CONTINUUM

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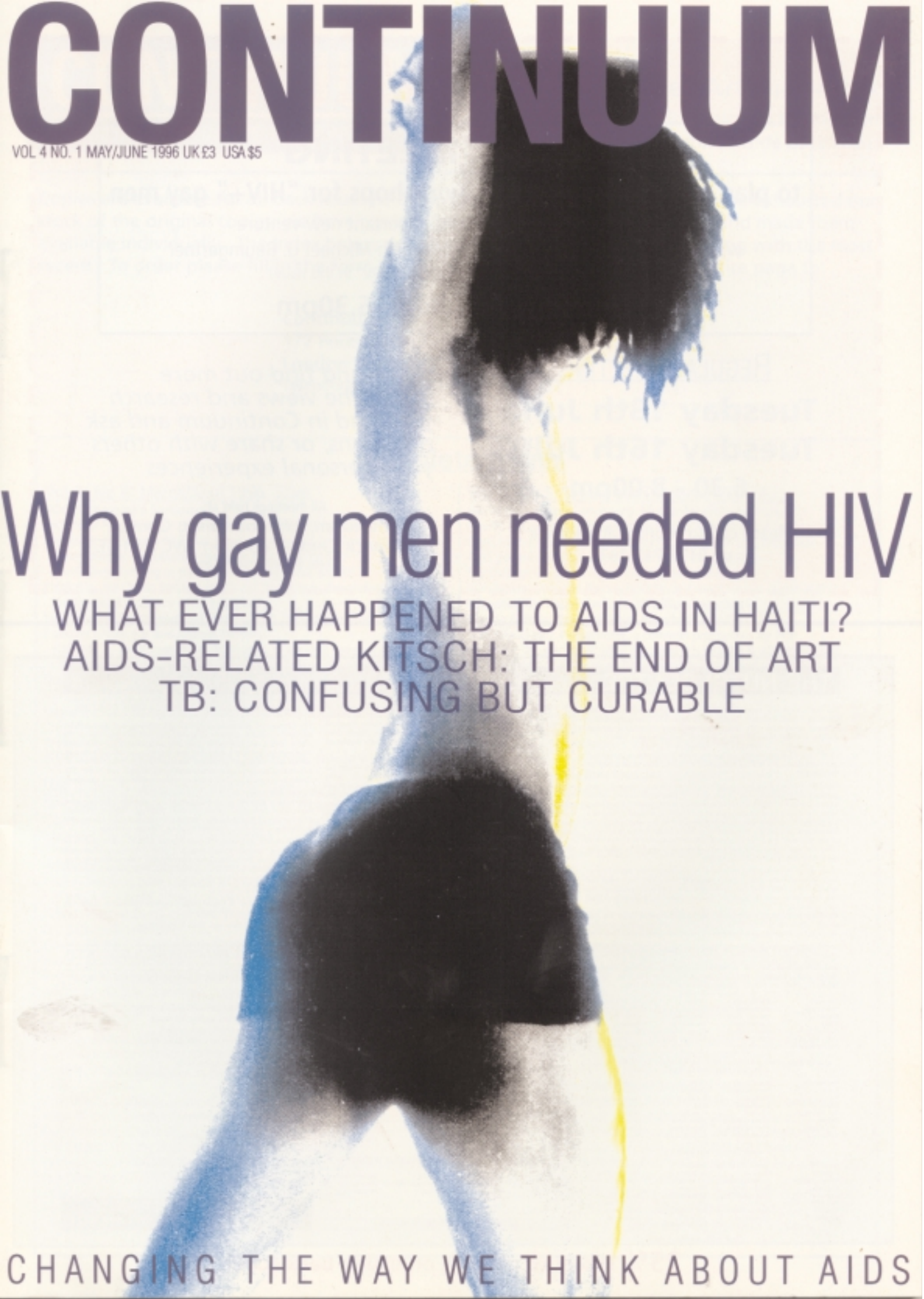

Why gay men needed HIV

WHAT EVER HAPPENED TO AIDS IN HAITI?

AIDS-RELATED KITSCH: THE END OF ART

TB: CONFUSING BUT CURABLE

CHANGING THE WAY WE THINK ABOUT AIDS

CONTINUUM

VOL 4, NO 1
MAY/JUNE 1996

WHY CONTINUUM?

The orthodox view on AIDS holds that it is caused by a virus known as HIV that is transmitted through the exchange of body fluids. Once infected, a person will remain well for a time, though infectious to others, before going on to develop AIDS and dying.

Despite the huge sums of money spent on medical research, there is still no cure, just drug therapies said to slow the progress of the disease, and regular T-cell counts to measure health.

A whole industry has evolved around AIDS, on which many careers and businesses depend, but which offers little hope to those affected. It works on the premise that HIV=AIDS=DEATH.

Continuum began as a newsletter encouraging those effected to empower themselves to make care and treatment choices. As we look further, anomalies in the orthodox view continue to appear.

Are you aware, for example, that the link between HIV and AIDS has never been more than hypothetical? That a growing body of scientists and doctors throughout the world doubt that HIV causes AIDS?

At the onset of the "epidemic", the hysteria that resulted from the linking of sex, death and an infectious virus created a climate where to question the "facts" was considered reprehensible. Many of those who dared to do so were silenced or ridiculed. Since the growth of the orthodoxy, those who question have also had to contend with the weight of vested interests.

Twelve years after HIV was first associated with AIDS many predictions based on the viral hypothesis are failing to materialise. **Continuum** is a unique forum for those in the scientific community challenging the orthodoxy and those whose lives have in some way been touched by the hypothesis.

FOCUS

FEATURES

PHOTO: SCOTT THODE

AIDS-related kitsch? see page 28

NEWS

REGULARS

CHANGING THE WAY WE THINK ABOUT AIDS

FALSE POSITIVE

A former BT operator is to sue Middlesex Hospital after being wrongly diagnosed as having HIV. George Hamer claims his life was ruined after the hospital carried out a single blood test in 1986 and told him he was positive. He says he was even offered, but refused, the toxic drug AZT, despite remaining healthy. The false positive result was only discovered six years later when Hamer forced staff to carry out a re-test.

COMPENSATION

Japanese haemophiliacs who claim they were HIV-infected by untreated blood products in the 1980s have agreed compensation pay-outs with the government and the drug companies after a seven-year court battle. The 458 claimants will each receive Y45 million (£28,000) while those with full-blown AIDS will get another Y150,000 a month.

AZT IN COURT

Several people who claim they have been damaged by the toxic drug AZT are preparing to sue the makers, Glaxo-Wellcome. The test case is being prepared by Charles Judge, a legal assistant with the Los Angeles law firm of Kananack, Murgatroyd, Baum and Hedlund. If successful, it could be the first of many to be filed against the pharmaceutical company and, possibly, the National Institutes of Health (NIH) and the Food and Drug Administration (FDA).

DEPRESSING HIV

Psychiatrists at St Vincent's Hospital, Sydney, have published a paper showing how depression, anxiety and other disorders, sometimes leading to suicide, commonly follow an HIV-positive diagnosis. The psychiatric care of HIV-positive people is highly significant to doctors in Australia where they are not allowed to interfere with patients' decisions to end their own lives, and where, in the Northern Territories, euthanasia is legal.

HIV IN A SPIN

The popular US lifestyle magazine Spin has published a scathing attack on the theory that HIV causes AIDS. Writer Celia Farber takes the US Centers for Disease Control (CDC) to task for failing to investigate properly cases of people with AIDS who do not have HIV. The article quotes pathologist Konstance Knox who says he became convinced that something other than HIV caused AIDS after investigating the first recorded case.

Test patent holder avoids US TV questions

VALIDITY DOUBT OVER WEISS TEST

Professor Robin Weiss of London, holder of the patent on a popular HIV antibody test, has twice refused to answer an interviewer's questions about the validity of the patent.

New York media and health personality Gary Null interviewed Weiss in London in April for a documentary for America's PBS television. On both occasions when his patent was mentioned Weiss pointedly addressed other matters.

The Independent on Sunday reported in 1991: "A cancer charity and a British pharmaceutical company face having to pay millions of pounds to a French research institute because of a possible patent dispute over the NHS blood test for AIDS."

Weiss, whose name appears on the 1986 patent along with Professor Tedder, works at the Institute of Cancer Research in London, and the test they designed, the CBL-1, was leased to Wellcome, who in turn marketed it to the NHS. But the official discoverer of HIV, Prof. Luc Montagnier of the Pasteur Institute, Paris, said he would like to compare the genetic sequence of "his virus" with Dr Weiss'. If as expected they proved to be the same, he said, he could not rule out the possibility of the Pasteur Institute pursuing legal action to recover patent royalties.

Since the holder of an HIV antibody test patent must also have isolated a genetic structure for the virus, the question over the validity of the patent revolves around who isolated the genetic structure Weiss used, assuming such a thing is possible and was fully done. When pressed by Null in the London interview over how many genes the virus has, Weiss seemed unsure. "About ten," he commented.

In 1984 Prof. Weiss signed an agreement with the Pasteur Institute that the French virus-like sequence, then called LAV, was to be used in his lab for research, not commercial, purposes. But in a 1991 letter in Nature he wrote that he "cannot exclude the possibility of cross-contamination during isolation and subsequent adaptation" of the virus he used for his commercially profitable test, acknowledging that Montagnier's genetic material may be the basis of his and Wellcome's success. "Both LAV and HTLV-IIIB were propagated in our laboratory at that time," he volunteered. Weiss' contention that airborne contamination may have been responsible for the mix-up has been generally scoffed at, since retroviruses are notoriously difficult to transmit. Claimed leading US retrovirologist and member of the American Academy of Science Professor Peter Duesberg in an Arté television interview broadcast in France and Germany in March this year: "Robin Weiss never isolated anything!"

Weiss consistently supports the HIV-causes-AIDS-hypothesis and this month gave an interview to Britain's National AIDS Manual claiming the challenge of isolating HIV, as posed by Continuum among others, "is simply not relevant".

Meanwhile, Murex Pharmaceuticals currently market two antibody kits having bought Wellcome Diagnostics, manufacturers of the CBL-1 test, from Glaxo. An increasing number of scientists doubt the specificity of such tests, whoever claims to have produced the genetic material on which they are based, on grounds that true isolation of the virus they are trying to detect has never been achieved.

Leading German virologist Dr Stefan Lanka commented: "These tests have no diagnostic value. The proteins are said to be viral, but are produced in the lab only when cells are stressed in special ways. The idea that they are viral was a only matter of consensus amongst the few scientists involved at the time."

GLAXO STOP DRUG

A new slow-release version of the toxic AIDS drug AZT has been blocked by Glaxo-Wellcome. The Sunday Times, 19th May, reports that the drug Aztec, from small US company Verex with financial support from Glaxo, will not be marketed. Despite pressure, including a pro-drug angle from the much-changed Sunday Times itself, Glaxo Chief Executive Sir Richard Sykes said: "If this drug was going to be better than Retrovir, we would be onto it." Recent reports indicate that 700 people taking retrovir/AZT as part of AIDS combination therapy in the UK have now died.

Commentators suggest that Glaxo's blocking of the drug has not been honestly explained. While it seems that the drug, despite fewer side-effects for some people, brings no long-term benefit, Glaxo's claim that Aztec contains a compound that does not have official approval in key European markets has been debunked – the compound is approved throughout Europe, Asia and America.

With an increasing number of court cases in progress against Glaxo-Wellcome over damage from AZT, the right to block drugs derived directly from their own products is matched by their responsibility for what AZT has done. In a move misunderstood by liberal lobbyists, who fear Glaxo are concerned only about their market dominance, Glaxo have gone on the offensive by criticising research in favour of AZT compounds.

Commenting on findings from Liverpool University that Aztec had "favourable" qualities, Glaxo said the team had made "sweeping generalisations". This represents a mindful survival strategy for Glaxo who have inherited the trials of the recently acquired Wellcome.

PHOTO: PATRICK MCMULLAN

"HIV+" – so what? Olympic swimming gold-medallist Greg Louganis (second from left), who published a book about his antibody diagnosis and homosexuality a few years ago, has now added to his achievements a positive status in Hollywood circles. Seen here with actress Demi Moore at a recent New York doll auction to benefit AmFAR, the US AIDS charity founded by Elizabeth Taylor, Louganis looks a picture of health – what Moore can a man want?

HIV-SEX CRIME RAISES ALARM OVER TESTING

Charges of criminal assault could be laid against a person officially told he or she is antibody-diagnosed who does not tell a partner before sex, according to the UK Law Commission. Such laws are already established in parts of the USA.

Consultation Paper No. 139 on Consent in the Criminal Law in Britain has until 30th June for public comment on questions of legal responsibility when obtaining consent for, amongst other things, sex. For example, "where the other person is making some unconscious assumption which the defendant knows to be ill-founded", is the defendant guilty of sex without consent because consent was obtained from someone not fully informed?

In the case of a positive man the paper suggests: "If he told [a partner] that he was negative, it would be a case of deception; if he knew that a mutual friend had assured [the partner] that he was, it would be a case of exploiting a mistaken belief." The paper continues: "Should any sexually transmissible disease qualify for this purpose?"

Campaigners against the non-specificity of HIV testing expressed alarm at the paper which describes "a person who knows that he or she is HIV-positive [who] might be required to disclose that fact...". Leading AIDS analyst Dr Eleni Papadopulos-Eleopulos has told the media: "There's not one test that can positively confirm H I V infection."

A senior UK government virologist looking beyond the issue of consent commented: "I could envisage a situation where the level of [HIV] infectiousness would be questioned. Ultimately, the only proof of infectiousness would be that the virus had, on that occasion, been transmitted."

A spokesperson for the CARA Trust, a pro-HIV, but anti-discrimination organisation, said: "If we do not allow HIV-positive people the right to have responsible sex without the fear of reprisal, we may be guilty of infringing their rights and marginalising them further."

Philip Johnson, Professor of Law at the University of California has commented on such legislation: "Of course they're irrational laws; they occur in the context of irrational fear."

The law Commission can be contacted for copies of the paper and comments. Tel: 0171 453 1220, fax: 0171 453 1297.

NAM FUDGES T-CELL ADVICE

T-cell counts can be misleading, says UK's National AIDS Manual. Factsheet 3, May 1996, claims: "Factors other than HIV can affect your CD4 count including infections, time of day, smoking, stress and which lab tests the blood sample."

The leaflet says: "Changes in your CD4 cell count (which looks only at the blood) may reflect the movement of cells into and out of the blood, rather than changes in the total number of CD4 cells in your body."

NAM fails to report the findings of the largest US study of gay men and HIV, the Multi AIDS Cohort Study (MACS), that the technology of T-cell counting gives a large margin of error. People should be "aware that a measured CD4 cell count of 300 may really mean it is likely that the 'true' CD4 cell state is between 178 and 505", the researchers advised.

TEST EXTENDED

The test most commonly used to detect HIV and other diseases is to be used to identify food allergies. The enzyme-linked immunosorbent assay (ELISA), extended to HIV in 1985, is now regarded by doctors as the most reliable way of spotting allergic reactions in up to 90 different food substances simultaneously.

HOME TESTING

The first D-I-Y test kit for HIV antibodies is to go on sale in US drug stores after it was approved by the Food and Drug Administration (FDA). The kit, called Confide, by Direct Access Diagnostics, a subsidiary of Johnson & Johnson, involves sending a blood-spotted paper anonymously to a special laboratory. Negative results are given by a recorded message on a freephone number but callers are put through to a trained counsellor for a positive result.

NEW DIRECTIONS

AIDS research in the US is to undergo a major upheaval in a bid to find more promising avenues of work. The National Institutes of Health (NIH), which controls the country's $1.4 billion AIDS programme, has been strongly criticised by a review panel of 118 scientists for failing to identify new lines of research. It recommends switching funds to more open-minded independent researchers, including those studying complementary and alternative medicine, but also vaccines.

VACCINE FAILS

A five-year test for an HIV vaccine which cost the US Defense Department $20 million has ended in failure. The vaccine, based on the supposed HIV envelope protein gp160, had no effect on the 304 allegedly infected volunteers studied between 1990-95.

NEW BOOKLET

Camden and Islington Community Health Services NHS Trust has published a controversial 39-page booklet which it describes as "a new approach to sex, relationships & HIV for gay men". The final chapter has been criticised for setting out acceptable circumstances under which partners could fuck without using a condom.

SALON SCARE

An HIV scare in Odessa, Ukraine, has led to 34 of the city's 133 hairdressing salons being closed down. Officials have accused the owners of spreading HIV by failing to sterilise scissors and razors. The city's caseload has jumped from 44 to 788 new cases, but none have been attributed to hair salons.

2ND BERKELEY BIOLOGY PROF JOINS DISSENT

Another member of the Department of Molecular and Cell Biology at U.C. Berkeley now agrees with Peter Duesberg that HIV is harmless and that AZT is toxic. He is Richard C. Strohman, who recently went on emeritus status. His "conversion" is important because Duesberg is so often dismissed by the ignorant as "crazy." What is the likelihood of finding two crazies in the same department of cell biology?

In Science magazine's investigation of Duesberg (Dec. 1994), Jon Cohen wrote that Strohman "stops short of endorsing Duesberg's view that it [HIV] can't cause disease and that drugs and AZT do." Instead, Cohen added, "Strohman says his main interest in the debate has been supporting Duesberg's right to dissent." More recently Strohman has confined himself to saying, with respect to the relationship between HIV and AIDS, that correlation does not imply causation. Here is the updated and more detailed story.

Shortly after completing his Ph.D. at Columbia University, in 1958, Dick Strohman joined Berkeley's Department of Zoology – a predecessor to what is now the Department of Molecular and Cell Biology. Since then, at various times, he has been chairman of Zoology and director of the university's Health and Medical Sciences Department. Duesberg joined the department in 1964, but 20 years elapsed before the two met. Strohman had developed a new technique for gene transcription and Duesberg wanted to know about it.

Later, Duesberg sent Strohman his 1987 Cancer Research paper which contained both his earliest criticisms of the viral theory of AIDS and questioned whether viruses could possibly cause cancer. The paper caused a stir at NIH because the search for a viral cause was the principal focus of cancer research. At the same time of course, it was assumed that Robert C. Gallo had already demonstrated that AIDS was caused by a human retrovirus, HIV.

When Strohman read the paper, he called a couple of his friends at the National Cancer Institute at Bethesda, including a former student. Strohman found that some "hard-core people" at the institute were saying that Duesberg's criticisms of oncogenes were well taken. But they were saying it privately. Couldn't rock that research boat. Strohman himself couldn't find any flaw in Duesberg's paper. A few years later a four-sentence statement was circulated, stating that the HIV hypothesis of AIDS should be re-appraised. Strohman signed it. But it was fairly innocuous (what scientist can oppose re-examining something?) and it did not deny that HIV causes AIDS. It merely questioned it.

Taking emeritus status gave Strohman time to examine the

Sonia Searing VENTS HER SPLEEN

Who's in charge

This morning my nice little and oh so helpful notebook – you know the mini computer where every thing that is in those huge deskjobs is jammed into about one foot by nine inches – broke down AGAIN!

When I called up the computer firm furiously (I'll give you the name next time if they refuse to replace it) nobody wanted to be in charge. "We don't sell them", "We don't manufacture them here either", "We just fix them". Well, how successfully I can now see ! They've only just sent it back from a five-week holiday with them and it's broken down AGAIN.

You know what that reminds me of? "HIV", the magic serial killer. Montagnier made it clear that he discovered "LAV", which is different – or at least was different at the time of debate. Weiss discovered who knows what, he is not so open about it – and the great Gallo didn't discover anything useful, at least not "HIV". (All he did was steal Montagnier's fake diamonds).

So, what are we dealing with? I'm sending my notebook back for it to be replaced! Can you do the same with a diagnosis?

Smell a rat?

I ran into an old copy of Thud. The one with the poppers-sniffing-homo-clone on the cover (and already a bit green round his face!)

And there it was again, the great debate about poppers. All that fuss about a room odouriser!? Now is it dangerous to consume them or not? (Why the hell would anybody "consume" room odouriser doing sex? When all they do is make you dizzy? I always have a hard time staying awake anyway when my boyfriend ....)

So here Mark White wrote: "...just because a statistical correlation between poppers use and KS appears to show itself does not prove a link." Well, does it or not? Or let me ask, why doesn't it? All the "HIV" dogma could ever come up with to "prove" causation in the greatly embarrassing AIDS debate was correlation! (Since they still have no clue how "it" causes AIDS! Well, should we tell them that "it" really isn't it!) So, "correlation" is good enough to prove "HIV" causes AIDS but not good enough to prove the only-way-gay-sex-can-happen-drug as possibly dangerous! Of course! It is not about "correlation" really, it is about do we want poppers to be dangerous or not!?

We all know that "HIV" must cause AIDS! So, make up your minds babes so we can move up to more important things....like living!

Who's who?

Does "HIV" exist? All I can say is: after 15 years of terror and death this question should not be an issue because it should have been answered before the battle started, or how the f... are we supposed to know what to fight!?!? Well, it has not been answered or let me put it this way: We have never been properly introduced to "I am HIV". I know, I know, all you guys announce that every day quite courageously – "Hi, my name's David. I'm HIV." Let me tell you from all I know about retroviruses, ("HIV"'s family tree), you are not one! But don't worry, you're in good company: "HIV" isn't either!

Suzy is taking a break for a while, and her twin sister Sonia has taken her place to gripe on about whatever she wants to gripe on about actually!

Suzy will be back from her Tibetan mountain-climbing expedition before long.

issue more carefully. In preparation for writing a preface to a collection of Duesberg's most important scientific papers on AIDS, recently published (Infectious AIDS: Have We Been Misled?, North Atlantic Books, Berkeley, Calif. 1995), Strohman devoted more time to the subject. His conclusion is that HIV does not cause AIDS and that AIDS itself "is not contagious." As for HIV, it is "only contagious with difficulty." He points out that it takes on average 1,000 sexual contacts to transmit it. He is also unsatisfied with the fall-back position that HIV is a co-factor for AIDS.

"That's the same argument that we had for genetic predictability: A gene may be necessary but not sufficient," he said. "What does that mean? It means you may get a gene mutation without any manifestation of it. Redundancy in the genome permits the 'mutation' to be consistent with normal behaviour." Which means 'mutation' in that context has no explanatory power. And it's the same with HIV. If "other conditions" must be combined with it, full causality can be imputed to those other conditions and HIV may well play no role at all.

What about AZT? Strohman says this: "In the Concorde study it was proven to be ineffective, and they don't mention the degree to which it may be harmful. It's interesting that they haven't published those numbers, although every cell biologist and certainly every cancer physician will tell you that AZT was designed to kill human cells. It's a cytotoxic drug, even though we don't have any studies nailing that down. But who is asking that from a research point of view? Unless scientists are given a grant to go out and get those numbers, they are not going to become available."

"HIV harmless, AIDS non-contagious, AZT toxic," says Richard Strohman

Strohman has also found emeritus status to be intellectually liberating. "I don't need a grant any more," he said. "But most of my friends–" here he hesitated and went on: "I remember feeling this myself. I was a little bit hesitant to be critical of mainstream ideas because I was afraid that in some way I would be threatened. My grant would be threatened. Basically, everybody feels it, whether it's true or not. So what that does, as the lawyers say, it has a chilling effect on the truth coming out."

When he was teaching an undergraduate introductory course, Strohman would give lectures on both sides of the AIDS controversy. The students found it very interesting, but the graduate-student teaching assistants "had extreme difficulty with it," Strohman recalled. "They would complain to my superiors, they would give me all kinds of trouble. They would quite sincerely tell the students that I didn't know what I was talking about." Strohman has had many discussions with his colleagues on the subject of AIDS – discussions that were both bitter and enlightened. He would raise some question and they wouldn't have the answer, but then they would come back to him with the latest headline, the latest finding. Strohman would study them in turn, and he soon realized that the HIV researchers "were finding out everything about HIV, but not about AIDS." His colleagues would glance at the same studies, and would see that they contained a lot of molecular biology about HIV. But because they had not really studied the question, they would not realise that molecular detail about HIV added nothing to our knowledge of AIDS.

"My colleagues in molecular biology by and large do not read the AIDS literature," he said. "They're just like everybody else who has to believe what they read in the newspapers. We all have to put our faith somewhere, otherwise we don't have time. And that's what scientists do. They get reassured everyday, by the newspapers, or by Science or Nature. And they look at Peter Duesberg and they say, well, Peter is a real good retrovirologist but on this one he has got to be wrong."

TOM BETHELL

Reprinted from Reappraising AIDS, May 1996

RAPID "AIDS" IN ITALIAN SURGEON

The Lancet of April 13th 1996 published a report from an Italian research team studying occupational risk of HIV infection, claiming the first instance of a surgeon developing HIV antibodies, as a result of an accident during an operation on a bi-sexual 29 year-old patient with HIV/AIDS in January 1994.

Briefly, a surgeon carrying out an emergency operation to remedy an anal abscess suffered a cut to his left index finger. The surgeon informed the authorities about the accident, and refused to take AZT by way of prophylaxis.

An immediate serum sample showed no sign of HIV infection, but seroconversion was allegedly demonstrated in a blood sample taken six weeks later. The surgeon denied any symptoms of "acute HIV disease". Apparently, there was no epidemiological evidence of 'risk' behaviour or transfusion associated with the surgeon.

Only one year later, the surgeon was admitted to hospital with oral Kaposi's sarcoma and a CD4 count of 170. The surgeon's strain of HIV was compared with that of the patient and found to vary by 1.3% genomically, making them more closely related than to three other randomly selected 'isolates'. The report states: "This finding indicates that the surgeon acquired HIV infection through occupational injury during the intervention on the HIV-infected patient."

However, there are enough anomalies in this case to render it little more than anecdotal.

a) No details are given of how seroconversion in the surgeon was proved. (What test was used etc.) Continuum readers will by now be aware of the unreliability of HIV tests.

b) The one year between the alleged infection, the development of KS, and the low CD4 cell count, is unprecedented.

c) KS is now known to be totally independent of HIV infection. Ironically, the following report in the same issue of Lancet is entitled "HIV-negative patient with HHV-8 DNA follicular B-cell lymphoma associated with Kaposi's sarcoma."!

d) Oral KS is usually associated with gay/bisexual men, and KS of any kind has never been known to result from a blood transfusion (or Factor 8 use in haemophiliacs). This case would be the first, even classifying the scalpel wound as a micro-transfusion.

e) We are not told if the surgeon's patient had or developed KS, but KS is endemic in Italy in men of all ages, especially after middle-age.

f) The impossibility of proving a relationship between strains of HIV is admitted by the expert Simon Wain-Hobson. (Nature, 199;347:18).

g) Low T4 cell counts are not a reliable prognosticator of disease, especially as prolonged anxiety and stress can depress CD4 cells.

The report states: "To those who work in the operating room, exposure to blood is a daily event that is often ignored or assumed to be unavoidable."

That the first case of accidental HIV infection of a surgeon should have resulted some 15 years after the identification of AIDS is questionable. That it should have occurred in treating a patient with a known history of 'HIV' infection is incredible.

MICHAEL VERNEY-ELLIOTT

With AZT's manufacturer Glaxo-Wellcome facing litigation later this year the BBC's recent Panorama documentary examining the controversy around the approval of the drug was a very public exposé of the methods the company used to ensure the licence was approved

A RAY OF HOPE?

On Monday 18th March, 1996 the BBC's flagship current-affairs programme Panorama dedicated a complete edition to an examination of the controversy around the approval and use of "anti-HIV" drugs such as AZT, and the mounting evidence that while they offer no clinical benefits, their toxic side effects are causing deaths amongst people diagnosed as "HIV positive" or AIDS cases.

The programme, A Ray of Hope, examined the claims made for anti-HIV drugs, in particular the much-publicised statement that early use may offer benefits for survival, in the light of statistically unanswerable evidence that the reverse is true.

More disturbingly, the programme found that the premature and unjustified claims made for AZT monotherapy are now being made for combinations of AZT-like drugs, with the same lack of supporting scientific evidence. Glaxo Wellcome's Dr James Palmer, when asked whether there was not a danger of "going around that whole cycle again," admitted that there was. "The simple answer to that question is 'Yes'," he acknowledged.

"we didn't know anything about the long-term effects"

The programme precedes and illuminates litigation against the manufacturers of AZT (zidovudine, Retrovir) scheduled for later this year. In an interview Mrs. Sue Threakell explained how her husband Bob, a haemophiliac in good general health, suffered an HIV positive diagnosis in 1985 but remained well until starting AZT treatment on medical advice in 1989. "He gradually began to lose more and more weight, then he began to get lots of minor infections. I'm totally convinced that the things he was suffering from were the side effects of AZT. If you look at the known documented side effects of AZT, there is a similarity, a very strong similarity, between those and the symptoms of 'full-blown' AIDS." Bob's medical records, her lawyer believes, clearly support her claim that the drug killed him, not the disease.

Examining the flawed and truncated trials of AZT in the United States, which led to the drug's approval, the programme interviewed a number of officials involved with the process who expressed the doubts they felt at the time. Dr Itzhak Brock, Chairman of the FDA Advisory committee said, "I had serious doubts whether we had all the information we needed about toxicity, about the dose, about even how effective it was, and I felt we needed a few more months to get answers from the company."

Dr. Ellen Cooper of the FDA had similar reservations: "We didn't know anything about the long-term effects." She pressed for a long-term study among patients with no symptoms. However, the requirement for a more scientific trial of the drug was waived. Dr David Barry, then Head of Research for Wellcome USA, was asked whether the company admitted applying pressure to the committee for quick approval. "Yes. Of course," he agreed.

On the basis of another trial, designed to be terminated early, ("Not a good thing to do," according to Dr Cooper), the company began to make claims for the early treatment of asymptomatic "HIV positive" individuals. "If they could take AZT," the BBC researchers explained, "it would become the great pharmaceutical jackpot; an expensive drug sold year after year to people who aren't ill." The company was aided by statements from government officials such as Louis W. Sullivan, U.S. Health Secretary, who encouraged people to voluntarily undergo "HIV testing", on the strength of the trial's dubious conclusions.

As AZT became the company's second biggest selling drug, promotional claims were made that had no basis in fact. The company alleged "tremendous benefits" and "dramatic effects" from early treatment, statements that Dr. Donald Abrams of the AIDS Program at San Francisco General Hospital wryly characterised as "slightly inflated". At the same time the serious side effects were understated by a large margin. The number of people affected by nausea was said to be "very small"; in fact between 22% and 27% of patients reported it.

AZT ran into more serious difficulties with the European Concorde trial, which showed (and continues to show) no clinical benefit from the use of the drug but increased mortality in a group taking AZT early after an "HIV" diagnosis. Panorama interviewed the members of the British Medical Research Council involved in the Concorde trial and learnt of the problems they experienced with the company. At the start of the trial, the MRC team revealed, the company had wanted to use CD4 cell counts as an indicator of the drug's success. The team refused to allow this, suspecting that CD4 counts could be raised by the action of the drug without offering any health benefits. "We were worried that the CD4 count might be a cosmetic measure," Concorde's UK Chairman Prof. David Warrell explained. This turned out to be correct. In the latest

"promotional claims were made that had no basis in fact"

analyses of the Concorde data, raised CD4 cell counts are found in the group, with higher mortality, starting AZT early.

"It did seem to be a surrogate marker, a potentially misleading index," Prof. Warrell said. "But this was one of the markers which the company had relied on in its own trials of AZT," the interviewer reminded him.

"Exactly! So we felt vindicated in our reserve, or scepticism, about what one could infer from the CD4 count alone," Prof. Warrell commented.

"Can you be certain there is no long term danger in taking AZT early?" Panorama asked Dr. Tim Peto, Scientific Secretary to the Concorde trial. "No," he admitted, "we certainly can't say that. There could easily be a long-term danger that the trials aren't quite large enough to reliably detect, that certainly is possible."

At the conclusion of the Concorde trial, the MRC team reported "frenzied" communications as the company strove to have the study's conclusions diluted or suppressed. "We wanted to say the results cast serious doubt on the value of using changes in the CD4 count," Prof. Warrell said. "The company were very keen that we should delete 'serious'. So we deleted 'serious' – under pressure from the company."

After publication of a letter summarising the trial in The Lancet, from which the company had succeeded in persuading the Concorde team to withhold their principal findings, Wellcome held a presentation for press and City analysts, in an apparent attempt to arrest a decline in share prices.

At the presentation Wellcome claimed the Concorde trial showed that "early treatment can improve survival", and that "survival appears to be correlated with CD4 cell response".

Concorde's Principal Investigator Prof. Ian Weller commented: "If anything Concorde showed that there wasn't a correlation between CD4 and survival so the whole exercise, and it's a personal view, was one of damage limitation."

"Was it a distortion of your findings?" Panorama asked. "I think you could interpret some of the overheads [projection slides] as a distortion of the conclusion, the main result, the 'bottom line', of Concorde," he agreed.

Concorde's U.K. Chairman Prof. David Warrell was more forthright. "Both the Chairmen of the Co-ordinating Committee were outraged by this behaviour of the Wellcome Foundation. I composed a letter and sent it to Wellcome, protesting at the misleading information provided at the City meeting."

"Did you get a response?"

"We didn't," he said.

Before the final trial results were released the company and the MRC scientists were implacably deadlocked. Prof. Warrell explained: "It was the conclusion, the main conclusion, that they couldn't swallow." This was that the results of the study do not encourage the early use of AZT.

"I must say we were a great deal more obstinate this time than we were after the letter [to The Lancet]. Because of our experience with the letter, there was no certainty at all that, had we compromised, the company would not have 'reneged' again after publication," Prof. Warrell said.

Summarising his experience with Wellcome and the Concorde trial, Prof. Warrell said: "What we learnt I suppose, and we shouldn't have been surprised, is that when the wrong result is produced for a famous and flourishing company on which a great deal of financial expectation rests, the company's representatives are going to be under a great deal of pressure, and the interpretation of those results is going to be 'stressed', there is going to be an attempt perhaps to blunt the message, to modify, to make a more mellow conclusion from results which seem to be inescapable in their implications."

Despite this setback, however, claims are now being made about "combinations" of AZT-like drugs, specifically about early treatment of asymptomatic "HIV positive" individuals, which cannot be supported by the Delta trial. This trial did not address the question of when (or whether) to start treatment with these drugs, but merely indicated that they may be less toxic than AZT alone.

"the MRC is now the responsibility of the Dept of Trade & Industry"

The programme closed on a worrying note. Britain's Medical Research Council is now the responsibility of the Department of Trade and Industry. "It will become harder for scientists to display any independence in future. More projects will be jointly funded and therefore controlled by the drug companies, which can only increase the risks that commercial pressures will compromise scientific enquiry," the BBC's Panorama team concluded.

The making of this programme indicates that the BBC, or at least its current affairs departments, are starting to take a realistic look at the AIDS phenomenon and report what they find, instead of accepting increasingly discredited AIDS industry dogma. Although the essence of the programme will already be familiar to many U.K. viewers from the Meditel film AZT – Cause for Concern, shown several years ago and credited with saving many lives, the Panorama team have added much new detail about the drug company's methods that was previously unknown.

The strange history of the "AIDS" phenomenon in the UK, and the commencement of legal action, makes it inevitable that the subject will, at last, begin to attract serious investigative attention. As an opening shot, this programme reflects credit on the diligence of the BBC researchers.

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US GAY EDITOR RESIGNS SAYING "NOW I'M HIV+"

Newspapers like The Independent and the Evening Standard have featured the departure of UK-born gay editor Andrew Sullivan from the American political weekly New Republic.

Asks the Standard: "Was it his health or a putsch?" Christopher Hitchens writing in The Independent, himself a frequent visitor to US cultural zones, claims to know. "Nobody really edits the New Republic except [proprietor] Martin Peretz, who does so by the grace of his wife's large fortune (Anne Peretz is the heiress to the Singer sewing machine empire)," Hitchens reports.

Apparently Sullivan was not the first to tangle with this stitch up. Anyway the perception has been that Sullivan threatened the standing of the magazine, letting it in for two "exhausting" lawsuits resulting from "oversights", and on the increasingly rare occasions when decisions were made to publish "serious" material, offending many people with the likes of Charles Murray's essay on an IQ deficit in black Americans.

Hitchens believes Sullivan's pressured departure was supposed to mark a return to "real seriousness" at the New Republic. However, Sullivan used the announcement of his going to reveal his "HIV positive status", stealing the thunder of his colleagues and, with his first book Virtually Normal published last year, coming out in a very 'in' way.

The news of Sullivan's "antibody status" puts into grim perspective his article in the New York Times last November claiming it's wrong of anyone to suggest AZT is a bad drug, and that the Delta Trial had clearly demonstrated the effectiveness of combination therapy.

All in all, Sullivan sounds a journalist with important choices to consider. New Republic's Literary Editor Leon Wieseltier was relieved: "I wish Andrew a long and fruitful life," he said. "But he's changing the subject. The problems around this office were not medical problems. He was responsible for an extraordinary amount of professional and personal unhappiness."

Hitchen paints a picture of an established magazine in decline aside from its hapless choice of editors. "The magazine has lost its standing and has started looking for a 'formula'. It's internal disputes are no longer ideological but emotional...Last week was a milestone in the decline of a magazine, not the health of an editor."

If Sullivan is popping AZT however, he may need more than just endorsements from fellow journalists to stay well.

HUW CHRISTIE

TUBERCULOSIS

In this issue's focus we reveal some facts and some fictions about tuberculosis and "HIV".
While it may be true that no-one antibody diagnosed need consider themselves more prone to TB than anyone else, it is possible that most of the population should pay heed to an increased incidence of the illness worldwide. The reasons for this are complex.
The history of TB is long, and its association with HIV/AIDS far from justified, as Neville Hodgkinson reports.
Maintenance of sound nutrition and proactive therapies when confronting TB are of profound importance, as outlined by Leon Chaitow and Gary Null in the article on Natural Treatments.
Joan Shenton visited a country where health care workers see TB cases everyday, but not all place faith in the HIV model.
In Drug Effects we look at standard allopathic treatments.

PREVALENCE AND CHARACTERISTICS

More humans – about 3 million – died from tuberculosis (TB) in 1995 than in any other year in history, suggested the World Health Organisation (WHO) in a report released on 24th March this year. Three years ago WHO declared a global emergency over TB, estimating 30 million people at risk of dying from TB in the next ten years. One third of the world's population – nearly two billion people – are considered to be infected with *mycobacterium tuberculosis*, the causative agent first recognised by Robert Koch in 1882.

It's generally found that five to ten per cent of infected individuals ever become sick, usually with lung disease. Less commonly, in very immune suppressed people, disease may occur in the intestines, liver, bones, brain or lymph nodes. In 1987, the Centers for Disease Control (CDC) revised the AIDS definition to include this non-pulmonary (lung) TB. TB is often acquired in childhood by inhaling the bacteria present in the sputum of someone who is actively infected. It may also be acquired from infected milk. Infection takes one of two forms. In 90 to 95% of those with primary infection, the body's immune system inactivates the bacteria. They remain alive however, and may spread via the lymphatic system and the bloodstream.

Infection is diagnosed by detecting scarring and inflammation in the lungs. Another indication is a reaction to an injection of tuberculin, a sterile extract from the bacterium. When this is injected into or under the skin, only those people who have the dormant primary infection show a reaction. Reactivation tuberculosis – the gradual emergence of the disease in adults – occurs in 5 to 10% of those with primary infection. The cause is questionable. Symptoms of reactivation (or reinfection) of TB can be deceiving as the disease may start in any part of the body originally seeded with the bacteria. It is most often seen in the upper lobes of the lung and frequently diagnosed after a chest X-ray. Early symptoms appear gradually and often include generally poor health, loss of appetite and weight, night sweats, recurrent fever and cough – indeed many of the symptoms that are supposed to indicate HIV infection.

CURES

The most remarkable aspect of the current epidemic, according to the WHO, is that TB is curable. According to their recent report, "the secret to curing TB is as simple as making certain that patients regularly swallow the right medicine." [see DrugEffects]

Supervision is the cornerstone of the WHO's TB control strategy known as DOTS – directly observed treatment, short-course. Since 1993, the number of countries running DOTS has reached 40, compared with eight before the state of emergency was declared. TB programmes set up in the '90s are reported to have led to 80% of TB patients being cured by 1995 in Guinea, Peru and Bangladesh. The report says that if the DOTS strategy was used throughout a dozen countries that have the largest number of cases of TB (Bangladesh, Brazil, China, Ethiopia, India, Indonesia, Mexico, Nigeria, Pakistan, Russia, South Africa, Zaire), nearly 75% of TB cases in the world could be cured.

Such pharmaceutically friendly strategies do not address the question of reinfection, and the underlying stresses of poverty and neglect that predispose people to illness. In the interests of primary action, however, by 1995 five of the 12 most affected countries had committed themselves to DOTS-based public health programmes.

VACCINATION

Although TB seems on the whole a disease of malnutrition, poverty and stress with resulting immune suppression, it is endured by princes and paupers. Discussing President John F. Kennedy's own struggle with Addison's disease, a commentator points out: "Addison's disease is now usually the result of an auto-immune condition, but when President Kennedy's suprarenal cortex failed the most common cause was TB, and while the President was serving in the navy TB was rife." From the 19th century romance of "consumption" – poet John Keats died of TB in 1820 aged 26 and two of the most popular operas of that century and ours, *La Boheme* and *La Traviata*, portray tragic heroines dying of TB – to today, immune competence with regard to TB has been a socially unpredictable thing. It remained one of the most common causes of death in Britain until the 1940s.

The belief that anti-TB vaccination (BCG) programmes had eradicated the risk of infection has had to be challenged. Active TB infections were reported in 1995 in areas considered clear of the disease for some time, including examples such as one person apparently infecting 41 people in a neighbourhood bar in Minneapolis or a health care worker in Western Canada giving TB to 100 people. According to the WHO report: "in recent years outbreaks of TB in wealthy countries have been investigated in discotheques, churches, subways, schools, aeroplanes, courtrooms and even on a riverboat casino." Professor Thomas McKeown has shown that TB was declining steeply before vaccination was introduced, probably as a result of greatly improved living standards. There appears to be a lack of evidence that vaccinations, often given at controversially young ages, have been responsible for the overall decline, and in countries like Haiti where vaccination has been universal yet TB is rife, the evidence to the contrary is strong.

DRUG RESISTANCE

Demanding of attention are reported outbreaks of multi-drug resistant (MDR) TB in New York City, London, Milan, India, Thailand, South Africa, Estonia, Pakistan and elsewhere. This problem may also be increasingly observed in "HIV" antibody diagnosed individuals taking a range of medical drugs in relation to a range of conditions. When the mycobacterium causing TB has been exposed to drugs that partly inactivate it, mutations occur that allow drug resistant strains of the bacterium to grow. Such strains can develop in a person receiving poorly judged treatment or be transmitted in an already drug-resistant form.

The WHO report blames careless treatment practices and unprecedented levels of medical neglect during the '70s and '80s, estimating 50 million people are now infected with drug resistant strains. "The world is becoming smaller and the TB bugs are becoming stronger," said Dr Arata Kochi, director of the WHO global TB programme. The symptoms of MDR TB are in themselves no worse than conventional disease. Curing it can be a more complex and lengthier process, in particular taking more time to test which of the dozen or more possible drugs will be effective and which are already excluded.

Treatment for TB before the era of antibiotics included rest and good nutrition, and cures were possible. (see *Treating TB Naturally*, page 11.)

HUW CHRISTIE

TB and the "HIV" epidemic that never was

TB is on the increase because of an epidemic of immune deficiency. But is this epidemic caused by HIV, asks NEVILLE HODGKINSON, *ex-Science Correspondent of* The Sunday Times. *He reveals that a lot of scientists working in the field of AIDS are convinced this is the case, merely because they have discovered that many patients with TB test antibody positive.*

False Positive

Is TB on the increase because of an epidemic of immune deficiency? The answer is a definite YES. Is the epidemic of immune deficiency caused by HIV? A lot of scientists working in the field of AIDS have developed the conviction that this is so, because they have discovered that many TB patients test HIV-positive.

However, a different way of looking at the link arises from the work of a group of Australian scientists who have demonstrated that the antibody proteins detected by the HIV test are not specific to a particular virus, but can be put into the bloodstream as a result of a variety of challenges to the immune system.

Eleni Eleopulos and colleagues at the Royal Perth Hospital and University of Western Australia, whose work has already been featured in Continuum, have shown that a positive result in the HIV test can be caused by so many different triggers that it should never be interpreted as meaning a person is infected with a lethal new virus. Indeed, they have argued that the very idea of "HIV" is a misinterpretation of distress signals issued by chronically over-stressed immune system cells.

Naturally, this idea is proving slow to win acceptance. People who have invested years of work in the HIV theory are reluctant to face the awesome possibility that their efforts were based on a false hypothesis.

Belatedly, some of those responsible for developing and marketing "HIV" tests have acknowledged that there were problems with the early kits, but assured us that those have been sorted out and that the tests are now reliable.

No evidence has been produced in support of these assurances. In fact, the kits continue to give widely differing results. Regularly, one or another kit is withdrawn from the market because its results are way out of line from the rest, but the scientific mainstream has not yet found the courage to re-examine the assumptions that underlie the entire "HIV test" concept.

It is in this context, of a non-standardised, non-specific, unvalidated diagnostic procedure for "HIV" positivity, that the illusion of a cause-and-effect relationship between "HIV" and TB arose.

An upsurge of TB, especially in Africa and in impoverished, drug-wrecked communities in some parts of the West, has for many years been mistakenly attributed to the arrival of "HIV".

Once one takes on board the non-specificity of the test, however, it becomes clear that there are other far more credible explanations for the increase in immune deficiency and accompanying increase in deaths from immune-deficiency diseases.

The epidemic of drug use itself, and in Africa the social devastation and accompanying malnutrition brought by economic failure and civil war, provided good reasons in themselves for expecting an increase in death rates. But a lethal "virus", springing out of nowhere and supposedly putting the whole world at risk, proved to be a much more politically comfortable way of looking at the problems.

TB, diarrhoea, leprosy, herpes, pneumocystis carinii pneumonia and candidiasis are among the list of infectious diseases demonstrated to be influenced by nutritional status. As far back as 1974, long before pneumocystic pneumonia became identified in our minds with AIDS, research demonstrating that protein-calorie malnutrition is "a host determinant for pneumocystis carinii infection" was published in the American Journal of Diseases of Childhood[1].

> TB microbes themselves result in the production of antibodies picked up by the "HIV" test

There is an especially strong link between risk of testing "HIV-positive" and infection with the microbes responsible for TB and leprosy, but this is not because "HIV" damages the immune system, but because the microbes themselves result in the production of antibodies picked up by the "HIV" test.

This was clearly demonstrated in an article published in

February 1994 in the Journal of Infectious Diseases[2]. One of the authors was Dr Max Essex, of the Harvard School of Public Health, an originator of the hypothesis linking HIV with AIDS and a leading exponent of the theory that the virus originated in Africa. Essex had been working with scientists from the University of Kinshasa and the health ministry in Zaire to see whether leprosy patients, and those in close contact with them, were at increased risk of being infected with HIV.

PHOTO: GIDEON MENDEL *Network matrix*

The realisation is growing that the problem of false positivity could be enormous

The results of the study were remarkable. Out of serum samples from 57 leprosy patients, 41 tested positive using one kit, 39 using another, and 37 (65 per cent) by both. Among the sera from 39 contacts, the figures were 12, 10, and 9 (23 per cent) respectively. The testing kits used were of the ELISA variety, the most commonly used in Africa and around the world.

When the sera were tested with Western blot (WB) kits and radioimmunoprecipitation analysis, however – more detailed and supposedly more specific tests which, because of their expense, are never normally performed in Africa – only two of the leprosy patients and none of the contacts were confirmed as positive. Even those two could be considered false positives, on the basis of a more stringent interpretation of the results.

About one third of the world's population are latently infected with TB

Most of the blood samples reacted with the proteins on the WB strips, although not strongly enough to provide a positive result. These "indeterminate" reactions were even seen in 85 per cent of patients, and 57 per cent of contacts, who were negative with the ELISA tests. In normal individuals used as controls, however, only 2.5 per cent gave a positive WB reaction.

Laboratory investigations indicated that antibodies induced by Mycobacterium leprae, the microbe responsible for leprosy, were causing many of these cross-reactions and false positives, both with Western blot and ELISA. Cross-reactivity occurred with all the supposed "HIV" antibodies. M. leprae might have this potential "since the disease it causes is associated with an immunodeficiency that resembles HIV-1 in several respects," the researchers said. "In addition, the immune dysregulation induced by M. leprae is often accompanied by the production of autoantibodies to numerous cellular proteins."

They concluded that leprosy patients and their contacts "show an unexpectedly high rate of false-positive reactivity of HIV-1 proteins on both WB and ELISA". Since M. leprae shared several antigens with other members of the mycobacterial family, including M. tuberculosis, the agent responsible for TB, "our observations of cross-reactivity...suggest that HIV-1 ELISA and WB results should be interpreted with caution when screening individuals infected with M. tuberculosis or other mycobacterial species. ELISA and WB may not be sufficient for HIV diagnosis in AIDS-endemic areas of Central Africa where the prevalence of mycobacterial diseases is quite high."

"Quite high" is an understatement. According to a WorldAIDS briefing paper published by the Panos Institute in September 1992, about one third of the world's population are latently infected with TB, and at any one time between nine and 11 million people are suffering from the active infection – 95 per cent of them in Asia, Africa, and Latin America. "In Africa, TB has already become the prime cause of death in adults with HIV," the paper said. "A recent study in the Ivory Coast showed that 35 per cent of adults with HIV died of TB. 'TB is clearly the most important HIV-associated disease in Africa', Dr Sebastian Lucas, author of the Ivory Coast study, told the 8th International Conference on AIDS in Amsterdam in July. 'Since Africa has 65 per cent of all cases of HIV, that makes TB the most important AIDS-associated infection in the world'."

According to Panos, "the established epidemic of TB and the new epidemic of HIV have shown a disturbing tendency to coalesce and to co-infect individuals. It is a dangerous liaison both for those who are co-infected and for those communities in the developing world at risk of TB."

It seems clear from the Zaire study that this "epidemic of TB/HIV co-infection", as the World Health organisation has taken to calling it, is another of the tragic errors created by the non-specificity of the "HIV" test. People with active TB infection are at greatly increased risk of testing positive because of M. tuberculosis, not "HIV".

As Professor John Papadimitriou, a colleague of Eleopulos, has commented, "Why condemn a continent to death because of HIV, when you have other explanations for why people are falling sick?"

There are signs that in Africa, at least, the realisation is growing that the problem of false positives could be enormous, and that it might explain why the predicted devastation of that continent by AIDS has not occurred. Latest estimates of "HIV-positivity" in Uganda, in which "HIV" was previously said to be raging out of control through the sexually active population, are substantially down. The most likely explanation for this remarkable fact is that scientists and health authorities there are beginning to understand the problems with the "HIV" test and are becoming more cautious in their interpretation of the test results.

This may mark the beginning of the end of the "HIV" myth

This is good news, as it may mark the beginning of the end of the "HIV" myth, which has been responsible for the biggest misallocation of medical resources and probably the biggest epidemic of iatrogenic (doctor-induced) fear and disease the world has ever known.

References

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Neville Hodgkinson covered AIDS for many years at The Sunday Times as medical and science correspondent. He is the author of AIDS: The Failure of Contemporary Science, to be published on June 27 by Fourth Estate.

Treating TB Naturally

TB is a curable condition and we asked LEON CHAITOW ND DO and GARY NULL PhD for some guidelines on natural treatment approaches

NATUROPATHIC APPROACH

This brief overview of methods used in naturopathic medicine which can assist in the healing of TB is not meant to suggest that orthodox medical care of this condition should be avoided. These methods are supportive and complementary – not alternative. **Dosages given in these notes are indicative and not prescriptive. It is suggested that anyone with TB should consult a qualified nutritional expert (naturopath, nutrition counsellor, medically qualified nutrition expert, etc.).**

SOUND NUTRITION

One of the first considerations in treating TB has to involve enhancing immune function via sound nutritional practices. This is difficult when the digestive system is compromised, as it often is in people previously malnourished and with a range of infections including yeast overgrowth in the gut. Therefore supplementation with probiotic bacteria, *L. acidophilus, bifidobacteria* and *L. bulgaricus*, can be a useful strategy. Additional focus on the state of the digestive tract may also call for antifungal and antiparasitic strategies including use of grapefruit seed extract and various herbal compounds.

DIET[1]

A dietary/nutritional pattern which includes the following features is usually helpful:-

- whole food (avoiding refined and processed foods)
- moderately low fat
- low sugar – unrefined sources only, such as honey, and then only in modest amounts
- high complex whole carbohydrates (vegetables, whole grains/rice, seeds and fresh nuts)
- protein 12-15% diet – vegetarian, fish, organic poultry, etc. – avoiding any sources of animal protein which may contain residues of antibiotics or hormones (i.e. this rules out most factory farmed animal sources.)
- vegetarian cleansing days and/or short alkaline fasts – under expert supervision only.

Therapeutic foods:

- foods rich in Vitamin A and E
- garlic, onions, leeks, turnips, grapes, pineapple, honey, green leafy vegetables, watercress, apple, apricots, parsnips, oranges, quinces, grapes, parsley, turnips, collards, salsify, seaweed, kelp.

Fresh juices:

carrot, carrot and spinach, celery, carrot and dandelion

Avoid:

cow's milk and other dairy products, white bread, refined foods, processed foods,, sugar and sweets, catarrh-forming foods, caffeine containing foods and drinks, alcohol

SUPPLEMENTS

These need to be individually prescribed. The following are all possibly useful – dosage will vary depending upon individual needs.

- Probiotics – *acidophilus, bifidobacteria* and *bulgaricus* (e.g. BioCare's REPLETE for several weeks followed by Bioacidophilus capsules x 3 daily, plus *bulgaricus*)
- Vitamin A (under supervision) high doses for several days (over 200,000iu) reducing to maintenance dose of around 50,000iu daily – because many TB sufferers are unable to convert carotenes to vitamin A adequately[2]
- Beta carotene (or newly researched substance, lycopene) – 20,000iu or more, under supervision
- Vitamin C – high dosage, to bowel tolerance, under supervision or 3 to 5 grams daily if unsupervised
- Vitamin B-complex
- Vitamin D – important to interact with calcium, which is essential for TB patients
- Vitamin B6 – especially if using isoniazid (see below)
- Zinc – 20mg daily
- Calcium – 1000mg daily (plus magnesium 500mg)
- Multimineral/multivitamin
- Full spectrum amino acids – 3 to 4 grams 3 to 4 times daily between meals
- Essential fatty acids (e.g. flax seed oil – tablespoon daily)

DRUG INTERACTIONS[3]

Vitamin B6 and **isoniazid** (INH, Laniazid) a drug used in TB treatment: as a hydrazine derivative, isoniazid is a B6 antagonist which inactivates pyridoxyl-5-phosphate and may lead to peripheral neuropathies (Ubbink, et al., 1990; 585: pp 285-294); supplementation of B6 may therefore be beneficial, but dose is uncertain and requires expert guidance if in excess of 200mg daily.

HERBAL APPROACHES

These include[1,4]

- allium sativum (garlic): bacteriostatic to *Mycobacterium tuberculosis*, TB's infecting agent)
- Centella Asiatica (gotu kola, Indian pennywort): promotes healing of damaged tissues
- Teraxacum Officinale (dandelion): wide application of uses, including antibiotic properties, immune enhancer, aids liver function, anti-inflammatory and diuretic
- Geranium maculatum: tonic, astringent, useful for night sweats
- Inula helenium: lung tonic, after protracted disease (Ellingwood, pp 276-277)

HYDROTHERAPY[5]

- Constitutional hydrotherapy: 5 x weekly
- Wet sheet pack: through to sweating/heating stage
- Artificial fever therapy (hyperthermia) – twice weekly for three weeks then none for several months and repeat.

LEON CHAITOW

NO DRUGS?

Dr Gary Null does not accept the need for pharmaceutical intervention in TB. He has published over 50 books on health and nutrition. In New York he broadcasts weekly on radio and TV, and has worked clinically with thousands of patients, including many with AIDS diagnoses, with ongoing success.
The following describes a treatment protocol he has found to be effective.

As TB is airborne and easily infectious, depending on the stage of the infection, when counselling somebody with active TB you should protect yourself by spraying a mixture of collodial silver, between 30 - 300 parts per million, together with citrus volatile oils. This will substantially neutralise tuberculosis bacteria in the immediate vicinity.
Surfaces can be disinfected with alcohol and hydrogen peroxide.
In the US, a commercial mixture of citrus oils called AirTherapy is available.

TREATMENT PROTOCOL

Intravenous vitamin C – start at 25,000mg, with vitamin A at 50,000 units, 5cc glutathione, and 2cc licorice extract, 3 days per week.
Increase amount of vitamin C by 25,000mg per week up to 150,000mg. Maintain for 4 weeks then reduce in the same steps as it was increased.
Daily echinacea 300mg, bee propolis 300mg, garlic (liquid spray for throat) 500mg five times daily, magnesium citrate 500mg twice daily, zinc picinolate 30mg, quercitin 300mg, co-enzyme Q10 300mg, milk thistle 200mg, and during the acute stage eleven ten ounce glasses of vegetable juice (i.e. hourly), of which 3 ounces is aloe vera.
10,000 units of mucopolysaccharides.
No sugar, wheat, corn, dairy products, red meat or chicken.
Hyperbaric oxygen therapy 2 hours per day; ozone twice per week intravenously, 10cc/30 seconds to a total of 50cc.

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There is no difference between TB patie

Based in the Dominican Republic to write her account of revelation, suppression and censorship surrounding HIV and AIDS, award-winning campaigning journalist JOAN SHENTON visited neighbouring Haiti, which in the early '80s was thought to have infected the world with AIDS. She reports the awful truth about mass HIV testing in countries suffering from poverty and malnutrition

PHOTOS: JOAN SHENTON

Whatever Happened

The verandah at the Oloffson Hotel was full the evening we arrived. The hotel, a graceful wooden great house, built as a family home by ex-president Sam and still run by members of the Sam family, provides an indispensable oasis for travellers and, this month, for the world's international correspondents gathered there to await the forthcoming elections, only three weeks away.

There had been rioting in the streets the week before; twelve wounded and seven dead. Demonstrators wanted President Aristide to run for another three years.

At every table journalists were tapping away at their lap tops or murmuring confidentially to their contacts, anxious that their conversation should not easily be overheard by those at the neighbouring tables.

How did Haiti, which takes up about a quarter of the island, with a population of seven millions, become blamed in the early eighties for spreading AIDS into the West? And how did Haitians as a nation become categorised as one of the original '4H Club' of haemophiliacs, heroin users, homosexuals and Haitians, who were most at risk of AIDS?

It is true to say that during the seventies Haiti became the Caribbean playground for American gay men willing to pay young Haitian boys for sex. Many of these tourists were already suffering from sexually transmitted diseases and later, when their immune system could no longer bear the repeated assaults, became very ill. However this does not implicate Haiti as a specific AIDS risk.

The story of how a group of very sick Haitians in a Miami hospital became tagged with the AIDS label and led to a whole nation being described as an AIDS risk can be described in a few sentences. It involves principally three men: Michael Gottlieb, a researcher into T-cells in Los Angeles; Wayne Shandera of the Los Angeles Epidemic Intelligence Service; and James Curran at the US Centres for Disease Control (CDC), Atlanta, Georgia. In their zeal to enlarge upon an original small cluster of gay men with Kaposi's sarcoma (KS), pneumocystis carinii pneumonia (PCP) and low T-cell counts, calls were made around the country looking for other similar cases with low T-cell counts.

When Jackson Memorial Hospital in Miami received a call from the CDC asking if they had seen any cases of homosexual men who were severely immune-suppressed the reply was "no", but the hospital did describe cases of undernourished Haitian boat people who had arrived with a virulent form of TB, salmonellosis, and a variety of gut parasites leading to diarrhoea and malnutrition. There were also cases of toxoplasmosis (common in Haiti), candida albicans (thrush) and PCP (which before the advent of HIV was normally associated with malnutrition). These Haitian patients were severely immune suppressed and many were not responding to treatment. They were quickly added to others from King's County Hospital in New York and from then on, supposedly, the risk of AIDS was no longer limited to homosexual men. Simply to be Haitian meant to be at risk of AIDS and to be unsuitable as a blood donor. Further fuel was added to anti-Haitian prejudice by a subsequent series of post-mortems carried out by the hospital in Miami which showed many women and children with widely disseminated internal Kaposi's sarcoma.

The effect of all this on Haiti was dramatic – the tourist industry collapsed and with it the economy. In the United States, Haitians all over the country lost their jobs. Incensed by this, Haiti's Minister of Health, Ari Bordes, demanded that the Centres for Disease Control strike Haiti off their list of risk categories. The CDC reluctantly agreed and with a little juggling of statistics, reallocated the Haitians to different risk groups.

HOMOSEXUALITY AND DRUGS

But one big misunderstanding took many years to clear up. Those early Haitian patients in the US, when asked if they were homosexual, denied it vehemently. In Haiti if a man is asked to pleasure another man, he expects to be paid and does not regard himself as homosexual. In Western terms he would be described as a gay male prostitute but they don't see it that way.

One of Haiti's leading intellectuals, Dr M Jolicoer, had lived through the whole period and was angry when I asked him about it. "Haiti has been greatly damaged by AIDS. We don't see any epidemic here, but now that all their predictions are wrong, they (the Americans) do nothing to put things right. They got the whole thing wrong. They questioned Haitians in Miami and they said they were not homosexual. So everyone believed that Haitians got AIDS without being homosexual. But they were prostitutes and in contact with US tourists who were homosexual. The Haitians that got sick

nts who are HIV+ and those who are not

were the ones that were in touch with the tourists. These same people were also in contact with the drugs scene, so I think it was the drugs that were contagious and affected their health."

Getting to Haiti at all had been an incredible experience. I had invited James Whitehead out to the Dominican Republic to make the journey with me. He has been involved in London campaigns against the use of AZT and represents the younger generation of gay men, now convinced that Peter Duesberg and Eleni Eleopulos are right in questioning the virus/AIDS hypothesis. Indeed Eleni even more radically questions the very existence of HIV. Our team was completed by Kenny Padilla, a trusted friend, who had travelled by car to Haiti before and had all the wit and skill we needed to get us out of any sticky situations.

We took off along the South West coast of the island past lake Enriquillo. At the border town of Jimani we waited several hours for a contact of Kenny's who helped us through customs.

It had been almost impossible to make appointments before arriving in Haiti. Whenever I rang anyone they said significantly "call when you get here" as though doubtful we would ever arrive. But I

condoms."

NO EPIDEMIC

We then ran through some of the WHO's AIDS figures for Haiti for 1993, which he had prepared for us: 20,000 HIV positive cases at the beginning of 1993 (60% male and 40% female). The HIV seroprevalence in urban areas was estimated at 5-10% and in rural areas at 2-6%. Yet the actual WHO figure for reported AIDS cases in Haiti over fifteen years, from 1979 to 1994 totals 4967 – and that from a country supposedly the Western epicentre for a deadly epidemic.

That afternoon we visited Port-au-Prince General Hospital to find out if they had many AIDS cases there. The administration office was not open but I waylaid a charming and very bright young woman doctor on weekend duty. She was a little hesitant, realising that she was speaking to a journalist without permission but allowed me to converse with her. There was no specific AIDS ward at the hospital, she told me. "People come to the hospital very sick with TB, malaria, dysentery. Some get tested and some are found to be

to AIDS in Haiti?

had managed to speak to a Spanish health worker at Medecins Sans Frontières called Manuel Duce. He had been very helpful and arranged to meet us on our first morning there. Anyone on a research trip into the unknown will know how important the first appointment is.

Manuel, a classically handsome Spaniard with a mop of light brown hair, is a nutritionist who with his team from the charity ACSUR Las Segovias, is setting up a series of medicine dispensaries in a rural province in central Haiti, with funding from the European Community. There are no medicines available to anyone in the rural areas and the idea is to select suitable candidates to run the dispensaries. The World Health Organisation then pays for their week's training and an initial free supply of essential drugs like antibiotics, TB and anti-parasitic medicines. Once the lay pharmacist is on his feet, he or she can then begin to sell the subsidised medicines and become self-supporting.

Relaxing in the Dominican sun before our journey through Haiti

In the eleven months he had been working in Haiti, had Manuel seen cases of AIDS?

"I hear people talking about AIDS but I have never seen one case of confirmed AIDS," he told me. Sick people, yes. TB was endemic and there was a marked increase in typhoid fever. Children in his area suffered an average of seven severe diarrhoeas in a year and many suffered from respiratory tract infections (pneumonias accounting for 24% of child mortality) and malnutrition. There was therefore an urgent need for his project's dispensaries, as no proper medication was reaching his people.

What did Manuel think of the AIDS money that had been pouring into Haiti from the WHO, and America's USAID, earmarked for sex education programmes and condom distribution? "People just don't use condoms here," he said. "It is a waste of money and a waste of

HIV positive." What did she think of the way the AIDS picture in Haiti had been painted? She told me she thought the situation had been greatly exaggerated.

That evening back at the hotel all the tables were humming with conversation. James began to chat with an American woman who turned out to be Michelle Karshon, President Aristide's Foreign Press Relations Officer. We told her all about our work on AIDS in Europe and Africa; about Peter Duesberg's view that AIDS was a risk-associated syndrome, not an infectious one, and that people in poor countries like Haiti were dying of the old diseases like TB and malaria but it was all being called AIDS. She listened keenly. The next day she came back and whispered confidentially that she was sure President Aristide would be in agreement with what we were exploring.

Michelle Karshon had arranged for us to meet an American researcher, Worth Cooley-Prost, who was in Haiti to look into how American foreign aid money, mainly channelled through USAID, the National Institutes of Health and various American universities was being spent. USAID and the NIH have funded the two longest running AIDS programmes in Haiti; one at the National Research Laboratories under Dr Jean Pape and the other in a suburb of Port-au-Prince called Cité Soleil, under Dr Reginald Boulos.

Worth is a formidable woman and an assiduous researcher. She told us she had discovered that National Security Study Memorandum (NSSM) 200 quoted Third World fertility as a US national security priority. Distribution of condoms was obviously an area that USAID considered a funding priority, and AIDS was the perfect channel.

Our next visit was to the National Laboratory Research Institute where most of the HIV testing is done. The labs are also the centre

for the GHESKIO Project. GHESKIO stands for the Haitian Group on Kaposi's Sarcoma and Opportunistic Infections. Funded by, amongst others, Cornell University, the WHO (which pays for most of the tests), USAID (who pay for most of the sex counselling and family planning) and UNICEF, GHESKIO provides free HIV testing for Haitian people.

NO AIDS FIGURES

More recently, another group called FHAME (Haitian Foundation for Endemic Diseases) has been formed there to combat AIDS and sexually transmitted diseases. Dr Pape was away but we were granted a twenty minute interview with his public relations officer Dr Marie Deschamps. She had worked at the project for fifteen years and was obviously one of Haiti's brightest stars in the AIDS field.

Dr Deschamps told us that she had no figures for AIDS in Haiti, only figures for people who are HIV positive ("HIV disease" is the fashionable phrase). In fact her fundraising letter for FHAME is careful only to quote WHO world estimates for HIV positive people (40 million by the year 2000) and an estimated figure of 6,500 orphans that, the letter states, will exist in Port-au-Prince because of AIDS.

From then on the talk is all in percentages. For example, she told us that the estimated HIV seroprevalence in the country prior to 1991 had been about 6% and after 1991 had remained stable at 8-9% of a population of 7 million. About 40% of those had been tested. The remaining 60% were based on clinical diagnoses without a test. Her laboratories perform double ELISA tests but no Western Blot (the test commonly used in the West to confirm the notoriously unreliable ELISA results). Of the 2000 blood samples that are sent to her lab for testing every month, about half are HIV positive, she told us.

Haiti adjoins the Dominican Republic

James Whitehead and our guide Kenny Padilla

INDETERMINATE TESTS

Dr Deschamps was worried that their very latest testing kits manufactured by Abbott, which were supposed to test for both HIV1 and HIV2, were causing problems. The first test was giving a "weak reaction" and when repeated with a second they were "not automatically reactive" meaning they were negative or indeterminate. However, when she performed the second test using the older test kit manufactured by Pasteur laboratories, she got a positive result.

All of this simply confirms Dr Harvey Bialy's strong criticism of what he describes as the sham of HIV testing. As there is no gold standard against which to compare each test kit, errors can become compounded instead of evened out. It is his view that as much as 80% of HIV testing in Third World countries produces false positives, owing to anomalies in the test kits themselves and also to the fact that it is well-documented that people who live in areas where leprosy, malaria, TB and lupus are common, can produce false positive HIV test results. Furthermore, current work by scientists in Australia and Germany has revealed a new perspective on these so-called false positive results. These scientists maintain that, as HIV has never been truly isolated, the proteins alleged to be specific to HIV are actually stress proteins released in response to a severe disease condition. So, HIV may not exist at all!

James asked Dr Deschamps what the latency period was for progressing to full blown AIDS. She said about 5 to 7 years. Did she think everyone would die who was positive? Everyone, she said.

"These predictions simply don't add up," said James in the car later on. "There should be hundreds of thousands of AIDS deaths by now," he said. This simply is not the case. The population has been increasing steadily and anyway, there are no figures for registered deaths to compare with.

Dr Deschamps told us that a paper of hers was expected to be published in The Lancet shortly. It describes an eight year study of 920 sexually active couples (condoms are not normally used in Haiti, she told us). 475 of these couples were "discordant", that is to say one partner was positive and one negative. "After eight years," she said, amazed at her own findings, "very few of those couples became 'concordant'," that is, both partners becoming HIV positive. "What do you mean by very few?" I asked. "Only 36 couples," she replied.

That means that over a period of eight years 439 couples did not "infect" each other. "I can't really explain it," she said. I said that Peter Duesberg would have no difficulty in explaining her findings, as they were in perfect accord with his view that HIV is extremely difficult to transmit sexually because there is so little of it about in the first place!

There remained only to find some AIDS cases. So we set out for Mother Teresa's Hospice, the Missionaries of Charity at St Martin.

We were getting nowhere, until Kenny spotted a little nun in neat grey habit trotting purposefully along, carrying a plastic shopping bag. James jumped out of the car and begged her to help us. Sister Marie Eugénie Beaulice of the Sisters of Mary came to our rescue with all the spontaneous generosity that real goodness engenders. She gave up her trip to the Silesian monastery, jumped into our car and led us to the Missionaries of Charity Hospice.

There I asked to see the Mother Superior and we waited in the courtyard. Sister Sunupa was from India and wore the familiar white toque edged with dark blue bands. She would be happy to take us round the hospice and told us about her work as we walked to the wards.

She told us that everyone that came to this shelter had TB, young and old, and many had parasites and other infectious diseases. Because her charity had enough money to test for HIV, everyone was given a blood test. She said that 90% turned out to be HIV positive. "Because we know they will definitely die of AIDS," she continued, "we have decided we cannot afford to give our HIV positive patients medication."

THE AWFUL TRUTH

There it was. The awful truth in one short sentence. All of those people, many of them young, with treatable infections, were being denied medicines that could save their lives.

The men's ward was full and there were one or two young men who looked very emaciated and close to death. The rest were ambulant, many of them elderly. It was the women's ward that caused us the greatest anguish. It was full of young, often plump, healthy-looking women, sitting disconsolately on their beds. They had probably been told the results of their HIV test and the death drums were already sounding in their ears. Some of them managed a brief smile. I was allowed to take photographs, and two of them posed for me beside the statue of the Virgin Mary.

On our last day we went to the second big AIDS project in Haiti. It is based at St Catherine's Hospital in a slum suburb of Port-au-Prince called Cité Soleil.

Driving into St Catherine's Hospital compound is like moving to first class from steerage on a luxury liner. Here you can positively smell foreign aid money. The centre is headed by the Haitian Organisation, Centres for Development of Health (CDS), under the directorship of Dr Reginald Boulos. In a paper recently sent to me by Worth Cooley-Prost, she writes: "Dr Boulos's CDS is by far the most powerful recipient of USAID 'humanitarian' assistance in Haiti. The flagship CDS offices are in Cité Soleil, with other major programmes in Gonaives and Cap Haitien. CDS receives a bewildering tangle of grants, contracts, sub-contracts and sub-sub-contracts

originating with USAID, the National Institutes of Health, and other US government agencies, amounting to many millions a year. Between those funds, money from the intelligence-linked charity AmeriCares, and some foreign donors, Dr Boulos has controlled a budget larger than the Ministry of Health [Haitian]. USAID has funded medical research in Cité Soleil continuously since 1975."

We made our way to the Senior Nursing Officer's office and found a quietly spoken woman, Mme Ursule François, whose calm intelligent face told you she had seen most things in life and there were few surprises left.

Slowly she began to open up. She had seen thousands of cases of TB. She said she saw no difference in the medical picture between patients with TB who were HIV positive and patients with TB who were HIV negative. She thought the whole 'AIDS and Haiti' scene had been exaggerated and believed that hidden agendas were at work. She did not think HIV was pathogenic, nor was it easily sexually transmitted.

We were then taken on a tour of the hospital. The women's ward had several older women patients in it, and the men's ward had one seriously ill young man. He was waiting for his HIV test result.

So much for the Haitian AIDS epidemic.

THE END OF AIDS

Mme François then kindly took us to the project statistician's office where we met Evelyne Leontus. She was concerned about the fear which AIDS plague terror tactics engendered. She said she knew of many people who, when suffering from infections, would not go near a doctor or hospital for fear of being diagnosed HIV positive. She opened her books up for us and we compared the number of tests in the month of January 1993, with the month of November 1994. In the first month of 1993, 154 tests were performed and 42 were positive, while in November 1994, 250 tests were performed and 78 were positive. "The more you test, the more you find," she said.

She listened as we explained Peter Duesberg's theories and said: "Your work is very important. If Peter Duesberg is right then it will be the end of AIDS."

We had noticed that the temperature in Haiti was rising, owing to the forthcoming elections. The air was tense and our hotel was now full of armed body guards, protecting one of the country's magistrates who had received death threats and could no longer live at home. It was time to go. We said goodbye to Jean Max Sam and his brother, our gracious hosts at the hotel, and set out at 4am for the border and the Dominican Republic.

In a small town between Port-au-Prince and the border we noticed a strange light. On approaching we realised that there was a road block of burning car tyres, with a sheet of flame rising high up into the dark early morning skies. "That's it," I thought. "We'll never get out," imagining the chaos that would reign a few hours later with the traffic mounting up on either side of this incredibly busy road. But, undaunted, Kenny drove up to the wall of flame and found just enough space to veer off the road to avoid it. The same thing happened again a few miles further on, and then we were away and at the border.

That day Kenny drove for thirteen hours, past the capital Santo Domingo, and on up north to our base at Puerto Plata.

Additional research by James Whitehead.
With special thanks to Prof. Alfred Hässig of the Study Group on Nutrition and Immunity, Berne, for making this journey possible.

This article forms part of a chapter in the forthcoming book,
ONLY MAKE-BELIEVE:
AIDS, Subversion of the Truth,
by Joan Shenton, to be published by I.B. Tauris.

Depression	**Vaginitis**	**Hopelessness**
Anxiety	**Acne**	**Thrush**
Irritability	**Cystitis**	**Pre-menstrual**
Constipation	**Bloating**	**tension**
Heartburn	**Tired all the time**	**Menstrual problems**
Allergies	**Migraine**	**Diarrhoea**

Candida Albicans: could yeast be your problem?
Leon Chaitow, ND, DO (Thorsons, £3.99)

If you read a list like that above and think, "That's me!" and especially if you've had long antibiotic treatment, use oral contraceptives and love a sugary diet, you may well be suffering from an overgrowth of a little parasite yeast-fungus called *Candida albicans*.

Natural health practitioners have learnt that candida can cause all sorts of problems thanks largely to the efforts of naturopath and osteopath Leon Chaitow. His book, first published in 1985, was the first to alert us to the new research from America that showed how candida was so much more than just the cause of thrush – a limited view that, unfortunately, many conventional medical practitioners still hold.

Out now is Chaitow's updated version of his original classic *Candida Albicans: could yeast be your problem?* He explains clearly how candida, a normal inhabitant of our digestive tract, is usually kept in bounds by our resident friendly bacteria, and what happens when it gets out of hand. We highly recommend this book – everyone with an interest in natural health should know about candida.

Leon Chaitow is also author of: Fibromyalgia and Muscle Pain – what causes it, how it feels and what to do about it *(Thorsons, £5.99) and* Body Tonic – a guide to detoxification *(Gaia £10.95)*

REVIEW

Natural treatment for beating Candida

The Practical Guide to Candida
Jane McWhirter (Green Library at £7.50)

Out now, too, is *The Practical Guide to Candida*, by chiropractor Jane McWhirter. She picked up on candida in 1992, simply because of the sheer number of her patients who were showing up with candida-related problems. She saw how well they responded to holistic treatment but had no real idea of the scale of the problem, nor that GPs were not dealing with it, until a *Daily Mail* feature on the Candida Support Group she was involved with produced 700 enquiries from all over the UK within a fortnight, all from people asking where they could get advice and treatment.

The Guide is one the answers; as well as giving a comprehensive description of every approach that has proved helpful, it includes the first UK directory of complementary practitioners who treat *Candida albicans* holistically – and includes how much they charge. Written sympathetically and with great understanding of what a candida sufferer goes through, it also explores the links between candida and ME – or post-viral fatigue syndrome, which leads to 'tired all the time' people who have been told they'll have to learn to live with it. All proceeds go straight into research and training in the holistic treatment and prevention of candidiasis.

Reprinted from Health Guardian, *May/June 1996*

They were willing to accept anything tha

The gay

Michael Urs Baumgartner, 31 years old, holds a bachelor degree in business and a masters in social work. He trained as an AIDS chaplain at San Francisco General Hospital.
Over the past 10 years he has worked both in the "HIV" establishment and as an AIDS-dissident in Switzerland, the US and England. He is currently planning his first workshops for gay men affected by "HIV" and AIDS.

In the early '80s AIDS was seen as a gay plague endangering the whole gay community. In the current climate of "re-gaying" AIDS MICHAEL BAUMGARTNER's essay explains the relationship between the gay community and "HIV", and the need gay men had to believe in a single cause of illness instead of examining their unaccepted lifestyle

To understand the relationship of gay men and "HIV" it is important to reflect on the context in which "HIV" has been established. I propose the example of the Gay-liberation movement in the US.

In the early '80s a new president was making an impact with his reign. Reagan's sociopolitical purpose was to re-establish the old value system by undoing the achievements of liberal movements that endangered the power of the economic order. Under the previous Democrat leadership of President Carter, the gay movement gained visibility and with gay leaders such as Harvey Milk even respect. This liberal tendency in human rights was now to be boycotted on the most powerful, the presidential, level in the White House.

Reagan took the road of traditional patriarchal family values and a neo-liberal economic approach. Instead of allowing the necessary changes to proceed, he promised to bring back the old value system. He was not battling the symptoms of a decadent world, but of necessary change that the powerbrokers of the establishment did not want, involving, as it did, danger to their patriarchal moral and economic structures. Change was what the gay-movement needed, to finally get constitutional rights – the grounds on which individual minds could have broken away from self-destructive behaviour: the step from abnormal illegal citizens defined by sexuality to legal respected members of society. As we know that step did not happen. One of the reasons was AIDS.

> These identifying sexual practices seemed to endanger the whole community

First established as GRID (Gay Related Immune Deficiency) at the start of the '80s AIDS shook to the core what has become known as the gay community. AIDS challenged gay men on the most intimate level, the sexual persona. First in our lives we were denied our sexuality by labels like "bad", "abnormal" and "unnatural". Once we came out we found ourselves having to conform sexually to be part of an identity that grew out of the sexual liberation movement. Now these same identifying sexual practices seemed to endanger not only each individual's life but the whole community.

In the gay ghettos of the US, where gays claimed a certain freedom, sexual habits had become competitive sports. To be part of the gay ghetto life, you played along – a night on the town easily led to lots of anonymous sex with as many men as possible. Men were really into each other – not on an affectionate level but with their hands up to their elbows "fisting", and not as a dangerous one-time experience but a repetitive addictive practice with the use of sexual stimulants. Designer drugs such as poppers – a hard sex ingredient – became a hallmark of style, as if men could not handle each other and homosexuality without artefacts. The marketing and selling of our sexual lives and their accoutrements was mostly managed by organised interests. We lived our lives according to the findings of the sexually liberated generation: anything could be good and everything was allowed that would fuel sexual pleasure. We wanted to enjoy the abnormal because we seemed to have lost the chance to be normal.

As gay activist and AIDS-dissident the late Michael Callen put it: "What ten years ago was viewed as a healthy reaction to a sex-negative culture now threatens to destroy the very fabric of urban male life." (Michael Callen, We know who we are, New York Native, Nov. 1982: 8-21) Many knew that their sexual practices were not only ruining their lives but once focused on by the public, making the gay community look like a bunch of perverse extremists. Healthy gay life, as it could be, was undermined by the emerging gay press. The infiltration by drugs of the gay ghettos was covered up by commercialising our very being. Many homosexual men, alienated by an excessive lifestyle, stayed in the closet.

The gay community at that time was split: there was an oversexed group, limiting themselves to cock'n'ass, "play-it-hard" sex, and the conformists – "let's be nice and agree as gays" and develop the political solidarity to be taken seriously by white middle-class heterosexual citizens. Each desired respect and some social power, if only in the gay ghettos, either by conforming or rebelling. If one saw no future, life's motto became "live fast and die young". A future meant compromise. For gay men growing older the compromise was a routine career. After all gay men were socialised as men . The older they grew the more they needed to have achievements to demonstrate manhood, be it a nuclear family, a career or both. The financial rewards of careers were often being combined in same-sex, double-income households. The gay men without families, enjoying free sex as long as possible, felt an urge to fit into a community with some sort of seniority, even if it meant polarising our actual lives.

Giving up their asses at night they impersonated dominant tops when it came to risk assessment by their local medical practitioner. These young ambitious patient-pleasing doctors were

t removed possible blame for this plague

community's need for "HIV"

conditioned in a very straight homophobic profession that labelled homosexuality a mental disorder until the early '70s. They persevered, not speaking up in training or later, probably for fear of endangering their career and dismissal. Often privately homosexual themselves they did not want to criticise health-threatening lifestyles they were often already part of themselves nor did they want to be labelled patronisers and become unpopular in their own community. How good could conclusions be that came out of medical data reported under such conditions? Data to prove the "growing wave" of illness was caused by an infectious agent destroying the immune system of a small group within the homosexual male population, and not by serial, often unhealthy sex, abuse of antibiotics as a quick fix for transmitted diseases, plus the use of designer drugs. Doctors increased the

> Going public with AIDS would have ruined their self-image as strong men

doses of antibiotics instead, without warning about the long-term effects. Hepatitis vaccinations along with "HIV-antibody testing" became routine ordeals in gay men's clinics. Who would inform gay men that these vaccinations could trigger a "false positive HIV-test" result? How many of us did not have a hepatitis shot?

Antibiotic use amongst gay men in the '70s increased drastically, as did sexually transmitted diseases. The physical outcome was that the pathogens responsible for such fashionable gay men's diseases as hepatitis and venereal diseases became resistant to the antibiotics prescribed prompting stronger doses for longer periods rather than the short intervention they were designed for. Individual immune systems, compromised with each dose of antibiotics, (sulphonamides among the worst yet widely in use amongst promiscuous gay men) were worn out and breaking down. The psychological effect of such superficial treatment was the expectation likewise of a repetitive quick-fix for this newest symptom of the gay lifestyle – AIDS.

The hidden patrons of the gay community – leaders through personal wealth, mostly upper class white men mingling with closeted powerbrokers in the gay Meccas San Francisco, New York and Los Angeles – were setting the gay agenda, not according to the needs of a young community but according to what their friends found acceptable. Anything that would not endanger the WASPs and keep the gay rabble in line became the gay political agenda. These few self-appointed gay opinion makers owned the gay community – the bathhouses, the magazines, clubs and bars. Behind closed doors they met at parties for celebrities from the political and entertainment industries. These parties, usually out of control through over-consumption of alcohol, drugs and sex were the only place for famous "straights" to be queer. As they were presenting a conventional public life, the addictions and homoeroticism of even the few out gays amongst them had to be kept "secret" from us.

When the first of them came down with AIDS going public would have ruined their self-image as strong men, not faggots. Trapped in the closet of their own lies, unable to move for fear of bursting open the already shaky closet door, they needed the street gays, the very men whose lives they had exploited, to fight in their interests. Hidden behind the scenes, they were providing the money and the direction. Anything that helped them would be "generously" shared with the common gay man of the ghetto. These rulers had created a lifestyle for themselves that incorporated everything – the legal and the illegal, the moral and the immoral, money, careers, drugs, crime and secret voluptuous homosexuality – the ultimate statement of power in their minds. The bitter ignorance their lives generated was the spur for the establishment of "HIV" as the cause of AIDS in the gay community. Much like the gay ghetto sex consumer, they victimised themselves into the beginning of the end, the rising plague, "HIV".

Our community leaders were fatally disorganised over the priority of issues, while gay men were falling ill because of a lifestyle that was never addressed. They became more concerned about how to present homosexual promiscuity to a generally unsophisticated ignorant homophobic heterosexual society than about how to address a misunderstood self-concept of gay life. Serial promiscuity, the engine of the gay sensibility in the '70s, was now a fast train to a far too early death. It endangered not only the self-image of individuals but the self-esteem of a whole community. Gay activists did not allow much time to question ourselves from within and were not all open to accept criticism from outside. Yet just that was overdue. Especially from within the com-

> We needed "HIV" to shout down our own inner critical voices

munity. In the AIDS years before "HIV" was established, '81-'84, the most challenging and fearful years, only a few of us started reflecting on the gay lifestyle, post-sexual "liberation". The core were good at identifying homophobes and fascists outside our community but critical voices from within were shouted down or simply labelled "self-hating homosexuals". The attitude to criticism showed the amount of pressure carried around by us as individuals and members of a community at the edge of society. That pressure was based on the collective experience of oppression which was real for all gay women and men.

We needed "HIV" to shout down our own inner critical voices.

Once "HIV" was declared the probable cause of AIDS, and the lifestyle question slowly diminished, we gladly took on the task of making sure that everybody knew: the possible war against homosexual lifestyle was re-routed into the war on AIDS/"HIV". In the medical mind both were based on clinical monocausal assumptions. That still proves to be wrong for homosexuality, yet we gladly hope it's true for AIDS and a quick fix for it will be found.

The new, convenient medical hypothesis, lodged in people's minds via the mass media, became scientific fact simply by dropping the word "probable" and agreeing for the assumption to be right. Gallo, head of the NCI, installed by Nixon in his war on Cancer, needed a deadly virus after many failed attempts to justify billions of dollars wasted in cancer labs. The gay community needed anything that took possible blame from them. Our fear was real. Only 40 years ago about one million gays were sent to concentration camps, few returning, most rarely mentioned in talks about the Holocaust, survivors never compensated. A New Right asked again for our imprisonment but thanks to the installation of "HIV", the public eye shifted from the gays to the Gallos. We had plenty to lose so we seemed to agree that anything is better than being thrown back into the closet. The curtain was raised for the tragic role of the gay movement in the AIDS-drama, reuniting the divided groups of the gay community.

The gay community needed anything that took possible blame from them

In 1984 already established data on stressing our bodies with drugs and polluted foreign proteins was dropped and we bought into a bad hypothesis from bad scientists not because it had any backup but because it was convenient. It passed the first criterion of modern medical science, expediency.

While tempers in the gay community were high when attempts were made to establish AIDS as a gay men's disease, tempers were now high about not receiving enough help from the mainstream to battle this invader. Defence mechanisms running at full speed were shifted to accusations of blame for the failure of the leadership to respond fast and comprehensively. While there certainly was unwillingness in the mainstream political leadership, the fast approach that was demanded does not work well in science. It is sad to understand that, had we only looked within our lives and community, instead of waiting for the world outside to move, we might just have solved the problem of AIDS by now. In the early days of the new phenomenon we became the frontrunners and soon managed the public response to this tragedy. But the constant struggle has blinded us, so we did not hear the wise voices from our own ranks. Our need to defend ourselves became our willingness to accept anything that would give us a clean bill as victims of this plague. "HIV", now declared a deadly threat to the whole world – the infectious agent never isolated, not proven to have killed one person yet diminishing a whole community constructed on the single pillar of sexual orientation – kept us from self-knowledge.

Once the image of a mutant killer virus was in everyone's head we became of sad importance. The first to be affected by this health crisis, our fears of blame, abandonment and death kept us ahead of the rest of the population. If a cure could be found it would be through us, not without us. This attitude became the credo of the AIDS '80s for gay men. In order to keep our interests in line we had to make sure that we were the "real" public experts on this disease, knowing that the rest of the world probably would not care much about our dying unless we made ourselves important to the world.

We learned quickly to take care of our own sick and dying. In a very short time self-help groups were established that became models for caregiving all over the world. While we took care of the already sick and dying, those sentenced to death, the straight white scientific establishment were in control of "scientific research", which was considered of real "importance". Gays were allowed a certain space as long as they did not claim the middle ground. In the shadow of the popes in white we were allowed to care for the lepers. As outsiders we had two options in this crisis: either we would die, mostly alone abandoned by the world, with little merciful help, for we were conceived as the guilty ones introducing the plague into the general population and deserved it, or we would repent our sinfulness into usefulness. We became human guinea pigs in the halls of modern medicine. Once we could establish to the world that, because we were the first to be hit, we could be important in finding a cure which even if it were too late for us would mean the general public – the innocent children, the trustful wives – would survive, we became the cross carriers. This willingness to be of general use even in the most vulnerable situation demonstrated the sense of worthlessness, even shame within us.

While it grew "politically incorrect" to consider AIDS a gay men's problem, it was "medically responsible" to blame AIDS on "HIV" without any scientific proof. Only the wisest of us could see any sense in it all: AIDS could not possibly be caused by a sexually transmitted virus. No known sexually transmitted disease ever originated in the gay community. That STDs occur in both genders simultaneously is the criterion to distinguish a STD. It could actually be argued that the heterosexual community introduced STDs into the gay community. But raising such arguments requires civil-courage, something rare in the pleasing groups of mingling men. AIDS soon defined the self-awareness of gay men for the future: sex and oppression, until now the corporate identity, were joined by AIDS and "HIV". Not a very inviting framework for a gay future.

The scientific community realised early the willingness of gays to help in any ways possible – just let there not be any hint of self-infliction. And so it was: AIDS was made a purely virological problem. Nothing self-inflicted and therefore no blame. The price was high. Not for the first time in medical history – but this time openly – humans could be used as guinea pigs. People would soon beg for anything that kept the final days of ultimate truth, the moments of death, away as long as possible. We wanted time to establish a better opinion, both personal and public about our lives. Humans need to feel good and make some sense of our lives before we can die with some kind of dignity. Scientists needed a good explanation to justify treating humans as disposable, and without any hesitation they used our tragedy – of the discarded, dying young man, and an all-endangering sexually transmitted disease – for their funding purposes. It was as if gay men were making a pact with the devil: if we would sell our bodies, hoping to save our souls, we would no longer be exposed to painful questioning about our privacy. We were given by the gods in white a groundbreaking heroic role: Jesus-like saviours. Too bad for ego-needy gay men that nobody really seemed to care. Yet some of us were still quietly arguing that certain behaviour, the other word for lifestyle, could be dangerous: do we handle the gift of homosexuality carefully enough?

Some of us were arguing that certain behaviour could be dangerous

AIDS foundations were established. Once people internalised the message of danger, public pressure, mainly from the gay-supportive political left, allowed conservative powers to establish what I call the gas chambers of the '80/'90s. Having so many important scientists worldwide looking for a cure for the very disease killing gays gave us a sense of importance. With Reagan still in office, AIDS was declared the number one health crisis, and we were part of that battle. Publicly acknowledged, it seemed almost that we had triumphed over Reagan's right-wing politics. Had we really?

Gay men whose only qualifications were to be personally affected by this health crisis established and ran the first AIDS-organisations. Almost none of the gay activists from the '60s and '70s were found heading AIDS agencies. The job of supporting all the people directly affected went to out-of-the-closet ex-clergy while street-smart political wannabees screamed for funding. Pharmaceutical companies donated money once they foresaw a possible market – a little at first to check who was the most

receptive, then paving the way for the future. Because the newcomers did not understand the manipulation intended with such generosity, grave mistakes were made while establishing otherwise trustworthy grassroots support agencies. The early AIDS activists would do what they saw as important for the people affected, which would eventually have led to the unmasking of the HIV-theory. Foreseeing such progress, the pharmaceutical companies, horny about the huge market ahead via HIV/AIDS, undermined dissent with an outburst of donations. Money that was first eagerly accepted in order to remain in the forefront of AIDS and to compensate for lack of public funding, became more and more linked with conditions. While the early advice given by AIDS-agencies was to do nothing that could endanger your health any further – which included the importance of safer sex – suddenly "early medical intervention" even for the uninfected (called "prophylaxis", sic.) became the issue to advise about. This line became demanded of AIDS groups, especially as time passed and no cure came about.

PHOTO: © SM GAYS

The cold anger of an oppressed minority was heating up: AIDS became its outlet

Something even odder happened. Suddenly lifestyle and the use of drugs (mainly poppers), were publicly announced irrelevant to AIDS by the gay establishment running our gay bars, glossy porn mags and bathhouses, with strong interests in widespread drug consumption. After the establishment of "HIV" the discussion of drugs, both recreational and medical, and their relevance to AIDS, went underground. We did not want to wake up our moral watchdogs, ready to whistle us down. Talk was only heard again when a clean bill (in the case of poppers a "blue print for health") could be given to our scene drugs, "affirming" there was no link between AIDS and drugs. The drugs industry was not only left untouched but established itself as a concerned supporter of gays. And while the conservative rulers set (low) standards in the fight against drugs – "Just say no" – the gay community increasingly made drug (ab)use part of our culture – legal medication such as AZT, antibiotics and other dangerous products, or illegal or partly illegal drugs such as poppers (both originally from the same manufacturer). Using drugs/poisons, medically or self-prescribed, enabled gay men to generate profits for organised crime and the pharmaceutical industry. That was OK with the political system of power.

While cancer could not remain the all-endangering sexually transmitted disease proposed to have originated with the homosexual community, AIDS could, due to the willingness of gay men. We de-stigmatised promiscuity and publicly announced independent thinking as the number one enemy. Commonsense was nothing, obedience everything, in times of specialised medicine.

At first self-help groups assisted people hit by an unspecific diagnosis and sentenced to a painful death. Once HIV was established as a killer more gifted and destructive than all the high-tech armies of modern war put together, and nothing could be done to help the ones who were designated by their MD, actual support for the sick became less important for fashionable AIDS charities and we could finally focus on our careers. More and more self-help groups turned into lobbying agencies establishing new risk groups as new sales markets. Gays with good intentions were replaced by young ambitious homosexual careerists eager to please the money-givers for the opportunity to earn good money and the freedom of being obediently queer or "out", albeit very "straightly" so. AIDS became very dear to them, hopefully not to be over too soon.

Suddenly the gay experience was interesting, broadcast into households, classrooms and counselling training centres worldwide. Thanks to AIDS, people who never thought about homosexuality got an introduction into the variety of sexual possibilities, constantly polarised as "safe" or "unsafe". AIDS became the first gay career machine, with one small flaw : it was run and dictated by straights, much like the homosexual entertainment industry and the drug market. The bigger an industry AIDS became, the more serious the business people needed to run it – certainly not gay women or men, with the exception of those conditioned along very straight lines. Of course gay men were needed – we were much nicer clientele than aggressive drug addicts or haemophiliacs with a mainstream self-image. We ensured there was enough willing lab-fodder, that those getting killed felt comfortable and appreciated so we all could sleep at night – no cure but at least quality attention. As "thanks" we were flown to wherever the next, biggest AIDS, or rather "HIV"-conference was held, allowed to sit in the same room with the prophets of "HIV", be granted a stage to show the latest safer-sex video and introduce the best new counselling tool to therapise the helpless. But were we ever taken seriously and dealt with on a mature adult level? No! Uncle doctors have led us by the hand into nice dying places (gas chambers with gold framed doors, peachy wallpaper and junk-food at midnight) for agreeable gay PWAs (no unreformed drug addicts).

The cold anger of an oppressed minority was heating up again and AIDS activism became its outlet. The medical establishment, still being reluctant to release a questionable drug like AZT too fast, gladly accepted the pressure of shaved-headed nazi-look-alike-clones storming the streets demanding the poison be distributed. With left-wing fascist attitudes they ran down anything and hissed anybody standing in their way or disagreeing on possible cures. In some people's minds a cure that kills seems better than no cure at all. A cure would define the disease! Looking for "a cure" imprints the idea that our suffering, our dying has been taken seriously. AIDS activists claimed importance to our dying – it suddenly was and seemingly is more important than our often difficult living. Those who weren't supporting these actions were simply "opponents". Medical ethics and the due process of drug licensing did not count. Those who obstructed were called homophobes.

> Our dying was more important than our often difficult living

The media gave gay radicalism some coverage, yet that kind of radicalism was not what we needed in this crisis. We needed alertness and solid action. The news coverage, mostly homophobic, allowed a increasingly inhuman scientific establishment to proceed with their cruelty. So ACT-UP claims credit for making AZT (cell-poison) available on a wider scale and Wellcome, happy to be given the chance to get the research expenses covered and make a few extra million with an useless old toxic cancer drug, sold it far too expensively to the new market. While homeopathic remedies were often unavailable and expensive, AZT was made available to the needy on the basis of fraudulent "scientific" back-up. The tax payers paid for it, financing our deaths while a few corrupt individuals got very rich. What a powerful achievement this seemed to be for vindictive minds.

By the end of the '80s AIDS had become the issue of concern for every gay man. It was prioritised for all of us for its possibilities for the gay agenda rather than its relevance on our health. In part two of this essay I will discuss the implications of such agenda and the consequences of the hypocritical patronising dictatorship of the "HIV"-establishment on gay life.

anti-tuberculosis

Although in the last fifty years a range of some fifteen pharmaceutical drugs considered effective against the causative agent of TB, *mycobacterium tuberculosis*, have been approved for clinical use, there are three or four first choice drugs in combination once a person has been diagnosed with an active form of the infection. In principle a combination helps overcome the danger that the bacteria may develop resistance to one of the drugs. After an initial two month period, if the treatment is successful, one drug is usually dropped from the combination.

Anti-tuberculosis drugs can successfully eradicate the infection from the body but cannot restore tissue destroyed by the bacteria or, unless taken as longterm prophylaxis, offer prevention against reinfection. The choice of drugs offered is determined by the areas of the body affected and by the results of sensitivity tests, which may take up to two months to confirm whether the infection is sensitive or resistant to the first drugs used.

Anti-tuberculosis drugs act like antibiotics, either directly killing the bacteria or preventing them from multiplying. Although they start to combat the disease within days, benefits of drug treatment are not likely to be noticeable for a few weeks. As the infection is eradicated, the body's healing processes repair the damage caused by the disease and the drugs. Symptoms such as fever and coughing gradually subside and weight is gained as appetite and general health improve.

Adverse reactions including severe allergic reactions are more likely to occur in the second month of treatment and may parallel the symptoms of the disease itself – fever and general ill-health, for example. If this is detected, another drug might be tried.

ISONIAZID

In use for over 30 years this drug remains effective for conventional TB. It is offered alone as prophylaxis (prevention) and with other drugs as treatment, usually for six months. Courses lasting nine months or a year may be prescribed. Taken in overdose it is dangerous. Serious unwanted effects have rarely been reported, and include jaundice, twitching and muscle weakness, and blurred vision, which require immediate attention. Other effects can include vomiting, weakness, numbness and rash. An important consideration is that the drug causes increased loss of vitamin B6 (pyridoxine), especially at high doses, which can lead to permanent nerve damage. This effect can be addressed with a B6 supplement.

RIFAMPICIN

Deemed highly effective in TB. Taken by mouth it is well absorbed in the intestine and widely distributed throughout the body, crossing the blood-brain barrier, and is consequently useful in tuberculous meningitis. It is always prescribed with other TB drugs to enhance its effect and prevent resistance developing, which can happen rapidly. The red-orange coloration of urine, saliva and tears it can cause is considered harmless. Serious effects can include jaundice, which usually improves during treatment and a flu-like illness, requiring immediate attention. Prolonged use may cause liver damage, so periodic blood tests are needed to monitor liver function. Muscle cramps and itching are rare but should not be ignored.

PYRAZINAMIDE

Active against both the active and intracellular forms of the mycobacterium, and most effective in the early stages of the disease. It crosses the brain barrier and is useful in TB meningitis. Effects can include jaundice, fever and liver toxicity, so periodic blood tests for liver function checks are performed.

ETHAMBUTOL

Given in conjunction with other TB drugs it appears to boost their effect. If resistance to other common drugs is suspected, it may be given early in treatment. Although the drug has few common adverse effects it may occasionally cause optic neuritis, a type of eye damage, leading to blurring and fading of vision. Rash and itching also should not be ignored, likewise severe nausea or dizziness.

RESISTANCE

In response to an outbreak of multi-drug resistant TB, the following treatment protocol was issued in 1995 by London's Chelsea and Westminster Hospital:

(a) All patients to receive at least 5 drugs. Treatment should be initiated in hospital.

The present outbreak has an organism resistant to: Isoniazid, Rifampicin, Pyrazinamide, Rifabutin, Clofazamine, Ethionamide.

Therefore first choice agents are: Ethambutol, Ofloxacin or Ciprofloxacin, IV Amikacin, Streptomycin or Paromomycin.

Second choice agents are: Cycloserine, Para-aminosalicylic acid (PAS).

Other agents which may be added: Augmentin, Doxycycline, Prothionamide, Clofazamine (current isolate resistant).

Start with small doses, and increase to planned doses over 3 to 10 days.

Determine peak and trough serum concentrations [of medications] because the bioavailability and clearance of most anti-TB drugs is unpredictable.

At present, monitoring of amikacin and streptomycin levels is available at the Chelsea and Westminster. Cycloserine levels can also be monitored by arrangement.

Document that absorption is adequate, because of higher prevalence of malabsorption in AIDS.

(b) Clinical monitoring – monitor for: (i) resolution of fever and clinical symptoms (ii) weekly sputum smears until first ZN negative smear. NB Induced sputums should never be performed in patients who are currently ZN smear positive.

(c) Duration of isolation: Patients should remain in negative pressure isolation until they are assessed to be non-infectious based on: sputum smear negative on three separate occasions over at least a 14-day period AND apyrexial [without fever] for at least one week and resolution of cough AND evidence of tolerance and compliance with full dose of medications for at least two weeks.

Length of treatment – 24 months.

see *Natural Treatments*, p.11.

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HUW CHRISTIE

FACING THE FATS

Fats have had bad press over recent years because of links made between saturated animal fats and heart disease. The importance of essential fatty acids often gets overlooked. BOO ARMSTRONG explains what the food labels don't always tell you about the types of fats and how to obtain them from your food

Food labels don't always tell you what you really want to know about the nutritional status of food. When it comes to fat, labels tend only to mention saturated and unsaturated fats, with the occasional polyunsaturated thrown in.

This kind of information is quite helpful for determining risks that you are causing your heart and arteries by having a certain amount of saturated fat running through your blood, slowly clogging them up and preventing the flow of oxygen and other nutrients to the cells. Most people have heard of cholesterol and you can almost be certain that if a food label shows saturated fat then you are getting a fair dose of artery clogging cholesterol with it.

ESSENTIAL FATTY ACIDS

Labels usually overlook the beneficial essential fatty acids. These actually help your body to resist disease, and build and maintain healthy muscles, arteries and nerve cells, so it would be nice to know when we are eating them. They are found predominantly in nuts and seeds, green leafy vegetables and fish. One reason you don't often find them on food labels is that they are easily destroyed by food processing and it would be pretty difficult to fit a label onto a pumpkin seed or a walnut.

The essential fatty acids are so named because we need them, on a daily basis for good health and we cannot make them for ourselves. There are two essential fatty acids, these are linoleic acid and linolenic acid, also known as omega 6 and omega 3 respectively. If either linoleic or linolenic acid are missing or deficient in the diet then deficiency diseases develop.

Symptoms of linoleic acid deficiency include: eczema-like skin eruptions, loss of hair, liver degeneration, behavioural disturbances, kidney degeneration, excessive water loss through the skin accompanied by thirst, susceptibility to infections, failure of wound healing, heart and circulatory problems and a host of other conditions. Prolonged absence from the diet is fatal. All of the deficiency symptoms (except death) can be alleviated by adding linoleic acid back to the diet from which it was missing.

The symptoms of linolenic acid deficiency include: retardation of growth, weakness, impairment of vision and learning ability, motor incoordination, tingling in arms and legs, and behavioural changes. These symptoms can also be reversed by adding linolenic acid back to the diet.

PROSTAGLANDINS

Essential fatty acids have antibacterial, antifungal and antiviral action as well, primarily by promoting T-cell activity and the production of certain hormone-like substances called prostaglandins. Prostaglandins are produced by nearly all mammalian cells and they are able to influence the functioning of any type of cell.

Prostaglandins are made by oxidising essential fatty acids, in enzyme controlled reactions. To make sure these reactions can take place when necessary you need not only enough unadulterated linoleic or linolenic acid, but enough of the co-factors for the reaction – these are vitamins B3, B6 and C and the minerals zinc and magnesium. When you get your essential fatty acid supply from nuts and seeds, they come pre-packaged with all these other nutrients. There are 20 known prostaglandins that we can make and they control many different body processes.

Prostaglandins are produced at cell membranes and are decomposed rapidly. Although they are produced in minute quantities and do not stay around for long they are potent substances and exhibit a wide variety of effects on the body. Unlike circulating hormones which act on distant targets (ACTH, for example is produced in the pituitary gland inside the brain and acts on the kidneys which are a long way away), the prostaglandins act locally, in the immediate area in which they were produced. Prostaglandins can be produced in response to many different internal stimuli.

Essential fatty acids from nuts and seeds come pre-packaged with all these other nutrients

Linoleic acid can be metabolised down several pathways in response to certain stimuli – one will give Prostaglandin 1 (P1) and another will end up with Prostaglandin 2 (P2).

P1 protects the heart and arteries by slowing down the production of cholesterol, preventing blood cells from sticking together and opening blood vessels. The proper functioning of the immune system depends on cells being able to produce it because of its beneficial effect on T-cells. Prostaglandin 1 also helps nerves, insulin utilisation and calcium metabolism as well as acting as a local anti-inflammatory.

Prostaglandin 2 causes blood clotting and inflammation. In swollen joint problems there is usually excess P2. It also induces the kidneys to retain salt which leads to water retention and high blood pressure. By lowering P2 levels it is possible to help heart disease and kidney damage. One important method used to reduce P2 is to remove meat from the diet because it contains lots of arachidonic acid, one of the intermediates in the reaction of linoleic acid turning into P2.

Linolenic acid can be turned into P3 or prostaglandin 3, which like P1 has potent platelet anti-stickiness properties and further decreases the likelihood of a person dying from a blood clot formed in an artery to the heart (heart attack) or brain (stroke).

To highlight both the importance of prostaglandins and the need for clear nutritional information about fats we can look at the Inuit Eskimo diet. The average Inuit diet has 300g of fat per day and the UK diet contains 120g. In the UK 50% of people die from arterial or heart disease whereas Inuits have a very low occurrence of these conditions – they tend to die from infectious diseases. The reasons for this are that Inuits eat mainly fish which has very high levels of omega 3 and low levels of omega 6 (if you are going to follow suit then eat the oily varieties – mackerel, tuna, eel etc.). In the UK the fat we have contains little omega 3 and lots of omega 6. High levels of omega 3 will protect your heart (anti-clotting, widens blood vessels etc.) and low levels will allow the heart and arteries to become unwell. Low levels of omega 6 will not support immune systems very well, because of the limited amount of prostaglandin that can be made. In contrast high levels can, and do protect us.

Healthy human beings can make all the prostaglandins they need out of the two essential fatty acids omega 3 and 6, but there are several nutritional and other metabolic conditions in which the ability to convert essential fatty acids to prostaglandins is blocked at the first step. In these conditions, the block can be bypassed by giving nutritional supplements. If P1 is not being made efficiently, Evening Primrose Oil can be taken to bypass a block in metabolism. Fish oils can be taken to bypass a block which is preventing P3 from being made. If these nutritional supplements are given, the production of prostaglandins by the body can proceed properly and health can be re-established and maintained.

Commercially manufactured oils are pretty lacking in nutrients by the time they reach the supermarket shelves

The pharmaceutical use of prostaglandins is extremely crude. Because they are so short-lived, much of an injected dose of prostaglandins breaks down before it reaches its target tissue. Comparatively huge doses have to be administered, far larger than the body would normally produce. If they are given orally or added to the diet, they are destroyed by digestion.

NATURAL SOURCES

By bypassing the known biochemical block with more basic nutritional supplements it is possible to support the body in making its own supply of prostaglandins, where, when and how much it needs according to its own internal requirements for health.

M E Bëgin, wrote in 1986 in Das UN: "Gamma-linolenic acid (an omega-6 fatty acid) and/or eicosapentaenoic acid (an omega-3 fatty acid) and their derivatives may be the source of natural endogenous agents against AIDS ...supplementation with these polyunsaturated fatty acids should be considered in the prevention, and possibly the treatment, of AIDS."

We need omega 3 and omega 6 in a ratio of 1:3 at about 2 grams to 6 grams. So 8 grams of fat a day, that's about 2 tablespoons. The best sources are rape seed oil, walnut oil and olive oil (not cooked because this destroys them) and straight from the seed it is best to consume pumpkin seeds, linseeds and walnuts. Chewing one handful of pumpkin seeds every day should provide you with a maintenance does of essential fatty acids, but if you are deficient in them you will need (guided) supplementation.

OILS

Commercially manufactured oils are pretty lacking in nutrients by the time they reach the supermarket shelves. The seeds or nuts go through a process of solvent extraction, degumming, refining, bleaching and deodorization. Supermarkets do have the courtesy of adding some artificial antioxidants to replace the ones they removed, but it's not exactly worthy of a consumers' award. The cold-pressed extra virgin types are slightly better but still get cooked for two hours, crushed, ground, pressed and heated before being filtered, bottled and sold at exorbitant prices.

The reason, however, for my rant against the oil manufacturers is hydrogenation. Most of the vegetable oils that are added to margarines, pastries, pies and biscuits have been hydrogenated. As the German philosopher Goethe said, "what you know about you see": start looking for hydrogenated fats and you will find them everywhere. When an oil has had hydrogen gas pumped through it under high pressure, it changes from being a liquid to a solid, which is great for the food manufacturers, but unfortunate for the consumers because 30-50% of a hydrogenated oil will be trans-fatty acids. These act in a similar way to saturated fats in the body and are potent free-radicals. See the last issue of Continuum to find out how to undo the damage of free-radicals using anti-oxidants and look out for the non-hydrogenated margarines.

Fats have had bad press over recent years because of saturated animal fats links to heart disease. The importance of essential fatty acids often gets overlooked which is tragic because they could change your life. C

HEMP SEED NUTRITION

Cannabis hemp seeds contain all the essential amino acids and essential fatty acids necessary to maintain healthy human life. No other single plant source provides complete protein in such an easily digestible form, nor has the oils essential to life in as perfect a ratio for human health and vitality.

Hempseed is the highest of any plant in essential fatty acids. Hempseed oil is among the lowest in saturated fats at 8% of total oil volume. The oil pressed from hempseed contains 55% linoleic acid (LA) and 25% linolenic acid (LNA). Only flax oil has more linolenic acid at 58%, but hempseed oil is the highest in total essential fatty acids at 80% of total oil volume.

"These fatty acids are responsible for our immune response. In the old country the peasants ate hemp butter. They were more resistant to disease than the nobility."[1] The higher classes wouldn't eat hemp because the poor ate it.

LA and LNA are involved in producing life energy from food and the movement of that energy throughout the body. Essential fatty acids govern growth, vitality and state of mind. LA and LNA are involved in transferring oxygen from the air in the lungs to every cell in the body. They play a part in holding oxygen in the cell membrane where it acts as a barrier to invading viruses and bacteria, neither of which thrive in the presence of oxygen.

The bent shape of the essential fatty acids keeps them from dissolving into each other. They are slippery and will not clog arteries like the sticky straight shaped saturated fats and the trans-fatty acids in cooking oils and shortenings that are made by subjecting polyunsaturated oils like LA and LNA to high temperatures during the refining process.

LA and LNA possess a slightly negative charge and have a tendency to form very thin surface layers. This property is called surface activity, and it provides the power to carry substances like toxins to the surface of the skin, intestinal tract, kidneys and lungs where they can be removed. Their very sensitivity causes them to break down rapidly into toxic compounds when refined with high heat or improper storage exposes them to light or air.

Nature provides seeds with an outer shell that safely protects the vital oils and vitamins within from spoilage. It's a perfect as well as perfectly edible container. Hempseed can be ground into a paste similar to peanut butter only more delicate in flavour. Udo Erasmus, Ph. D. nutritionist says: "hemp butter puts our peanut butter to shame for nutritional value." The ground seeds can be baked into breads, cakes and casseroles. Hempseed makes a hearty addition to granola bars.

Some pioneers in the fields of biochemistry and human nutrition now believe cardiovascular disease (CVD) and most cancers are really diseases of fatty degeneration caused by the continued over-consumption of saturated fats and refined vegetable oils that turn essential fatty acids into carcinogenic killers. One out of two Americans will die from the effects of CVD. One out of four Americans will die from cancer. Researchers believe many cancers erupt when immune system response is weakened. And more Americans are succumbing to immune deficiency diseases than ever before. Promising studies are now under way using the essential oils to support the immune systems of people diagnosed "HIV+".

The complete protein in hempseed gives the body all the essential amino acids required to maintain health, and provides the necessary kinds and amounts of amino acids the body needs to make human serum albumin and serum globulins like the immune enhancing gamma globulin antibodies.

The body's ability to resist and recover from illness is related to how rapidly it can produce massive amounts of antibodies to fend off the initial attack. If the globulin protein starting material is in short supply the army of antibodies may be too small to prevent the symptoms of sickness from setting in.

The best way to insure the body has enough amino acid material to make globulins is to eat foods high in globulin proteins. Hempseed protein is 65% globulin edestin plus quantities of albumin (present in all seeds) so its easily digestible protein is readily available in a form quite similar to that found in blood plasma.

Hempseed was used to treat nutritional deficiencies brought on by tuberculosis, a severe nutrition blocking disease that causes the body to waste away.[2]

The energy of life is in the whole seed. Hempseed foods taste great and will ensure we get enough essential amino acids and essential fatty acids to build strong bodies and immune systems, and to maintain health and vitality.

References
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Excerpted from Hempseed Nutrition by Lynn Osburn. Produced by Access Unlimited, P.O. Box 1900, Frazier Park, CA 93225, USA.

VIRUSCHALLENGE

The challenge by Continuum to produce proof of the isolation of HIV particles to enable their characterisation has drawn a response in an article published in the National AIDS Manual Treatment Update. Although this article makes several points which are claimed to answer the challenge they do not unambiguously satisfy the requirements of proof.

1. "...there is no standard 'set of rules' for isolating retroviruses".
It is impossible to make scientific claims unless one is guided by scientific principles. In fact, as far back as 1957, J. W. Beard, a leading retrovirologist of the day, discussing the isolation and analysis of particles wrote: "Although this has resulted in considerable success in some instances, there remain numerous unresolved problems in the general field, as well as outstanding omissions in the systematic use of the principles and procedures of well-recognised applicability. Fundamentally, the scheme of approach, as well illustrated by that devised and rigorously tested in investigations of viral agents, is relatively simple. This consists in (1) isolation of the particles of interest; (2) recovery (purification) of the particles in a given preparation that are homogeneous with respect to particle kind; (3) identification of the particles, and (4) analysis and characterisation of the particles for the physical, chemical, or biological properties desired"[1]. The "rules" employed by HIV/AIDS researchers, that is, detection of a protein, p24, OR an enzyme, reverse transcriptase, do not satisfy any scientific principle proving isolation of a viral particle and indeed defy common sense. If detection of p24 by an antibody is "HIV isolation" then why is the detection of the protein b-HCG in blood or urine (pregnancy test) not proof of placental isolation? The same argument can be advanced for reporting the measurement of cardiac enzymes in cases of suspected myocardial infarction as "isolation" of heart.

2. "...while some of Continuum's proposed seven steps (involving the propagation, purification and characterisation of the virus from a tissue sample) can easily be demonstrated for HIV..."
It may be possible but the fact is to date nobody has purified the "HIV particles" and propagation and characterisation are impossible without purification.

3. "Contrary to the implication by Continuum, the Pasteur Institute did not draw up such guidelines in 1973".
At the 1973 meeting at the Pasteur Institute[2,3] the steps which one has to follow to isolate retroviruses were thoroughly discussed and indeed are straightforward commonsense and are not dissimilar from those enumerated earlier by Beard. In the first of the two papers from the Pasteur Institute meeting published in Spectra entitled "RNA tumor viruses purification using zonal rotors [RNA tumor viruses=retroviruses]", figure 1 is a "Flow chart for purification of RNA viruses by double sucrose density gradient zonal centrifugation". The flow chart is:

RNA Tumor Virus Purification

VIRUS FLUID	80 litres
Ø	
CLARIFICATION	4000G X 10 min.
Ø	
K-3 ROTOR	RNAase-free sucrose 20-55% 12 litres/hour
Ø	
K-3 VIRUS ZONE	500 ml., 30-38%
Ø	
B-29 ROTOR	RNAase-free sucrose 30-45% 25,000 rpm X 180'
Ø	
B-29 VIRUS ZONE	150 ml., 32-37%
Ø	
DIALYSIS OR ULTRAFILTRATION	
Ø	
FINAL CONCENTRATE	150-200 ml.

The particles thus obtained are then characterised by performing a number of assays. The flow chart for these assays is given in Table 3 and is as follows:

Assays for RNA Tumor Viruses

Physical: Electron Microscopy (neg stain and thin sect.) Æ Virus count Æ Morphology Æ Purity
Biochemical: Reverse transcriptase Æ 60-70S RNA, total RNA Æ Total protein Æ Gel analysis of viral and host proteins and nucleic acids
Immunological: Gel diffusion Æ Complement fixation* Æ Immunofluoroescence*
Biological: Infectivity in vivo Æ Infectivity in vitro
*With specific reagents for enveloped and internal antigens gs and env

Toplin, the author of this paper, pointed out it is much easier to isolate retroviruses than other viruses. Nonetheless: "The RNA tumor viruses also have buoyant densities that coincide with those of certain cellular constituents. Therefore, if the cell cultures used for virus propagation are not maintained at maximum viability, purification problems can also be encountered with these viruses in relation to contaminating microsomal and membrane fragments...". Because of this Toplin regards double banding as a necessity. It is worthwhile noting that "HIV" cell cultures are not maintained at maximal viability and in fact, unlike all other retroviruses, HIV is said to kill cells. Thus, unlike the supernatants (cell free culture fluids) from other retroviral cultures, in "HIV" cultures one would expect to find subcellular material, at least "cellular fragments", microsomes from disrupted cells and "membranous vesicles which may enclose other cellular constituents including nucleic acids"[2,4-6].

4. "...but did not themselves meet the seven steps Continuum was now requesting for HIV".
This is true but they did not have to meet these steps. Toplin's aim was to discuss in general terms the stages one has to follow in order to isolate and characterise retrovirus-like particles. Nonetheless, he does give electron micrographs (EM) of double banded particles. In his figure 6 there is an "electron micrograph (thin section) of Rauscher murine leukaemia virus from cell culture fluid after double sucrose zonal centrifugation".
In the second paper "Purification and partial differentiation of the particles of murine [mouse] virus (M.MSV) according to their sedimentation rates in sucrose density gradients", Sinoussi, Chermann and their colleagues aimed to obtain a purified particle preparation and not to fully characterise the MSV. In double banding sucrose density gradients they obtained particles "banding in the region of the gradient corresponding to a density of 1.14- 1.15 gm/ml". "No apparent differences in physical appearances could be discovered among the viral particles in these regions. There was no sign of aggregation of particles". They also showed that: "The viral particles separated by zonal centrifugation are able

180 DAYS...

The Jody Wells Memorial Prize

MISSING VIRUS!

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Blind romantics still believe HIV causes AIDS. But if 'HIV' has never been isolated, what *is* AIDS?

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continuum

CHANGING THE WAY WE THINK ABOUT AIDS

It's taking a very long time for someone to show clear proof of isolated HIV. In a two page article last month, NAM's monthly *Treatment Update* seems to believe, in the words of Prof. Robin Weiss, that "*Continuum*'s challenge is simply not relevant to the issues facing people at risk of AIDS", but what is AIDS if HIV doesn't exist?
In the next issue we will publish the thoughts of Prof. Peter Duesberg and others on the subject.
The following response to NAM's article on the Prize is by AIDS analysts ELENI PAPADOPULOS-ELEOPULOS, VALENDAR TURNER, JOHN PAPADIMITRIOU and DAVID CAUSER.
The Prize is still available.

...we're still waiting!

to cause focus formation in murine embryonic fibroblast tissue cultures" and that reverse transcriptase (RT) "activity was found in the region of the gradient where particles were found".

5. "But if one put together three or four papers, all the data are there and have been published for years".
Where are these three or four papers? Where is even one paper where there is electron micrographic evidence revealing particles of any shape or form at the density of 1.16 gm/ml, the density that defines retroviral particles, let alone retrovirus-like particles with "No apparent differences in physical appearances" as Sinoussi and Chermann wrote in 1973 or, as Beard much earlier wrote, "homogeneous with respect to particle kind"?

6. "...purification by this method is no problem..."
If purification of HIV particles by density gradient centrifugation is no problem why has it not been reported?

7. "...[HIV] loses most of its infectivity during this laboratory process".
Given the fact there is no electron microscopic evidence for the existence of HIV particles at the density of 1.16 gm/ml, how may one have evidence that the particles lose their infectivity during density gradient centrifugation? If the infectivity of HIV particles is so labile, how do they retain their infectivity during the processing of plasma into the factor VIII clotting concentrates which are administered to individuals with haemophilia? (This procedure involves collection of blood, separation of plasma by centrifugation, cool storage followed by freezing, transport to a facility for pooling with donation of similarly obtained plasma, thawing, further freezing and thawing, filtration, lyophilisation and storage as a dry powder for weeks to months before use[7]).

8. "HIV particles look different" from "naturally existing viruses".
In the scientific literature there is no data which permits one to distinguish on the basis of appearances between endogenous (natural) and exogenous retroviruses. "Retroviruses are enveloped viruses with a diameter of 100-120 nm budding at cellular membranes. Cell released virions [individual virus particles] contain condensed inner bodies (cores) and are studded with projections (spikes, knobs)"[8]. The particles are further categorised according to "site of core assembly (preformed in the cytoplasm or formed during the budding process at the plasma [cell] membrane); shape and size of surface protrusions (spike- or knob- like); presence or absence of electron-lucent space between envelope and core in immature particles, and shape and position of cores in mature particles". There are three subfamilies of retroviruses (Oncovirinae, Lentivirinae, and Spumavirinae). The particles of the subfamily Oncovirinae are in turn subdivided into four genera, type A intracisternal and intracytoplasmic particles, and type B, type C and type D particles[9].

As far as "HIV particles look different" is concerned, in cultures of tissues from AIDS patients one can see a "zoo" of particles with varying morphologies. For example:

(a) Hockley and his colleagues from the Electron Microscopy and Photography Section and Division of Virology at the National Institute for Biological Standards and Control in the United Kingdom describe a profusion of particles which they divide broadly into three groups, mature, ring-like and small with spikes. The mature particles "were approximately spherical in shape and 100 to 150 nm in diameter. The outer lipid membrane was frequently broken or absent in places, and there was no evidence of surface spikes...A few mature particles were found that were larger than average and appeared to contain a double nucleoid...in the preparation of HIV there were always many vesicles with granular contents in which it was not possible to recognize a distinct nucleoid". Also, "The ring-like particles had a more consistently spherical shape and were larger (140 nm in diameter)" and the small particles "were usually spherical but sometimes slightly angular in shape and 65 to 90 nm in diameter" and had spike-like projections on their surface[10].
(b) Gelderblom who has done most of the EM studies in HIV/AIDS research reported that although HIV is considered to have a cone shaped core he and his colleagues found centrosymmetric and tubular cores as well. The caption to one of the many photographs reads: "Virions can be seen having either elongated, 'baton-like' tubular cores 30-35 nm in diameter or containing more than one core. Tubular and regular cone-shaped cores can coexist within one virion". The text states: "Rarely, tubular core structures reminiscent of batons with a diameter of 30-35 nm and a length of 150-250 nm are observed"[8]. (If cores are of such dimensions then some of the particles must exceed twice the diameter of retroviral particles).

in cultures from AIDS patients one can see a "zoo" of particles

c) Lekatsas and other virologists from Pretoria and Johannesburg: "We used the characteristic cylindrical structure in the core as an identifying characteristic for the virus to distinguish it from cellular debris and also noted that it may vary considerably in its dimensions and morphological features. Fig. 1 depicts a variety of such features encountered in our preparations. We have found two basic virus particle sizes, 90nm and 120 nm, both present in large numbers. The larger particle bears no surface projections while the smaller particle is rarely 'naked' and usually bears projections. We have seen no particles with partial loss of projections, suggesting that small particles retain these structures while large particles lose them soon after liberation"[11].
(d) The US CDC: HIV particles are "usually round and have a diameter of about 85-95 nm...Virus with bar-shaped nucleoids and particles with a tear-drop shape are commonly seen in HTLV-III/LAV infected lymphocytes, sometimes ring-shaped particles without dense nucleoids are also seen"[12].

Particles of the smaller dimension have also been found in both the non-infected H9 cell line and in another cell line called CEM. Both cell lines are used extensively in HIV/AIDS research and they are the cell lines from which practically all the EM studies have been reported.
Particles have also been found in other cell lines such as C8166, EBV transformed B-cells, and cord blood lymphocytes[13].
Although all HIV/AIDS researchers report the finding of "HIV" particles in the cultures of tissues originating from AIDS patients or those at risk, there is no agreement as to which Genus or even Subfamily of retroviruses such "HIV" particles belong. For example:

(a) Montagnier and his colleagues reported HIV initially as a type C particle, then as a type D particle and then as a Lentivirus[14-16];
(b) in 1984 Gallo and his colleagues reported HIV as a type C particle. However, in 1985 he wrote: "A possible unique feature of the virions is the cylindrical core observed in many presumably mature virions. Virions having this type of core have been frequently reported for certain type D retroviruses, and in some instances, for type C retroviruses"[17];
(c) Jay Levy, reported HIV as a type D particle[18];
(d) Others at the University of California wrote that "AIDS virus isolated show morphologic characteristics of type C, type D and Lentiviruses"[19];
(e) Dr. Anthony Fauci and others: "T-cells and macrophages handle the virus very differently. In the T-cell, the virus buds out of the external plasma membrane of the cell. In the monocyte/macrophage cultures it buds into membrane-bound vesicles inside the cells"[20]. The latter is a description of a type A, retroviral particle[9].

Thus, although HIV has been described as a member of two subfamilies of retroviruses including three different Genera of one of these subfamilies, by consensus at present HIV is regarded as a Lentivirus. However, it is of pivotal significance that in cultures of tissues from AIDS patients although there are particles with the diameter of 100-120 nm these particles do not have spikes or knobs. The particles which possess spikes and knobs have diameters smaller than 100-120 nm. In other words, there are no particles which fulfill the two principal morphological characteristics of retroviruses, that is, particles which have BOTH "a diameter of 100-120 nm" AND surfaces which "are studded with projections (spikes, knobs)".

In view of the above, the question then arises if the particles with the "unique" morphology considered to be HIV represent an exogenous retrovirus originating from tissues of AIDS patients or those at risk, then what is the origin and role of the many non-HIV particles and which, if any, of these particles or the "HIV particle" band at 1.16 gm/ml?

9. "The relationship between infection with HIV (indicated by the antibodies produced by the body in response) and risk of developing AIDS is clear; among groups of drug users, haemophiliacs or gay men, it is only those that are HIV-positive who are at risk of developing AIDS".
One cannot talk about "HIV antibodies" as being synonymous with "HIV infection" unless one has proof that the antibodies present in sera are specific to HIV. The only way to obtain such scientific proof is to use HIV isolation as a gold standard. To date, since HIV has not been isolated, no such proof exists[21,22]. However, as far back as 1934, Andrews, addressing the Royal College of Physicians in London on the subject of the Rous sarcoma retrovirus presented data that anti-retroviral antibodies are non-specific: "Most viruses evoke the production of antibodies which are demonstrated by their power of neutralising the virus in question when mixed with it in vitro...Normal fowls, particularly as they grow older, may develop in their sera varying amounts of similar neutralising properties...It is likely, therefore, that the antibodies in the birds with chronic tumours represent only an enhancement of a property occurring to a varying degree in normal birds"[23].
The main immunogenic (antibody generating) retroviral proteins are said to be coded by two genes, gag and env. From the beginning it was known that the gag gene of retroviruses is present in all cells, including those that do not have retroviral particles and in fact this observation forms the basis of the oncogenic theory of cancer. In 1970, Huebner, one of the originators of

this theory wrote: "Natural history studies of the prevalence of the gs [gag] antigen [protein] in virus-free laboratory mice revealed gs antigens in high titers in the hematopoietic tissues of individuals of most mice strains"[24]. One year later Robin Weiss wrote: "The idea that normal cells of chickens might contain avian tumor virus genomes first arose from the observation that normal embryonic tissues of some "leukosis-free" chicken strains possessed an antigen which was indistinguishable from the group-specific (gs) antigen of avian tumor viruses"[25]. The p17/18 and p24 proteins of "HIV" are said to be coded by its gag gene. The evidence that the p18 and p24 proteins (and antibodies) are non-specific is overwhelming and can be illustrated by a few examples:

(a) Genesca et al conducted WB assays in 100 ELISA negative samples of healthy blood donors; 20 were found to have HIV bands (antibodies) which did not fulfill the then (1989) criteria used by the blood banks for a positive WB. These were considered as indeterminate WB, (WBI), with p24 being the predominant band, (70% of cases). Among the recipients of WBI blood, 36% were WBI 6 months after transfusion, but so were 42% of individuals who received WB-negative samples. Both donors and recipients of blood remained healthy. They concluded that WBI patterns "are exceedingly common in randomly selected donors and recipients and such patterns do not correlate with the presence of HIV-1 or the transmission of HIV-1", "most such reactions represent false-positive results"[26];
(b) According to researchers from Germany and the United Kingdom (Wellcome Research Laboratories), "Western blotting should not be used as a screening assay because rates of up to 20% indeterminate results are found in blood donors"[27];
(c) In most cases, by "HIV isolation" is meant detection of p24 in cultures. However, in cultures with whole unfractionated blood, positive results have been reported in 49/60 (82%) of "presumably uninfected, but serologically indeterminate" individuals and in 5/5 "seronegative blood donors"[28];
(d) Detection of p24 has been also reported in organ transplant recipients. In one kidney recipient (the donor was negative for p24 antigen) who, three days following transplantation developed fever, weakness, myalgias, cough and diarrhoea, all "Bacteriological, parasitological and virological samples remained negative [including HIV PCR]. The only positive result was antigenaemia p24, positive with Abbot antigen kits in very high titers of 1000pg/ml for polyclonal and 41pg/ml for monoclonal assays. This antigenaemia was totally neutralizable with Abbott antiserum anti-p24...2 months after transplantation, all assays for p24-antigen became negative, without appearance of antibodies against HIV. Five months after transplantation our patient remains asymptomatic, renal function is excellent, p24 antigenaemia still negative and HIV antibodies still negative"[29]. Using two kits, the Abbott and Diagnostic Pasteur, in one study, p24 was detected transiently in 12/14 kidney recipients. Peak titres ranged from 850 to 200,000 pg/ml 7-27 days post-transplantation. Two heart and 5/7 bone marrow recipients were also positive, although the titres were lower and ranged from 140-750 pg/ml. Disappearance of p24 took longer in kidney (approximately 6 months) than in bone-marrow (approximately 4-6 weeks) recipients. According to the authors: "This may be related to differences in immunosuppression therapy". Discussing their findings they wrote: "The observation of a 25-30kD protein [the French researchers report p24 as p25] binding to polyclonal anti-HIV human sera after immunoblots with reactive sera raises several questions. This protein could be related to a host immune response to grafts or transplants...Its early detection after transplantation might indicate the implications of immunosuppression therapy...The 25-30kD protein could therefore be compared with the p28 antigen recently described with human T-cell-related virus lymphotropic-endogenous sequence...The characterization of this 25-30kD protein may represent an important contribution to the detection of HIV-1-related endogenous retroviruses"[30];
(e) In addition to the WB p24 band, the p17/18 band is the most often detected band in WB of healthy blood donors[31]. Also, sera from AIDS patients bind to a p18 protein in mitogenically stimulated HIV infected T-cells, but not to non-infected, unstimulated lymphocytes. However, when the lymphocytes are mitogenically stimulated, but non-infected, the AIDS sera bind to a p18 protein in these non-infected lymphocytes[32]. Similarly, a monoclonal antibody to HIV p18, reacts with dendritic cells in the lymphatic tissues of a variety of patients with a number of non-AIDS related diseases and the "same pattern of reactivity was present in normal tissue taken from uninfected individuals as in those taken from HIV positive subjects"[33];
(f) Strandstrom and colleagues reported that 72/144 (50%) of dog blood samples "obtained from the Veterinary Medical Teaching Hospital, University of California, Davis" tested in commercial Western blot assays, "reacted with one or more HIV recombinant proteins [gp120—21.5%, gp41—23%, p31—22%, p24—43%]"[34].
(g) According to Philip Mortimer and his colleagues from the UK Public Health Laboratory Service: "Experience has shown that neither HIV culture nor tests for p24 antigen are of much value in diagnostic testing. They may be insensitive and/or non-specific"[35].

it was known that the *gag* gene of retroviruses is present in all cells

Regarding antibodies found in human sera which react with the envelope proteins (p41, p120, p160), in 1981 Gallo accepted the evidence that the antibodies which reacted with retroviral glycoproteins were directed not against the proteins "but against the carbohydrate moieties on the molecule that are introduced by the host cell as a post-transcriptional event, and which are therefore cell-specific and not virus-specific"[36]. This is amply confirmed today for the HIV envelope glycoproteins by many HIV researchers including the 1994 studies of Essex and his colleagues[37].

10. "...many pictures of HIV have been published..."
What has been published is pictures of virus-like particles present in cell cultures where several types of particles are present and some are arbitrarily said to be HIV. There are no published EMs of material banding in sucrose density gradients.

11. "...is next to impossible to remove all other debris from the culture..."
It may not be possible for "HIV" but animal retroviruses have been isolated by banding in density gradients (see EM in Pasteur/Spectra publications).

12. "...it's like saying that it is impossible to identify a German shepherd dog by its unique appearance, if it happens to be surrounded by a pack of poodles".
How does one look at a zoo and know one has a German shepherd or a poodle? The differentiation between a German shepherd and the remainder of the universe including poodles is possible only because German shepherds are obtained separate from all other objects in the universe and shown to possess unique morphology, constituents and behaviour such as walking, barking and biting. The analogy with HIV is more like someone who does not know what a German shepherd is but who looks at an aerial photograph of a zoo, expects to see dogs (retroviruses) but all he sees is many objects some of which look like animals (viruses) and decides that one of the objects is a dog, in fact a dog with unique composition and behaviour without first showing the object is:
(a) an animal;
(b) the animal is a dog;
(c) the dog is unique.
Pursuing the analogy, is it possible to mince up all the objects in the zoo, before there is ever proof of the existence of the Family Canidae (the Family Retroviridae) let alone dogs known as German shepherds and poodles, centrifuge them in density gradients and then proclaim that the material which bands at 1.16 gm/ml (proteins and nucleic acids) belongs to the German shepherd (HIV)?

If the virus-like particles seen in cultures of tissues of AIDS patients and those at risk are HIV, what then are the particles seen by Weiss and his colleagues in cultures of patients with common variable hypogammaglobulinaemia "which on electron microscopy showed a retrovirus morphologically indistinguishable from HTLV-III/LAV [HIV] and animal lentiviruses? Supernatant from this co-culture was positive by reverse transcriptase, and the cells were positive by immunofluorescence with serum from a patient with AIDS and with the anti-HTLV-III monoclonal antibodies to p24 and to p19 (from Dr. R. C. Gallo) indicated that the viral genome showed homology to HTLV-III/LAV"[38]. According to Weiss: "It has long been known from electron microscope and immunofluorescent studies (24) that HIV is found in massive amounts in the lymph nodes, even in the asymptomatic phase of infection"[25].
Firstly, the authors of reference 24[39] did not claim to have proven the existence of HIV particles or even retroviral particles but only "retrovirus-like particles". If the virus-like particles seen in the lymph nodes of AIDS patients and those at risk are HIV, then what are the particles with identical morphology seen with the same frequency in the enlarged lymph nodes of patients who do not have AIDS and who are not at risk of developing AIDS? In a study conducted by O'Hara and colleagues from Harvard, "HIV particles" were found in 18/20 (90%) of patients with enlarged lymph nodes attributed to AIDS. However, the identical particle was also found in 13/15 (87%) of patients with enlarged lymph nodes not attributed to AIDS leading the authors to conclude, "The presence of such particles does not, by themselves indicate infection with HIV"[40].
13. "...the insistence that the experiment must start with pure particles makes this unattainable".
If the proof of the existence of pure particles is unattainable then:
(a) how can one claim virus purification or isolation? Isolation means obtaining an object separate from everything else that is not that object;
(b) how can one know that the "HIV" proteins and nucleic acids belong to this virus and not to the impurities such as other viruses or non-viral material?
(c) how can one claim that the effects, if any,

of "HIV" are caused by "HIV" and not by impurities?
(d) since no EM has been published showing virus-like particles in the material which bands at 1.16 gm/ml, how can one know that such particles, pure or impure, are present at the retroviral density?

14. "...grow HIV isolates..."
How can one grow HIV isolates when the virus has not been isolated?

15. "HIV's genetic material, on the other hand, can be purified".
A critical analysis of the HIV literature shows that by "HIV genome" is meant nothing more than the selection of part of the RNA from cultures which bands at a density of 1.16 gm/ml. Since no evidence exists for the presence of retroviral particles at this density, it is impossible to say that such RNA belongs to HIV or even to a virus-like particle.

16. "Gene cloning techniques allow researchers to extract the viral genes found in HIV-infected cells".
This cannot be the case unless one first has nucleic acids which have been proven to belong to a unique retroviral particle, which can be done only by isolating the particle.

17. "When the complete set of genes is re-introduced into healthy human cells in culture, the cells produce HIV particles".
In the vast HIV literature there is not one paper with such evidence.

18. "It would clearly be unethical to inject these particles into humans to see if they caused AIDS".
If it is impossible to obtain such evidence, or to have an animal model, how can the claim that the cause of AIDS is HIV be justified?

19. "However, experiments with purified SIV, the monkey equivalent of HIV, have proved that the pure retrovirus causes the selective loss of CD4 cells resulting in an AIDS-like disease".
(a) The evidence for SIV isolation and "purified" SIV is no better than that for HIV;
(b) In most cases SIV, like HIV, has been "isolated" from cultures with the human leukaemic cell line H9 (HUT78) a cell line which Gallo claims to have shown contains the HTLV-1 genome, a "human retrovirus"[41].
(c) The effects obtained when animals are injected with "SIV" have nothing to do with the AIDS diseases. In fact, in many cases, they may represent nothing more than graft vs host effects.
(d) Even if the diseases were similar or identical to AIDS they may be the result of impurities in the "SIV preparations" and not to SIV.

20. "Moreover, three American laboratory workers have been infected with purified HIV..."
How is it possible to prove this when the "insistence that the experiment start with pure particles" is "unobtainable"?

21. "By 1993, all three had developed low CD4 counts and one had been diagnosed with PCP, proving the link between HIV, immune suppression and AIDS".
Even if these individuals were proven to have repeatedly low CD4 counts and to have PCP diagnosed by lung biopsy and not by the non-specific methods presently used, it does not mean that these abnormalities are caused by HIV. The existence of low CD4 counts and the AIDS-like diseases are nothing new and are not specific to HIV. Furthermore, a superficial glance at the AIDS literature shows that no relationship exists between CD4 cell counts and the syndrome[42]. Indeed, in those at risk, low T4 cell counts frequently antedate "infection" with HIV which can be interpreted as low T4 cell counts being the "cause of HIV" and not vice versa.

CONCLUSION

Retrovirus-like particles including particles with morphologies attributed to HIV are ubiquitous. The first absolutely necessary but not sufficient step in proving that the particles represent a retrovirus is to show that in sucrose gradients the particles band at the retroviral density of 1.16 gm/ml. The first absolutely necessary but not sufficient step in claiming the existence of a retroviral protein and genome is to prove that each belongs to one and the same type of retrovirus-like particle such as type C, type D or Lentiviruses.
No such evidence exists for the "HIV" particles, proteins are nucleic acids.

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PHOTOS: SCOTT THODE

In this issue we hand the CounterCulture pages to ALEX RUSSELL who surveys the sentimental excesses of AIDS culture. From poetry to needlepoint he finds uncompromising examples of falsified art and manipulative iconography.

AIDS-RELATED

If one word describes the AIDS culture it is kitsch. The Collins English Dictionary defines kitsch as: "tawdry, vulgarised, or pretentious art or literature, etc., usually with popular or sentimental appeal, from the German: rubbish".

Clement Greenberg in 1939 defined kitsch as the reproduction of high art for easy consumption of the new urban masses.[1] Today kitsch has become politicised and subverted. An artist such as Jeff Koons uses kitsch imagery inspired by the vulgar excesses of the Catholic Church. Likewise 'AIDS-art' and 'AIDS-propaganda' is infected with Catholic kitsch-smaltz with its pappy-soft sentimental appeal to the lowest common denominator of popular 'bad taste'. The Australian artist David McDiarmid uses acidic-AIDS kitsch slogans perverted from pop songs such as: "It's My Party and I'll Die if I Want To" to "Honey Have You Got It".

AIDS activists have utilised kitsch dross imagery to express grief. Christian humanism, gauche-nihilism, apocalyptic-chic, occultist belief[2], and ersatz science are constituents of HIV/AIDS kitsch. AIDS has been hijacked by the purveyors of kitsch consumerism from Derek Jarman's 'HIV'-related film Blue (a masturbatory-meditation on living-with-the-virus) to Benetton's calculatedly sensational poster campaign using the slogan 'H.I.V. positive' tattooed on body-parts.

Benetton's provocative image of the body branded 'H.I.V. positive' caused an outcry from OutRage and Act Up: Benetton were accused of 'exploiting' people with 'HIV/AIDS'. Yet only recently, The London Lighthouse itself promoted an almost identical image and slogan: "I'm HIV + Stop ignoring me". Benetton were making a cynical analogy between a branded designer-disease-identity and their own designer brand label. Many saw Benetton's image as a camp-invertion of the Auschwitz death camp inmates tattooed serial number. Could Benetton's image become a reality? William F. Buckley, editor of the right-wing National Review, advocated tattooing "AIDS" on those tested 'HIV positive' (on the forearms of I.V. drug-users and on the buttocks of homosexuals) so they could be easily identified, segregated and quarantined.

Perversely, the National AIDS Manual and Gay Men Fighting AIDS have embraced this fascist dogma of tattooed-identification and incarceration with their Malthusian 'Regaying of AIDS'. The spurious 'HIV-positive' test result becomes the tattoo for those who are stamped with the stigmata of criminality. Dominic Gough of Positive Nation has the symbol of Bio Hazard tattooed on his arm as a HANDLE WITH CARE sign. 'HIV Belief' becomes internalised paranoia where one imagines that one has become 'invaded'. John Campbell of the UK Coalition of People Living with HIV/AIDS stated: "The only tattoo that I would have is: 'I'm HIV positive and Proud'."

Disease-identity-politics becomes the petty-bourgeois death-style of the urban queer. We even have an inmates 'HIV poz look': the Belsen-styled 'convict-cut' shaven head has become the dominant image of 'HIV propaganda'. 'HIV' high-life-styles publications proliferate from POZ magazine to the oracle sermons of Positive Times and Positive Nation.

What could be more kitsch than to wear a pseudo-'viral' construct as an ephemeral fashion garment? Our will to disease and death became the marker of our homoaids-fascist identity. We desired 'AIDSing' to transgress the limits of experience. We fear losing 'AIDS'. One Bay Area patient stated in the San Francisco Examiner: "AIDS is the most wonderful thing that has ever happened in my life"; while Mike Esser stated in QX Magazine (21.2.96): "At the moment I'm on the dream combination of AZT, 3TC and Indinavir, and I feel great, as alive as I've ever been".

Here we have the social formation of a hybrid-sub-species: the homoaids, the homoDNA chain terminator. This may be what Michel Foucault terms: "the technology of the self" – where individuals take on various operations on their bodies to transform themselves. The commodification of 'AIDS'-related-identity ends up in the aestheticization of the commodity as pathologised clone fashion accessory. No longer pro-

claiming: "I'm gay", but "I'm HIV". Mass 'HIV' testing of homosexuals is the collectivisation of the hypnotic spell. This socialised hypnosis of 'HIV in-group' identity becomes analogous to the Fuhrer ideology. Both the 'fascist' and 'HIV' community of the people correspond exactly to Freud's definition of a group as being: "a number of individuals who have substituted one and the same object for their ego ideal and have consequently identified themselves with one another in their ego". The 'HIV positive Blood Brotherhood' constitute the 'in-group'; the 'HIV negative', the out-group.

This pernicious apartheid of HIV positives and HIV negatives becomes a grotesque parody of the Auschwitz death-camp selection process: 'left', right', 'left', 'right', 'poz', 'neg', 'poz', 'neg'. After Auschwitz, 'AIDS' becomes farce. Belonging to the in-group is seen as more authentic, purer, higher; whereas the 'HIV negatives' are negated. (The paradox being that they are all 'negatives'). Adorno gives a striking insight into the regressive psychology of organised groups which fits the ethos of 'HIV' occultism: "What happens when masses are caught by fascist propaganda is not spontaneous primary expression of instinct but a quasi-scientific revitalization of their psychology – the artificial regression described by Freud in his discussion of organised groups. The psychology of the masses has been taken over by their leaders and transformed into a means of their domination. The collectivization and institutionalization of the spell have made the transference more and more indirect so that the phoniness of enthusiastic identification and the dynamics of group psychology have tremendously increased."[3]

Testing 'HIV+' becomes mental, not viral, infection. Gustav Le Bon states: "In a group, every sentiment and act is contagious, and contagious to such a degree that an individual readily sacrifices his personal interest to the collective interest."[4] Le Bon classifies contagion as a form of hypnosis where the individual becomes an "automaton". This may explain why many 'tested positives' appear to be in a tranced and lobotomized state – refusing, or perhaps being unable – to question their new tranced-baptised-status.

KITSCH

The AIDS communities' growing distrust for the 'antiviral drug zeitgeist' has generated a faith in the nostalgia for medievalist remedies and New Age cures. The smaltz film Men in Love pines for a pre-scientific world of punk primitivism; rejecting traditional medicine for moonlit healing circles. Positively Healthy offered us Menergy Weekends that were marketed like Nazi Youth camp meetings set in a Middle Ages theme-park: "The weekend is full of the energy of life, love and celebration of ourselves as gay men who have traditionally been Shamen, Medicine Men and Wisdom Warriors of their culture.." Their advert for Alchemy Scotland Weekends mimics the body-fetishism of a Leni Riefenstahl film: "At low tide we will walk over a seabed made of seashells to a deserted island, at high tide swimming off the lawns. There is nude sunbathing in an enchanted walled garden, peacocks roaming amongst our warm bodies. Physical activities are plentiful, mountain-climbing at sunset, picnicking on the mountain plateau, and lying in the long grass under a canopy of stars"[4].

AIDS Prophet, Dr Jon Kaiser advises his patients to open up a dialogue with their mythic 'virus'. In his 'self-help' treatment guide Immune Power he encourages his clients to engage in a warm one-to-one relationship with the 'virus' by writing letters to 'it'. As an object of desire, 'HIV' is always already a substitute for another lost object. As an object of research, 'HIV' is just an objectification of a void.

Christian ritual has been revamped by 'AIDS propagandists' and marketed as new forms of secular service: Die-Ins, Healing Circles, Quilt Ceremonies, Candle Light Vigils.

The Christian Communion is replayed via the introjection of 'HIV Belief' (displacing God, the Primal Father). The 'HIV positive blood brotherhood' becomes Freud's "cannibal savages" who, out of fear and envy, murder and ingest the father ('HIV') to strengthen their identification with him/it. The Christian Eucharist, the ritual consumption of the flesh and blood of the deity becomes 'antiviral-cytotoxic' therapy. 'AIDS' demonstrations are infected with pappy-pulp slogans: 'SILENCE=DEATH', 'GENOCIDE', 'HEAL AIDS WITH LOVE', 'FIGHTING FOR OUR LIVES'. This evangelical battle cry for the 'War on AIDS' was aptly portrayed in The Independent on Sunday's spread 'Facing Facts' (26.11.95). We see tacky Woolworth's 'Weeping Orphan' portraits of persons assumed to 'have' either 'HIV' or 'AIDS'.

These photographs by Scott Thode epitomised sentimental 'AIDS' kitsch in all its serious smug soulfulness. We see a Christ like figure with a duff white dove, we see naked women holding hands to heart, eyes shut in a trance state. The article proclaims: "The men, women and children in these pictures are all HIV positive or have AIDS. They speak of passion, hope strength and love; may the portraits and the writings on these pages serve as a testament to the human spirit". Under each naff portrait are poems that present 'HIV Puritanism' as revelatory and redemptive, purifying and purging.

The myth of 'HIV' infection had disseminated the fatal contagion of another disease: the Born Again politics of Praise the Lord Redemption. The fantasy of an assumed 'HIV positive' test result becomes a Puritan sign of the Elect. 'HIV Puritanism' finds ways of intensifying guilt. You are

'saved' by your faith in 'HIV Belief': "Having the 'Virus' is a blessing in disguise. It is a catalyst that has brought us together and helps us to stay 'clean'. We all know that cleanliness is next to Godliness and nowhere in the world could you be more at home than next to God". By Danny Ramirez and Yvette Fontanez.

"Being HIV positive has set me free from another disease I was already fighting, the disease of drug addiction. To be free from drugs is truly a blessing. I look at my virus as another chance of life". By Linda Jordan.

These examples of viral-poetics display a smug-virtue-smaltz that have made 'HIV/AIDS' the hallmark of 'bad taste'. What other medical conditions have inspired such sentimental dross? As pulp-science fiction constructs, 'HIV/AIDS' have installed extreme emotionalism, irrational fear and vulgar sensationalism. As Theodor Adorno stated: "The notion of vulgarity is closely related to kitsch. It too reflects marketable emotions. One of the defining characteristics of kitsch may be that it simulates non-existing emotions. Kitsch neutralises them. Kitsch is based on phoney emotions. Kitsch preys on fictitious feelings, thereby neutralising real ones".[5]

The language of hope, salvation and redemption, essential tenets of 'AIDS kitsch', are exemplified in the 'War on AIDS' vigil schlock-spiel entitled The Day After That:

> "Someday we'll be free, I promise you we'll be free if not tomorrow
> then the day after that.
> And the candles in our hand will illuminate this land if not tomorrow
> then the day after that
> And the world that brings us pain, that fills our lives with fear
> then the day after that will disappear
> And the war we've got to win - I promise you we will win
> If not tomorrow then the day after that".

Liza Minnelli sings this muzac with chorus and orchestra, arms raised, hands clasped. She stated regarding this song: "Every great war has had its song – and we haven't had a song for the WAR AGAINST THE DISEASE" (Liza's emphasis).

The construction of the 'innocent AIDS victim' came to us in the image of the child. London's Daily Mirror had a headline: "Liz weeps for AIDS girl" to promote a coffee-table book on 'Children with HIV'. In it Hollywood celebrities (including Andy Garcia, Liz Taylor and Nicolette Sheridan) are photographed in glossy chocolate-box poses devouring an assortment of pap soft-centred 'HIV poz' bambinos. 'AIDS-BABES' propaganda proliferates: a colouring book entitled It's OK to Be...Me: A Book About Life and Being HIV+; and the ditties of 'HIV poz' kids from the album Answer the Call: "We need love/We need compassion to live/We've got hugs/We've got kisses to give".

'AIDS Celebrities' have jumped onto the HIV hypothesis bandwagon to use AIDS patients as photo opportunities. The Oscar ceremony is riddled with red ribbons. The richer stars have them set with precious gems. Whoopi Goldberg is seen at AIDS galas pushing a PWA in a wheelchair brandishing her compassion but ultimately using him as a diseased designer accessory. Princess Diana indulges her obsession with PWAs by visiting hospitals at three a.m. Miss America tours the AIDS wards molesting patients. Publicity stunts such as Elton John flying Ryan White to Disneyland. The ubiquitous U.S. Queen of AIDS TV light entertainment, Barbara Walters, wrings the heartstrings of the nation in cringe-making schlock interviews.

San Francisco's Castro District has its own AIDS shopping mall housed in the Workshop Building of the AIDS Memorial Quilt entitled Under One Roof. Here one can buy AIDS-related accessories such as Red Ribbon Ruby brooches, Red Ribbon paper weights, Cuddle Wit teddy bears sporting tiny red ribbons, T-shirts with inane Born Again slogans and sentimental sympathy cards.

The Quilt is pap folk art kitsch that oozes virtue, purity, innocence. Cleve Jones, the Quilt's founder stated that: "The Quilt is the embodiment of pure good which emanates cosiness, humanity and warmth". Daniel Harris stated in Harper's Magazine, "Making AIDS From Kitsch"[6]: "The Quilt is the sublime expression of AIDS kitsch. It evokes a nostalgia for a simple, more innocent time, a pastoral world of buggies and butter churns – an America that never existed. Nostalgia, the longing for a legendary small-town America, is a fundamental component of AIDS kitsch, and selling the Quilt obeys one of the primary rules of marketing: the romanticisation of home made goods. The Quilt effectively exudes an aura of the homestead..."

Kitsch performance art was typified by Dr Robert Willner's theatre of dissent who toured the world ready at the drop of a hat to inject himself with so-called 'HIV' infected blood (providing he was in front of the media). As Peter Duesberg, who himself has offered to be injected with 'HIV' (providing it didn't come from Robert Gallo's lab) observed of Dr Willner's antics: "The public likes these crude gestures much more than a subtle, logical argument. Knives and swords and lions and crucifixions. Willner quite deserves the media attention he's getting. He did the thing that excites the public".7 Dr Willner was found dead in his car that year, apparently from a heart attack.

The acronym 'HIV' bares no relation to 'its' existence or alleged action; 'it' has never been demonstrated to do what 'its' name suggests it does. The sign and the real are not equivalent. 'HIV' is the 'signifier'
without the 'signified'. 'HIV' is a simulation of hyper-reality. 'HIV' is apocryphal. 'HIV' is the 'real-fake', schlock-imitation, paste-jewellery with 'its' camp gp160 dish-ariels. This makes 'HIV' pure kitsch. The hyper-reality of the no-thing 'HIV' is summed up in the Book of Ecclesiastes: "The simulacrum is never that which conceals the truth – it is the truth which conceals that there is none. The simulacrum is true".

In Nietzschean parlance, the followers of 'HIV Belief' become the 'reactive-forces' of the 'slave-class' who do nothing but accept their 'victim' status. The 'HIV Voodoo Priests' have lobotomised the 'HIV Herd' to the state of the zombie. The army of flesh-eating zombies in George Romero's pulp-film Night of the Living Dead are an apt metaphor for the 'living-dead' who have become 'infected' by the 'HIV Trance'.

We need to practice 'safer-thinking' to protect ourselves from the hypnotic-infection of the 'HIV' voodoo-curse.

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False Negatives? FALSE ALARM

Over Easter a scandal broke in the European media over the possibility of false negative antibody results with a test kit from Abbott. Since a positive antibody diagnosis is built into the definition of AIDS – pneumonia plus positive test = AIDS, pneumonia plus negative test = pneumonia – the reliability of antibody testing is a defining quality for AIDS risk populations.

Some of the media have circled like vultures around a story of false negative antibody results with a test kit produced by Abbott. With the uncertainties around BSE, here was a story of a presumably reliable effort restoring confidence in testing as a public service: 650,000 tests in Germany alone would be disallowed, 20,000 in Britain checked. The implication is that there are some methods, albeit not the Abbott test, that are reliable. No expense would be spared in setting matters right.

Wrong. There is no antibody test that can give a reliable positive result. It is probable that all positive results are false positives, and that no such thing as a false negative exists. Why? Because the antibodies tested for (it's not an AIDS test, it's not a virus test, it's an antibody test) are not specific to HIV. As far back as 1989 Philip Mortimer, head of the government's virus lab (the Public Health Laboratory Services' Virus Reference Division) wrote: "It may be impossible to relate an antibody response specifically to HIV-1 infection." He should know. For years scientists have struggled with the difficult fact that no-one can truly isolate the virus. Without isolating the virus, you've no way of judging whether (and which) antibodies always, usually or ever were caused by the virus. In 1984, when Gallo announced HIV as the probable cause of AIDS, he'd found 'virus' antibodies in at best 85% of AIDS patients. Since loads of other things result in the same sorts of antibodies – well-documented things like flu vaccines, TB, glandular fever, leprosy, malaria, hepatitis B, hepatitis B vaccine, foreign T-cells, foreign cellular proteins and still other proteins from our own oxidised cells, a positive test means only that something required antibodies, but no-one knows exactly what.

The problem suggested with the Abbott test kit was that too high levels of these (non-specific) antibodies prevented the chemical reactions the lab technicians look for from happening at all. Do they know the person even had reactive antibodies? What about ICL or ickle (idiopathic cytolymphopenia), the new media topic in the US, it's AIDS without HIV and by now well recognised. The Abbott business itself arose because four patients who seemed to have AIDS, tested antibody negative – that's ickle in other countries. Abbott were consistently cautious in dealing with the media, since it seems no-one is really clear what's going on. Nature Medicine recently reported a possible prozone effect in the tests that may help explain the anomalies.

The real problem is the shoddy pretence that when antibodies are found they are known to be caused by HIV in any case.

There are two types of antibody test for HIV – the ELISA and the Western blot (WB). The WB uses up to ten supposed viral proteins in stripes to test blood for antibodies. ELISAs are cheaper and quicker and test with two or three.

WBs were dropped in this country in 1992, even though they are more detailed. They were showing some people with some viral antibodies, other people with others, and making an expensive nonsense out of the idea that a uniform virus was infecting people. How could you be semi-antibody positive? Before the decision to withdraw the WB in Britain, Mortimer wrote in 1991: "Western blot detection of HIV antibodies began as and should have remained a research tool." In other words, when you examine things in detail, there are lots of questions left open. Even so in the USA, WB positivity is essential to a positive diagnosis. ELISAs are considered far less specific. At the prestigious US Walter Reed Research Institute 12,000 positive results with ELISA reduced to 2,000 when checked with WB: ELISAs are up to six times less specific. In Britain they are the standard.

Of course, without an isolated virus, even Western blots are based only on assumptions of which actual proteins would make up HIV, assuming it to be something like a lentivirus and a bit like an oncovirus. Dish antennae receptors, core proteins, viral enzymes, all are theory. The virus has never been isolated.

Amazingly, even with the generally preferred Western blot, the antibody reactions necessary to call the test positive vary all over the world. A positive WB in Africa need not be positive in Australia for example. In the largest US study of gay men and HIV/AIDS, the MACS, just one strong reaction stripe meant positive, whereas in the uncommon circumstances in Britain where WB is still used, three stripes are necessary. False negatives? The phrase has no clear meaning when positive depends on which country you were tested in! A paper recently cited by Australia's top virus lab showed 20% of non-risk group people tested positive for one or more stripes on the WB: the proteins that are supposed to be viral are all over the place, just never all together in one virus!

Of course some people with positive antibody tests of either type do get ill. There is a range of reasons for this, including the toxic medication that often accompanies the trauma of a positive diagnosis. The majority of people with a positive diagnosis however do not have AIDS, and, so long as people take charge of their health, it can stay that way. In other cases, treating people for a virus which has defied proof of existence is distracting doctors from commonsense approaches to genuine ailments.

It seems whenever HIV/AIDS makes it into the mainstream media, as with Abbott's Easter transubstantiations, the gay community in particular feels almost grateful. THT spokespeople were massaging the airwaves for renewed funding. Are homosexuality and HIV being used to reassure the wider public that tests per se work and public health policy is reliable? Is it just to let anybody believe that?

HUW CHRISTIE

This article was first published in the May issue of PRIME magazine but, due to a printing error, did not appear in full.

LIVE, LIVE, LIVE!

Yes, this is a new column that is going to appear in the *Continuum* magazine every issue. With your letters and comments I hope that this is the birth of a long life.

I'm Michael, and the title comes from Auntie Mame, as that's how I live my own life and if I can help you to live through your HIV+ diagnosis, I will by first telling you what I did when I found I was positive.

First I tried to destroy myself and everything I stood for. But then I realised that I had more to offer than most, you see I have lived through this for 17 years and still going strong. Yes, I do get the same illnesses that most normal people get and I'm as far away from being normal as Diana is queen.

I will tell you a little story. A few weeks ago I got a chest infection, and the doctors were bound and determined to make me start taking Septrin. But I have come this far without any of that crap as I told the doctor, and if it's my time to go, well, I've had a good time, although I'm still looking for that body builder who needs oil.

In all seriousness, I take massive amounts of vitamin C and I don't smoke or drink, but I do have a life. For God sakes get out into the sun whenever there is some and you'll feel a lot better for it. I won't tell you what not to take cause I know for some of you this is life.

Well, I had better sign off for now. But I hope to hear from you and you from me in July. If you could send all your comments to Michael, c/o *Continuum.*

With love, *Michael G*

COMMENT

The dual questions of the reliability of antibody testing and isolation of HIV have never been more debated by more people than they are now. This magazine seeks to do its part, but new books and television programmes are also carrying the issues into the mainstream where, when a real resolution is achieved, some serious changes may come about in the way HIV, and AIDS, are perceived and treated. The intimate linkage of the two matters – has the virus ever been individually characterised, and have the antibodies said to indicate it therefore been proved to be specific – is a connection of deep importance to people with and without an antibody diagnosis.

The pall of uncertainty, so often presented as irrelevant, is taking a toll on people's freedom which is unacceptable. Of course it is disturbing when the foundations of an apparent reality are questioned, but where there is uncertainty there is hope for greater understanding, and greater understanding means a fuller chance for well-being and discovery. Don't be intimidated by people who say it's too complicated – it's a debate about logic and common sense. Don't be deterred by assurances that it has nothing to do with you – it has as much to do with you as with anybody, if not more.

Turning off from the discussions about HIV and AIDS can be as important as turning on. What most of us want, and particularly many Continuum readers, is to take back our futures, and the time to start is now. Taking back the present, setting healthy and fulfilling priorities, nurturing and nourishing oneself, these are the real freedoms that we all deserve. We hope the variety of stories, news and information in this issue provides interesting diversion as well as compelling focus.

LETTERS

NO MORE MISTAKES

After a year of finding out what is really important to me, Continuum has pointed the way. It has been a difficult journey, knowing what I do now, I would have started it differently.

When I was diagnosed as being positive, I was advised to give up work. This I did and have regretted it. I have come to realise how important my work was to me. I should have simply re-organised my work to reduce stress; I find dealing with the state just as stressful as my work was, and I do miss it. First mistake!

The second mistake was giving in to fear. As my CD4 count dropped, so fear rose. My reaction was to get disgustingly drunk, go with anyone with a cock between their legs, and feel sorry for myself. Doesn't it ring a bell? I really think that counselling at diagnosis is at best misplaced, and now I don't speak to health advisors.

Anyway, as a result, I suspect, of all these excesses, I went down with cryptosporidiosis. Massive weight loss and a spell in hospital later, I realised what Continuum had been telling me. Diet is important. I swear by antioxidants and garlic now!

Things are a good deal better now; I have regained some control over my life. I am lucky, I have the support of my lover, my family, and even my doctor. I do regret the attitude of the gay community. It seems to me that at best, being HIV+ is fashionable, at worst, it's a plague and stay clear. I avoid the Lighthouse and BP, I can't bear all this "Ooo, I'm really ill!" bit. I am now described as being 'atypical' by my doctor, I intend staying that way. I am sure that freedom from stress, a good diet and living this wonderful life is the way; forget AZT and all the other poisons, just read Continuum for a healthy life.

Colin, London

Then recycle it! HC

EXCHANGE OF INFO

My health advisor at Chelsea and Westminster Hospital suggested I should try and find out about your group as she thought I might find it useful.

I was diagnosed as being HIV+ in January of this year, but because of my lifestyle it is very, very likely that I have positive for about seven years without my knowledge. Suddenly, in the eyes of the medical profession I have gone from being a healthy young man to a patient with a problem. One of the first things I was told was that my life "would be seriously foreshortened". I simply can't accept that this needs to be so. How can you define "seriously foreshortened" anyway?

I do accept that having the knowledge of my HIV status is

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Rejecting the party line

In the April edition of *Death Camp*, Celia Farber gives a striking analogy between HIV Fundamentalism and Stalinism. She argues that Stalinism, like HIV Totalitarianism, is founded on its obsessive insistence that whatever the cost, it must retain the appearance of Party Unity.

Nobody really believes in the ruling ideology of HIV and everybody knows that nobody believes in it, but still the appearance is to be maintained at any price to save the careers of 'HIV Ideologues'. The appearance is essential: if it were to be destroyed the whole belief system would fall apart. This is why Lanka is a challenge to 'HIV Ideology': he has exposed its illusion and fraud.

'HIV Ideology', like Stalinism, feigns to rule in the name of the People (the Positives) while everybody knows that it rules in its own interest – in the interest of reproducing its own power.

Warm regards.

Chris Brind, London

All letters are equal but some are more equal than others. HC

useful; it means I can do everything in my power to stay well. However, I have felt a bit knocked about by the medical side of it, even though I know the doctors are doing what they believe to be the best for me.

It was with a great deal of relief then that I came across your publication today (I found it in the Information Exchange at Chelsea and Westminster). I am very interested in subscribing to Continuum and also of knowing if you have a group which meets and shares information, etc.

Jon, London

FREUDIAN SLIP

In you article "Where Have All the T-Cells Gone" (Continuum, Jan/Feb '96) Professor Alfred Hässig asserts that Psychoneuroimmunology was "born around 1975 in Davos, Switzerland". Actually this is untrue. Sigmund Freud's contribution to neuroscience was considerable and his clinical research into psychoneuroimmunology and psychosomatic conditions is well documented. Freud (and later Lacan) deconstructed the mind-body dualism by demonstrating that the human psyche is not a separate work house to the immune system, but an intrinsic marker for its functioning and well-being. Indeed, Lacan had demonstrated that cancer can be a psychosomatic condition: immunologists and psychoanalysts have demonstrated that there is a connection between depression and susceptibility to cancer.

How many 'AIDS-related conditions' may have been triggered by the psychosuppresive 'HIV positive' test result? Freudian and Lacanian psychoanalysis can be an effective 'treatment' for 'healing' AIDS-related conditions. Psychoanalysis may probe the patient to deconstruct his/her 'relationship' with a particular 'symptom': why do some people psychologically desire/need certain conditions? Why do so many gay men want to be diagnosed as 'HIV' antibody-positive? The desire for the mythic 'HIV infection' may be related to Freud's thesis on the 'pleasure principle' as being intrinsically tied to the 'death-drive'. The psychoanalytic doctrine of the 'death-drive' points us back to the unknowable source of all drive forces and thus roots the life of the mind in the unthinkability of the body. In Freud, psychoanalysis emerges as a theory and practice that addresses the ineffability of the body.

Though expensive and elitist, psychoanalysis still works out cheaper per patient per year than cytotoxic DNA-chain terminating 'Combination Therapy' drugs, and is far less likely to kill the patient in the process.

Karl-Heinz Reinisch, Hamburg

CLOWNING AROUND

It has come to my attention from reading the latest edition of your publication that reference is made to a certain "Fucko the Clown", erstwhile editor of the humorous "Viz"-like comic "My AIDS Nightmare".

May I make it clear that this individual has for many years been forbidden to use the title "clown" by the International Registry of Clowns, as it is a well-known fact that he is just not funny (very sad, in fact), and frightens small children.

I would be obliged if you would make this clear in future articles, and inform your readers that "Fucko" may be described as a "fool", "idiot" or "troll", but he most certainly will never be a "clown".

JC, International Registry of Clowns

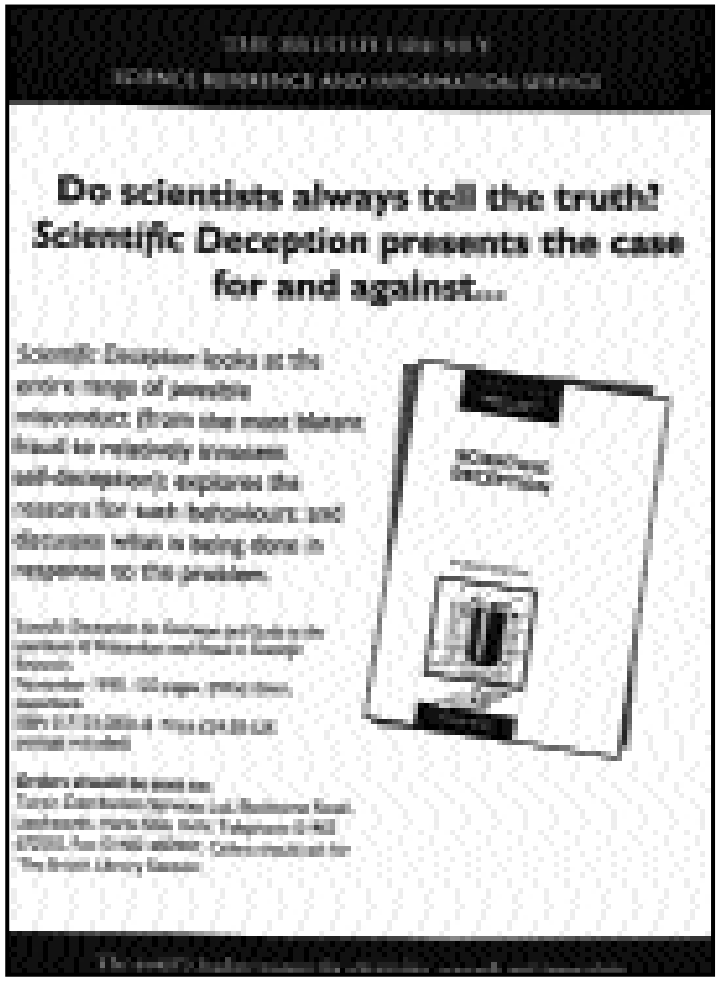
WELCOME CRITIQUE

Mr T. Sobel's letter (Continuum, March/April) on Positively Healthy's crusade against poppers use is a much-needed critique of AIDS politics. Both the 'AIDS establishment' and the 'AIDS dissidents' seem to have become indoctrinated into a kind of moralism of 'saving lives'. The baseline reactionary politics of Pro-Lifers seems to have infected aids-activists and aids-theorists.

Our AIDS histories have censored out of existence a sub-set of gay men that invoked AIDS (from the late sixties till the early eighties in the S&M bath-house and drug scenes) as a form of post-modern transgression: excess intoxification, risk-taking, danger and the burn-out syndrome (or GRID).

The AIDS establishment's 'safe-sex' (and AIDS dissident 'safe-drugs') ideologies seem to ignore the libidinal-intensities and death-drives that have come to be a part of our post-modern aids-culture. The writings of Baudrillard, Lyotard, Foucault have celebrated 'AIDSing' as a new form of being-in-the-world. The ultimate trip of the 'AIDSing' experience can be found in Avital Ronell's Crack Ward (University of Nebraska Press) which is an analysis of the role of addiction, pharmacology, intoxification and destructive desires.

Diane Rubenstein, London



ENQUIREWITHIN

Q 2 -3 years ago I was told I could no longer donate blood as a screening had shown that hepatitis-C antibodies were present. To this day I have not been able to work out for sure how I became infected (through food or sex?), if I have even got the disease (I am still symptomless), what I should be doing about it (lifestyle-wise and treatment-wise), and to put it bluntly, how long I have got live.
What should I be doing about it?

G. W., Saudi Arabia

A Hepatitis-C virus was never a reality or even an artefact, only an invention.

After the riddle around Hepatitis-B virus (HBV) – still "not available for experiments" – was set so the general public had the impression the Hep-B antibody test really detects antibodies formed in reaction to infection with HBV (and the vaccination programme against it was established), innovative scientists filled the gap in explaining hepatitis without antibodies against Hepatitis-A virus (HAV) and HBV as "a viral non-A-, non B- Hepatitis". As in the case of the illnesses grouped under the artificial diagnosis "AIDS", it didn't occur to them to mention other well-known reasons for Hepatitis, e.g. alcohol and bad diet. [see PS]

It was then just a matter of years until some US scientists with corporate backing came up with an antibody test, using only synthetic proteins produced on the basis of some genetic sequences which were defined, in an ad hoc act, as being part of the genetic sequence of "Hepatitis-C virus"(HCV). These tests simply use some synthetic, non-viral proteins, that were never even said to be taken from a virus! So, like all such tests , the HCV test can have no diagnostic value whatsoever. Everybody who claims otherwise is acting irresponsibly, and in the case of medical doctors, have no real ethical values: the result of a positive HCV test frightens people, who are then in danger of treatment with problematic medications in high concentrations (interferons) and their bodies may be damaged by psychosomatic reactions. Just ignore this result, and avoid contact with any medical staff who believe in HCV and if possible start legal action against them. This may be healing not only for you but for others too (e.g. in Germany people say HCV is worse than AIDS). So, look out for a young responsible scientist to help you. The older ones have failed badly by challenging nothing.

PS These scientists had the power of industrial and political institutions behind them, and as in almost all areas of biomedicine have no inbuilt controls any more, such as is found in most engineering sciences, for example, where a machine does obviously work or does not. Biomedical scientists claim all sorts of things, and if people get ill in increasing numbers, it's said to be because the illness, and the bugs causing it, are getting more dangerous.

Leaving aside the tremendous interests the pharmaceutical companies have in this way of thinking, this development was foreseen long ago because such scientists are not really scientists any more but bureaucrats who "control" themselves by reading the results of their colleagues before a probable publication, and censoring any information that may interfere with their own concepts, their models, their business.

For a deeper understanding of this sorry and dangerous state of biomedicine do read McKeown, Illich, Mendelsohn, Foucault, Feyerabend etc.

Dr Stefan Lanka

LISTINGS

Think Pink

At the Ritzy Cinema, Brixton, 1st - 8th July. An expression of Gay/Lesbian/Bisexual works intended as an artists' forum and an opportunity to raise money for the Pride Trust. A programme of events will be launched with a fashion show (Dexter Wong, Harris K and Colin Ferrira), a poetry recital will also be taking place and Della Grace will be offering to answer 'everything you wanted to know about me but were too afraid to ask'. Plus paintings from O. Rodrigues and the photography of Jean-Marc Prouveur and Time Out photographer Christine Haller. Films will be showing all week from gay/lesbian and bisexual directors and a 'Pride Eve Think Pink' party will close the event.
For information contact Ritzy Box Office on 0171 737 2121 after 15th June.

CRUSAID Walk For Life

Sunday 9th June, in 20 cities and town across Britain, starting at 12 noon in all except Scotland, where it will start at 2pm. The London walk starts at the Royal Festival Hall and ends at Shepherd's Market, near Piccadilly.
For further information including start locations freefone 0500 - 011696.

CONTINUUM Workshops

Meeting to talk about possible workshops for gay man diagnosed "HIV+". Come and discuss important issues with workshop facilitator Michael Baumgartner. Thursday 6th June, 6.30 pm at the Continuum office. Please call to confirm attendance.

Monthly meetings

Next meetings: Tues. 18th June & Tues 16th July, 6.30, Continuum office. All welcome.

by ***FATSY & TEDDY***

TEN HANDY TIPS TO REDUCE SURVIVAL RATES

– FROM THE QUACKS AT THE COBBLERS CENTRE

1. Ensure you have financial motives for diagnosing people HIV+ (we get about £20,000 per person) rather than acting out of genuine care and compassion for the individual.
2. Break the Hippocratic oath we all undertook (no-one notices) by prescribing highly toxic pharmaceuticals which do direct harm to the patient.
3. Never miss an opportunity to wield that prescription pad we all worked so hard to get our hands on – always prescribe drugs for the patient before a proper diagnosis has been made – preferably in combination with other drugs in order to increase the toxic load of the patient and totally confuse the originally presenting symptoms.
4. Prescribe more drugs for the side-effects of the drugs in current usage rather than admit the side-effects are genuine or that the drugs may not be working. Just tell them it's HIV disease, they always believe you.
5. Use fear and coercion to enrol as many people into as many desperately flawed drug trials as possible. We have an obligation to keep the pharmaceutical companies happy as they may increase their financial rewards for us.
6. Perform as many physically intrusive tests as possible in order to make the patient feel like his or her body is no longer their own – an essential prerequisite to get them to hand themselves over to us for experimentation in medical science. Terrify the person by sparing no details when reeling off the list of possible horrific illnesses which might fit their presenting symptoms.
7. Distress and traumatise patients on each and every visit by playing God and predicting their time of death. It's ever so easy to disguise such delightfully bad news with kind words – the patients never suspect it might not be true and you get an incredible buzz from the power trip.
8. Psychologically destroy as many people with HIV as possible. Ensure that no-one has many sneaky ideas of there being any hope of survival or recovery. This speeds up the time between testing positive and death and has the added advantage of accelerating CD4 cell loss.
9. Lose patient records, X-rays and blood samples as often as possible to further enhance psychological stress, weaken the constitution by having more X-rays and by taking even more of the vital fluids they need out of the body and into a test-tube.
10. Above all have total belief that all you do is above and beyond question. Remember our positions are unassailable and we always know best.

CLASSIFIED ADS

Advertising rates:

BOX: £10 per column centimetre (min £20)
LINEAGE: 75p per word (min £10)
PERSONAL ADS: Up to 25 words - £10
(additional words 40p each)

DISCOUNTS: **3 consecutive insertions – 5%**
6 consecutive insertions – 10%

All adverts must be prepaid with order. Cheques & Postal orders accepted payable to Continuum.

All enquiries to Tony on **0171 713 7071**

Personal Contacts

The following Personal Contact adverts are examples showing how you can contact other people. Why not submit an ad, but make yours as interesting as possible for the widest response. Each ad is given a different box number to ensure confidentiality.

Sample adverts

WHERE HAVE ALL the sensible people gone? I need to socialise with intelligent, sincere friends, not those whose minds are blinkered. We can talk, read, challenge authority, but let's do it now! A piece of your dissident writing ensures reply. Box 1000.

GAY MAN, 31, diagnosed HIV+, wants to meet other interesting people bored with the standard view of HIV & AIDS. Let's have fun together! Box 1000.

WOMAN, 28, HIV+. Desperately wants to have a baby, seeks like-minded HIV+ man who doesn't care what people say. Photo essential. Box 1000.

LOVED WHAT YOU had to say at the Continuum open meeting last month. It really inspired and reassured me. Can we meet up sometime? Hope to see you at the next meeting on Tuesday 18 June, 6.30 pm. Box 1000.

Why not place
your advert
here?

Therapists

REFLEXOLOGIST
specializing in: neuropathy, insomnia, energy, stress, depression, bereavement & much more. Phone for a chat. Sliding scale.
Janice: 0171 254 1397

EXCELLENT MASSEUR
(MTI, IPTI registered)
gives deep tissue massage
Comfortable, safe environment
Refreshments & shower available
Ring Tom on 0171 262 0237

Put yourself in the hands of a qualified holistic therapist
for a highly relaxing
and invigorating massage
using essential oils

MASSAGE THERAPIST
using
Therapeutic Acupressure
Ring Patrick on 0171 226 5476
(North London)

HOLISTIC THERAPIES
If this is what you do, why not let our readers know?
Reach more clients with this space

CONTINUUM

is now holding

regular monthly meetings

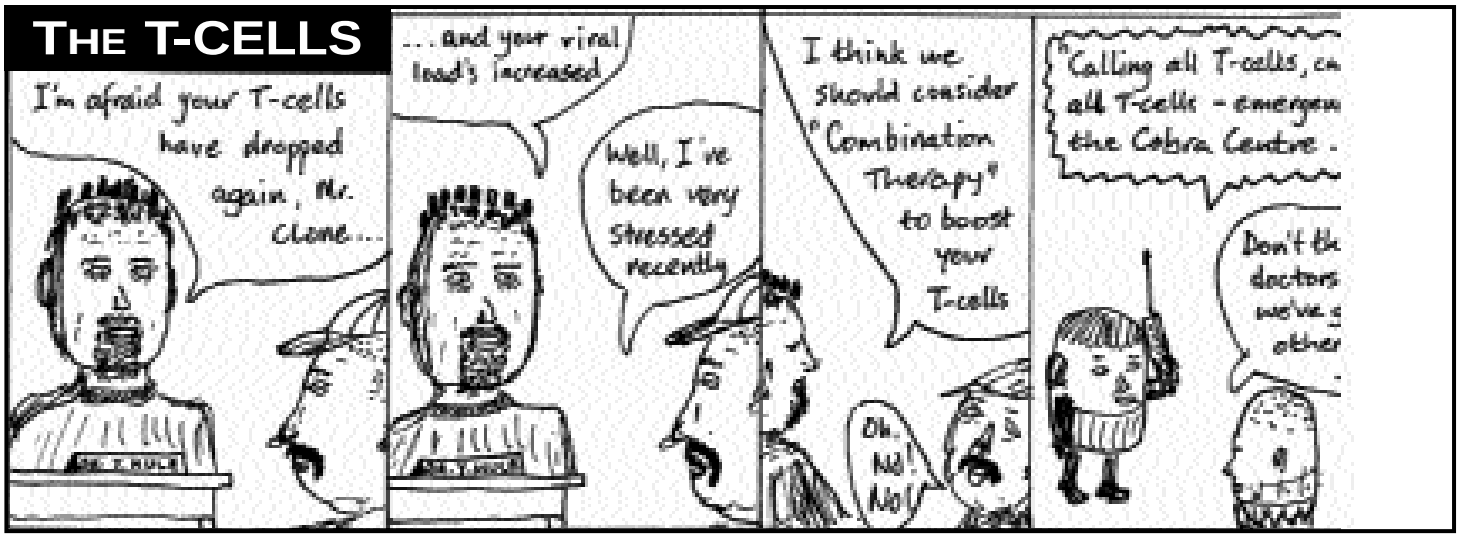
An opportunity to discuss issues around improving and maintaining health and finding out more about alternative research and ideas.

Why not join us – you may be surprised to find how helpful these times can be

See details inside front cover

To fill this space call
Tony on 0171 713 7071

As forecast in the Letters page in the last issue we have amended our subscription policy to reflect our view on the usefulness of "HIV" testing. We have made uniform the rates for individual subscribers, which will mean that some individuals will pay more than before to renew their subscriptions and others less.
We regret any inconvenience this may cause but look forward to your continued involvement.



Lust for Life

Kevin runs the Complementary Therapy Information Group and is proud of his decision ten years ago not to take long-term medication. He has not been without illness, however, and his inspiring account urges others to find alternative ways to improve their health.

An HIV diagnosis in 1986 was not my first brush with the medical profession. Having grown up with a mother unhelpfully labelled as schizophrenic, I saw first hand the patient as a toy that psychiatrists could play with. I watched helplessly as my mother was drugged up to the eyeballs and subjected to ECT as we were told this would make her better. All I could see was her deterioration. She died in 1979 from liver failure and cancer of the bowel not diagnosed until two weeks before her death, in my opinion both linked to her many years of medical treatment. Whilst this was a personal tragedy it has given me an enormous amount of strength to deal with my own health and a healthy cynicism towards the men and women in white coats.

When I was diagnosed I was told that I was symptomatic as I had Post Generalised Lymphadenopathy (PGL), which I accepted but found a little strange as I had had swollen lymph nodes throughout my life. In an intuitive fashion I decided that I would not take any long-term medication and I am proud of the fact that ten years on I have managed to not swallow one capsule of AZT, which I believe to be a killer. However, suffering from an upper respiratory chest infection in 1987 and panicked by a frightened hospital consultant, I was prescribed four weeks of heavy-duty antibiotics. Every minor illness I had over the ensuing five years was treated with high doses of antibiotics. This I believe was the cause of a catalogue of symptoms which were to follow.

First of all I was hit by chronic fatigue in the summer of 1987. I remember people telling me that everyone gets tired from time to time but this was unlike anything I had ever experienced. In 1989, at the end of my tether, I attempted to end my life overwhelmed by the pressures of my diagnosis. How absurd it felt trying to kill myself because I was afraid to die.

The periods of fatigue became longer and longer until by 1991 it was almost a permanent state of affairs. Along with severe constipation, then diarrhoea, a host of fungal infections, chronic ear infections and night sweats the symptoms started to pile up leaving me feeling desperate, frightened and unable to understand what was happening.

My frustration was compounded by doctors telling me that there was nothing seriously wrong with me and, at worst, I had Irritable Bowel Syndrome, for which there was no known cure. It was suggested that all my problems were caused by replicating virus and depression and that I should start anti-viral treatment and a course of anti-depressants. I did neither. I now realise that at this point my immune system was starting to fail me.

On August bank holiday 1993 at the Notting Hill carnival, surrounded by friends who I suddenly realised could not see what was happening to me, I came to the realisation that I had to do or die. Too many slushy films had subconsciously led me to believe that some wonderful human being was going to come along and make it all better. Perhaps one of those nice men and women in white coats! Once I really accepted that my health was my responsibility and that I was bored of being a victim things started to shift.

I had come to the conclusion that most of my problems were caused by an overload of Candida. I decided that I did not want to live my life half well and that I would aim high and resolve to rid myself of all the symptoms that I had. A private dietitian confirmed that I was very ill with systemic Candida. It was also affecting my brain which I found the most frightening aspect of all.

I knew in my heart that it had taken me a long time to get in this state and that it would probably take at least two years to get myself back to health. Eighteen months down the line this has proved to be true. With a combination of dietary changes, colon cleansing practices, vitamins and food supplements I am slowly rebuilding my immune system. Many times I have cursed the decision to get well as I have experienced severe healing crises and reached the depths of darkness wondering if I was not making a big mistake. The path has not been well sign-posted but I have been inspired by people with other illnesses, not HIV-related, who have managed to turn their health around and then bothered to write down their experiences.

Seeing many friends die over the past ten years I have noticed that they all had severe Candida problems which I am increasingly convinced causes the fundamental breakdown of the immune system. Candida also, in my opinion, explains the growing number of so called HIV-related cases of AIDS. Candida's role in the body is as a decomposing agent when you die. Activate it before death and you start to rot long before you reach the cemetery.

I do not have any firm feelings about whether HIV exists or not but I am firmly convinced that it's not the cause of death. It is difficult sometimes to hold such an opinion and it is not one that came overnight but my own experiences don't allow me to draw any other conclusion. I cannot say an HIV diagnosis is the best thing that ever happened to me. I would have preferred not to have been an eyewitness to the deaths of so many beautiful people and perhaps the hardest part of all now is to heal my heart. I am still angry that medication is prescribed like jelly babies. Antibiotics have been around for some time now and it is clear that many people around the world are suffering from their poorly studied side effects.

I am now involved in setting up the Complementary Therapy Information Group which is a self-help group for people with an HIV diagnosis who use or are interested in non-toxic therapies. I am convinced that only when patients get together and demand alternatives and a voice in their clinics, will this nightmare have a different ending.

You can contact the Complementary Therapy Information Group at: The Information Exchange, 369 Fulham Road, London SW10 9TR. Tel: 0181-746-

Could your *Lust For Life* be an inspiration to others? Phone 0171 713 7071