The AIDS Debate
The Most Controversial Story You've Never Heard

By Liam Scheff

Part 1

Prologue

In 1984, Robert Gallo, a government cancer-virologist, called an international press conference to announce that he'd found the probable cause of AIDS. He claimed that a retrovirus called HIV was destroying the immune systems of young gay men and IV drug abusers, leaving them open to a variety of both viral diseases and cancer.

According to the Centers for Disease Control and Prevention, AIDS is not a single disease, but rather a category of 29 unrelated, previously-known conditions including herpes, yeast infections, salmonella, diarrhea, fever, flus, TB, pelvic cancer in women, pneumonia and bacterial infections. The CDC also designates HIV- positive people who aren't sick, but have a T-cell count below 200, as AIDS patients (T-cells are a subset of white blood cells). The only thing that separates an AIDS diagnosis from any of these conditions is a positive HIV test, which itself is based on Robert Gallo's research.

Gallo's HIV theory, however, was not the only AIDS theory, and according to a growing number of concerned scientists, researchers and activists, it wasn't the best. For 70 years before Gallo, retroviruses were known to be a non-toxic part of the cell; moreover, no single virus could simultaneously cause a viral disease like pneumonia, in which cells are destroyed, and a cancer like Kaposi's Sarcoma, in which cells multiply rapidly.

These scientists argue that Gallo's unified HIV/AIDS theory is flawed and that treating 29 unrelated diseases with extremely toxic AIDS drugs like AZT and protease inhibitors is at best irresponsible and at worse medical genocide.

They may have a point. Ninety-four percent of all AIDS-related deaths in the US occurred after the introduction of AZT, according to CDC statistics through the year 2000. And according to the University of Pittsburgh, the No. 1 cause of death in US AIDS patients today is liver failure, a side-effect of the new protease inhibitors.

The questions arise: Did Gallo truly solve the AIDS riddle, and are we treating AIDS humanely and effectively?

To answer these questions, I spoke with three prominent AIDS researchers.

Dr. Peter Duesberg is a chemist and retroviral expert. Duesberg discovered the Oncogene (cancer gene) and isolated the retroviral genome (of which HIV is one) in 1970. He is professor of molecular biology at UC Berkeley.

Dr. David Rasnick is a protease specialist and has been in AIDS research for 20 years. He and Duesberg work in collaboration on cancer and AIDS research. Both Rasnick and Duesberg were advisors on President Mbeki's South African AIDS panel.

Dr. Rodney Richards is a chemist who worked with Amgen and Abbot labs, designing the first HIV tests from Robert Gallo's HIV cell line.

The interviews were conducted separately and integrated into a dialogue. Individual points-of-view belong to individual speakers.

How did you get involved with AIDS research?

Rasnick: I'm a chemist and protease enzyme researcher. I design and synthesize inhibitors to stop tissue-destroying viruses and cancers. When Robert Gallo announced HIV caused AIDS, I wanted to work on inhibitors that would stop it.

In '85 I was at a research meeting where HIV was being discussed. An AIDS specialist was asked how much HIV was present in an infected AIDS patient. He was asked, "What's the titer of HIV?"

What's a Titer?

Rasnick: The titer is the number of infectious virus particles in a blood or tissue sample. A titer of live virus is easily obtainable from the particular tissue that the virus infects. A sample from this infected tissue contains millions of infectious virus particles. If you have herpes, the sample comes from a cold sore; if it's polio, it's from the intestine; if it's smallpox, from a pustule; if it's a cold, from the throat.

When you're infected with a virus, it infects and kills about 30 percent of the specific tissue that it targets before you get any symptoms. You can take a titer of any infected area, put it under a microscope and see millions of living viruses.

So, the virologist was asked, "What's the titer?"

He answered, "Undetectable. Zero."

I thought, how is that possible? How can you be made sick from something that isn't there? With polio, researchers threw away a hundred viruses before they found the right one. I assumed Gallo had simply gotten the wrong virus, and we'd have to start over.

By 1987, there were 30,000 cumulative AIDS cases. Numbers were not growing as predicted; and AIDS hadn't left its original risk groups. Six years after the first AIDS cases, 95 percent of infections still occurred exclusively in men - 2/3 gay men, and 1/3 IV drug users. Additionally, each AIDS risk group suffered from specific diseases.

Viruses don't cause different diseases based on gender, sexual preference or lifestyle. Viruses have unique but limited genetic structures, which manifest in a limited but identical set of symptoms in all patients. The herpes virus makes herpes lesions, but never a sore throat. The chicken pox virus always produces skin sores, but never paralysis.

Viral epidemics spread exponentially in the first months and years, killing everyone who can't survive long enough to develop immunity to it. HIV wasn't growing; it remained in its original risk groups, and it caused different diseases in each. It clearly wasn't acting like a contagious virus.

In 1988, I came across an article written by Peter Duesberg in the science journal *Cancer Research*. The article was on retroviruses in general, and HIV in particular. Duesberg was the world's preeminent retrovirologist. He'd studied and mapped the retroviral genome in the '70s. Duesberg's knowledge of retroviruses was unparalleled. In the article, he laid out, point for point, what retroviruses are, and what they can and can't do.

HIV is a retrovirus; what are retroviruses?

Rasnick: Retroviruses are a subset of viruses that are not toxic to cells. They were discovered in the early 20th century. They're one of the first identified cellular particles. There are about 3,000 catalogued retroviruses. They exist in every animal: dogs, cats, whales, birds, rats, hamsters and humans. Retrovirologists estimate that one to two percent of our own DNA is retrovirus.

Retroviruses are RNA strands that copy themselves into our DNA using an enzyme called Reverse Transcriptase. Retroviruses are passed down matrilineally - from mother to child. They're not sexually transmissible. Lab animals do not exchange retroviruses with each other, no matter how much they mate. But babies always have the same retroviruses as their mothers.

Current research strongly indicates that they're simply a naturally occurring part of us. In 50 years of modern lab research, no retrovirus has ever been shown to kill cells or cause disease, except under very special laboratory conditions.

Peter Duesberg: In 1987 I was invited by *Cancer Research* to discuss whether retroviruses, including HIV, could cause disease or immune deficiency. I was invited because of my experience with retroviruses.

In 1970, I was working in UC Berkeley's virus lab. The big program in virology at the time, which we were part of, was to find a virus that caused cancer. There was also a large government cancer-virus program at the National Institutes of Health. Robert Gallo was one of the scientists working on that project.

We began looking at retroviruses because of their unique qualities. Typical viruses kill cells. Their strategy is to enter the cell, kill it and move on to the next one. However, with cancer, cells aren't killed; in fact, they multiply very rapidly. Therefore a virus couldn't cause cancer. Retroviruses, however, don't kill cells. This quality made them an outstanding candidate for a cancer virus.

In 1970, I made a discovery that got a lot of attention. I isolated a retroviral gene from a cancer cell, and infected other cells with this gene. The cancer virologists were very excited. They thought this might be the thing they'd been looking for - a retrovirus that could infect other cells and cause cancer. I was suddenly famous. There were job offers; I was given tenure at Berkeley and admission into the Academy of Science.

Of course, if a virus, or a unique retrovirus, caused cancer in the real world, then cancer would be contagious. But nobody "catches" cancer. A "case of cancer" doesn't go around the office. However, such fundamental thoughts were not on the minds of the virus hunters. Scientists like impressive-sounding proofs, regardless of what we know is true in the real world. The retroviral cancer-gene was just a lab artifact. It didn't exist in humans or animals in nature. We created it in the lab, and that's where it stayed. It was purely academic.

As part of the cancer-gene experiment, my associates and I mapped the retroviral genome. We made the maps that today are used as the blueprints for all retroviruses, including HIV.

What do retroviruses do?

Duesberg: In terms of disease, they do nothing. They're transcribed into the DNA in a few cells, and they hang around there for the rest of your life as part of your genome. Nevertheless, cancer-virus hunters continued to look for a cancer-gene using the technology we created and the retroviral maps we made.

Rasnick: In the mid-'70s, Robert Gallo claimed he'd found a cancer-retrovirus in the cells of a leukemia patient. He called it HL23V. He found it the same way he would later find HIV - not by finding the retrovirus in the blood - but by looking for antibody and enzyme activity that he claimed stood in for the actual retrovirus.

By 1980, his claim was refuted by both the Sloan-Kettering Cancer Research Center and the National Cancer Institute. Gallo's supposed HL23V antibodies weren't the result of a cancer-virus, but rather the result of "exposure to many natural substances" which create antibodies in humans. Today nobody, not even Gallo, claims HL23V ever existed.

In 1980, he tried again. Gallo claimed to have a new cancer retrovirus called HTLV-1, which caused a kind of leukemia in which T-cells multiplied into fluid tumors. T-cells are one of many subsets of white blood cells. Once again, the proof was less than convincing. Less than one percent of people who tested positive for HTLV-1 ever developed leukemia. It was a less-than-successful validation for his theory.

How did Gallo move from cancer to AIDS research?

Rasnick: In the early '80s, gay men were showing up in emergency rooms with a variety of simultaneous illnesses and infections. At the time, medical journals speculated that the diseases were drug-related. Gay men had been abusing toxic, immune suppressing and even carcinogenic drugs like poppers, cocaine and amphetamines on a daily basis for the better part of the '70s.

In 1983, Luc Montagnier, a French scientist at the Pasteur Institute, claimed to have found a new retrovirus in AIDS patients. But nobody paid attention, because he hadn't isolated a virus, and he hadn't found a single viral particle in the blood - remember the titer was zero, undetectable. Seeking some academic support, Montagnier sent a cell sample to Robert Gallo at the NIH. Gallo took the cell-line Montagnier sent him and modified it slightly. Then he did something strange. He stole it.

In 1984 Gallo called an international press conference and together with Margaret Heckler, the head of the Department of Health and Human Services, announced that he'd discovered the "probable cause" of AIDS. It was a new retrovirus called HTLV-III, (later re-named HIV). Later that same day, he patented the modified cell-line he'd originally gotten from Montagnier. He hadn't published a single word of his research. Robert Gallo, a government-backed scientist, simply announced that a retroviral-epidemic was on its way.

He sold the cell-line to Abbot Labs, a pharmaceutical company that makes HIV tests. The French government demanded that all patent rights be returned to Montagnier. Gallo refused, claiming it was all his work. In 1987, Gallo and Montagnier were forced by President Reagan and French Prime Minister Chirac to meet in a hotel room to work out the HIV patent rights. In 1992, Gallo was officially convicted of theft by a federal scientific ethics committee.

Rodney Richards: At first Gallo claimed he invented the whole process. Now he claims his sample might have been "contaminated" by Montagnier's.

Duesberg: The NIH itself ran a two-year investigation of Gallo's HIV claim, and they couldn't come up with any convincing evidence that he came up with it on his own.

What did Abbot labs do with Gallo's cell line?

Rasnick: Abbot labs makes HIV-antibody tests out of it. Abbot's made billions selling HIV tests, and Gallo's made millions from his patent.

So when we're given an HIV-antibody test, we're tested based on what Gallo and Montagnier claim to have found. How did Luc Montagnier find HIV?

Richards: First he looked in his patients' blood, but he couldn't find it there. In fact, no one has ever found HIV in human blood.

Right, the titer was zero - so where did he look?

Richards: Montagnier took tissue from the swollen lymph node of a gay man who was a suspected AIDS patient. In an infected person, the lymph tissue will presumably be littered with infected cells.

Montagnier attempted to perform a cell culture with that tissue. This is the lab technique used to isolate viruses like herpes and mononucleosis. In a cell culture, infected cells are mixed with uninfected cells in a petri dish. Separated from the body's immune system, viruses that are being suppressed can surface. The virus travels from the infected cell to the uninfected cell through the liquid in the dish. The scientist collects this liquid, concentrates it, and spins it through a sucrose density gradient to isolate the virus.

A sucrose density gradient is a tube of layered sugar solution of specific densities. The layers become thicker from top to bottom. The cell liquid is gently placed on top of the sugar solution. This is spun in a centrifuge for many hours to force the viral particles to descend through the density layers. Cellular particles, including retroviruses, have known densities. The known density corresponds to a layer in the test tube. The descending particles stop when they find a density equal to their own. This layer is photographed with an electron microscope. In cultures from virally-infected patients, the photo plate is filled with millions of identical viral particles.

Finally, a new cell culture is performed with the isolated viral particles to see if they are indeed infectious. Once again, the cell fluid is separated, spun and photographed to verify that the same virus appears. This is what's known as viral isolation.

Is this what Montagnier did?

Richards: He tried to, but it didn't work. Montagnier took lymph tissue from a suspected AIDS patient, mixed it with cells from a healthy blood donor and performed a cell culture. He removed the liquid and spun it in a centrifuge, but he found no virus. But that didn't stop him. Montagnier repeated the experiment but added a crucial new step.

He took the suspected AIDS tissue and mixed it with a variety of cells in a culture, including cells from an umbilical cord. Then he added powerful chemicals called Mitogens that artificially force cells to replicate. He found, after 2 or 3 weeks, evidence of an enzyme called reverse transcriptase, a sign of possible retroviral activity.

But he hadn't found any virus?

Richards: No. He found an enzyme that retroviruses use. But reverse transcriptase is found in many other microbes, cellular components and processes, including umbilical cells, and forced replication. Montagnier then separated the mitogenically stimulated fluid from the culture and poured it into another dish of healthy cells and again found reverse transcriptase activity.

He put this through a sucrose density gradient and found reverse transcriptase activity at the density layer where retroviruses were known to purify. What he did not find was a virus. When he looked through the electron microscope at that same density gradient, he found nothing - but he didn't acknowledge that until years later.

That's what's known as isolation of HIV.

How does this prove that an infectious virus was making people sick?

Richards: It doesn't. This is insufficient evidence to prove that HIV, or any infectious virus exists, let alone that it causes disease.

How did Gallo use Montagnier's cells to prove HIV existed and caused AIDS?

Richards: Gallo cultured the cells, but didn't find enough reverse transcriptase activity to convince him that Montagnier had found a retrovirus. So Gallo added another step. He mixed cells from 10 AIDS patients together; then he added those to leukemia T-cells from his HTLV-1 retrovirus experiment. At that point, Gallo found enough reverse transcriptase activity to convince him that there was indeed a retrovirus. That's how he claims to have found HIV.

But Gallo had already found reverse transcriptase activity in the leukemia cells. How did he prove that there was a new retrovirus - HIV?

Richards: Many scientists don't believe that he did prove it.

You said Gallo used a T-cell line to grow HIV. Isn't HIV supposed to kill T-cells?

Richards: That's what Gallo initially claimed, but Abbot labs grows its HIV in human T-cells. It's even called an immortal cell line, because the leukemia cells don't die. To date, no researcher has demonstrated how HIV kills T-cells. It's just a theory that keeps money flowing into the pharmaceutical approach to treating AIDS.

Rasnick: Gallo patented the leukemia T-cell mixture the very same day he announced he'd found the "probable cause" of AIDS.

What do HIV tests do?

Rasnick: They look for antibodies in your blood to proteins that are taken out of this mixture. Your body produces antibodies as a response to all foreign material - germs, yeasts, viruses, even the food you eat. Viruses are DNA or RNA strands wrapped in protein building blocks. Antibodies grab onto these proteins, immobilizing and destroying the virus. When these antibodies encounter different viral proteins in the future, they'll very often grab onto them, too. This is called cross-reactivity.

Duesberg: Viruses are only dangerous the first time you encounter them. Once you've made antibodies to a virus, you have immunity for the rest of your life, and the virus can't get you sick anymore. This is the opposite of HIV theory, which states: You become infected; you don't get sick; you make antibodies; and 10 years later, you get sick and die.

Rasnick: There are two common HIV antibody tests. One is the Elisa, in which a bunch of proteins from the T-cell mixture are stuck in a series of little plastic wells on a test plate. The other is called Western Blot. In this test, the proteins are separated onto individual paper strips. Your blood is added, and if antibodies from your blood stick to proteins from this mixture, you're said to be HIV positive.

They're assuming the proteins are from HIV; but they never isolated HIV, so how can they say these tests can diagnose HIV-infection?

Rasnick: They can't, and they don't. None of the proteins in the Elisa and Western Blot tests have been proven to be specific to HIV or any retrovirus. For this reason the FDA has not approved a single test for diagnosing HIV-infection.

Richards: There are at least 30 tests marketed to test for HIV. None of them are approved by the FDA to diagnose the presence or absence of HIV. Not the Elisa, not viral load, not Western Blot, not the P24 antigen test. The FDA and manufacturers clearly state that the significance of testing positive on the Elisa and Western Blot test is unknown.

AIDS researchers admit that the tests contain at least 80 percent non-specific cellular material - they're, at best, 20 percent effective. But in my scientific opinion, they contain no HIV at all. The medical literature lists at least 60 different conditions that can register positive on the HIV-test. These conditions include candidas, arthritis, parasites, malaria, liver conditions, alcoholism, drug abuse, flu, herpes, syphilis, other STDs and pregnancy.

Rasnick: It's very simple to see how you can get false positives. Antibodies cross-react. The more viruses and germs you're exposed to, the more antibodies you'll produce, the greater risk you'll test positive on a non-specific antibody test. If you live in a country without clean water or sanitary living conditions, you're going to have constant microbial and parasitic infections that produce antibodies.

You carry antibodies to all the colds, flus, viruses and vaccinations you've ever had. If you're pregnant, you're producing antibodies that will react with Abbot's Elisa test. Pregnancy is a known cause of false positives on the HIV test.

Different races have different ranges of naturally-occurring antibodies. That's why blacks have a nine times greater chance of testing positive than white Europeans, and a 33 times greater chance than Asians. It doesn't have anything to do with infection or health. In one study, a tribe of South American Indians was given Elisa tests. Thirteen percent of them tested HIV-positive, but nobody was sick. They just had antibodies that reacted with the test.

If the tests aren't specific, and we can't find HIV in the blood, then what is AIDS?

Richards: According to the CDC, AIDS works like a formula: If you have an AIDS-indicator disease like salmonella, tuberculoses, pneumonia, herpes, or a yeast infection, and you test HIV-positive, then you're said to have AIDS, and you're treated with toxic AIDS drugs. If you test negative or don't know your HIV status, you're spared the toxic drugs and simply treated for the disease you have.

In 1993 the CDC expanded their definition of AIDS to include people who are not sick at all but who test positive and have a one-time T-cell count under 200. Based on this new criteria, by 1997, about 2/3 of all AIDS cases were perfectly healthy people. As it happens, '97 was the last year the CDC told us how many people were healthy and how many were sick. Now they just count everyone who's HIV-positive as an AIDS patient, whether they're sick or not.

Let me clarify this. When people die of AIDS, they actually die of a known disease. But if their blood reacts with an HIV-antibody test, they're no longer said to have the disease, they're said to have AIDS?

Rasnick: That's how it works. And the sick people who test HIV-positive are put on the most toxic drugs ever manufactured and sold.

What about AIDS in Africa?

Rasnick: It's the same story, even worse. Fifty percent of Africans have no sewage systems. Their drinking water mixes with animal and human waste. They have constant TB and malaria infections, the symptoms of which are diarrhea and weight loss, the very same criteria UNAIDS and the World Health Organization use to diagnose AIDS in Africa.

These people need clean drinking water and treated mosquito nets [mosquitoes carry malaria], not condoms and lectures and deadly pharmaceuticals forced on pregnant mothers.

We've put 20 years and $118 billion into HIV. We've got no cure, no vaccine and no progress. Instead we have thousands of people made sick and even killed by toxic AIDS drugs. But we can't just treat them for the diseases we know they have because if we do, we're called "AIDS denialists." Treating them for the diseases they actually have would be more humane and effective than forcing toxic drugs down their throats, and it would also save billions of tax dollars. AIDS is a multi-billion dollar industry. There are 100,000 professional AIDS researchers in this country. It's as hard to challenge as big tobacco at this point.

What does Luc Montagnier say about this?

Rasnick: In 1990 at the San Francisco AIDS conference, Montagnier announced that HIV did not, after all, kill T-cells and could not be the cause of AIDS. Within hours of making this announcement, he was attacked by the very industry he'd helped to create. Montagnier's not a liar. He's a so-so scientist who's in over his head.

Afterword:

In a 1997 interview, Luc Montagnier spoke about his isolation of HIV. He said, "We did not purify [isolate] ... We saw some particles but they did not have the morphology [shape] typical of retroviruses ... They were very different ... What we did not have, as I have always recognized it, is that it was truly the cause of AIDS."

Robert Gallo hasn't made such large concessions. He has, however, amended his AIDS death sentence. He now believes that it's possible to live with HIV "for 30 years until you die of old age," as long as you live a healthy lifestyle and avoid immune-compromising substances.

In 1994 Gallo quietly announced that the major AIDS defining illness in gay men - Kaposi's Sarcoma, could not be explained by HIV but that nitrite poppers, a drug that had been extremely popular in the gay community, "could be the primary cause." Somehow, this didn't make headlines.

Gallo also said that Peter Duesberg's research into a drug-based AIDS model should be funded. Duesberg's funding has all but evaporated since he publicly challenged the HIV/AIDS model.

Dr. Duesberg and Rasnick's articles can be found at: www.duesberg.com and www.virusmyth.net.

Next week: Who were the first AIDS patients; who's getting sick now; and what do AIDS drugs really do?

Part 2

Prologue

In 1984, Robert Gallo announced that a retrovirus called HIV was the "probable cause" of AIDS.

In Part 1 of "The AIDS Debate," AIDS researchers gave startling evidence that retroviruses are, in fact, not toxic to cells, and are too biochemically inactive to cause any disease, let alone the 29 different diseases the Centers for Disease Control (CDC) classifies as AIDS. These researchers claim AIDS was correctly diagnosed in the early '80s as a lifestyle disease typified by immune damage caused by massive drug use and malnutrition.

Ten years after his announcement, at a 1994 National Institute on Drug Abuse (NIDA) meeting, Robert Gallo quietly admitted that the first defining AIDS disease in gay men, Kaposi's Sarcoma, could not be explained by HIV, but that nitrite drugs called "poppers" could be the primary cause. Poppers were a popular, legal drug heavily marketed in the gay community in the 1970s.

Gay men were indeed using poppers and other cell-damaging, mutagenic drugs in huge quantities in the 1970s, immediately prefiguring the first outbreak of AIDS diseases. But the specter of AIDS didn't stop recreational drug use. Many gay men in the party scene continue to abuse the same drugs, including nitrite poppers.

Now they're adding toxic AIDS pharmaceuticals to this already deadly cocktail, and it's costing them their lives. A national study conducted by Dr. Amy Justice, an AIDS researcher at the University of Pittsburgh, revealed that liver failure is now the leading cause of death in HIV-positive individuals taking AIDS drugs. While liver failure has never been an AIDS disease, it is the primary, well-known side-effect of the new AIDS pharmaceuticals.

At the 1994 NIDA meeting, Dr. Gallo said that Dr. Peter Duesberg's drug-based AIDS theory should be funded and investigated. Taking Gallo's advice, I spoke with Duesberg and two other health advocates about the first AIDS patients, drug abuse and the new prescription drugs that are killing AIDS patients today.

Peter Duesberg is a professor of molecular biology at UC Berkeley. He is an expert in the field of HIV science and retrovirology.

John Lauritsen is a journalist and gay historian who's investigated and written about AIDS for over 20 years. In 1992, he uncovered documents through the Freedom of Information Act, which revealed that the toxic AIDS drug, Azidothymidine (AZT), was approved based on fraudulent medical trials. His books include *The AIDS War* and *The Early Homosexual Rights Movement - 1864 to 1935.*

Darren Main is an author, holistic health practitioner and AIDS educator. According the CDC's 1993 redefinition, Main has AIDS, though he is not sick.

Interviews were conducted separately and integrated into a dialogue. Individual points-of-view belong only to the speaker.

The gay rights movement emerged as a powerful force in the early '70s after decades of repression and abuse of gay men and women. What was the gay scene like in the '70s?

John Lauritsen: There was a marvelous sense of freedom for gay men in the early '70s. The gay liberation movement after Stonewall [a major turning point in the gay rights movement] allowed men who'd been held back by cultural taboos to come out in the growing gay centers. These were strong, healthy, young men who suddenly had this tremendous freedom offered to them. Using a lot of drugs and having a lot of sex was part of that freedom.

I lived in New York from '63 to '95; I was there, right in the heart of it. I lived around the corner from an extremely popular gay club called The Saint. On some nights, a couple thousand men would show up. The main activity was consuming drugs of every sort: ecstasy, poppers, marijuana, quaaludes, MDA, crystal meth, LSD, cocaine and designer drugs. Some drugs only showed up once, like the one they made specially for the club's opening night.

At clubs like The Saint, there was a drug schedule. Someone would say, "Now it's time for ecstasy, now it's time for crystal, now it's time for Special K," and hundreds to a couple thousand guys would all do drugs at the same time. This went on all evening. They mixed this with alcohol through the course of the long, long night. A drug called "poppers" was used constantly, because it was cheap and legal.

What are poppers?

Lauritsen: Poppers are nitrite inhalants. The nitrites (amyl-, butyl- and isobutyl-) have a number of effects that made them attractive to young gay men. If used during sex, they prolong and enhance orgasm. Some men became incapable of having sex or even masturbating without them. Poppers were used to facilitate anal sex, because they deaden pain and relax the muscles in the rectum.

How were poppers used?

Lauritsen: They were used ubiquitously. They came in little vials that you'd pop open and snort. Some gay men used poppers first thing in the morning, on the dance floor and every time they had sex. At gay discothÃ¨ques, men shuffled around in a daze, holding their poppers bottles under their nose. The acrid odor of poppers was synonymous with gay gathering places.

How do nitrite poppers affect health?

Lauritsen: Poppers are an extraordinarily toxic drug. They cause brain damage from strokes, severe skin burns and heart failure. They suppress the immune system and damage the lungs. They've caused death from a single use. They're such an effective poison that they've been used to commit suicide and murder.

The nitrites are strongly mutagenic, which means they cause cellular change and genetic mutation. Nitrites produce deadly toxins when mixed with commonly used chemicals like antihistamines, artificial sweeteners and painkillers. Virtually all antibiotics are converted into potent carcinogens by nitrites.

Why were poppers legal?

Lauritsen: Poppers were originally manufactured by the Burroughs-Wellcome Corp. as a remedy for emergency heart pain, but they were replaced by nitroglycerine. In the '60s, only a few gay men used poppers as a recreational drug.

Poppers found new life during the Vietnam War, sold on the black market to soldiers overseas. When the soldiers came home, they kept up the habit. Reports of blackouts, headaches, blood abnormalities and terrible skin burns forced a reclassification of the drug.

In the '70s and '80s, the FDA permitted poppers to be legally sold under the ridiculous pretext that they were "room odorizers" - at the same time that the new gay sex industry blatantly marketed them to gay men as aphrodisiacs, under such names as "Rush," "Hard Ware" and "Ram."

Poppers were cheap, as little as $2.99 per bottle, and they were extremely popular. Every single gay publication at the time was filled with full-page, color ads for the drug. In the '70s, poppers were a $50 million per year business. Gay magazines like *The Advocate* relied heavily on ad revenue from poppers; some magazines owed their very existence to the drug. They were so popular that there was even a "Poppers" comic strip named after them.

By the end of the '70s, some of the healthy young men weren't looking so young and healthy. They were worn out. Their faces were gray. They looked prematurely old. I remember going to a party in the late '70s and being shocked to see how many men were gravely ill.

In 1983, I began to work with Hank Wilson, a Bay Area gay rights activist, on researching and writing about poppers. We started writing about the dangerous medical effects of the drug and were savagely attacked for doing so. The gay press called us "homophobes" and "gay traitors" because we criticized a chemical.

In the early '80s, medical reports on AIDS considered it a lifestyle disease. The fast-lane lifestyle of gay men was defined by incessant sex and drug use. These men had constant STD infections - concurrent cases of syphilis, gonorrhea, chlamydia, VD, bowel and parasitic infections - which they treated with increasingly strong rounds of antibiotics whenever they thought they'd caught something. Some doctors gave their gay patients open prescriptions for antibiotics and even advised them to swallow a few capsules before going to the baths. One bathhouse in New York sold black market antibiotics on the second floor, along with all kinds of street drugs.

One of the primary AIDS diseases was Kaposi's Sarcoma, which is an overgrowth of the blood vessels that manifests as dark purple patches on the skin and face. Doctors speculated that nitrite poppers, a known mutagen, were the cause of Kaposi's Sarcoma (KS). Scientists wrote *The Advocate* with strong warnings about the dangers of poppers, but their letters were rejected or ignored.

The gay community's reaction to the idea that chronic drug use had anything to do with illness was overt denial. In 1983, *The Advocate* actually ran a series of ads defending poppers. The series, called "A Blueprint for Health," falsely claimed that government studies showed poppers were harmless and should be considered a healthy part of gay life. This was for a drug that said, "flammable, fatal if swallowed" on the label.

Peter Duesberg: AIDS was correctly diagnosed by the CDC from '81 to '84. They identified it as a probable lifestyle disease caused by excessive drug use and malnutrition. The *New England Journal of Medicine* published four articles on the drug lifestyle of what was then called GRID (Gay-Related Immune Deficiency) patients. This syndrome was typified by opportunistic infections, pneumonia and KS.

The one factor that all these people had in common was very high use of recreational drugs: amphetamines, nitrite inhalants, cocaine and heroin. The theory was simple. These men had spent a decade destroying their immune systems and were now susceptible to all sorts of infectious disease. This theory was compatible with the non-random distribution of illness.

Until '84, this was the only credible hypothesis. But when the government supported HIV theory, the lifestyle theory was abandoned, because all the money went into retroviral research. That's how science works; if it's not funded, it doesn't exist.

Lauritsen: The media immediately supported Gallo's unproven hypothesis, and public health services followed suit. For 20 years, virtually all government funding has poured into Gallo's HIV-equals-AIDS theory, with nothing to show for it, while the drug and malnutrition models have been ignored.

In 1994, Robert Gallo quietly admitted that KS could not be caused by HIV. But this was never reported in the mainstream press. Gallo told the audience of scientists and activists at the '94 NIDA meeting that HIV couldn't cause KS and that he'd never even found it in T-cells, which HIV is supposed to kill. He said, "I don't know if I made this point clear, but I think that everybody here knows - we never found HIV DNA in the tumor cells of KS. And, in fact, we've never found HIV DNA in T-cells. So in other words, we've never seen the role of HIV as transforming [cancer-causing] in any way."

This was in complete opposition to everything Gallo had ever said about HIV or AIDS. But very few people paid attention to his retraction. The CDC ignored it, and continues to tell people KS is an AIDS disease.

When Gallo was asked what, if not HIV, caused KS, he said, "The nitrites [poppers] could be the primary factory" because "Mutagenesis" is the "most important thing." It's a very embarrassing situation for the AIDS establishment, and they've kept it quiet. One of the two hallmark diseases of AIDS is now clearly understood to be totally unrelated to AIDS or HIV.

Take any AIDS diagnosis - there are good reasons why that person became sick the way they did. Take a heroin addict who develops pneumonia or a severe lung infection. This is what science has always expected as a consequence of taking opiates in excess, because opiates damage the lungs and reduce immunity.

If a gay man takes nitrite inhalants and develops KS, the best explanation is that he's been affected by nitrite inhalants, not an infectious agent. Nitrites are mutagenic drugs that directly affect blood vessels. It's telling that gay men who developed KS got it around the lips, nose and mouth - the same place he'd inhaled the toxic drug.

Duesberg: The defining symptoms of AIDS are chronic diarrhea, dementia, weight loss and increased incidence of viral and bacterial infection. These are the very conditions that define chronic drug abuse and malnutrition, but no one's funding this research. Instead, billions of dollars are poured into beating AIDS with deadly drugs like AZT and protease inhibitors.

Many Americans use amphetamines, diet drugs, cocaine and designer party drugs. When you do this for years, you start getting sick. You go to the doctor, who says the first thing you need is an HIV test. You test positive because HIV tests cross-react with antibodies produced by drug use. The doctor puts you on AZT, a DNA chain terminator, which, in high doses, will finish you off in six months.

I'm not talking about a one-time use of a party drug. We're designed to consume a lot of junk, but we're not designed to tolerate a gram of cocaine, nitrite inhalants or heroin per day, and we're even less capable of handling AZT.

What is AZT?

Duesberg: AZT is a DNA chain terminator. AZT kills your DNA. It kills your bone marrow, where your blood is produced; it kills the cells in your intestines so you can't eat.

AZT was designed 40 years ago as a chemotherapy drug to treat cancer. The principle of chemotherapy is simple - to kill all cells. If chemotherapy works, the cancer cells are dead before you are. But it doesn't work often, and there's terrible collateral damage. Of course, chemotherapy is a short-term process. A cancer patient is only treated for a short time, because the treatment is so toxic. But AIDS patients are given AZT daily, presumably for the rest of their lives.

How was such a toxic drug approved for use on sick AIDS patients?

Lauritsen: AZT was approved on the basis of fraudulent research. The Phase 2 AZT Trials were conducted by the FDA in 1986 and monitored by Burroughs-Wellcome (now Glaxo-Wellcome), who manufacture the drug. Incidentally, Wellcome is the same corporation that first manufactured nitrite poppers for heart pain.

The Phase 2 trials were supposed to demonstrate that AZT was "safe and effective." The report on the trials, published in 1987, claimed that AZT dramatically prevented people with AIDS from dying. But these results were based on fraud.

How was fraud committed?

Lauritsen: First, the study wasn't truly blinded. Doctors and patients knew who was taking AZT and who was taking placebos. In a medical study, one group of patients is given the test drug, the other is given harmless sugar pills. This allows doctors to observe the effects of the drug by comparing the two groups.

In a true double-blinded study, neither the doctors nor patients are supposed to know who's on the drug. This is considered the most accurate and bias-free method for approving a pharmaceutical.

In the Phase 2 trials, everybody knew who was on AZT; the information was shared among doctors and patients. Patients in the placebo group wanted to be on AZT because they thought it would help them, so they got it from other patients or their own doctors. But they were still recorded in the placebo group.

Most importantly, the case report forms were falsified. Patients taking AZT who almost died from anemia were recorded as having "no adverse reactions" to the drug. These patients had to get multiple blood transfusions to save their lives. [AZT causes anemia by destroying bone marrow, where blood cells are produced.]

One patient, who was supposed to be in the placebo group, was actually being given AZT by his doctor. He dropped out of the study but continued to take AZT, and quickly died. The investigators recorded his death in the placebo group, as if not taking the drug is what killed him. If that's not fraud then the word has no meaning.

On the basis of these tests, AZT was approved and introduced to patients in 1987. HIV-positive men became the focus of a multimillion dollar media campaign from Wellcome. Full-page ads promoting AZT appeared in *The New York Times* and in lesser publications all over the world. City public health departments echoed the idea that AZT would help people live longer.

Duesberg: Doctors give HIV-positive patients drugs before they're even sick. As of 1993, the CDC no longer requires people to be sick to call them AIDS patients. If they have a positive antibody response to the nonspecific Elisa test and a one-time T-cell count below 200, the CDC says they have AIDS. Based on this criteria, doctors are prescribing AIDS drugs to healthy individuals.

This is what I call AIDS by prescription. Imagine that you go to your doctor and are told that you've tested HIV-positive. You're perfectly healthy, but your doctor tells you that you have AIDS because your T-cell count is low, and you'd better take the drugs to stop the progression of the disease. You're confused and alarmed, but you trust your doctor, so you take the drugs, which destroy your intestines and your immune system. Your hair falls out, you become impotent, and sooner or later you have the diseases you were trying to prevent.

The doctor says, "If you hadn't come to me, you would've had the same problems six months earlier. I've added a half-year to your life."

Now, because so many people died taking AZT, doctors are prescribing lower doses, which simply delays and masks the damage being done to the body.

Who's taking AZT?

Duesberg: According to the *New York Times* and *Time* magazine, 450,000 Americans are taking AZT every single day of their life. Many patients can't take the drugs because they're throwing up so badly. But they try to follow their doctor's orders.

Lauritsen: Ninety-four percent of all AIDS deaths have occurred since people started using AZT in 1987. More people died taking AZT in 1993 alone than died in the first six years of AIDS.

Did AIDS stop recreational drug use?

Lauritsen: No, by the early '90s, gay men in San Francisco and New York had returned to the levels of drug abuse and promiscuity of the '70s.

In '92, several thousand gay men attended a "morning party" on Fire Island, held to benefit Gay Men's Health Crisis. At least 95 percent of them were in a state of extreme intoxication from ecstasy, poppers, cocaine and alcohol. The playwright Larry Kramer described it, saying, "There were 4,000 or 5,000 gorgeous young kids on the beach drugged out of their minds at high noon, rushing in and out of portosans to fuck. All in the name of GMHC."

Darren Main: Drug use is very high in the gay community right now. Large circuit parties are very popular.

What's a circuit party?

Main: It's an event that occurs at a specific location, like the "White Party" in Palm Springs or the "Black and Blue" in Montreal. Thousands of people attend. It's four to five days of heavy drug use, like nothing you can imagine - crystal meth, ecstasy, special K, designer drugs, poppers.

People are still using poppers?

Main: Absolutely. It's a real pharmacy. Guys stay up for four to five days, taking drugs and having orgy-like sex. In addition to the big circuit parties, there's a regular party scene. A lot of guys spend their weekends going to dance clubs and getting stoned out of their minds.

These party drugs are being combined with antibiotics, because these guys are constantly exposed to syphilis, gonorrhea, herpes, amoebic infections and other STDs, which are all on the rise again in the gay community.

This sounds like the first AIDS crisis.

Main: It is. A lot of guys think that that they're protected from infections because they're taking the new AIDS drug cocktails, called HAART (highly-active anti-retroviral therapy). HAART is a combination of the older nucleoside analogues like AZT, DDI and 3TC, and the newer protease inhibitors like Saquinavir and Crixivan. *[Nucleoside analogues work by stopping DNA production; protease inhibitors work by stopping protein assemblage in your cells.]*

What are common side effects of protease inhibitors?

Main: Protease inhibitors cause lypodystrophy - a deformation of fat. Body fat moves out of the face, arms and legs, which become veiny sticks; the face becomes skeletal. The fat collects into a "buffalo hump" on your upper back. The belly becomes distended and bloated.

And that's just what's visible. The drugs cause massive cholesterol increase, which frequently leads to heart attacks. Diabetes and blood-sugar imbalances are also common. Protease inhibitors do the most damage in the liver. As a result, liver failure is now the No. 1 killer of AIDS patients in this country, though it's not an AIDS disease.

I've observed that if you go on the drugs, your symptoms will start with an upset stomach and diarrhea. Within a year, it'll begin to show in your face. The people I know who've been taking the drugs for a few years are visibly altered. There's no way to know if quitting the drugs will reverse the damage. In LA, San Francisco and South Beach, there are plastic surgeons whose entire practice is based on liposucting buffalo humps and putting in cheek implants.

You consult with people diagnosed with HIV and AIDS. What do you tell them?

Main: I teach them how to rebuild and support their immune systems by doing very basic things: Developing a supportive diet, getting enough sleep, no recreational drugs, no stimulants, and adding supportive supplements. If someone's on AIDS drugs, I encourage them take a "drug holiday."

A lot of people are afraid to quit the drugs or challenge what doctors and pharmaceutical companies tell them. I have a client we'll call "Jack," whose partner died a couple years ago from drug toxicity. Jack is HIV-positive and takes the drugs. He had a very severe reaction to them - he went blind. His eyes stopped working and began to waste away due to the AIDS drugs. Jack's doctors confirmed that the blindness was indeed caused by the drug cocktails, not by any virus or AIDS disease. When I met him, he'd just had his eyes removed. He now has prosthetic, glass eyes.

So he finally quit the drugs?

Main: No, he's still taking them. I asked if he'd consider going off them. He said no, because he didn't feel comfortable with his T-cell count or his viral load. He felt better losing his eyes than quitting the drugs. Protease inhibitors are slightly less toxic than AZT, but they still can be deadly. It's a slower death.

You don't take the drugs, even though you have an AIDS diagnosis. How's your health?

Main: Perfect - no health problems that I know of. I've never had an opportunistic infection or AIDS-defining disease. I have AIDS because of a T-cell count. Mine is 120. According the CDC, that's what AIDS is; HIV-positive plus a T-cell count below 200. Of course, in other countries, I don't have AIDS. This is just how the CDC defines AIDS in the US, and only since '93. But I'm quite healthy. I rock climb, go hiking and teach yoga for a living. Because of my AIDS diagnosis, I've been harassed by doctors to go on the drugs. "Hit hard and hit fast," they say.

According to Dr. Amy Justice of the University of Pittsburgh, gay men are dying taking AIDS drugs. They're taking them even though HIV theory is highly debatable, and more supportive treatment options exist. Why are gay men buying into this treatment option, if it causes them so much pain and suffering?

Main: If you look at the history of the gay movement, you'll find that HIV and AIDS have, ironically, really brought people together. In the early days, gay liberation was a bunch of guys whose main interaction was partying. When people started getting sick, these guys, who'd been rejected by mainstream society, had to support each other. They took care

of each other and developed a real community. They supported each other in a way that they'd never been supported by their own families or society.

HIV and AIDS became the glue that kept people together. We've got a lot invested in AIDS - billions of dollars, AIDS drives, thousands of volunteer hours at community centers, full-time jobs and organizations invested in the notion that HIV is killing gay men. It's very hard for people to let go of something they've put their whole lives into - their hearts, their minds and their beliefs. It's very difficult.

It would be nice if gay men felt that they could find validation, support and community outside of HIV and AIDS. But I think that too many people are too attached to have that happen soon. Which is unfortunate, because that attachment is killing a lot of people.

Organizations dedicated to treating AIDS illnesses without toxic AIDS drugs do exist. For alternative AIDS treatments and action, go to: HEAL - www.healaids.com Alive and Well AIDS Alternatives - www.aliveandwell.org Darren Main - www.darrenmain.com Act Up San Francisco - www.actupsf.com Articles by Peter Duesberg and John Lauritsen can be found at: www.duesberg.com and www.virusmyth.net In three weeks the final installment in The AIDS Debate *will take a look at AIDS in Africa: Treating malaria and malnutrition with deadly AIDS drugs.*

Part 3

"As to diseases, make a habit of two things-to help, or at least to do no harm."
- Hippocrates, 5th Century B.C.E. Greek Physician, regarded as the father of medicine.

According to the World Health Organization (WHO) and UNAIDS, 42 million people around the world are infected with HIV, and nearly 22 million people in Africa have died of AIDS. But AIDS isn't a single disease; it's a collection of diseases. When people are said to die of AIDS, they're known to die of a particular disease or condition, such as pneumonia, tuberculosis, malaria or basic malnutrition. AIDS researchers claim that HIV plays a role in the development of these illnesses, but in spite of this claim, 20 years of AIDS research has failed to prove causation between HIV infection and any so-called AIDS disease (as explored in "The AIDS Debate" parts one and two). So why do we call them AIDS deaths?

In the US, AIDS is defined as a collection of 29 previously-known conditions including yeast infections, hepatitis, the flu, pneumonia, tuberculosis and Kaposi's Sarcoma. These conditions are not known to be caused by HIV. Nevertheless, the one thing that classifies any one of these conditions as AIDS is a positive HIV-antibody test.

But even if HIV was found to cause these previously known conditions, a problem remains. The HIV-antibody tests do not diagnose actual HIV-infection. Instead, they look for non-specific antibody reactions in your blood to proteins in the HIV-test. The test manufacturers claim that the proteins stand in for HIV, but in reality, none of the test proteins have been proven to be specific to HIV. These tests are, in fact, so nonspecific that they cross-react with nearly 70 other documented conditions, including the flu, previous vaccinations, blood transfusions, arthritis, alcoholic hepatitis, drug use, yeast infections and even pregnancy, as well as conditions endemic in Africa: tuberculosis, parasitic infection, leprosy and malaria. Because no HIV test can actually find HIV, not a single HIV-test has been approved by the FDA for diagnosing HIV-infection.

In light of this nonspecific, cross-reacting test, how does the World Health Organization (WHO) diagnose AIDS in Africa?

Simple: they don't require any test at all. In 1985, the WHO created a new definition of AIDS for African nations and third world countries. The WHO's "Bangui Definition" allows Africans with common physical symptoms including diarrhea, fever, weight loss, itching and coughing to be automatically designated as AIDS patients, with no HIV test. But these very symptoms define life for the majority of Africans who lack essentials like sufficient food, safe drinking water, proper sanitation and basic medical care. These symptoms are also synonymous with the biggest killers on the continent: malaria, infectious diarrhea and tuberculosis.

Western AIDS organizations are working to get toxic AIDS drugs into the hands of African governments, but what's the use of potentially deadly AIDS pharmaceuticals to people suffering from poverty-related diseases like chronic tuberculosis and malaria infection, or to pregnant mothers whose blood cross-reacts with the nonspecific HIV tests?

To answer these questions, I spoke with AIDS researchers who've worked in Africa and studied the African AIDS epidemic.

Dr. Christian Fiala is a medical doctor and specialist in obstetrics and gynecology in Vienna. He's worked extensively in Uganda and Thailand researching AIDS.

Dr. Rodney Richards was one of the founding scientists for the biotech company Amgen where he helped develop some of the first HIV tests. Richards currently works full-time researching AIDS.

The interviews were conducted separately and integrated into a dialogue. Individual points-of-view belong to individual speakers.

How is AIDS diagnosed in Africa?

Christian Fiala: Your readers may be surprised to learn that AIDS in Africa is diagnosed completely differently than in Europe or the US. In Africa, an AIDS diagnosis can be made based on commonly occurring physical symptoms alone. This is ironic, because AIDS is a collection of diseases, and has no uniform symptoms. Even the co-founder of HIV theory, Luc Montagnier, admits that AIDS has no specific clinical symptoms.

How was this new AIDS definition devised?

Fiala: In 1985 the WHO held a meeting in Bangui, the capital of the Central African Republic. A WHO official, Joseph McCormick, wrote about it in his book *Level 4: Virus Hunters of the CDC*.

He wrote: "If I could get everyone at the WHO meeting in Bangui to agree on a single, simple definition of what an AIDS case was in Africa, then, imperfect as the definition might be, we could actually start counting the cases..."

This is what's known as the Bangui Definition.

How does the Bangui definition define AIDS?

Fiala: There are two categories of symptoms, major and minor. A patient is given an AIDS diagnosis when they have two major symptoms and one minor symptom. The major symptoms are weight loss, chronic diarrhea and chronic fever. The minor symptoms include coughing and generalized itching.

Let me clarify, based on the WHO's definition, if you have a fever, a cough and diarrhea in Africa, then you have AIDS?

Fiala: That's correct.

That seems absurd.

Fiala: It is. It's more absurd when you understand how common these symptoms are in resource-poor settings like sub-Saharan Africa. To begin with, less than 50 percent of Africans have access to safe drinking water. Over 60 percent have no sanitation. Most African villages don't have sewage systems. Human and animal excrements mix with the water supply. People drink this water and ingest infectious parasites and bacteria. As a result, dysentery is endemic.

When your intestines are full of infectious microbes, you'll likely develop a fever. Your body will try to purge itself by expelling the bacteria as quickly as possible. This is infectious diarrhea, and it's incredibly common in Africa.

Diarrhea drains liquid, salts, minerals and nutrients from the body. It weakens the immune system. When you have no safe water, you'll have diarrhea chronically. When you have chronic diarrhea, you can't help but to lose weight.

At this point, you've fulfilled the major symptom criteria in the African definition for AIDS. So you need one minor symptom, like generalized itching or coughing. In Uganda, a so-called "AIDS epicenter," 80 percent of houses have floors made of packed soil or cow dung. An entire family lives on this floor. There are, on average, seven children per family, all living in this room. This is not what we in the US and Europe call proper housing, and it's easy to see how a problem like "generalized itching" might come up. At this

point, an African suffering from itching, diarrhea and weight loss should be - according to the WHO - officially reported as an AIDS patient. The Bangui Definition simply relabels symptoms of poverty as AIDS.

The second problem with the Bangui Definition is Tuberculosis. TB is very widespread in Africa. It's a bacterial infection that infects the lungs. TB is spread by coughing, and it's highly infectious. The typical symptoms of Tuberculosis are fever, weight loss and coughing. This is exactly what is required for an AIDS diagnosis.

So if you have Tuberculosis in Africa, you can be diagnosed with AIDS?

Fiala: That's correct. According to the WHO, the typical symptoms of TB define AIDS in Africa.

Another problem with the Bangui Definition is malaria. Malaria is the most widespread disease in Africa and tropical countries. It's the leading cause of death in Uganda. It's spread by mosquitoes, so people are reinfected several times a year. A great many people die every year, while the rest develop a relative immunity, even though it's wearing away at them. The symptoms of malaria include fever, weight loss and fatigue. If you have a cough or itching, and you have malaria in Africa, you can be diagnosed with AIDS.

As if this wasn't problematic enough, in some African countries, such as Tanzania, health authorities have decided that a one-criteria diagnosis is all they need. A patient exhibiting just one of the major symptoms - diarrhea, fever or weight loss - can be given an AIDS diagnosis.

This is hardly scientific, and it's very different from what people are told about AIDS in Africa. The idea that there should be a different kind of AIDS for Africans or Europeans or Americans defies the scientific definition of viral infection. A single virus doesn't cause different diseases in different people or in different countries. A viral infection doesn't vary so wildly so as to create pelvic cancer in women, Kaposi's sarcoma in gay men, and tuberculosis in Africans. But this is what we're asked to believe about HIV.

What's the treatment for TB and Malaria?

Fiala: The best treatment is prevention. The most effective way to reduce all of these infectious diseases is to improve the standard of living and hygiene for local residents - to provide safe, clean water; plentiful, healthy food; proper housing and basic medical care. This is exactly how the incidence of TB and other infectious diseases was dramatically reduced in the US and Europe.

The treatment for malaria is well known and simple: treated mosquito nets that protect villages; clean, safe, non-stagnant water; and the inexpensive, highly efficient drugs that effectively fight the disease.

Why don't African Countries have clean water systems?

Fiala: You could've asked that question 100 years ago in the US and Europe. Sewage and water systems rely on economic development. We have these things in the West because we know they're absolutely essential, so we've invested money and energy in them.

Many African nations don't have the money to develop this infrastructure and modernize the villages. The money they have is being re-routed into AIDS. These countries are being pressured by international AIDS organizations to take money out of rural development and put it into AIDS education, condom distribution, abstinence campaigns and toxic AIDS pharmaceuticals.

We're told that there are nearly 30 million African AIDS patients. This is an enormous number of people. How are these cases counted?

Fiala: The United Nations AIDS organization (UNAIDS) and the WHO use various computer modeling programs to come up with their numbers.

Rodney Richards: When you read about the millions of HIV-infected in Africa, you may notice that the word "estimated" precedes the number in the official publications.

What does "estimated" mean?

Richards: All WHO/UNAIDS reports of HIV-infection in Africa are "estimates" based on HIV tests performed on blood samples taken at pregnancy clinics. These global reports are created jointly by the WHO and UNAIDS.

Why is blood taken from pregnancy clinics?

Richards: In countries with little infrastructure, medical care is very limited, and is generally reserved for the most vulnerable segment of the population, such as infants and pregnant women. Even in the poorest countries, there are pregnancy clinics serving expectant mothers and women who've just given birth.

Pregnant women regularly line up at these clinics for a check-up that includes a blood screening for syphilis. Syphilis infection is common in many African countries, and must be treated before a baby's birth, or the child could die or be severely damaged.

Once a year, UNAIDS researchers collect leftover blood samples from these clinics, and test them with a single HIV-antibody test called the Elisa. The resulting number of HIV-positive results is fed into an epidemiological computer modeling program (Epi-model) at the WHO headquarters in Geneva. The Epi-model program then extrapolates the HIV-positive test results onto the entire population - young and old; men, women and children. When we hear about the number of people infected with HIV, it's this number that's being reported.

How do reported numbers of HIV-infection correspond to actual number of people tested?

Richards: The WHO/UNAIDS tells us that there are currently 30 million HIV-positive Africans, yet less than one in a thousand of these people have ever been tested. In South Africa, the WHO/UNAIDS reports 5 million people are infected with HIV, but this number is based on only 4,000 actual HIV-positive test results from pregnant women.

But even these positive test results are hardly indicative of HIV-infection. The HIV-antibody tests used in these surveys are known to come up positive based on cross-reactions with antibodies produced from malaria, TB and parasitic infection - all common conditions in Africa. The test manufacturers themselves warn that pregnancy is a known cause of false positives.

Fiala: Testing pregnant women for HIV-infection is a self-fulfilling prophecy, but pregnant women are the only people regularly tested for HIV-infection in sub-Saharan Africa.

We're told that 28 million people worldwide and 22 million Africans have died of AIDS. How are AIDS deaths counted in Africa?

Richards: AIDS deaths are also estimates. The number of deaths is projected from the Epi-model estimate of HIV-infections. It is assumed that if a certain number of people are HIV-infected, then a certain number will die of AIDS. This assumption is based on what researchers know historically about disease progression in AIDS patients, primarily from studies done on HIV-positive IV drug abusers and male homosexuals in the US and Europe.

Are these numbers accurate?

Richards: No, the numbers have been greatly inflated. For example, the WHO/UNAIDS says that there has been 2.2 million AIDS deaths in Uganda so far, but the Ugandan Ministry of Health records a cumulative total of only 56,000 AIDS deaths since the beginning of the epidemic. The WHO's report is 33 times higher than the actual number of recorded, verified deaths.

As of the end of 2001, official government bodies in the developing world have managed to account for only 7 percent of the cumulative AIDS deaths that the WHO/UNAIDS claim have occurred. The Russian Federation can only account for only 3 percent of the UNAIDS estimate of AIDS deaths. India has 2 percent of the UNAIDS estimate. China has only 1 percent.

If I understand correctly, the number of people we're told have HIV and AIDS in Africa is actually an inaccurate computer extrapolation based on test results from non-specific, cross-reacting antibody tests given to pregnant women?

Fiala: That's correct.

And the number of AIDS deaths in Africa is a projection based on the previous estimation, and is also greatly inflated?

Richards: That is also correct.

What does an AIDS diagnosis mean for an African with TB or malaria?

Fiala: In many African clinics, basic medical supplies like antibiotics are extremely limited. A clinic may only have 10 bottles of antibiotics. AIDS patients are frequently refused antibiotic treatment, because it's assumed that they'll die, no matter what. Western doctors have made it clear that AIDS is a fatal disease. Helping them is considered a waste of scarce resources.

What's the main AIDS organization in Uganda?

Fiala: TASO - The AIDS Support Organisation. They claim to be independent, but they're heavily funded by the pharmaceutical industry. They're currently constructing buildings to prepare the ground for massive HIV testing, with this non-specific, cross-reacting test, and to distribute toxic AIDS drugs.

In Africa, 50 percent of the population has no access to clean drinking water and the vast majority lack even basic medical care. And the response from multimillion dollar AIDS organization is to promote HIV testing, give out condoms and to implement treatment with deadly AIDS drugs. These drugs are similar or identical to chemotherapy drugs used in cancer treatment. They work by stopping cell growth. They kill your body from the inside out.

Which AIDS drugs are being used in Africa?

Fiala: Boehringer, a pharmaceutical company, has been doing studies in Uganda with a drug called Nevirapine. The FDA refused approval of Nevirapine in the US for so-called mother to child transmission because it's ineffective and has deadly side effects, but this is exactly how the drug is being used in Africa - on pregnant women and unborn children.

In one drug trial, 17 percent of patients taking Nevirapine developed liver problems. A US health care worker taking Nevirapine had to have a liver transplant to save his life as a result of drug toxicity. Five women in South Africa died and dozens developed severe liver problems in a combination AIDS drug trial that included Nevirapine.

The manufacturer's warning label for Nevirapine itself states that patients taking the drug have experienced: "Severe, life-threatening and in some cases fatal hepatotoxicity [liver damage]," and "severe, life-threatening skin reactions, including fatal cases."

These are the most toxic drugs known to medicine, and they're being applied to the most vulnerable part of the population - pregnant mothers, unborn children and newborns - all based on a faulty test, or no test at all, while their actual food, shelter and water needs continue to be ignored.

What would actually help Africans is infrastructure development: proper sanitation, safe water, basic medical care and plentiful, nutritive food. This is simple, clear and logical. What's astounding is that the UN is recommending just the opposite.

In 1999 the UNAIDS commission gave its official recommendations to a meeting of finance ministers representing various African countries. The UN's exact recommendations to African nations: to redirect billions of dollars from health, infrastructure and rural development into AIDS - condoms, safe sex lectures and deadly pharmaceuticals. This is not what these already suffering people need to be healthy and successful. This is exactly how to propagate death, disease and poverty.

Afterword:

If the AIDS story in Africa feels like a parody of a bureaucratic blunder, take note: In April of this year, the US Centers for Disease Control (CDC) announced a new HIV testing strategy for the United States. Rather than relying on voluntary HIV-testing, federal officials are urging the testing of all pregnant women in the US, and are implementing measures to make HIV-testing a routine part of hospital visits. The CDC is promoting a rapid HIV-test for use in all federally funded clinics, as well as homeless shelters, prisons and substance abuse treatment centers.

The HIV-antibody tests are known to cross-react with antibodies produced during pregnancy, drug abuse and nearly 70 other common conditions, and no HIV test is FDA approved to diagnose HIV infection. The standard medical treatment for HIV infection is a combination of the most toxic drugs ever manufactured.

"The AIDS Debate" series has explored the scientific and sociological process that formed HIV theory, and the ramifications of a speculative theory enforced upon a trusting, uninformed public.

We must ask ourselves, are we doing the best we can for sick people? Is the best we can offer impoverished Africans AZT and Nevirapine? Is the best we can do for drug-addicted mothers is force more drugs into their system? And what about people unlucky enough to register HIV positive on these scientifically unvalidated tests. Do they deserve to be told that they have a fatal illness?

"As to diseases, make a habit of two things-to help, or at least to do no harm."

As for human beings, one thing's for sure. We can always do better.

* http://www.weeklydig.com/dig/content/3593.aspx