Chapter IV

However, the rejection of the argument by the omnipotent apparatus - that there is no special African HI Virus, but, rather, the scourge of poverty and underdevelopment - means that there are more questions that require answers.

One of these concerns the constitution, therefore, of our own unique HI Virus. How is it composed? How does it behave? What are its various mutant forms?

Scientists say that for them to be able to answer these questions, first of all, they need to isolate the Virus. They say that the tried and tested method of doing this is to use an electron microscope capable of magnifying this minute retrovirus to 300, 000 times its size. They would then be able to photograph and analyse it and thus answer the questions that have been posed.

There is at least one such an electron microscope in our country. The questions that arise are whether the Virus has been isolated and analysed, using this microscope and whether the resultant photographs exist!

Given the numbers of people who are said to have died of HIV/AIDS, the question must be asked – has the HI Virus been isolated during

medical examinations and post-mortems to establish that the prime cause of illness and death is HIV infection?

The reality is that this seemingly critical first step that would enable us to know the nature of the creature we are dealing with has not been taken.

Strange as it may seem, given what our friends tell us about **the Virus** everyday, nobody has seen it, including our friends. Nobody knows what it looks like. Nobody knows how it behaves. Everybody acts on the basis of a series of hypotheses about the Virus, which are presumed to be facts, supposedly authenticated by 'clinical evidence'.

Those who have imbibed the faith that millions among us are infected by a deadly HI Virus, will disbelieve the assertion that the work of isolating our unique HI Virus has not been done. The omnipotent apparatus will scream loudly that the telling of this truth constitutes the very heart of the criminal non-conformity that must be denounced and repressed by all means and at all costs.

Rather than perpetuate our self-repression, it is time that we demanded that the necessary scientific work be done to isolate and analyse the Virus that is said to be so deadly.

To defeat the HIV/AIDS pandemic requires that science does what it does normally, as it tries to understand viruses. It is difficult to understand why the HI Virus stands in a caste of its own, as an untouchable.

In any case, the scientists have the advantage that, more than 15 years ago, the scientists Robert Gallo and Luc Montagnier claimed that they had identified and isolated this Virus. The scientific world accepted this claim and continues to do so.

There should therefore be no problem in repeating the established scientific work carried out by Gallo and Montagnier, who are accepted as the "co-discoverers" of the HI Virus.

What the Africans do not know, of course, is that at the time HIV was 'discovered' in 1984, Montagnier's French Pasteur Institute accused

Gallo of having stolen the HIV discovery from them. Ultimately, this controversy was resolved when the two scientists, together with US President Reagan and French Premier Chirac signed an agreement in 1987, which proclaimed the two scientists as co-discoverers of HIV.

Interestingly, nobody asked the question – what do the political signatories know about science!

But even after this document was signed, in 1991 the US government's National Institutes of Health's (NIH) Office of Scientific Integrity found that, with regard to the discovery of HIV, Gallo, as laboratory chief, had "created and fostered conditions that give rise to falsified/fabricated data and falsified reports."

In 1992, the NIH Office of Research Integrity determined that Gallo was guilty of scientific misconduct. Nevertheless, it said that this did not "negate the central findings" of Gallo, with regard to HIV.

In 1984, before any information was published in the scientific journals, and therefore examined by the scientific community, Gallo and US President Reagan's Health and Human Services Secretary, Margaret Heckler, announced at a press conference that Gallo had isolated the "AIDS virus" and developed the test to prove the existence of the virus in human blood.

Clearly, the later findings about the scientific conduct of the "co-discoverer" could not, and would not, be allowed to interfere with what had been announced to the press and the world!

We must accept that all this belongs to an ancient and unchangeable past. What was stated as fact then, has become set in stone as fact.

Dr Joseph A. Sonnabend published an article in *AIDS Forum* 1989 entitled "*Fact and Speculation about the Cause of AIDS.*" He wrote:

" The precise point at which a conjecture comes to be accepted as an established fact is far from clear, although in a commonsense fashion, the distinctions between them is usually quite evident. That HIV-1 is the cause of AIDS is a contention that was ceremoniously

propelled out of the realm of speculation into that of proven fact by Margaret Heckler in 1984 in her public pronouncement the U.S. government scientists had discovered the 'probable cause of AIDS' – HTLV-III, later to be renamed 'Human Immunodeficiency Virus', of 'HIV', in an apparent confirmation of its etiologic role. Thus, overnight, a new orthodoxy came into being, unruffled by the subsequent discovery that there was a second cause of AIDS in another retrovirus...Despite the widespread acceptance of the etiologic roles of the HIVs in AIDS, these must remain conjectural as long as two questions (at least) remain open. One concerns pathogenesis and the other the association of the HIVs with AIDS. Both are important to the original presentation of HIV as the cause of AIDS, as the relate to the two props on which this presentation rested...

“ It is now known that insufficient numbers of helper lymphocytes are actively infected to account for their loss by a direct cell-killing effect of HIV, and there is an alternative explanation for the association of HIV seropositivity with AIDS that does not require that it play an etiologic role, and that has yet to be excluded. To these two problems concerning the etiologic roles of the HIVs in AIDS must be added the apparent failure, thus far, of antiretroviral chemotherapy...

“ The premature acceptance as fact of a contention that more properly belongs in the realm of speculation has had a number of far reaching consequence – let alone the painful fact that it has provided virtually no help to people with AIDS, despite a massive investment and six years of intensive work on the biology of the HIVs and the chemotherapy of infection with these viruses...

“ The acceptance as fact rather than hypotheses that the HIVs cause AIDS is responsible in great part for a number of grave consequences...

“ A. The almost total commitment of resources to the study of the HIVs has left alternative etiologic hypotheses unexplored. Should the HIVs be proven not to be the cause of AIDS, we will have to go back to the beginning in our studies on the cause of this disease, and will have lost six years and countless lives.

“ B. Aspects of pathogenesis apparently unrelated to HIV have not been explored. Some examples will be given that could have been pursued as early as 1981...

“ It has been suggested that questioning the etiologic role of HIV in AIDS may promote the spread of disease as it ‘frees one of the worry about testing positive as it ‘frees one of the worry about testing positive or the guilt of spreading the disease’. This is an irrational and poorly thought out objection. The reality of the mode of transmission of AIDS, whether sexually or by blood or blood products, is of course quite obvious, whether it is HIV or some other factor or factors that are transmitted.

“ In fact, a ground-breaking booklet presenting the first safer sex guidelines appeared in 1883 and its was based on a multifactoral mode – not a single agent model. The measures suggested were identical to those usually proposed to limit the spread of HIV.”

Despite the objections by the South African born and trained Dr Sonnabend, one of the first doctors to treat AIDS in New York and the US, speculation had been accepted as fact, that HIV causes AIDS.

Chapter V

If, however, despite and perhaps because of this peculiar manner of ‘advancing’ science, it is true that we have not identified our own unique virus, the question then arises – what methods were used to identify the millions in our country who are said to be HIV-positive? The response to this question is that blood or saliva specimens were and are subjected to the ELISA test, said to be a test to establish whether specific anti-HIV antibodies exist in the particular specimens.

Yet some scientists have raised questions about whether, in fact, this ELISA or any other test, actually tests for the presence of HIV. But before we deal with this, let us mention what the manufacturers of the ELISA testing kits themselves say.

The manufacturers, Abbot Laboratories, say:

“ EIA (ELISA) testing alone cannot be used to diagnose AIDS, even if the recommended investigation of the reactive specimens suggests a high probability that the antibody to HIV-1 is present.”

They go on to say:

“ Although for all clinical and public health applications of the EIA both the degree of risk for HIV-infection of the person studied and the degree of reactivity of the serum may be of value in interpreting the test, these correlations are imperfect. Therefore, in most settings it is appropriate to investigate repeatedly reactive specimens by additional more specific or supplemental tests.”

They also say:

“ At present there is no recognised standard for establishing the presence or absence of HIV-1 antibody in human blood. Therefore sensitivity was computed based on the clinical diagnosis of AIDS and specificity based on random donors.” (Our emphasis.)

(Quotations taken from: ABBOTT LABORATORIES. Human Immunodeficiency Virus Type 1. FUVAB FffVI EIA. Abbott Laboratories, 66-8805/R5, January 1997:5.)

Another manufacturer of HIV-testing equipment, Roche, says:

“ The amplicor HIV-1 Monitor test is not intended to be used as a screening test for HIV or as a diagnostic test to confirm the presence of HIV infection.”

(ROCHE. Amplicor HIV-1 Monitor test. Roche Diagnostic Systems, 13-06-83088-001, 06/96.)

To return to the scientists, Roberto A. Giraldo, MD, a physician and specialist in internal medicine, infectious and tropical diseases, says: (*Continuum*: Midwinter 1998/9.)

“ The scientific literature has documented more than 70 different reasons for getting a positive reaction other than past or present infection with HIV. All these conditions have in common a history of polyantigenic stimulations.”

He goes on to say:

“ Since there is no scientific evidence that the ELISA test is specific for HIV antibodies, a reactive ELISA test at any concentration of serum would mean the presence of nonspecific or polyspecific antibodies. These antibodies could be present in all blood samples.”

Indeed, Dr Giraldo explains in this article that he conducted his own tests at the New York *Yorktown Medical Laboratory*. He says:

“ I first took samples of blood that, at 1:400 dilution (the recommended dilution for the ELISA test), tested negative for antibodies to HIV. I then ran the exact same serum samples through the test again, but this time without diluting them. Tested straight, they all came out positive. Since that time I have run about 100 specimens and have always gotten the same result.”

In another article written by Dr Giraldo et al, published in *Continuum*, Summer 1999, the authors say:

“ Some of the conditions that cause false positives on the so-called “AIDS test” are: past or present infection with a variety of bacteria, parasites, viruses, and fungi, including tuberculosis, malaria, leishmaniasis, influenza, the common cold, leprosy and a history of sexually transmitted diseases; the presence of polyspecific antibodies, hypergammaglobulinemias, the presence of auto-bodies against a variety of cells and tissues, vaccinations, and the administration of gammaglobulins or immunoglobulins; the presence of auto-immune diseases like erythematous systemic lupus, sclerodermia, dermatomyositis or rheumatoid arthritis; the existence of pregnancy and multiparity; a history of rectal insemination; addiction to recreational drugs; several kidney diseases, renal failure and hemodialysis; a history of organ transplantation; presence of a variety of tumours and cancer chemotherapy; many liver diseases including alcoholic liver disease; hemophilia, blood transfusions and the administration of coagulation factor; and even the simple condition of aging, to mention a few of them.”

Citing various other scientists, such as Seligman M., et al, writing in the *New England Journal of Medicine* 1984: 311, 1286-1292; and

WORLD HEALTH, Magazine of the WHO, 1994; 47(6): 1-31; Giraldo et al write:

“ Malnutrition is known as the world’s first cause of immunodeficiency. Poverty is the main risk factor for malnutrition. Economical disparities have increased all over the world, but mainly in Africa, Asia, Latin America, and the Caribbean, as well as in the larger impoverished strips of the developed cities. Never before has poverty been so prevalent and intense, nor has affluence been so big and concentrated in the hands of so few.”

One mystery has always been the reported high sero prevalence of HIV in South Africa of over 15% (as extrapolated from Antenatal Clinic Survey data), compared with rates of 2% in West Africa and the Caribbean. In this regard, the experience of a physician working in an Eastern Cape prison, Dr Stuart A. Dwyer, is of note. His institution of 550 inmates has high rates of men having sex with men, with very little use of condoms. He routinely checks the HIV status of those who present to him with various illnesses, including STD. In the past 5 years, he has noted a sero prevalence of 2.8% for the jail as a whole, but recorded only a few deaths from AIDS-related disease. His conclusion is that the meaning of a positive HIV ELISA test in the African setting needs to be re-examined, and that in his “high risk” group, there is little evidence of an “AIDS pandemic”.

(Dr Stuart A. Dwyer, *British Medical Journal*, 22 September, 2001.)

A number of questions arise from all this.

What do the HIV tests test?

When our own health workers says they have tested people for HIV, what do they mean?

When they say a person is HIV-positive, have they discounted all the conditions, other than HIV, which could make a person falsely test HIV-positive?

If so, how have they done this?

How do they arrive at the figure of millions of HIV-positive people, which they regularly proclaim?
Why do they discount poverty and the various conditions of ill-health it produces, as one of the most obvious causes of immune deficiency?

Surely, it is obvious that for them properly to treat any person who tests HIV-positive, they need to know the exact medical or health condition against which the immune system produces antibodies! This is the case even with veterinary scientists who have to treat cattle!

We say this because exactly the same generic system (the ELISA test) that is used to “test for HIV” in human beings, is also used to test for Foot and Mouth Disease in cattle! When it was used in this country to test our bovine herds for this disease, presumably having been designed to test the specific virus that causes the disease, it recorded many of our cattle as being “Foot and Mouth Disease-positive”.

However, further clinical work carried out by both South African and British scientists demonstrated conclusively that all these were false-positives. None of the cattle tested and found to be “positive”, in fact suffered from Foot and Mouth Disease!

Apart from the confirmation of the fact, well-known to scientists, that this equipment produces “false-positives”, the critical point is that some scientists have made the point that these testing kits are not designed specifically to detect the presence of a particular virus in the human body, HIV. Accordingly, they assert that they do no such thing, in much the same way as, in this case, they detected a non-existent Foot and Mouth virus.

It was for these reasons that the Presidential Scientific AIDS Panel decided to seek an answer to the question – what do the HIV tests test?

Other questions arise concerning the incidence of disease and death in our country. The first questions emanate from the phenomenon of

“opportunistic diseases”. These are said to attack the body when it has been weakened by HIV.

The US government’s Centres for Disease Control (CDC) lists at least 29 of these “opportunistic diseases”. These are:

Pneumocystis carinii pneumonia, Kaposi’s sarcoma, toxoplasmosis, strongyloidosis, aspergillosis, cryptococcosis, candidiasis, cryptosporidiosis, cytomegalovirus, herpes simplex, progressive multifocal leukoencephalopathy, lymphoma of the brain, mycobacterium avium complex, histoplasmosis, isosporiasis, Burkitt’s lymphoma, immunoblastic lymphoma, candidiasis of the bronchi, trachea and lungs, encephalopathy, mycobacterium tuberculosis, wasting syndrome, coccidioidomycosis, cytomegalovirus retinitis, salmonella septicemia, recurrent bacterial pneumonia, invasive cervical cancer, pulmonary tuberculosis.

Of course, all these diseases existed before AIDS was discovered. A US activist, Christine Maggiore, has observed that:

“ AIDS is a new name for 29 old illnesses and conditions, including yeast infection, diarrhoea, pneumonia, cancer and tuberculosis.”

The issue of the diagnosis of AIDS in Africa was “simplified”, and made more difficult, by the decision of the WHO that such diagnoses should be based only on four clinical symptoms. This goes by the name of the “Bangui definition”.

These conditions are a fever, weight loss of 10 per cent, a persistent cough and diarrhoea.

But as Maggiore comments:

“ These four symptoms used to identify AIDS are identical to those associated with common African conditions such as malaria, tuberculosis, parasitic infections, and the effects of malnutrition and unsanitary water, all of which have troubled the continent for decades.”

One of the questions that arises from all this is what has changed many well-known diseases from being well-known curable diseases into one incurable, and little known disease, called AIDS?

The French physician and historian of medicine, Mirko Grmek, tried to explain the puzzle in the following way:

“ (AIDS) is not a disease in the old sense of the word, in as much as the virus is immunopathogenic, that it affects the immune system and produces symptoms only through the expedient of opportunistic infection or malignancy...In the past, a disease was defined either by clinical symptoms or by pathological lesions, which are morphological changes in organs, tissues, or cells. Nothing of the sort, neither clinical symptoms nor lesions, observable by the old means, characterises AIDS. It is not a disease in the sense given to the term before the twentieth century. **Persons affected by HIV suffer and die with the signs and lesions that are typical of other diseases.** As recently as twenty years ago, these opportunistic disorders were the only reality that physicians could observe and conceptualise.”

(“*History of AIDS*” by M. Grmek: Princeton University Press, 1990. Our emphases.)

US Professor of Physiology, Robert S. Root-Bernstein, has written:

“ There are no criteria listed in any definition of AIDS that allow a person to fight off AIDS or to be cured of it. Once a person is diagnosed, he or she will have AIDS forever after, regardless of any improvement in state of health and regardless of whether death results from a non-AIDS associated death (for example, heart disease or diabetes.) This is another way in which the definition of AIDS is a medical novelty. A person has pneumonia as long as he or she is symptomatic and the germ causing the disease is present. Destroy the germ and eradicate the clinical symptoms, and the person is cured, regardless of the fact that both antibody to the germ and scarring of the lungs may persist for their lifetime...No such criteria exist for AIDS, despite the fact that some AIDS patients are still alive a dozen years after diagnosis with Kaposi’s sarcoma, Pneumocystis pneumonia, and other opportunistic diseases.”

Bernstein makes the important observation that:

“ This makes AIDS the first disease that no one can survive by definition. (Our emphasis). Not only is this description of AIDS logically bankrupt, it sends the demoralising and inaccurate message to people with HIV or AIDS that they have a disease that is not worth fighting. A more legitimate, and more hopeful, definition must be devised.”

Because of all this, it has become imperative for us to know as precisely as possible what our people are dying from, specifically. To say that they are dying of AIDS will not help us in our struggle to improve the health of our people.

As Bernstein says, to say this would be to say our people have a disease that is not worth fighting. This would certainly condemn them to premature death. **It is this that would constitute genocide.** Yet the mere report that the government is compiling a report on the causes of death, as reflected in the Notices of Death filed with our Department of Home Affairs, aroused the ire of the omnipotent apparatus, which characterised the search for accurate information about ourselves as “AIDS denial”.

Nevertheless, to be able to intervene with regard to the health of our population, we must ask a number of questions, regardless of the anger of the omnipotent apparatus.

What is the incidence of disease among our people?

What are we doing to prevent and treat these diseases, including those described as “opportunistic”?

What are the causes of death among our people?

If deaths are said to be HIV-related, on what is this based, scientifically – i.e. did the cadaver have the HI Virus?

This brings us to the question of treatment.

Chapter VI

In this article, we will mainly discuss the issue of so-called mother-to-child-transmission (MTCT/MTC), given the extraordinary volume of publicity around this matter. In this regard, we will concentrate on the drug “*Nevirapine*”, which is said to be the most effective for this condition, the cheapest and the easiest to administer.

On HIV/AIDS treatment generally, we will only cite some comments made by people who should know what needs to be known about this matter, namely, the scientists.

In its edition of May 10, 2001, *The New York Times* reported that:

“ A leading maker of drugs that fight AIDS, the Agouron Pharmaceuticals division of Pfizer, and its agency, CCA Advertising in New York, are changing a consumer campaign they recently introduced for the drug Viracept. They are adding cautionary words that such drugs are not a cure for AIDS nor do they prevent the spread of HIV, the virus that causes AIDS. (Our emphasis.)

“ The change is coming two weeks after the (US government) Food and Drug Administration sent letters to eight makers of anti-AIDS drugs, including Agouron, warning that these products could no longer be advertised without noting their limitations.”

A press statement released by the US government health agencies on February 5, 2001, quotes Dr Fauci, director of the National Institute of Allergy and Infectious Diseases, as saying:

“ Although antiretroviral therapy has provided extraordinary benefits to many patients, we know we cannot eradicate HIV infection with currently available medications...We are very concerned about a number of toxicities associated with long term use of antiretroviral drugs,” says Dr Fauci. “ Particularly alarming is the alteration of fat metabolism that can emerge during treatment. We are seeing an increasing number of patients with dangerously high levels of cholesterol and triglycerides...The bad news is that we must now find

ways to deal with unanticipated toxicities, including the potential for premature coronary disease.”

On February 7, 2001, *Reuters* reported:

“ One of the first studies to look at the success of HIV treatment in inner-city patients from the time of diagnosis reveals a dire situation, a doctor working in Atlanta, Georgia, said here on Tuesday at the 8th Conference on Retroviruses and Opportunistic Infections. His study found that only 1 in 10 patients newly diagnosed with HIV achieved a reduction in virus in blood to “undetectable” levels – a major goal of treatment...

“ One year after being diagnosed, 24 patients (18%) had died, del Rio reported. Of the 103 eligible to attend an outpatient clinic, the majority discontinued treatment after a few months...

“ Nobody has really looked at the number of HIV-infected patients who achieve successful viral suppression with antiretroviral therapy starting from the time of diagnosis, del Rio told *Reuters Health*. Other studies have looked at the success of antiretroviral therapy in those patients who remain in care.

“ ‘What is striking to me, is that we think that those are the problems of Africa – but they’re the real problems of our country. I tell people I work in a developing country called inner-city Atlanta,’ del Rio said.’ ”

In “*The AIDS Reader*” 11(5): 236-237, 2001, its editor, Jeffrey Laurence, MD, writes:

“ One must recognise that few clinicians anticipate that current ART (anti-retroviral therapy) regimens will extend the lives of HIV-infected patients more than a few years. Viral resistance and drug side effects undermine their utility. Indeed, in 1 of the 2 US economic studies, quality-adjusted life expectancy rose only 1.84 years for those initiating ART at higher CD4 cell counts; for those with low CD4 cell counts, it was not much better. Although this degree of life gained proved similar in magnitude and cost to that of thrombolytic therapy in myocardial infarction, such comparisons are irrelevant where more than 90% of HIV infections occur – in the developing world.”

In another report dated May 25, 2001, *Reuters* said:

“ Treatment with highly active antiretroviral therapy, or HAART, often damages the liver, leading many HIV-infected patients to halt treatment, according to study results presented in Atlanta this week...

“ Regardless of drug class or combination, there appears to be ‘an across-the-board high rate’ of severe liver toxicity...

“ Regimens that contained drugs called nonnucleoside reverse transcriptase inhibitors, especially nevirapine and efavirenz, were particularly hard on the liver...In November, the US Food and Drug Administration issued an alert for nevirapine based on reports of liver toxicity.” (Our emphasis.)

Addressing the 39th Annual Meeting of the Infectious Diseases Society of America on October 25, 2001, Dr William G. Powderly, said:

“ The safety of PEP (postexposure prophylaxis) was called into question earlier this year with reports of nevirapine-associated liver toxicity in otherwise healthy recipients, resulting in a recommendation that nevirapine not be used for PEP.”

During the Durban XIII International AIDS Conference in 2000, the Chicago-based NGO, the International Association of Physicians in AIDS Care (IAPAC), issued the following statement, datelined “Durban, South Africa, July 11:

“ Today researchers at the XIII International AIDS Conference presented preliminary data suggesting didanosine (Videx, also known as ddl) and stavudine (Zerit, also known as d4T) are **safe, effective and tolerable alternatives to existing drug therapies in preventing mother to child transmission (MTCT) of HIV**. Videx and Zerit are part of the reverse transcriptase inhibitor class of anti-HIV drugs and **are proven to safely reduce HIV replication among infected adults and children**. (Our emphases).

“ The AI455-094 pilot study conducted at the Chris Hani Baragwanath Hospital in Soweto, South Africa randomised 373 HIV-1 infected

pregnant mothers to an orally administered regimen of ddl, ddl+d4T, or zidovudine (AZT)...

“ These early data show the potential of Videx and Zerit to be safe, tolerable and effective in preventing the transmission of HIV from infected mothers to their unborn children when compared to existing medical interventions,” said Dr Glenda Gray, co-director of Perinatal HIV Research Unit at Chris Baragwanath Hospital in South Africa.”... (Our emphasis).

“ Zerit and Videx are manufactured by Bristol-Myers Squibb Company, a global health and personal care company **whose mission is to extend and enhance human life.**” (Our emphasis).

On January 8, 2002, the US *Wall Street Journal* reported as follows: “ While the Food and Drug Administration (FDA) conducts a review of the two products, Bristol-Myers Squibb has issued a warning to AIDS doctors around the world cautioning that two of its AIDS drugs, Zerit and Videx, should be used sparingly in pregnant women **after the deaths of three expectant mothers who were taking the medications.** An FDA official suggested it is possible that although **toxicity problems** affect other drugs in the nucleoside analogue class – which includes the GlaxoSmithKline drugs AZT and 3TC – **the reaction to a particular enzyme is stronger for the two Bristol-Myers products than for other drugs in the class.** The deaths could have far-reaching consequences than just **the potential withdrawal of the drugs** and the passing of the women: two of the deaths occurred in clinical trials abroad, **with one of those deaths taking place in South Africa,** where the issue of AIDS drugs is particularly volatile. The women died of lactic acidosis, a rare but recognised complication associated with the nucleoside analogue class, and seven other cases of nonfatal lactic acidosis have been reported among pregnant women taking either a combination of Zerit and Videx or of Zerit with 3TC.” (Our emphases.)

Dr Glenda Gray features regularly in our media as a much-quoted and generally believed expert who denounces our government for its cautious approach to the widespread use of anti-retroviral drugs. In the IAPAC statement, she is quoted as endorsing Videx and Verit as being better than AZT and nevirapine in the context of MTCT.

She shared this view with the NGO, IAPAC, which described the company producing Videx and Zerit as “a global health and personal care company whose mission is to extend and enhance human life.” Despite the undisguised competition with AZT in the IAPAC report, nothing is said about the legitimate commercial mission of Bristol-Myers Squibb to maximise its profit – to attend to the bottom line!

This company has now admitted that its products are not the “safe, effective and tolerable alternatives to existing drug therapies in preventing mother to child transmission (MTCT) of HIV” that Glenda Gray and IAPAC claimed they were. Pregnant women have died because they were subjected to these “safe, effective and tolerable alternatives”! Reportedly, one of them is a black woman, on whom Glenda Gray experimented with toxic drugs at Chris Hani Baragwanath Hospital.

Interestingly and ironically, this year the US Kaiser Family Foundation (KFF) conferred the *Nelson Mandela Award for Health and Human Rights* on Dr Glenda Gray (and Professor James McIntyre) for the supposedly ‘outstanding’ work she has done on MTCT. Nothing was said of the women who died!

Of Gray and McIntyre the KFF says:

“Dr Glenda Gray and Professor James McIntyre are co-founders and co-directors of the Perinatal HIV Research Unit at the Chris Hani Baragwanath Hospital, the largest in the world...The Perinatal HIV Research Unit is one of the world’s leading centers of excellence for research and implementation activities in the field of mother-to-child transmission of HIV and has been at the forefront of work in this field...Responding to the changing needs around HIV/AIDS, the Unit has expanded to undertake work in antiretroviral treatment for adults and children, psychosocial support issues, HIV and tuberculosis and HIV vaccine trials...The *Mandela Award*...is given annually in recognition of extraordinary dedication and achievement in improving the health of the disadvantaged populations in South Africa and the United States.”

Bristol-Myers Squibb must have been mightily pleased that their own Glenda Gray, enthusiastic promoter of Videx and Zerit, was honoured

with so prestigious an award for improving the health of the disadvantaged populations in South Africa and the United States! A number of questions that demand urgent answers arise in the context of the foregoing.

Why was the South African and global public told lies?
Since Glenda Gray must be held accountable, how has this been expressed?

Since Chris Hani Baragwanath Hospital must be held accountable, how has this been expressed?

Since the Medicines Control Council (MCC), which presumably approved the Glenda Gray clinical trials, must be held accountable, how has this been expressed?

How has the Gauteng Provincial Government accounted for its own conduct in this affair?

How have the national Ministry and Department of Health for their own conduct in this affair?

Have Videx and Zerit been licensed by the MCC for any indication, and if so, on what evidence?

What reports, in any, have been submitted to the MCC on the safety of these drugs if they are generally available in our country?

People have died as a result of using these drugs. The highest US regulatory authorities have instituted processes to study their impact. As of now, we do not know what the WHO and UNAIDS have to say.

But we need to know what our own regulatory authorities have to say. We also need to know whether our own health authorities have communicated to everybody concerned the substance of what the *Wall Street Journal* reported. What are the answers to all the questions that have been posed?

Last year, the periodical *ANC Today* posed other questions relating to another clinical trial conducted in our country. This concerned a

microbicide that was touted as being potentially effective in the context of MTCT.

We quote this article in full because of the important issues it raises, especially in the light of what we have just said with regard to Videx and Zerit.

“ DRUG TRIALS

“HIV/AIDS, profit and fundamental human rights

“THE STORY OF NONOXYNOL-9, known as N-9, an active ingredient used in chemical barriers to HIV and STD transmission, raises disturbing questions about research ethics, drug company profits and the role in Africa of international development agencies.

“Products designed to provide a chemical barrier to HIV and STD transmission, such as N-9, are called microbicides.

“According to a circular of the US Centres for Disease Control (CDC), dated 4 August 2000: "From 1996 until May 2000, UNAIDS sponsored a study of the effectiveness of a gel which contained 52.5 milligrams of N-9., compared to an inactive gel. The study was conducted in several locations in Africa. Nearly 1,000 HIV-negative commercial sex workers were enrolled in the trial, and all women were counselled to use condoms consistently and correctly. In addition to condom use, the women were asked to use a vaginal gel each time they had intercourse. Half of the women were provided a placebo (non-active) gel and half of the women received an N-9 gel."

“Later, we will report on the results of this trial and the recommendations of the CDC. But before this, we have to give a short account of the history of N-9.

“The conclusions of a 1992 N-9 study were published in the journal *JAMA* 1992 July 22-29; 268(4):477-82 and stated that: "Genital ulcers and vulvitis occurred with increased frequency in nonoxynol 9 sponge users. We (who conducted the trial) were unable to demonstrate that nonoxynol 9 sponge use was effective in reducing the risk of HIV infection among highly exposed women." The trial referred to here was conducted among sex workers in Kenya in

1992.

“The results of another study were published in 1993 in the *International Journal on STD and AIDS* 1993 May-June; 4(3):165-70. This study concluded that: "The rate of epithelial disruption (genital ulcers) for women using N-9 4/day was five times greater than that of placebo users."

“After another study conducted in Kenya, the *Journal of Infectious Diseases* 1991 February; 163(2):233-9, had concluded that genital ulcers were associated with increased risk of HIV-1 infection.

“By the time UNAIDS began its studies in 1996, published scientific knowledge was that:

- genital ulcers increased the risk of HIV infection;
- the use of N-9 increased the incidence of genital ulcers; and,
- more frequent use of N-9 led to a higher incidence of genital ulcers.

“The August 2000 CDC circular to which we have referred said that the results of the UNAIDS trial were reported at the 2000 Durban International AIDS Conference, as follows:

"At the end of the trial, researchers found that the women who used N-9 gel had become infected with HIV at about a 50% higher rate than women who used the placebo gel. Further, the more frequently women used only N-9 gel (without a condom) to protect themselves, the higher their risk of becoming infected. Simply stated, N-9 did not protect against HIV infection and may have caused more transmission. Women who used N-9 also had more vaginal lesions, which might have facilitated HIV transmission."

“As we now know, these precise results of N-9, announced in 2000, were already publicly known by 1993. And yet UNAIDS began its trial in 1996, knowing that N-9 increased the risk of HIV infection, especially among those who might use the microbicide with high frequency, such as prostitutes.

“Despite this knowledge, after the results were announced at the

Durban AIDS Conference, Dr Joseph Perriens of UNAIDS could still say: "We were dismayed to find out that the group using N-9 gel had a higher rate of HIV infection than the group using a placebo."

"South Africa was one of the African countries in which UNAIDS conducted its trial. In a press release issued in Durban on 12 July, 2000, an organisation named AEGiS reported that the sites for the South African trial were Durban and Johannesburg.

"It also reported that the Principal Investigators responsible for the trial in these two cities were, respectively, Dr S. Salim Abdool Karim and Dr Helen Rees. At the same time as he was leading investigations into the efficacy of a chemical compound that was known to be extremely harmful, Dr Karim was head of AIDS Research at our Medical Research Council. For her part, Dr Rees was Chairperson of the Medicines Control Council, the body charged with the responsibility of licensing drugs and medicines.

"The *Business Day* edition of 13 July 2000 reported Dr Rees as 'caution(ing) that the (negative) results were not conclusive and more work needed to be done on the issue. She pointed out, for instance, that it was possible that the group using the placebo (or substitute with N-9) may have been exposed to a more active microbicide.' Presumably by saying that "more work needed to be done", she meant that more women needed to be exposed to the highly toxic N-9.

"In its edition of August 14, 2000, the *Washington Post* reported that:

"Two U.S.-funded studies involving nonoxynol-9 are underway in African women at risk of HIV. One, sponsored by the Agency for International Development to test the ability of nonoxynol-9 gel to prevent sexually transmitted diseases among a group of women in Cameroon, is due to be completed in September. The other, a study sponsored by the NIAID to look for protection against HIV in women in Zimbabwe and Malawi, is getting underway. In light of the disturbing findings, reported last month at the 13th International AIDS Conference in Durban, South Africa, researchers have abandoned plans to test nonoxynol-9 in that study, said Ward Cates of Family Health International, a non-profit health research

organisation that is co-ordinating the project. Cates said there is no evidence that nonoxynol-9 is harmful to women when used as a contraceptive. Nonoxynol-9 is a detergent that is a contraceptive and a microbicide (or germ-killer)."

"It is puzzling that Cates should have found it necessary to promote the use of N-9 as a contraceptive, to soften the impact of the negative results announced in Durban.

"We do not know whether the US-funded trials in other African countries represent the "more work" to which Dr Rees referred.

"The gel mentioned in this article is produced by a US company called Columbia Laboratories Inc and is marketed as Advantage-S. According to the *Wall Street Journal*, after the N-9 trial results were announced in Durban, Columbia shares 56%, to \$5.75. The paper also reported that, nevertheless, President and CEO of the company, Mr William Bologna, said the negative N-9 results "may not be scientifically meaningful."

"In a press release dated March 20, 2000, Columbia Laboratories Inc said: "Prospective investors are cautioned that any.(Columbia) forward looking statements are not guarantees of future performance and involve risks and uncertainties, and that actual results may differ materially from those projected in the forward-looking statements (of the company). Such risks and uncertainties include, among other things, the successful timely completion of the study now being conducted by the UNAIDS group."

"Despite this cautionary note, Columbia Laboratories Inc could not avoid the retribution of either the market or its shareholders. According to the *Wall Street Journal*, not only did its share price fall dramatically, but it was also sued by its shareholders. The shareholders charged that insiders sold more than \$1 million in stock at inflated prices before the results were announced.

"This is a highly disturbing story that has directly affected us as a country. It raises a number of questions that require urgent answers, some of which are:

- Why did the MCC approve N-9 trials knowing the toxic effect of this compound?
- Why did Drs Karim and Rees assume the role of principal investigator given the positions they occupied in the state medical institutes?
- What other trials related to HIV/AIDS have been and are being carried out in our country?
- What impact have these trials had on the health of the subjects recruited to participate in these trials?
- Why was the N-9 trial conducted only in African countries (and Thailand) and not the United States, which also has prostitutes?
- What measures have been taken to care for the prostitutes used in the trial, who suffered genital lesions and turned HIV-positive as a result of the use of N-9?
- What measures have been taken to care for other people whose health might have been adversely affected as a result of other trials?
- Why did UNAIDS decide to use our people as disposable objects who could be exposed to N-9, when UNAIDS knew that N-9 had been proved to be toxic?
- What steps has UNAIDS taken to look after the people whose health has been seriously undermined by its wilful activities?
- What will our government do to ensure that this serious matter is attended to?
- Has the attention of the UN Secretary General, the UN Security Council and the General Assembly been drawn to these UNAIDS activities?
- What steps has UNAIDS taken to ensure that especially the developing countries discontinue and do not allow any N-9 trials?
- What role did our Ministry and Department of Health play in the N-9 matter?
- What role have our Ministry and Department of Health played and are playing to ensure that ethical norms are observed in the conduct of all drug trials in our country, and that the poverty of our people is not exploited to test dangerous drugs here, in a manner that would not be allowed in the developed world?

- Has the informed consent of those who have been involved in the drug trials been obtained and what steps have been taken to ensure that those involved are truly properly informed?
- What measures have been taken to ensure transparency and a system of accountability with regard to the drug trials?
- Once the efficacy and safety of drugs previously tried in South Africa has been established, and these drugs accordingly registered, what steps have been taken to ensure that these drugs are available at affordable prices to our people?

“All these questions, bearing on the very lives of our people, require urgent answers.

“The story contained in this article speaks of our vulnerability as an African country to the anti-human activities of some corporate forces. It also speaks to our own capacity, as South Africans, willingly to co-operate in the promotion of these activities. It tells a story of how easy it is for some, further to entrench the abuse of already abused African women - this time in the name of science and health.

“Dr Rees, Chairperson of the MCC, argues that 'more work' needs to be done on N-9 because the negative results announced in Durban 'were not conclusive'. This sentiment is echoed by the CEO Bologna of Columbia Laboratories Inc., who says that these negative results 'may not be scientifically meaningful.'

“On the other hand, the CDC says: "However, given that N-9 has now been proven ineffective against HIV transmission, the possibility of risk, with no benefit, indicates that N-9 should not be recommended as an effective means of HIV prevention."

“What we ask is - what else about HIV/AIDS is more about profit and less about the health of our people. Time will tell.”

To this day, the important issues raised in this article have not been answered. We do not know how many of our people have died as others, such as those at Chris Hani Baragwanath Hospital, conducted experiments on our people or “treated” them, relying on dangerously

tendentious results of clinical trials and MCC approvals of trials sponsored by the pharmaceutical companies.

Chapter VII

Before we proceed to the matter of MTCT and nevirapine, let us briefly discuss the issue of AZT, which continues to have its own fans in our country. It is used by the provincial government of the Western Cape among African women allegedly for MTCT. Despite the unequivocal advice of its manufacturer that it should not be used in instances of rape, those intent on marketing this drug continue to demand that it should be made available for this purpose within our public health system.

In her book "*Positively False*", (I.B. Tauris, London: New York, 1998), Joan Shenton has written:

"In spite of the manufacturers claiming that (AZT) prolonged life and delayed the onset of AIDS, doctors actually working with patients could only see them getting sicker and sicker before their very eyes and then dying.

"Why? Quite simply, **AZT is a DNA chain terminator. That means it destroys the mechanism by which new cells are made in the body.** It stops the growth of DNA causing the fast or slow death of the immune system because all growing cells will be killed by the incorporation of AZT. Its action is similar to cancer chemotherapy, whereby bad cells are killed in the hope of keeping enough good cells to survive. In cancer chemotherapy the treatment is given for a limited period of time. AZT is prescribed indefinitely – until death. (Our emphasis).

"Other supporting evidence supporting irreversible damage from AZT had been published in *The Lancet* in 1988. Drs Christine Costello and Naheed Mir reported serious bone marrow damage in their patients on AZT, with 36 per cent requiring blood transfusions. The authors write, 'It is worrying that bone marrow changes in patients on zidovudine (AZT) seem not to be really reversed when the drug is withdrawn...(*The Lancet*, 19 November, 1988)...

“Apart from inhibiting DNA synthesis and killing healthy cells, AZT (according to <the manufacturer> Wellcome’s own official literature) has other serious effects on the body.”

It is not accidental that AZT action is “similar to cancer chemotherapy”, as Joan Shenton puts it. This is because it was developed in 1964 by a Dr Jerome Horwitz as a cancer chemotherapy drug. However it was abandoned even before it reached the stage of human trials because of its high levels of toxicity and its ineffectiveness against cancer.

The manufacturers of AZT, the then Glaxo Wellcome, presented it 20 years later as an anti-HIV drug. This was at a time when the scare mongering referred to earlier had produced great panic in the US that millions were going to die as a result of HIV/AIDS, the same panic that is now being sown among our people. Overnight, the abandoned cancer “treatment” AZT, became the miracle drug that would contain HIV/AIDS!

So great was the fear generated by the scare mongers that even the approved trial was abandoned before it was concluded.

In his book “*Poison by Prescription: The AZT Story*”, (Asklepios 1990), John Lauritzen writes that ‘Martin Delaney of Project Inform gives a fair summary of what emerges from the FDA material:

“The multi-center clinical trials of AZT are perhaps the sloppiest and most poorly controlled trials ever to serve as the basis for an FDA drug licensing approval. Conclusions of efficacy were based on an endpoint (mortality) not initially planned or formally followed in the study after the drug failed to demonstrate efficacy on all the originally intended endpoints. Because mortality was not an intended endpoint, causes of death were never verified. Despite this, and a frightening record of toxicity, the FDA approved AZT in record time, granting a treatment IND in less than five days and full pharmaceutical licensing in less than 6 months.”

(NB: the FDA is the US Government’s Food and Drug Administration which licences drugs and medicines. The FDA material used by

Laurintzen and Delaney was obtained from the FDA under the Freedom of Information Act.)

Laurintzen reports that a conference on AIDS was held at Columbia University, New York, on 19 November, 1988. Dr Sonnabend was one of the speakers. Lairintzen says:

“Sonnabend began by saying that the toxicities of AZT should not lightly be dismissed. The harmful effects of the drug are real, and they are serious. **Technically, AZT is a poison; it is cytotoxic (i.e. it kills cells). The drug cannot distinguish between infected and healthy cells; it kills both.** Never before has a drug as toxic as AZT been prescribed for long-term use. The long-term effects of AZT, the cumulative toxicities are unknown. Sonnabend emphasised the ethical responsibilities of the physician, to be sure that there was a sound scientific basis for the benefits of the drug, considering that its toxicities were firmly established.” (Our emphasis).

Ellen C. Cooper, M.D., M.P.H., was one of the FDA medical officers attached to the AZT trial. In her *“Medical Officer Review of NDA 19-655”* and *“Addendum #1”*, she wrote that:

“(Several measures of viral activity were used,) and ‘no statistically significant changes in the percent of positive cultures or time to detection of virus in culture were observed...

“Of particular concern is the possibility that the hematologic toxicity of the drug when administered over a prolonged period of time may eventually debilitate patients to such an extent that they may become less able to resist opportunistic infections and other complications of HIV-disease (sic) than if they had been left untreated...

“The majority of patients who were randomised to receive AZT in this trial experienced significant toxicity.”

In his *“Review & Evaluation of Pharmacology & Toxicity Data (of AZT)”*, Harvey I. Chernov, Ph.D., wrote:

“AZT may be a potential carcinogen. It appear to be at least as active as the positive control material, methylcholanthrene, (a known and extremely potent carcinogen)...

“Thus, although the dose varied, anemia was noted in all species (including man) in which the drug has been tested...

“In conclusion, the full preclinical toxicological profile is far from complete with 6-month data available, but not yet submitted, one year studies to begin shortly etc. The available data are insufficient to support NDA approval.”

“*Current Medical Research and Opinion*”, Vol 15: Supplement, 1999, carries the following comment:

“At present, evidence also exists which shows that AZT is rapidly reduced by compounds containing sulphhydryl (-SH); that is, AZT oxidises the –SH groups. Ample evidence also exists which shows that oxidation in general (and of –SH in particular) and decreased levels of ATP may lead to many laboratory and clinical abnormalities, including wasting, muscular atrophy, anaemia, damage to the liver and kidney, decreased cellular proliferation, cancer and immunodeficiency. Since patients who are at risk of AIDS are exposed to many oxidising agents and are known to have low –SH levels, one would expect AZT to have particularly toxic effects in these individuals – and the sicker the patient the more toxic the drug. That this is the case was accepted by researchers from the National Cancer Institute, Wellcome Laboratories and Abbott Laboratories as far back as 1988: ‘Azidothymidine (AZT), however, is associated with toxicities than can limit its use...These toxicities are particularly troublesome in patients with established AIDS; the use of azidothymidine is often limited in this population...”

Despite all the foregoing concerning the toxicity of AZT and the strange circumstances surrounding its licensing in the US, there are some in our country who are desperately keen that we make AZT generally available in the public health system, as we would ordinary headache tablets. Boldly, they claim to be the best friends of the African!

At least two questions arise from the foregoing:

- on what scientific basis did our Medicines Control Council (MCC) license AZT in our country?; and,
- should those doctors who prescribe AZT and other anti-retroviral drugs not be held personally liable in the event that their patients develop the illnesses caused by the toxicity of these drugs?

Chapter VIII

Let us now return to the matter of MTCT and nevirapine. Roxane is a pharmaceutical company that produces nevirapine, selling it under the brand name Viramune. This company published the following warning (in capital letters) in the Physicians' Desk Reference (PDR 2001), considered the best available source of information on the safety of medications for humans:

“WARNING: SEVERE LIFE-THREATENING SKIN REACTIONS, INCLUDING FATAL CASES HAVE OCCURRED IN PATIENTS TREATED WITH VIRAMUNE. THESE HAVE INCLUDED CASES OF STEVEN-JOHNSON SYNDROME, TOXIC EPIDERMAL NECROLYSIS, AND HYPERSENSITIVE REACTIONS CHARACTERISED BY RASH, CONSTITUTIONAL FINDINGS, AND ORGAN DYSFUNCTION. PATIENTS DEVELOPING SIGNS OR SYMPTOMS OF SEVERE SKIN REACTIONS OR HYPERSENSITIVITY REACTIONS MUST DISCONTINUE VIRAMUNE AS SOON AS POSSIBLE. SEVERE AND LIFE-THREATENING HEPATOTOXICITY, INCLUDING FATAL HEPATIC NECROSIS, HAS OCCURRED IN PATIENTS TREATED WITH VIRAMUNE. RESISTANT VIRUS EMERGES RAPIDLY AND UNIFORMLY WHEN VIRAMUNE IS ADMINISTERED AS MONOTHERAPY, THEREFORE, VIRAMUNE SHOULD ALWAYS BE ADMINISTERED IN COMBINATION WITH ANTIRETROVIRAL AGENTS.”

PDR 2001 also says:

“ Patients should be informed that Viramune therapy has not been shown to reduce the risk of transmission of HIV-1 to others through sexual contact or blood contamination...Viramune is not a cure for HIV-infection; patients may continue to experience illnesses associated with advanced HIV-1 infection, including opportunistic infections.”

It also says that:

“ Evaluation of the pharmacokinetics of nevirapine in neonates is ongoing” and “ the safety profile of Viramune in neonates has not been established.” (Our emphasis).

PDR 2001 further says:

“ Severe or life-threatening hepatotoxicity, including fatal fulminant hepatitis (transaminases elevations, with or without hyperbilirubinemia, prolonged partial thromboplastin time, or eosinophilia), has occurred in patients treated with Viramune.”

The most recent guidelines of the US government on HIV treatment were issued on February 5, 2001. With regard to HIV-infected pregnant women, the Guidelines say:

“ Guidelines for optimal antiretroviral therapy and for initiation of therapy in pregnant HIV-infected women should be the same as those delineated for non-pregnant adults. Thus, the woman’s clinical, virologic and immunologic status should be of primary importance in guiding treatment decisions. However, **it must be realised that the potential impact of such therapy on the fetus and infant is unknown**...Long-term follow-up is recommended for all infants born to women who have received antiretroviral drugs during pregnancy...(Our emphasis)...

“ There are currently minimal data available on the pharmacokinetics and safety of antiretroviral agents during pregnancy for drugs other than ZDV (AZT)...There are insufficient data available at present to justify the substitution of any antiretroviral agent other than ZDV for the purpose of reducing perinatal HIV transmission; further research will address this question...

“ It is important to recognise that the predictive value of *in vitro* and animal screening tests for adverse in humans is unknown.”

In the Summary to the Guidelines, the point is made that:

“ Patient education and involvement in therapeutic decisions is important for all medical conditions, but is considered especially critical for HIV infection and its treatment.” (Our emphasis.)

(**NB**: these observations are reiterated in the updated Guidelines published in February 2002.)

We emphasise the observation underlined in the last but one paragraph above to draw attention to the fact that the US scientists who drew up the *Guidelines* sought to highlight the point that the treatment of HIV should not be approached in a routine manner, however experienced, in general, the medical personnel that is then called upon to deal with this condition.

As we have also pointed out, the *Guidelines* also say that HIV-positive pregnant women should also be handled and prepared in the same way as any other adult with regard to treatment. We will therefore quote at some length what the Guidelines say on this matter.

“ **Care should be supervised by an expert...**Before initiating therapy in any patient, however, the following evaluation should be performed:

- Complete history and physical (All)
- Complete blood count, chemistry profile (including serum transaminases and lipid profile (All)
- CD4+ T lymphocyte count (AI)
- Plasma HIV RNA Measurement (AI)

“ Additional evaluation should include routine tests pertinent to the prevention of OIs, if not already performed (RPR or VDRL, tuberculin skin test, toxoplasma IgG serology, and gynecologic exam with Pap smear), and other tests as clinically indicated (e.g., chest X-ray, hepatitis C virus (HCV) serology, ophthalmic exam) (All). Hepatitis B

virus (HBV) serology is indicated in a patient who is a candidate for hepatitis B vaccine or has abnormal liver function tests (AII), and CMV serology may be useful in certain individuals, as discussed in the “USPHS/IDSA Guidelines for the Prevention of Opportunistic Infections in Persons Infected with the Human Immunodeficiency Virus” (2) (BIII)...

“ It is necessary for the patient to be entered into a continuum of medical care and services, including social, psychosocial, and nutritional services, with the availability of expert referral and consultation. In order to achieve the maximal flexibility in tailoring therapy to each patient over the duration of his or her infection, it is imperative that drug formularies allow for all FDA-approved NRTI, NNRTI, and PI as treatment options.”

(NB: In the immediate preceding paragraphs, ‘A’ stands for “Strong, should always be offered”; ‘B’, for “Moderate, should usually be offered. ‘I’ stands for “At least one randomised trial with clinical endpoints; ‘II’, for “Clinical trials with laboratory endpoints; and ‘III’, for “Expert opinion”.)

With regard to the immediate foregoing, at least three questions arise in the South African context.

Are these *Guidelines* being followed by our medical practitioners?

Does the public health system have the capacity to implement these guidelines?

If this capacity does not exist, would it be ethical for our doctors nevertheless to prescribe anti-retroviral therapy?

If our medical practitioners do not follow the *Guidelines* as indicated above, would they not be guilty of justiciable malpractice?

Recently, in October 2001, Eleni Papadopulos-Eleopulos et al, published a monograph entitled: “*Mother to Child Transmission of HIV and its Prevention with AZT and Nevirapine.*” We will quote a few paragraphs from this monograph, which we will identify as EPE.

EPE says:

“ As far back as 1988, there was evidence that the antibody tests in children are non-specific. **It is accepted by all AIDS experts that a child can have positive antibody test without being infected.** This is because maternal antibodies cross the placenta as early as the 12th week of gestation. As a result of normal catabolism, the level of these antibodies decreases post partum and by 9 months of age they are no longer present in the child. In other words, if the HIV antibody test is specific, any child who has a positive HIV antibody test beyond 9 months should remain positive for the remainder of his or her life. In the only study providing a detailed analysis of *post partum* loss of infant HIV seropositivity, the European Collaborative Study, approximately 23% of the children became seronegative between birth and 9 months. However, 59% became seronegative between 9 and 22 months. Since the latter cannot be due to loss of maternal antibodies, the only explanation is that: (i) the antibody test is non-specific or; (ii) the children managed to clear HIV infection without treatment. If 23% of children test positive because of maternal antibodies and in 59% the test is non-specific, how certain can one be that in the remaining 18% of children the test will also not seroconvert after 22 months? Or if the test remains positive it is true positive?” (Our emphasis).

All the studies of transmission of HIV from mother to child use the Roche Amplicon PCR to detect neonatal HIV infection, as HIV antibody detection by HIV ELISA cannot be used in the first 18 months due to the persistence of maternal antibodies in the infant's circulation.

Yet the US CDC states that PCR must not be used to diagnose HIV infection in adolescents and neonates. It then says that nevertheless it can be used in infants!

We should also note that the abundant 'copies per ml' that PCR detects in the bloodstream are not whole virus particles, despite the misleading appellation of 'viral load'. They are genetic material whose sequence is the same as that of constituents of the HIV genome.

Therefore, ‘high viral load’ on PCR does not automatically assume profound infection with HIV. This is presumably why the manufacturers caution against use of the test to diagnose HIV infection – lest they be sued by a patient who subsequently proves not to have HIV infection.

Despite all this, all the evidence for reduction of vertical transmission using antiretroviral drugs is premised on the detection of neonatal HIV infection using PCR. Not surprisingly, the evidence is consequently self-contradictory, with a proportion of so-called infected babies spontaneously becoming disease free in the first 9 months and later, while another subset initially negative, developing positive PCR despite the mother abstaining from breast feeding.

Most puzzling of all is the finding from the (still unpublished!) PETRA B study in which the well-known Dr Glenda Gray was a principal investigator.

This study demonstrated that at 18 months following birth, there was **no difference** in HIV free survival between the infants whose HIV positive mothers had been given AZT plus 3TC just before birth, and those whose HIV positive mothers had received placebo.

Perhaps not surprisingly, Dr Gray’s PhD thesis, which is presumably largely based on this study, is, several years later, still in the ‘pipeline’ and unpublished. **Is this because the study shows that antiretroviral therapy for HIV positive pregnant women does not, in fact, “save babies’ lives”?**

The EPE also cites a study conducted in 1999 by researchers from France and Rwanda. Among other things, this study said:

“ Of 436 eligible children, 54 were diagnosed as infected...A total of 347 children were considered uninfected...In HIV-1 infected children, the most frequently observed clinical signs were chronic cough, failure to thrive, and generalised lymphadenopathy, which also were reported among the most frequent HIV-related conditions in other developing countries. Chronic cough and failure to thrive were present in almost half of the initial patterns of symptomatic disease in our series. However, these three conditions were also common in

uninfected children. In our cohort, the most specific findings of HIV-infection were oral candidiasis and chronic parotitis, a pattern similar to the one observed in the New York City cohort...Twenty-eight (52%) infected children and 13 (4%) uninfected children died during follow-up...The risk of death was not significantly higher in children who had developed AIDS in comparison to the other children. No specific combination of clinical manifestations was associated with differences in survival. Biologically, neither the maternal CD4 cell count at day 15 nor the child's CD4/CD8 ratio at 6 months of age was predictive of death."

EPE also quotes the WHO, as follows:

" In the 1989 'Report on the Meeting of the Technical Working Group on HIV/AIDS in Childhood', World Health Organisation, global programme on AIDS, it is stated:

" Many infections that are common in children, particularly in developing countries (such as pneumonia and diarrhoea), mimic the HIV infection in their clinical signs...Because of the incompletely defined spectrum of disease in infancy and childhood and the limitation of correct laboratory diagnostic tests (antibody, PCR, virus culture, HIV antigens, *in vitro* antibody production) **there is no clear standard against which to measure existing or proposed paediatric AIDS definition.**" (Our emphasis).

One of the conclusions that EPE draws from its extensive study of existing scientific material on MTCT is that:

" There is no valid method to prove infection of the child with HIV. There is no proof that any of the tests used to prove infection are HIV specific. Neither are the tests reproducible or standardised. This is well illustrated by the fact that there are few studies in which the same methodology and tests are used (in some studies an "in-house" definition of MCT is used) and the extreme variability in the findings of different groups, the findings are not consistent even within one and the same group or even with the site in the same study. This is best illustrated in the ECS and the Ariel project studies. There is nothing specific either in regard to the immune deficiency (T4 decrease) or the clinical signs, symptoms and diseases, that is, AIDS reported in

infants and children of HIV positive mothers and used to prove MCT of HIV. Such abnormalities existed in infants and children long before the AIDS era, and in fact, in high frequency in the two groups in which the claims for MCT of HIV have been obtained, that is, in women living in poverty and using drugs...At present, there is no proof that HIV, even if it is assumed to be present in pregnant mothers, is perinatally transmitted to their offspring.” (Our emphases.)

EPE also says:

“ The pharmacological mode of action of nevirapine can only prevent infection of cells not already infected. Thus, when given to the mother, it could prevent transmission only if the child is not already infected.

“ Since nevirapine like AZT is capable only of preventing infection of new cells and is unable to inhibit the expression of HIV within already infected cells or eradicate the virus, when the drug is given to neonates, especially three days *post partum*, it will have no effect on MCT *in utero* or during labour and delivery. Under these circumstances nevirapine may prevent transmission via breast feeding and then only for a very short period of time (days). However, since,

- (a) a single dose of 200mg administered to the mother leads to a drug concentration in milk much lower than the concentration necessary to have an anti-retroviral effect;
- (b) the concentration reached in the infant after a single dose of 200mg to the mother and 2mg/Kg to the infant is much lower than that necessary to induce an anti-HIV effect;

such a regime of the drug cannot inhibit MCT via breast milk even for a very short period of time.

“ Given the pharmacological action of the drug and its pharmacokinetics, one wonders how anyone can propose a protocol like that used in the Uganda study and expect an effect on MCT?

“ In recommending nevirapine as mono or combination therapy it is important to consider that not only is its anti-viral effect even when administered for lengthy periods limited and of extremely short duration, but that it confers resistance to the treatment with other anti-retrovirals. It is also significant that the European Agency for the Evaluation of Medicinal Products recommends the use of nevirapine only for combination therapy and only for ‘infected patients with advanced or progressive immunodeficiency.’

“ At present, no proof exists that children become infected by their mothers either *in utero* or *post partum* with a unique human retrovirus, HIV or (that) this can be prevented by AZT or nevirapine.”

EPE also quotes a 1998 study carried out by Ian Timaeus of the London School of Hygiene and Tropical Medicine. Relying on this study EPE says:

“ It is worth emphasising that infant and child mortality fell in Uganda in the early 1990s despite the severity of the HIV epidemic in this country. Presumably developments acting to improve child health have outweighed the impact on mortality of the spread of HIV. Thus, these estimates suggest that the HIV epidemic exerts an important but not decisive influence on trends in infant and child mortality. Without additional data (said Timaeus), one cannot separate the impact of AIDS on infant and child mortality from that of other factors.

“ In other words, in Africa no proof exists of an increased mortality in children above that reflected by the ‘enduring impact of under-development’, resulting from HIV infection, not even in Uganda, where no less an authority on HIV and AIDS than Robert Gallo reported that as far back as 1973, 50/75 (67%) of a sample of 75 children were infected with HIV. This means that a similar proportion of mothers and presumably fathers in Uganda would also have been infected in 1973. If the HIV antibody tests do prove HIV infection and if HIV is the cause of AIDS one should have witnessed an inexorable decline in the Ugandan population over the past twenty years. Instead:

“ Timaeus says: ‘The population in Uganda has increased from the 4.9 million enumerated in the 1948 census to 6.5 million in 1959; 9.5

million by 1969; 12.6 million by 1980; and 16.7 million were enumerated at the 1991 census. Uganda's population is growing at a rate of 2.5 per cent which leads to an estimated population of 21 million people by 1998. It is estimated that 47 per cent of the population is under 15, while only 3 per cent are above 65 years. Thus the population is young and has in-built potential to grow (momentum) as the large proportion of children become parents.'...

“ The one necessary and sufficient measure to decrease childhood mortality in the developing world, including death from ‘AIDS’, as well as the phenomena claimed to prove HIV infection and thus the putative mother-to-child-transmission of ‘HIV’, is to eliminate poverty.”

(NB: the population of Uganda is now 23 million!)

Chapter IX

This, of course, raises the critically important question of where these resources are to come from, “to eliminate poverty.” For those who think that the route of the extensive distribution of anti-retroviral drugs is the most affordable, they should take heed of what an IMF staff study had to say.

The newspaper, *Business Day*, reported on November 15, 2001 that:

“ No southern African nation will be able to offer general access to antiretroviral treatment for HIV/AIDS through its public health service, even if the drugs are available at marginal cost, concludes a grim new International Monetary Fund (IMF) staff study.

“ SA and Botswana are possible exceptions, but ‘only to a limited extent’, says the study’s author, Markus Haacker of the IMF’s research department, in an analysis that highlights the quandary faced by SA policy makers.

“ By 2010, Haaker estimates, the cost of providing highly active antiretroviral treatment to 30%, or less than a third, of South Africans

who need it would represent about 1,4% of gross domestic product (GDP).

“ With just 10% of those needing the treatment receiving it, the cost of all HIV-related health service for SA would be close to 1% of GDP in 2010, equivalent to nearly a third of public health expenditure in 1997...

“ Haaker concludes that even getting antiretrovirals to 10% of patients will be difficult. ‘Given the serious shortages in personnel and infrastructure the health sector is facing, the scope for alleviating the (effect) of HIV/AIDS on the health sector through financial aid is limited.’”

In the article we have already cited, Dr Laurence of “*The AIDS Reader*” also says:

“ In addition, these 2 (US) studies did not consider the economic costs of resistance testing and medication adherence monitoring, as well as public health consequences should these issues not be an integral part of all economic discussions of HIV/AIDS. This omission will have a great impact worldwide if recent calls are heeded and wide distribution of ART (anti-retroviral therapy) in Africa and similar areas being decimated by HIV occurs without adequate oversight of medication adherence...

“ Many factors may facilitate such resistance, but patient noncompliance and drug interactions are key. Arguably, these confounders can only be exacerbated in the developing world, in the setting of poverty, instability of social structures, and lack of health care resources.

“ In the United States, spread of resistant strains may be mitigated by genotypic and phenotypic resistance testing. Like ART itself, these assays are cost-effective in some instances. But they could double the cost of many ART regimens. This will confound future assessments of the economies of HIV treatments in the context of public health predictions for the growth and medical impact of resistant strains...

“ In 1993, when HAART was not yet conceived, an editorial appeared in the *Annals of Internal Medicine* entitled, “*The hazards of misguided compassion*”. It addressed the issue of rapid, unmonitored dissemination of 2-drug ART in the community before what the writer felt was sufficient clinical testing. We now know that such use had a very small impact on life expectancy but promoted resistant viral strains, which persist for the life of the patient. Based on this experience, I would argue for limited and monitored distribution of free or low-cost ART in those regions where, based on poor existing infrastructures or known problems with treatment of other communicable infections such as tuberculosis, it is least likely to be of benefit to the individual or the community...

“ (Statements about affordability) and the quality of existing infrastructures, must receive careful review and updates, based both on economic valuations and on public health considerations, in the design and dissemination of ART worldwide.”

The WHO supports this conclusion when it says:

“However, it should be noted that **drug costs** may represent **only a fraction of the costs** of the services that are required for an effective MTCT-prevention programme.” (WHO/RHR/01.21). (Our emphases). The fact of the matter, however, is that the omnipotent apparatus has succeeded to convince everybody that all that needs to be done is to reduce the price of the drugs, and all problems of cost will be solved!

Taking advantage of this, some of the pharmaceutical companies have sought to capture particular markets, especially in the poor countries, by offering to donate their drugs free-of-charge, for particular periods of time. The manufacturers of nevirapine/viramune, Boehringer-Ingelheim (sp?), have offered our country a free supply of this drug for five years.

Our national Ministry and Department of Health have not accepted this offer. Nevertheless, some of our provinces have been both proud and loud to announce the acceptance of this offer.

The leadership in these provinces is happy to ride a crest of dangerously misinformed popularity, in fact to threaten the health, and

lives, of our people, while claiming to be acting in the interest of life itself. This is a matter that has to be dealt with strongly and in a principled manner.

For now, we will only report on WHO Guidelines relating to the issue of *“Managing Nevirapine Donations”*. These guidelines appear in the 2001 WHO document entitled *“Prevention of mother-to-child transmission of HIV: Selection and Use of Nevirapine: Technical Notes.”*

Among other things, this document says:

“ The drug donation should be based on an expressed need and should not be sent without prior consent of the recipient country...

“ The programme should not be promotional in character, or increase market opportunities for a specific commercial enterprise to the detriment of others;

“ The donation should be based on a sound analysis of the recipient country’s needs, and the selection and distribution of nevirapine must fit within existing policies and guidelines on MTCT-prevention; the standards of the MTCT-prevention programme must be promoted; health workers must be trained and systems for supervision, and monitoring and evaluation must be put in place;...

“ The additional costs to the recipient country should be calculated in advance and funding arrangements made;

“ Financing mechanisms for ensuring sustained access to nevirapine beyond the five years of the donation programme should be defined.”

The WHO document says all these guidelines, and others, **“require special attention in the case of the nevirapine donation”!**

The pharmaceutical company concerned has deliberately and consciously ignored all these Guidelines. Consciously and

deliberately, it has decided to treat our government and country with contempt. It has taken the decision that both what the government our people have chosen and the decisions they take, are immaterial to what it decides to do in our country.

Like some NGO's funded by the "haves", it has understood the phenomenon of **self-repression among us** and the instinct 'to love to look upon or to be noticed by the possessor of Power or Conspicuousness'.

It has understood what poverty does to people, driving them to think with their stomachs rather than their heads. To gain material advantage, **the privileged poor** among us are quite ready to transform themselves into defenders, representatives and sales agents of the Powerful and Conspicuous.

The privileged poor know that the latter will reward them with dollars. They do not care what happens to the powerless and inconspicuous they claim to represent! As with their paymasters, what makes their world go round is – money, money, money!

Because of all this, the manufacturers of nevirapine have acted in our country in a manner they would not dare in the developed world. Pressure on our government to ignore the WHO guidelines will not come from the company. It will come from those among us who have accepted the need for **self-repression**, who tell us everyday that what the pharmaceutical companies say, is correct and should be , acted on.

As the Chicago NGO, AIPAC, undoubtedly supported by our own Glenda Gray, said in relation to the drugs Videx and Zerit, we must accept that the manufacturer is 'a global health and personal care company whose mission is to extend and enhance human life'!

What our people are about, both black and white, to decide what happens to themselves, their children and their country, demands that they decide what they do with their health. This requires that they think independently.

They must refuse to be bribed or intimidated as some presume that because they are poor, and by definition deprived and dis-empowered, they are ready to be bought and terrorised.

Difficult as it is, the possibility to think independently must also apply to the question of HIV/AIDS. This, too, is about what happens to us as a people. It has to do with our physiological health, our psychological health, our political health, our assessment of ourselves as Africans.

And so we come to the questions which the omnipotent apparatus decrees should not be asked.

Since the US government does not recommend nevirapine for MTCT, on what basis are we being asked to use this drug for MTCT?

Since its safety relative to the child has not been established, why are we being asked to give it to our mothers and children?

What do those who argue for the efficacy of nevirapine in MTCT base this conclusion on?

Given the difficulties associated with determining the HIV status of infants, how is this status determined in our country?

What study exists in our country that measures comparative infant mortality between 'HIV-positive' and 'HIV-negative' infants?

What is meant by an AIDS-orphan – how are these scientifically determined as 'AIDS-orphans' as opposed to mere orphans?

Chapter X

We have already referred to the need to get accurate information about the incidence of disease and death in our country. Everyday, we are fed with "information" that large numbers of people are dying from AIDS, with many anecdotes being told.

On November 22, 2001, the US periodical, “*Rolling Stone*”, published an article by the South African writer and journalist, Rian Malan.

There are many things that Malan says in this article that, undoubtedly, will have enraged the omnipotent apparatus.

Referring to the HIV-tests we have already dealt with, Malan says that in the US each person is subjected to a number of tests. He says:

“ In other words, we’re talking six tests in all, doubly confirmed. Such a protocol is probably foolproof...In the annual pregnancy-clinic surveys on which South Africa’s terrifying AIDS statistics are based, the protocol is **one** ELISA only, unconfirmed by anything. In America, **one** ELISA means almost nothing. ‘Persons are positive only when they are repeatedly reactive by ELISA and confirmed by Western Blot,’ says the CDC.” (Our emphases).

Malan continues:

“ My education in the complexities of the ELISA test started when I came across an article in a scientific journal published last year. It told a story that began in 1994, when researchers ran HIV tests on 184 high-risk subjects in a South African mining camp. Twenty-one of the subjects came up positive or borderline positive on at least one ELISA. But the results were confusing. A locally manufactured test said two subjects were positive. A British test indicated seven, but different people in almost every case. A French test declared fourteen were infected.

“ It seemed something was confounding the tests, and the prime suspect was *plasmodium falciparum*, one of the parasites that causes malaria. **Of the twenty-one subjects who tested positive, sixteen had had recent malaria infections and huge levels of antibody in their veins. The researchers tried an experiment: They formulated a preparation that absorbed the malaria antibodies, treated the blood samples with it, then retested them. Eighty per cent of the suspected HIV infections disappeared.**” (Our emphasis).

Malan reports that he asked a member of a team of demographers who had studied African mortality statistics:

“ Do you accept the high levels of HIV infection being reported by Geneva (UN AIDS)?” To which the demographer replied:

“ I don’t have much faith. **It’s essentially a modelling exercise, and the exercise has always seemed to have a political dimension.**” (Our emphasis).

Earlier in his article, Malan says:

“ Geneva’s computer models suggested that AIDS deaths here (in South Africa) had tripled in three years, surging from 80,000 odd in 1996 to 250,000 in 1999. But no such rise was discernible in total registered deaths, which went from 294,703 to 343,535 within roughly the same period. The discrepancy was so large that I wrote to Statistics SA – the nation’s census bureau – and to the Medical Research Council – a governmental body – to make absolutely sure I had understood these numbers correctly. Both parties confirmed that I had, and at that exact moment, my story was in trouble. Geneva’s figures reflected catastrophe. Pretoria’s did not. Between these extremes lay a gray area populated by local experts such as Stephen Kramer, manager of insurance giant Metropolitan’s AIDS Research Unit, whose own computer model shows AIDS deaths at about one-third Geneva’s estimates. But so what? South African actuaries don’t get a say in this debate. The figures you see in your newspapers come from Geneva. **The WHO takes pains to label these numbers estimates only, but still, these are the estimates we all accept as the truth.**” (Our emphasis).

(NB: At least part of this increase in the mortality figures is due to the fact that national statistics are now capturing data from those sections of the majority African population that had previously been excluded, because of the apartheid system. The apparent absolute increase may therefore not reflect an actual relative increase of mortality among our population, and almost certainly does not.)

Malan then says:

“ Since (I assumed that) it was indeed true that very large numbers of South Africans were dying, then the nation’s coffin makers had to be laboring hard to keep pace with growing demand...

“ So I called the real-wood firms, three industrialists who manufactured coffins on an assembly live for the national market.

“ ‘It’s quiet’, said Kurt Lammerding of GNG Pine Products. ‘We aren’t feeling anything at all.’ His competitors concurred – business was dead, so to speak.

“ ‘It’s a fact,’ said Mr A.B. Schwegman of B&A Coffins. ‘If you go on what you read in the newspapers, we should be overwhelmed, but there’s nothing. So what’s going on? You tell me.’

“ I couldn’t, although I suspected it might have something to do with race. Since the downfall of apartheid in 1994, illegal backyard funeral parlors have mushroomed in the black townships, and my sources couldn’t discount the possibility that these outfits were scoring their coffins from the underground economy. So I called a black-owned firm, Mmabatho Coffins, but it had gone out of business, along with others I tried calling...(In downtown Johannesburg) Penny’s place was locked up and deserted. Inside I saw unsold coffins stacked ceiling-high, and a forlorn CLOSED sign hung on a wire.”

Inevitably, the omnipotent apparatus will kill Rian Malan’s article by ensuring that as many people as possible do not know that it was ever written and published. Among other things, this will help this apparatus to sustain the fiction of catastrophic figures of “HIV infection” in our country.

The sustenance of these figures, which derive from drastically wrong testing practice even in terms of the “orthodox” paradigm and process, is important because it creates a market for the sale of anti-retroviral drugs. In this context, findings such as those made by Rian Malan, that after the necessary scientific work was done, “eighty per cent of the suspected HIV infections disappeared”, are totally unacceptable.

Having sounded thunderous drums about millions of our people being “infected by HIV”, imagine what would happen to the domestic and global army that lives off this “apocalypse”, if suddenly it would be said that eighty per cent of the suspected HIV infections are a result of pure imagination or defective medical processes!

It seems obvious that the omnipotent apparatus will never allow such an outcome, in its own interest. Of no consequence to the omnipotent apparatus in this regard is the actual health condition of our people.

The story will therefore continue to be told, with no respect whatsoever for the truth, that, as a people, we are destined to perish as a result of an overpowering “HIV infection” of millions of our people.

We will not, at this stage, ask the questions to which the omnipotent apparatus is opposed. Having conducted some research, rather than rely on anecdotes told as a result of “perceptions”, Rian Malan could not find the catastrophic deaths regularly reported from Geneva.

He was also able to establish that Geneva produces these figures with no reference whatsoever to the actual record of deaths, as reflected in the reports contained in the detailed Population Register kept by the Department of Home Affairs.

He will, of course, have noticed that since he spoke to them, the “governmental body”, the Medical Research Council, has changed its tune on the matter of our mortality statistics. To do this, without notifying anybody, it broke away from a committee of government bodies charged with the task of studying the Home Affairs mortality figures and preparing a report on this matter.

Having raised money, partly from an international pharmaceutical company, with no authorisation by anybody in government, it proceeded to produce its own profile and projections of mortality in our country. These were as catastrophic as those regularly peddled by Geneva.

For its efforts, it received the resounding acclaim of the omnipotent apparatus. Obviously, it is in the interest of the omnipotent apparatus

that the “truth” as told by Geneva should prevail, rather than the truth reflected in our national Population Register. The question is – why is the telling of damaging falsehoods about our country so important to the omnipotent apparatus!

Undoubtedly, as he began his inquiry, Rian Malan would have read the many statements that are made about the catastrophic impact of HIV-AIDS on our industry and economy. *Anglo American plc* is one of South Africa’s major corporations, employing many people in South and Southern Africa and elsewhere in the world.

The corporation has been implementing its own programmes to respond to the AIDS challenge. It began these programmes in Zimbabwe, which it says is “six years ahead of South Africa in terms of HIV/AIDS impact.”

In the journal “*Optima*” (Vol 46 No 1, July 2000) it reported:

“ The combined death and early-retirement rate (in Zimbabwe) equated to 25.3 per 1,000, or ‘only’ 2.5% - a manageable figure...

“ In the case of the Anglo American group...the maximum expected annual staff loss because of AIDS is not likely to be higher than 5%. You have to compare that level, and the associated replacement costs, with the natural attrition rate of workers leaving for whatever other reasons. In economic boom years we can lose more than 15% of certain skilled workers through job-hopping for better pay and prospects.”

We can cite more examples from the mining industry that confirm the story told by Anglo-American plc. The question that arises from all this is – whence do the stories emanate that project a future economic crisis caused by death from AIDS among our economically active population!

The same question should be posed with regard to the similarly projected catastrophe with regard to the public service.

The story we have told so far shows unequivocally that, at best, the “scientific” story that is told about the “HIV/AIDS pandemic” in our country, is highly tendentious.

The more any open-minded person probes it, as Rian Malan did, the more will this person find that what this “science” states as incontrovertible truths throws up more questions than it answers.

The problem with all this is that, here, we are dealing with matters of life and death. The issues we are discussing have to do with the lives of millions of people. This does not allow for any recklessness or anything other than a rigorous understanding of all the matters we have raised, and others besides.

It does not permit of submission to a herd-instinct, to which many of us are so prone. Because we are dealing here with science and facts, we cannot allow the truth to be defeated by perceptions, faith and fear of the omnipotent apparatus.

In this situation, we have to accept that the search for the truth will be denounced and punished by the omnipotent apparatus as unacceptable non-conformity.

The question that faces any honest person, having been exposed to the reality that there are many outstanding questions that require scientific answers, is whether it is possible both to be conformist and retain one’s sense of personal integrity! Is it possible for us to be conformist and actually defeat the AIDS threat that faces our people!

The “scientific proofs” adduced to convince us about the various facets of the HIV/AIDS question rest on very tenuous grounds. Yet, the reality is that the majority of our people and the rest of the world, including our Continent, believe that these “proofs” are indeed scientific proofs.

The question arises naturally – why this groundswell of belief and faith!

Chapter XI

The answer lies in the reality that the hypotheses about ourselves, that are presented as facts, rest on an age-old definition by others of what and who we are, as Africans.

In her book, *“Women, Race and Class”*, the African-American progressive activist, Angela Davis, writes of the attitude of white America towards her people. She says their view has been:

“ The conditions of our problem are as follows: 1. A century or two ago the negroes were savages in the wilds of Africa. 2. Those who were brought to America, and their descendants, have acquired a certain amount of civilisation, and are now in some degree fitted for life in modern civilised society. 3. This progress of the negroes has been in very large measure the result of their association with civilised white people. 4. An immense mass of the negroes is sure to remain for an indefinite period in the midst of the civilised white nation. The problem is, how can we best provide for their peaceful residence and their further progress in this nation of white men and how best can we guard against their lapsing back into barbarism?”

This extract appears in the book, *“AIDS, Africa And Racism”*, written by Richard and Rosalind Chirimuuta. (Free Association Books, London, 1989.)

The Chirimuuta’s (themselves Medical Doctors) go on to say:

“ Black people were disease ridden, dirty in their habits, uncontrolled in their sexual behaviour, and incapable of higher human values such as honesty or sexual morality. Such views were succinctly expressed by an apologist for racism, Winfield Collins, in a book published in 1918 entitled *“The Truth about Lynching and the Negro in the South (In which the Author Pleads that the South Be Made Safe for the White Race)”*:

“ ‘Two of the Negro’s most prominent characteristics are the utter lack of chastity and complete ignorance of veracity. The Negro’s sexual laxity, considered so immoral or even criminal in the white man’s civilisation, may have been all but a virtue in the habitat of his origin.

There, nature developed in him intense sexual passions to offset his high death rate.”

In his book “*Debating AZT*”, (Open Books, Pietermaritzburg, 2000), Anthony Brink quotes an article carried by *The New York Times* of 2 July 2000, in which, in a revised rendition of the preceding paragraph, the author says:

“ How much would it cost to banish ignorance, to deaden lust, to shame rape, to stop war, to enrich the poor, to empower women, to defend children, to make decent medical care as globally ubiquitous as Coca-Cola – in short, to get rid of all the underlying causes of the (HIV/AIDS) epidemic in the third world?”

This view was backed by our own Charlene Smith, who wrote in the *Washington Post* of June 4, 2000 that:

“ Here (in Africa), (AIDS) is spread primarily by heterosexual sex – spurred by men’s attitudes towards women. We won’t end this epidemic until we understand the role of tradition and religion – and of a culture in which rape is endemic and has become a prime means of transmitting disease, to young women as well as children.”

The Chirimuuta’s also cite a letter published in the prestigious British medical journal, *The Lancet*, contributed by one F. Noireau in 1987. In his letter, Noireau says:

“ The isolation from monkeys of retroviruses closely related to HIV strongly suggests a simian origin for this virus...Several unlikely hypotheses have been put forward to explain the indirect transmission of the virus from monkey to man – for example, the theory that the disease spread to man through bites or the cutting up and consumption of monkey meat or the arthropod vector hypothesis. In his book on the sexual life of people in the Great Lakes area of Africa, Kashamura writes: ‘pour stimuler intense, on leur inocule dans les cuisses, la region du pubis et le dos du sang preleve sur un singe, pour in homme, sur une guenon, pour une femme’ (to stimulate a man or a woman and induce them to intense sexual activity, monkey blood (for a man) or she-monkey blood (for a woman) was directly inoculated in the pubic area and also in the thighs and back). These

magic practices would therefore constitute an efficient experimental transmission model and could be responsible for the emergence of AIDS in man.”

They also quote an article written by two British scientists, Paul Nunn and Keith McAdam, which appeared in the September 1988 edition of *Medicine International*. They say:

“ The scale of the African AIDS epidemic has led to speculation that heterosexual transmission is more efficient in Africa than elsewhere...Social and cultural factors, such as the African tradition of male sexual freedom, may also play a part. The circulation of myths, such as the only cure for AIDS being to have sex with a virgin is likely to have a greater effect on transmission in Africa than in developed countries.” (Our emphasis).

It is instructive for us that this particular insulting fable surfaced in our country, not as a speculative circumstance broadcast by European intellectuals in the decade of the '80s, but as a fact of life in the South Africa of the '90s.

But unfamiliar as we are with the existing huge volume of literature on the issue of HIV/AIDS, how were we to know that the supposed behaviour of our people was, in fact, pre-prescribed by the scientists of the developed world! Naturally, having foretold of its inevitability, these scientists, supported by the media, discovered this behaviour in our country as well. Was this a self-fulfilling prophecy?

Interestingly, and inevitably, we too, the Africans, proved, once more, that we were quite willing to authenticate as the truth what the omnipotent apparatus told us was the truth. And as we behaved, as it were as to the manner born, we helped to create a self-fulfilling prophecy.

Having done this, we then felt very useful when we stood up, relying on such authority as we enjoyed among the people, to urge them not to do what they had never thought to do, until we told them they were doing it! Such are the ironies and tragedies of our age and our condition!

The Chirimuuta's also inform us of a report sent to *The Lancet* in 1987 by a London-based Ghanaian physician, Dr Konotey-Ahulu, after he had toured sub-Saharan Africa for six weeks. He wrote, like Rian Malan 14 years later:

“ If tens of thousands are dying from AIDS (and Africans do not cremate their dead) where are the graves?...

“ ‘Why do the world’s media appear to have conspired with some scientists to become so gratuitously extravagant with the untruth?’ – that was the question uppermost in the minds of intelligent Africans and Europeans I met on my tour.”

The Chirimuuta's also quote an article by A.J. Venter that appeared in the *International Defence Review* in 1988, in which the author says:

“ The potential depopulation of much of Black Africa holds serious consequences for the international community. Africa is still the world’s largest single commodities resource, from uranium, copper and gold all the way through to hundreds of consumer items as diverse as cocoa, hardwoods, maize and a host of tropical products...

“ But what if current projections are correct, and more than half the population of countries like Uganda, Kenya, Zaire and much of equatorial West Africa are wiped out before the turn of the century?

“ Who will fill the vacuum?...It will be interesting to see at what stage the developed world starts its new scramble for Africa.”

In a Chapter contributed to the book, “*AIDS in Africa and the Caribbean*”, eds George C. Bond et al, WestviewPress, 1997, the Chirimuuta's write:

“Many leading doctors and scientists of their day made their contributions to the pseudo-science of racism. (vide Fryer P. “*Staying Power: the history of black people in Britain*”, Pluto Press, London 1984 & Ferguson, J. “*The laboratory of racism*”, *New Scientist* 1984, Sept 27, 103.) When humans were placed at the top of the evolutionary tree, Africans were allocated a separate species between other humans and apes and there were numerous

suggestions that Africans had sexual intercourse with apes, or were the result of such unions. As Africans were deemed more akin to animals than humans, they were by definition incapable of civilised behaviour. They were believed to be sexually unrestrained and to have larger sexual organs than other races, and were therefore more prone to sexually transmitted diseases. They were deceitful, treacherous, lazy, faithless, cruel and bad-tempered. African skulls were studied and were considered to be smaller than those of Europeans, establishing beyond doubt that Africans had the lesser intelligence. In one form or another, explicitly or implicitly, many of these notions have appeared in the scientific literature about AIDS and Africa.”

One among a number of examples quoted by the Chirimuuta’s is a paper entitled “*Population differences in susceptibility to AIDS: An evolutionary analysis*”, *Social Science and Medicine* 28 (12): 1211-1220, 1989, by Rushton, J.P. and Bogaert, A.F., which says:

“Previously we have reported population differences in sexual restraint such that, higher socio-economic status > lower socio-economic status, and Mongoloids > Caucasoids > Negroids. This ordering was predicted from a gene-based evolutionary theory of r/R reproductive strategies in which a trade-off occurs between gamete production and social behaviours such as intelligence, law abidingness, and parental care. Here we consider the implications of these analyses of sexual dysfunction, including susceptibility to AIDS. We conclude that relative to Caucasians, populations of Asian ancestry are inclined to a greater frequency of inhibitory disorders such as low sexual excitement and premature ejaculation and to a lower frequency of sexually transmitted diseases including AIDS, while **populations of African ancestry are inclined to a greater frequency of uninhibited disorders such as rape and unintended pregnancy and to more sexually transmitted diseases including AIDS.**” (Our emphasis.)

The Chirimuuta’s conclude their own book with the words:

“ We have shown how racism has guided the direction of AIDS research; moreover, that the problem is not simply the subjective prejudices of individual AIDS researchers but a racist world-view that

coincides with the material self-interest of research institutions and of the Western governments that fund them. There is an illusion that science is objective, that scientists search for the truth irrespective of outside pressures. In reality the only science that exists is the science that is done, and he who pays the piper calls the tune.”

More recently than everything we have said about racism and AIDS, what we have recounted above was illustrated in an ugly racist incident that took place at a Caravan Park near Port Edward in southern KwaZulu-Natal at the end of December 2001.

A group of white school children decided to have an end of the year party at this Caravan Park. Among them was one black boy, Castro Hlongwane, 17, their schoolmate.

Because he is black, the owners of the Park ordered him to leave, despite the fact that he was properly booked in together with his white friends. One of the witnesses to this incident, Amy Godfrey, said this was “pure racism like I have never seen in my life.”

Relevant to our story, *The Sunday Times* of January 6, 2002, reported:

“ Schoolmate Ryan Templar, 18, said he was told by (Park owner) Theresa Smit that Hlongwane had AIDS and would rape other campers.”

The unsophisticated Theresa Smit expressed openly a conviction and belief that many other sophisticated Theresa Smit’s hold, but would never express in public, **because they are mature practitioners of the deceptions of the sophisticated.**

Nevertheless, they do everything they can to demand the implementation of policies and programmes based on the conviction and belief that, **because he is black, “Hlongwane has AIDS and will rape other campers”!**

When they are caught red-handed in their immersion in racism, they readily respond that their accusers seek to silence them by “playing the race card!”

Thus does the victim of racism get transformed into a racist, while the racist escapes scot-free by the transformation of the perpetrator into a victim! In spite of the spectacular advances in science, miracles are still part of our daily lives!

(NB: the Hlongwane incident and Foot & Mouth Disease have provided us the title to this dissertation.)

For those who question the truth of the statements made by the Chirimuuta's about 'outside pressures' on scientists, we recommend that they read the well-researched and illuminating novel by John le Carré, "*The Constant Gardener*." Most important, this includes the explanatory notes the author has provided. Please read them carefully, having accepted the need for suspension of disbelief.

Regardless of the fact that the scientific proof is hard to come by, nevertheless the conviction has taken firm hold that sub-Saharan Africa will surely be wiped out by an HIV/AIDS pandemic unless, most important of all, we access anti-retroviral drugs.

This urgent and insistent call is made by some of the friends of the Africans, who are intent that the Africans must be saved from a plague worse than the Black Death of many centuries ago.

For their part, the Africans believe this story, as told by their friends. They too shout the message that – yes, indeed, we are as you say we are!

Yes, we are sex-crazy! Yes, we are diseased!

Yes, we spread the deadly HI Virus through our uncontrolled heterosexual sex! In this regard, yes we are different from the US and Western Europe!

Yes, we, the men, abuse women and the girl-child with gay abandon! Yes, among us rape is endemic because of our culture!

Yes, we do believe that sleeping with young virgins will cure us of AIDS! Yes, as a result of all this, we are threatened with destruction by the HIV/AIDS pandemic!

Yes, what we need, and cannot afford, because we are poor, are condoms and anti-retroviral drugs!

Help!

The Africans do not hear the message communicated by the Israeli scientists we cited, who, among other things said, as they sought to provide a scientific answer to the incidence of HIV/AIDS in Africa (and the developing world):

“ The average African host is exposed to a huge number of infectious diseases from early childhood onwards. These include various bacterial, viral and parasitic infections. Noteworthy is the wide prevalence of helminth infections, malaria and tuberculosis in most parts of Africa: especially in Sub-Saharan Africa, and in East and West Africa. Also of central importance is the very high prevalence of STDs, particularly genital ulcer diseases (GUDs), which play an important role in facilitating the dissemination of HIV infection into the general population...

“ In addition to the central role of STDs, important cofactors such as the cultural habit of scarification, as well as transfusion, hygiene and nutrition, may facilitate HIV transmission and infection.”

In the main text of “*Eros & Civilisation*”, Marcuse quotes Sigmund Freud as having written during and about the First World War:

“ Think of the colossal brutality, cruelty and mendacity which is now allowed to spread itself over the civilised world. Do you really believe that a handful of unprincipled place-hunters and corrupters of men would have succeeded in letting loose all this latent evil, if the millions of their followers were not also guilty?” (Sigmund Freud: *A General Introduction to Psychoanalysis*, New York, 1943.)

If we think of the colossal intellectual brutality, cruelty and mendacity which is now allowed to spread over Africa, we need to ask the question – are we the followers, the Africans, not also guilty!

We must ask ourselves whether we do not comply with the image painted by Marcuse:

“ The people, efficiently manipulated and organised, are free; ignorance and impotence, introjected heteronomy is the price of their freedom.”

In his time, Marcuse saw a different form of violence being perpetrated against the victims of poverty and underdevelopment by affluent societies. He said:

“ It makes no sense to talk about liberation to free men – and we are free if we do not belong to the oppressed minority. And it makes no sense to talk about surplus repression when men and women enjoy more sexual liberty than ever before. But the truth is that this freedom and satisfaction are transforming the earth into hell. The inferno is still concentrated in certain far away places. Vietnam, the Congo, South Africa, and in the ghettos of the ‘affluent society’: in Mississippi and Alabama, in Harlem. These infernal places illuminate the whole. It is easy and sensible to see in them only pockets of poverty and misery in a growing society capable of eliminating them gradually and without a catastrophe. This interpretation may even be realistic and correct. The question is: eliminated at what cost – not in dollars and cents, but in human lives and in human freedom? I hesitate to use the word – freedom – because it is precisely in the name of freedom that crimes against humanity are being perpetrated. This situation is certainly not new in history: poverty and exploitation were products of economic freedom; time and again, people were liberated all over the globe by their lords and masters, and their new liberty turned out to be submission, not to the rule of law but to the rule of the law of others.”

He went on to say:

“ Historical backwardness may again become the historical chance of turning the wheel of progress to another direction. Technical and scientific overdevelopment stands refuted when the radar-equipped bombers, the chemicals, and the ‘special forces’ of the affluent society are let loose on the poorest of the earth, on their shacks, hospitals, and rice fields. The ‘accidents’ reveal the substance: they tear the technological veil behind which the real powers are hiding. The capability to overkill and to overburn, and the mental behaviour that goes with it are by-products of the development of the productive

forces within a system of exploitation and repression; they seem to become more productive the more comfortable the system becomes to its privileged subjects. The affluent society has now demonstrated that it is a society at war; if its citizens have not noticed it, its victims certainly have...The odds are overwhelmingly on the side of the powers that be.”

And yet he entertained the hope that the risen masses of the “backward countries” would help to unleash a global movement that would humanise the world. He wrote:

“ When, in the more or less affluent societies, productivity has reached a level at which the masses participate in its benefits, and at which the opposition is effectively and democratically ‘contained’, then the conflict between master and slave is also effectively contained. Or rather, it has changed its social location. It exists, and explodes, in the revolt of the backward countries against the intolerable heritage of colonialism and its prolongation by neo-colonialism...Yet the revolt in the backward countries has found a response in the advanced countries where youth is in protest against repression in affluence and war abroad. Revolt against the false fathers, teachers, and heroes – solidarity with the wretched of the earth: is there any ‘organic’ connection between the two facets of the protest?”

In time, the explosion and the revolt came to an end. With regard to the developing countries, Marcuse spoke of the physical violence inflicted on them by the affluent societies.

Perhaps he did not foresee the intellectual violence that was to come, as a result of which we, the Africans, have come to accept that we are the immoral, diseased and sexually depraved animals which all racism had, from the beginning, defined us as – the putative Castro Hlongwane’s!

He did not see that the overkill would be an overkill of the mind, achieved not with laser directed bombs, but the capacity to over-communicate through satellite saturation media communication.

Perhaps he did not see that, in the aftermath of the bombs, this intellectual offensive would be the trigger that would result in:

“ repression from within, (when) the unfree individual introjects his masters and their commands into his own mental apparatus. The struggle against freedom reproduces itself in the psyche of man, as the self-repression of the repressed individual, and his self-repression in turn sustains his masters and their institutions.”

To break out of this condition, with regard to HIV/AIDS, perhaps we need the rebellion of the intelligentsia he thought was necessary when he wrote:

“ To the degree to which organised labour operates in defense of the status quo, and to the degree to which the share of labour in the material process of production declines, intellectual skills and capabilities become social and political factors. Today, the organised refusal to cooperate of the scientists, mathematicians, technicians, industrial psychologists, and public opinion pollsters may well accomplish what a strike, even a large-scale strike, can no longer accomplish but once accomplished, namely, the beginning of the reversal, the preparation of the ground for political action. That the idea appears utterly unrealistic does not reduce the political responsibility involved in the position and function of the *intellectual* in contemporary industrial society.”

Chapter XII

With the help of *some* of these intellectuals, we have learnt to analyse the acronym AIDS. The omnipotent apparatus told us that this is a *disease*. What we have come to understand is that it is a *syndrome*. It is uncontestable that AIDS stand for the – Acquired Immune Deficiency Syndrome.

Central to this is the proposition of *immune deficiency* (ID). There is no question but that there is such a condition with regard to human health.

Accordingly, there is no debate about the ID in AIDS.

AIDS also represents the concept – *acquired*. This is to distinguish acquired (*secondary*) immune deficiency from *primary* immune deficiency. Again, there is no controversy about this. It can be proved scientifically that there are both primary and acquired immune deficiencies.

This means that, so far, there is no dispute about the AID in AIDS.

Whether through *primary or secondary factors*, it is possible, and does happen, that immune deficiency develops. As a result of this deficiency, the body is unable to defend itself from a large variety of otherwise curable diseases. The collection of these diseases that, most typically, attack the person suffering from immune deficiency, together constitute a *syndrome*.

It is therefore clear that the concept and the reality of AIDS is one of the challenges that we, the Africans, have to deal with. We have to wage a war against the Acquired Immune Deficiency Syndrome (AIDS). All this is simple to understand and to explain.

The omnipotent apparatus then intervenes. It says that immune deficiency is acquired solely from the HI Virus. It also says that AIDS is one disease, with one cause and one set of symptoms. It is not a syndrome that manifests itself in a number of diseases!

And, therefore, the ‘syndrome’ is deliberately designated as a ‘disease’!

It is here that the problem begins, because the question must be answered whether we are dealing with a disease or a syndrome. This question arises despite what we quoted earlier, from what a French scientist said about AIDS not being a ‘disease’ in the ‘ordinary’ sense of the word, but a ‘disease’ nevertheless.

Marcuse foresaw a day when the intelligentsia would lose its fear of the omnipotent apparatus and act in the interests of the ordinary working people. Many African lives would be saved, if this intelligentsia picked up courage now, simply to state what is

objectively scientifically correct with regard to the many matters that relate to AIDS.

As Africans, one of the matters we have come to understand is that the critical issue to which we have to attend is *immune deficiency*.

This means that we have to do everything possible to protect and strengthen our immune systems. These healthy immune systems would then be able successfully to discharge their mission of protecting our bodies from the diseases to which they are exposed.

This is the matter on which we are focused as we wage a relentless fight against AIDS. The objective we seek to achieve is that our immune systems must be strong enough to defeat everything that attacks the body, including HIV.

On the contrary, the omnipotent apparatus demands that we should focus on fighting HIV with anti-retroviral drugs. Despite the fact that these drugs cannot destroy this virus, which the omnipotent apparatus admits, nevertheless it demands that we must buy and use them.

These drugs also work further to weaken the immune system. Whether the omnipotent apparatus acknowledges this or not, a large volume of scientific information exists that proves the toxic, anti-immune effect of these drugs, as indicated above.

Certainly the US health authorities, as we have indicated, have had the courage publicly to admit that the drugs designed to fight the Virus, rather than strengthen the immune system to fight the Virus, are, indeed, highly toxic. These authorities have therefore laid down specific rules governing the prescription of these drugs.

It is perfectly clear that we, the Africans, cannot meet these conditions, which we explained earlier in this monograph.

From this point of view, we can deduce that the question that life has posed is simple and straightforward. It is – what should the focus of scientific research and development be!

Should it be the development of medicaments to fight the HI Virus!

Should it be the development of medicaments to strengthen the immune system so that the body can fight the HI Virus!

One of the problems with this is that the former creates the possibility for those who produce drugs to make a lot of money. The latter creates the possibility for those who produce drugs to lose a lot of money.

To ensure the success of the latter, in the interest of the people, guarantees that a war will be waged against these, to serve the interests of those who want to make a lot of money. This makes it certain that, ahead of us, we have a hard fight, unless, of course, we succumb to the notion that condoms and anti-retroviral drugs constitute the solution to our problems.

Conscious of the might of the omnipotent apparatus, Marcuse said:

“ The price of progress is frightfully high, but we shall overcome. Not only the deceived victims but also their chief of state have said so.”

It is clear that there are some within African society who are not prepared to pay this price. These think that the view that we shall overcome is mere and poisoned pie in the sky. This includes some of the intellectuals that Marcuse would summon to the barricades.

Writing of such an intellectual in 1912, the Irish poet and patriot, W.B. Yeats, said:

“ I have had an interminable letter from a man called Strangways suggesting alterations in (the Indian poet Rabindranath) Tagore’s (Yeats) translation. He is the sort of man societies like the India Society fatten. He is a manifest goose. I want (you) to get the society to understand that I am to edit this book & that they are (to) send me proofs as any other publisher would. I cannot argue with a man who thinks that ‘the ripples are rampant in the river’ should be changed because ‘rampant’ suggests to his goose brains ‘opposition to something’. I am very busy – I work like a clerk – and I cannot carry on a correspondence with this man. I have replied politely saying I

would go carefully through the text in proof but do please see that he goes back to his pond.”

(Quoted in: “*W.B. Yeats, A Life: I – The Apprentice Mage*”, by R.F. Foster, Oxford University Press, 1997.)

We too have our own geese, posing as writers, thinkers and scientists, who have been fattened by the equivalent of the India Society. To justify their feed, they work hard to build repression from within our ranks. It would be good if we could assist them to return to their ponds as quickly as possible, taking their goose brains with them.

These are the same cats that seek to befriend the elephant, of whom Mark Twain was ashamed.

Whether cats or geese, one purpose they serve for those who fatten them, is **to medicalise poverty and underdevelopment**. Thus problems that require a determined global effort to end African poverty and underdevelopment are presented, with African acquiescence, as problems that can be solved with condoms and drugs.

Given a bout of sustained public agitation, the affluent societies, the friends of the Africans, can meet the cost of the latter. Happily for them, this would unburden them of the responsibility to find the unimaginably larger resources that are required to address the former.

Once this was done, we, for our part, would have no basis to urge the affluent to act in solidarity with us. After all, we would have been rescued from a catastrophe and a cataclysm worse than our poverty and under-development – the HIV/AIDS pandemic!

The omnipotent apparatus has adduced all manner of argument precisely to lead us in this direction. Among other things, it has sought to ridicule and denounce even accessing of the Internet by some of our leaders, as the height of risible and “unscientific” behaviour.

It has also advanced the extraordinary argument that our political leaders in government should not comment on scientific questions. It demands – leave science to the scientists!

If our government heeded this absurd argument, it would then have to cede the exercise of the function of government to the specialists!

The logic of the argument of the omnipotent apparatus is – leave the economy to the economists!

Leave education to the pedagogues!

Leave agriculture to the agriculturalists!

Leave mining to the engineers and the geologists!

Leave social development to the sociologists and the anthropologists!

Leave defence to the generals!

Leave the environment to the ecologists!

Leave politics to the political scientists!

Leave health to the medical doctors!

Leave sanitation to...and so on!

Conscious of the need to access the best available scientific advice on the all-important issue of HIV/AIDS, without abandoning its responsibility to govern, our government did, in fact, constitute a **Presidential International Scientific AIDS Panel**, to help provide answers to the questions posed in this document.

The Panel has published its Interim Report, which includes the decisions it has taken to seek to answer these questions, scientifically. But because the scientists who make up this Panel decided to behave as scientists, the omnipotent apparatus decided to treat their Interim Report as part of the non-conformity it is committed to punish.

Because it could not denounce the scientists for behaving as scientists, it decided to kill and bury their Interim Report by silence. In this instance, it applied the principle it knows well – if it is not known, it does not exist!

Not known, though known, is precisely the fact that, contrary to what our government is being charged with not doing, it has, in fact, gone back to the science intelligentsia whose task it is to inquire, and asked them to inquire and to advise the government, as scientists.

But the omnipotent apparatus is intent that this known fact should become unknown. Thus will its campaign succeed to present our government as a monkey troupe of imbeciles, intent to trouble an established and comfortable world of ecclesiastic belief and practice.

It believes that unless it is stopped, this simian troop of African clowns will thrive and grow fat and important, feasting on dangerous ignorance.

We hope that the Panel of Scientists will do their work, loyal to their consciences as scientists and true to their courage as people of integrity. What they have to do is of the greatest importance to us as a people. Inevitably, for no fault of their own, what they have to do is both about science and politics.

For us, the recipients of their expert knowledge and advice, their work is about our health and our dignity as human beings. It is about helping to find answers to many unanswered questions about HIV/AIDS.

Chapter XIII

Vol 1 No 4, 2001 of the journal, *ANC Today*, carried an article about some of these questions. It said:

“ The *New York Times* (carried an) article...entitled "[The AIDS Questions that Linger](#)" ...written by Lawrence K. Altman, M.D. of the NYT. It was published on 30 January (2001).

“ Early in his article, Dr Altman quotes Sandra Thurman, the top AIDS official in the Clinton administration, saying: "People say that the more we learn about HIV, the more we realise we don't know a whole lot." (Our emphasis).

“ On the contrary, our own (South African) opposition alliance is convinced that it knows everything that needs to be known about HIV. Undoubtedly, it has the answers to the questions posed by Dr Altman, who writes that the list of unanswered questions about HIV/AIDS "could fill a newspaper, and even then would create debate".

“ Among others, Dr Altman poses the following questions:

- "Why does AIDS predispose infected persons to certain types of cancers and infections and not others?"
- "Equally puzzling is why AIDS patients are also more prone to infections like pneumonia. Studies of the immune system have not answered the question, and 'we do not know very much more about why that is than we did 20 years ago when the first work was done,' said Dr Henry Masur, an official at the National Institutes of Health."
- "What route does HIV take after it enters the body to destroy the immune system?"
- (What) is not known is how the virus proceeds to destroy the body 's CD4 cells that are needed to combat invading infectious agents. 'We need a breakthrough' said Dr David A. Cooper, an AIDS expert in Sydney, Australia."
- "How does HIV subvert the immune system?"
- "(There) is widespread variation in the rate at which HIV-infected people become ill with AIDS. So scientists ask: Can the elements of the immune system responsible for that variability be identified? If so, can they be used to stop progression to AIDS in infected people and possibly prevent infection in the first place?"

- "Anti-HIV drugs suppress replication of the virus, which should give the functioning parts of the immune system a chance to eliminate remaining virus. That does not happen. 'So something is bizarre about that that we don't understand,' Dr Fauci (the director of the US National Institute of Allergy and Infectious Diseases) said."
- "What is the precise function of HIV genes? HIV's nine genes have multiple functions, but they are only partly known. One gene was called nef (for negative factor) because it was thought to inhibit HIV. But now it turns out to have an opposite effect. Nef accelerates HIV's ability to infect. In the United States, an experimental vaccine made by deleting the nef gene from a simian AIDS virus provided strong evidence of protection against an AIDS-like virus in early tests in monkeys. However, longer-term follow-up showed that the vaccine caused the disease it was designed to prevent."
- "What is the most effective anti-HIV therapy? What combinations of drugs should be started first and when? Why do side effects like unusual accumulations of fat in the abdomen and neck develop? Is it possible to predict who will get them or how best to treat them?"
- "One avenue being explored is treating for a period of time and then stopping in hopes of stimulating the immune system to combat HIV. An unanswered question is: will it work any better than standard therapy?"
- "Another critical unanswered question is: what is the best way to deliver anti-HIV therapy in the third world where medical facilities are scarce?"
- "Is a vaccine possible. There is little question that an effective vaccine is crucial to controlling the epidemic. But many unanswered questions exist about whether and when one can be developed. When HIV-1 was isolated in 1984, Margaret Heckler, the US secretary of health and human services, promised an AIDS vaccine within a few years. Seventeen years later prospects for an AIDS vaccine still appear quite remote, said Dr Neal Nathanson, the former head of the National Institutes of Health's Office of AIDS Research."
- "It is not known whether a vaccine derived from one type of HIV will confer protection against other types."

- "Scientists also do not yet have some basic information about vaccines against HIV. For instance, they do not yet know which antibodies produced in response to a vaccine indicate the greatest likelihood of protection, a crucial step in developing any vaccine. 'Unfortunately, we still don't have the knowledge to create an effective vaccine, and I honestly don't know if we will ever have one because the problems are so great,' Dr Wainberg, an AIDS researcher at McGill University in Montreal, said."
- "Why do most babies born to infected mothers escape infection? Why do 75 percent escape? Do these infants manage to mount a successful immune response to avoid infection? Relatively little research has been done to answer these and other questions, said Dr Esparza, the UN official."
- "Why do HIV rates differ so greatly among regions in Africa and elsewhere? Despite studies, there is no simple explanation for the regional differences, said Dr Piot, the UN AIDS official."
- "Where did AIDS come from? We can only guess. Determining the answer would be important because discovering how AIDS came to be epidemic might prevent a similar catastrophe in the future."

Despite its pursuit of the necessary answers to these and other unanswered questions, the South African Government has nevertheless put in place an anti-AIDS programme, as good as any other anywhere in the world. This is contained in the *"HIV/AIDS/STD Strategic Plan for South Africa: 2000-2005."*

Included in the goals of the Plan, which are currently being pursued, are:

- to promote safe and healthy sexual behaviour;
- to improve the management and control of STDs;
- to reduce mother-to-child HIV transmission;
- to address issues relating to blood transfusion and HIV;
- to provide appropriate post-exposure services;
- to improve access to voluntary testing and counselling;

- to provide treatment, care and support services in health facilities;
- to provide adequate treatment, care and support services in communities;
- to develop and expand the provision of care to children and orphans;
- to ensure AIDS vaccine development;
- to investigate treatment and care options;
- to conduct policy research;
- to conduct regular surveillance;
- to create an appropriate social environment; and,
- to develop an appropriate legal and policy environment.

Nevertheless, the omnipotent apparatus is not satisfied with this programme, which is based on the thesis – “*HIV causes AIDS causes Death*”. It denounces the South African government as being “in denial” and not doing much to fight the ‘HIV/AIDS pandemic’.

To achieve its purposes, once more it takes care that this Strategic Plan that is known becomes unknown. **It creates the perceived reality that what exists does not exist.** It convinces people who should know, that nothing is being done when something is being done. Thus does the message spread throughout the world that ours is a genocidal government.

The question arises – why is the omnipotent apparatus so angry when the kind of programme that is closest to its heart has, in fact, been adopted and is being implemented!

The simple answer to this question is that this programme, as implemented in South Africa, does not include wide-spread availability of anti-retroviral drugs within the public health system.

The South African government is not spending the billions of Rands on these drugs that would be like music to the ears of those who sell these drugs.

This is happening in a situation in which economic surveys have told those who are interested, that among the countries of sub-Saharan

Africa, South Africa (and Botswana) are in economic terms, potentially the most lucrative markets for anti-retroviral drugs.

If, tomorrow, the government were to announce that it was making these drugs generally available within the public health system, it would be showered with praises and a surfeit of congratulations. Overnight, our country would be redefined as one of the best fighters against HIV/AIDS.

This is in spite of what *The New York Times* said, as we have already reported, that – “such drugs are not a cure for AIDS nor do they prevent the spread of HIV, the virus that causes AIDS”.

The question that the South African government will have to answer for itself is whether it chooses an *A-rating* because it is making anti-retroviral drugs generally available, or it addresses the real health concerns of the millions of our people!

Our government, and the country, are, of course, also awaiting the report from *Statistics South Africa* (SSA) and others, on health and mortality statistics.

This will provide as accurate a basis as possible of the burden of disease in our country. It will help to ensure that our health and other programmes are properly focused to address all the actual diseases and health risks our people face, and not just AIDS.

In the meantime, despite the fury of the omnipotent apparatus last year generated by reference to this table, and therefore the truth about the health of our people, we reproduce below the latest figures available to us.

**SELECTED WHO NUMBERS AND CAUSES OF DEATH IN SOUTH AFRICA - 1995
INCLUDES DATA RECEIVED SINCE PUBLICATION OF
1996 EDITION**

	MALE	FEMAL E	TOTAL	RAN K	% OF 29 CAUSES
All causes	137751	101547	239298		
External causes	36138	10337	46475	1	19.83923708
Diseases of the circulatory system	19854	21045	40899	2	17.45895551

Signs, symptoms & other ill-defined conditions	17278	14678	31956	3 13.64136977
Malignant neoplasms	12743	10427	23170	4 9.890804156
TB of the respiratory system + other forms	8414	3946	12360	5 5.276233896
Bronchitis, emphysema, asthma & other respiratory	6647	4220	10867	6 4.638902407
Pneumonia	5394	4690	10084	7 4.304655551
Senility without mention of psychosis	3096	5714	8810	8 3.76081073
Birth trauma & other originating in perinatal period	4456	3770	8226	9 3.511512947
Diabetes mellitus	3145	4900	8045	10 3.43424771
Other intestinal infectious diseases	3405	3169	6574	11 2.806307575
HIV disease	2653	2568	5221	12 2.228739253
Septicaemia	1864	1827	3691	13 1.575613213
Nephritis, nephrotic syndrome & nephrosis	1661	1628	3289	14 1.404007547
Other diseases of the digestive system	1593	1056	2649	15 1.130804498
Chronic liver disease & cirrhosis	1421	590	2011	16 0.858455208
Malnutrition & nutritional deficiencies	924	822	1746	17 0.74533207
Epilepsy	1053	559	1612	18 0.688130181
Other diseases of nervous system	824	638	1462	19 0.624098216
Meningitis	626	503	1129	20 0.481947255
Ulcer of stomach & duodenum	556	407	963	21 0.411085214
Other infectious & parasitic diseases	397	183	580	22 0.247590264
Other viral diseases	319	259	578	23 0.246736504
Anaemias	202	299	501	24 0.213866762
Mental disorders	362	119	481	25 0.205329167
Congenital heart anomalies & circulatory system	241	217	458	26 0.195510932
Sexually transmitted diseases	109	78	187	27 0.079826516
Malaria	88	39	127	28 0.05421373
Typhoid fever	61	46	107	29 0.045676135
TOTAL FOR THE 29 CAUSES			234258	

In our work, concretely to respond to our actual burden of disease, the approach taken would do well to draw on such experience as that of the United Nations Development Programme (UNDP) in India. In August 2001, the UNDP explained its approach to health matters in India in the following way:

“ Recognising a close nexus between poverty and powerlessness, and given UNDP’s global mandate of poverty

eradication, UNDP India in close consultation with the Government decided to support interventions which promote access to basic services in the areas of health, education and prevention of HIV/AIDS. (Our emphasis).

“ UNDP interventions focus on empowerment of communities as a basic prerequisite for human development, and are being implemented in convergence with ongoing UNDP-supported initiatives in other areas...

“ The lack of access to quality health care has been identified as a leading cause of human deprivation in India...

“ **Expensive disease-oriented programmes tend to enhance dependency and weaken community capacities to cope with the issue of prevention.** Experience has shown that wherever people have been empowered and provided appropriate information, resources and encouragement, **the efforts have yielded better results at a much lower cost.** (Our emphases).

“ UNDP interventions with the Government in the health sector are directed towards facilitating a fresh consideration of these issues from a social perspective. **The effort is to make visible the links between health and poverty,** and to demonstrate a range of equity-based interventions that would have a direct, even critical bearing on public health...(Our emphasis).

“ UNDP is extending support to a Government project that has been created to develop and demonstrate three inter-related but independent model interventions in the areas of Multi-sectoral Approach to Health, School Health and Community Health Care Financing. The project is based on the assumption that empowered communities, in partnerships with local government units and Community-Based Organisations/Non-Governmental Organisations, can plan, implement and manage their own health programmes...

“ **The pilot interventions focus on diseases which basically emanate from poverty and ignorance, and which have their roots in the social, economic and political system. These diseases account for more than 80 per cent of all disease incidence and**

are mainly preventable infectious diseases caused by the lack of adequate nutrition, safe drinking water, a healthy habitat, basic maternal and child care and health awareness. (Our emphasis).

“ Since subjects like public health, sanitation, drinking water supply and women and child care form a part of the functions of the Panchayats (local self-government) and municipalities, this pilot initiative focuses on developing capacities of these institutions of local self-government to respond to the health needs of communities...

“ Two initiatives with somewhat varying strategies and emphasis are being simultaneously undertaken under this pilot programme :

“ **Urban School Health Initiative:** Assisted by a local health NGO, this pilot initiative focuses on building capacities of school teachers, Parent Teacher Associations (PTAs) and Government health personnel in select clusters, and has helped to develop a common perspective and understanding of the health of children.

“ The intervention supports training of one teacher from each class to do the initial screening of children in her/his class. PTAs are playing a critical role not only in monitoring the programme interventions but also in carrying the issues of hygiene and sanitation into their own neighbourhoods.

“ **Initiative for Learning Disabilities:** With technical backstopping and assistance in networking from the Society for Rehabilitation of Cognitive and Communicative Disorders, this initiative builds on the experience of Government's District Primary Education Programme (DPEP) in community mobilisation for advocacy on issues of learning disabilities. Educated youth in the community are being identified and trained along with school teachers and Primary Health Care (PHC) doctors and other health personnel to assist in screening children, providing ongoing support for children with mild learning disabilities and in maintaining a record of the progress of each child...

“ UNDP-supported interventions are being carried out in select sites in the state of West Bengal and Karnataka. Women's groups already working among communities in the area under various government projects are being supported to mobilise resources, including

premiums for risk, for managing health care financing, so as to ensure access to quality primary health care and services. The intervention is helping to establish a linkage between NGOs and the existing health practitioners in the area and building their capacities to respond appropriately to the health care demands of the community. The project is also, in close collaboration with the National Insurance Company trying to evolve insurance packages of the poor (through shared risks) for better utilization of the existing primary health care facilities...

“ UNDP support focuses on creating an enabling environment for selected groups such as people infected and affected by HIV/AIDS. The activities cover counselling at the individual level, education and alternative vocational training, micro-credit facilities for setting up small enterprises at the community level and night shelters for children of commercial sex workers.

“ Policy issues such as accepting children in schools without requiring the father’s name are being supported at the state level. In partnership with the Confederation of Indian Industry (CII), the workplace activities include interventions for health/medical insurance and job replacements for those affected with the epidemic.

“ The project envisages support and endorsements from political leaders, religious leaders, opinion-makers, health care practitioners, lawyers and police so that people living with HIV can continue to contribute to society.

“ The strategies and interventions under the UNDP-supported project will also converge with the work of the Regional project on HIV/AIDS for South and South West Asia. The Regional project is focusing on issues such as mobility and migration, and is exploring a range of legal and ethical issues related to HIV/AIDS.”

In addition to the directions suggested by the UNDP, we must continue to focus on the established policies with regard to health care. These include:

- primary health care;
- prioritising the prevention and treatment of the main diseases affecting our people;

- strengthening of our health infrastructure, including clinics, hospitals and equipment;
- increasing the number and professional competence of our health personnel; and,
- providing safe and affordable drugs and medicines.

Recently, **Professor Jeffrey Sachs** of Harvard University chaired a commission of the *WHO* called the “*Commission on Macroeconomics and Health*”. When he presented the findings of the Commission at the Novartis Foundation for Sustainable Development ‘Health and Development’ Symposium, on December 4, 2001, Professor Sachs said:

“ The commission found the disturbing, distressing, but not surprising fact that literally millions of people – perhaps it is to save more than ten million people per year – are dying of readily preventable or treatable conditions. An overwhelming proportion of these are unnecessary deaths in the low income countries. And overwhelmingly among those deaths are deaths due to communicable diseases of course. The overwhelming proportion of the avoidable mortality falls into a small subset of categories which all of you know well: malaria, AIDS, tuberculoses, diarrhoeal disease, acute respiratory infection, micronutrient deficiency, vaccine preventable diseases and unsafe childbirth, basically because of unattended childbirth which results in mortality rates for mothers a thousand times higher in the poor countries than in the rich countries. So it is a relatively well defined group of diseases which accounts for the overwhelming access of disease burden – both morbidity and mortality – in the poor countries...Everybody knows that higher income would improve health outcomes. People are probably not as aware of how poor health impedes economic development in the economic growth. We pulled together a great deal of evidence – and some of it original – showing indeed that poor health is a major barrier to economic development itself...So we have a situation where even for the most basis and humble diseases – like measles where there is still almost a million deaths per year – as well as for the complex treatments for anti-retroviral therapy, treatments are not reaching poor people...**The poor in the world are unimaginably poor...**” (Our emphasis).

Professor Sachs went on to address the issue of the resources needed to address the health challenge in the developing countries. He reported that that, because they are poor, these countries have **no possibility whatsoever** to generate the funds that are urgently and desperately needed. He said:

“ And we costed out with considerable care in more detail than has ever been done before the levels of donor assistance spending that will be needed to meet these essential health interventions: it all comes down to about *one tenth of one percent* of GNP of the rich countries. One tenth of one percent of the current twenty-five trillion dollars of the high-income economy GNP combining the US, Europe, Japan and a few other rich countries, that is about 25 billion dollars per year. With that level of commitment from the rich countries, we believe it would be possible to make very deep inroads into disease control against the great pandemic diseases – to treat AIDS-patients, to address malaria, to get substantial coverage for patients on directly observed therapy for tuberculosis, to increase immunisation rates, to address diarrhoeal and acute respiratory infectious diseases and to dramatically scale up access to save child birth. And at the same time to put in about three billion dollars a year into increased research and development (R&D) spending for new medicines in partnership between private industry and the public sector. So we believe that it would be possible to make a comprehensive approach.”

During the last two years or so, our political leadership, and others in the world condemned and marginalised as ‘dissidents’, have advanced **exactly** the same arguments presented by Professor Sachs and his Commission. In response, this leadership, and the scientists, have been denounced as genocidal and therefore criminal, a bunch of blackguards that must be excommunicated from human society - neutralised!

An example of what our government has been saying is reflected in the speech made by our President at the opening of the *Durban 13th International Aids Conference*, as reported earlier in this monograph.

The anti-HIV paid professional civil society (the NGO’s), a powerful regiment of scientists, including some of our own, and the mass

media, condemned this speech, which was based on what the WHO had said in its published official documents.

Chapter XIV

Parks Mankahlana rose from his deathbed to oppose this campaign against the President and the truth. He spoke in words that polite society, the friends of the Africans, considered unacceptable because they were not pretty.

And then he died, vanquished by the anti-retroviral drugs he was wrongly persuaded to consume. He suffered from anaemia and received dedicated attention from his doctor. Nevertheless he died prematurely, because some, **other than his doctor**, advised him to take anti-retroviral drugs.

The professionals who fed him the drugs that rendered his anaemia treatment ineffective by destroying his immune system, remain free to feed others with the same drugs. They live to tell us and the world that their patient, who was not their patient, died of a virus they had never found in his body.

And then came young *Nkosi*.

He, too, died, vanquished by the anti-retroviral drugs he was forced to consume.

But because he was too young to have a voice of his own, unlike Parks Mankahlana, the omnipotent apparatus gave him a new identity.

Ignoring his parentage and his family, it re-named him "*Johnson*". He became the property and the hapless dependent of a world to which he did not belong. He was reborn as a creature of the imagination and the resources of white South Africa.

This world decided to accord him the status of a hero, the new *Hector Petersen* murdered not by the apartheid regime, but by our country's

democratic government. The pain of his unnecessary death, and the undignified media pictures of his suffering, were a platform that was used to market precisely the drugs that killed this child.

And then the call was made that we should all convene at his last place of rest to celebrate the fact that he had spoken words that adults had put into his mouth; to confess guilt that we had not fed him with anti-retroviral drugs, (which other 'benefactors' provided); to give thanks that others had taken him away from his family; to deify him, and therefore those who supervised his progression to death, as the new heroes and heroines of the struggle for a new South Africa.

And because this was a new struggle, defined and led by people other than his own, his ultimate name had to be Johnson!

As his grandparents watched his small coffin descend into his grave, they had to accept that their grandchild would be identified and remembered forever, not as their own, but the progeny of another, acceptable to the omnipotent apparatus - which they were and are not – Johnson!

In his speech at the Durban World AIDS Conference, **the President did not say anything different from what the official WHO Sachs Commission has now said.**

We wait to see whether the authorised and official **WHO Sachs Commission** will meet the same cruel fate as our President did at the hands of the omnipotent apparatus!

The English poet, Percy Bysshe Shelley, wrote a poem entitled "*Hymn to Intellectual Beauty*". It said:

“ Ask why the sunlight not forever
Weaves rainbows o'er yon mountain river,
Why aught should fail and fade that once is shown,
Why fear and dream and death and birth
Cast on the daylight of this earth
Such gloom, - why man has such a scope
For love and hate, despondency and hope?”

Perhaps, when our government asked the scientists to answer the questions that had not been answered, we expected too much of them. We expected them to help us to answer the questions that Shelley posed. We expected that they would give us the knowledge forever to weave rainbows over the rivers that spring in the mountains of *Ukhahlamba*.

Chapter XV

Because we are African, who have to overcome centuries of treatment as the repulsive and unacceptable Other, could we avoid to ask the question – why have fellow human beings such a scope for love and hate, despondency and hope!

Writing about “Colonial War and Mental Disorders”, Frantz Fanon said:

“ We have since 1954 in various scientific works drawn the attention of both French and international psychiatrists to the difficulties that arise when seeking to ‘cure’ a native properly, that is to say, when seeking to make him thoroughly a part of a social background of the colonial type. (For example: when a Nkosi is transformed into a Johnson. <*Our addition*.>)

“ Because it is a systematic negation of the other person and a furious determination to deny the other person all attributes of humanity, colonialism forces the people it dominates to ask themselves the question constantly: ‘In reality, who am I?’ ”

But we have asked the questions that we have, of scientists, of the intelligentsia of the world. Since we have done this, because we could not do otherwise, Marcuse may be proved to have been correct, that:

“ Historical backwardness may again become the historical chance of turning the wheel of progress to another direction.”

But for this to happen will require of us, and the scientists, the courage to face up to the omnipotent apparatus, conscious of its power and capacity to punish non-conformity. The question is – do we have a choice!

In spite of our friends, the friends of Africa, we must stand up to say that we have had enough of the insults that demean Africans, whatever their nationality. The time has come that we gather the courage and the intellect to say that we too are human, as human as any other human being.

We are neither freaks, nor do we behave like freaks.

We have never been barbarians and are not now.

We are poor.

We live in conditions of under-development.

We are concentrated within the tropics and suffer from and enjoy the physical conditions that nature has imposed on this part of the globe.

None of this makes us sub-human.

Nor should the impact of disease, including AIDS, that afflicts us, be used in the name of questionable science and friendship with us, to reduce us to a peculiar species of humanity likely to slip back into a state of savagery.

Like the “Africans and Europeans” that Dr Konotey-Ahulu of Ghana met when he spent six weeks touring sub-Saharan Africa, we must pose the question:

“ Why do the world’s media appear to have conspired with some scientists to become so gratuitously extravagant with the untruth?”

The posing of that question begins the process of the humanisation of the African.

Even if we have been deceived before, we must know that the asking of this question, to which the omnipotent apparatus will object most strenuously, means that we *shall* overcome the centuries of racism that continue to define a subservient place for us in the world.

We must also know that we have succeeded to produce geese among us that have been fattened by those who hold us in contempt.

Writing of his own country, the African-Brazilian, Abdias do Nascimento, says:

“ Black people require a scientific knowledge that allows them to formulate theoretically – in systematic and consistent form – their experience of almost five centuries of oppression, resistance, and creative struggle. There will be inevitable errors, perhaps, in our search for systematisation of our social values, in our efforts towards self-definition and self-determination of ourselves and our future paths.

“For centuries we have carried the burden of the crimes and falsities of ‘scientific’ Eurocentrism, its dogmas imposed upon our being as the brands of a definitive, ‘universal’ truth. Now we return to the obstinate ‘white’ segment of Brazilian society its lies, its ideology of European supremacy, the brainwashing with which it intended to rob us of our humanity, our national identity, our dignity, our liberty. By proclaiming the demise of Eurocentric mental colonisation, we celebrate the advent of *quilombist* liberation.” (Our emphasis).

We must also remember what the demographer told Rian Malan about South African and African HIV/AIDS statistics:

“ I don’t have much faith. It’s essentially a modelling exercise, and the exercise has always seemed to have a political dimension.”

Why did we ever succumb to the introjected heteronomy, and presumed that there was no political dimension - only science, the truth, friendship and light!

It may be that Frantz Fanon provided some of the answers to this question about our 'introjected heteronomy' when he wrote '*On National Culture*' that:

“ When we consider the efforts made to carry out the cultural estrangement so characteristic of the colonial epoch, we realise that nothing has been left to chance and that **the total result looked for by colonial domination was indeed to convince the natives that colonialism came to lighten their darkness.** The effect consciously sought by colonialism was to drive in the natives' heads the idea that if the settlers were to leave, they would at once fall back into barbarism, degradation, and bestiality. (Our emphasis).

“ On the unconscious plane, **colonialism therefore did not seek to be considered by the native as a gentle, loving mother who protects her child from a hostile environment,** but rather as a mother who unceasingly restrains her fundamentally perverse offspring from managing to commit suicide and from giving free rein to its evil instincts. The colonial mother protects her child from itself, from its ego, and from its psychology, its biology, and its own unhappiness which is its very essence.” (Our emphasis).

Thus, this (African) child which, according to the colonialist paradigm has no natural parents, becomes an object such policy as would be determined by its imposed, but real, surrogate, colonial, mother.

This mother and her society intervene to decide what is good for the child, regardless of what the child thinks. They do this to protect the child from what it thinks and feels. And so the child is exposed to all the violence that the mother will visit on the child to assert her authority and to restrain it from the folly of its thoughts and actions.

Between it and its mother, a struggle is joined, centred on the question of power, money and pure survival.

Between it and its mother there is a titanic contest centred on the conviction of the mother that her offspring is diseased with HIV/AIDS and that it infects itself with a destructive virus because of its depravity.

The mother demands that, to save itself, the child must abide by a religious dogma she has elaborated, given her power as a goddess, of chastity, condoms and drugs.

The child fights to tell the truth about its experience and reality. But it cannot defeat the concentration of financial, media, political and institutional forces that are determined to ensure that the colonial mother protects her child from itself, from its ego, and from its psychology, its biology, and its own unhappiness which is its very essence.

Unable to feed itself, the child must either accept the material and intellectual food from its mother, or perish.

At the same time, the child cannot escape from the hostile environment created by the same mother who, in the natural world, is supposed to protect her child from such an environment.

In this situation, it is clear that as Africans, we must learn well the instructions of **Sun Tzu**, the Chinese strategist, who lived more than two millennia ago. For its part, the omnipotent apparatus understands what he said, thoroughly. He said:

“ When the enemy approaches carelessly and without a plan, when his flags and banners are confused and disorderly, when both men and horses often look to the rear, one can attack an enemy force ten times his own and surely rout it.

“ When the forces of the feudal lords have not yet assembled, when sovereigns and ministers are not in accord, when moats and ramparts are not yet completed, when prohibitions and commands are not yet published, when the entire host is in an uproar, when they wish to advance and cannot, or to retire and do not dare, then one may attack an enemy twice his size, and in one hundred battles there will be no calamity.”

(Sun Tzu: The Art of War: tr. Samuel B. Griffith, Oxford University Press, 1963.)

Perhaps, as we have fought for our humanisation and humanity as Africans, our flags and banners have been confused and disorderly.

The sovereigns and the ministers have not been in accord. Our defensive moats and ramparts have not been in place. We have wished to advance and could not. We have sought to retire but dared not. Because of all this, those who have opposed us, the omnipotent apparatus, have fought us in a hundred battles without experiencing any calamity.

Even when we have won strategic battles, despite the omnipotent apparatus, we have not recognised our historic victories.

Now, at last, we must understand in its fullest meaning that the struggle to win our right, as Africans, to be accepted by all, as human beings, is one of the most difficult struggles we will ever be called upon to wage. It calls for determination and perseverance. It demands new sacrifices. It will produce its own martyrs.

Now must we recognise that, even among the Africans, we have seen that the best lack all conviction, while the worst are full of passionate intensity. In spite of everything we are and what we have done, some among us are capable of being bought.

We must identify the cats and the geese in our midst. We must say that we have seen how easy it is even for those, including Africans, who walk our streets as respectable citizens, to be gratuitously extravagant with the untruth about us.

Having read Sun Tzu, we must, at last, say – no more shall we approach carelessly and without a plan. The ceremony of African innocence is drowned!

We will fight for and defend the reality that we are African and human. Young Castro Hlongwane must never again be expelled from the Caravan Park. No longer must Africans be outcasts from the caravan park and the global village.

No longer will the Africans accept as the unalterable truth that they are a dependent people that emanates from and inhabits a continent

shrouded in a terrible darkness of destructive superstition, driven and sustained by ignorance, hunger and underdevelopment, and that is victim to a self-inflicted “disease” called HIV/AIDS.

For centuries we have carried the burden of the crimes and falsities of ‘scientific’ Eurocentrism, its dogmas imposed upon our being as the brands of a definitive, ‘universal’ truth.

Against this, we have, in struggle, made the statement to which we will remain loyal – that we are human and African!

Because we are human, we shall no longer permit of control by a colonial mother who claims for herself the right unceasingly to restrain us from reclaiming our dignity.

We shall overcome!

March, 2002.