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CHANGING THE WAY WE THINK ABOUT AIDS

Vol 3, No 3 Sept/Oct 1995

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continuum *presents*

Reflections on the Pathogenesis and Prevention of AIDS

Lecture by Prof. Alfred Hässig from Switzerland

Weds 22 Nov. - London Lighthouse, 111-117 Lancaster Rd, London W2
Thurs 23 Nov. - Body Positive, 51b Philbeach Gardens, London SW5
at 7.30 pm

Prof. Hässig was head of the Swiss Red Cross Blood Transfusion Service for 37 years and now heads the Study Group on Nutrition and Immunity in Berne. For many years he has questioned the role of HIV in AIDS and believes it is important to look instead at toxicity as the cause.

The lectures are free, donations will be welcome.

LUC DOES IT AGAIN

It turns out that Luc Montagnier, the 'discoverer' of HIV, never discovered it. Paradoxical? Read on!

When he was asked by Jeremy Selvey of Project AIDS International if he'd ever isolated HIV he laughed and replied, "No, Gallo did." Which means, it hasn't been isolated, because all Gallo ever did was to steal the 'isolate' from Montagnier, which wasn't an isolate in the first place. Montagnier also contends that he never said HIV causes AIDS. A search through his papers shows this to be true.

The stage is set for him to jump off the AIDS bandwagon - but is he brave enough to do it? Excuses as to why he can't right now run along the lines of: "No-one would believe me if I said HIV doesn't cause AIDS" and "No-one would listen", followed by "I'd lose my funding if I said it".

Doesn't your heart just go out to him?

A CLAP FOR THE CLINIC?

A retrospective study conducted at St. Mary's Hospital, London, has come up with some intriguing results. They looked at the different survival times of G.U.M. patients who presented with their first 'AIDS-defining' condition at the same time as they received a HIV+ result, and those patients who tested HIV+ up to 8 years previously and had been attending the clinic for follow-up since.

The findings appear to show that those who went for follow-up fared worse than late-presenters - *quelle surprise!* Does this mean that kindly doctors and HIV educators will now be advising us to avoid clinics for a healthier, longer life? I can see it now: "The best prophylactic is abstinence: stay away from G.U.M. clinics." It would make a welcome change from the usual "put a rubber on it" message.

AIDS EXCESSES

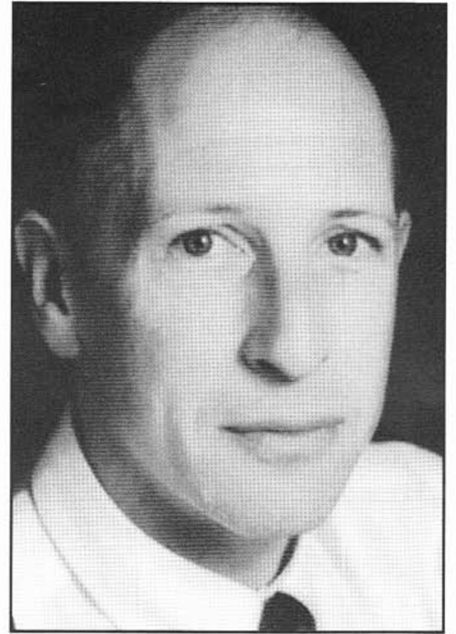
There are fears among US AIDS scientists that Congress intends to cut funds for AIDS research. The Office for AIDS Research, set up two years ago to co-ordinate efforts, is to be closed and overall responsibility handed back to National Institutes of Health, after concerns at attempts to single out AIDS research for special treatment.

US Congress spending on research, per patient, is $295 for cancer, $158 for multiple sclerosis, $93 for heart disease, $54 for Alzheimer's, $26 for Parkinson's - and $36,000 per AIDS patient. In the UK an estimated £250 million is spent on AIDS by the government. Some say this is an excessive amount that should be cut, since it isn't used productively.

continued on page 3

JOSEPH WELLS (JODY)

12th March 1947 - 26th August 1995



No self-respecting survivor of 'HIV' is going to ignore the passing away of this magazine's founder on 26th August - a proud and angry man has been lost.

Jody had said in 1993, "If I'm going to leave the planet early I want to have done something worthwhile." The comment of a man who remained, despite his usual persona, unsure whether he could escape the force of the HIV=AIDS theory; also the comment of a prophet. If you seek his monument, read in this magazine.

Jody was diagnosed HTLV3 (earlier called LAV and later HIV) positive in 1984. It was 18 months after the traumatic breakup of a 14-year relationship of which he said later, "I simply could not handle the situation and began to drink, something I had never done in my life before. I very quickly became alcohol dependent, my nutrition suffered badly and I came down with glandular fever. I was tested and found to be positive. When I asked the doctor her opinion she said if I was lucky I might have a year to live."

Eight years later Jody began *Continuum*, putting out the news to all who would listen that HIV was a life-sentence, not a death sentence; and perhaps not a sentence at all. He lived to see the publication in this magazine and others around the world of scientific confirmation that the 'virus' which has misled and terrorised people everywhere is not even isolated.

In the past ten years, working first at the London Lighthouse and then with *Continuum*, his defiant qualities enabled him to stand aside from the the drug-based medical orthodoxy over AIDS. It became obvious to him that nutrition, drug use (prescribed and recreational) and quality of life were significant factors in individual progression, or not, to a definition of AIDS. His observations made him adamant that the so-called side-effects of 'HIV and AIDS medications' were very contributory to the onset

Jody Wells - from across the office desk

I was manning the *Continuum* stall in the health tent at Manchester's Mardi Gras Festival when Huw joined me and told me that Jody had died the previous morning in hospital. The news came as a surprise, but I can't say that I was shocked, having gone with him to hospital the previous week, when he was extremely weak from a collapsed lung - I suppose I'd been prepared in a way.

I first met Jody some 15 months ago, when I answered the advert for an office manager for *Continuum*. I arrived at his flat in North-West London, which housed the office, at 10am. He seemed surprised to see me, as he said he thought the arrangement was for 11 o'clock. (After I started working with him I soon learned why the organisation needed an office manager.) Initially I held Jody slightly in awe due to his manner and the esteem in which he was held by many people who knew him. But as we became friends, I came to enjoy working with him, even though he was arrogant, independent and individualistic. He wasn't always easy to work with, as many who've tried will testify.

He loved a good strong cup of tea, and we used to drink a lot when taking a break in the kitchen of his tastefully furnished flat, when we'd both get through a few cigarettes and chat about all manner of things - this was when his sense of humour was particularly evident, when he was relaxing, and sometimes I'm sure we sounded like a couple of schoolgirls. Another pleasant side of 'office life' was the odd trip to the stationery superstore. Jody would often combine this with a visit to his favourite whole-food shop. He'd not be too concerned about the cost, but would stock up with organic fruit and vegetables and other delicacies I'd not even heard of. He loved his food and knew how to cook properly, which was why he complained about the hospital food later on.

and perpetuation of an AIDS definition in an individual. In this opinion he was eventually confirmed in more than principle by respected London immunologist Professor Tony Pinching (among others) who told a journalist, "The trouble with AZT is its side-effects mimic the symptoms of AIDS."

But Jody found himself facing choices, including the use of regular nebulised Pentamidine as possible PCPneumonia prophylaxis, which were reinforced in the community past the point where he wanted to resist them. His pneumonia was diagnosed with tests known for their high false-positivity rates, after he suddenly ended his long cigarette addiction in the middle of last winter. Jody also used Septrin, Dapsone, Trimethroprim, steroids etc. With reminders, he began to question the use of these drugs, but his will to support his body in real ways, in its crisis, seemed drained.

John Lauritsen has said of senior gay men, "As the AIDS epidemic developed, they experienced grief; they were in perpetual mourning, their hearts broken by the loss of their closest friends..." This was true of Jody, despite his cheerful face, for he was a lover of mankind who resented loss, and cherished the richness of the present.

Burdened with the loss after Christmas of yet another close (medicated) contemporary, and a tendency to overwork, Jody's fighting spirit was sadly depleted. Two weeks before his last admission to the AIDS ward at Chelsea and Westminster Hospital he 'wrote off' his car, and when he died both his lungs had collapsed. One had been reflated. The senior consultant's provisional first diagnosis? "It could be heart failure. HIV gets everywhere."

In January Jody had confided to Maggie Turner, a close friend, that he was ready to die. She's commented, "I respected him, and knew him well enough to know that Jody wanted to be in charge of his life - and his death."

Jody's known past health risks for mid-life illness included alcoholism, syphilis, heavy tobacco addiction, sustained stress and no exercise. He experimented for the second half of last year by not taking vitamin/mineral supplements. Although Britain's *Pink Paper* printed that he had used further "recreational drugs" there is no evidence for this, and he himself had denied it except for his own report of unwittingly having some hash-cake on an unrepeated occasion. He liked to joke that he had outlived the family members whom he'd told of his HTLV3 diagnosis in '84, which might have been cold comfort.

His cremation took place on Tuesday 5th September with several friends and colleagues absent. Jody's paid domestic carer for recent months, with whom he had once had a 14-year relationship, made the arrangements. A believer in HIV, he'd correctly predicted, "Jody isn't going to get better."

It is a great tribute to Jody that *Continuum* lives on, empowering people by disseminating information often not found elsewhere and asking important questions. He will be missed by many whom he inspired and especially by those carrying on the work he began. ■

His innate artistic bent was very useful on the magazine, and he taught himself how to use the computer to work with graphic images. But I'll remember especially the trouble he took to make the stall at Gay Lifestyles '94 an inviting sight. He'd had the idea for mounting enlarged versions of the magazine covers on a black and red backdrop, and on his way to the exhibition he bought three poinsettias. The final thing was a table cloth, which he scrounged from another stall at the last minute, completing the arrangements (his window-dressing experience showed here).

It wasn't easy to see a great man laid low as he was at the beginning of this year. I really think he had overworked himself over the previous three years, giving to others and taking little in return. I believe that he was satisfied that he had achieved something special with his life, and that he realised his involvement and effort had to diminish.

He spent the last few months dealing with pneumonia, which seemed to start after he suddenly quit smoking. I think it gave him plenty of time to review his life and to decide that there wasn't anything else that he wanted to do here. I'm sure he was satisfied that he had helped others turn their lives around, and now he wanted a break. It was weird to see him not heeding his own advice regarding nutrition, vitamins, etc. and eventually taking prophylactic medication. But I believe he knew what he was doing; he used to say that we were providing information for people to make their own, informed decisions. And now it was *his* turn to do just that. He was, as always, doing it *his* way.

I am certain that Jody 'hung around' just long enough to see that *Continuum* became established for the future, and, with Huw and Molly, I am determined to see that the work which Jody had the vision to begin is continued for as long as it is necessary. We believe, as Jody did, that our job is to expose the myths surrounding HIV and AIDS. ■

TONY TOMPSETT

NewsInBrief

Why governments don't put resources into preventative medicine, informing of the toxicities of drugs, say, is a mystery....that can be solved with the understanding that medicine is market-led. Money makes the world go round....

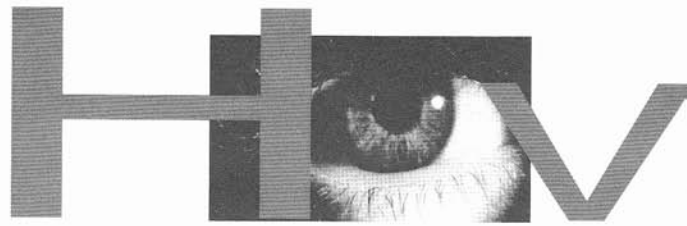
SLIGHTLY POSITIVE

Currently in Romania the mother of Iasmina Calinciuc, a six-year old girl said to have AIDS, is suing medical authorities over alleged negligence. Iasmina, of Iasi, has apparently contracted HIV while in hospital. She has received many oral and parenteral (injected) treatments for respiratory infections and has subsequent infections and bronchitis. Her AIDS classification is "slightly symptomatic with a severe depression of immune function". Her mother is diagnosed HIV-negative.
A Romanian investigative commission, diagnosed Iasmina as having "rickets and a slight seropositivity" (sic), rejecting the claim by a team of French doctors that on the basis of described symptoms she has AIDS.
It's hard to see who benefits from Iasmina being given an AIDS diagnosis. The belief that she has a 'deadly virus' and an 'incurable syndrome' is *slightly* unhelpful, to put it mildly.

MONKEY BUSINESS

In Pittsburgh, USA, Suzanne Ildstad, a transplant developer, has received permission to go ahead with transplanting baboon bone-marrow into Jeff Getty who has an AIDS diagnosis. Her assumption is that baboon bone-marrow is resistant to HIV infection and that a 'facilitator cell' in the marrow (which no-one except her has isolated and she has patented - sound familiar?) will prevent Graft Versus Host Disease. Unfortunately her assumptions cannot be backed up by data as she has not yet been able to conduct a successful grafting and therefore *has* no data.
Hugh Auchincloss of Massachusetts General Hospital commented, "the likelihood that this will work is extremely small....the difficult procedure will probably hasten his death and not prevent it." The same procedure was tried in an AIDS patient two years ago: he never made it out of the hospital. Perhaps we're seeing the birth of a new medical protocol here: if it has absolutely no benefits at all, use it!
There are also fears that it will present a public health problem; Getty is promising he'll only have safe sex in the future to prevent possible transmission of as yet unknown baboon pathogens to others. Experiments like this should keep virus-hunters in a job for years....now that *is* useful.

Absurd Convictions



There's the scent of blood in the air. The word is out - we could consider criminalising the transmission of 'HIV'. It's been an issue in the USA for 9 years now, since Lyndon LaRouche, "former Marxist" and founder of the (some would say) reactionary National Democratic Policy Committee, launched Proposition 64 in California in 1986 to quarantin 'HIV-positives' in camps in the desert (defeated in a state-wide referendum).

Three weeks ago Edward King wrote in Britain's *Pink Paper* of the "ethical responsibilities" of "people with HIV", who should "grasp the nettle" of not "passing on the virus", supporting BBC2's *Public Eye* programme "accusing AIDS organisations of failing to advise HIV-positive people that they have a responsibility not to infect others". There have already been dozens of arrests in America for criminal assault with "HIV-infected" semen or saliva, one in 1989 resulting in a sentence of 99 years for an inmate in transit spitting at a prison officer. Professor of Law Philip Johnson at the University of California, Berkeley says, "Of course they're irrational laws; they occur in the context of irrational fear."

Of course they're irrational laws; they occur in the context of irrational fear

Fear of 'HIV' requires ignorance. Would fear thrive if it was generally known there are thousands of recorded 'AIDS' cases without 'HIV', and hundreds of thousands of 'HIV' without AIDS?

The remaining "discoverer of HIV", Professor Luc Montagnier, has recently said he and his team never isolated the virus, and that their non-isolate is anyway not the cause of AIDS. And now he says there will not be a European heterosexual epidemic of AIDS. It has been demonstrated by Lanka, and Papadopulos-Eleopulos, and others, that the antibody tests cannot rationally exist for a virus that is not defined, and that the antibodies they indicate are not even retrovirus-specific. Testing is in big trouble! An angry Miami woman, Vernelle Lowder, sued in the courts and won a $600,000 settlement last year after a lab supervisor testified the "highly accurate Western Blot test for AIDS came back positive" although two years later she was certified not to have or ever have had "the virus". How reliable does the evidence have to be?

In the current O. J. Simpson Trial in the US, Nobelist Kary Mullis inventor of the PCR test for sequencing genetic material is being kept off the witness stand because he's not afraid to say his PCR is not evidence in itself, any more for the Los Angeles District Attorneys prosecuting O.J. than for HIV researchers. To be rational about 'HIV' is to recognise that its link with AIDS is artificial.

Is it astonishing that the law (let alone medicine) in western democracy could destroy personal liberty on recognisably artificial evidence alone? Certainly not. The law sails with the wind of 'reasonable doubt'. When the Mullises, Lankas, Duesbergs, etc. are kept off the stand, people's ideas of what's genuine in science will be formed by current prejudice. Are our western democracies glossing over the very essence and fact of science, that most things remain unknown? That theories become less likely the more they fail? Do we get the 'justice' we deserve?

An enigmatic example of confusion in this maze is the case of Brenda Jensen, a 34-year old "mentally impaired woman" in Muskegon, Michigan, USA, who was convicted of "AIDS Endangerment" for failing to tell her sex partner she was HIV-positive. She was convicted after 90 minutes of jury deliberations and faced four years imprisonment. Defence attorney Christopher Wilson suggested, "Society has to find a different way to deal with people like Brenda Jensen because the legal system is not the appropriate forum." The County Prosecutor forecast, "There will be many more Brenda Jensens in the future." Apparently prosecution witnesses *(sic)* testified during the three-day trial that Jensen had unprotected sex with a 38-year old transient three times in July 1994 and *failed to tell* him about her HIV status. Jensen's court-appointed guardian Robert Laughing Wolf testified that Jensen disrupted an adult foster care home he operates and demanded last year to live independently. He dropped her off in July 1994 at a hotel and paid her rent for two days. Jensen called within days and asked to return to the foster home.

The gang of "HIV-positive" thieves in Italy ... are the free radicals of the whole unhappy AIDS-system

After she moved back, Jensen told him she had unprotected sex with a man and *failed to tell* him she was HIV positive, Laughing Wolf testified. "She knew she was supposed to (inform

sex partners)", he said. The sexually active man who had been her partner said he "...felt like somebody dropped a bombshell on me. I wanted to hurt somebody real bad....I was confused, hurt, angered."

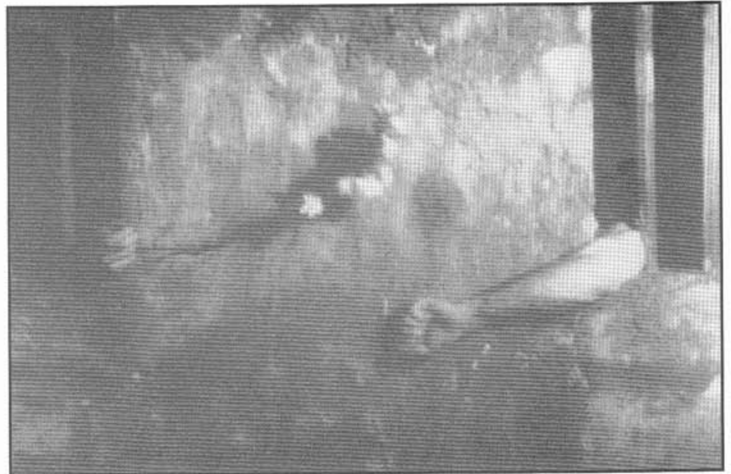
Jensen's was one of about a dozen cases of AIDS Endangerment prosecuted in Michigan in recent years. Asked for her response to the verdict, Jensen simply replied, "I don't know."

Jensen was reported to have an "IQ of around 68", which is no more accurate than claiming an IQ of around 70 and in the right circumstances indistinguishable from an IQ of around 170. The perception of diminished responsibility seems to have worked in her favour. Even the prosecutor insisted, "To me, it's a public health problem. It is imperative the state of Michigan addresses this as the public health issue it is." He confirmed to *Continuum* that Jensen is likely to be released after two years and eight months, so long as she has not become a "behavioural problem case"...

Sometimes perversities in the law produce their own trials. The gang of 'HIV-positive' thieves in Italy who hold up stores with syringes of their blood but can't be gaoled - since Italian law forbids imprisoning the 'terminally ill', which is the unholy view of 'HIV infection' in Rome - are the free radicals of the whole unhappy AIDS-system. It's not 'HIV-positives' who should worry, it's the overburdened body politic which is showing symptoms of stress - the backbite to all this might be very much worse than its bark.

In a compelling article titled "HIV, the virus that causes suicide" in last month's *San Francisco Sentinel*, Brian Cole noted that, "There are hopeful signs, however, from CNN news in particular. They have changed the phrase, when reporting AIDS stories, to 'the virus most closely associated with AIDS'." In societies fuelled by news media, the interchange between those media and the law is a complex business. The O. J. Simpson trial is state-of-the-art, with its absolute restrictions on what parts of the courtroom the videocamera can even show, and the constant media commentary on institutional racism. Conversely the new reporting policy at CNN could - and should - be introduced to a court by any defence lawyer in an AIDS Endangerment case as evidence that there *is* quite reasonable doubt at large as to whether HIV *causes* AIDS. The prosecution would have to argue that CNN were behaving *un*reasonably, a contention which would not survive the evidence, although it would make good news.

It's sad but true that 'HIV-positive' people who, with no pathogenic virus in sight, conform with the argument that 'HIV transmission' is criminal, or at least as King puts it, that there's "a moral obligation not to infect others", have become refugees from the wider reality; internal exiles in a prison of shadows. Didn't we all see the picture of convict-cut King beside his pro-HIV-theory



Jean Genet's homo-erotic vision of prison *(Un Chant d'Amour)*

article entitled "Cell Mates" in July's *Positive Times?* We got the pun, but did we get the significance? Political, mental and now plague asylum. To the vulnerable there *can* be security behind bars. At what price?

Human rights organisations and lawyers, such as Amnesty International, have apparently yet to acknowledge the wild abuses of justice occurring in the name of 'HIV'. The list of the unjustifiably accused and punished grows by the week. Two men in Germany are charged with "5,837 counts of attempted murder" over supposed infection with 'HIV' of hæmophiliacs via blood product Factor VIII, when the CDC itself has published that the chance of 'HIV' surviving the drying of blood products - the central process in preparation of Factor VIII - is "essentially zero". Those people supposedly diagnosed 'HIV-positive' should make lawyers, police, lovers, employers and co-workers aware of the following points should a defence against 'HIV' transmission be necessary:

1. Has 'HIV' been isolated? No, so how can it be identified as a weapon?
2. Is the 'HIV' test legitimate proof of infection? No, the antibodies are non-specific.
3. Is 'HIV' pathogenic? There remains no proof of this.

Cases to free those wrongfully charged will not be difficult to win. ■

HUW CHRISTIE

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Supporting the Psychoneuroimmunology

A study carried out, on men diagnosed HIV+, by the Touch Research Institute in Florida has demonstrated a convincing link between receiving massage and an increase in the number of natural killer cells. Roz Carroll, an experienced massage therapist, puts the case for taking a more serious look at the benefits of massage.

A standard description of the immune system will tell you that it is made up of certain glands and organs (spleen, thymus, bone marrow) which produce special white blood cells which are programmed to seek out and destroy foreign particles, such as bacteria and viruses, which can be harmful. A typical description of massage will define it as "manipulation of soft tissue for therapeutic purposes". So how can massage influence the state of an individual's immune system?

Both these definitions need to be re-examined in a holistic light, rather than through the lens of the medical model. Western medicine often reduces the body to its component parts, ignoring the relationships between systems, and treating symptoms in isolation. Scientific research now confirms the view - implicit in holistic thinking - that the immune system operates within a total bodymind network, one in which beliefs and feelings, diet and environment, and the health of all parts of the body, play a part. Holistic massage is particularly suited to immune support because the massage therapist works directly with the body as a whole, perhaps literally touching the body from head to toe, and, through warmth and focus, extending that contact from the skin into the heart of the person. A well qualified massage therapist is capable of working on a multiplicity of levels, and maintaining a minute sensitivity to the overall needs of the body. It can be effective whatever the individual's health status because it is not centred on eliminating symptoms but on amplifying the body's own self-healing capacity.

Psychoneuroimmunology: creeping towards holism*

Research into the various ways in which the immune system in an individual appears to be breaking down and even backfiring (as in autoimmunity), has revealed how profound is the impact of beliefs and emotions upon the body's ability to fight off illness. It has opened up a whole new scientific field, that of psychoneuroimmunology (PNI). For example, several major studies have revealed how grief can suppress the immune system. A study carried out in New York on men who were married to women in advanced stages of breast cancer showed that they had a drop in activity of white blood cells immediately after their wives' deaths, and that the numbers rose again as they came to terms with bereavement.

A range of separate studies demonstrate that immune function can be depressed by despair, confusion and feelings of failure, powerlessness and social isolation. All these feelings are responses which are inevitably provoked - at least initially - to a greater or lesser degree by an HIV or AIDS diagnosis. This is particularly so because those diagnosed with HIV/AIDS have been subject to an unprecedented victimisation in Western society. Declaration of positive status can lead to loss of family, friends, and jobs, as well as the right to insurance or a mortgage. Immunity is thus subject to a double blow - physiological and psychological.

Research also reveals that suppression of 'negative' feelings - anger, depression, guilt - inhibits the immune system. However, expressing such feelings has been demonstrated to enhance its functioning. Norman Cousins, author of *The Healing Heart*, recounts how he met a vivacious older woman who had once been told by her doctor she had only six months to live. Her response to the doctor had been a direct "Go fuck yourself", a story she was still gleefully telling six and a half years after she was given her death sentence. It brings a whole new dimension to the saying, "to vent one's spleen"!

Illness is not a sign that the body has broken down, but that it is trying to re-establish equilibrium

This anecdote also points to another increasingly well-documented phenomenon: survival time following diagnosis of a serious illness depends to some extent on the patient's attitude. People who are unquestioning of their doctors' authority and who are susceptible to 'negative programming' are likely to die within the stated time limit. Conversely, people who take a very challenging look at the whole HIV/AIDS 'machine' (Western medicine, research methods, drug companies, the media and other vested interests) are likely to fare much better. Perhaps it says something about the upstart attitude of the gay community that many of those diagnosed as HIV-positive and given a short-term sentence have had the cheek to stay alive way beyond their deadline. Their immune systems might literally be boosted by solidarity, gay pride and a fighting spirit.

Stress = slow strangulation

But how do feelings influence the immune system? Emotional conflict, along with any kind of pressure to adapt (social, economic, environmental) all affect the autonomic nervous system (ANS) as "stress". The ANS does not differentiate between the frustration of being stuck in traffic on the M25, conflicting feelings in a relationship, or being threatened by an attacker, except in the degree of perceived severity. It

[* The term holism from the Greek holos (whole) refers to an understanding of reality in terms of integrated wholes whose properties cannot be reduced to those of smaller units.]

Immune System
and the Role of Massage

responds with stimulation of the sympathetic branch of the ANS ('sympathetic' because it responds to feelings) that produces what is known as the "fight or flight" mechanism, the instinctual response to a challenge. However, fighting or running are inappropriate responses to most of the stresses in our culture. But this is what the body prepares for: the heart rate increases, glucose is released from the liver to provide quick energy, muscles are charged for action, adrenalin production is increased. The whole system is raised and focused to react. Meanwhile, non-emergency functions, such as digestion and immune function, are slowed down.

This sympathetic - or "overdrive" - state is supposed to be balanced by its other half, the parasympathetic system. This basically creates the opposite effect of relaxation: softening of muscles, deeper breathing, easier digestion, and repair of the body (including optimal immune function). For example, if you are suddenley grabbed from behind, you will probably tense up immediately, but when you turn and find out it's your best mate, you heave a sigh of relief and relax. However, due to the amount of stress generated in our society, people often get stuck in a chronic state of imbalance without rebounding into the parasympathetic to relax in between. In this way, stress becomes internalized throughout the body and can get 'locked in', creating a constriction which the individual becomes so used to that he or she thinks of it as 'normal'.

If you receive a major shock - rape, a business disaster, or getting a positive result on an HIV test - your body may continue to hold the initial 'frozen' posture, including a feeling of a vice-like grip around the diaphragm holding in the sharp intake of breath. What is significant is how the event effects your perception of your capacity to survive, and whether you believe you can act to protect yourself. It has been shown that the greatest stressor of all is the 'no way out' situation, which acts to keep the body permanently overstimulated. Whether the research is carried out on rats or undergraduates, it has shown that there is a correlation between finding resources for coping and the level of natural killer cells in the immune system.

Interestingly the word "stress" from the Latin *stringere* (to draw tight) is similar in meaning to the Latin word *angere* (to press tightly) which is at the root of our words anger, anxiety, and anguish. This inner turmoil translates in the body as tightness, tension, sensations of pressure in some cases, literally hardening and narrowing the arteries, as in angina pectoralis, a medical condition which can precede a heart attack.

Massage: moving towards balance

From this point of understanding that social and emotional pressure is manifested as physical tension and constriction, it is perhaps easier to recognise the benefits of holistic massage. Most people associate massage with tense muscles, but the constrictions and imbalances created by stress affect all the body systems. These can be positively influenced by massage aimed at relaxation because it directly stimulates parasympathetic action. People often need the permission of an allotted time to be able to let go. The massage therapist's ability to create an atmosphere of emotional safety and comfort is another factor in enabling people to relax. Allowing oneself to receive is crucial for reminding the body of the state of calm in which healing can take place.

At its best, massage has the effect of creating space through deepening the breath, releasing tension in the tissues, facilitating the movement of fluids (blood and lymph) and more subtle energies. Some sessions leave people in touch with a profound feeling of peace. Another common reaction is a deep feeling of tiredness followed later by an uplift in energy. In some cases, it may take many sessions and the gradual building of trust in the relationship before any kind of deeper relaxation can happen.

The basic premise of holistic therapy is that illness is not a sign that

the body has broken down, but that it is trying to re-establish equilibrium. Rather than being mechanical, the body is perceived as intelligent, that is, capable of making choices based upon the information available. The nervous system constantly processes information from outside the body (via the senses) and from inside in order to maintain health (see *AIDS Babes?* in this issue). However, under stress or from lack of use, the pathways can become congested, which slows down the flow of data. Information received via the skin plays a vital role in this complex circuitry. The effect of massage is to increase that information a hundred-fold, flooding the nervous system with rich new insights about the body, inside and out. This creates an experience of feeling lighter, clearer, and more integrated.

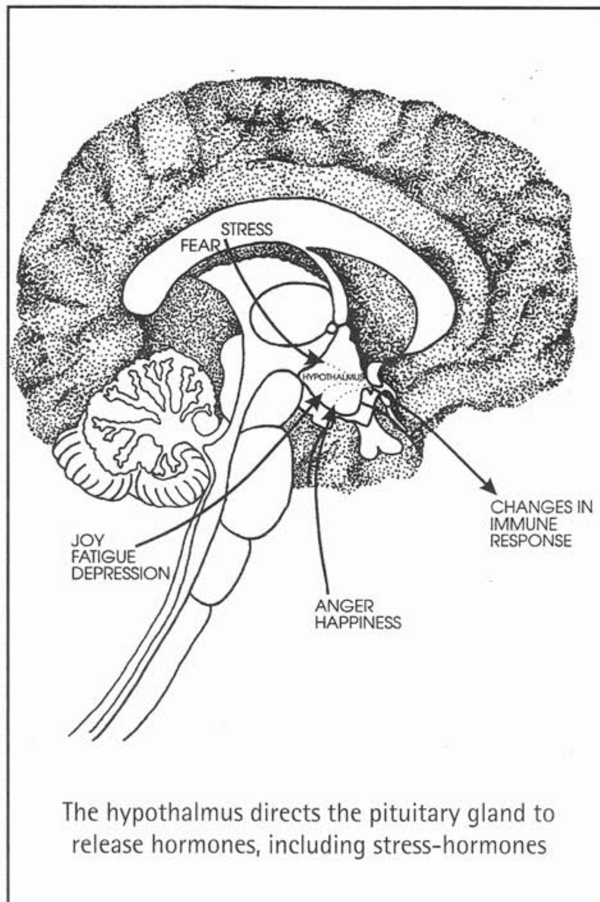
The regulation of the perception of pain is one example of this feedback loop. Pain alerts the body to a problem. However, when the body is in the sympathetic mode, it releases endorphins, the body's own pain killers. Endorphins can also create a high feeling, masking exhaustion, which is very valuable in an emergency, but which can also become quite addictive. In illness, or during depression and anxiety, the perception of pain may be increased, and even become unbearable. However, massage can help release endorphins and encourage relaxation simultaneously. This both produces the experience of pleasure, for which massage is well known, and helps re-educate the person to have positive associations with the body. The effectiveness of massage in relieving pain, depression and anxiety, and in assisting individuals in giving up antidepressants and tranquillisers has been well-documented.

Until the body has released its emotional toxins as well as more biological toxins, its tissues will be unable to return to full health

In and Through Touch: the psychological effects of massage

Massage therapy involves a complex and subtle interaction between two people - even though the client may remain in a largely receptive state. The therapist will ask some questions, but most of the evaluation of your psychological and physiological state happens through touch and close observation of changes in breathing, skin colour, tones and sensing of fine energy movements. At the same time, she or he is responding to you with carefully selected and appropriate touch, working specifically on certain aspects or parts of your body, but maintaining an overall awareness of your emotional and physical needs.

Holistic massage encourages gentle cleansing processes including the stimulation of the lymphatic system (where white blood cells develop and destroy viruses or bacteria), increased oxygenation and cirulation of the blood, decreased stress on the liver (the main filter of blood), and easier and more frequent urination. It stimulates digestion which promotes a better processing of food and efficient elimination of waste products, including toxins. In immune dysfunction the bowels can be affected by an overgrowth of harmfull bacteria such as candida and therefore anything which maximises their function is beneficial.



The hypothalmus directs the pituitary gland to release hormones, including stress-hormones

Gerda Boyesen, the Norwegian psychologist and physiotherapist who developed biodynamic massage, has suggested that the gut also digests emotional experience. Massage stimulates peristalsis which helps in ridding the body of residual hormones, such as adrenalin, produced by stress. Like Wilhelm Reich, a student of Freud's, she argues that traumatic experience, especially where appropriate reactions and feelings are prevented from being discharged, remains 'stuck' in the tissue of the body. The idea of the body having a cellular memory, not just of its chemical history, but of its emotional life, is rapidly gaining more widespread acceptance. In fact, Boyesen's work proposes that until the body has released its emotional toxins as well as more biological toxins, its tissues will be unable to return to full health.

The increased body awareness that results from receiving regular massage usually enhances the individual's awareness of his or her feelings. Particularly with massage systems designed to work psychologically (such as biodynamic massage) there can be a surge of memories or images, or strong physical experience of feelings which may have been buried for a long time. Just contacting the feelings or memories may be all that it needs, and this can precipitate major physiological changes and healing.

Opening the Heart

Touch has many profoundly important functions to play in the health of the body. Touch that is caring, non-sexual, and does not demand any reciprocity or action creates a deep feeling of well-being and a sense of being nurtured. It recalls the safety and love of a mother's touch which has a powerful effect on immunity (see *AIDS Babes?*). Touch can soften the heart, causing a physiological relaxation of the organ as well as an emotional opening up. The thymus, which produces hormones to regulate the activity of T-cells, is located close to the heart. Although orthodox medicine does not document any physiological influence of the heart on the thymus, some holistic practitioners believe it plays an important role. The thymus primes the T-suppressor cells which make sure that the killer cells don't get out of control and start attacking the body itself (as in autoimmunity). It is interesting to speculate whether there is a connection between autoimmunity and experiences of being victimised or scapegoated, either in the family or in society. If so it would seem that, at an organic level, the individual is anticipating or reproducing the external attack.

Western society has been described as one of the most "touch-deprived" in the world, referring not only to the limited physical comforting contact but also the touching of minds and hearts, the time spent being with someone without having to 'do' anything except be yourself. Massage cannot replace loving friends and family, but it can provide a space where, through a professional contract, people can allow themselves simply to receive. Massage has the potential to communicate a positive message to the person directly through the body: I am here with you, I accept you as you are. Touch is a natural way to express acceptance, support and appreciation.

The experience of non-judgemental presence and a compassionate touch may be fundamental in overcoming an ingrained sense of shame about the body. In our society there is a great deal of fear and embarrassment about the body which is translated into non-touching, which can feel like a rejection. Indeed 'untouchable' is a word we use to describe those who have been ostracised. This is particularly relevant to those with a positive or AIDS label. Not only is there a widespread and irrational fear of

contact among the general public, but some groups have wanted to view HIV as a punishment for sexual activity. A number of AIDS-related conditions affect the skin, erupting on the boundary between the individual and his or her world, and receiving touch may be vital to counteract the feeling of being marked.

It is unfortunate that massage in our society has been so strongly and negatively associated with sex. This has occured partly because it is used as a cover for prostitutes who are not allowed to declare their services more explicitly. Also, between lovers the intimate touch of massage may be directly sexual, or a prelude to intercourse. But perhaps the confusion around massage and sexuality has to do simply with society's unhealthy repression of touch and sexuality. As a result of this many people are anxious about trying holistic massage because they are not sure what will happen. Massage therapists are trained to be sensitive to individuals' different feelings about being touched. Many people are uncomfortable about having some parts of their body massaged, such as abdomen, buttocks, feet or perhaps their heads. These feelings will be respected. Sometimes fear of being massaged is a result of past experiences of abusive contact - physical abuse in childhood or as an adult, including any kind of unwanted or inappropriate touch.

Psychoneuroimmunology is confirming that the most powerful healing agent in existence is an individual's own immune system, and that system is strongly conditioned by how a person feels about themselves. The massage therapist's ease and confidence with the body, his or her

Touch is a natural way to express acceptance, support and appreciation.

skillful and considerate care, can generate in the client a new sense of their body as something to be nourished and cared for. This is hard to communicate in words, and its effect can be much deeper than 'good resolutions'. Self-acceptance can lead to a commitment to self-care, which is an ocean apart from self-indulgence, for which massage is often mistaken. Self-care means nurturing the body in an unforced and spontaneous way. In this way, feelings of hope and anticipation, combined with a healthy lifestyle, are translated by the organism into biological processes that can re-vitalise the immune system.

Cautionary note

Massage does not work miracles. This article has focused on the potential of massage, stretching way beyond the benefits ordinarily attributed to it. Like other complementary therapies, it suits some better than others, and therapists vary from being merely competent to being extremely gifted healers. To truly have a positive effect on the immune system, you need: a well qualified and experienced practitioner; regular sessions over a period of months or years; and a lifestyle that is generally supportive of health.

What is well qualified? I recommend practitioners with training of one to three years, where the therapy is based on holistic principles, as opposed to sports massage, physiotherapy, or remedial massage. The practitioner should ideally belong to a professional association. For more information and a register of approved therapists, contact the British Massage Therapy Council.

Massage can be provoking - it can speed the release of physical toxins and repressed feelings. A session may occasionally stimulate a cleansing reaction, such as diarrhoea, a cold, shivering or deep sobbing. Some of the massage therapies listed below are appropriate for those in moderately good health, for example, rolfing. Those described as including energy work or energetic touch (which work on the subtle energy which permeates the body) are also suitable for more serious conditions.

Contra-indications for massage are standard. Practitioners should not massage open sores, or close to the site of a tumour, but working over KS is fine, and often very welcome. Even with severe wasting, sensitive contact down to the bone can be comforting. If there is fever, simple holding or stroking of the face is soothing. Similar very light touch can ease the passage of someone who is dying.

The following summary is a rough guide to the different massage approaches.

Aromatherapy.
Types of massage used vary. Most famous for the potent effect of essential oils (see Christmas issue).

Biodynamic massage.
Works across the spectrum from deep cathartic work to light energetic touch. Particular emphasis on psychological understanding of the body.

Intuitive/Holistic massage.
Draws on different massage techniques, especially Swedish. Usually quite flowing and gentle.

Polarity.
Rebalances the body energetically, mostly through quite light touch. Includes a system of diet and exercise for improved health.

Postural Integration/ Rolfing.
Works deeply on the tissue in the body. Can be powerfully cathartic, releasing deeply held emotional trauma. The aim is to re-align the body for optimum functioning.

Reflexology/Zone therapy.
Diagnosis and treatment take place through the feet, where there are reflexes to all parts of the body.

Shiatsu/Jin Shin Do/Acupressure.
Based on T.C.M. (Traditional Chinese Medicine), the aim is to balance the Ki (vital force) of the body using pressure applied with hands, feet, elbows etc. Client remains fully clothed.

Swedish massage.
This is the most common form of massage. It tends to be more 'physical', involving kneading, pummelling and friction.

There is a bewildering array of massage therapies available now. In some cases the term 'bodywork' is used to differentiate the therapy from more basic massage therapies, or because the therapy does not involve skin to skin contact. Some of the therapies described below - such as shiatsu, biodynamic massage or postural integration - involve an in-depth training. Others - such as reflexology, aromatherapy, or intuitive massage - have more variety in length of training: usually between three months and a year. Many practitioners now combine more than one therapy and may be trained in the use of Bach Flower remedies, counselling, or other supplementary arts. A variety of therapies are available free to HIV positive men and women though London Lighthouse, the Immune Development Trust and other 'HIV/AIDS support' organisations. ■

Useful Addresses

Associaton of Holistic Biodynamic Massage Therapists, 30A The Loning, Colindale, London NW9 6DR. 0181-200 4944.

British Massage Therapy Council, Greenbank House, 65a Adelphi Street, Preston, PRl 7BH. 01772 881063.

Immune Development Trust, The Basement, Gatesden, Cromer Street, London WC1H 8EA. 0171-837 2151.

London Lighthouse, 111-117 Lancaster Road, London W11 1QT. 0171-792 1200.

Other associations - see *Here's Health* Magazine.

References

All references to research into psychoneuroimmunology are drawn from chapter 10, *The Healing Brain* (Macmillan, London, 1988), Robert Ornstein & David Sobel.

Other studies are quoted in *Healing Breakthroughs* (Piaktus, London, 1993), Larry Dossey.

Massage magazine (US) publishes regular summaries of research into massage. The study of massage and HIV positive men was referred to in issue 50, July/August 1994, p. 126.

A fully referenced summary of types, applications and research into the effects of massage can be found in Gill Westland's "Massage as a Therapeutic Tool", *British Journal of Occupational Therapy,* 1993 56 (5).

Job's Body: a handbook for bodyworkers (Station Hill,) Deane Juhan, gives an in-depth look at the benefits of massage.

A summary of the principles of biodynamic work can be found in the chapter by Clover Southwell in *Innovative Therapy in Britain*, Eds. Windy Dryden and John Rowan.

Cases due to be heard in a London Magistrates Court in October will finally decide the legality of the sale of Poppers in the UK, under prosecutions being brought against sex shops selling them. Cass Mann, of Positively Healthy, examines the case against this popular 'gay' drug.

Poppers...

...high time to think again?

Poppers is the street name for Amyl, Butyl and Isobutyl Nitrites or Nitrates, a class of drug for which the only legitimate usage today is that of Amyl Nitrite as a Cyanide antidote, and of Amyl Nitrate as an anti-spasmodic for Ergot poisoning.

Poppers are used almost exclusively by gay men as a euphoric stimulant for dancing (recently in combination with Ecstasy), as well as to facilitate penile penetration in anal intercourse and also in 'fisting' (the insertion and manipulation of the hand in the rectum). Poppers are gaining popularity in S&M circles and were implicated in the recent death of transvestite MP Stephen Milligan where a poppers-soaked segment of orange was found in his mouth, a popular mode of delivering the drug in the asphyxiation S&M practice he was involved in when he choked to death. Poppers are also becoming increasingly popular amongst schoolchildren, where the drug is sold in playgrounds for 10p a sniff of the colourless liquid from the capped 10ml bottles which sell for £5 a bottle.

The drug's *modus operandi* is to cause vasodilation (dilation of blood vessels), which means the heart has to pump faster. Smooth muscle, such as anal and heart, is relaxed, accompanied by a sense of euphoria. Despite the increasing popularity of poppers amongst solvent abusers, not one government-funded drugs agency dealing with solvent abuse dares include poppers amongst its warning list of solvents, because of a politically correct stance preventing them from singling out the gay community whose major drug of choice it is. Amyl Nitrite has been used medically since 1867 for coronary insufficiency (Angina Pectoris), but has long been superceded by a new class of drug. There is, today, no legitimate use for these drugs outside of the aforementioned extremely rare cases of poisoning requiring emergency medical intervention.

Marketing poppers is illegal, because such sale contravenes the 1990 UK Medicines Act (they are already banned in the US and France on health grounds), and lethal because data published since 1983 in medical and scientific journals, as well as in the gay press, has clearly demonstrated the health risks associated with poppers usage. As early as 1973, patients had presented with unusual symptoms of immune deficiency at London's St Mary's Hospital, all of whom were gay men who used poppers, and all of whom had unprotected anal intercourse (mirroring exactly the first group of gay men who officially gave AIDS its designation a decade later in the US). The inhaled Nitrites (or Nitrates which then convert to Nitrites in the body) combine in blood with the Amines present in faeces to form mutagenic Nitrosamines, the most lethal group of carcinogens known to man. This results in mutations of faecal micro-organisms and viruses and to DNA damage in leucocytes, as well as the formation of Nitrosoglutathione which depletes the body's natural Glutathione defence against toxic chemicals and drugs and against the toxicity of the ubiquitous oxygen radicals. This cascade of immunodestructive events is established today as a causal factor in AIDS.

The annual profit in the UK alone is estimated at £8.5 million

The world's first conference on poppers was held last May in Maryland, USA, convened by the US Department of Health & Social Services, at which the world's leading researchers attended and presented data. Dr Robert Gallo, leading US AIDS researcher, stunned the conference by announcing that "The primary cause of Kaposi's Sarcoma in AIDS could be the use of poppers ". KS was one of the original AIDS-defining illnesses, which became known as "Gay Cancer" at the start of the AIDS decade. His statement was, however, largely ignored by the very reporters in the gay press who until then slavishly reported every single word he uttered. Why? The reasons make chilling reading.

The burgeoning 'Pink Pound Economy' in the UK is significantly based on the profits made by the sale of poppers, with advertising revenue silencing potentially critical journalists. The widespread sponsorship of gay events such as Pride 1994 and Mr Gay UK 1994 raised the status of poppers manufacturers and sellers to that of philanthropic community benefactors. It seemed impossible to enter a dance tent at Pride without suffering a blast of poppers into your lungs whether you wanted it or not. (Passive poppers inhalation has also been implicated in immune system destruction in studies, akin to the dangers established in passive smoking.) The annual profit from sales in the UK alone is estimated at £8.5 million, most of it undeclared, with manufacturing bases in the UK even exporting poppers to the US at massive profits.

The drugs are concocted in unlicenced and unmonitored premises by unregistered personnel, with no hygiene regulations or quality control governing their manufacture. Their ingredients are unlabelled, with the various chemical toxins and poisons making up the formulae being of unknown composition, which makes antidoting in the case of a toxic reaction impossible. This has been known to have resulted in deaths in the UK.

In 'Drugs R Us', broadcast last summer in Channel 4's gay 'OUT' series, it was established that the commercial gay scene was almost entirely fuelled by drugs, with interviewees stating that it was "impossible to be a card-carrying homo without taking drugs now". All it takes is a weekend out in any club to establish that the use of poppers is so ubiquitous, normalised and desirable that you are considered homophobic, sexphobic and the destroyer and betrayer of all the hard-won gains made by gay liberation if you dare to warn users about the health hazards. Well, if gay liberation meant only the freedom to die of drug abuse, it wasn't worth it!

In conclusion I list the health hazards of poppers usage, in addition to the clear link made by Dr Gallo of its causal role in Kaposi's Sarcoma:

Primary or secondary cause of AIDS-defining symptoms such as brain damage, sustained alterations to the immune system, susceptibility to opportunistic infections and irreversible alterations in T-cell Lymphocyte function. Other symptoms include Heinz body cell anæmia, Methemeglobinæmia (depletion of red blood cells), cardiovascular damage, skin burns and strokes, Oh, and death. ■

Image from 'The Relief Fund for Romania' leaflet

AIDS Babes?

Who can forget the chilling images of Romanian children dying of AIDS that were common on our screens a few years ago? Molly Ratcliffe examines the story behind the story.

"Being touched and caressed, being massaged, is food for the infant. Food as necessary as vitamins and proteins. Deprived of this food, the name of which is love, babies would rather die. And they often do."[1]

Leboyer

In 1990 the media was suddenly awash with stories of Romanian AIDS babies. Haunting photographs and TV footage showed infants and children wasting away, staring forlornly from inhospitable rooms, lacking even the basic necessities of survival; rocking themselves obsessively in corners and lying immobile in cots. Their symptoms were respiratory infections, failure to gain weight, recurrent fevers, mental retardation, stunted growth. On the surface it looked like an epidemic, a tragedy of epic proportions; innocent children unknowingly harbouring a killer virus. But scratch below the surface and many questions arise, such as: Where are the adult cases of AIDS in Romania? How did all the children become infected? Why such an outbreak in Romania of all places? If you were to enquire more deeply and ask what is the cause of their symptoms you might go beyond the ready answer "HIV causes them" and discover that the list of symptoms mimics with startling exactitude those observed,

the list of symptoms mimics with startling exactitude those observed in babies reared in orphanages elsewhere

since the turn of the century, in babies reared in orphanages elsewhere.

To understand further it's necessary to establish what the situation was in Romania at that time.

The government changed in 1989 when Ceaucescu was deposed. Prior to that there had been Draconian government family planning policies (contraception and abortion were banned) as a means of enlarging the population. The result was unwanted pregnancies and infants being abandoned, on a large scale, by their parents shortly after birth. The infants became wards of the state and were kept in institutions. Numbers rose throughout the 80's until by 1990 these were home to approximately 16,500 infants and children of less than four years of age, out of a total population of about 23 million. Those who were malnourished or of low birth weight were kept in dystrophic centres - chronic care hospitals - and the rest were placed in other institutions and orphanages.[2]

Until 1989 the Romanian government were against diagnosis and reporting of AIDS. The first AIDS case had been reported in 1985 in a 42-year old gay man and a few others were noted that year, but none in children.

In the first half of 1989 cases were reported in children and by late 1989 many more had been found. The majority of children with AIDS (62%) were under four years of age and living in institutions. The other 38% lived at home. ["Children" or "pædiatric" refers to those less than 13 years of age; "adult" refers to those above 13 years.]

It was presumed that adult AIDS occurred because of sex with foreigners since the first Romanian AIDS case was a steward on an international rail line, and others were said to be students who had spent time abroad or foreign students attending Romanian universities. AIDS was characterised as an STD coming from foreigners and foreign places - the diseased unknown.

Pre-1989 testing was discouraged, but with the change of government came testing in full force. Special surveillance workshops were held between February and June 1990 by the CDC (Centers for Disease Control) who were called in by the WHO (World Health Organisation). The idea was to set up epidemiological studies and test various groups of people to ascertain the distribution and levels of HIV positivity and AIDS in the population.

Case-finding was hospital- and institution-based, for children as well as for adults, although it was "less intense" for the latter group.

This sudden onslaught of surveillance and testing did, naturally, increase the numbers of people diagnosed with AIDS, especially among children. A "seek and ye shall find" situation. From four new diagnoses of AIDS in children in the half-year Jan-June '89, numbers rose to 228 new cases for the period July-Dec '89, 650 for Jan-June '90 (the time of the CDC operation) and then fell for July-Dec '90 to 212 and continued to fall: in adults the numbers newly diagnosed remained in the range of 10 -15 for the same periods.

Why were so many children testing HIV+ and being diagnosed with AIDS? In some studies as many as 60% of HIV+ infants had symptoms of AIDS.[3] The answer to that question is complex.

The test-kit being used for HIV-antibody results was ELISA which is documented as very inaccurate, thereby already throwing into question whether it was HIV-antibodies present. ELISA tests are notoriously cross-reactive with antibodies to other foreign proteins present in blood, Hepatitis B antibodies being a common cause of false positivity.[4] Perhaps it's not a surprise then to find that tests done in 1990 found 94% of a

group of Romanian children in hospitals and institutions had antibodies to Hep.B virus. Why so many children had these antibodies is answered by examining the kinds of treatment they had been exposed to.

In institutions they frequently suffered from acute respiratory and gastrointestinal problems and what appeared to be malnutrition. Physicians believed, though who knows what evidence supports this, that whole blood transfusions would provide nutrients to sick children and stimulate their immune systems. Consequently they received repeated transfusions of small amounts of blood, called microtransfusions. In addition, oral medications were often not available, therefore children with common pædiatric disorders had multiple intramuscular injections of antibiotics and vitamins. Some of the children with AIDS had been recipients of as many as 300 intramuscular injections in the first 2 years of life.[5]

At this point in my research I came across a term new to me - nosocomial infection. It means 'infection acquired during hospitalisation.' How comforting to know that the phenomenon is so wide-spread that a special term has been coined! Aren't hospitals supposed to be where people go to be helped back to health - or did I miss something?

Infants were dying of loneliness and inadequate stimulation

The Romanian situation was paralleled in Zaire where risk factors for children that had tested HIV+ were hospitalisation, injections and blood transfusions. Problems most commonly occurring were malnutrition, anaemia, gastrointestinal disorders, malaria and pulmonary diseases.[6] Further research has shown that up to 90% of children in parts of Africa given injections of medical drugs either did not require the drug in the first place, or were given the wrong drug and/or at an inappropriate dosage.[7]

According to believers of the HIV-AIDS hypothesis, the above factors meant that children were contracting HIV from the transfusions and injections, since needles were frequently re-used, without being disinfected, due to lack of resources. The microtransfusions also served to explain the disproportionately large number of children 'infected' while very few adults were, since a single adult HIV+ blood donation would get divided up and could infect many pædiatric recipients. Researchers had found a tiny prevalence of HIV positivity of 0.006% among adult blood donors in Romania.[8] As for the mothers of children, of those who could be traced only 7.5% were 'HIV-antibody positive'.

Despite apparent correlations between HIV-antibody positivity and pædiatric AIDS, HIV's role cannot be decisively implicated. Firstly, Hep.B is spread easily through blood products and re-use of needles. That is why the majority of hæmophiliacs test Hep.B positive. Health-care workers in Britain are routinely given Hep.B vaccinations every three years to guard against infection from needle-stick injures. Such ready transmission of Hep.B can account for the high level of 'HIV-antibody positivity' among infants. Indeed Hep.B positivity is said to "parallel the pædiatric AIDS epidemic in Romania".[9]

Furthermore the children would be suffering immune suppression due to the blood transfusions they received.[10] Long-term exposure to antibiotics is also known to be damaging to the system, producing fungal infections, diarrhoea and fatigue.

Conditions ocuring as a result of sensory deprivation	AIDS-defining conditions in Romanian children
-merasmus (wasting away) -stunted growth -mental retardation	-weight loss > 10% body weight (or stunted growth)
-fevers of unknown origin	-prolonged fevers > 1 month, intermittent or constant
-respiratory infections	-severe or persistent lower respiratory tract infection
-frequent bowel movements and diarrheoa	-chronic diarrhoea > 1 month
-infections and immunological weakness	-repeated common infections and generalised lymphadenopathy
-poorly developed stress response	-infections not responding to usual therapies
-pruritis - scratching and skin disorders	-pruritic dermatitis
-listlessness, apathy, depression	-chronic parotitis (mumps)
-poor muscle tone and co-ordination	-hepatomegaly or splenomegaly
	-herpes zoster
-self-rocking behaviour	-herpes simplex

So what causes this AIDS, or rather, what *IS* AIDS?

When the acronym AIDS is used it is generally supposed to refer to a single syndrome, the same that occurs in gay men in London as in heterosexuals in Uganda or in babies in Romania. That is not so. The AIDS definition varies, according to:

a) which organisation's version is used. There are CDC, WHO and modified CDC (i.e. UK) ones;
b) which year it dates from, the first being from 1982 and the last from 1993; and
c) to whom it is being applied.

In Romania a modified WHO definition of pædiatric AIDS is used, involving clinical symptoms plus a positive HIV-antibody test result (ELISA). The primary AIDS indicating signs are weight loss, prolonged fever, respiratory tract infections and diarrhoea. Not very AIDS specific!

The consensus has been that these illnesses are a result of HIV infection (despite it never having been demonstrated to have harmful effects on the body).

What is startling is that no-one seems to have noticed that these symptoms in the infants and children bear a remarkable resemblance to those found in infants in foundling homes and orphanages from the beginning of this century.

So common was the problem then that it was given a name - *merasmus* - Greek for "wasting away". Orphanages in the US in the 1920s had mortality rates as high as 90-100% among abandoned offspring despite adequate food and professional medical care. Those that survived had severe physical and mental retardation.[11]

It was presumed that the high mortality reflected poor nutrition. Evidence from a wealth of research indicates that what they actually suffered from was sensory deprivation, ie. not receiving enough physical contact. Sparse staffing was found to be the cause; infants were dying of loneliness and inadequate stimulation.

As James Haliday observed in 1948, "Infants deprived of their accustomed maternal body contact may develop a profound depression with lack of appetite, wasting and even *merasmus* leading to death. As a result of these findings volunteer women now attend some of the children's hospitals to provide infants that are fretting with periods of handling, caressing and rocking."[12]

Only with the introduction of tender loving care did infants begin to thrive. The high mortality rates spurred on reforms . The outcome: mortality rates plummeted, stunted growth and mental retardation were reversed. There were increases in weight, height, energy and mental acuity. Fewer respiratory and gastrointestinal infections occurred, bowel movements returned to normal, and fevers of unknown origin ceased.[13]

Wasting away was found among babies in even the best family homes or institutions, apparently in receipt of care but not much contact. Babies in poorer homes with more physical contact, less food and poorer hygiene, thrived. Even extreme deprivation can be survived as long as infants are touched. Experimentation showed it is not absence of the mysterious mother-child bond that causes problems, but sensory deprivation. Some called it sensory malnutrition.

The explanation for this incredible phenomenon lies in the origin and complexity of the skin, our organ of touch. Skin develops from the same layer in the embryo as the brain and nervous system - the ectoderm. This ancient relationship is reflected in the intimate connection that continues throughout life between the Central Nervous System (CNS) and the skin, for they function more as a single unit than separately. For this reason the skin is sometimes referred to as "the surface of the brain".[14]

Tactile experience is necessary for complete development of the CNS, and consequently the entire body, in its function and form.

A. Montagu who has spent his life investigating human development, writes, "The raw sensation of touch as stimulus is vitally necessary for the physical survival of the organism. In that sense it may be postulated that the need for tactile stimulation must be added to the repertoire of basic needs of all vertebrates...Basic needs, defined as tensions which must be satisfied if the organism is to survive, are the needs for oxygen, liquid, food, rest, activity, sleep, bowel and bladder elimination, escape from danger and the avoidance of pain...the evidence points unequivocally to the fact that no organism can survive very long without externally originating cutaneous stimulation."[15]

Most mammals lick their infants immediately after birth. Assumed by researchers to be a measure of hygiene, it has been revealed that licking is necessary to stimulate complete development of internal organs and the nervous system. In the absence of licking, offspring die of malformations and malfunctioning of the bladder and rectal regions. In human infants the process of labour and, post-partum, stroking, touching and holding replace licking not as a luxury but a need. At birth human infants are immature, development is only half complete. Suckling at the breast aids development of the respiratory tract, blood vessels, myelin sheaths protecting nerve cells and brain metabolism, as well as stimulating heart beat. An absence of suckling leads to unfit development and a lack of adaptability to stress. Children that have not been breast-fed have four times more respiratory problems, 20 times more diarrhoea, 20 times more miscellaneous infections, eight times more eczema, 21 times more asthma and 27 times more hayfever than those that were.[16] Surprisingly it is sensory deprivation more than nutritional loss that is significant.

A stimulating exercise is to note the many metaphors involving touch that arise in our language, which surely reveals its importance to us. We recognise the depth that touch implies when we speak of being touched, i.e. emotionally moved, by a piece of music.

Sadly in our culture in the UK as well as in Romanian institutions, the vital necessity of touch has often been missed. How often do we turn to sex when what we really want is to be held in a loving and supportive way? And on the AIDS wards in hospitals, patients lie hopelessly, surrounded by tubes and drips, visitors unable to get close enough to hug them for fear of disturbing the modern medical accoutrements.

A nurse, who set up a hospice for children in Romania called "Simona's Shelter", writes, "Cuddles are important, but cannulæ, I.V.s and antibiotics are what the children really need when they become so sick",[17] and therefore she prioritised medical staff over volunteer carers. What she didn't know is that if infants are inadequately stimulated they cannot absorb nutrients, nor can their systems function well, and they are in a state of constant internal stress.[18]

Significant biochemical differences are found in deprived infants that fail to thrive. Incomplete CNS development is expressed in malfunctioning of the pituitary gland. It has been called emotionally induced pituitary deficiency. The secretion ACTH (Adrenocorticotrophic hormone) is released from the pituitary gland at the base of the brain. ACTH regulates carbohydrate metabolism and is released when the body is under stress. Infants that have received plenty of stimulation have a normal response, ie. when exposed to stress ACTH is quickly released and stops when the danger is passed. When the body is under stress it functions in fight-or-flight mode (see massage article page 6) and the processes of repair and regeneration, as well as absorption and digestion, are impaired. Lack of stimulation in infancy produces ACTH to be released slowly and for long periods beyond the time when it is needed, an inefficient reaction. Absence of handling in animals or infants causes extreme, inappropriate and damaging stress responses which have deep-reaching consequences on the organism. In addition, the release of somatotrophin, growth hormone released from the pituitary, is interfered with by lack of contact, resulting in stunted growth.[19]

While the body is engaged in a stress response the immune system is depressed. Studies have found that the trauma of separation experienced by infant primates removed from their mothers reduces the effectiveness of immune responses, producing increased vulnerability to disease. If social support and a friendly environment are re-established vulnerability can be reversed.[20]

Not only, then, were the unfortunate children in Romania deprived of vital physical contact which caused incomplete development, but their immunity to infections was also weakened. Self-rocking, that was often to be seen in the TV footage of Romanian orphans, can be seen as an instinctual attempt to alleviate their own suffering. It recreates the comfort experienced in the womb and has parallels in the behaviour of people mourning. Physiologically, rocking strengthens the heart-beat, circulation, respiration, muscle-tone and increases the efficiency of gastrointestinal function. Rocking a child in a cradle has similar benefits.

Pruritis, another of the "AIDS symptoms" can also be understood in terms of tactile deprivation, when a mechanism by which HIV causes it has never been demonstrated. Scratching often represents the unconscious striving to obtain attention that was denied in early life, especially attention denied to the skin. Unexpressed rage and frustration as well as a repressed need for love may find symptomatic expression in the form of scratching, even in the absence of itching. Have you ever noticed people scratching when they are nervous?[21]

Peter Makrith, who spent time in Romania working with adults with mental health problems, told me that touch was a difficult activity there. Romanian workers in the hospitals were shocked that therapists touched clients at all since they were seen as untouchable. Babies experiencing abandonment and the additional trauma of an 'AIDS' label suffered a similar fate. There are reports from dystrophic centres of staff afraid to touch children, only doing so when necessary, ie. to change nappies, and then it probably wasn't loving contact they received. They have been described as "forgotten children...tiny bundles swaddled in their cots".[22] I have spoken with nurses in the UK working on pædiatric wards and they have confirmed that the same kind of irrational fear and subsequent abandonment happens here too, when a baby is perceived to be at risk of HIV infection or AIDS. Hospitals would like to believe they don't discriminate but the reality is a different picture. Can it be any wonder, then, that babies in Romania and elsewhere are dying? The pattern of their illnesses is attributable not to "HIV" but to deprivation of sensory stimulation. ■

How often do we turn to sex when what we really want is to be held in a loving and supportive way?

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False Positivity of ELISA and Western Blot HIV-antibody tests

Both tests, which are routinely used by laboratories to ascertain 'HIV positivity', are very inaccurate and neither sensitive nor specific. Sensitivity is the measure of how many tests show positive when the person actually is positive, i.e. how many false negatives. Specificity is the measure of how many negative results you get when people are actually negative, i.e. how many false positives.

What is meant by 'actually positive' is that other tests can supposedly show that HI Virus is present, though Eleni Papadopulos-Eleopulos and Stefan Lanka have eloquently shown that HIV has never been isolated. The phenomena said to be the 'genetic sequence of the retrovirus HIV' has most certainly been misinterpreted, and is probably an expression of processes occurring within the body.

The following things can cause a cross-reaction on the ELISA and Western Blot tests and give a false positive result:

- Hepatitis B vaccination
- Prior pregnancy
- Blood transfusion
- Alcoholism
- Certain cancers
- Auto-immune diseases
- Malaria: 75-80% of malaria patients test false positive
- Liver disease: affects IV drug users and alcoholics often
- Heat treatment of the blood samples
- Prolonged storage of blood samples
- Many other viruses
- Lupus
- Kidney failure
- Parasitic diseases (ubiquitous in sections of the gay community)
- Rheumatoid arthritis
- Antibodies to nuclear antigens
- Human Leukogenic antigens
- Human T-cell antigens
- The ingestion of foreign sperm
- Semen in the blood from anal sex
- Antibodies to the products of muscle wastage (mitochondria)
- Hypergamma globulinemia (excess gamma globulin in the blood)

Other factors to take into consideration are:

- False positive results increases with age
- Stickiness of the serum (blood), which increases with oxidation, a result of taking drugs.

Source: Christine Johnson, US journalist involved with HEAL L.A., interviewed on the Matthew Grove N.Y.C. Cable TV Show.
This list is not conclusive.

Sufficie lea

The HIV Debate is ho with the publication an international r

On 7th September the extensively read international science journal *Nature* published a lengthy letter with data from Sarah C. Darby *et al.*, and an accompanying editorial, claiming that through an epidemiological study of hæmophiliacs with diagnosed HIV infection, the causative link between HIV and AIDS had been proven. A vigorous press release from the Medical Research Council ensured maximum attention.

The main newspapers and television news programmes ran the story within days, with at times angry calls, repeated from the *Nature* editorial, for all manner of dissidents to apologise for ever doubting that HIV=AIDS ("a heavy responsibility that can only be discharged by a public acknowledgement of error, honest or otherwise") and for leading the vulnerable astray. The internet buzzed with more hum than usual.

Continuum was approached early on the day of *Nature*'s publication by a BBC news team for comment and information - a news story which

PRESS RELEASE...I

12th September 1995

The recent widely publicised study in *Nature* (7/9/1995) which claims to provide conclusive proof that HIV causes AIDS in people with hæmophilia, is deeply flawed, because the following points were not taken into account:

1. a. The age at which the people with hæmophilia received an AIDS diagnosis, because this determines the total amount of Factor VIII they received. Until a few years ago, Factor VIII was only 1% pure, ie. 99% of it consisted of other people's proteins which are self-evidently highly immuno-suppressive to the recipient.[1]
   b. The data concerning cause of death is not provided: how many died of AIDS related diseases, how many of hæmophilia itself, and how many of natural causes. How many deaths were confirmed by autopsy/necropsy studies?
   c. The drug regimes, intended to forestall the onset of AIDS (eg AZT and its analogues, pentamidine and Septrin), but known to be highly damaging over time, are not adequately described.

2. No explanation is given as to why deaths escalated between 1989-1992. We consider this to be attributable

nt proof that HIV ds to AIDS?

ng up, with *Nature*'s retiring editor, John Maddox, fanning the flames study of people with hæmophilia. *Continuum* helped co-ordinate onse to recent events, detailed here. More will follow next issue...

even so made it on air with only a hint that there was another way of looking at the conventional conclusions of the study. The UK national weekly *Pink Paper* began putting together a lead story on the controversy.

The letter in *Nature* reported that the Darby study followed the total membership of the British Hæmophilia Register between 1977 and 1991, and claimed a ten-fold higher mortality among those considered infected with HIV than those not, and that mortality did not depend on the severity of the hæmophilia. The study reported 403 deaths in seropositive patients out of a total of 1,227 in the period 1985-1992, while deaths among seronegative hæmophiliacs remained at eight per 1000 people. "Most of the excess deaths were certified as due to AIDS or to conditions recognised as being associated with AIDS." The letter also noted that, "Treatment by prophylaxis against Pneumocystis carinii pneumonia or with Zidovudine has been widespread for HIV-infected hæmophiliacs since about 1989...This study includes deaths only to 1992, and so does not permit examination of data following widespread use in the UK of high purity concentrate [Factor VIII]."

In collaboration with our colleagues also involved in questioning and challenging the prevailing HIV/AIDS dogma, *Continuum* produced a press release which went to 20 media sources and was put onto the internet by John Lauritsen, leading US journalist and HIV critic.

Overtures to a pre-eminent scientist published in the field of hæmophilia and AIDS, Dr Eleni Papadopulos-Eleopulos of Perth, Western Australia, brought forth the promise of a complete and liberating scientific rebuttal of the many inconsistencies and false conclusions apparent in and drawn from the Darby *et al.* study, for the next issue. A preliminary draft indicates there are grounds for serious worry on the part of those who have thought and published only shallowly on this important matter. ■

ESS RELEASE...PRESS RELEASE...PRESS RELEASE

to the use of AZT in asymptomatics, administered in the completely mistaken belief it would slow down or arrest HIV disease progression (cf Concorde study, 1993).

3. Given that nobody in the study should have been infected after 1985 (because of heat treatment and donor screening), those infected before 1985 should by now all have died, if the ten-year latency for HIV is correct. In fact, only 403 out of 1,227 have died. This implies that the latency period of HIV is about 30 years, or that HIV is not the cause of AIDS. Which is it?
4. HIV has never been detected in, isolated from or otherwise demonstrated to be present in the Factor VIII used by hæmophiliacs! It has only ever been ASSUMED to be present.[2]
5. In the course of preparing Factor VIII from blood, it is freeze-dried. This procedure effectively destroys any HIV that may have been present in the pooled blood samples from which it is obtained. This, therefore, means that the deaths attributed to HIV would have to have been caused by a destroyed virus, or alternatively, the CDC is completely mistaken.[3] Which is it?
6. Even if cell-free HIV could have survived the process of freeze-drying, it has been known since 1989 on no less an authority than the head of the NIH that the virus particles would have spontaneously lost the gp120 spikes, essential for it to attach itself on to the CD4 receptors of the cells which it is thought to infect.[4] This means that the virus could never have been infective.

Far from apologising as called for in an editorial in *Nature* accompanying the present study, we "the obstinate community of the unconvinced" have every reason to remain so, and consider that the study simply supports the views held by Professor Duesberg (Berkeley), Dr Papadopulos-Eleopulos (Perth), Dr Harvey Bialy (New York) and others that HIV is not the cause of AIDS.

On the contrary, we hereby request and require that the scientists involved re-adopt proper scientific principles in this very important field of public health.

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Surviving, and other problems

Principal investigator of the long-term survivors/non-progressors study at the Kobler Centre, London, Dr PHILLIPA EASTERBROOK talked to Huw Christie and Molly Ratcliffe about the study and also some of the complexities of HIV and AIDS research.

Dr Easterbrook's history is intriguing. She has a background in clinical medicine and went on to work in Epidemiology, having been converted by the charismatic epidemiologists of Oxford. Realising that to get known as a research scientist is extremely competitive and entails spending all available time in the laboratory, the 'big picture' of epidemiology seemed more attractive. Thus she found herself going to the US and working on the M.A.C. (Multicentre AIDS Cohort) Study. Subsequently she returned to London and in August 1993 set up the long-term survivors/non-progressors study at the Kobler Centre, which is the GUM clinic of the Chelsea and Westminster Hospital. The results have yet to be analysed and interpreted, but there was much to talk about with her meanwhile.

First, why call it a 'Long-term Survivors/Non-progressors' rather than simply 'Long-term Survivors' study, as it has previously been referred to? It appears there is current dispute about the definitions of these terms among AIDS researchers. Dr Easterbrook uses the term 'long-term non-progressor' in the protocol of the study to mean a person with these characteristics:

1) HIV-positive test result pre-1988;
2) CD4 count of 500 or more and not dropping below that number;
3) No AIDS-defining conditions;
4) May or may not have used antiretrovirals.

A 'long-term survivor', however, is someone who has:

1) HIV-positive test result pre-1988;
2) CD4 count may fall below 500;
3) May have AIDS-defining conditions but still be surviving beyond three years of diagnosis;
4) May or may not have used antiretrovirals.

The third group of people enrolled in the study are 'Rapid Progressors', ie. those who progress to AIDS and die, within the expected medical model. There is no HIV-negative control group. The total number of people enrolled since 1993 is 162, of which, at entry, 71 are non-progressors, 75 are slow progressors and 16 are rapid progressors.

It seems sad to define a group as 'non-progressors', thereby suggesting they may be lagging behind in some way, when actually their condition is most hopeful and their *non*-progression means not getting AIDS, when doctors presume they should. (But when did allopathic medicine ever empower through language?)

What partly inspired Dr Easterbrook to set up the study was seeing a long-term survivor speak at the XIth International AIDS Conference, Berlin, 1993. The aim of the study is to look at biological as well as psychological/life-style factors in order to understand how they influence progression (or not) to AIDS. Biological factors being measured include CD4 counts, CD4/CD8 ratios, 'HIV' genetic sequences, 'viral' load etc. Lifestyle and psychological factors taken into account are many and varied, including diet, complementary therapies used, antiretroviral use, beliefs about self and what is important to own well-being. As Dr Easterbrook described the kinds of questions asked some of the problems of epidemiology as an accurate tool became apparent. Namely, that you can only study people that are willing to be studied, come to clinics, fill in a long, detailed questionnaire, return regularly for check-ups, and, as such, the participants are self-selecting. The reliability of the information you receive is dependent, then, on the accuracy or honesty of their replies to the questions. Do you know anyone who was ever 'economical with the truth' in a questionnaire, even an important one? Certainly it happens and therefore affects the usefulness of such a study.

Another problem in the study protocol is the use of CD4 counts as markers of disease progression. Dr Easterbrook agreed that CD4 counts, as shown in a recent study (among many others) "fluctuate according to a number of factors not related to immune activity (eg. cell migration, circadian rhythms). In addition, there is evidence that the relationship between immune cell presence in peripheral blood and immune cell function is at best tenuous."[1] Why, then, use CD4 counts? Though she didn't offer a convincing explanation, she did tell us that CD4 *percentages* are a more accurate result to use. CD4 percentages, she told us, are the percentage of the total number of lymphocytes/mm^3 that are CD4s.

Dr Easterbrook agreed that CD4 counts fluctuate according to a number of factors not related to immune activity

We have since tried to confirm the accuracy of CD4 percentages and found that they are as inaccurate as the CD4 counts, since the percentage is calculated from the count. There are studies showing that CD4/CD8 ratios change while the total number of CD4s and CD8s remains constant or even grows.[2] However, the point remains that in the Kobler Centre study CD4 counts are being used as part of the definition for progression and non-progression to AIDS.

It becomes clear that the absence of an HIV-negative control group is a serious flaw in the study. In 1989 it was shown that "HIV does not appear to cause more impairment [to CD4 cells] than seen in....uninfected peers".[3] And the researchers went on to state "the importance of using seronegative peer group controls in studies on HIV infection". With no negative control group of her own Dr Easterbrook is using results from HIV-negative controls in the M.A.C. Study, which involves people from several US cities, with different climates, cultures, diet, lifestyles and ethnic origins, etc. from those people in her study here in the UK (an example of these differences is the ethnic origin of participants; the

M.A.C. Study is composed mostly of afro-Americans, whereas in the Kobler study all but two are Caucasian in origin). It could hardly be called a suitable control group. From 1985-87 blood samples were tested to ascertain HIV antibody positivity with two separate ELISAs and a confirmatory Western Blot carried out at Colindale Public Health Laboratories. From '87 onwards blood was tested with two ELISAs, called confirmatory ELISA produced by Envacor. Well-documented problems with both these tests persist.

Alluding to 'HIV-related symptoms' in the non-progressors group, Dr Easterbrook felt it necessary to put quotation marks in the air. By way of explanation she told us that many of these conditions - gingivitis, skin problems, etc. - are common in the general population as well as occurring in the 'HIV+s', therefore they are not certain to be 'HIV-related', though that is how they are referred to in the study. Had there been a proper control group it might have been possible to know the incidences of such conditions in 'HIV+' and 'HIV-' people.

The results of the study have yet to be examined and will, she hopes, be published in the autumn. Dr Easterbrook has already presented papers at conferences and made some observations as to what they might find: her feeling is that non-progression may be related to genetic make-up, predisposition in the individual to having aggressive killer cells, or to the type of HIV present (its genetic sequence). It would be difficult, she agreed, to isolate a genetic effect from all the other variables occurring in a person's life from conception onwards, yet she felt it was biological factors that would prove to be important. From her observations, she feels

It's clear that the absence of a HIV-negative control group is a serious flaw in the study

that psychological factors, such as feeling good about oneself, were irrelevant to disease progression. Psychological factors have previously been shown to influence susceptibility to diseases in individuals,[4] making her observations surprising. That biological factors are more fact-based and apparently precise may be a reason why they are being given more credence than psychological factors that are obviously infinitely variable. Yet the biological factors are also infinitely changeable, and tests merely describe one moment in the moving frame of a person's life. Sadly this is often forgotten by those wishing to have fact-based data.

As Dr Easterbrook often appears on television, giving her opinion on the latest HIV/AIDS media story, we were keen to know her views on how HIV causes AIDS. Her answer was shocking.

"I'm a believer!" she exclaimed.

That may be so, but as a scientist, what substantial reasons back up her belief? She declined to comment on whether HIV killed CD4 cells, needs co-factors to produce disease or had another mechanism of pathogenicity. Has HIV ever been isolated, has she seen a native gel of it?[5] On this she couldn't comment either; indeed, she didn't know the significance of the question, "not being a virologist". Neither could she discuss whether HIV is a lentivirus or not. Steven B. Harris, proponent of the 'HIV definitely causes AIDS' theory, whose work has been promoted by Dr Easterbrook, is convinced HIV is a lentivirus. In light of recent research done by Ho and Wei[6] HIV would have to be, according to the orthodox view-point, the fastest lentivirus (lenti = slow) ever proposed.

Epidemiology is, for Easterbrook, where the conclusive proof that HIV causes AIDS is found. "AIDS," she says, "conforms to an epidemic curve"; an outbreak of measles among six children could conform to an epidemic curve. Does she believe, therefore, that there is an epidemic of AIDS? "It's actually called a pandemic," she replied. "There is a colloquial use of epidemic, however there is also a biological one....." Pandemic means (of a disease) 'prevalent over a whole country or the world'. The diseases that are lumped together as AIDS do occur throughout the world, but that doesn't prove HIV causes AIDS. All of the diseases existed before HIV was 'discovered' or AIDS was named, and then, as now, occur in groups of people with susceptibility to them, for various reasons.

Pressed further on the views of Steven B. Harris, disagreement between them emerged. On prognosis, Harris states that maybe 90% of people with HIV get AIDS, that 50% of HIV+s will die of AIDS in 10 years, and in 15 years 75% will be dead. Dr Easterbrook diverges from these postulations. She emphatically asserted, "Figures, from time of infection to AIDS, are very well established. 5 - 10% infected for 10 - 14 years will be well. 75% being dead is excessive. Median time between infection and development of AIDS is 10 years. From AIDS diagnosis to

"I'm a believer!"

death is 18 months median. 50% will still be AIDS-free at 10 years and of those who've developed AIDS, half will still be alive."

Small comfort to 'HIV+' people that doctors cannot agree on prognosis, and dependent on who you ask, may give you divergent answers. It is therefore news that the figures are well established. Could it be empirical science or hopeful beliefs behind these figures?

Regarding prognosis, we were interested in her views on recent findings from St. Mary's Hospital, London.[7] It appears that HIV+ patients attending clinics for up to eight years fared worse than patients presenting with their first AIDS-defining illness at the same time as testing HIV+, which has huge implications for the therapeutic value of prophylaxis or regular, sustained attendance at GUM clinics (see *News in Brief*). Dr Easterbrook's position is that the research will be found to have other variables accounting for the results, and that attending clinics couldn't be harmful. (Coincidentally, there was an outbreak of TB in the Chelsea and Westminster Hospital at the time this interview was conducted.)

On AZT use, Dr Easterbrook is confident that it is not useful to give it to asymptomatics. Disappointingly, however, she didn't have an opinion on the 1994 CDC fact sheet[8] that shows 'HIV' could not have been in Factor VIII products in an infectious form. Hæmophiliacs, she implied, were to her an unknown, which is again surprising, since references to hæmophiliac studies appear in her 1994 paper.[9]

Her role as an epidemiologist is to communicate with researchers and patients, and co-ordinate the results. Unfortunately, perhaps her lack of knowledge prevents her from having the right questions asked or understanding the 'big picture' that she seeks. At times it seemed there was more to learn from what she didn't say than from what she did, and her unfamiliarity with whole areas of AIDS research was profoundly worrying.

Gesturing, with an air of exasperation, to piles of papers which she had to read, she expressed a wish to take a week off to do so. If her credibility as a media AIDS expert is to survive, it's imperative that she do just that. ■

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The Focal Point Hypothesis of AIDS

Goya captioned one of his most powerful etchings "The Sleep of Reason Produces Monsters". He might have added, "So does Political Expediency"!

In the heady days when Robert Gallo was still being venerated as the discoverer of 'The probable cause of AIDS', before the scientific sleaze and international filching of viral isolates came to light, he was asked by a deferential reporter what made him first think that a retrovirus might be the cause of AIDS. Gallo's reply, departing from the kind of quip we would later come to recognise as typical 'Gallo's humour'*, was ambiguous - "We needed a focal point." Did the Saviour of Mankind let the cat out of the bag almost from the outset? With the benefit of hindsight, more then a decade later, it is worth examining that sentence more thoroughly in order to understand how this focal pointillism came to dominate AIDS research.

The Latin legal phrase *cui bono?* gives us the key to understanding the way that AIDS research developed. It translates roughly as 'who benefits?', meaning who stood to profit, and is usually associated with trying to find the motive behind a crime. So far the only people who have consistently failed to profit from the 'focal point' AIDS hypothesis in terms of survival are people with AIDS.

So who did stand to profit from proving that a retrovirus was the single cause of AIDS? Obviously, 'experts' in retrovirology, of whom Gallo was one. Indeed, he was by 1981 the golden boy of cancer research, smothered with fame and awards for appearing to show that a human retrovirus could, after all, cause a form of cancer, namely Adult T-Cell leukaemia. It is worth noting here that this form of cancer was unknown to the medical profession until 1975, some five years after Howard Temin *et al.* discovered the phenomenon of reverse transcription, and the intensive study of the newly dubbed 'retroviruses', and their relevance to disease, clinical or otherwise, began. We are meant to believe that a disease should conveniently appear five years after the discovery of its potential cause, which smacks of precognitive serendipity allied to wishful thinking rather than true science. In 1987 the world's leading retrovirologist Peter Duesberg elegantly demolished the retroviral causation of this rare cancer in a paper in the journal *Cancer Research*, and at the same time declared HIV to be a harmless passenger virus, and not sufficient or necessary to cause AIDS, another previously unknown illness. Robert Gallo, by then elevated to the Papacy of AIDS research, never forgave the Martin Luther of retrovirology. Duesberg was not the first Prophet without honour to be elbowed aside by lesser men in their frantic pursuit of dishonourable profit.

Despite clear early epidemiological evidence that AIDS was restricted to certain groups of people who all had a specific prior reason to be immunocompromised, in order to link them together and classify AIDS as an infectious disease, a unifying factor had to be sought - a 'focal point' in fact. Such Cartesian reductionism would allow many people to acquire profitable relevance to the threatened epidemic, soon to be conflated into a global pandemic. If AIDS could be marketed as an infectious disease caused by a transmissible agent, then the Centers For Disease Control, who had been twiddling their thumbs since the polio epidemic fizzled out in the 50's, could expand and start to track the spread of the illness; the Republican administration could affect to be concerned about AIDS without appearing to pander to the dangerously vociferous gay community and thereby risk the wrath of their traditional redneck homophobic voters; a 'focal point' pathogen would give the pharmaceutical industry, ever agog with altruism, unlimited scope for marketing preventive vaccines and medicines; even the Press would make a few extra bucks, as nothing sells newspapers so well as dire news and moral indignation, and sodomy sells copy even more profitably than straight canaille canoodling.

the virus theory absolved gays from responsibility for AIDS

A puzzling factor was the readiness of the gay community to embrace the 'focal point' hypothesis. Our gullibility was originally hard to fathom until it could be seen for what it was - a pragmatic acquiescence for reasons of gay politics and the survival of our hard-won but precarious liberation.

AIDS was originally called Gay Related Immune Deficiency or GRID, much to the alarm and anger of the gay community, who quite understandably, after millennia of persecution, felt discriminated against and threatened by a seemingly judgmental acronym. GRID labelled the disease as a specifically gay problem, unlikely to receive much sympathy from the straight population, or attract much in the way of government spending to remedy the illness, it being seen as self-inflicted. Indeed, there were early signs of hostility from a predominantly homophobic society never very anxious to spend tax dollars on health care. This led the militant members of the gay community to go along with an infectious agent hypothesis of the origin of AIDS, and the logical consequent assumption that it would eventually be everyone's problem, thereby deflecting the heat from themselves. As Dr. Joe Sonnabend observed to me, "The virus theory absolved gays from responsibility for AIDS." The scientific community went along with this, and a lot of the soon-to-be demobbed army of retrovirologists fired up their electron microscopes and prepared for battle on behalf of their unlikely gay allies. The difference between an illness restricted to a grudgingly tolerated group of men, and a catastrophic disease threat-

ening the entire population lay in hugely increased grant funding and very rich pickings for the researchers concerned. Several of the failed cancer researchers of the 70's are millionaires in the 90's, due to their status as 'AIDS experts'.

The US administration went along with the strategic charade. Nothing unites a people behind the government of the day more than war fever whether it be a foreign war or the war against AIDS, and Reagan's rednecks could assume a virtue though they had it not. The cause of political correctness would be served and everyone could feel worthy - but first it had to be shown that not only gay men had contracted the illness. The epidemiologists got busy with a will, eagerly misinterpreting the appearance of 'clusters' of AIDS cases to conform to the infectious, transmissible disease model. The first group to add in were the 'needle-sharing' drug addicts. They were a godsend to the 'everyone is at risk' ploy, especially as nobody thought to point out that drug addicts were already very sick people at high risk of less than average life expectancy, with or without HIV, or that the overwhelming majority of gay cases of AIDS were amongst men heavily addicted to recreational drugs and poppers. All the studies carried out since the 1960's, when the growing threat of drug addiction was first observed, detailing the life-threatening illnesses and premature death of people addicted to illegal drugs, were conveniently swept aside, and everyone ignored the fact that the drugs were primarily responsible for their generally wretched state of health. The Virus from Hell was well on its way. It had merely struck the gays and the drug addicts first, but would rapidly pose a threat to everyone - or so they predicted.

No-one really wanted to kill the virus that lays the golden eggs

Soon Haitians and haemophiliacs were added to the growing number of 'high risk' groups, the latter being very important in justifying the infectious agent origin of AIDS. Still no-one thought to point out that they were all sick anyway for group-specific reasons, and with group-specific diseases. Attempts to co-opt prostitute women into the 'high risk' groups failed, as AIDS seemed to discriminate against them unless they were also drug addicts. It did not seem to matter much that a genuine epidemic is not restricted to 'risk' groups, but spreads exponentially through the whole susceptible population. It seems astonishing today that no-one asked a very simple question - "Would all these people have been healthy without the 'focal point' infection?" The honest answer would have been an embarrassing "No!" so the question was never asked. Correlation was seized on as proof of causation, and designer science and virtual virology prevailed in overcoming logic, common sense and scientific method to produce a predetermined result.

Thus the scientific community was thought to have identified the disease and found the cause; the medical profession would do their blindfolded best to deal with those who fell sick; the pharmaceutical companies were eager to provide remedies and nostrums at luxury prices; the US government gave the impression that they were on top of the problem; and the general public was reassured that the terror would soon be under control. It would cost billions, but it was considered money well spent, especially by the devisors of the focal point theory who pocketed a lion's share of the cash and the kudos. The only people who did not seem to benefit were the people with AIDS, but they were considered as irrelevant as they were expendable, and trampled under foot by the accelerating stampede towards the AIDS-research gold fields. Patient doctors, nurses and voluntary gay care organisations could only comfort the dying.

This focal point, this ambiguous smudge on a micrograph, this lethal dot over the 'i' of AIDS became the black spot presaging death in *Treasure Island*, the invariably fatal maguffin. Simultaneously it became the microscopic foundation stone of a gigantic belief system with all its hugely profitable ancillary growth industries, from 'AIDS counselling' to red ribbon manufacture, body bag makers to snake oil salesmen. Even the ingenious fraudsters who wrought the Holy Shroud never enjoyed such success. Just as that ingenious clout was constructed as a stage prop 'focal point' to bolster faith in a belief system, wring money from the gullible and manipulate the credulous, so HIV was intended to have the same effect. Compared to the multibillion dollar HIV hoax run by the NIH Mafia, the Turin Windingsheet Mob were merely running a back alley crapshoot. Whereas the Holy Shroud symbolised eternal life - New Testament newspeak for death - HIV symbolises inevitable death, and highly toxic AZT would be the inexorable extreme unction, the officially sanctioned euthanasia.

The gullible bought the whole sick belief system, and apocalypse chic was marketed in good time to cash in on the traditional *fin de siecle* malaise.

By purveying terror and despair, from which only HIV's inventors could deliver us, the scientific cynics struck a vein of gold usually reserved for the makers and purveyors of horror films. By concentrating on the minutiæ of gay sex techniques, they could even work in the prurience so beloved of the Church, the impotent and the tabloid press. The obsession with anal sex became the new fundamentalism, and the anally retentive in pursuit of the rectally receptive was just one of the diversions afforded by the new 'Virus from Hell' belief system.

By "We needed a focal point" Gallo was stating a political fact. The truth is that the cause of AIDS was already correctly surmised by 1982, but a political hot potato. There was no way the governments of the USA and Europe could say to the gay community that they should modify their sexual behaviour without risking a direct confrontation with a militant minority group, and in so doing appearing to be bigoted and repressive. After giving the matter some thought, it was realised that blaming the Virus from Hell would have beneficial side effects - the wrong explanation would have the right results. Terror of the 'focal point' would promote the use of condoms, thereby helping to cut down on the number of sexually transmitted diseases, which had reached epidemic proportions and were beginning to show signs of resistance to known antibiotics. Sexual terror would also promote condom use in poor heterosexuals in the developed as well as the Third World, who had a tiresome habit of breeding too many children. If the numbers of AIDS cases appeared to decline due to 'safer sex', then they merely added new diseases to the syndrome to keep the numbers up. No-one really wanted to kill the virus that lays the golden eggs, even if they could. When women wanted a

slice of the action, because HIV benefits were more generous than those given for conventional illnesses, they were catered for by adding cervical cancer to the list of 29 AIDS-defining diseases; Africa was brought into the system by adding pulmonary tuberculosis, endemic in poor countries. The HIV Mafia had covered all the bases.

Although paying lip service to the dangers inherent in drug addiction, these were played down. As long as injecting drug users used clean equipment, it was considered safe to drink their cyanide out of a clean glass. Coincidentally, it would also help to cut down on the spread of viruses like Hepatitis B and the septicæmia endemic amongst needle users. In an unholy alliance between the authorities and the drug barons, the dangers from the drugs themselves were played down for everyone's benefit - except current and future addicts.

Promoting the use of the DNA chain terminator drugs AZT, ddI and ddC was a master stroke in dispelling wavering belief in the ability of the 'focal point' to cause AIDS. By using drugs which could be guaranteed to kill, producing side effects indistinguishable from symptoms of AIDS, the belief that HIV was the cause of death was maintained, and AIDS accelerated. What the virus had never been proved to achieve could be accomplished by the very drugs used to 'treat' it. Again, the belief system remained intact and all the interested groups benefited - except the people with AIDS.

The original 'focal point' or HIV=AIDS hypothesis has been tried and found lacking. After billions have been spent, public health programmes mounted, medicines tried and tested, there is still no hope of a cure or a

The general epidemic so confidently promised never materialised

vaccine, and not one life has been saved. Most importantly, not one prediction based on the original hypothesis has ever been fulfilled, even by juggling the figures, changing the criteria for diagnosis, and adding new diseases into the syndrome to boost the flagging numbers. The general epidemic so confidently promised never materialised as heterosexuals stayed away from AIDS in droves, although STDs and unwanted pregnancies continued to rise. Luc Montagnier, the true discoverer of the 'focal point' on which so much AIDS careerism was founded, recently admitted that AIDS in the West was no longer a problem, and that attention should now be focused on a hapless Third World. When the show begins to get the bird in Europe, they can take it on a world tour, but it's doubtful it will play to packed houses in Africa and the Far East now word is out the show is jinxed, and it only ever had a limited audience.

Necessity being the mother of invention, she duly spawned a 'focal point', HIV, sired on her by expediency still moist from his previous rape of scientific principle. The unscrupulous scientists and medical community eagerly stood godparents to this bastard offspring, and set about making sure that more legitimate claimants to the causation of AIDS went unheard. They were shrewd enough to know that the whole advertising industry is predicated on the belief that invention is the mother of necessity. Thus more logical and plausible hypotheses about the true cause of AIDS were denied a hearing or research funding, and the tenuous, scientifically risible legends surrounding a dormant retrovirus became the official dogma of AIDS causation. Well might E.H.Waddington have said, "The most formidable barrier to the advancement of science is the conventional wisdom of the dominant group." Make that 'expedient wisdom' or 'conventional expediency' and you have the situation in a nutshell.

Any attempt to question the 'focal point' hypothesis is either contemptuously ignored or shrilly denounced as irresponsible, and likely to confuse the public; just the reasons traditionally used by the Church to dispel attempts at reformation. This is as good as admitting that the theory of HIV is merely an expedient myth, designed originally to reassure worried people whilst simultaneously terrorising them into changing their lifestyle. To seek explanations for the myriad scientific paradoxa which soon came to light after the adopting of the HIV=AIDS=DEATH dogma was seen by the authorities as subversive, and stamped out where possible. However, as Thomas Kuhn points out, anomalies are invariably ignored by holders of the current paradigm, but are the means of its overthrow. A corrupt oligarchy knows how to protect itself - for a time.

The final, sickening phase of the charade is even now being played out. Forty volunteers with no high risk behaviour are being co-opted to test a vaccine against HIV. Kate Copstick, a compassionate, sincerely concerned young woman unconnected with any high risk behaviour and at zero risk of AIDS, has agreed to receive this trial vaccine. The hope is that this will protect her from future infection with HIV. No-one will care that her own naturally generated antibodies would have protected her in that unlikely event. How will the vaccine be challenged? Will she be told to go out and have a lot of unprotected sex or share dirty syringes, just to see if the vaccine works? Once she is producing antibodies induced by the vaccine, how will she know if she has been subsequently infected by HIV? Will she be encouraged to donate blood, or will she be warned not to? If no-one can tell the difference between vaccine antibodies and those caused by a 'natural' infection, where will this leave the blood supply? Is this merely the thin end of a particularly nasty wedge whereby gay men will be told not to donate blood if they have received the vaccine for fear of confusing the issue? If the virus mutates as rapidly as is claimed, how will a vaccine against a current strain protect against future strains? What of the AIDS researchers and vaccine experts who warned that it may be the antibodies themselves causing AIDS via some unexplained autoimmune mechanism? Can we be sure the vaccine will not generate lethal lymphocytotoxic antibodies?

All this has obviously been given due thought, and the cynical reasoning goes like this. Since Montagnier has spilled the beans that AIDS is no longer a threat in Europe, the gravy train is slowing down. One final moneymaking scam is possible and worth a try, one final screw of the twist. As AIDS figures decline, due to gay men cleaning up their act and lessening their risk behaviour, the purifying of hæmophiliac clotting factor, and free needle exchange combined with less Draconian laws for drug addicts, the credit will be given to the wonder vaccine, and its manufacturers will make a fortune out of ridding us of the epidemic that never was. Remember the joke about the man in Oxford Street using an aerosol spray? When asked why by a policeman, he explained he was getting rid of the elephants. When the policeman pointed out there were no elephants in Oxford Street, the man smiled triumphantly and said, "There you are you see! It's working, isn't it!" Only a cretin could believe that an aerosol would rid Oxford Street of an imagined infestation with pachyderms. The really sick probability is that inevitable future cases of AIDS will be reclassified, in order to protect the reputation and sales of the useless vaccine. They have already done this with the 4,500 or so recorded cases of clinically diagnosed AIDS who don't have HIV infection. They are classified as Idiopathic T4 Cell Lymphocytopoenia cases - medical jargonese for AIDS without HIV. How can a vaccine protect against irresponsible high risk behaviour, STDs and contaminated street drugs or poppers?

Remember that the black spot brought to Cap'n Billy Bones at the beginning of *'Treasure Island'* frightened him to death. The black spot was delivered by someone who instinctively understood the psychological power of terror, even though he could never see it. He was blind. Blind Pugh personifies all the doctors of the world who give an HIV positive diagnosis to patients, sentencing them to psychological death, then hurrying them trustingly to their graves by giving them nucleoside analogue drugs like AZT, and all in the name of a 'focal point' which has never been proved to do anything or cause anything biologically except stimulate an antibody response. It is time to stop asking 'how' HIV causes AIDS. The new focal point must be how to help people with AIDS to recover their health, and prevent future generations damaging theirs. We must warn them that whether the trip to the crematorium begins with the first curious sniff of poppers, the first snort of cocaine or the first desperate gulp of AZT 'the smoke goes up the chimney just the same'.

* Examples of 'Gallo's humour':
When asked why, as the world's leading AIDS researcher, he never had any contact with PWAs - "You don't have to live in a leper colony to cure leprosy."
When asked if co-factors may be necessary in addition to HIV to cause AIDS - "If you're hit by a truck, who needs co-factors!" ■

MICHAEL VERNEY-ELLIOTT

Pentamidine

Commonly prescribed as a prophylactic against PCP, the drug and its side-effects are examined

Pentamidine is an antiprotozoal/antifungal drug developed for use in tropical diseases in the 1930s and approved in the US in October 1984 for treatment in PCP diagnoses as an alternative to Septrin (co-trimoxazole), and further licenced in June 1989 as PCP prophylaxis ('prevention'). In the UK its original licence lapsed in 1983, but it was re-licenced in April 1991 as treatment and prophylaxis for PCP.

PCP is a pneumonia whose cause is still medically debatable.[1] Pneumonias are diseases of the lungs characterised by inflammation and consolidation - there are about 60 sometimes indistinguishable kinds. However, antiprotozoals/anti-fungals usually clear acute diagnosed PCP.

Protozoa are single-celled organisms, which are often present in soil and may be passed to and between humans. Fungi are some of the simplest plant organisms. The majority of healthy people test positive for dormant PCP through their lifetimes, though the common tests for PCP have a false positive rate of 20% - 40% by orthodox estimation.[2]

Protozoa are considered often difficult to eradicate from within the body, and drug treatment may therefore be prescribed for months to eliminate an organism completely, or with the intention of keeping it in check in people who are thought to have weakened natural immunity. Ongoing Pentamidine prophylaxis against PCP by regular inhalation of a nebulised solution of the drug is frequently prescribed for 'HIV-positive' people considered 'at risk' for PCP.

The side effects of Pentamidine include: fatalities due to severe hypotension (low blood pressure), hypoglycemia (reduction in blood sugar), and cardiac arrhythmias (irregular heart function). Of 424 mostly 'AIDS' patients treated with Pentamidine Isethionate 57.5 % developed some adverse reaction, with the most severe being: leukopenia (a 'low' white blood cell count, below 500/mm3), hypoglycemia, thrombocytopenia (abnormal decrease in the number of blood platelets, possibly accompanied by purple or brown skin blotches), hypotension, acute renal (kidney) failure, hypocalcemia (abnormally low levels of calcium), Stevens-Johnson syndrome (a severe form of red lesions with the possible eye disorder conjunctivitis, accompanied by pain in single joints), and ventricular tachycardia (unusually rapid beating of the lower chambers of the heart, typically over 100/minute).[3]

More frequent side effects include: anxiety, chills, cold sweats, cool pale skin, headache, increased hunger, nausea, nervousness, shakiness, blurred vision, confusion, dizziness, fainting or lightheadedness, drowsiness, flushed dry skin, fruit-like breath odour, increased thirst, increased urination, appetite loss, hallucinations, rapid/irregular pulse, skin rash, sore throat and fever, unusual bleeding/bruising, or unusual tiredness/weakness. Other sources have reported that use of Pentamadine may cause pain, swelling, and sterile abscess or induration (hard spot) at the site of intramuscular injection; thrombophlebitis (clots in veins) and generalised or localised urticarial eruptions (raised discoloured patches on skin) with intravenous administration; severe hypotension with single intramuscular injection following rapid intravenous infusion; diabetes mellitus, and toxicity to pancreas beta cells.[3]

Pentamidine's mode of action in the body remains poorly understood. *In vitro* studies with mammalian tissues and the protozoan, *Crithidia oncopelti*, indicate the drug interferes with nuclear metabolism, inhibiting the synthesis of DNA, RNA, phospholipids and proteins.[3]

Decreasing amounts of the drug are excreted in urine up to 6 - 8 weeks after ceasing treatment. It appears to be stored in body tissue, as only small amounts appear in the blood for a short time following a single dose. It does not cross the blood-brain barrier, but is apparently taken up primarily in the kidneys, then the liver and lungs. Aerosolized Pentamidine is taken up by the alveoli of the lung, and is associated with less overall bodily absorption, though how much less is unclear as is the effect this has on urinary excretion. Broncho-alveolar (lung) fluid was found to contain 70-fold higher levels of pentamidine from the aerosolised drug compared with intravenous therapy.[3]

Some recent research suggests a high risk of developing pneumonia soon after stopping use of Pentamidine: the drug fully destroys natural immunity in the lungs after 2 1/2 years. Its withdrawal leaves them vulnerable to infection before immunity can possibly be restored.[4]

Interactions are known to occur between Pentamidine and other drugs, including: acyclovir, cyclosporin, plicamycin, streptozocin, amphotericin B and gentamicin.[5]

Pentamidine is rarely prescribed in conjunction with intensive immune-enhancing therapies such as high dose intravenous vitamin C/antioxidants or PADMA 28, and even nominal nutrition is generally considered secondary to drug administration until the acute phase of the pneumonia is past. Since little is known of the drug's pharmacological action in the body, it is unclear what susceptibilities govern the variation amongst users in the nature and severity of side effects. Eventual detoxification from the body must depend on the efficiency of individual metabloism and therefore on individual micronutritional resources. ■

Research suggests the drug destroys natural immunity in the lungs

HUW CHRISTIE

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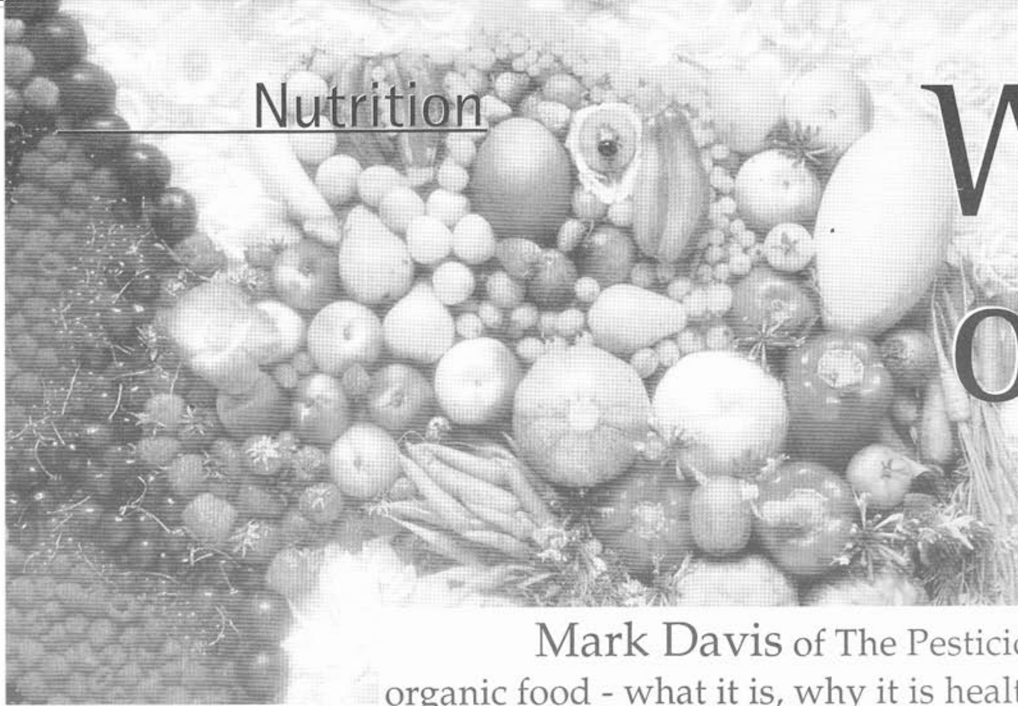

Nutrition

What *is* organic food?

Mark Davis of The Pesticide Trust unearths the reality of organic food - what it is, why it is healthier and where you can buy it

Most farmers in the developed world and many in the developing world use a vast armoury of chemicals to protect their crops and animals, and help them grow bigger and quicker. Many of these chemicals leave residues in the food which we then eat, or they contaminate the environment and find their way into drinking water, seas, fish, even air and rain. A small proportion of farmers and a growing population of consumers have rejected these 'conventional' food production processes and turned to organic production methods.

Organic agricultural produce comes from farms which use no synthetic chemical fertilizers or pesticides on their crops, no growth hormones or pesticides on their livestock, and medicines such as antibiotics which are often used routinely in conventional agriculture can only be used in emergencies on organic farms. Animals are fed on organically produced feed: ruminants (cows, sheep) must eat at least 90% organic, non-ruminants 70%. They are free range in the true sense of the term rather than just the legal sense. Organic production is a philosophy and a way of life, and not simply a set of rules.

What's wrong with agrochemicals

Agriculture has come to rely heavily on chemicals and drugs not merely as 'medicines' to cure acute problems, but as prophylactics in an attempt to prevent future problems. Not only is this misguided agronomic and ecological practice, but it also means that there are more toxic chemicals in the environment, in our water and our food.

Over the years there have been many high profile media stories featuring pesticides and agricultural medicines. Remember DDT killing birds of prey in the 60s and 70s; cancer-causing Alar in apples in the late 80s; Benlate and babies without eyes in 1993? Many of these media stories turn out to be debatably false (Alar) or are never conclusively proven (Benlate), but other, less high profile issues may ultimately be of greater concern.

Antibiotics have been misused for years in animal husbandry after it was discovered that they can promote growth. These drugs can leave residues in meat and animal products which are then consumed by humans. Overexposure to antibiotics results in resistant strains of disease organisms which can affect animals and humans.

There are pesticides in our drinking water which water companies are having to spend billions to monitor and remove in order to comply with EU legal standards. They don't always succeed. During 1993 throughout England and Wales 54 different pesticides were detected and over 25,000 water samples were contaminated at levels above the legal limit.[1]

34% of food samples analysed by the Ministry of Agriculture, Fisheries and Food in 1993 contained detectable residues of pesticides. Of these 1% of samples were found above the Maximum Residue Limit (MRL) indicating bad farming practice and potential threats to the health of consumers.[2]

There is strong evidence to suggest the insecticide lindane (also known as gamma-HCH) may be a cause of breast cancer because of its hormone mimicking properties. Its use in the UK is currently under review. It enters the food chain in sugar-beet pulp (a by-product of the UK sugar industry), which is fed to wintering cows. Other pesticides which imitate oestrogen are among environmental pollutants which have been linked to reductions in male fertility. The Department of the Environment has just announced a research programme into this problem.[3]

After years of standard residue testing some carrots were suddenly found to contain much higher residues of organophosphorous insecticides than had previously been found. The Ministry of Agriculture has no explanation for this and is investigating.[4]

Organic production is a philosophy and a way of life, not simply a set of rules

Organophosphorous sheep dips have been found to be causing long term damage to the nervous system of farmers using them. They are probably also affecting the sheep but since their lifespan is relatively short, and relatively minor nervous disorders may not be noticed, there is little reporting of this. However, a current theory suggests that BSE, otherwise known as Mad Cow Disease, may be caused by organophosphate insecticides used to control parasitic flies.[5]

It is debatable whether these issues can be classed as scaremongering since they have all been addressed by central government, and public money is being spent on dealing with them.

The fact that pesticides are potentially dangerous to health is undeniable. They are, after all, chemicals which are specifically designed to kill living organisms, and they often work by affecting biological functions which are identical in all animals - insects and humans included.

The question is at what levels do they become dangerous, and at what levels are we consuming them in our diets? Unfortunately there are no clear answers since so many variables exist. Factors which can affect residue intake and toxic effects include:

- Some crops are more susceptible to pest attack and therefore more pesticides are used;
- Some countries use older pesticides which are more likely to leave residues;
- Some pesticides can be washed off the surface of foods while others are in the flesh and cannot be removed;
- Some pesticides can be removed if produce is peeled;
- Some pesticides are broken down by cooking, others may form more toxic breakdown products, and other still may remain stable;
- Certain individuals may be more susceptible to the toxic effects of pesti-

cides than the general population;

- Pesticide residues in combination with each other or with other environmental contaminants may act synergistically to increase their toxicity.

What makes organic food healthier?

Organic food should not contain pesticide, drug or fertilizer residues, though in reality some very low levels can occur due to 'drifting off' from non-organic farm fields. The food is produced using traditional methods which are in harmony with the environment. The only chemicals which can be used on organic produce to control pests are derived from natural sources, leave no residues, and break down harmlessly. Medicines on livestock are used sparingly only when necessary, and in many cases not at all, for example where homeopathy is used.

Organic produce invariably contained higher levels of vitamins and micro-nutrients

Organic crops are rotated so that the soil is not drained of its nutrients and the pests of particular crops cannot build up indefinitely. Land is regularly allowed to rest in fallow years, and animals graze on it which helps to increase soil fertility and results in healthy meat and animal products.

Organic food is not produced with the sole aim of providing big, shiny fruit and veg. The cost of such attractive produce can be measured in high chemical use as the crop varieties used may be more susceptible to disease and pest attack, and they often need high fertiliser inputs to produce the yields. Organic agriculture typically uses traditional varieties which are more resistant to pests and diseases but may produce lower yields and may be less attractive superficially.

Apart from having no harmful residues, is organic food more nutritious? Some studies suggest higher levels of protein, vitamin C and micronutrients in organic food. A study commissioned by the Ministry of Agriculture, Fisheries and Food but which was never published compared the nutritional value of organic and non-organic fruit and vegetables. This showed that organic produce consistently contained less sugars than non-organics but almost invariably contained higher levels of vitamins and micro-nutrients.[6]

No scientific epidemiological studies have been carried out to determine whether consumers of organic food are healthier than the general population. However, a Danish survey of sperm counts in men showed that those who ate entirely or mainly organic food had almost twice the sperm count of the national average. The sperm count in western men is known to be steadily falling and this is widely thought to be the result of exposure to environmental pollutants including pesticides.

What organic produce is available?

Many people assume that only organic fruit and vegetables are available, but this is far from the case. Organic farms are often mixed and produce livestock as well as plant crops. This fits in well with the holistic approach of organic agriculture where animal manure is used to fertilise the land, animals graze land lying fallow and help to maintain its overall productivity, and animals can also consume plant waste thereby completing the natural cycle.

Organic milk and other dairy products are now very widely available, organic meat and meat products of all types are available through specialist butchers, as are varieties of cheeses and eggs from many farmyard fowl.

Products made entirely or largely from organic produce can also be found in many health food or whole food stores. These include bread, cereals, bakery produce, prepared foods, snacks, drinks and more. Look carefully and you can find dried fruits, nuts, grains, beans and pulses, oils, stock cubes, coffee and tea and more.

Beware however, of confusing labelling. Free range does not necessarily mean organic, and neither do the plethora of other titles such as farm fresh, nature's choice, natural, additive-free or what have you. It is now illegal to label produce 'organic' unless it conforms to the relevant EU regulations and the producer is registered by one of the approved schemes listed below.

The regulations are governed in the UK by the United Kingdom Register of Organic Food Standards (UKROFS) which is a department of the Ministry of Agriculture, Fisheries and Food. All producers of organic food in the UK must be registered with UKROFS.

Much organic food is imported and may be approved by non-UK schemes. Throughout the EU the same laws apply as in the UK, and therefore anything carrying an organic label which comes from an EU Member State, must by law be truly organic. Produce from other countries needs to be approved by UKROFS or one of the approved UK or EU schemes.

The officially recognised UK labels are:

The Soil Association;
Demeter label issued by the Biodynamic Agricultural Association;
Irish Organic Farmers and Growers Association;
Organic Farmers and Growers;
Organic Food Federation;
Scottish Organic Producers Association. ■

Where can you get organic food?

Shops:

Many supermarkets now sell a limited range of organic produce including some basic fruit and vegetables, milk, butter, yoghurt. Wholefood shops sell a wide range of dry goods, bread, prepared foods and dairy produce and often sell fruit and vegetables too.

Some organic farms have shops which sell their own produce and some of these also sell a range of brought in produce. The Soil Association produces lists of organic producers and suppliers which are available by mail order from the contact address below.

Box schemes:

Some farms, wholesalers and cooperatives have set up schemes where, for a given regular amount of money, a seasonal box of organic produce is supplied. Some schemes allow the customer more choice than others, but the general principle is that you take what you get and if necessary, supplement from other sources. Box schemes are included in the Soil Association lists.

Markets:

The biggest organic produce market in the country is at Spitalfields near Liverpool Street in London. The main day of trading is Sunday but some shops are open at other times. Other food markets sometimes have a stall selling organic produce.

Home deliveries:

Some shops will deliver either at an additional charge or if a minimum quantity is ordered. There are also some mobile shops operating, and even some mail order schemes. Many of these again are included in the Soil Association lists.

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Useful Contacts

The Soil Association: 86 Colston Street, Bristol BS1 5BB. Tel: 0117 929 0661.
Organic Farmers and Growers Ltd: Church House,50 High Street, Soham, Ely, Cambridgeshire, CB7 5HF. Tel: 01353 720250.
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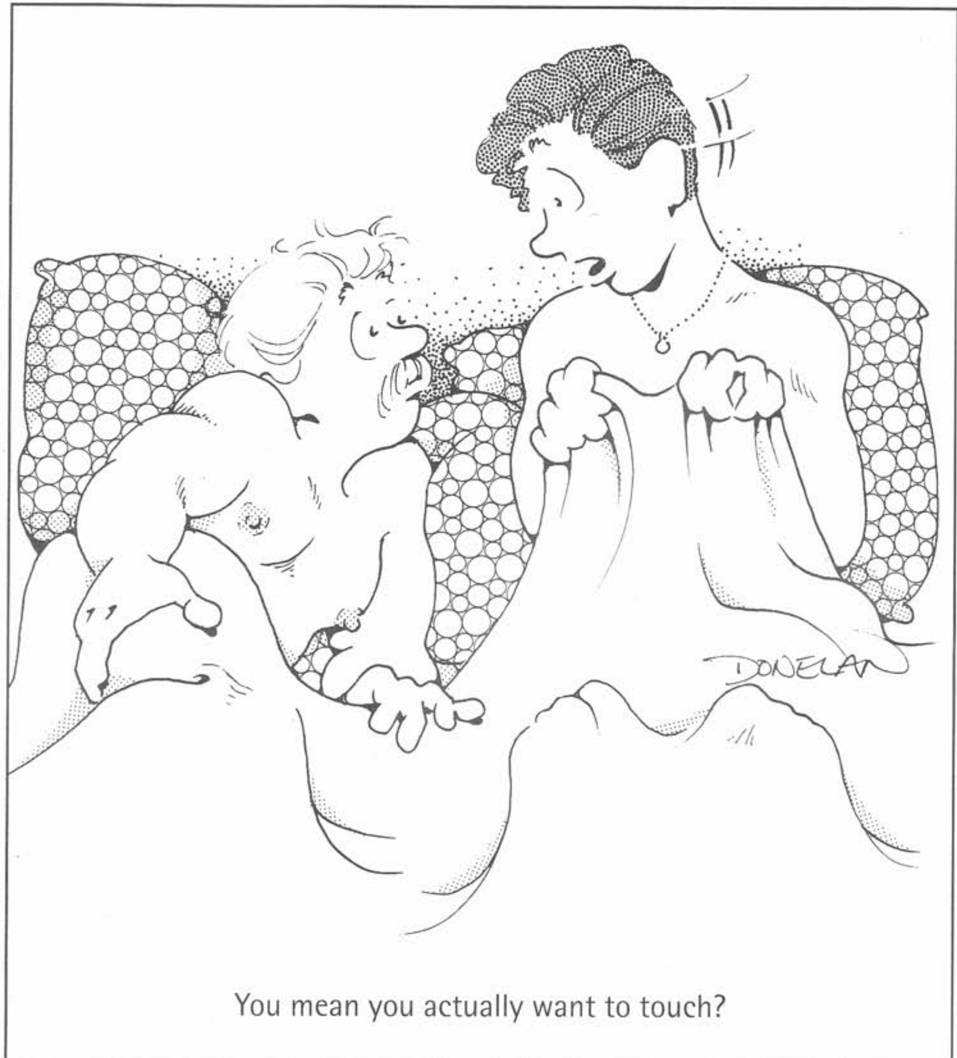

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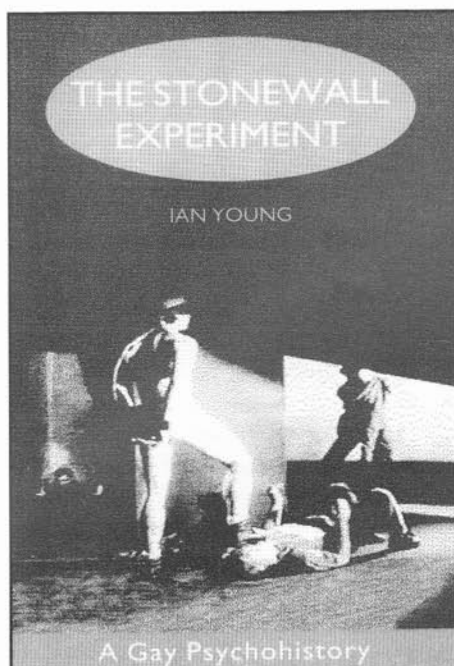

The Stonewall Experiment - a Gay Psychohistory, by Ian Young.

Published by Cassells, £14.99

This is an easy, and uncomfortable, book to read. The ease is afforded by Ian Young's pellucid prose style; the discomfort lies in the sadness of his account of the betrayal of gay hopes following so soon after the Stonewall rebellion, and the consequence of that betrayal - the seeming inevitability of AIDS.

Young gives a brief account of the pioneers of gay culture, headed by Walt 'Dad' Whitman, with his Platonic ideal of male love and comradeship. This had a profound influence on the Englishman, Edward Carpenter, who became outspoken in his championing of homosexual emancipation. He lived openly with his lover, George Merrill, at Millthorpe in the North of England, and even after Wilde's trial and disgrace, he remained steadfast to his 'Uranian' ideals, when more timorous writers kept a low profile. Until virtually the 1960s, writers fought shy of open expression of gay sympathies, but there were exceptions in the previous decade - Gore Vidal with *'The City And The Pillar'*, James Baldwin with *'Giovanni's Room'*, spring to mind. Things then started to get more graphic - and even more depressing and pessimistic - with the works of John Rechy. By the 70s, Young says, ".... the mystical/political patrimony of Whitman and Carpenter had been largely forgotten." The rest of his book explains how and why.

A 1979 screenplay by William Burroughs (a relative of the Mr. Burroughs who teamed up with Mr. Wellcome to form the company which eventually brought us AZT!) presents an uncannily prescient description of AIDS. "The hero of the story is Billy, a gay man who is a 'blade runner', a courier of medical contraband. His attempts to spread the word about a new medicine are hampered by the atmosphere of distrust and paranoia generated by the official Health Control as well as by an illness he has contracted - pneumonia."

Long before the word 'homosexual' was coined by Karl Benkert in 1867, gays had been persecuted and demonised. In his chapter on 'The myth of the Homosexual', Young states:

"The homosexual was thus installed in a rogues' gallery with other mythical creations of Western diabolism: the Vampire, the Leper, the Witch, the Gypsy, the Werewolf, the Jew - figures concocted out of the the fears, folk memories and repressed desires of a civilisation, aspects of Christian society's dark unconscious, its shadow side."

Gays have been systematically classified as sick by the medical profession, criminalised by governments and brutalised by police, abused and derided by heterosexuals. Young draws a parallel between the gay urban ghettos of the 60s and the plague-stricken city of *'Death in Venice'*, and has this to say:

"The Stonewall Experiment began in the untutored hands of gay people who had had enough of being second-class citizens, partial people, never fully human. It was an experiment in reclaiming full humanity from the medical/governmental establishment. Within a few years, control of the experiment had fallen into other hands, and the initiators found themselves in the position of experimental animals. The new phase of the experiment involved the development of a commercial gay scene that could be test-marketed as a prototype of the urban lifestyle of the future."

Young unflinchingly depicts the cynically commercialised hedonism of the bathhouse and backroom bar 'culture' which ironically came to symbolise gay 'liberation', using descriptive passages from novels like *'Faggots'* by Larry Kramer. Other writers extolled the virtue of promiscuity, and even STDs, as proof of homosexual political commitment; drugs and poppers became an indispensable part of the gay scene; the Mafia took over the pornography market; whether a gay man was 'deep' or 'wide' defined whether he could take one forearm up his arse to the elbow, or two fists simultaneously. Crisco and nitrite inhalants became the anointing oil and incense of the new religion. "The impulses that led young men to join in these darkly alluring activities had something in common with feelings that an older writer of the time recalled encountering in himself as a young man, decades earlier. 'It seemed to me', he wrote, 'that I had passed a threshold, and that in passing it, I was dimly dismissing something from where I had come: my land, my past, the traditions of my country. But these men fascinated me and I wanted to incorporate myself there. I perceived them as strong, generous and pitiless: beings without weakness who would never putrefy.' The words are those of the French author Christian de La Maziere, remembering his emotions when, thirty years earlier, he joined the Waffen SS."

Young's descriptions of AIDS are very moving. His own partner, Jamie, died aged 32, on World AIDS Day, 1993, as this book was nearing completion. His understanding and summation of the dissident views of Duesberg, Lauritsen and others who have never been blinded by the official 'explanations' for the malady, are quite the best and most comprehensive I have been privileged to read.

"Piece by piece, the stone wall of orthodoxy was crumbling. But the ruins were heavily defended. Over a decade into the epidemic, the public

People considered their allotted blood 'status' as the key to both their identity and their fate

was still being told by newspapers and television, and all but a tiny handful of physicians, that a positive result from an HIV-antibody test showed present and lifelong 'infection' by the virus; that the virus was certain or very likely to lead to AIDS, and that AIDS was universally fatal. None of these assertions had been proven. Yet the psychological effect of believing them could be catastrophic....In the post-1984 world, a growing number of people considered their allotted blood 'status' as the key to both their identity and their fate."

In not purporting to be a "history of homosexuality, the gay movement, or the health crisis" but merely the observations of a poet with a "particular interest in images, verbal messages and psychic undercurrents...", Ian Young is being modest. His book is all these and much much more. Whatever his intentions, he has written a wonderful book, and Cassell Lesbian and Gay Studies have published an important one. This book should be read by all those concerned about the truth and the tragedy of AIDS - gays, lesbians and straights. They may make what they will of Young's last sentence, "The experiment continues." ■

MICHAEL VERNEY-ELLIOTT

Local Groups

We have had a few responses from people interested in forming local groups for discussion, sharing ideas/experiences or just talking with like-minded people.

If you would like to be a part of this exciting development, please contact Tony on 0171-713 7071

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ERRATA (Vol. 3, iss. 2)

page 9 The Amber Fluid
Coen van der Kroon is the correct title for the author and his book is *The Golden Fountain*.
page 17 The Debate goes on ... line 34
10^9 virions should read 10^5
page 29 Lanka/Harris debate ... line 2
should read "also involving Robin Weiss"

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editorial

Autumn in Europe, season of mists, mellow fruitfulness, and concurrently elsewhere, the vigour of Spring. Time touches us with infinite shades of change: eclipse and dawn, condensation and sublimation, birth and death. The values that endure through the changes in human experience become culture. In this issue we look at, amongst other things, the culture of non-contact and its detrimental impact on well-being. 'The body is the temple of the soul', wrote Alice Walker in her novel *The Temple of My Familiar*, and it's a temple that's being desecrated on a multiplicity of levels in this culture of ours. It's important to make contact with some basic realities and ask ourselves where our rejection of the sacred, our bodies, takes us.

Think of drugs taken in the name of pleasure and freedom and the toll they take on the delicate balance of our human bodies, or the drugs doctors and pharmaceutical companies supply us with, partly for their own pleasure: the pleasure of profit. Think, too, of how difficult it can be to ask for a supportive arm around your shoulder and yet how easy to have sex with a stranger, substituting the extreme exposure of sex for a more subtle contact.

How important it is to touch base with reality is revealed in recent comments from the head of Iran's public transport authority. Like scientists who use indirect markers to conjure large numbers of theoretical entities (e.g. Ho and Wei) he recently explained plans to segregate men and women on buses thus:

"Every day 370,000 women ride mini-buses, and if 10 men brush against them by mistake then 3.7 million accountable sins are committed every day."

Multiplying entities that threaten the integrity of the system, just from casual contact....a familiar theme?

When we touch we meet at the boundaries of self, where we end and the rest of the world begins. AIDS has stigmatised and marginalised, taking experience to the limits, and there holes have appeared in our own boundaries and those set by our society. The time is ripe for stimulating change.

Could it be that the less humans touch, the more revolutionary the honesty of intimacy can become? Real human contact is subversive - try it!

continuum doesn't accept the validity of the terms Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or any compounds involving these terms. Nor do we accept HIV to be the cause of AIDS. Views expressed in this magazine usually, but not necessarily, reflect the views of continuum.

Please send your letters to: Continuum, 172 Foundling Court, Brunswick Centre, London WC1N 1QE

Dear Continuum...

Dear Continuum,

Thank you for your letter and I am grateful that I can help in a little way.

Your magazine does indeed, for me, provide information that has helped and I hope will continue my understanding of the virus. Along with Continuum, I have taken several paths to pull me out of the dilemma of a 'Death Sentence' and indeed smash the prognosis that HIV=AIDS=DEATH.

That an antibody test, without evidence of the virus, does appear to be a prognosis and as my medical knowledge is limited I am content to accept the paradox of the said diagnosis: HIV.

As for treatments by the medical world available to a patient, I simply asked of the physician with whom I have been tested and examined: "Can you guarantee a cure with use of these diabolical drugs (AZT etc.) or can you say the drug or drugs will arrest the stage of the virus's development?" And the answer is always NO to both questions. And apart from a T-cell count, of which I understand the T-cell is only a minuscule part of the little-known immune system, I have asked, "What is the meaning of the count of the virus?" and "What is an antibody, but a body defence against an unwanted intruder?"

You can imagine the reaction of a physician to these last two questions! - That this patient is becoming, or is, 'difficult'. By one so-called specialist I was told to "go elsewhere if you don't like our treatment." But by more enlightened medics, they have accepted without fear, defence or insinuation, that I do have the choice and they have offered to treat any said opportunistic infections as they may arise. So far for me, nothing. No O.I.'s. I trust the future, keep it that way!

This leads to prophylaxis. For me the danger here is to presume a disease for the future. Planting the idea in the mind that it may or even will occur. I am convinced that the mind so conditioned to a prophylactic attitude can indeed develop a 'condition'. The mind is very powerful and dangerous when it considers the future and projects that which is God's to decide. Even to the unbeliever, agnostic or atheist, a continual thought is like a prayer. If you continually think by your own will or by medical suggestion, that your body will contract a given disease, that is like a prayer and may be answered. God does have the habit of answering prayers, even bad desires, and will give you that condition. You may gather that I am not for prophylaxis, not just the diabolical side effects I understand that can happen, but that to take these drugs is an insult to God.

I wish to point out that I am not religious, or of any persuasion or cult. I feel that denominations and institutions, though with some fundamental truths, err on the defects of hypocrisy and fear.

Any victim of a malady or problem must seek, with help, an answer to the problem and make their own decision to get better. That the virus will not go away is fact. But your article in volume 3, issue 1, "Health as a Virtue" from the book Limits to Medicine by Ivan Illich, embodies all that is the 'answer' or 'solution' to the 'problem', and that it is the willingness to see change and courage to make the decision to change, that can and will gain a good life, living with HIV, and not against it, "one day at a time". Not for the regrets of yesterday or the promises of tomorrow. Just live well in the day.

That is where I am. It is not plain sailing all the time. After all I am human too. Perfectly imperfect I am and acceptable for me to make mistakes.

In truth I am glad or grateful that I contracted the said HIV condition. I woke up. Have learned to accept who I am and what I am as a total human being. I have learned to enjoy life with growing peace, serenity, prosperity (not of the financial means) and above all, love for myself and other people, whatever and however we are.

Ron, N. Yorks.

The sleep of reason produces nightmares and political expediency

Dear Continuum,

I thank you for sending me the latest issue of the Continuum magazine.

I have been looking forward to new publications and I can't wait reading more and more of the latest improvements and letters from the readers. I find the letters very strong, touching and promising.

Since 1986 I have always said that there was something wrong and no-one was interested because after all I wasn't a doctor nor a specialist. I have seen people being misled and being an African where the so-called rulers do care less and depend on the western world nothing was done.

Thanks to Continuum now I believe in myself more than before not relying on specialists and others. Whenever I talk to my friends who are HIV-positive they simply say, you are not HIV-positive how can you know what we are going through?

I only had to keep quiet. Now I have my Continuum volumes - they are doing the job for me. I enjoy the look on their faces after reading a few pages and that makes me feel great.

Recently I had a friend from Norway who didn't know anything about HIV and living positive. All he knew was once you catch the virus you are dead. After reading all the volumes I had he became very happy and enjoyed every single bit.

He said he was going to Norway to spread the news and help those much in need; even if he has to leave his job he is willing to do so. Last week he sent me Norway's national newspaper with some of his work and I was really very impressed by the work he is doing and I think we have a lot to offer.

And all this is because of your work. I thank you with all my heart.

May God be with you all at Continuum.

Winifred, London.

LifeStory

This is the first article of a new section in which we feature the personal stories of people who have addressed the impact of an HIV/AIDS diagnosis on their lives. We hope this will be of encouragement and even inspiration to others, and if you would like to tell your story, please contact us on 0171-713 7071.

Let's go back some sixteen years when I lived in Palm Springs, California. I was going to a dermatologist who was about to put leeches on my ankle as he couldn't find any other way to cure the ulcer. Then one day when I went to see him he asked or told me of a new test that had just come out and could he do this test on me? At first I didn't want to but as nothing else was working maybe this would give us the answer we had been looking for for so long. Mind you this was before it was called HIV - in those days it had a much longer title.

Well, anyway I was positive. I asked, "What does this mean?" His answer was that my T-cell count was way down and I thought life for me was over in 1979. I couldn't believe it - what had I done to deserve this? It wasn't fair, so I went home and started to smoke. Then I thought there must be another way. Besides I hated cigarettes: they make your clothes smell. I was advised to go to my regular doctor to find out more about this and I can tell you now that was the biggest mistake of my life, as he wanted to put me on all kinds of drugs and the only drugs that I take are the ones for my epilepsy and no others. Now maybe that's what kept me around for so long, as I could never take all the drugs and things that you others could.

You remember Divine (star of John Waters' movies)? Well, I used to live with her, and then there was Sylvester, before he became a great star (*"Do you wanna funk?"*), and to this day I truly believe that the drugs they were pumping into her is what killed him, not the big "A". As I think of it I've lost so many friends because they did exactly what their doctors told them to and took all the drugs. I have a friend who is a nurse in Palm Springs and she has told me that more people die of the side-effects than they do of AIDS.

When I found out about me there were no drugs to take and then in the mid-eighties a new and different drug was coming out of Mexico and its name or letters was AZT. People from California went in droves to Mexico to buy this wonder drug that could save their lives. But it could only be purchased on the black market. I thank God I don't know how to drive or I might be on it myself!

I remember when I started that group in San Francisco called the "Cockettes" and the reason for this was the Vietnam war. There just weren't enough people laughing, so I got together with some friends including Sylvester and became "Goldie Glitters and The Cockettes". I remember how my macho friends used to tease me about it until they realised what a great service we were doing. I had the power to make people laugh and I still do.

Goldie proudly surveys his new home!

Now back to the main point. I came to England to study yet more theatre in August 1992. To think it will be three years this Saturday the 27th.

In March of '93 I had a seizure and was taken to Addenbrooks Hospital where I contracted pneumonia, and I hope that's spelt right. I was kept in the hospital until April of the same year. While I was there I was told that if I didn't let them do an HIV test on me then they couldn't help me. So finally after they promised that everything would stay the same I let them do the test. Naturally the test came back positive and as soon as that happened they decided that I would be much happier in a private room on another floor, where you had to dress from head to toe to keep from catching the disease, whatever that might be. Dr David Wilks said I should start taking AZT and of course as always I say NO to drugs. Also the Concord report had just come out and it said that AZT was crap.

Now last year, 1994, my test was given to me again and my T-cells were down to 170. So in sixteen years I've lost 40 cells. The kind and worried doctor wanted me to start taking Septrin at 960ml three times a week, so I asked the doctor how would that mix with my epilepsy medication and he looked it up and told me I would have a few more seizures but I wouldn't get PCP, another HIV-related illness! I said that I'd take my chances - what's the cure for PCP if you become immune to Septrin? Since 1950 I've always had bronchial problems so unless all of this started it then I'm OK. I must go on to say that after this last test the doctor said that if I were to go back to the United States of America I would have full-blown AIDS and be given six months to live on my own. It's strange how in this country you don't have AIDS until you are sick but in America you do according to your T-cell count. So if I stay here in England I can live to be 80 if I choose to.

Now I know you want to know what my secret is:

I believe first that the brain is a very powerful thing and if you want to be sick you will be. But if you don't want to be sick you aren't. I don't want to be ill. There's too much for me to do and I still haven't fulfilled my dream and that is to someday go to Egypt and walk in the valley of the Kings, and until I do that I can't die. Always have a dream or a goal.

I also take a lot of vitamins such as (and this is a daily regimen):

a. 1000 units of vitamin C, buffered as the other upsets my tummy;
b. 1000 units of vitamin E before bed;
c. Once every three months I get a B12 booster;
d. I take Chlorella, 15 tablets; it's a good immune booster;
4. Bee propolis 500ml;
f. Alpha and kelp tablets (3);
g. Garlic pills;
h. Bee pollen tablets;
i. Once a month I do a 10-day course of royal jelly (Ortis);
j. RNA/DNA, also a booster;
k. Natural Bee pollen;
l. Of course, a multi-vitamin.

Last but not least I drink filtered water as the stuff from the faucet in the sink is crap.

In all I hope this gives you a better view on how to live; after all I was in the very first Gay Pride Parade in Hollywood, California, the very first in the world. If I can come this far then so can you and take it a lot further. For all you know, we may outlive the discoverers of this disease that we were supposed to have started.

I know it sounds like I'm not afraid but this I share with you my darlings - I just don't let myself get hung up in the mush.

The last thing I want to say in this is that safe sex can be fun. Believe one who is still here after all of these years. Someday I hope to do a book on the things that I have done and the places that I've gone both spiritually and physically but first I need someone who can type, as I sure as Hell can't.

Love to you and all of yours. ■

Goldie Glitters

GOLDIE GLITTERS

THE NUTRI CENTRE HALE CLINIC 7 PARK CRESCENT LONDON W1N 3HE Tel: 071-436 5122/071-631 0156

The Nutri Centre is located on the lower ground floor of the Hale Clinic in 7 Park Crescent, London W1N 3HE. The prestigious (Nash Terrace) crescent is only a few minutes away from underground stations at Great Portland Street, Regents Park and Baker Street.

Clients are often faced with a dilemma when they have been prescribed or recommended a course of nutritional regîme by their practitioner or Nutritionist

One often doesn't even know where to begin to find a company which provides all the products he or she needs. It may mean placing orders with a number of different manufacturers whose despatch times may vary. Consequently the institution of the regime is delayed or becomes staggered. Since delay can cause further upset to someone already in distress and staggering can mean that it takes longer for the full benefit of the treatment to be effected and felt (nutrients interact with each other and the regime will have been designed with this in mind) the client may lose heart and motivation.

In an effort to circumvent some of these problems some practitioners have arrangements with certain manufacturer's or else stock the remedies themselves. But time spent in administering the purchase and sale of remedies simply increases the stress load on practitioners and their practices.
For those individuals who do not wish to see a practitioner for any specific illness there is problem of trying to obtain professional advice on the use of vitamins and nutritional products to suppliment their diet.

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The aim of the recently opened NUTRI CENTRE at the Hale Clinic in London is to lift all of these burdens from practitioners and clients. Essentially it stocks or has access to the most extensive range of nutritional supplements – from those you would find in a health food shop, to practitioner products, to exclusive lines, even to the occasional batch made up for specific requirements.

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The Nutri Centre operates a prompt and reliable mail order service for those not fortunate enough to live or work within striking distance, and next day delivery is guaranteed. This service can also be extended to ordering "repeats" enabling them to maintain continuity of the Dietary Supplementation Therapy. The intention, therefore, is that clients from anywhere in the country should be able to order their supplies from just one phone call to the centre.

> *"The Nutrition Centre's influence on the industry as whole will be considerable, and indeed, it is already leading the way in a number of areas..."* Jan de Vries (June 1991)

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◆ Prof. Alfred Hässig: An in-depth introduction

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