IN THE HIGH COURT OF SOUTH AFRICA

(CAPE OF GOOD HOPE PROVINCIAL DIVISION)

Case No. 12156/05

In the matter between:

TREATMENT ACTION CAMPAIGN	1st Applicant
SOUTH AFRICAN MEDICAL ASSOCIATION	2nd Applicant

and

MATTHIAS RATH	1st Respondent
DR RATH HEALTH FOUNDATION AFRICA	2nd Respondent
SAM MHLONGO	3rd Respondent
DAVID RASNICK	4th Respondent
ALEXANDRA NIEDWIECKI	5th Respondent
ANTHONY BRINK	6th Respondent
TREATMENT INFORMATION GROUP	7th Respondent
GOVERNMENT OF THE RSA	8th Respondent
DIRECTOR-GENERAL OF HEALTH	9th Respondent
CHAIRPERSON, MEDICINES CONTROL COUNCIL	10th Resp.
REGISTRAR OF MEDICINES	11th Respondent
MEC FOR HEALTH WESTERN CAPE	12th Respondent

ANSWERING AFFIDAVIT:

SIXTH AND SEVENTH RESPONDENTS

I, Anthony Robin Brink, affirm that to the best of my knowledge and belief the contents of this affidavit are true and correct, and state:

1. I am an adult male, 47, an advocate of the High Court of South Africa and the sixth respondent in this application.

2. I am the convener and the national chairman of the Treatment Information Group, the seventh respondent, and it's in this capacity that I make this affidavit with the agreement of my associates.

3. The seventh respondent, to which I'll refer as 'my group', is a voluntary association that I founded in 2002, whose mission is to promote research-based public debate of antiretroviral ('ARV') drug policy, non-toxic treatment approaches to AIDS and HIV testing issues in South Africa.

4. I've been engaged full-time in political work as a researcher, writer, speaker and activist since quitting twenty years of legal practice as a trial lawyer at the end of 2003, variously as prosecutor, district and regional court magistrate, civil magistrate and mostly as an advocate at the Pietermaritzburg bar.

5. At the time this application was launched I worked for the second respondent, but no longer – although my group and I remain strategically allied with it.

6. I've been researching and reviewing the clinical and molecular pharmacology literature on the ARV drugs AZT and nevirapine (and AIDS generally) in depth over the last decade, and have written extensively about them. (By using the expression 'ARV' I do not mean to imply that I accept that these drugs so named have the antiretroviral pharmacological activity that their manufacturers and other champions allege.) My expertise as an autodidact expert in the pharmacology of AZT and nevirapine has been recognized by senior scientists worldwide: My self-published book *Debating AZT: Mbeki and the AIDS drug controversy* (Pietermaritzburg: Open books, 2000) was described by Dr Etienne de Harven MD, Emeritus Professor of Pathology, University of Toronto, Canada as 'excellent … the best, most comprehensive review on AZT currently available'. Dr Harvey Bialy PhD, founding scientific editor of the leading, widely cited scientific journal *Bio/Technology* (now *Nature Biotechnology*)

and scholar in residence at the Institute for Biotechnology, University of Mexico, considered it 'Absolutely spectacular … superb … the definitive refutation.' Dr Peter Duesberg PhD, Professor of Molecular Biology, University of California at Berkeley, US, and member of the National Academy of Sciences of the United States of America, described it as 'superb, extremely well researched, analyzed, written … I could not have done a better job … Are you a scientist or do you collaborate with one? How could you survey so many scientific publications as an attorney? … Could you publish your article or a variant of it in a medical/scientific journal? It would strengthen our case no end, if scientific papers of that quality would come from several sources, not only from Berkeley and Perth.' To a journalist from India he remarked in my presence: 'I still can't believe he wrote that. He's really a molecular biologist pretending to be a lawyer.'

7. From the horse's mouth, however, none other than the inventor of AZT, Dr Richard Beltz PhD, Professor of Biochemistry at Loma Linda University School of Medicine, California, said I was 'justified in sounding a warning against the long-term therapeutic use of AZT, or its use in pregnant women, because of its demonstrated toxicity and side effects. Unfortunately, the devastating effects of AZT emerged only after the final level of experiments was well underway … Your effort is a worthy one. … I hope you succeed in convincing your government not to make AZT available.' I'm glad to report that the foetal toxicity data that I drew to his attention changed his mind about the use of AZT in pregnancy. This is canvassed in an essay I wrote, *Inventing AZT*, in which Professor Beltz related to me how he first synthesized AZT in 1961 as an experimental cell poison. (Annexure 'AB1') Professor Beltz's original emails to me were lost on a computer burgled from my office.

8. South Africa's leading investigative journalist Martin Welz wrote an effusive foreword to *Debating AZT*. His counterpart in England, the late Paul Foot appreciated it equally, telephoning me from London: 'Very good. Convinced me completely.' As did the late Donald Woods: 'Deserves serious treatment. More strength to your arm.'

9. After reading my detailed history and analysis, *The trouble with nevirapine*, on the internet, Dr Jonathan Fishbein MD, formerly

Director of the Office for Policy in Clinical Research Operations, Division of AIDS, US National Institutes of Health, wrote to me praising it as 'an expertly written piece about this very dangerous drug'. Dr Fishbein is the high-ranking official who blew the whistle on the irredeemably corrupt manner in which HIVNET 012 was conducted (i.e. the clinical trial founding the TAC's nevirapine case in the Constitutional Court), and how the serious adverse event data were corruptly suppressed by the director of his division.

10. In recognition of my expertise as a self-trained expert in the subject of ARV pharmacology, I was honoured with a co-authorship credit of a major scientific monograph, *Mother to Child Transmission of HIV and its Prevention with AZT and nevirapine: A Critical Analysis of the Evidence*, a critically important literature review and analysis, to which I'll be referring below.

11. All my completed work has been published on the internet in the public interest, where it can be freely accessed for non-commercial use at my group's internet website www.tig.org.za and on many other websites around the world. Some of it has been translated into Russian, German and French. [*Postscript March 2008: And now also into Spanish, Italian and Dutch.*]

12. In answering the applicants' case, I intend to treat every component aspect of the contemporary virus/chemotherapy AIDS model that they propound in their papers. In performing this exercise I respectfully crave some latitude from this court in being more discursive than would ordinarily be in order in litigation like this. Mentioning just three peer-reviewed published scientific papers in support of their case, the applicants have made a profusion of ex cathedra assertions and unreferenced factual allegations. My answer will necessarily be reasoned as well as factual; and as I radically deconstruct and refute the applicants' case, I propose to make repeated reference to what I consider to be cogent illustrative medical and historical precedents and analogies.

13. Although I support nutritional therapy in AIDS, I claim no special expertise in the subject of nutrition, and while working for the second respondent I was not involved in the micronutrient

supplementation programme that it initiated in poor African communities, which lies at the core of this case. I'm accordingly not placed to give useful direct evidence about it, and so shall not address the applicants' case in this regard.

14. Since the founding papers are very long, I'll generally quote or excerpt the relevant parts of the principal allegations with which I take issue before answering them. This will facilitate reference and make it possible to read this answering affidavit in one pass; and I trust that the assistance and convenience that this approach affords this court will outweigh the small paper increase so generated. My references to numbers after 'Ad' in bold typeface and underlined hereunder are to the serial paragraph numbers in the founding affidavits. In quoted speech or text, I've italicised interpolated explanations in square brackets. I've departed from the rule of practice requiring the presentation of complete documents where the document in question is large but only a line or two is relevant to my case, and where putting up the whole of it would needlessly encumber the record. Time constraints in the preparation of this affidavit have resulted in sometimes uneven numbering of its many annexures, for which I apologise. These are initialled on their first pages only, in view of their size and number, and I respectfully ask that this be condoned.

15. The extraordinarily broad case set up by the first applicant (hereinafter referred to as 'the TAC') is plainly intended to achieve a legal imprimatur on the merits of the medical dogmas around which it fundraises for its multi-million rand salary payroll and political activities, and at the judicial abjuration of any rival redemptive philosophy, approach and practice in the field of public health – all of which, with submission, makes the case redolent of a politico-religious mediaeval heresy prosecution. I accordingly beg some forbearance in the manner in which I answer the TAC's claims and charges, narrowly or broadly as needs be, and in a forthright prose style to suit, since in my estimation the HIV/AIDS paradigm is best understood – beyond being a highly lucrative medical theory based on demonstrable junk science – as an essentially reactionary, authoritarian, sex-negative, neo-colonial socio-political construct, and a prop to racist ideology, fuelled by middle class moral panic. If my tone is found to be somewhat tart, it's because I think the

HIV theory of AIDS and its treatment with ARVs is unbelievably stupid. And after reading this affidavit, I expect this court will heartily agree.

16. I appreciate, however, that like the government's at the highest level, my scepticism for the contemporary AIDS scare sold by the medical industrial complex and its agents, such as the TAC and its supporters in the media, is out of keeping with the ardour of the South African judiciary for this ridiculous bogey, and that my frankness in stating and arguing it bluntly may be unsafe, having regard to former US Supreme Court Justice William Douglas's warning that 'The curious man – the dissenter – the innovator – the one who taunts and teases or makes caricature of our prejudices is often our salvation. Yet throughout history he has been burned or booed, hanged or exiled, imprisoned or tortured, for pricking the bubble of contemporary dogma.' Notwithstanding this, I find myself bound by American political dissident Professor Noam Chomsky's injunction in his essay 'The Responsibility of Intellectuals' to 'speak the truth and expose lies'. The TAC's papers are full of them.

17. Having regard to the orders it seeks, most of the TAC's case is irrelevant to the determination of the essential issues in my view, and hence liable to be struck out or safely ignored in the answering papers. Given the inestimable public importance of the broader issues raised by the TAC, however, I consider it obligatory to refute all the TAC's false claims on the record. The direct relevance of this to the decision of this case is that in the exercise of this court's overarching general discretion to grant the interdicts sought by the TAC, the evidence contained in my affidavit will militate against this, irrespective of whether this court finds the TAC to have made out the case for them that it supposes it has.

18. As I address the TAC's case I'll be asking this court for the issue of several special directives in the public interest, particularly having regard to its role as the upper guardian of our country's minor children, in circumstances where those entrusted with protecting their welfare have shown themselves to be too slack, incompetent or corrupt to carry out their statutory charges.

19. **Ad 7.** I dispute the TAC's presumption to act 'on behalf of the many HIV-positive people who cannot do so in their own name through lack of knowledge or lack of access to legal representation, and in the public interest'. This claim is transparent propaganda, made to engender moral authority and political legitimacy for the TAC's promotion of the pharmaceutical industry's ARVs, and it's at odds with the facts:

20. In truth, the national representative association in this regard is the National Association of People Living with HIV/AIDS (NAPWA).

21. Unlike NAPWA, the TAC is not a representative organization and it does not have a due-paying membership. As its original name the 'AIDS Treatment Action Campaign' indicates, the TAC is a dedicated pharmaceutical drug advocacy organization formed to campaign for the provision in the public health service of certain synthetic chemicals owned under patent by foreign pharmaceutical corporations and marketed as ARVs – in practical terms, to engage in coercive political 'Action' to compel the South African government to do trade with the pharmaceutical industry and spend billions of rand to buy its merchandise, irrespective of and over-riding the informed, adverse policy assessments of our country's democratically elected leadership in regard to the utility of the goods being pressed on it and the merits of this massive expenditure.

22. In this project the TAC has been prodigiously successful, and it can rightly claim full responsibility for the state's allocation on 2 March 2005 of R3.4 billion over three years for the purchase of ARVs from the pharmaceutical industry for provision in the country's public hospitals and clinics. Without the TAC's skilful political campaigning and propagandizing, arm in arm with its local and foreign allies, this squandering of public revenue and enrichment of the pharmaceutical industry would never have occurred, and the enormous public resources so wasted would have been available for social services, social development and other real social needs in the democratic era.

23. Although it publicly positions itself as antagonistic to the pharmaceutical industry, the only trouble that the TAC makes for

it is in harrying it to reduce the prices it charges for its goods – thereby burnishing their reputation – and to yield to the demands of other privately-owned drug companies registered in developing countries to be permitted to produce generic versions of patented drugs (in consideration for which the generic producers in the Developing World remit licence fees to the patent-holding dominant corporations in the First World). The message this sends the public is that the drugs are good, the companies selling them bad. The political climate thus worked up by the TAC makes it politically groovy to knock the pharmaceutical corporations for being greedy but not what they're selling; this is beyond the pale, and so for anyone to point out that a huge corpus of research literature establishes that their products are actually very harmful is to risk getting gunned down in an intense, demonising propaganda campaign from the human rights activists of the TAC, who make their living marketing them. Even if it's the President stating this plain fact, with a reputation for extraordinary assiduity in his approach to the country's policy issues. Or none other than the country's Minister of Health, a physician and public health expert with multiple professional qualifications.

24. In this way the TAC functions as loyal opposition to the pharmaceutical industry, acting as its marketing agent, unceasingly extolling the magnificence of the goods that it produces and sells, talking down their widely acknowledged dangerous defects, and attacking their critics.

25. Politically the TAC operates vis-à-vis the pharmaceutical industry in keeping with a classic tame, controlled opposition model, just as the Bantustan leaders served the apartheid regime, putting up a show of opposition now and then for appearance's sake, but sharing a basic unity of interests and functioning in mutually rewarding symbiosis.

26. For this reason, the TAC functions as an inestimably valuable asset of the pharmaceutical industry, all the more for the pose it strikes, and the general public acceptance in Western countries that it receives, as a progressive, popular organization spawned by 'civil society', rather than as a snow-plough for the pharmaceutical industry's marketing operations.

27. The TAC's virulent propaganda campaigning against our country's democratic leaders in persistently branding them, in effect, *génocidaires* has created a political paradigm justifying interference in our domestic policy making by our elected government and the intrusion into our country of (a) the US government with its $15 billion PEPFAR fund to distribute to compliant local AIDS agencies serving US foreign policy objectives; (b) the UN, bypassing our national government in doling out millions of rand from its Global Fund to ARV-friendly organizations and provincial administrations; and (c) richly endowed foreign foundations, ostensibly on white-knight, philanthropic missions, but in reality serving foreign corporate interests.

28. The TAC commenced its activities as a subcommittee of NAPWA. Following a demonstration of about a dozen people in Cape Town on 15 December 1998 to demand that the government provide AZT to HIV-positive pregnant women, the TAC's founder Zackie Achmat walked out of NAPWA in 1999 over NAPWA's rejection of his assertion of the primacy of providing ARVs over other approaches to the problem of broken health among the African poor. (Though a Doctor of Laws (honoris causa), I'll refer to Achmat by his surname without prefacing it with the honorific 'Dr', since the degree wasn't earned, and it's not conventional to do so in such cases.)

29. On quitting NAPWA, Achmat established his TAC as an independent organization with a core agenda to promote the ARV drugs being touted by the pharmaceutical industry as a safe and effective treatment for AIDS, and to campaign to force the government to buy them.

30. The splendid service that the TAC has rendered as pharmaceutical industry compradors in our country has attracted phenomenal foreign funding, almost doubling every year since the TAC's inception. According to a report it commissioned and posted on its website under the title 'Treatment Action Campaign (TAC) Evaluation 29 June 2005', the TAC currently has what is justifiably described as a 'staggering' operating budget of R38 million this year for marketing the pharmaceutical industry's ARVs to the African poor under the guise of 'treatment literacy', politically drumming the government into accelerating the 'roll-

out' of these drugs in the public health service, and pursuing its other wider political agendas and programmes. An excerpt of the report is annexed marked 'AB2'.

31. The same report states that the TAC's drug 'marketing' campaign in the newspapers has cost it nothing: 'TAC has developed an excellent national press strategy and profile. At no additional cost, the organisation has been able to secure regular space and retain its profile … with the organisation relying almost exclusively on the media for its marketing.' (Annexure 'AB2A') These observations are undoubtedly true; and the TAC has the local and international media on its side as its mouthpiece as completely as the apartheid government had the SABC.

32. Occasionally the TAC buys 'space' in the 'press' for the 'marketing' of the pharmaceutical industry's drugs on its behalf. On 1 April 2005, for example, the TAC paid the *Mail&Guardian* about twenty thousand rand (the going rate) for a full-page colour advertisement for AZT and nevirapine (annexure 'AB3'). Both were proprietary drugs at the time, owned under patent by GlaxoSmithKline ('GSK') and Boehringer Ingelheim respectively (GSK's patent over AZT expired on 17 September 2005), so these companies were the direct commercial beneficiaries of the TAC's third party marketing of their products. Obviously the fact that the TAC identified the drugs by their chemical and generic names (AZT and nevirapine) and not their proprietary brand names (Retrovir and Viramune) made no difference to the patent-holders, who were certainly most gratified by the TAC's punting of their wares.

33. The TAC's most recent service to the pharmaceutical industry has been to lend its assistance to Gilead Sciences and Aspen Pharmacare to push the ARV drug tenofovir through the Medicines Control Council's approval process in order to speed its delivery to market in South Africa. (Annexures 'AB3A' and 'AB3AA')

34. Big Tobacco would be delighted to have opponents like these, a Smoking Action Campaign ('SAC') promoting smoking as being the key to a sexy persona and pleasure in life (annexure 'AB3B') and scientifically proven safe (annexure 'AB3C'), for which service the SAC takes the highly principled stand not to accept

Big Tobacco funding, but it gladly takes millions from foreign corporate philanthropies, the political arm of capital. Not only does the SAC promote smoking, and in extravagant terms that not even Big Tobacco can legally get away with, it also coerces the government to buy cigarettes for free provision to the poor, so they can be sexy and safely enjoy themselves too. The SAC attacks anyone in government or outside it, who points out that Big Tobacco's claims in its advertising are fake, and that smoking is actually an unhealthy thing to do. The SAC does criticise Big Tobacco on one score, though, namely for charging too much for its excellent cigarettes and putting them out of reach of the poor, and it urges it to allow locally registered corporations to make its cigarettes too, so that more people can smoke more affordably. The SAC then protests indignantly and rushes off to court to get an interdict when identified as Big Tobacco's running dog, a Trojan horse for foreign interests, a front for the cigarette companies.

35. Subsequent to the TAC's first public demand in 1998 that the government provide AZT to pregnant women, numerous further research findings have been published in the medical and scientific literature reporting the grave harm that it causes babies exposed to the drug in utero and after birth. An exhaustive review of the literature that I performed for the MCC in this regard is annexed marked 'AB4'; with some key citations and excerpts listed in annexure 'AB5'. Notwithstanding this, the TAC remains committed to its original mission: the country-wide administration of AZT to pregnant women and their newborn babies, mostly African, mostly poor, as reflected in a formal resolution at its national congress on 25 September 2005 that 'Government must introduce … the better AZT and nevirapine regimen …for pregnant women [in place of] the single-dose nevirapine regimen currently in use throughout most of the country.' (Paraphrased by the TAC in its magazine, *Equal Treatment*, December 2005, annexure 'AB5A')

36. The TAC has a hostile relationship with NAPWA and has repeatedly endeavoured to destroy the organization as a rival voice in the policy controversies concerning the government's provision of ARVs. One of its most effective stratagems has been to choke off NAPWA's financial support with publicly levelled

accusations of financial corruption, which, although never established on full investigation, have succeeded in causing the intended credibility damage in the form of funding drying up. Unlike the TAC, NAPWA recognizes natural and indigenous schools of medicine as legitimate and effective therapeutic options as an alternative to patented, factory-produced, commodity-based allopathic medicine for the treatment of AIDS.

37. Whatever the risibly naive personal convictions of the TAC's leaders about in whose interests they act, on any objective appraisal, as will appear more fully hereunder, the TAC plainly does not serve 'the public interest', by which it presumably means the poor African majority in South Africa; instead, the TAC serves capital, and specifically the investment groups earning dividends on their shareholdings in the leviathan foreign and local pharmaceutical industry, generated by its immense profits on trade – with sales last year of $602 billion, according to the pharmaceutical market analyst corporation IMS Health (per current report on its website).

38. In this regard, it's manifest from the TAC's public statements and publications over the years that its leaders have been successfully gulled by the multi-billion dollar marketing campaigns of the drug industry: broadly, that pharmaceutical drugs deliver 'healthcare', that the industry is 'committed' to providing this, and that ARVs particularly are 'life-saving'; and not only do the TAC's leaders implicitly and unquestioningly believe this fraudulent sales propaganda concerning the marketed benefits of ingesting ARV drugs, recycled and amplified by uncritical journalists and rote-trained doctors, they also bridle (evidenced by this application) at any suggestion that the drugs might be defective in regard to either their safety or their efficacy – that they are not life-saving, but in reality therapeutically useless, dangerously toxic and frequently lethal.

39. Concerning the TAC's assertion that 'The HIV/AIDS pandemic is a major public health crisis in South Africa', I agree that the economically marginalised rural and peri-urban poor in South Africa suffer a high incidence of disease. I deny, however, in the absence of any evidence for this, that that the well-fed and well-housed classes are suffering the same sort of disease burden. I further deny that there's any evidence of any significant sudden

change in the pattern of disease in this country over the last two decades that isn't parsimoniously and adequately explicable in terms of the deprived social and economic conditions of the African majority and other coloured peoples.

40. I further deny that there's any evidence of a new sexually-transmitted infectious disease pandemic racing through the suburban bourgeoisie and economic elites in South Africa, whatever their ethnic origins, but mostly white. In other words I deny the TAC's assertion to the extent that it's freighted with the implication that there's a raging pandemic of infectious immune deficiency afoot in South Africa affecting all colours and classes because people are having unsafe sex with multiple partners without protective condoms, due to a sexually transmitted virus passing between their genitals (but not their lips) that gradually destroys the immune system, leading, about a decade after infection, to the advent of any one of about thirty primordial diseases and malignancies, which these days are incurable, although not before, if the patient is HIV-positive, and which now always lead inexorably to an early death; and that people are keeling over from these AIDS-defining diseases in South Africa at a much higher rate than they used to since before the HIV/AIDS hypothesis was cooked up in the US in the early eighties to account for the poor health of a particular subset of inner-city homosexuals in Los Angeles, San Francisco and New York.

41. I hold the considered view that the high disease burden of the African poor – presenting in a wide range of drearily familiar, classical illnesses – has nothing to do with their allegedly indiscriminate, irresponsible and extreme sexual profligacy, said to be spreading a deadly virus; but rather that it's the natural consequence of their widespread poverty, resulting in chronic malnourishment and consequent broken health, and that this is caused by the structural political, economic and social conditions that are the well-entrenched, persisting legacy of centuries of colonialism and apartheid, during which African people lost their lands.

42. I admit, however, that HIV is extremely infectious – as a contagious idea, particularly among susceptible whites and other non-African people, who think of African men as heartless sexual

predators and of African women as powerless and abused sexual victims, which is to say that in their intimate relationships Africans are different, because they're less human. President Mbeki alludes to this sort of thinking, citing examples, in his 'Letter from the President' in *ANC Today* Volume 4, No. 39. 1-7 October 2004. (Excerpts, annexure 'AB5B') This is major reason why the AIDS craze is so big in South Africa as an immediate successor to apartheid ideology among the largely unchanged dominant classes: it provides a substitute reason – since the threatened bloodbath never happened – to fear and abhor the native and continue confining him behind the bitter almond hedge. And it's huge among perennially racially patronising neoconservative South African white liberals, including white liberal lawyers, as is evident from the prominence of the African AIDS construct in the neoconservative liberal media as grist for morally agitated editorializing, news and feature articles, and cartoons, all of which routinely insult our country's democratic leadership in the most demeaning way, frequently drawing on vicious racial stereotypes. But which are very popular all the same, sell newspapers galore and get reprinted in the TAC's glossy propaganda publications distributed free at Exclusive Books to amuse the leisured, mostly white elites.

43. **Ad 24.** I deny that that it has ever been shown in any properly conducted clinical trial that the ingestion of ARVs, solo or in combination, make sick people better. It's abundantly established, on the other hand, that these drugs make people very sick. The TAC cites a single review study (by Jordan et al.) in support of its proposition that 'AIDS can be effectively treated with … ARVs'. However, I'll be showing below that the study was useless and that its conclusions are worthless. I'll be dealing with all these issues in depth below.

44. Apropos of the TAC's assertion 'ARVs are not the only means of dealing with HIV, but they are an essential element of any effective treatment programme', I dispute this proposition as a scientific fact rather than a political plank, because it's unsupported by any clinical evidence. That is to say I deny that there's any support in the medical literature for the contention that a person diagnosed HIV-positive will fall sick and die of an AIDS-defining illness unless he or she swallows certain synthetic

chemicals owned under patent and sold by Western pharmaceutical corporations, as the TAC suggests. I further deny that only the toxic chemotherapies that these corporations manufacture and sell can keep an HIV-positive person healthy or restore his or her health when sick, any more than deadly arsenic compounds were 'an essential element of any effective treatment programme' for 'syphilis' diagnoses in the first half of the 20th century. Which, in the view of all the most eminent medical authorities, they were. I'll revert to this aspect.

45. **Ad 29.** In support of its case that South Africa has a national health emergency on its hands, TAC quotes from the Constitutional Court judgment in the nevirapine case: 'The HIV/AIDS pandemic in South Africa has been described as "an incomprehensible calamity" and "the most important challenge facing South Africa since the birth of our new democracy" and government's fight against "this scourge" as "a top priority". It "has claimed millions of lives, inflicting pain and grief, causing fear and uncertainty, and threatening the economy". These are not the words of alarmists but are taken from a Department of Health publication in 2000 and a ministerial foreword to an earlier departmental publication.' With all due respect to the justices of the Constitutional Court, the TAC's citation of this passage from its judgment in the nevirapine case is perfectly irrelevant and has no probative value in this case whatsoever:

46. In the first instance it's trite that the opinion of a court expressed in a judgment is merely that and nothing more; in the second, the dramatic scary scenario painted in the judgment was taken as a given in the case without the truth of it ever being tested at trial; in the third, the alarmist government statements quoted with approval by the learned justices were made before the leadership of our government began questioning the integrity of these gripping Malthusian fantasies around the turn of the millennium in 2000, and certainly, President Mbeki, once a believing subscriber completely taken in by all the panic, indeed the energetic condom promoting, AIDS ribbon sporting architect of AIDS policy during the Mandela presidency, is now an entirely lapsed sceptic, as evidenced by his studied silence about or lip service to these marvellous concepts in his public pronouncements since then (his scepticism for all the fuss again

recently reported in the newspapers on 26 February 2006: annexure 'AB6'; his irksome silence about it on 2 May: annexure 'AB6A'); in the fourth, it's a commonplace, based on ample past and present experience, that for all their knowledge of the law even the highest judges are generally no more or less wise or foolish, rational or irrational, superstitious or sceptical, silly or sensible, hysterical or sober, bright or dim than the lay people whose case they try – Achmat for example – as recently evidenced again by the appalling professional misjudgement of 51 judges of this Division accepting the largesse of a notoriously disreputable insurance company by attending a lavish 'free lunch' costing a reported R460 a head, thrown for them and their partners. Judges are no less prone than ordinary people to believe and follow the most absurd dogmas and social rules of major religions, and kneel in temples decorated with barbarous, repugnantly gruesome iconography; belong to secret societies with bizarre rituals and tenets carrying out narrowly sectarian, self-serving, anti-social agendas; support racist and fascist political parties in power practising criminal domestic and foreign policies; make disastrous personal judgments in picking horrible spouses; and so on.

47. Judges also invariably think within the intellectual paradigms reigning in any given time, hence the two-hour long opinion of US Supreme Court Chief Justice Roger Brook Taney in Scott vs. Sandford in 1857, supported by a majority of his brethren 7-2, delivered after ponderous ratiocination within the Western worldview then regnant, that people of African descent are 'beings of an inferior order, and altogether unfit to associate with the white race, either in social or political relations, and so far inferior that they had no rights which the white man was bound to respect'.

48. And while essentially the same racist, white supremacist ideology was officially normal in South Africa, the then Judge President of the Eastern Cape Provincial Division, Van der Riet AJP, affirmed in S v Xhego 1964 (1) P.H. that Africans are congenitally dim-witted, mendacious and inferior to whites, noting that 'Had the evidence [of torture] been given by Europeans it might well have prevailed … But the native, in giving evidence, is so prone to exaggeration that it is often impossible to distinguish the truth

from fiction. … There are … other factors which militate strongly against the acceptance of the allegations of the accused, again resulting largely from the inherent foolishness of the Bantu character.'

49. More recently, Chief Justice Rumpf, at the very pinnacle of the country's judicial ranks at the time, commented consonantly with the racist foundations of apartheid ideology in S v Augustine 1980 SA (1) 503 (A) that (I translate from Afrikaans) 'Apparently the advocate for the defence and the trial court haven't yet found out that that Coloureds and Blacks will actually stab people sometimes without any reason, other than apparently for the fun of it (*steeklus*).' The rest of the Appellate Division bench unanimously concurred with this penetrating insight into the character of the lower orders.

50. The country's top court likewise unanimously approved apartheid – defined as a crime by the UN General Assembly in 1973 and the International Criminal Court in 2002 – in Minister of the Interior v Lockat and others 1961 (2) SA 587 (A), describing it as a 'colossal social experiment and long term policy', with ethnic cleansing in the form of 'compulsory population shifts of persons occupying certain areas' held perfectly acceptable within the legal and social norms then extant among those in power.

51. Nor are judges any less susceptible than the general public to being swept up in mass hysterical delusional enthusiasms. Sounding remarkably like the Constitutional Court justices quoted by the TAC, Lord Chief Justice Anderson anxiously warned in England in 1602 that 'The land is full of witches. They abound in all places. [Without prompt, firm measures against them, they will] in short time overrun the whole land.' (Cited in Oxford historian Professor Keith Thomas's extensive history, *Religion and the Decline of Magic*, London: Penguin Books, 1991.)

52. For centuries in the West, all judges, along with the general public, including all men of learning, once thought, without any evidence whatsoever, that taking a needle or thorn and hatefully pricking a doll-sized 'picture' of clay or wax made in the likeness of a person you disliked could cause that person to sicken and die or go lame or 'waste and consume' or have a stroke or go mad by the work of a malevolent, invisible force several months later. Of

course were this proposition to be made in court today, any judge hearing it would ask counsel and his client whether they weren't lunatics, if not clutch his sides and fall about laughing. Nowadays, however, all judges as far as I know, along with the general newspaper-reading public, including most men of learning, think, without any evidence whatsoever, that fondly pricking a woman you like, for real and not in effigy, without a permit from a magistrate or a priest, especially if she's African according to the Human Sciences Research Council (particulars below), can cause you to get sick and die from any one of a couple of dozen disparate medical causes by the work of a malevolent, invisible virus several years later – no joke.

53. But luckily you needn't worry about getting cancer of the testicles or leprosy or dandruff or emphysema or mumps or cholera or foot fungus or measles or dysentery or breaking out in warts or having an annoying itching, dripping member in about ten years time from enjoying the intimate company of this woman *au naturel*. American AIDS experts have drawn a list, to which they add every now and then, of about thirty arbitrary illnesses and malignancies that they say having the HI virus in you inevitably leads to about a decade after you catch it (although they can't tell you which one; you just have to wait and see), and the just-listed complaints aren't on it. But knowing this woman can certainly drive you mad eventually, according to these Americans; dementia ('HIV encephalopathy') is on their list.

54. Thousands of innocents were tried and condemned to death by criminal court judges in Europe and the British Isles for the statutory offence of practising the devilish art of witchcraft, a judicial fashion peaking in the 17th century – a popular mania also shared by the judiciary in New England at its very intellectual centre, Massachusetts (Harvard had already been established), where, of 150 arrested and imprisoned, Chief Justice Stoughton and his brothers convicted 26 and hanged 19 for witchcraft at Salem in 1692, before the show was stopped by the government, on the basis of invisible 'spectral evidence': the mere say so of approximately 60 complainants that they had been invisibly afflicted by the sort of devilry of the accused described above (six of whom actually died in the terrified conviction they'd been

hexed). (*The Witches of Salem: A Documentary Narrative* ed. Roger Thompson (The London Folio Society, 1982.)

55. It's universally accepted today (indeed within a few years of the trial) that these judges were totally deluded, along with everyone else caught up in the madness at the time – although they all considered it all highly scientific then, and not mere hysterical superstition: many authoritative tomes, on which judges relied, detailed the hard facts of it, such as Reginald Scot's *Discoverie of Witches* (1584), James I's *Demonologie* (1597), and the encyclopaedic *Hammer of Evil* (*Malleus Maleficarum*) (1486) by the Dominican inquisitors Heinrich Kramer and Jacob Springer. Even though at its core the whole system had no substance. And notwithstanding which, a huge body of learning was built up and enormous power aggregated around it.

56. As it does now concerning its plentiful apartheid-supporting judgments, I venture that in time to come the South African judiciary will look back in cringing embarrassment at its once fervent participation in the characteristically Christian, Western *fin de siècle* delusion (based on an ancient European horror of tainted blood and poisoned semen), invented in the US at the height of the right-wing cultural backlash in that country against the sexually permissive trends of the sixties (heterosexual) and seventies (homosexual), that carnal conversation unapproved by the authorities can strike you down with a mortal disease several years later, from a smorgasbord of about 30 entirely unrelated possibilities ranging from pulmonary tuberculosis to invasive cervical cancer and so on; but that swallowing cell poisons every day can maybe delay your inevitable early end by a few years; and that a mother can make her baby sick and die by nurturing it during gestation and then giving birth to it naturally down the usual channel and likewise breastfeeding it with the best nutrition nature has to offer, thereby afflicting it with an invisible deadly germ, but that a single magic bullet (a German superstition of mediaeval vintage) administered to the mother during labour and to the baby after birth, comprising an exceptionally toxic chemical, nevirapine, owned by the German pharmaceutical corporation Boehringer Ingelheim, and dumped in the Developing World to be given away free as a marketing stratagem, being a treatment flop and a disappointing seller in the West, has special

protective power from this dreadful fate, even though for nine months while sharing its mother's vital fluids the baby had all the time in the world to become incurably infected. Particularly considering that there's no evidence for any of these fabulous conceptions that bears intelligent scrutiny, as I'll detail in due course. And considering further that the single clinical trial upon which the entire nevirapine case was based has since been rejected as corrupt and worthless by our Medicines Control Council taking the lead of the US Food and Drug Administration ('FDA'), which information about the clinical trial was made known to the Constitutional Court by the third respondent, Professor Sam Mhlongo, in a detailed urgent application that I drew for him to be heard as an amicus curiae telling these things, which was dismissed so as not to hold up the hearing, since there were lives to be saved and the court's business was accordingly pressing. So that there exists no basis for the continued registration of nevirapine in our country as a perinatal anti-HIV prophylactic in the form of any randomized, placebo-controlled, double-blind clinical trial acceptable by First World standards, much less any reason to expose babies under judicial mandate, mostly African, to the severe toxicity of this drug, which is accordingly not licensed for giving babies by any drug regulatory authority in any First World country, precisely because it's not considered safe and effective for doping blue-eyed, fair-skinned babies in those places.

57. In a judgment just delivered – on 3 March – three judges of this Division (all non-African) signified their enthrallment in the contemporary delusion by noting, not how appalled they are by the continuing extent of widespread poverty, malnutrition and consequent disease among the African majority and other coloured people in our country more than a decade after liberation, but how frightened they are by 'the scale of the pandemic [of invariably fatal sexually transmitted infectious disease] and its frighteningly severe consequences'. It's certain that the frightened judges weren't referring to any 'pandemic' slaying their colleagues, friends, wives and children in heaps – because there isn't any to be seen among them – but to the diseases of the mostly African poor. The first two and last pages of the unreported judgment in Case No. 2807/05 are annexed marked 'AB7'.

58. It would seem that the entire Supreme Court of Appeal bench labours under the same fantastic apprehensions: Cameron JA, who, like Achmat, also believes he's permanently inhabited by a deadly sex-virus, and is forever babbling about it whenever given the chance (attacking the government too), announced on SABC national radio on 18 April 2003: 'I have the support of my colleagues on the Appeal Court.' (In bravely bearing what he claims to be his special sexually-acquired disease that he got from an injudicious one night stand.)

59. Earlier this year, South Africa's Chief Justice Pius Langa reaffirmed his faith in the canards of AIDS orthodoxy, approved unanimously by his brethren in the nevirapine case in 2002, in his 'Keynote Address' delivered at the HIV and Access to Legal Services Conference at the University of the Witwatersrand on 17-18 February 2006, hosted by the TAC's de facto legal wing, the AIDS Law Project (the organizations share top officers Mark Heywood and Jonathan Berger) and other groups. The whole of his Lordship's speech is posted for propaganda purposes at the top of the TAC's webpage (to show who's side, between the believers and the doubters, the Chief Justice is on); I annex, marked 'AB8', the relevant opening lines only. Though African himself, the Chief Justice evidently still subscribes to the fancies of a white American originated worldview and perception of Africa, its people and the causes of its health problems that were initially adopted wholesale and then seen through and abandoned years ago by the revolutionary intellectuals leading our country's governing party. And by several top officials in the health sector, who, I am aware, feign acceptance of the HIV/AIDS system for reasons of expediency only, like Jewish *conversos* in Spain during the Inquisition, pretending for safety's sake to believe the claims of the Christian religion.

60. More recently, in Costa Gazidis v the Minister of Public Services and Administration and others (Case No: 25519/01), in a judgment of the full bench of the Transvaal Provincial Division given on 24 March, Bertelsman J wrote, apparently following a pointed, morally inflamed question from the bench, that 'Counsel for the respondents conceded that the decision not to supply AZT to HIV-positive mothers amounted to a conscious, deliberate and informed policy to sacrifice the life of babies that would contract

HIV/AIDS because their mothers were not treated with AZT, in order to save the expense that would have had to be incurred if AZT was to be supplied to mothers suffering from the infection who were on the verge of giving birth. … It is hardly surprising that some members of the medical profession and of the public at large would describe this policy as a murderous one.' (Excerpts from the yet unreported judgment in an AIDS Law Project press release, annexure 'AB9') As I'll detail below, there's no evidence whatsoever that AZT saves babies' lives; contrariwise, there's plenty that it gravely harms and in some cases kills them.

61. The same sort of fevered imaginings about murderous, callous African politicians sacrificing innocent little babies doomed to die by denying them an inexpensive, miraculous, life-saving Western potion equally troubled Constitutional Court Justice Albert Sachs: During the argument of the government's appeal against the grant of an order for immediate execution of the mandamus won by the TAC against it for the provision of nevirapine to pregnant women and their newborn babies country-wide, he reportedly asked the government's counsel, 'What one is asking for is a generation of mothers [sic: babies] to be sacrificed in the name of scientific planning. Isn't that asking too much?' Enchanted by the selfsame set of thrilling morbid beliefs, then Chief Justice Arthur Chaskalson reportedly set the downward slope of the main appeal by commencing to ask the government's counsel whether he agreed that the case was 'a matter of life and death'. In reality, there's no evidence whatsoever for the founding premise of the case, expressed in the judgment, that babies born to HIV-positive mothers who are dosed with nevirapine live, and that those that aren't will almost certainly die – and extremely painfully so too: 'The prospects of the child surviving if infected are so slim … the nature of the suffering so grave'. In fact there's no evidence whatsoever that exposing babies to nevirapine has any clinical benefits for them at all. On the contrary, there's substantial evidence that it is harmful, detailed below. (The source of the dreadfully suffering AIDS babies fiction was the overheated journalism of the *Mail&Guardian*: annexure 'AB9A'.)

62. Acquitting Mr Jacob Zuma of rape on 8 May, van der Merwe J of the Transvaal Provincial Division pronounced to the country watching on television that 'It is inexcusable and totally

unacceptable to have unprotected sex with someone who … has HIV.' What the relevance of this pontification was to the case he was trying is anyone's guess; but what the facts clearly reveal is that unlike the judge Mr Zuma isn't really a believer – even as he threw a bone to the morally frenzied AIDS activists afterwards: 'I should have known better and acted with greater responsibility. I erred on this issue and on this I apologize.' But this statement only underscored that he doesn't really think you can get a terrible disease and die on some future date from a sexual encounter with an attractive and eager young woman who's not your wife. Even if she's a bit dilly.

63. In sum, in the democratic era in South Africa it's no longer officially normal to consider that Africans are naturally stupid, dishonest, violent and inferior to whites, and so can quite properly be trucked off into remote, arid ghettoes after their entire villages and urban quarters have been bulldozed; but it remains normal in the bastions of unelected, unrepresentative power in our country to consider them sexually debauched, copulating indiscriminately and unemotionally, with the result that they have brought a plague of deadly sexually transmitted disease upon themselves and their children (the Biblical reward, for their illicit private conduct, of a sprinkling of mostly non-African homosexuals too); and so they should always keep their privates wrapped during their intimate moments lest they spread this frightful, imagined plague around among themselves even further.

64. This is notwithstanding the predictable findings of numerous research investigations, as Gisselquist et al. pointed out in an editorial in the Royal Society of Medicine's *International Journal of STD and AIDS*. 2002 Oct;13(10):657-66, that 'Studies of sexual behavior do not show as much partner change in Africa as modelers have assumed, nor do they show differences in heterosexual behavior between Africa and Europe that could explain major differences in epidemic growth.' And likewise, Brewer et al. reported in their paper, 'Mounting anomalies in the epidemiology of HIV in Africa: cry the beloved paradigm', in the same journal (2003 Mar;14(3):144-7): 'Levels of sexual activity reported in a dozen general population surveys in Africa are comparable to those reported elsewhere, especially in North America and Europe.' (I'll not burden the record with these

papers (which posit a tangential iatrogenic hypothesis), but shall make them available to this court on request.)

65. The meta-narrative of AIDS ideology – that unapproved intimacy will inexorably be punished with death – derives from the religious sexual codes of Western Judeo-Christian culture and is consequently entirely alien to African thinking, but it thrives among non-African South Africans, particularly whites, with a long history of 'othering' Africans as a necessary psychological precursor to their prejudicial and oppressive social and political relations with them.

66. The racist view of Africans underpinning the African AIDS construct and the public discourse about it is usually inarticulate and implied, but it's sometimes express: South Africa's top academic AIDS expert, Professor Hoosen 'Jerry' Coovadia, and leading AIDS activists, Achmat and Cameron JA (all of them non-African), have all been shamelessly explicit. I quote these gentlemen, and mention the same sort of thinking about Africans exhibited by the like-minded President of the US, George W Bush, Vice President Dick Cheney and fellow Republican, Representative Mike Pence, in a letter I wrote to the CEO of the Human Sciences Research Council, Dr Olive Shisana, in January, annexed marked 'AB10'. Pungently identifying and ventilating these usually occult thinking currents among non-African AIDS enthusiasts, I further quote President Mbeki in my letter, who is keenly alive to the racist burden of much of the discourse about AIDS in Africa, carried on for the most part by non-Africans.

67. **Ad 25.5.** I confirm that my group and I are opposed to the marketing and administration of ARV drugs as a treatment for AIDS, and that we've publicly campaigned against their use. The reason for this is that they are both ineffective and very harmful to health, not infrequently lethally so. I further confirm that we intend continuing with our information campaign, subject to any order this court might make. And as our name suggests, our preferred mode of work is the dissemination to policy makers and shapers carefully researched hard information about these drugs reported in the medical and scientific literature that one never reads about in the newspapers or hears about on TV, rather than marching in the streets, conducting mass propaganda campaigns and obstructing government business with sit-ins and the like to

help drug companies sell their useless and poisonous drugs to the government as the TAC does.

68. I deny that we've made any 'false statements' about these drugs. Our statements accord with President Mbeki's warning to the people of South Africa, issued in the second chamber of Parliament, the National Council of Provinces, on 28 October 1999. On a conspectus of the peer-reviewed research literature on AZT published to date, which I'd redacted and sent up to government a few months earlier, President Mbeki correctly pointed out that 'There … exists a large volume of scientific literature alleging that, among other things, the toxicity of this drug is such that it is in fact a danger to health. These are matters of great concern to the Government as it would be irresponsible for us not to heed the dire warnings which medical researchers have been making.'

69. And in a letter to Democratic Alliance leader Tony Leon on 1 July 2000 – part of an exchange of correspondence subsequently released to and published in the media – President Mbeki warned similarly, and quite correctly: 'In your letter to me of June 19, you make the extraordinary statement that AZT boosts the immune system. Not even the manufacturer of this drug makes this profoundly unscientific claim. The reality is the precise opposite of what you say, this being that AZT is immuno-suppressive. Contrary to the claims you make in promotion of AZT, all responsible medical authorities repeatedly issue serious warnings about the toxicity of antiretroviral drugs, which include AZT.' This lesson by the President for the ignorant Leader of the Opposition is archived by the *Sunday Times* on the internet at: http://www.suntimes.co.za/2000/07/09/news/news13.htm

70. The usual mainstay of ARV treatment is AZT or chemical compounds closely similar in the nucleoside analogue class, such as 3TC, d4T, ddI and ddC, all of which the TAC promotes as life-saving – although it currently appears to be developing cold feet about d4T, which Achmat believes crippled and disabled him within just months of his starting it in September 2003. (I'll revert to this.) President Mbeki's warnings about the toxicity of AZT – as well as those of National Health Minister Dr Tshabalala-Msimang in Parliament and in other fora – accordingly apply to these other drugs equally.

71. My review of the toxicity literature on AZT that I sent government was later published in expanded form, including subsequently published severe toxicity reports, as a book: *Debating AZT: Mbeki and the AIDS drug controversy*. It can be accessed free on my group's internet website www.tig.org.za and on numerous other websites around the world, and is stocked by public libraries all over the country. I'll make a copy available to this court on request.

72. To the extent that the TAC's allegation that ARV drugs are 'an essential element of an effective treatment programme' is intended to be a statement of fact rather than a flourish of political propaganda, I deny it. If by this statement the TAC means to allege that HIV-positive and/or AIDS patients are inexorably doomed to an early demise unless they take ARV drugs, I deny that there exists any evidence for this proposition in the form of any duly conducted and completed, randomized, placebo-controlled, double-blind clinical drug trial for any ARV drug. In short, the allegation is false.

73. I deny the TAC's suggestion that the my group and I are contravening any law in calling public attention to the severe toxicity of ARV drugs, their inefficacy, and the fact that they induce disease in healthy people and worsen disease among the sick. There's abundant published research data supporting this, to which I'll refer below.

74. **Ad 30.** In truth, the only 'treatment for all people with HIV/AIDS' that the TAC campaigns for is chemotherapy, manufactured and marketed by pharmaceutical corporations. This is because the TAC, so to say, has bought the propaganda of this industry and its ancillary supporters among medical professionals, academics and journalists that the only proper, effective and legitimate treatment of 'immune deficiency' diseases is with synthetic chemotherapeutic drugs. It's the TAC's dogmatic view that at best any other treatment approach may be adjunct to, but never in place of the patented goods hawked by the pharmaceutical industry.

75. **Ad 31-32.** A brief look at the TAC's financial statements will dispel the fake impression created in these paragraphs that the TAC is a genuine popular grassroots organization, spawned and

supported by 'civil society'. Nearly all of its massive funding derives from foreign sources and organizations based in major pharmaceutical drug producing countries. (Excerpt from 2005 financial statement, annexure 'AB10A') It's elementary in politics that sacks of cash can transform seemingly ridiculous marginal groups led by hysterical, shouting, gesticulating, aggressive, uncouth, untutored boors espousing simplistic, reductionist, narrow causes for alleged social ills and claiming the exclusive route to national deliverance from them (benefiting capitalist enterprises), and always denouncing, accusing, threatening, vilifying and belittling their opponents, into formidable undemocratic political forces. Four hundred thousand Marks given the Nazis by the giant pharmaceutical and chemical cartel IG Farben in 1932 paid for the election propaganda campaign that propelled Hitler into power the following year (Joseph Borkin, *The Crime and Punishment of IG Farben*, New York: Free Press, 1978).

76. It's the millions in foreign funding that has enabled the TAC to build the enormous nation-wide political machine, of which it boasts, for the prosecution of the pharmaceutical industry's commercial agenda to get its commodities sold in our country and for the conduct of its propaganda campaign to subvert the local and international standing of our country's democratic leaders. (For obvious reasons, it's a serious crime in the US for politicians and political parties to take money from foreign sources, but the TAC's not hampered by any such legal impediment to doing this here, even as it openly acts in the interests of alien corporate and geopolitical interests.)

77. It's unsurprising that such an extraordinarily wealthy organization should attract mostly African 'volunteers … in the poorest communities', who would otherwise be unemployed and on the edge of starvation. It's a conventional route to employment in the international NGO sector to perform voluntary work as a way of eventually securing paid work by these organizations; and the TAC abusively cashes in on such hopes among the African poor to get its drug business done by these people without paying them for it, even though it's rich.

78. The apparent enthusiasm of the African poor for the pharmaceutical industry's ARV drugs, on display for television

cameras at centrally planned and well coordinated street demonstrations herded by young white marshals on the perimeters (I've seen this), is not natural, and it can't be. In the first place, swallowing toxic, synthetic, factory-produced Western drugs to kill germs is foreign and inimical to African healing tradition, which has no concept of nor need for germ theory, nor of antibiotics of any sort; and in the second, none of these 'volunteers' has the first notion of what these chemicals that they're marching for actually are. None of them have studied the toxic pharmacology literature on ARVs (indicating that they are all cytotoxins); and none would be able to give an account of the critical nucleoside analogue triphosphorylation bottleneck problem (in relation to AZT, 3TC, d4T, ddI and ddC), which takes some considerable study to understand (as President Mbeki does, having twice been quoted in the media referring to it). Indeed, even at the level of its leadership, Achmat is clueless about these issues, having declaimed to the nation in an interview in *Rapport* on 10 February 2002 (I translate from Afrikaans): 'With great honesty the TAC has always tried to understand medical science. And this is something with which all South Africans have always struggled. We are scientifically illiterate.' Indeed, it's always perfectly obvious.

79. Unlike the overwhelmingly supported political tendency in our country, the African National Congress, the voice of the country's majority, none of the TAC's driving political energy in forcing national health policy is authentically African. I believe the author of the main founding affidavit and Achmat's current general office factotum, Nathan Geffen, is an English immigrant – as is Achmat's other white subaltern, Mark Heywood. Despite any show of democracy within its ranks, like Mangosothu Buthelezi's Inkatha Freedom Party, the TAC is essentially a cult-of-personality one-man-band practically owned and completely controlled by Achmat, its founder and leader. The Africans hired by the TAC to give colour to its administration are conspicuously mere ciphers echoing their master's voice, with the letters sent out in their name seemingly ghost-written for them. Achmat and his white lieutenants' racial tokenism is revealed in an article in *City Press* on 23 April 2006, which describes how they witlessly stepped into and were caught in a trap set to expose them for this. (Annexure 'AB10AA)

80. The indissociable identity of leader and party was underscored in a piece of absurd theatre by the latter's resolution in mid-2003 that the former must start taking his medicines, with Achmat making a show of meekly subordinating to the democratic will of his party (and publicly reversing his refusal to take ARVs – on the basis, he'd been alleging, to great political and financial advantage, of high moral principle).

81. **Ad 35.** Since Achmat (along with the leaders and members of his organization) is a scientifically challenged person on his own version, his appointment in 2004 to the WHO's 'HIV Strategic and Technical Committee' is a revealing indication of the extent to which the WHO has become essentially the executive arm of pharmaceutical corporations in the industrialized countries that dominate the WHO and set its medical ideology (allopathic: synthetic, patented drug-based). That the WHO, ably assisted by the said Achmat, operates primarily to serve the commercial interests of the pharmaceutical industry is vividly illustrated by its 'WHO Model List (Revised March 2005)' of 'Essential Medicines … a list of minimum medicine needs for a basic health care system':

82. Apart from a couple of essential micronutrients at the very bottom of the list, all these so-called 'Essential Medicines' are artificially-synthesized chemicals, alien and disruptive to human metabolism, owned under patent by pharmaceutical corporations, and produced as factory-manufactured commodities for sale at immense profit relative to other commercially traded goods; and the claim 'minimum medicine needs' ipso facto implies that any country that doesn't buy them has serious public health problems, current or in store. The further implication is that other medicinal/healing modalities that spring from irreconcilably and entirely distinct, ancient, indigenous health paradigms are useless or second rate. Predictably, the WHO's list of 'Essential Medicines' includes AZT and nevirapine, along with a shopping list of other exceptionally toxic synthetic chemicals that the pharmaceutical industry makes and sells as treatments for AIDS. To limit the record, I annex a relevant excerpt only, annexure 'AB10B'.

83. The WHO is now openly enmeshed in drug company business in the form of numerous 'partnership' agreements with

pharmaceutical corporations to export and deliver its goods to developing countries at discounted prices.

84. It's relevant to mention, in regard to the TAC's appeal to medical authority in the shape of the WHO, a sort of latter-day medical Vatican, that the WHO's predecessor as 'the world's leading authority on public health matters' was the Health Organization ('HO') of the League of Nations. In 1952 the 23rd edition of Martindale's *The Extra Pharmacopœia*, the standard reference used by allopathic doctors for deciding what commercially produced patented drugs to give people when sick, advised that injections of arsenic – today rated by the US Agency for Toxic Substances and Disease Registry, weighted for risk of exposure, as the very deadliest substance known to man – 'may cause severe, and even fatal, reactions … a few days to several weeks after administration; these include jaundice, acute yellow atrophy of the liver, acute purpura, aplastic anaemia, and agranulocytosis. Severe nervous manifestations may occur after an interval of weeks or even months of treatment; these include cranial nerve palsy and neuritis of the auditory, optic and facial nerves; these are generally regarded as being syphilitic rather than of arsenical origin and their occurrence calls for more vigorous arsphenamine medication. … The standards of treatment laid down by the League of Nations Committee in 1934 are now almost universally accepted. They include … treatment as early as possible [with] comparatively heavy individual dosage of the arsenobenzene and of the bismuth and mercurial compounds, the doses being administered in comparatively rapid succession … persistent attack on the disease, avoiding intervals of such length as to afford the parasite an opportunity of recovering.' (Annexure 'AB11')

85. Today, only half a century later, any doctor injecting arsenic into his patient on its own, or in combination with such other deadly toxins as mercury and bismuth, even once, let alone repeatedly, no matter whose authority he cites for this, would be considered criminally insane and arrested for attempted murder. And obviously any doctor who interpreted the textbook symptoms of arsenical poisoning that he'd just caused as 'being syphilitic rather than of arsenical origin' and proceeded to administer 'more

vigorous arsphenamine medication' would be struck off for completely hopeless professional incompetence.

86. Evidenced by a series of incremental retreats, the tide of medical opinion is already turning against toxic ARVs, as I'll illustrate below.

87. **Ad 36.** It is materially false to claim, as the TAC does in this paragraph, that it has 'challenged both government and the private sector, including pharmaceutical corporations to make information about treatment more widely available'. Any impartial and complete 'information about treatment' will naturally include its grave hazards, where they exist. What the TAC has 'consistently' done is disparage our country's democratic representatives for 'mak[ing] information about treatment more widely available' in warning the public about the serious dangers to health posed by the ingestion of toxic ARV drugs. In other words the TAC has done precisely the opposite of what it hypocritically claims here. And the TAC has certainly never called on 'pharmaceutical corporations' in 'the private sector' to come clean about the dangerous toxicity of their ARVs and frankly draw public attention to the masses of published research reports establishing this. For instance, the TAC never 'challenged' GlaxoWellcome (now GlaxosmithKline) to keep its promise to Dr Tshabalala-Msimang, given at a meeting on 9 November 1999, to deliver all available, relevant data to her on the question of the toxicity of AZT, a promise the lying corporation evidently never had any intention of honouring. Which flagrant dishonesty it compounded the following day in a statement by medical director Peter Moore (since migrated to Bristol Myers-Squibb) that 'The review ordered by President Mbeki of the anti-AIDS drug is neither necessary nor justified … there is no new data [sic] that will raise legitimate concerns about AZT's safety.' Right after the publication of a whole lot.

88. Apart from the fact that the TAC is in the ARV promoting business, a further reason for its failure to take up the issue of ARV toxicity with 'pharmaceutical corporations' is the know-nothing ignorance of its leadership, as evidenced by Achmat's statement in the *Saturday Star* on 12 January 2002: 'It can only be Thabo Mbeki's belief that antiretrovirals like AZT are toxic and destroy the immune system. There is no other explanation for

the paranoia that's going on.' The quality of thinking on display in this moronic expostulation is consistent with Achmat's Standard Six education, lacking, as he does, even the rudiments of high school level science and biology.

89. Equally ignorantly, the TAC's national treasurer Mark Heywood – he has an English degree – claimed on CNN on 1 April 2000 that 'There is no evidence that has been tabled showing that AZT is toxic to either mother or child.' In fact there was already plenty, and much more has been published since.

90. There seems to be no reason to consider Mr Heywood to be a deliberate liar; what is much more probable is that he is merely ignorant of the many published research reports to the contrary about this horror, and has turned Nelson's eye to them, because any honest, intelligent response would entail a U-turn of opinion that would render his continued tenure of his offices with the TAC and AIDS Law Project impossible and put him out of a job. I drew the leading literature to Mr Heywood's attention last year (annexure 'AB12', with annexure 'AB5' appended to it) but as I expected he didn't respond. The issue of Achmat's credibility I'll deal with below.

91. Where the TAC mentions ARV drug toxicity in its publications at all, it does so in such an inadequate and misleading manner that were such claims, supported by their sunny images, to be published by a pharmaceutical corporation in the US they would amount to a criminal violation of the law and be prosecuted:

92. On 12 May 2001 the *British Medical Journal* reported that 'The US Food and Drug Administration (FDA) has issued a warning letter to manufacturers of AIDS drugs cautioning them to tone down the optimistic tenor of their antiretroviral ... billboard and magazine ... drug advertisements. Thomas Abrams, director of the FDA's division of drug marketing, advertising, and communications said that current antiretroviral advertisements directed at consumers are misleading as they fail to depict the limitations of AIDS drugs and also feature healthy looking people … sexy and athletic models in the prime of health who were climbing mountains, sailing boats, and riding bikes. These are pursuits which are quite difficult for people with HIV infection, who have to take drugs several times a day that have debilitating

side effects … The advertisements therefore violate the Federal Food and Drug Act.' (Text of the article, annexure 'AB13')

93. Noting this move by the FDA, our governing party correctly predicted in *ANC Today* (Vol 1. No 17; 18-24 May 2001): 'Most unfortunately, there is little chance that the politicians, corporate, medical, non-governmental and media people in our country, who are involved in a campaign that is not different from the one which the US FDA seeks to prohibit, in the public health interest, will listen and respond to the message of the US FDA. In the consequence, innocent people in our country will continue to suffer, even to the point of death, thanks, in part, to the wilful behaviour of these fellow South Africans.' (Annexure 'AB14')

94. Achmat is currently pretending that whereas the toxicity of his ARVs had crippled him within months of starting treatment with them (detail below) his drugs are now giving him a zest for life that he never had before, to the extent that he is even scaling mountains for the first time. (Annexure 'AB15') That is to say, he's now presenting himself as a poster-boy for ARVs in precisely the bogus terms and images that even the drug industry-friendly FDA has outlawed as misleadingly false: 'healthy looking people … sexy and athletic models in the prime of health who were climbing mountains, sailing boats, and riding bikes. These are pursuits which are quite difficult for people with HIV infection, who have to take drugs several times a day that have debilitating side effects.'

95. As a further example of Achmat's new role as poster-boy for ARVs – literally – I annex marked 'AB16' the back page of the March 2006 issue of his TAC's *Equal Treatment* magazine, adorned with a picture of him looking happy, as if ARVs put a smile on your face, rather than make you very sick, as they did him (detail below), and as all chemotherapies do. Achmat claims in the caption beneath his photograph that 'I have been on antiretrovirals since 2003. I am healthy again because of them.' I regret the discourteous language, but this claim can only be described as a blatant lie:

96. When Achmat publicly announced on 29 August 2003 that he proposed starting on an ARV cocktail of stavudine (d4T), lamivudine (3TC) and nevirapine the following month, he

explained in the *Sunday Times* that he was still healthy twelve years after his diagnosis and that he 'attributed his lingering good health to the fact that he has never smoked cigarettes or abused drugs and has drunk alcohol "occasionally only over the last four years"'. (Annexure X16A)

97. So irrespective of his doctor's interpretation of his blood test results, at the time that Achmat embarked on his ARV treatment he was physically healthy. Consequently, contrary to his false claim in his poster, the drugs did not restore him from sickness to health because on his own showing he was not clinically ill.

98. He also remarked at the time: 'I am in a lucky position because I have a strong set of organs' – signifying that he'd noted President Mbeki and Dr Tshabalala-Msimang's warnings, in line with the ARV drug manufacturers' package insert warnings, that the drugs would be dangerously toxic to his whole body: his heart, brain, liver, blood, nervous system, muscles, the works. (How very toxic he'd soon be discovering firsthand.)

99. At a media briefing on 8 September 2003 Achmat said that he'd swallowed his first dose of Triomune, a generic ARV cocktail in one tablet, four days earlier in the company of a few friends and family members. He'd suffered no serious side effects from it, he said, apart from a severe headache and a light-headedness that made him feel 'high'. Within just a few months, however, the poisonous drugs had made him so sick that he'd become totally invalided. An article in the *Daily Dispatch* on 28 May 2004 revealed that not only had the toxicity of his triple-combination ARV regimen crippled and incapacitated Achmat both physically and mentally, he had also been determinedly concealing this from the people of South Africa – for the reason that he had not wanted to lose face to President Mbeki and Dr Tshabalala-Msimang over this, by seeing their many public warnings about the toxicity of ARVs publicly vindicated by his admission that they had caused him severe injury, particularly since he had been vilifying them without any kind of decent restraint throughout their first terms as President and National Health Minister on account of their aversion to the drugs that he himself had now found too hot to stomach. (Annexure 'AB16B', the text of an online version of the original report wired by Health-e.) And more than not lose face, he had not wanted to lose the political ground he'd won through

his relentless propaganda campaigning, by conceding that they'd been perfectly right about the drugs and he'd been flat wrong. In a legal rather than a political context Achmat's conduct would have been condemned by a judge as a fraudulent non-disclosure.

100. 'Things have changed in Zackie Achmat's life,' went the report. 'Once readily accessible and always quick with a sound bite, a personal assistant now monitors the cellphone and diary of the chairperson of the Treatment Action Campaign (TAC) and screens visitors before ushering them into Achmat's study. ... As much as these changes signify a new level of structure in Achmat's life and the need to manage multiple requests for interviews, the more profound changes emerge from his first six months of anti-retroviral therapy and how this has forced the charismatic activist to review his life. … a frightening setback ... occurred in February and March ... which shook Achmat's self-confidence. ... "Going into my fifth month I started feeling a sensation in my feet. At first I dismissed it, thinking I'd done something at the gym. The second week it was clear to me and I thought, 'I can't let Manto win and I can't let Mbeki win', and I kept quiet for three more weeks." When Achmat finally told his doctor about his symptoms, the nerves in his feet were so sensitive that he could barely walk. A change of drugs (from d4T to AZT) has arrested the situation and his left foot feels better, but he still can't put any weight on his right foot for any length of time, nor can he walk long distances. ... Achmat, who has a clinical history of depression, says that the fact that he was immobile for a week while his doctor tried to bring the side effects under control brought on a terrible depression, the worst he's had in two years.'

101. In point of fact, AZT is no less neurotoxic than d4T: as nucleoside analogues the drugs are in precisely the same chemical class, and have substantially the same toxic pharmacology (dealt with below). Furthermore, the neurotoxicity of the drugs that had physically incapacitated him also appeared to have caused him conspicuous mental deterioration (an ill effect called 'chemobrain') by late 2004:

102. The early indications of this in the *Daily Dispatch* report were confirmed by journalist Willemien Brummer, who observed Achmat during an interview published by News24.com on 1

December 2004. She was perturbed to notice that 'His words were bats that flew into each other in the dark. His sentences ended in mid-air. It was as if he looked at you through a dense layer of fog. It was during these times that I wondered what was happening to him. Especially when he cancelled press conferences and public appearances at the eleventh hour. … Between gulps ['of soup and a glass of orange juice'] he talks about his past and the complex interaction between the chemicals in his brain, his genes and the virus with which he was diagnosed in 1990.The HI virus already penetrates the brain during cero-conversion [sic]. ... Every patient's reaction to this penetration is different. Chances are good this can lead to depression and cognitive reduction and, during the final stages, even to dementia – a condition that usually only afflicts the elderly.' (Annexure 'AB16C')

103. Achmat's own subjective appreciation of his declining mental condition, his incipient ARV-induced AIDS dementia, was conveyed by his concern expressed to Brummer that 'Losing control of his mind [was] his biggest fear' – worrying: 'As long as I hold on to my dignity.' Like a senile old man aware that he is losing his marbles.

104. It was apparent from Brummer's article that Achmat was having difficulty reconciling himself psychologically with the unpleasant reality that he was being poisoned by the drugs at the centre of his life: 'And then came the physical side effects of the antiretrovirals. Especially peripheral neuropathy – a condition that takes place when the nerve endings are impaired; burning pains are felt in the feet and legs. It was so bad for Achmat, that by the fifth month of antiretroviral treatment he could no longer walk. "I was totally melancholic and dysfunctional at the beginning of the year. I fought with my nearest and dearest, and I did not want to accept that I was experiencing side-effects."'

105. Achmat's phrase 'experiencing side-effects' would seem to be inappropriately light for being physically crippled and mentally reduced, but in any event the admitted fact that he had been very seriously harmed by his ARVs within months of starting to swallow them contradicts his false claim on his poster 'I am healthy again because of' ARVs'.

106. Anxious to project an impression that he was thriving on his pills, not sinking on them, Achmat insisted to Brummer: 'I have been fine since June. In September I went to London, Germany, Addis Ababa and back to London, and I managed three appointments a day. I returned from Durban on Tuesday.' This can only mean that 'since June' he'd no longer experienced the poisonous drugs as poisonous. With submission, the more likely reason is that, contrary to his claim in the caption to his grinning mugshot on the poster under discussion, Achmat was either no longer taking the drugs, or no longer taking them at the prescribed doses and at much reduced ones instead. This surmise is supported by Achmat's admitted public deceitfulness, and the perfect impossibility that a mix of toxic chemicals that had made him very ill, should thereafter be experienced as benign and health-supporting, after switching one of them for another almost chemically identical one.

107. He definitely doesn't want anyone checking up on him to make sure he really is swallowing his pills as prescribed (what doctors call DOT, i.e. Directly Observed Therapy – routine in TB treatment), and not cheating, because he says, 'That, for me, is unacceptable because it limits the autonomy and dignity of every person.' (Annexure 'AB16CC')

108. What compounds the situation is that it's no more possible for Achmat to admit a fundamental and terrible mistake about the ARVs that he and his TAC push for a living than it is for Archbishop Ndungane to announce that the marvels and wonders in the legend of Jesus are all nonsense; hence Achmat's persistence. By the same token, Achmat can never publicly admit that his HIV status is actually not much more significant than having a mole on his nose (detail below), because once his delusion that he's permanently possessed by a sex-virus, with whom he lives, is punctured, and he snaps out of it and laughs the whole idea off, he loses the special power and political advantage that comes of being part of a select group of self-identified permanent victims that everyone's supposed to feel sorry for. At a stroke he loses his vocation as a world-famous career-patient and international human rights hero, sees his R38 million a year fiefdom fold into dust before his eyes as all the foreign funding taps close, and he becomes unemployed with a collapse of

credibility so complete that he'll be unemployable, except perhaps as a car guard.

109. Nevirapine, which Achmat was also taking, is neurotoxic too, and was reported to cause severe mental deterioration by Wise et al. in the *British Medical Journal* on 13 April 2002, under the title, 'Neuropsychiatric Complications of Nevirapine Treatment' BMJ. 324(7342):879. (Annexure 'AB16D') Another report along the same lines followed that year: Morlese et al.: 'Nevirapine-induced neuropsychiatric complications, a class effect of non-nucleoside reverse transcriptase inhibitors?' *AIDS* 2002;16(13):1840-1841. (Discussed by the Public Health Agency of Canada: annexure 'AB16E'.)

110. In Achmat's case these 'neuropsychiatric complications' were in evidence almost immediately. He told journalist Jennifer Barrett during an interview published in *Newsweek* on 24 November 2003 (text of the interview, annexure 'AB16F') that 'The most remarkable thing after I started taking the medicines actually is that in the first three weeks, I became so depressed – I'd never been as depressed in my life.' Ignorant of the clinical research literature reporting the brain and other neurological toxicity of the ARVs he was on, because he's scientifically illiterate, Achmat made up some involuted, preposterous psychological reasons to account for this. The abundant reported data establishing the neurotoxicity of nucleoside analogue drugs such as d4T (stavudine), 3TC (lamivudine) and AZT is dealt with in the literature cited below.

111. Having replaced d4T in his drug combo with AZT, imagining this would solve his problems, apparently, Achmat continued with a daily ARV fix of AZT, 3TC and nevirapine (so he claims) – until on 28 March 2005 he suffered a heart attack at the age of forty-three, following which he was rushed to hospital by ambulance and kept there for several days. This misfortune was eminently predictable having regard to Reisler's et al. reported finding a year and a quarter earlier under the title, 'Grade 4 events are as important as AIDS events in the era of HAART'. *Journal of Acquired Immune Deficiency Syndromes* 2003 Dec 1;34(4):379-86. (Abstract, annexure 'AB16G')

112. Actually, the title to the paper is an understatement considering the findings that the researchers reported after reviewing the cases of 2947 patients treated with ARVs between 1996 and 2001 with the stated objective: 'To estimate incidence and predictors of serious or lifethreatening events that are not AIDS defining, and death among patients treated with highly active antiretroviral therapy (HAART) in the setting of 5 large multicenter randomized treatment trials conducted in the United States' – i.e. to determine the toxicity of ARVs having regard to the incidence of dangerous side effects, sometimes fatal. Noting that 'All 4 classes of antiretrovirals (ARVs) and all 19 FDA approved ARVs have been directly or indirectly associated with life-threatening events and death', they found that more than twice as many people (675) had suffered a drug related (grade 4) life-threatening event as against an AIDS event (332.) The most common causes of grade 4 events from drug toxicities were 'liver related'. 'Cardiovascular events', the researchers found, are 'associated with the greatest risk of death'. They concluded: 'Our finding is that the rate of grade 4 events is greater than the rate of AIDS events, and that the risk of death associated with these grade 4 events was very high for many events.'

113. Treated with ARVs then, one's greatest risk of dying is not from an AIDS-defining disease but from ARV-induced 'cardiovacular events' like Achmat's.

114. In plain speech, Reisler et al. found the cure to be deadlier than the disease, and that heart failure caused by ARV toxicity is the leading cause of death among people treated with these drugs.

115. In the same month that Achmat was falling down having his heart attack, kicking and groaning on the floor, McKee et al. were reporting one of the several ways in which AZT damages hearts in their paper 'Phosphorylation of Thymidine and AZT in Heart Mitochondria: Elucidation of a Novel Mechanism of AZT Cardiotoxicity' in *Cardiovascular Toxicology* 2004;4(2):155-67: 'Antiretroviral nucleoside analogs used in highly active antiretroviral therapy (HAART) are associated with cardiovascular and other tissue toxicity associated with mitochondrial DNA depletion.' The reason: '…our work shows that AZT is a potent inhibitor of thymidine phosphorylation in heart mitochondria.' Mitochondria are the energy powerhouses

inside all cells of the body. (Abstract and summary introduction, annexure 'AB16H')

116. And as far back as January 2001, when the US Department of Health and Human Services was announcing its abrupt renunciation of its 'hit early, hit hard' approach to AIDS with ARVs (to be discussed below), a year after President Mbeki had drawn the world's attention to the dangerous toxicity of AZT in Parliament, National Institute for Allergies and Infectious Diseases director Anthony Fauci explained: 'We are very concerned about a number of toxicities associated with the long-term use of anti-retroviral drugs. … We are seeing an increasing number of patients with dangerously high levels of cholesterol and triglycerides. … The bad news is that we now must find ways to deal with unanticipated toxicities, including the potential for premature coronary disease.' (Annexure 'AB16J') 'Premature coronary disease' like Achmat's:

117. 'The primary event is coronary heart disease with a rupture of a fatty plaque and blockage of the vessel,' diagnosed Achmat's cardiologist, Dr Zaid Mohamed, on the basis of an angiograph showing 'an atherosclerotic plaque rupture with non occlusive thrombus (clot)'. Achmat, he also found, suffered from 'dislipidemia' (sic: dyslipidaemia), before hastening to conclude: 'While ARVs are incriminated in heart disease, it [sic] is certainly not playing a pivotal role here.' (Affidavit, Case No. 2807/05, Cape High Court) But 'Dyslipidemia is common among patients receiving antiretroviral therapy for HIV infection' reported Stein et al. in their paper 'Postprandial lipoprotein changes in patients taking antiretroviral therapy for HIV infection' in *Arteriosclerosis, Thrombosis and Vascular Biology* 2005 Feb;25(2):399-405 (Annexure 'AB16K'); and as Koppel et al. noted five years earlier in the *International Journal of STD and AIDS* 2000 Jul;11(7):451-5, 'Serum lipid levels associated with increased risk for cardiovascular disease is associated with highly active antiretroviral therapy (HAART) in HIV-1 infection': 'The long-term effects of fat metabolism, storage and utilization in HIV-1 infected patients on highly active antiretroviral therapy (HAART) including a protease inhibitor are profound and cause increasing concern. The main importance of these lipid/metabolic disorders lies in their assumed contribution to an increased risk of

coronary heart disease (CHD). In the general population increased levels of lipoprotein(a) [Lp(a)] constitute an independent risk factor for CHD by itself.' (Annexure X16L) Dr Mohamed obviously hasn't read these reports and so doesn't know about this stuff.

118. Lipoatrophy (resulting in wasting, the characteristic skeletal look of ARV-treated white American homosexuals) is a toxic metabolic ill-effect of AZT and similar ARVs that's related to dyslipidaemia. On 26 April 2005, a month after Achmat was rushed to hospital gasping and clutching his chest, the British HIV Association released its latest draft treatment guidelines, drawn by leading UK AIDS doctor Professor Brian Gazzard, warning that 'as evidence accrues that AZT (zidovudine, Retrovir) is associated with lipoatrophy, the guidelines move away from firmly recommending an AZT-containing regimen as part of a nucleoside backbone'. (Annexure 'AB16M' is the first page of a news report citing the actual language of the draft guidelines, as quoted above, without enclosing it in quotation marks; the draft guidelines themselves are no longer accessible online.)

119. As I've mentioned, it would be illegal in the US were a pharmaceutical corporation to dishonestly puff its drugs in the way Achmat does in our country.

120. Apart from Achmat's publicly admitted dishonesty over his concealment of his crippling ARV side effects, there are other indications that he lies freely, and that his claims to be taking ARVs (as prescribed) and that he's doing swell on them, unlike most other people, consequently can't be trusted.

121. On 20 November 2003 the BBC published an elated statement Achmat made on learning of the government's capitulation to his demands for ARVs to be supplied in the public health system. (Annexure 'AB16N') 'I danced the whole morning,' he alleged. 'I am a black man without rhythm so it was very difficult for me.' Firstly, not being a white man doesn't make him a 'black man'; but more pertinently, he's supposed to be a person with a terrible disease, so grave that his organization had recently ordered him to start taking his medicines. Normally, when you are sick, if you really are and aren't perpetually shamming for a living, you don't

feel like dancing, not having the energy for it, and you need to lie down. But Achmat claims to have 'danced the whole morning' – that is, for several hours on end. Although it's possible that with his delicate health caused by a virus ravaging his immune system he danced a physically undemanding slow shuffle all morning, this is unlikely considering his celebratory mood, and so a foxtrot or other such lively quickstep to an up-tempo disco or hip-hop beat would have been more appropriate to the occasion. But even if he took regular breaks to take vitamins, as he claims he does everyday, it's still unimaginable that he would have been up to this, particularly because dancing 'the whole morning' would have been doubly 'difficult' for him as a professional medical invalid 'without rhythm'.

122. In short, although he's ducked appearing before this court (having sent his young assistant Nathan Geffen, previously his computer technician, into the fray to testify on his behalf), Achmat is a manifestly unreliable witness in his public testimony as an ARV evangelist; and his TAC's constantly repeated allegation, most recently to UNAIDS, that a thousand people a day are dying of AIDS in South Africa because of the government's denialism and inaction (annexure 'AB16O') should be weighed accordingly. (It would appear that what Achmat would ultimately like to see is regime change here so the corporations can really get their drugs in.)

123. Examples of the sort of extraordinarily misleading information given to the public by the TAC in reckless pursuit of its ARV promoting mission are annexed marked 'AB17' and 'AB18'. As is plain from a glance at the falsely reassuring 'happy native' imagery (of the sort typically used to sell goods such as Surf washing powder), even before one reads the deceptive text, both pieces of propaganda are contrived to allay the due concerns of people targeted by the TAC that they face the prospect of being severely harmed by the ARVs being pitched to them, as President Mbeki and Dr Tshabalala-Msimang have repeatedly warned. Again, the imagery would be illegal in the US.

124. Indeed, annexure 'AB17' pertinently seeks to discredit President Mbeki and Dr Tshabalala-Msimang's accurate warnings about the dangerous toxicity of ARVs: 'We must take action when anyone, even politicians, create fear and confusion in our communities.'

The action the TAC would like taken against out country's democratic leaders for hampering its drug promoting business is not specified, but the successful political subversion of several Eastern European governments by Western corporate philanthropy-funded 'human rights' NGOs in recent times (followed by the wholesale sell-off of public assets to Western corporations) is suggestive. The TAC has recently attempted to pervert the democratic process in South Africa by smearing as a 'denialist' any political candidate for municipal election who questions the organization's marketing of the drug industry's chemotherapy for AIDS in favour of natural and nutritional approaches, and by calling on voters to boycott him. Annexure 'AB19' is an example of this from the TAC's website. (The TAC's attempt to sabotage the voting in this manner failed, and the candidate in question was swept into office on a massive majority.)

125. In the case of its leaflet annexure 'AB17', by framing the title, 'SIDE EFFECTS OF MEDICINES AND ARVS', the TAC implicitly likens ARVs to other medicines, rather than warning that they belong to a special category of exceptionally dangerous drugs with life-threatening toxicities warned against by their manufacturers. Lewis and Dalakas made precisely this point, highlighting the sharp distinction between ARVs and other drugs in the prestigious journal *Nature Medicine* (1995) 5:417-22: 'Clinical manifestations of ANA [antiviral nucleoside analogues, such as AZT] toxicity: It is self-evident that ANAs, like all drugs, have side-effects. However, the prevalent and at times serious ANA mitochondrial toxic side-effects are particularly broad ranging with respect to their tissue target and mechanisms of toxicity: Haematological; Myopathy; Cardiotoxicity; Hepatic toxicity; Peripheral neuropathy.' (Annexure 'AB20') That is, the toxicity of AZT and similar ARVs for blood, muscle, heart, liver and nerve cells.

126. It is accordingly deplorably disingenuous and potentially fatally misleading for the TAC to misinform people, mostly African, mostly poor, that ARVs are like any other medicine, and that they are in much the same boat as far as their side effects are concerned – relatively rare and insignificant.

127. The TAC does not mention in its ARV propaganda that the drugs have killed some of its members (detail below) and that they crippled, disabled and nearly killed Achmat in 2004. Nor does it mention the TAC's particular concerns about d4T toxicity (which Achmat blames for the severe injury he suffered on a cocktail including the drug, accounting for why he discontinued it). Instead, in 'SIDE EFFECTS OF MEDICINES AND ARVS' attention from the toxicity of d4T is diverted by suggesting that when harmful side effects are encountered all will be well to continue taking it, as long as one of the other drugs in the combination is discontinued and switched with another similar one in the same chemical class.

128. The reason the TAC is currently pressing the MCC to approve tenofovir is precisely because, in the words of AIDS journalist Anso Thom, quoting representatives of the TAC and *Médecins Sans Frontières*, d4T is proving to be 'highly toxic for many patients' in the African township of Khayelitsha, Cape Town (per report in Health-e, annexure 'AB3A').

129. The TAC goes so far as to equate the use of herbal and traditional African medicine with ARV treatment, falsely suggesting that these ancient traditional and natural medicines typically have the same sort of well-established, well-defined, life-threatening side effects that have been repeatedly reported from the use of synthetic, highly toxic, cytopathic ARVs that inhibit the formation of cellular DNA: 'Report side effects of all medicines, including herbal and traditional medicines, at your clinic immediately. If using traditional or herbal medicine at the same time as ARVs, it may be hard to tell which is causing the side effects.' What the TAC dishonestly implies is that the two very different types of medicines have indistinguishably similar dangerous ill effects. And it implies that people would be better off avoiding the use of natural herbal or traditional medicines so as not to confound the clinical picture.

130. Even the TAC's own members are concerned that in the TAC's ARV marketing drive 'issues of side-effects and resistance might not be getting the prominence they deserve'. (Annexure 'AB21', an excerpt from 'Treatment Action Campaign (TAC) Evaluation 29 June 2005') That is, from what they see, people propagandized by the TAC are aware that it is presenting a skewed picture of

ARVs in its marketing propaganda, which fails to warn of the serious harm that these chemicals have been reported to cause in hundreds of research papers, news of which is apparently getting around by word of mouth as people are being poisoned.

131. The TAC pamphlet entitled 'Immune Reconstitution Syndrome (IRS)' (annexure 'AB18') is rather more frank with the facts, although still dangerously misleading. Again it features a smiling man in a sparkling white print shirt incongruously looking a model of good health (rather than a more appropriate image of a wasted, feverish, grievously ill TB patient sweating on a hospital cot) announcing: 'I got sick with TB after starting ARV treatment'. The perverse, infantile, magical reason provided by the TAC for this is that it's 'because the TB that was sleeping in my body took a chance to wake up as my immune system began to recover'. Since ARVs are potent general metabolic poisons, further comment on this inane explanation for why healthy people fall severely ill when poisoned by them would be superfluous.

132. No manufacturer of any ARV drug alleges, as the TAC does in its propaganda piece on 'IRS', that its drug, alone or in combination, will make and keep a person who has fallen ill with TB 'well and healthy again'. This is because there's no reported clinical evidence supporting this false claim.

133. The TAC's false allegation that 'When you start ARV medication your immune system gets stronger' would seem to be par from an organization led by people who brag of being 'scientifically illiterate'. The first target of the cytotoxicity of ARV drugs is blood and bone marrow, where blood cells are generated. In its 'Prescribing Information' AZT manufacturer GlaxoSmithKline warns: 'Patients should be informed that the major toxicities of RETROVIR are neutropenia and/or anemia.' (Excerpt, annexure 'AB22') The *Oxford Concise Medical Dictionary* explains that 'neutropenia [means a] decrease in the number of neutrophils in the blood. … It results in an increased susceptibility to infections. … [A] neutrophil [is] a variety of granulocyte (a type of white blood cell) … capable of ingesting and killing bacteria and provides an important defence against infection.' (Annexure 'AB23')

134. President Mbeki, quoted earlier, was accordingly quite correct in educating DA leader Tony Leon about the fact that AZT (and other nucleoside analogues), are immuno-suppressive cell poisons, whose consequent serious side effects have been reported in hundreds of published studies.

135. And Achmat yet again displayed his admitted scientific illiteracy in implying to the contrary when blurting in the newspapers (cited above) in his characteristically uneducated and histrionic manner: 'It can only be Thabo Mbeki's belief that antiretrovirals like AZT are toxic and destroy the immune system. There is no other explanation for the paranoia that's going on.'

136. That nucleoside analogue drugs such as AZT themselves destroy immune cells is also emphasized by Cheson, Keating and Plunkett on the very first page of the preface to their standard text, *Nucleoside Analogs in Cancer Therapy* (New York: Marcel Dekker Inc, 1997), mentioning the 'profound immunosuppression that often accompanies therapy with nucleoside analog drugs', and their 'potent immunosuppressive properties'. (Annexure 'AB24')

137. The clinical developments described in the TAC's IRS pamphlet following the first false statement, 'When you start ARV medication your immune system gets stronger', have an obviously more plausible explanation than the puerile one mooted by the TAC: 'This can cause germs that were sleeping in your body to wake up too. This is called Immune Reconstitution Syndrome (IRS). Some people become ill with TB, Pneumonia, Cryptococcal Meningitis or generally feel sick because of IRS.' With submission, any intelligent person would conclude that the ingestion of immune-cell killing, broad-spectrum metabolic poisons is likely to be the proximate cause of the onset of the deadly illnesses that follow. And would not be terribly surprised to read in the TAC pamphlet that 'people sometimes do not survive despite having started ARV treatment'. I respectfully draw this court's attention to the rest of the claims made in this pamphlet and suggest that their palpably foolish quality is too obvious to warrant spelling out in any further comment. The language used seems to be that of someone who never got close to finishing school.

138. **Ad 39.** Insofar as Achmat got nominated by the Quakers for the Nobel Prize, it bears mentioning that following an assessment of what he does for a living in South Africa, the Nobel Committee did not find him worthy of the honour.

139. **Ad 40.** I'll address and refute all of Professor Dorrington's allegations when I answer his affidavit.

140. **Ad 43.** I'll address and refute all of Dr Venter's allegations when I answer his affidavit.

141. **Ad 65 and 66.** I admit that I authored the two statements in the public health notice published as a paid advertisement in the *Mail&Guardian* on 26 November 2004: 'Hundreds of studies have found that AZT is profoundly toxic to all cells of the human body, and particularly to the blood cells of our immune system. Numerous studies have found that children exposed to AZT in the womb suffer brain damage, neurological disorders, paralysis, spasticity, mental retardation, epilepsy, other serious diseases and early death.' (The newspaper space had to be bought to bring these facts to the public's attention.)

142. Both of these statements are precisely factually accurate and are supported in the medical and scientific literature as I claimed, as is borne out by the research findings reviewed and cited in annexure 'AB4'.

143. I'm also the author of the caption under the photograph of the bottle of AZT that appeared in the notice, whose label bears an orange stripe imprinted with a skull and crossbones icon to signify potentially fatal toxic chemical hazard to the handler – spelt out in six languages: 'Toxic Giftig Toxique Toxico Tossico Vergiftig' – and the warning: 'TOXIC Toxic to inhalation, in contact with skin and if swallowed. Target organ(s): Blood Bone marrow. In case of accident or if you feel unwell, seek medical advice immediately (show the label where possible). Wear suitable protective clothing.'

144. I have an original bottle of AZT thus labelled, which I can produce to this court for examination and verification on request. (Photograph, 'AB24A')

145. The latest version of this label also contains a warning that accidental exposure to the drug may cause cancer. This warning

accords with a substantial volume of research literature reporting that AZT is carcinogenic for adults, children and unborn foetuses. Since the carcinogenicity of AZT has not been the main focus of my campaign, and the fact of it has never been disputed by the TAC, I'll not in this affidavit canvass the research literature in this regard, which would otherwise swell it considerably.

146. The caption I drew reads: 'This is a 25 mg bottle of AZT supplied by Sigma-Aldrich for use in research laboratories. The label speaks for itself. GlaxoSmithKline recommends between 500 and 1500 mg of AZT daily – twenty and sixty times the quantity that Sigma-Aldrich warns research workers could kill or severely injure them – alleging that "AZT has extended and improved the quality of life of millions of people living with HIV/AIDS around the globe". Also that "GlaxoWellcome [now GlaxoSmithKline] are a reputable company. We do not lie to people."'

147. I highlight the fact – in relation to the TAC's claim that on 'ARV medication … your immune system gets stronger' – that consistent with GlaxoSmithKline's warning that 'the major toxicities of RETROVIR are neutropenia and/or anemia', Sigma-Aldrich warns that the 'Target organs' of AZT are 'Blood, bone marrow'. It's in our bone marrow that our blood cells, including our immune cells, are generated. And it's with AZT that they are destroyed. Thus, in reality, on 'ARV medication … your immune system gets' weaker.

148. The use of AZT for the prevention and treatment of AIDS is consequently entirely incomprehensible outside an Orwellian medical *denkstil*.

149. All the facts stated in my caption are true, and my ironic citation of GlaxoSmithKline's public statements was intended to insinuate that the company is perpetrating a gargantuan, murderous fraud in the marketing of AZT as an AIDS drug, as a remedy for a deficient immune system, which it is. It's notable that the TAC, not GlaxoSmithKline, took exception to these true statements and justifiably sarcastic innuendoes, and went off to the Advertising Standards Authority ('ASASA') to file a complaint in defence of the reputation of the company and its product, which it zealously defends against critics like me.

150. I deny the suggestion arising from the bold-face upper-case heading to paragraphs 63 to 87, 'PUBLICATION AND DISTRIBUTION OF FALSE ADVERTISEMENTS CONCERNING MEDICINES', that my statements were false; on the contrary, they were perfectly and precisely true, being based on a careful and very thorough survey of the research literature that I'd performed.

151. If the TAC's mention of the registration of AZT and nevirapine in this context is intended to imply that this renders it illegal to criticise these drugs on efficacy and safety grounds, the implication is plainly specious and I deny it: there can obviously be nothing unlawful in alerting the government and people of our country to the dangerous toxicity of ARVs, particularly AZT and nevirapine, in paid advertisements, public speeches, radio talks, open letters, books and pamphlets, and to the fact that such drugs 'make people with AIDS sicker'. They sure do.

152. **Ad 68 and 69.** It is so that the ASASA found for the TAC, namely that the statements were unsubstantiated, but it did not do so on the merits. It did so after declining to consider three lever-arch files full of substantiating peer-reviewed published research reports and other documentation, on the basis that the hundreds of independent experts cited were not acceptable; it wanted a single one. A subsequently submitted statement by Professor Mhlongo drawn to suit this requirement was rejected by the ASASA on the spurious ground that he works for the second respondent, which is untrue. I thereafter asked the tenth respondent, Professor Peter Eagles, to vouch for the accuracy of my statements on AZT, since as chairman of the MCC he ought to know better than anyone (annexure 'AB25'), but he has not favoured me with a response to my request. His reluctance to confirm the truth of the contested statements about AZT may be on account of his possible personal financial investments in the pharmaceutical business, and his concern not to jeopardise the rich flow of pharmaceutical industry money into his faculty for the conduct of clinical trials, as is the norm in pharmacology departments, which would make him a very unpopular person among his colleagues. If these are not the reasons, Professor Eagles might care to file a declaratory affidavit concerning his reticence about confirming my matter-of-fact statements that 'Hundreds of studies have found that AZT is

profoundly toxic to all cells of the human body, and particularly to the blood cells of our immune system. Numerous studies have found that children exposed to AZT in the womb suffer brain damage, neurological disorders, paralysis, spasticity, mental retardation, epilepsy, other serious diseases and early death.' I've given his MCC all the supporting literature.

153. Both President Mbeki and Minister of Health Dr Tshabalala-Msimang have repeatedly warned the people of South Africa that ARV drugs plied by medical practitioners to people diagnosed HIV-positive by doctors are extremely toxic and are harmful to health. I've quoted President Mbeki above; and among many other well-founded warnings issued since, Dr Tshabalala-Msimang made an informed, thoughtful and detailed statement about AZT in Parliament on 16 November 1999. (Annexure 'AB26') My group and I have the same understanding and we warn similarly – except that cancer has been observed in murine studies at human equivalent doses, and not only at 'high doses' as the Minister stated; nor has the foetal exposure to AZT resulting in cancer necessarily been 'for long periods'.

154. **Ad 71.4.** I'm not the author of this statement but I accord myself with it and defend it as precisely accurate.

155. **Ad 71.5-6.** I've dealt with these statements already.

156. **Ad 71.7.** I'm not the author of this statement but I accord myself with it and defend it as precisely accurate.

157. **Ad 131.** The allegations made in this statement are mere rhetoric: there's no good evidence that ARVs are 'life-saving' as alleged, and that people 'have had their health compromised by stopping their antiretrovirals'. There's no support in the scientific literature for the notion that anyone ever died from discontinuing their daily ingestion of toxic ARV drugs given to them by AIDS doctors, any more than anyone ever died from the suspension of their blood-letting treatment. The rest of the allegations I've dealt with already.

158. **Ad 168.** It's an appalling demonstration of the Western cultural supremacist and ultimately racist contempt with which the TAC's (mostly, and de facto) non-African leadership holds traditional African medicine in South Africa that it claims that it has 'no

scientific basis at all', and in reproving the Minister of Health, Dr Tshabalala-Msimang, for defending such medicine – thereby rubbishing the vast, centuries-old store of indigenous medical knowledge in Southern Africa, which, as the Minister pointed out, 'may help to treat numerous symptoms of opportunistic infections that are part of AIDS'. The sort of people running the TAC seem to think that when it comes to medicine, if it's not happening in a laboratory full of glass jars, and the people involved don't wear white coats, it's not 'scientific'.

159. Befitting a pharmaceutical industry interest group, the TAC's contemptuous dismissal of indigenous African medicine is inconsistent with the democratic will manifest in the passage of the Traditional Health Practitioners Bill, and the planned Traditional Medicines Directorate within the Department of Health, reflecting our government's recognition of this most widely followed and applied healing system in South Africa by giving it equal legal recognition and status vis-à-vis imported Western commercial pharmaceutical medicine.

160. Although traditional medicine is integral to indigenous culture and natural healing, and, according to the WHO, is effectively relied upon and by about 80% of South Africa's people, in the view of the TAC it evidently amounts to unscientific, retrograde, primitive, worthless mumbo-jumbo that should be replaced by the pharmaceutical industry's propaganda conceptions of modern scientific commodity-based capitalist medicine – which, in the case of AIDS medicine, is based squarely on the highly lucrative sale of patented synthetic chemicals, resting in turn on the medical dogma that people, mostly African, fall ill with AIDS because they promiscuously engage in condomless sexual intercourse and thereby get infected by a new germ, which unlike all others known to man, is incurable and inevitably fatal. And that although they'll inevitably die early from this, toxic drugs produced by the pharmaceutical industry that are poisonous to all human cells, if taken every day without fail, can delay it a bit.

161. The TAC even smears any traditional healer who treats people suffering from AIDS-defining illnesses with indigenous, natural medicine, and who warns against the toxicity of ARVs, as 'unethical' and should be subject to punitive sanctions imposed by the state. In the May 2005 issue of its journal *Equal*

Treatment, Achmat wrote in an editorial, under the subheading 'Stop unethical healers': 'Some traditional healers spread dangerous messages. They claim they can treat AIDS and antiretrovirals are toxic. Their behaviour gives other traditional healers a bad name. This shows that regulation is needed so that the traditional healing profession will serve patients better. This is something traditional healers should support. If we modernise traditional medicine, it will benefit everyone, traditional healers most of all.' (Annexure 'AB27') By 'modernise', Achmat clearly means that traditional healers should abandon indigenous models of understanding and treating disease, and adopt allopathic, capitalist, pharmaceutical bio-medicine. Another article in the same magazine contemplates the only role for traditional healers in AIDS as being servants to the allopathic pharmaceutical medical system, with healers enjoined not to treat their patients but instead to herd them into Western hospitals so that they can be treated with the pharmaceutical industry's ARVs. (Article per Zach Rosner in boxed insert, annexure 'AB28')

162. **Ad 167.** I dispute the TAC's allegation that 'good nutrition cannot reverse the course of AIDS'. Though it's central to the virus/chemotherapy paradigm of AIDS, which propounds ARVs as the only means of redemption, I deny that there's any foundation for this claim. I myself have seen how gravely sick AIDS patients have returned to vibrant good health with nutritional support alone. The TAC's allegation springs from the business model of the pharmaceutical industry that AIDS is an incurable condition caused by an incurable viral infection that will inexorably kill the patient, but whose early demise may be postponed a few years if he buys and swallows the industry's ARV drugs every day until he dies. (Or, if he doesn't have enough money to pay for them himself, his government buys them for him.) This model is generally accepted by allopathic doctors taught at medical schools and learned off by heart, and reinforced in advertisements and articles in medical journals, and it's widely believed by lay people whose opinions are informed largely by what they read in the newspapers, but there's no sound evidence supporting it. Nonetheless, these core organizing creeds keep in work an empire of researchers, consultants, bureaucrats, medical professionals, counsellors, activists, advertising and

marketing professionals, journalists and so on, and of course support the prime beneficiaries, the pharmaceutical industry.

163. I agree with the TAC's statement that 'Good nutrition appears to help people with HIV live longer, healthier lives', to the extent that having enough good nutritious food to eat generally helps one to live a long and healthy life. I dispute all and any other inconsistent meanings and implications with which this statement may be charged.

164. **Ad 170.** Health Director-General Mseleku is entirely correct in pointing out that 'in some instances' the 'side-effects' of ARVs are not manageable – which is to say the toxicity of these drugs is unendurable in many cases and may be fatal. Dozens of papers have reported treatment adherence problems arising from the toxicity of ARV drugs. In a novel investigation, the first of its kind, to quantify the 'Prevalence of adverse events associated with potent antiretroviral treatment in single, double, and triple regimens of AIDS drugs', published in *Lancet* on 20 October 2001 (358(9290):1322-7), Fellay et al. reported 'a high prevalence of toxic effects' in a cohort of 1160 patients. More than two thirds of patients on ARVs suffered side effects severe enough to affect treatment adherence – i.e. prevent them taking the drugs as prescribed. Forty-seven per cent reported clinical problems like vomiting, diarrhoea, nausea, fat growth, mood swings, insomnia and fatigue. Blood tests revealed 'potentially serious' abnormalities among twenty-seven per cent. The researchers classed a 'significant proportion' of these adverse events as 'serious or severe'. Kidney dysfunction and severe fatigue that were 'probably or definitely' due to their HIV treatment led to some patients winding up in hospital. (Abstract, annexure 'AB29')

165. And as Reisler et al. found and reported in their major investigation (canvassed earlier), 'Grade 4 events are as important as AIDS events in the era of HAART' – in fact more so, given that they found that on ARVs 'the rate of grade 4 events is greater than the rate of AIDS events, and that the risk of death associated with these grade 4 events was very high for many events'; i.e. people treated with 'potent combination therapy' have a stronger prospect of being severely poisoned or killed by ARVs than they do of developing an AIDS defining disease. GlaxoSmithKline

long ago obliquely admitted this in as many words in its entry under 'Retrovir' (AZT) in the *Physician's Desk Reference* that 'it was often difficult to distinguish adverse events possibly associated with administration of Retrovir from underlying signs of HIV disease or intercurrent illnesses' – i.e. that AZT can cause AIDS-defining diseases. The current edition of the 'Product Monograph' for AZT published in September 2005 by GlaxoSmithKline's Canadian subsidiary says the same. (Excerpt, annexure 'AB31') GlaxoSmithKline's concession to the indistinguishable clinical sequelae of taking toxic ARVs obviously confounds any distinction by Reisler et al. between 'AIDS events' and 'events that are not AIDS defining' and renders the researchers' assessment of the incidence of serious, life-threatening events conservative, as bleak as it already is.

166. I dispute the TAC's mindless commercial boiler-plate claim that 'the benefits of ARVs outweigh their risk'. In truth, ARVs have never been shown in any properly designed and conducted clinical trial to have therapeutic or prophylactic benefits. But the joy of this phrase for the TAC is that it has the ring of medical authority about it, and therefore tends to block enquiry by people hearing it into whether it's true or not.

167. It is a brazen falsehood to allege as the TAC does that 'ARV side-effects are only unmanageable in rare circumstances, where death from AIDS would probably occur anyway' – i.e. it's only very occasionally the case that people find the toxicity of ARV treatment unendurable, and only among people who are likely irreversibly moribund. There's no factual basis in the research literature for making this false claim. It's a fabrication, and it's contradicted by the research literature, as discussed above.

168. It may be that most allopathic doctors consider, because they have been so trained, that 'there is no scientifically accepted alternative treatment to ARV treatment for people who have developed AIDS'. However, numerous Western allopathic physicians, medical scientists and biologists working in molecular biology, virology, pathology, epidemiology, public health and other related disciplines, many of high rank in their respective fields, do not support the use of ARVs in AIDS. A representative contingent of about a dozen of these scientists and clinicians attended the Presidential AIDS Advisory Panel meetings in 2000.

169. Dr Kary Mullis PhD, perhaps the Einstein of modern biology, awarded the Nobel Prize for chemistry in 1993 for his invention of the inestimably important breakthrough biological technology, the Polymerase Chain Reaction, put it pithily in the foreword to *Inventing the AIDS Virus* by Professor Peter Duesberg (Washington: Regnery, 1996): 'We have not been able to discover why doctors prescribe a *toxic* drug called AZT (Zidovudine) to people who have no other complaint than the presence of antibodies to HIV in their blood. In fact, we cannot understand why humans would take that drug for any reason.' (Emphasis in the original; annexure 'AB32')

170. Even prominent orthodox AIDS expert Professor Jay Levy of the University of California at San Francisco agrees: 'I think AZT can only hasten the demise of the individual. It's an immune disease and AZT only further harms an already decimated immune system.' (Quoted in *Newsday* on 12 June 1990, and in *Inventing the AIDS Virus* op cit.)

AFFIDAVIT: ROBERT DORRINGTON

171. Professor Dorrington puts up as an annexure to his affidavit the Department of Health's 'National HIV and Syphilis Antenatal Sero-Prevalence Survey in South Africa 2004' report, marked RD2.

172. Since the report's findings about the incidence of 'syphilis' in our country are irrelevant in these proceedings, no purpose will be served in debunking them here and I'll therefore not do so.

173. Concerning 'HIV prevalence', the survey report is worthless, and it's obvious that the anonymous AIDS experts who designed the study had no idea what they were doing:

174. 16 000 pregnant women attending antenatal clinics in South Africa were 'tested for HIV using ELISA' once: 'For HIV testing, all specimens were tested with one ELISA in all provinces.' On the basis that blood specimens of 29.5% of these women were reactive, the AIDS experts involved in the survey announced in their concluding 'DISCUSSION AND IMPLICATIONS OF FINDINGS' chapter that 'The survey estimates an HIV prevalence rate of 29.5%'. In their 'INTRODUCTION', the

researchers stated: ‘The antenatal survey provides the best available estimate of HIV infection among the South African population.’ And in their ‘EXTRAPOLATION OF HIV ESTIMATES TO THE GENERAL POPULATION’ section, they state their unexplained assumption that ‘Estimates of males infected = 85% of infected females.’ This then would amount to about a quarter of the ‘South African population’ being ‘infected’.

175. The survey, however, was about as scientific as counting the number of brown-eyed people in South Africa as Xhosa: No ELISA HIV antibody test kit manufacturer claims that a reactive result to a single (or even repeated) test indicates that the person tested is infected with HIV, and no health authority anywhere in the First World claims this either. Because they are non-specific, ELISA tests are manufactured and licensed for screening blood only, not for diagnosing infections, and it was accordingly incompetent for the researchers to have reported that a certain number of people are infected with HIV because they were reactive to a single non-specific ELISA screening test. The methodology of the survey was so fundamentally flawed that the reported findings have no value whatsoever, except to keep those involved in it in jobs.

176. None of South Africa’s army of AIDS experts working at the Medical Research Council, at universities and at other institutions seem to have noticed the basic, hopeless defects of the survey design, either at the time of publication or since, because none have raised their voices to mention them.

177. In uncritically citing this useless report, and in relying on it and on previous ones like it to derive his own numbers, Professor Dorrington demonstrates his own professional incompetence: ‘The Actuarial Society of South Africa estimates that 5 million people in South Africa are currently infected with HIV. Below are the data from the ante-natal sero-prevalence survey [sic: surveys] conducted by the DoH. Models of the epidemic in South Africa are derived from these data and supported by other studies.’

178. In its ‘Introduction’, referring to a similar survey the year before, the Department of Health report states that ‘In South Africa, a total number of 5.6 million individuals had acquired HIV infection by the end of 2003 (Department of Health, 2004).’

Professor Dorrington states in paragraph 9 of his affidavit that the most recent survey (the Department of Health one under discussion) found that there were 'over 6 million ['people in South Africa infected with HIV'] in 2004' according to Department of Health estimates.

179. How the numbers are worked down from over ten million, having regard to the data reported in the Department of Health's latest antenatal survey ('The survey estimates an HIV prevalence of 29.5%'), to 'over 6 million', is unaccounted.

180. Professor Dorrington cites an estimate by Statistics South Africa in its 'Mid-year population estimates, South Africa 2005', which pegs the HIV infection rate at 4.5 million people in that year. I'll deal with the Stats SA estimate below.

181. Considering that Professor Dorrington's data are demonstrably worthless, except for the purposes of securing funding, his statement in paragraph 9 that 'every credible epidemiologist recognises that this is the single largest epidemic we have experienced and one that poses challenges to government and society' is pointless and irrelevant. He is not an epidemiologist but an actuary, and so without establishing his competence in this discipline (indeed he clearly shows that he has none) he can't speak for what 'credible' epidemiologists 'recognise'. He appears to be referring to his friends and collaborators at the Medical Research Council, such as his wife Debbie Bradshaw, who works with him in turning out reports of the same quality as his, mainly for the thrills they give the newspaper-reading public, mostly white.

182. **Ad 10.** Apropos of the statement that 'The Actuarial Society of South Africa estimates that over half-a-million of the over 5 million people in South Africa with HIV have AIDS and require anti-retroviral therapy. (Annexure "RD3" – The Demographic Impact of HIV/AIDS in South Africa: National Indicators for 2004)', I highlight that the first page of this apologia for the purchase of ARVs from the drug industry by the government reveals that Professor Dorrington's research was paid for in part by a leading ARV drug producer, Bristol-Myers Squibb.

183. Since Professor Dorrington has no knowledge of AIDS therapeutics from what I've been able to gather from his

evidence, his opinion concerning how many people 'require' the merchandise of his financial sponsor and other drug companies is no more cogent than the weekly dustman's; in fact it's less so given his financial conflict of interest.

184. **Ad 11-13.** Professor Dorrington claims as a sworn fact that 'Mortality due to the HIV epidemic has risen dramatically'. In support of this he cites a 'report released in February 2005 by Statistics South Africa [that] showed a 57% increase in mortality between 1997 and 2002'. However, before being found out, he quotes from the Stats SA report which explicitly records that it 'does not focus specifically on HIV and AIDS'. At best, says the report, it gives 'indirect evidence that HIV may be contributing to the increase in the level of mortality for prime-aged adults, given the increasing number of deaths due to associated diseases'.

185. In short, the allegation 'Mortality due to the HIV epidemic has risen dramatically' is unsupported by Stats SA, and it was a false and misleading misrepresentation of the facts to suggest otherwise.

186. None of the 'associated diseases' referred to by Stats SA are new; all are old, and have always been the concomitants of poverty. There's no evidence that healthy, well nourished people are falling ill and dying from any new illness or collection of illnesses that speaks to a novel infectious disease epidemic in South Africa. (Obviously, relatively rare scattered cases of disease among the rich do not constitute an epidemic. The same goes for homosexuals.)

187. It's true that Stats SA reported a '57% increase in mortality between 1997 and 2002'. However, it also reported an increase in deaths from TB over the period 1997 to 2001 of 134%. Deaths due to assault increased by 187%. Those due to gunshots went up by 250%. The suicide rate exploded by 275%. Except they didn't really: despite these paper numbers, no expert of any sort believes they did, as far as I know, not even AIDS experts such as Professor Dorrington.

188. The jump in numbers simply derives from huge improvements in death reporting in South Africa in recent years. Making this case convincingly, I annex hereto, marked 'AB33', a detailed analysis by Dr Rodney Richards PhD in the US. Although thoroughly

referenced, it's unsworn – not having been prepared for this application, and coincidentally sent to a friend of mine ten days before it was launched – but I've read it carefully and I adopt it as my own evidence for the purposes of this case.

189. **Ad 15.** Concerning Professor Dorrington's estimate, adopted by his society, that '300,000 people in South Africa died of AIDS-related illnesses in 2004' (a remarkably nice round figure), it all seems to be computer games: all his numbers were generated by the 'default scenario' of his new ASSA 2002 programme according to his 'Demographic Impact' report – the previous one used by him, ASSA 2000, having had to be thrown away with the trash because it was found to have inflated estimates of HIV infection by 'about a third' according to the 'Introduction' of his report.

190. It is important to appreciate that, as Professor Luc Montagnier, the scientist generally credited with discovering HIV, has pointed out, 'AIDS has no particular symptoms.' This is because AIDS is an American-conceived syndrome comprising an expanding list of unrelated, age-old diseases, namely pneumocystis carinii pneumonia, Kaposi's sarcoma, toxoplasmosis, strongyloidosis, aspergillosis, cryptococcosis, candidiasis, cryptosporidiosis, cytomegalovirus, herpes simplex, progressive multifocal leukoencephalopathy, lymphoma of the brain, mycobacterium avium complex, histoplasmosis, isosporiasis, Burkitt's lymphoma, immunoblastic lymphoma, candidiasis of the bronchi, trachea and lungs, encephalopathy, salmonella septicaemia, recurrent bacterial pneumonia, invasive cervical cancer, pulmonary tuberculosis, pneumonia recurrent. Also having a CD4 cell count of under 200/µL though not sick, if you're American, or live in other parts of the world (but not Canada) and you go for that diagnostic brainchild of American AIDS experts too.

191. So basically, if you have TB and you're HIV-negative, you've just got TB. If you have TB and you're HIV-positive (reactive to a non-specific antibody test), you don't have TB anymore, now you've got AIDS. An AIDS indicator disease becomes AIDS if the patient is HIV-positive. So it's meaningless for Professor Dorrington to speak of 'AIDS-related'. It's either AIDS by definition or it isn't. But by redefining TB deaths as AIDS deaths, or 'AIDS-related' deaths, AIDS experts like him can conjure up

career-enhancing dramatic AIDS mortality figures on paper, without there being any new real disease phenomenon occurring on the ground.

192. There's no good evidence that the population of South Africa is being cut down by AIDS in the manner of the great flu after the First World War; instead, all experts unanimously agree that it's growing at an agreeably healthy lick of about 2% per annum according to the hard numbers returned in census counts.

193. **Ad 16.** Professor Dorrington's service to the pharmaceutical industry in having 'modelled the effect of introducing antiretroviral treatment with respect to mortality' was, as he states in his report, partly paid for by it.

194. His medical claim that 'an ARV programme would have a substantial effect on improving life-expectancy, reducing mortality and reducing pediatric [sic] infections' is way beyond his competence as an actuary and is founded on propaganda-driven assumptions about the therapeutic efficacy of these drugs which have no basis in medical science. He evidently thinks ARV drugs are life-saving and make you live longer, as he's read in the newspapers and TAC pamphlets.

195. A couple of weeks after this application was launched, the Human Sciences Research Council (HSRC) released its own 'HIV Prevalence' report. I do not wish to fatten the record with this thick document as it can be readily accessed at the HSRC's website. I mention it, however, in anticipation of the possibility that the TAC might rely on it to shore up Professor Dorrington's collapsed and discredited claims about the allegedly terrible extent of the HIV/AIDS epidemic in South Africa.

196. I took the HSRC study to pieces in my letter to its lead author, Dr Olive Shisana (annexure 'AB10'). Employing an equally caustic, ironic tone in a letter to the CEO of the South African National Blood Service, Professor Anthon Heyns, I played up the implications of the study findings for blood donor policy. (Annexure 'AB33A') My letter to Dr Shisana was widely acknowledged by my many cc addressees in government, but not by Dr Shisana herself, so I recently sent her a reminder containing further awkward observations. (Annexure 'AB34')

197. By the time I signed this affidavit, the HSRC still hadn't commented on my critique or answered any of my questions. Nor had the SANBS.

198. In view of Professor Dorrington's manifest ineptitude reflected in his affidavit, and pointed up in my answer to it, I respectfully request that this court consider referring these papers to his professional society for an enquiry into whether he's competent to render professional services to the public, whether he should be permitted to charge professional fees for them, and whether he's a fit and proper person to be a registered member.

AFFIDAVIT: FRANCOIS VENTER

199. **Ad 2.** I deny Dr Venter's claim that the Southern African HIV Clinicians Society ('the society') is a 'public benefit organisation', working for the public good. It's a perfectly ordinary professional guild guarding and extending the privileges, benefits and financial interests of its members, and restraining the professional trading of rivals, just like any other, employing mystification to bamboozle the public as its basic tactic to achieve this. Its further role outside this, but closely tied to it, is to promote the trade of the pharmaceutical industry by puffing its wares on its behalf, for which service it's paid:

200. According to an editorial, the cost of producing the June 2005 issue of the society's glossy *Southern African Journal of HIV Medicine*, being handed out free at the 2nd South African AIDS Conference in Durban last year, was paid for by the leading ARV manufacturer Bristol-Myers Squibb – indicating brightly how the drug industry appreciates the immense value that the society has to it as a loyal and dependable ancillary service organization in its commercial operations. The magazine is packed with ARV drug advertisements placed by several big manufacturers, Aspen Pharmacare, Merck Sharpe & Dohme, Bristol-Myers Squibb, Roche and GlaxoSmithKline, which latter company has its logo at the foot of the 'Contents' page, apparently signifying ongoing financial sponsorship of the society. Page 22 has a grinning photograph of the magazine's 'delighted' editor Dr Desmond Martin, Dr Venter's predecessor as society boss, accepting a R75 000 payoff from Aspen Pharmacare 'for the sponsoring of

selected members to attend local and international conferences' – usually entailing business class air tickets, swish hotels, conference registration fees and generous per diem honoraria for the inconvenience of going along. I'll make my copy of this magazine available to this court for inspection and verification of the foregoing if requested. (Naturally an AIDS doctor such as Dr Martin would vaunt AZT as 'a medicine from Heaven', as he described it in *The Citizen* on 31 March 1999.)

201. On a more acute analysis of the society's activities, however, rather than being a respectable public service association as it pretends to be, the society is a criminal gang conducting a fraudulent and murderous racket. The template for the scam is a tried and tested one in Western culture, successfully used before to accumulate respectability and legitimacy, wealth and power, including the power to kill with impunity, a scam which the society has rechromed to suit and tap modern sensibilities and foibles. These include our perennial credulity in regard to the claims of authority figures, especially wearing distinctive garments; our persistent yearning for father-figure protectors; our essential need for a magical, unseen, ritual and irrational component to our lives even in an ostensibly modern age of reason, and our indispensable need for myth in some or other form; our limitless gullibility for the charms and potions hawked by medicine men; our natural aversion to thinking hard and our tendency to follow easily, especially self-billed experts; and the ascent of the scientific establishment as a source and provider of our vital beliefs, correlative to the decline in the credibility and power of established Western religious institutions and their belief systems. (Unlike the grocer, the pharmacist sells his goods in a white smock from a raised pulpit; and the physician always dangles an all but useless stethoscope around his neck, in place of a crucifix, to signal his learning, his wisdom and his authority.)

202. The scam works like this. The first trick is to dupe the laity into believing that a terrible and dangerous peril threatens their lives and wellbeing. Naturally, unlike hungry lions, hissing serpents and enemy warriors, this peril can't be seen with the naked eye or by ordinary persons. Fortunately, though, the society's members have special diagnostic implements with which to divine the evil of which they warn, and of which they claim arcane knowledge.

Moreover they know just how to defeat it with their special ministrations, or at least keep it at bay. They emphasize that their services in detecting and smiting this diabolism, which they have scientifically defined for us and given an awful, alarming name, are essential. Few things in life come free, so of course we must expect to pay for these professional services, and, being vitally indispensable, quite dearly. A crucial part of the scam is the accompanying threat that if we disrespect and disregard the assertions of these specialist professionals and decline their proffered services, we will come to dreadful harm; in fact we will die horribly.

203. The ministrations sold by the society happen to be deadly poisons. As they cause people to sicken and die, the society's members attribute this misfortune to the Devil that their lives are selflessly dedicated to fighting, explaining that although their ministrations are essential and life-saving, sometimes they don't have sufficient power. The people thus killed by these rogues are held up to the public as victims of the diabolical affliction, especially when they are the children of beloved leaders (annexure 'AB35') or are other renowned and fondly regarded figures; and there then generally follows a great awed murmuring and lamentation among the populace about the latest tragedy, reported in the broadsides read by all, all of which reinforces the mythology that the society has invented, consolidates the society's professional power, and increases the market for its professional activities, thereby keeping its members' private income stream flowing healthily.

204. The society's other trick is to attribute diseases that since the beginning of time have been natural consequences of poverty, a condition in South Africa arising chiefly from colonial dispossession and structural economic marginalisation, to a thoroughly reprehensible sort of private misconduct, namely a sexually indisciplined way of life out of sorts with the prescriptions for acceptable behaviour in this matter traditionally prescribed by the Western churches. This notion obviously attracts enthusiastic support from the clerics, in that it affords scientific validation of their mandates about these things. It also has the handy political advantage of obfuscating the root political causes of the heavy burden of disease among the poor, and

distracts from any disagreeable feeling among the rich that something needs doing about it since it's unfair and therefore uncomfortable, and again it expands the society's market for the rendering of its paid professional activities by penetrating this vast sorry constituency. Thus is poverty medicalized and monetized, and healing commoditized, all to the benefit of capital and the professional class. All the while, the society fraudulently masquerades as a 'public benefit organisation', its ringleader even uttering such crass fraudulent misrepresentations on oath in litigations.

205. What exposes the society's pretensions to serve the public interest rather than strictly its own is that were its members to be prohibited from charging special fees for their special services they'd flee their 'public benefit' work with the alacrity of thieves running from the police.

206. **Ad 3-11.** I admit that Dr Venter is a highly qualified AIDS clinician. In fact by virtue of his election to the leadership of his specialist professional order, he can probably be considered the most distinguished, knowledgeable and competent AIDS doctor in South Africa. As this court evaluates Dr Venter's evidence in the light of my answer to it, I respectfully request it keeps in mind his unparalleled brilliance among his peers in the field of applied AIDS medicine in South Africa. When it comes to AIDS medicine, Dr Venter's the brightest and the best.

207. **Ad 14.** It is false and it is perjurious of Dr Venter to claim on oath that 'There is scientific consensus that HIV is the cause of AIDS.' There's no 'scientific consensus', and Dr Venter is full-well aware that numerous scientists of the highest rank regard the HIV theory of AIDS to be 'bankrupt', to quote a correspondent of mine, Dr Richard Strohman PhD, emeritus professor of cell-biology, University of California at Berkeley, US, and that, in the words of Dr Bernard Forscher, former managing editor of the leading scientific journal, *Proceedings of the National Academy of Sciences of the United States of America*, it 'ranks with the "bad air" theory for malaria and the "bacterial infection" theory of beriberi and pellagra [caused by nutritional deficiencies]. It is a hoax that became a scam.' (Quoted in the *Sunday Times* (London) 3 April 1994) Actually, HIV as the cause of AIDS was not determined by 'scientific consensus'; it was officially established

by the American government by way of an announcement to journalists at a press conference held in a New York bistro on 23 April 1984 convened and attended by then US Secretary for Health Margaret Heckler, prior to the publication of any evidence by its proposer Dr Robert Gallo, let alone any proof; and in that remarkable manner did an alleged new retrovirus mooted by Dr Gallo as 'the probable cause of AIDS' become the official cause, described the next day in the *New York Times*, and ever since, as 'the virus that causes AIDS'. (I have a video recording of the press conference, which I can screen on request.) However, Dr Gallo's bogus claims to have identified a new retrovirus and to have demonstrated it to be the probable cause of AIDS in four papers in *Science* the following month were exploded in a close analytical review by Papadopulos-Eleopulos et al. in 'Has Gallo Proven the Role of HIV in AIDS?' *Emergency Medicine* [Australia] 1993;5:113-123. The paper commences with a summary of findings of scientific misconduct made against Dr Gallo in a subsequent enquiry by the US National Institute of Health's Office of Research Integrity – in short he was found to be a crook. I have copies of Dr Gallo's four papers in question, as well as the latter one, archived online at www.theperthgroup.com/SCIPAPERS/emedhivgallo.html, and I can produce them if required.

208. The lie to Dr Venter's false claim that there is 'scientific consensus that HIV is the cause of AIDS' is readily given by the attendance of 33 scientists and clinicians at two multi-session symposia convened at President Mbeki's instance in Pretoria and Johannesburg in May and July 2000 to debate the core controversies concerning the HIV/AIDS hypothesis and the conventional treatment of AIDS. About half of the them, all with impeccable academic and professional credentials, dispute the integrity of the HIV theory of AIDS and consider it, in the straight-talk of Nobel Laureate Dr Kary Mullis, to be 'one hell of a mistake'. (Annexure 'AB32') The other half, the believers, attended the symposia acknowledging that many scientists of high rank and reputation reject their beliefs as not being scientifically founded. No 'scientific consensus' was reached after the discussions that 'HIV is the cause of AIDS'.

209. It may be that since English is his second language Dr Venter does not appreciate that the word 'consensus' implies general agreement following the debate of an issue. There's never been any concerning the HIV theory of AIDS.

210. Among the leading critics of the HIV/AIDS hypothesis are a group of scientists led by biophysicist Eleni Papadopulos-Eleopulos of the Royal Perth Hospital, Western Australia, who consider AIDS to be caused by cellular oxidation induced inter alia by malnutrition. Lately, Professor Montagnier, the generally credited discoverer of 'HIV', appears to be in agreement with this view (detail below).

211. In any event, even if there were to exist a consensus of opinion about the HIV theory of AIDS, which there isn't, the fact of a consensus would not establish that it was true, as the history of science teaches over and over. Nor does the agreement of a majority – which is certainly the case concerning the HIV/AIDS model. Galileo identified the problem centuries ago: 'But even in conclusions which can only be known by reasoning, I say that the testimony of many has little more value than that of a few, since the number of people who reason well in complicated matters is much smaller than that of those who reason badly. If reasoning were like hauling I should agree that several reasoners would be worth more than one, just as several horses can haul more sacks of grain than one can. But reasoning is like racing and not like hauling, and a single Barbary steed can outrun a hundred dray horses. … I believe that good philosophers fly alone like eagles, and not in flocks like starlings. It is true that because eagles are rare birds they are little seen and less heard, while birds that fly like starlings fill the sky with shrieks and cries, and wherever they settle befoul the earth beneath them.' (*Galileo's Daughter* Dava Sobel, London: 4th Estate, 2000)

212. It's pertinent to mention that in the past there has been unanimous or majority scientific agreement among doctors that scurvy, beri-beri and pellagra are infectious; leprosy is sexually transmitted; malaria results from inhaling foul air; drilling a hole in the skull (trepanation) releases the bad spirits causing disease; syphilis is cured with mercury and arsenic; the transplacental carcinogen and teratogen diethylstilbestrol safely and effectively prevents miscarriage and premature delivery (1938-1971, thousands of

victims in the US); blood is made in the liver and reaches the arteries via invisible pores in the interventricular septum (this view, that of Galen, lasted 1400 years until Harvey's time); disease results from an imbalance of the four humours in the body: blood, phlegm, yellow bile and black bile – the latter, a plethora of which causes melancholy, being completely invisible and produced in suprarenal glands situated immediately above the kidneys, which glands are not visible either; bloodletting cures cholera, fever and any number of other maladies (a mainstay of Western therapeutics from Hippocrates's time for two and a half millennia, and advocated for pneumonia until as recently as the 1942 edition of Sir William Osler's venerable reference, *Principles and Practice of Medicine*); opium cures diabetes, otherwise arsenic; and slicing the front lobe of the brain off from the rest is a brilliant way to fix emotional or psychological distress and even calm unruly children.

213. In a recent letter to Dr Venter, I challenge an atrocious English and American medical practice, with all manner of mythological benefits claimed for it by doctors over the years (but never in continental Europe), which had been in decline in medicine, but whose revival in the AIDS age he and his fellow AIDS experts advocate enthusiastically. (Annexure 'AB36')

214. Crucially, to claim that 'HIV is the cause of AIDS', the first absolutely necessary (but not sufficient) condition is to have proof that HIV exists, namely a viral particle with unique morphology, proteins and RNA; and then, when this is proven, to have proof that the tests presently used to diagnose infection by this virus, i.e. the antibody, PCR and other sorts of tests are specific. Without such proof Dr Venter's statement is no more empirical than the claim, 'witchcraft is corrupting the realm'; and Dr Venter produces none. There is none. Obviously, images of 'HIV' generated by computers aren't evidence of 'HIV' any more than artists' impressions of variously named imps and familiar spirits, with their horns, tails, wings and cloven hooves – especially when the people turning out these impressive computer pictures are working with nondescript little blobs, ubiquitous in cell biology, the wrong size and the wrong shape, claimed nonetheless to be photomicrographs of 'HIV', but being as scientifically definitive as the many photographs of the mythical 'Loch Ness monster'.

Annexure ‘AB36A’ is an example of such a computer image of ‘HIV’, which the TAC, not knowing any better, puts about as proof that the virus exists.

215. The missing virus problem, the black hole at the centre of the HIV theory of AIDS, is discussed in summary in the journal *Medical Hypotheses* 2004;63(4):597-601 under the title ‘A critique of the Montagnier evidence for the HIV/AIDS hypothesis’ (annexure ‘AB37’, the abstract indexed by the US National Library of Medicine marked ‘A’, the full text, ‘B’), and extensively in Appendix XI to *Mother to Child Transmission of HIV and its Prevention with AZT and Nevirapine: A Critical Analysis of the Evidence*, annexure ‘AB38’ (at page 175ff), which I mentioned at the beginning of this affidavit. (I’ll refer to the main text of this monograph below.)

216. Dr Venter’s allegation that ‘Without medical intervention the vast majority of people with HIV will progress to AIDS and consequently die’ is fallacious on numerous scores. As will be plain to the intelligent reader of the just-cited discussions, there’s no proof that ‘HIV’ exists, that the tests currently used to diagnose it are specific, and that people diagnosed by doctors as HIV-positive (‘with HIV’) will get sick and die from AIDS. (‘Specificity’ as an expression used by antibody test-kit manufacturers does not denote specificity in relation to the putative pathogen, ‘HIV’; but since the question of the reliability and meaning of antibody test results is not raised by the TAC in this case, I’ll not treat this question any further here, and instead refer this court to the short discussion of the problem in annexure ‘AB38’ at page 3ff.) Dr Venter’s claim that without the charms he’s selling, the people he’s soliciting and importuning will die is the fraud of a medical huckster, no less than that of a mountebank in the seventeenth to nineteenth centuries selling mercury compounds for supposed syphilis infection on the same basis. Obviously the idea that sick people generally recover their health naturally in positive health-supporting conditions is an anathema to Dr Venter because it threatens his and his colleagues’s business: their business with prescribing artificial, alien, poisonous chemicals every day until the patient dies on them.

217. Assuming that Dr Venter is referring to ARVs, the standard medical treatment for AIDS, I reiterate that there has never been a

duly conducted and completed, randomized, placebo-controlled, double-blind clinical drug trial for any ARV drug, alone or in combination, that proves his allegation. On the other hand, there are innumerable cases of HIV-positive people referred to in the medical and popular press living in perfect health who have never taken ARVs. In fact this is the case of for the overwhelming majority. The point is easily proved thus:

218. 'Aids suspect has blood test at Edendale', an article published in the *Echo* supplement of *The Natal Witness* on 6 August 1987, announced the first case of suspected AIDS in Pietermaritzburg, the capital of KwaZulu-Natal. (Annexure 'AB39') I don't know what the result of the test was, but supposing it was positive, 1987 was the start of the excitement in that province.

219. In December 2005, thirteen years later, the Human Sciences Research Council reported that 40.7% of women in KwaZulu-Natal had the virus in them – by any reckoning an explosive spread of the plague. However, it's strictly been a paper epidemic keeping experts and activists busy, and newspapers selling, because there has been no observable correlative, sudden massive spike in the disease and mortality rate. Nothing is going on in KwaZulu-Natal that isn't consistent with, and can't be explained by, the distribution of the good things in life among the privileged as against the penury of the largely African poor and the burden of disease they carry – about which President Mbeki told the Leader of the Opposition Tony Leon in a letter in early 2000, later made available to the press, that 'even a child, from among the black communities, knows that our own "burden of disease" coincides with the racial divisions in our country'. This followed Mr Leon's manifestly vacuous claim in a preceding letter, obviously so to anyone who lives in this country and has travelled outside the leafy suburbs, that 'death and disease know no distinction of politics, creed or race'. (The exchange is archived by the *Sunday Times* at the internet address mentioned earlier.)

220. In short, contrary to Dr Venter's false claim about this, reacting positively to a so-called HIV-antibody test, even repeatedly, does not predict that you will get sick and die. (At most, there's some evidence of a weak, but not necessary, correlation between HIV antibody test reactivity and any number of health stresses and illnesses – just as an Erythrocyte Sedimentation Rate test ('ESR')

non-specifically but nonetheless usefully points to a possible health problem of some sort.)

221. Dr Venter states that 'medical intervention' will keep 'people with HIV' alive. But this is out of line with the orthodox medical view that a person diagnosed HIV-positive is doomed to die early and that at best ARVs can put off the evil day by a few years. LoveLife is no medical authority, but this marketing organization for the AIDS industry accurately captures general thinking among allopathic doctors in stating: 'Cool! The government is now providing Aids drugs. But, while this is going to improve the lives of peeps living with HIV/Aids, these drugs are NOT a cure for HIV/Aids. Anti-retroviral drugs can, in some cases, extend the life of somebody living with HIV for as much as eight to 12 years and even more. But there is no cure for HIV and you will eventually die from Aids-related causes or the side-effects of the drugs.' (Annexure 'AB40'; emphasis in the original.)

222. White homosexuals in the US, who've been in the front ranks of the HIV/AIDS delusion in that country, politically and as self-selected willing victims, know this well. The late Steven Gendin, a contributing editor of *POZ* (i.e. HIV positive), an ARV-promoting magazine supported by pharmaceutical advertising and sponsored directly by GlaxoSmithKline, wrote an article in the January 1999 issue candidly entitled 'If the virus doesn't get you, the drugs you take will'. In July 2000 he went himself at the age of 34, killed by ARV-induced heart failure. Annexed marked 'AB41' and 'AB42' are Gendin's article and ACT-UP founder Larry Kramer's eulogy to him, which is very revealing about the toxicity of ARVs experienced directly by the white gay AIDS set in the US. ACT-UP is the original gay ARV advocacy group in the US on which the TAC is closely modelled. Relative to its heyday it's virtually dead now in terms of turnout at its meetings; and the entire San Francisco chapter now repudiates ARVs. In Parliament on 19 April 2000 then Deputy President Zuma read from a letter it had sent to President Mbeki: 'For the past decade in San Francisco we have witnessed the destruction of human life caused by AIDS drugs. We hoped that by exhibiting at the [13th International AIDS] conference [in Durban in July], we could warn participants to prevent a similar catastrophe occurring in their countries.'

223. There's not a single properly conducted controlled clinical trial that has reported that people taking ARVs live longer than people who don't. The ARV manufacturers themselves are quite frank about this. For instance, AZT manufacturer GlaxoSmithKline says about its new state of the art ARV drug Ziagen in its 'Product Information': 'Ziagen has not been studied long enough to know if it will help you live longer or have fewer of the medical problems that are associated with HIV infection or AIDS.' (Excerpt, annexure 'AB42A') About Combivir, a combination of its drugs AZT and the chemically similar compound 3TC, GlaxoSmithKline notes: 'COMBIVIR is not a cure for HIV infection and patients may continue to experience illnesses associated with HIV infection, including opportunistic infections.' (Excerpt, annexure 'AB42B') Boehringer Ingelheim says about nevirapine: 'VIRAMUNE does not cure HIV or AIDS, and it is not known if it will help you live longer with HIV. People taking VIRAMUNE may still get infections common in people with HIV (opportunistic infections).' (Excerpt, annexure 'AB42C') Merck is no more encouraging about its protease inhibitor drug in its package insert: 'It is not known whether Crixivan will extend your life or reduce your chances of getting other illnesses associated with HIV.' (Excerpt, annexure 'AB42D') Gilead Sciences is equally pessimistic about its drug tenofovir, which the TAC is currently trying to ram through the MCC approval process; its 'Product Information' reads: 'VIREAD does not cure HIV-1 infection or AIDS. The long-term effects of VIREAD are not known at this time. People taking VIREAD may still get opportunistic infections or other conditions that happen with HIV-1 infection. Opportunistic infections are infections that develop because the immune system is weak. Some of these conditions are pneumonia, herpes virus infections, and Mycobacterium avium complex (MAC) infections.' (Excerpt, annexure 'AB42E')

224. According to the HSRC's latest 'HIV Prevalence' report published in December 2005, '24.4% of African females in this age group ['15-49 years'] were found to be HIV positive'. The HSRC reported that among young African women aged between 25 and 29 years 37.9% are infected; and of those aged between 30 and 34 years 31.7% are. In KwaZulu-Natal 40.7% of women are allegedly HIV infected, as I mentioned earlier. None of these

women were reported sick. There's no basis in reason and experience anywhere in the First or Third World to believe that they are all going to fall sick in the future with an invariably fatal pestilence, and that in a few years time a scythe will be cutting down the 'vast majority' (Dr Venter's phrase) of the putatively HIV infected African women of South Africa. A plague hardly touching whites, though, since the HSRC claims that a negligible 0.6% of whites are HIV infected. Every past doomsday prediction made by the AIDS experts has failed:

225. In the US, for instance, on 14 January 1986 the *New York Times* quoted Dr Anthony Fauci: 'By 1996, 3 to 5 million Americans will be HIV positive, and 1 million will be dead of AIDS.' (Fauci is the director of the National Institutes of Allergies and Infectious Diseases, a dominant branch of the National Institutes of Health, the founder of its Division of AIDS, head of a large AIDS research laboratory, and one of the government's leading spokesmen on AIDS. He is also the co-author, with his deputy Clifford Lane, of the AIDS chapter of the authoritative reference text, *Harrison's Principles of Internal Medicine*, and can justifiably be regarded as America's top AIDS expert – Dr Venter's counterpart in his country.)

226. Back in the real world, however, the US Centers for Disease Control reported that a mere 16,765 'AIDS deaths' occurred in the US in 1999, of a national population of about 270 million, which amounts to a miniscule, entirely uneventful 0.006%. (Annexure 'AB43') And the imagined infection rate in the US has remained a steady million or less for two decades, from the beginning of the AIDS era to the present time, all the American AIDS experts agree, contradicting every prediction of an exponentially multiplying epidemic sweeping through that country. But it's not ARVs keeping this estimated one million HIV infected Americans alive, because the overwhelming majority of them have never been tested, say the American AIDS experts. So not knowing they've got the virus in them, they aren't being treated.

227. As I've already explained, as chillingly sinister as it might sound, an 'AIDS death' is in any event simply a death from any number of age-old diseases rechristened, because AIDS has no specific

symptoms of its own – not being a disease but a syndrome of old diseases.

228. In Uganda, once vaunted by the AIDS experts as the very epicentre of the future African AIDS apocalypse, before South Africa was correctly identified as a more lucrative market, the anticipated explosion of AIDS has never taken place; instead the HIV infection rate is said to have plummeted. This is generally ascribed by Western AIDS experts to the lessons learned by Africans in Uganda concerning the importance of changing their sexually irresponsible, promiscuous habits and adopting a sexually restrained life-style – a profoundly racist, insulting explanation, but one that sits well in the white Western mind. No one has tried explaining how adopting a chaste way of life in line with the advice of AIDS counsellors fanning out all over the country, even if it were true, might cause the allegedly high percentage of HIV-positive Ugandans to drop to a low percentage; how by abstaining from enjoying sex, or becoming monogamous, or taking to wearing a condom, when you didn't before, you convert yourself from HIV-positive to HIV-negative. There's no good evidence that Ugandans are suddenly using condoms now, like never before, or have radically changed their sexual behaviour in line with Christian norms – in fact that it was ever any different from that of other people anywhere else in the world in the first place – nor are there mass graves to be seen throughout the country in which the missing HIV-positive people have been buried all on top of each other.

229. On 24 October 1997 the *Natal Witness* newspaper published a report of a statement by the Department of Health, based on the claims and predictions of the AIDS experts, that 'between 3.5 and 4.8 million South African children younger than 15 years will have lost their mothers to AIDS by 2000' and that these roaming masses of motherless children would in time 'comprise an estimated nine percent to 12% [sic] of the total population of South Africa'. Looking back in 2006, it's obvious that this wild talk, emanating from professional AIDS consultants, mostly white, was just rubbish. (Annexure 'AB44')

230. In short, having regard to the HSRC's numbers, the apocalypse in store for South Africa predicated on Dr Venter's alarming claims

is just a ruse to keep him and his colleagues in business, living in nice houses and driving luxurious cars.

231. I agree that some people sick with AIDS defining diseases such as tuberculosis may die without therapeutic intervention, but I dispute that they need ARVs, and I dispute that ARVs have ever been shown in any properly conducted clinical trial to make sick people better. (Since I'm persuaded that the several disease states grouped together under the rubric 'tuberculosis' are primarily the result of energy deficiency arising from malnutrition, I support intensive nutritional therapy. I do not support giving TB patients, who are typically severely malnourished, frank cell poisons such as antiquated, decades-old, severely and often unendurably toxic, and largely ineffective pharmaceutical TB drugs – all of which characteristics are widely acknowledged within conventional medicine.)

232. To buttress his claim that without ARV drugs, 'the vast majority of people with HIV will progress to AIDS and die', Dr Venter asserts that 'No reputable scientific body disputes this.' In the first instance scientific bodies are made up of people like him, or are advised by experts of his calibre, so that the fact that his opinion is shared by a group of people who think and reason as he does not render it more cogent. In the second, Dr Venter's style of argument is defective in a scientific as opposed to an ecclesiastical controversy: As Galileo's father Vicenzio commented aptly in *Dialogue of Ancient and Modern Music*; 'It appears to me that they who in proof of any assertion rely simply on the weight of authority, without adducing any argument in support of it, act very absurdly. I, on the contrary, wish to be allowed freely to question and answer you without any sort of adulation, as well becomes those who are in search of truth.' (*Galileo's Daughter* op cit)

233. **Ad 15.** It is false and it is perjurious to claim that 'There is scientific consensus that the benefits of ARVs, when used as a chronic lifelong treatment for people with advanced HIV-disease, outweigh the risks, and that currently ARVs are the only medicines that specifically treat HIV and reverse the course of AIDS.' There's no 'scientific consensus' as alleged, and many scientists and clinicians of high standing disagree with the orthodox fashion for treating 'advanced HIV disease' with ARVs,

and do not consider that such drugs have any benefits to outweigh their considerable risks. One of the principal issues on the agenda specified for discussion by the Presidential AIDS Advisory Panel in 2000 was whether ARVs such as AZT are good or bad drugs. No 'scientific consensus' was reached after the Panel's two meetings that they are safe and effective. There's no 'scientific consensus' and it's dishonest of Dr Venter to pretend there is.

234. That people diagnosed HIV-positive (with non-specific antibody tests) and told by practitioners of commercial allopathic bio-medicine they have low CD4 cell counts (in fact a medically insignificant state, like having freckles) and that they must therefore buy and consume the pharmaceutical industry's ARVs for the rest of their lives is certainly not the scientific consensus of experts teaching and practising in other much more widely followed medical schools around the world in all their enormous individual variety, such as African, Ayurvedic (Indian), Chinese, Native North and South American, European and American homeopathic, chiropractic and eclectic (herbal) medicine, and dozens of other medical schools, some modern (e.g. Shiatsu in Japan), but most ancient, all widely practised and respected in the regions and in the cultures that they are, often with formal governmental recognition in legislation and in other ways, precisely because they are effective, and evidently so. Unlike commercial allopathic medicine, these schools do not consider that disease should be attacked and fought, and their symptoms aggressively suppressed. Since they aren't shaped by the same savage, violent religious heritage as the West's, their organizing philosophies are wholly different.

235. Furthermore, not only is there a considerable body of professional medical and scientific opinion recognizing that ARVs such as AZT and nevirapine are unacceptably toxic and do not have any proven clinical therapeutic and prophylactic value, there's also published research and review literature demonstrating that these drugs cannot, and, by all conventional markers for virostatic activity, do not have the pharmacological action claimed for them by their manufacturers, i.e. they do not 'specifically treat HIV'. I'll deal with this in detail below.

236. Not a single manufacturer of ARV drugs claims that its drug or drugs can 'reverse the course of AIDS', either in that language, or

in any other with the meaning that such drugs can make sick people well or keep healthy people from falling sick. This is because there's no good clinical evidence that they do. It's in any event a fallacy that AIDS, a syndrome of completely unrelated diseases including madness, has a 'course' in terms of a set, predictable pattern of clinical deterioration. So Dr Venter's statement about this is false.

237. **Ad 16.** The statement that 'There is a scientific consensus that ARVs, including AZT and nevirapine, are effective at reducing the risk of mother to child transmission of HIV' is false. There's no such 'scientific consensus'. Many scientists disagree. Annexure 'AB38' is a comprehensive submission to the South African government in late 2001 closely examining and refuting this popular medical mythology. In summary: to claim that ARVs reduce mother to child transmission of HIV one needs a specific test for HIV infection. There's no such test. Even if such a test existed, there's no evidence that HIV is transmitted mother to child during pregnancy or labour. And even if there was, there's no evidence that these drugs have the prophylactic action claimed for them. But the root problem of the medical paradigm in question, the peculiar Western medical idea that a mother can kill her child by nurturing it in her womb, and giving birth to it naturally – by breastfeeding it too – by dint of infecting it with an invisible virus in the process, is laid bare in Appendix XI of the monograph (page 175ff): there's no virus any more than there's a tokoloshe. (An Indian prosecutor once told me, quite seriously, that she'd woken up in the middle of the night and seen a tokoloshe, as she described it, standing at the foot of her bed with an enormous penis wrapped around his neck; and the following day she'd had terrible pains in her private parts. (The mediaeval histories are stuffed with similar accounts.) Though, unlike Miss Maharaj, Dr Venter and his fellow AIDS experts haven't actually seen their tiny Satan with their own eyes, they believe, quite seriously, that it lurks permanently in this unmentionable crevice, especially in the case of African women – but not in our mouths, ears or up our noses.)

238. According to Professor Brooks Jackson, a principal investigator of the HIVNET 012 nevirapine clinical trial, 'No researcher can assess a drug's effectiveness with scientific certainty without

testing it against a placebo. That's the only way we can know for sure if a short course of AZT or nevirapine is better than nothing.' Annexure 'AB45' is a letter published in *Nature* quoting him in paraphrase, and providing the source of his statement. (The inapposite subtitle of the letter was added by the journal's editors.) No such placebo-controlled study of these drugs for this indication (preventing mother to child transmission of 'HIV') has ever been performed. Though the original AZT mother to child prevention study, ACTG 076, was described as 'randomised, double-blind, placebo controlled', it was a shambles, exposed as such at page 71ff of annexure 'AB38'.

239. Dr Venter's expression 'HIV-disease' is a disease-mongering concoction of AIDS experts, which, albeit practically useful to them in extending their professional and economic power over the sick to over the perfectly healthy as well, is devoid of empirical content. If you are clinically well, feeling 100% hale and hearty, but are determined to be HIV-antibody positive with a high 'viral load' reading and/or a low CD4 cell count based on the interpretation of laboratory test results, AIDS experts such as Dr Venter tell you as you blink in disbelief that you have 'advanced HIV disease'. In reality, for reasons to be detailed in due course, the diagnosis of 'advanced HIV disease' is uninformative and irrelevant, except to the extent that a healthy person terrified by the medical pronouncement may be induced thereby into swallowing ARVs, in which case there's a high probability that he will fall seriously ill and die (per Reisler et al., cited above).

240. **Ad 17.** It is so that 'ARVs, including AZT, are recommended in government policy for post-exposure prophylaxis following occupational exposure and sexual assault', but this is on the advice of distinguished AIDS experts such as Dr Venter.

241. **Ad 18.** To the extent that Dr Venter means what is ordinarily meant by 'controlled clinical studies', namely randomized, double-blind, placebo-controlled ones, his statement that such studies have duly been performed to prove the therapeutic and perinatal prophylactic efficacy of ARV drugs is false. They haven't. His statement that the 'balance of evidence' shows that ARVs are effective for 'post-exposure prophylaxis' is also false. There can be no balance of evidence because there's no reliable evidence to balance: According to the US Centers for Disease

Control's MMWR (Morbidity and Mortality Weekly Report) on 21January 2005 (54(RR02);1-20, 'The provision of antiretroviral drugs to prevent HIV infection after unanticipated sexual or injection-drug-use exposure *might be* beneficial.' (My emphasis; the word 'might' appears more than 60 times in the CDC recommendation.) Furthermore, the CDC's position on ARV administration for post-exposure prophylaxis is not supported by the FDA. To avoid cluttering the record, I annex the first five relevant pages of the MMWR in question only, marked 'AB46'.

242. In its 'Antiretroviral Side Effects and Toxicity' discussion in this MMWR, the CDC opens with the soothing claim that 'Initial concerns about severe side effects and toxicities have been ameliorated by experience with health-care workers who have taken PEP after occupational exposures.' In other words, what the CDC's AIDS doctors, who can't speak English properly, mean is that people contemplating taking these drugs needn't worry about being poisoned by them: the early reports about how unendurably toxic most health workers found ARV drugs, even for short periods, can and should be disregarded.

243. Because it says ARV drugs 'might be beneficial', the CDC recommends a '28-day course' after 'exposure to blood, genital secretions, or other potentially infected body fluids of persons known to be HIV infected'.

244. Just a few months later, however, the CDC published its 'Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Postexposure Prophylaxis' September 30, 2005 / Vol. 54 / No. RR-9.

245. Now the CDC informs us in the 'Toxicity and Drug Interactions of Antiretroviral Agents' that 'Persons receiving PEP should complete a full 4-week regimen (*3*). However, as a result of toxicity and side effects among HCP ['health-care personnel'], a substantial proportion of HCP have been unable to complete a full 4-week course of HIV PEP (*15–20*). … Side effects have been reported frequently by persons taking antiretroviral agents as PEP (*15–23*). In multiple instances, a substantial (range: 17%–47%) proportion of HCP taking PEP after occupational exposures to HIV-positive sources did not complete a full 4-week course of

therapy because of inability to tolerate the drugs (*15–17,19,20*).' I annex the relevant pages only, including the numbered references, marked 'AB47'.

246. Completely ignorant of this, apparently, AIDS experts such as Dr Venter reckon that South Africans, mostly African, mostly poor, should take these toxic drugs – which up to half of nurses and doctors like him can't bear for more than a couple of weeks – every day for the rest of their lives.

247. **Ad 19.** It is notorious that 'South African government policy to provide ARV treatment to people through the public health system' was adopted only after the most intense, concerted, orchestrated political coercion of our country's democratic government by pharmaceutical industry interest groups based locally and abroad, in the teeth of President Mbeki and Dr Tshabalala-Msimang's vehement, vocal, informed opposition to these drugs, along with that of many other senior representatives of our country's overwhelmingly popularly supported liberation movement, the African National Congress. This tragic debacle vividly illuminates the undiminished strength of corporate power well into our democratic era, exercised though the many agencies and individuals that it dupes, controls, influences, corrupts and coopts, including retired presidents in South Africa and the US, senior clerics incumbent and retired, ostensibly progressive and left wing individuals and groups, the mass media, and of course powerful 'scientifically illiterate' ARV lobby groups such as the TAC.

248. Government policy to provide nevirapine to mostly African, mostly poor women in labour and to their newborn babies was forced on it by the judiciary on the strength of a single clinical trial, HIVNET 012, since rejected as corrupt and worthless by our Medicines Control Council. The High Court judge and the Constitutional Court justices involved in the case all imagined that their judgments would actually save babies' lives: all proceeded from the folly that if a mother would only swallow a pill during labour and permit a shot of the same chemical to be squirted down her newborn baby's throat, her baby would be saved, like at a Catholic christening. I'll return to this below.

249. **Ad 20.** If by putting up his HIV Clinicians Society's 'Guidelines for Antiretroviral Therapy in Adults', 'produced by local experts' of the society 'in accordance with new developments in therapeutic technologies' marketed by the pharmaceutical industry and 'Printed by the Treatment Action Campaign and Southern African HIV Clinicians Society', Dr Venter means to demonstrate reliably established medical science, I would point out that in reality AIDS therapeutics are chaotic, with treatment orthodoxy not merely shifting here and there, but up-ending and reversing itself every couple of years – a pattern evincing a medical paradigm in deep decay.

250. For instance, the 32nd edition of the authoritative *Martindale: The Complete Drug Reference* published in 1999 (kept in the library of the University of Cape Town's medical school) records that 'Treatment options for patients with HIV infection are changing rapidly with a trend towards initiating therapy with combinations of antiretroviral drugs at an early stage of the infection. Until recently zidovudine was given as monotherapy.' But just a year later, on account of mounting grave toxicity reports and concerns, top US government AIDS experts had abruptly abandoned the 'trend towards initiating therapy with combinations of antiretroviral drugs at an early stage of the infection', and were again urging the delay of treatment initiation for as long as possible:

251. *New Scientist* reported on 16 December 2000, under the headline, *No More Cocktails*, that 'Four years of "hit hard, hit early" HIV treatment may be on the way out in the US, as evidence mounts of the drugs' serious side effects. AIDS experts in the US are about to complete a humiliating U-turn when the Department of Health and Human Services launches its revised HIV treatment guidelines in January.' (Annexure 'AB48') As leading US AIDS journalist Laurie Garrett put it in *Newsday* on 17 January 2001, 'Instead of telling American physicians to "hit early, hit hard", a policy in effect since 1996 that calls for giving HIV-positive patients powerful drug cocktails before the patients actually experience any symptoms of illness, the new National Institutes of Health guidelines will call for caution and delay in treatment.' She mentioned an epiphany arrived at by 'prominent AIDS physician' Charles Carpenter of Brown University, a member of

the AIDS advisory committee to the US National Institutes of Health ('NIH'), which he shared with the Royal Society of Medicine in London in a speech he had given in December: 'In retrospect, we now realize the risk of drug toxicity is greatly enhanced by taking these drugs early.' (Since 'drug toxicity' is chemically inherent, what this person was trying to say, but couldn't quite get out, is that the sooner you go on ARVs, the sooner their toxicity to your body becomes evident as you get very sick.) Anthony Fauci, director of the National Institute of Allergies and Infectious Diseases, and one of the Co-Chairs of the panel convened to review the official treatment regime, agreed, more or less, that not only is the medicine dangerous, it doesn't even work: 'It's clear we're not going to eradicate the virus with the drugs we have now. And we're starting to see a greater and greater realization of the accumulation of toxic side effects.' (Doctors are waking up.) *Newsday* dashed off a litany of some of them: 'death of hip bone tissue, increase in blood cholesterol levels, neuropathy or loss of nerve sensations, kidney failure, radical alterations of liver metabolism, diabetes, skin rashes, pancreas failure, severe anemia, liver dysfunctions so acute as to require transplants and near-instantaneous death due to buildup of lactic acid.' (Annexure 'AB49')

252. Breaking the news on 4 February 2001, the *New York Times* quoted Fauci: 'We are adopting a significantly more conservative recommendation profile' – the idea being, as article paraphrased him, to allow 'the virus to remain in the body longer in return for sparing the patient the drug toxicities'. (Annexure 'AB50')

253. In short, Fauci conceded, in the face of the published evidence, that ARVs are much more harmful than the supposed virus.

254. The Americans released their *HIV Treatment Guidelines Updated for Adults and Adolescents* the next day. In an editorial in the *AIDS Reader* in early 2002, 'Update From Seattle: The 9th Annual Retrovirus Conference', Jeffrey Laurence spelt out the reason for the rethink as being 'the side effects of all HAART regimens [*ARV combinations*] and the limited evidence of survival benefit for initiating therapy in asymptomatic persons even at relatively low CD4 cell counts … Much of this is being driven by some prominent cardiovascular, endocrine, and bone metabolism effects of HAART.' (Annexure 'AB51')

255. More examples of the chopping and changing in AIDS therapeutics protocol: Whereas the US Public Health Service (PHS) announced in its 1993 Guidelines for the treatment of HIV-positive people that AZT monotherapy was the way to go, its revised 1997 Guidelines said no, combinations of ARVs were – but only when patients' CD4 cell count dropped below 500 cells per mm^3 or their 'viral load' rose above 10 to 20 000 'copies' per mL. The next retreat was in 2001 when the Guidelines were changed again, recommending raised criteria before initiation of treatment to 350 cells and 55 000 'copies' respectively. The bar was raised even higher in 2002, when the recommendation that all people with 'acute primary HIV infection' (i.e. high 'viral loads') be treated was dumped. (This is to say, the AIDS experts were having doubts about whether a high 'viral load' really did have any real world meaning for clinical health prognosis.) All these changes – backwards – by the AIDS experts were intended to limit the entry of people going on ARVs, in their growing appreciation of how dangerously toxic they are.

256. A further instance of the hopeless disorder in treatment orthodoxy: AIDS experts have persistently frightened their patients into staying on their drugs, notwithstanding their terrible ill effects, by threatening that unless they do, drug-resistant strains of HIV will appear, due to their 'propensity to induce resistance when not taken with absolute consistency', as Professor Susan Ball put it in 'Patients Who Want to Stop Their Medications: Treatment Interruption in HIV Infection', published in the *AIDS Reader* in August 2003, in line with the revised *Guidelines for the Use of Antiretroviral Agents in HIV-Infected Adults and Adolescents* released by the US Department of Health and Human Services in January 2001. (Annexure 'AB52') Co-chairman of the panel that drew then, John Bartlett, chief of the division of infectious diseases at the Johns Hopkins University Medical Center said, 'Extraordinarily high rates of adherence to an antiviral drug regimen are necessary to maintain control over HIV replication. HIV is very unforgiving in this regard. It is impossible to over-emphasize the importance of maximizing adherence once the decision is made to begin therapy.' But 'Accrued HIV evidence turns treatment dogma on its head', wrote Erika Check in the world's most prestigious scientific journal *Nature* in the same month as Ball's article appeared: 'A series of

studies has dispelled the widespread notion that patients who don't take every dose of their anti-HIV medication create a public-health risk by helping to nurture HIV strains that resist therapy. The findings suggest instead that some patients who do not take all of their medicine are actually less likely to become resistant to therapy than those who adhere rigidly to their doctors' instructions.' (Annexure 'AB53') Comment would be superfluous.

257. The latest indication of an imminent further retreat from deadly toxic nucleoside analogue-based ARV cocktails, the standard workhorse of AIDS therapeutics for two decades, appeared in the *Washington Post* on 19 January 2006, with these drugs looking set to be displaced by a two-thirds lighter dose, single-pill a day combination of others: 1100mg daily of newer drugs versus a current typical 3300mg of the older ARVs combined. (Annexure 'AB53A') As is evident from the abstract of the study mentioned in the news report, claims to efficacy had nothing to do with effects on clinical health – whether the drugs make you well or not – but were on so-called surrogate markers only, to be discussed below. (Annexure 'AB53B')

258. There's accordingly every reason to think that Dr Venter's HIV Clinicians Society guidelines will have all the lasting worth of the Mark in the Weimar Republic.

259. Past experience in South Africa tells that the government's AIDS treatment guidelines, cited by Dr Venter, and drawn on the advice of AIDS experts like him, will soon be yellowing and forgotten too: *Public Health in South Africa* (Central News Agency, 2nd ed., undated, but *c*. 1940) by EH Cluver M.A., M.D., B.Ch. (Oxon) D.P.H. (LOND.), B.A. (C.G.H.), F.R. San. I., Secretary for Public Health of the Union of South Africa, and Director-General of Medical, Hygiene and Dental Services, Union Defence Forces; Chief Health Officer, Union Department of Public Health; Honorary Professor of Public Health, University of the Witwatersrand; Associate Editor, Journal of Industrial Hygiene (U.S.A. and Great Britain); Late Professor of Physiology, University of the Witwatersrand, Johannesburg, records numerous obsolete medical notions, some amusing, some appalling to read half a century later, among them the European medical wisdom that venereal diseases 'tend to spread

particularly among uneducated non-Europeans crowded together in the less salubrious portions of our towns. … The detribalizing of large masses of natives was also followed by promiscuous habits so that infection rapidly spread over wide areas of the country.' (Non-African AIDS experts in our country today blame African migrant workers spreading AIDS along similar lines; and white AIDS doctors always set up their AIDS treatment missions in African townships (not in the white suburbs), being the 'less salubrious portions of our towns' where HIV 'infection' is claimed by them to have 'rapidly spread' among these 'non-Europeans crowded together'.)

260. The test for 'syphilis' then in universal use was the Wasserman test. However, the *Oxford Illustrated Companion to Medicine* (3rd edition, 1986) mentions that 'It was not until the early 1940s that it was fully realized that many diseases could be responsible for a positive Wassermann reaction.' The Wasserman test has since been abandoned as hopelessly non-specific, but not before hundreds of thousands of people were killed or physically and mentally crippled by the standard treatment of the day:

261. This standard treatment was described in 1944 in *The Sick African: A Clinical Study* (Cape Town: Stewart Printing Co.) by Michael Gefland M.B., Ch.B. (Cape Town), M.R.C.P. (Lond.), D.M.R. (Eng.), Government Medical Service, Southern Rhodesia; Medical Officer, Salisbury Native Hospital; Physician to the Emergency Hospital and Government Pathologist, Pasteur Institute and Public Health Laboratory, Salisbury: 'Syphilis is a subject of paramount importance. The incidence is difficult to gauge, but it seems to be present in 20 per cent. or more of all Natives. Its recognition is important, not because the treatment given to the Native is in any way inadequate, but largely in order to prevent his spreading the infection by contact with the Europeans or his own people. This is accomplished by giving the syphilitic a short course of arsenical injections, to render him non-infectious. … Of course, if ... the Native can be persuaded to attend for a longer course, better results will be obtained. … Perhaps the solution to the problem may be found in the administration of arsenic in massive doses by intravenous injection continued over a few days. Reports from the Union of South Africa … appear to be promising. This is certainly a form

of therapy that should draw the attention of the public authorities. … I am confident that the solution to syphilis in the Native lies in this form of treatment, but its potential danger must not be overlooked.' After this neurotoxic treat, the next bit follows naturally: 'Certain doctors appear to believe that neuro-syphilis in the Native is rare. This is incorrect, for the disease is by no means uncommon. … No difficulty should be experienced in recognising a case of general paralysis, providing the condition is remembered. It is characterised by gross mental disorders, such as depressive and maniacal states of dementia. The patient may be euphoric or may exhibit grandiose delusions and hallucinations. … Voluntary power is impaired and inco-ordination marked. The gait may be unsteady. Epileptiform seizures occur in some of the cases, or an apoplectiform attack may set in, with resultant hemiplegia or aphasia. In the Native, G.P.I. ['general paralysis of the insane'] must be distinguished from other causes of psychosis. … The G.P.I [case] should be certified and sent to an asylum for treatment.' (With more arsenic.)

262. Dr Cluver mentioned that the Public Health Act of 1919 provided for the compulsory (Wasserman) testing and (arsenic) treatment of suspected 'syphilis' cases – in practice mostly of 'Natives'. A preceding statute passed in the Cape Colony in 1885, the Contagious Diseases Act, provided for such victims of high European medical intentions to be 'detained for treatment in lock hospitals established for the purpose'. Prior to the introduction of the injectable arsenic compound Salvarsan for 'syphilis' in 1909, the standard treatment was with the equally deadly heavy metal mercury, still being described in 1939 in the 24th edition of *Hale-White's Materia Medica*: *Pharmacy, Pharmacology and Therapeutics* as 'one of the most valuable medicines we have'. By the middle of the century all references to mercury and arsenic in therapeutics reference texts were to 'poisoning by' only.

263. I'll produce my copies of all these books at the hearing if requested.

264. As with non-specific Wasserman testing for 'syphilis', more than sixty diseases and conditions have been documented in the medical literature to cause reactivity to HIV antibody testing. (Annexure 'AB54') That an increased rate of reactive results to these non-specific tests will occur among the African poor is

therefore to be expected, given that apart from not getting enough nutritious food to eat, they also suffer a consequent high incidence of disease.

265. **Ad 21.** The number of people 'being treated with ARVs in the public health sector' cannot be assumed to equal the number of people actually swallowing these drugs – or swallowing them for very long. As Fellay et al. have found and reported (cited above) ARVs are unendurably toxic for more than two thirds of people prescribed them. And Department of Health HIV/AIDS directorate head Dr Nomonde Xundu has recently pointed out that the absence of a national patient information system makes it impossible to say 'how many patients had dropped out of the programme, how many had died … how many had been forced to change drugs because of dangerous side-effects', according to a report in *Business Day*, 3 March 2006. (Annexure 'AB55')

266. **Ad 23.** It is so that on its face the registration of a medicine means that it has been found acceptably safe and effective by the Medicine Control Council. According to the MCC's internet website, decisions in this regard are taken by 'external consultants' teaching at the country's medical and pharmacy schools. Like the Broederbond, however, they operate secretly, anonymously and unaccountably, picking their friends to join them whenever a vacancy opens up, and avoiding taking in troublemakers for the smooth running of the pharmaceutical business (detail below). Since such pharmacology academics routinely pad their meagre academic incomes with handsome fees for conducting pharmaceutical drug trials, conflict of financial interest is rife among them. But moreover, in the area of ARVs the MCC's decision-making 'external consultants' have repeatedly revealed themselves to be disgracefully ignorant, indolent, incompetent and demonstrably incapable of discharging their statutory responsibility to protect the South African public from being harmed by useless and ineffective drugs:

267. On 6 August 2002 Professor Mhlongo filed a submission to the MCC concerning the perinatal use of nevirapine, a list of one hundred points that we drew summarising the case against this special indication, based on the information about HIVNET 012 publicly known at the time. (Pages 22-34 of annexure 'AB4') This is the clinical trial on the basis of which the MCC

provisionally registered nevirapine for use in maternity wards. (Much more grave information about how corrupt the study was emerged in December 2004 and early 2005, including evidence of innumerable unreported severe adverse reactions and fatalities. This is canvassed in detail in Part Nine of my book *The trouble with nevirapine*, online at www.tig.org.za. I'll deal with this aspect in depth below.)

268. On receiving the submission, Dr Rajen Misra, head of the MCC sub-committee reviewing the drug, telephoned Professor Mhlongo two days later to confirm receipt and thanked him for it. He remarked that it was obvious from the submission that Professor Mhlongo knew more about the drug in question than any member of the MCC, and went on to tell him that he consequently intended proposing to the council that he be invited aboard it. He never did; though extraordinarily highly qualified, with a string of advanced English and American medical accreditations and licences to his name, Professor Mhlongo was passed over, and Roy Jobson, one of his very junior white colleagues, got taken in instead.

269. Notwithstanding Dr Misra's remark that we know what we are talking about, that we know more about nevirapine than anyone on the MCC, the MCC has never addressed the submission. There's no indication that its members have ever applied their minds to it, despite Dr Misra's undertaking to Professor Mhlongo in their conversation that it would be duly considered.

270. To its credit, despite the dishonest endeavours of the American director of the NIH's Division of AIDS, Dr Edmund Tramont, to deceive the MCC about the fatal problems with HIVNET 012 (detail below), the MCC eventually rejected the study (although on narrow, superficial grounds only, none of which were the subject of Professor Mhlongo's 100-point submission) and put the manufacturer Boehringer Ingelheim on terms to table acceptable proof of efficacy. When in June 2003 the time allowed had come and gone without Boehringer Ingelheim having complied, but the MCC had still not deregistered the drug, I wrote to the MCC asking why. (Pages 10-22 of annexure 'AB4')

271. The MCC didn't answer. Its next move was on 12 July 2003, not deregistering the perinatal administration of nevirapine on the

basis that no proper clinical trial evidence existed to support its continued registration as I'd pointed out, but instead issuing a statement that it now recommended the drug be taken by HIV-positive pregnant women in tandem with AZT.

272. Over the following months I wrote several letters to the MCC drawing its attention to the serious foetal and neonatal toxicity of AZT and the grave proven harm that it has been reported to cause unborn and newly born children. (Pages 35ff of annexure 'AB4', including an afterword mentioning some critically important recent research findings.)

273. I can assure this court that to the best of my knowledge no one has performed and published a more thorough and exhaustive review and analysis of the research literature on the foetal and neonatal toxicity of AZT than I have; and this has been confirmed to me by the most informed, exacting and rigorous critics of the drug, Papadopulos-Eleopulos et al. at the Royal Perth Hospital, Western Australia.

274. I have it that on receiving my letters, a member of the MCC telephoned the Minister of Health remarking that he was 'amazed' by the 'detailed research' evident in them, of which he'd been 'unaware'.

275. Nonetheless, the unequivocal findings of serious permanent harm caused to children exposed to AZT (and similar drugs) in utero and post-natally, which I brought to the attention of the MCC's members, and which on their own version they hadn't known about, were blithely dismissed by MCC chairman Professor Eagles. (Annexure 'AB58')

276. On a consideration of the foetal toxicity data that I brought to the MCC's attention, and which I've put up with these papers, it will be obvious to this court that the MCC's decision-making 'external consultants' are inept and incapable of doing their job. It's inconceivable that on a full appreciation of the reported data that I've synopsized any of them would permit the administration of AZT and similar drugs to their pregnant wives or girlfriends and babies. I am certain this court wouldn't.

277. **Ad 24.** It is true that 'AZT, nevirapine and other ARVs are approved' by the US, European, Canadian and other regulatory

bodies. The corrupt circumstances in which AZT came to be registered in the US and the rest of the world as an AIDS drug are detailed in the history of the process that I wrote, *Licensing AZT*, annexed hereto marked 'AB59'. The way in which nevirapine was 'fast-track' registered in the US and by the continental European drug regulatory authority, without the manufacturer having provided any evidence of clinical efficacy, are described by me in Part One of *The trouble with nevirapine*. How nevirapine was licensed in Canada under direct political pressure after twice being rejected as both ineffective and unsafe is detailed by me in Part Two – informed by copies of internal government memoranda that I obtained. Since the TAC's main complaint goes to my group's statements about AZT rather than nevirapine, to contain the case and its ambit I've not put *The trouble with nevirapine* up with these papers, but I'll make the book manuscript available if requested at the hearing. As I mentioned, the entire text is freely available online at www.tig.org.za. It includes an uncompromising critique of the conduct of the Constitutional Court in its handling of the nevirapine case.

278. **Ad 25.** Indeed the WHO and UNAIDS recommend ARVs (just as the League of Nations's Health Organization recommended arsenic injections for syphilis) but the doctors working for those organizations have never presented any of their own or any other researchers' evidence to support their claims concerning these drugs: Among all the masses of data published about AZT and other ARV drugs, it has never been shown by way of a properly conducted clinical trial that they are therapeutically beneficial in terms of real-world clinical outcomes, meaning making and keeping people well.

279. **Ad 26.** The 'Durban Declaration of July 2000, affirming that HIV is the cause of AIDS, and affirming the life-saving nature of ARV treatments' manifestly has no greater evidential value than a joint religious confession of faith. It was a political stunt conceived by Simon Wain-Hobson of the Pasteur Institute in Paris, apparently intended to drown out the dissident voices given space by President Mbeki at his AIDS Advisory Panel meetings in May and July that year. A copy of the request for signatories circulated by Wain-Hobson by email is annexed marked 'AB60'. As it

shows, people were recruited even if they weren't *au fait* with the HIV theory of AIDS. When President Mbeki let it be known through his spokesman that should the 'Durban Declaration' be presented to him it would go straight into 'the dust bins of his office', the conspirators lost heart and cancelled the press conference that they'd arranged at the 13th International AIDS Conference in Durban, where they'd intended making a theatrical announcement of their achievement.

280. Obviously, from the many lessons of history, even if five million had signed the 'Durban Declaration', this would not have scientifically validated its core claims because science has never been established by counting a show of hands. *Au contraire*, time usually shows the majority in medicine to have been completely and dangerously wrong. Over and over again.

281. **Ad 27.** I am unable to discern any scientific significance in the fact that 'The Revised Guideline 6 of International Guidelines on access to prevention, treatment, care and support promulgated jointly by UN High Commissioner for Human Rights and UNAIDS (2003) calls on all states to "ensure …the availability"' of ARVs. This is not evidence for efficacy but rather of drug industry influence and hegemony, and I submit that this statement is accordingly completely irrelevant.

282. **Ad 28.** The WHO's statement 'acknowledging that antiretroviral therapy has reduced mortality and prolonged healthy lives' is another political declaration made without any proof of its substance. To the extent that the WHO is referring to AZT in 'acknowledging' that it 'reduce[s] mortality and prolongs healthy lives', this fallacy is based on the hopelessly corrupt clinical trial that preceded approval by the FDA, detailed in my article *Licensing AZT* (annexure 'AB59'). My principal sources in the peer-reviewed scientific literature, investigative journalism in the print media, two dedicated books and two separate documentary exposés of BW002, broadcast on national television in the US and the UK, are indicated in the first paragraph of my article.

283. **Ad 36.** Dr Venter chooses the pejorative expression 'AIDS denialists' for what he refers to as 'a fringe group of people collectively referred to in the media and in debate as "AIDS dissidents", "AIDS denialists" or "HIV denialists" [who] argue

that HIV is not the cause of AIDS and/or that the risks of ARVs outweigh their benefits'. His language is apparently contrived to arouse a feeling of moral repugnance, given that the expression 'denialist' is most commonly applied to anathematise people who question the received history of the catastrophe suffered by the Jewish people in Europe at the hands of the Nazis and other European fascists. And it distinguishes his HIV/AIDS belief system from science, because any paradigm that's dogmatically subscribed to rather than tentatively so, and doesn't tolerate, indeed encourage, close scrutiny and vigorous challenge (i.e. is falsifiable), is not science but its brain-dead, quasi-religious usurper, scientism.

284. Significantly for the conceptual vocabulary which Dr Venter invokes, the earliest reference to the concept of denialism in the matter of contested knowledge that I've found is in the complaint of Pope Innocent VIII on 9 December 1484 that the widespread practice of witchcraft, which he'd just alleged and detailed in a bull, 'had met denials by the local authorities that these enormities were being practised'. (*The Trials of the Lancashire Witches: A Study of Seventeenth Century Witchcraft* Edgar Peel and Pat Southern (Devon: David & Charles, 1969)) He accordingly authorized his inquisitors to (I quote the Pope) 'call on the help of any secular arm, and anyone, of whatever rank, pre-eminence or dignity who opposes them is threatened with excommunication, and yet more terrible penalties and punishments without any right of appeal'.

285. I found another enlightening reference to the concept of 'denialism' in a statement by the Rev Samuel Parris, the Salem minister, who described the 'hellish operations' in his village in 1692: 'It is altogether undeniable, that our great and blessed God, for wise and holy ends, hath suffered many persons in several families of this little village, to be grievously vexed, and tortured in body, and to be deeply tempted, to the endangering of the destruction of their souls; and all these amazing feats (well known to many of us) to be done by witchcraft and diabolical operations.' (*The Witches of Salem* op cit)

286. Like Pope Innocent VIII, the TAC has just accused the students of the University of Cape Town of denialism for not accepting its claim that HIV and AIDS are everywhere on the campus, even if

there's no evidence of this that level-headed young people can see. (Annexure 'AB60A')

287. Given the intense political electricity with which any challenge to, or even passive doubt over, the closed, perfect belief-system of HIV/AIDS orthodoxy is charged, no matter how tentative or mild, and the frequently virulent intolerance of its defenders, I suggest that 'AIDS dissident' is the more apposite appellation than 'denialist', and I'm personally comfortable with it. I therefore have no objection to being rated at the top of the hit parade of 'South Africa's Top Twelve AIDS Dissidents', a blacklist published by the Democratic Alliance last year. (Annexure 'AB61') The TAC ranks me alike; speaking at the John Foster Lecture at the University of KwaZulu-Natal on 10 November 2004, Achmat stated: 'There are few rivals to Lysenko's position in the South African AIDS debate. I wish to give this dishonourable achievement to Anthony Brink, an AIDS denialist who seems to have found the ear of the President.'

288. It's not even necessary to express a dissentient opinion to attract the TAC's vindictive persecution and haranguing in extravagant and hateful terms. In a latter-day revival of the ancient ecclesiastical offence of accidie (failure to exhibit sufficient pious zeal) even a disinclination to share in the ardour about the sexual theory of AIDS is continuously denounced by the TAC in a McCarthyesque manner. I annex, marked 'AB62', a typical example of this pattern of conduct in an excerpts from the TAC's 'Submission to African Peer Review Mechanism: February 2006: The HIV Epidemic: A discussion of the response of the South African Government':

289. 'As we show in this submission, while a number of important interventions have been implemented to respond to the HIV crisis, there has been a lack of leadership from the highest political level, especially from President Mbeki and the Minister of Health. This lack of leadership, which has been epitomised by expressions of support for pseudo-scientific views on the HIV epidemic, has resulted in a lack of co-ordination at national level of worthy interventions. Consequently, time and resources have been wasted, with the effect that many people have become unnecessarily infected with HIV and many have died avoidable deaths due to AIDS. … In the governance section we will show

evidence that poor governance characterised by lack of leadership from President Mbeki and Minister Tshabalala-Msimang has been the key obstacle to the response to the HIV epidemic. … The manner in which President Thabo Mbeki has encouraged and defended AIDS denialism has been widely examined. Government and ANC spokespersons have been at pains to insist that President Mbeki has not expressly or publicly "ever denied a link between HIV and AIDS". He questioned in Parliament how a virus could cause a syndrome. He has also never publicly affirmed that HIV does cause AIDS. Instead he has left a paper trail of his questions about HIV and hints about his sympathies with the denialists, the impact of which can be traced through what was not done by his government as well as what was questioned and resisted. The tragic consequences of denialism have been the delayed and/or muted implementation of HIV programmes and public confusion. This has resulted in numerous avoidable deaths. … In 2000, the President set up an AIDS advisory panel which included numerous AIDS denialists, almost in equal proportion to scientists proposing the indisputable conventional science. Instead of determining an appropriate response to the HIV epidemic, this panel diverted attention to the already answered questions as to whether HIV causes AIDS and whether the benefits of antiretrovirals outweigh their risks. Much time and money was wasted. Much confusion was generated.'

290. Achmat's most recent attack on President Mbeki and Dr Tshabalala-Msimang along these lines was in a speech given to the Microbiocides 2006 conference in Cape Town on 26 April. (Excerpts, annexure 'AB62A')

291. Like the Bush and Blair governments' lies about Weapons of Mass Destruction in Iraq, the TAC's lies succeed so well at the level of propaganda because they bank on people's general expectation that public leaders tell the truth. Hitler explained this principle directly in *Mein Kampf* (Fredonia Books (NL), 2003): 'It would never come into their heads to fabricate colossal untruths, and they would not believe that others could have the impudence to distort the truth so infamously.' Consequently 'in the big lie there is always a certain force of credibility', so people 'more readily fall victims to the big lie than the small lie'.

292. And concerning the TAC's basic propaganda technique for driving its lies home, Nazi Reichsmarshall Hermann Goering explained to psychologist Dr Gustave Gilbert during the Nuremberg Trials that 'it is always a simple matter to drag the people along, whether it is a democracy or a fascist dictatorship or a Parliament or a Communist dictatorship. … All you have to do is tell them they are being attacked and denounce the pacifists for lack of patriotism and exposing the country to danger. It works the same way in any country.' (*Nuremberg Diary* GM Gilbert, New York: Farrar, Straus & Co., 1947)

293. I myself have experienced the sort of intense, intolerant antagonism from Achmat of which I speak, most recently on the steps of the Cape High Court in mid-2005, where he was attacking the government in front of a crowd of bussed-in demonstrators wearing the TAC's 'HIV Positive' tee-shirts (given out free to attract the African poor). As I walked past him to go into court, Achmat pointed his finger in my face, yelling as the international television cameras rolled, 'This is Anthony Brink, the biggest liar.' I've been publicly accosted by this rather vulgar and ill-mannered person on other occasions as well; and impugning my personal integrity in public, by suggesting that I'm dishonest, has become a repeated tactic in the TAC's dealing with the threat that I pose to its fortunes. I surmise that the main basis of this aspersion is an affidavit I made in an application in this Division, Case No. 2807, in which I detailed how the TAC received financial grants from several sources funded by the pharmaceutical industry. The TAC confessed and avoided in reply: the money was ring-fenced and clean it said; it was not drug money it took. This was not apparent from any financial statements in the public domain, which the TAC had invited critics of its funding sources to examine.

294. After calling me 'the biggest liar', I later watched Achmat shouting, 'Mbeki is responsible for the deaths of thousands of people.' This sort of vicious propaganda subversion of our democratic leadership, and of Africa's most significant and influential statesman plays directly into the hands of the Northern powers, whose absolute control and hegemony over the international economic and political order President Mbeki is concerned to loosen, with a view to improving the lives of the

peoples and nations of the South. Achmat's base and disgusting tactics are a standard Western technique in character-assassinating leaders of the South, whose independent, challenging line threatens the commercial interests of the North, and they not infrequently provide the pretext for violent foreign intervention and ouster from office. Just as Achmat and US President Bush agree that governments in the Developing World should be supine and compliant with the First World economic agenda, and buy its exported goods without inspecting them first, they are also of one mind in regard to ARVs in particular, with the US President speaking like Achmat in his State of the Nation address on 27 January 2003: 'Anti-retroviral drugs can extend life for many years.' (Excerpt, annexure 'AB62B')

295. Unlike AIDS dissidents, no such venom is attracted by other medical dissenters: anti-vaccination campaigners, for example, who contend that the whole of vaccination theory is a grotesque and ridiculous superstition based on childish fairy tales about milkmaids and horsegrease and cowpox, whose practice, though fabulously lucrative to the pharmaceutical industry, is causing serious injury to hundreds of thousands of infant children – including, in the case of injections of vaccines preserved with the mercury-based antibiotic thimerosal, brain and other neurological damage that has presented in a massive epidemic of autism and learning difficulties in recent decades.

296. I propose that a major underlying reason for the hysterically emotive attacks on AIDS dissidents, even just quiet sceptics, arises from the fact that like the belief in witchcraft, in which sexuality loomed large – extra nipples (usually just moles) to suckle familiar spirits, tell-tale spots in intimate places ('the Devil's marks'), alleged sex with incubi and succubi, etc – the whole of AIDS dogma is founded on the core myth that it's spread via uncontrolled, unlicensed sex, and this gives HIV/AIDS mythology its tremendous pull on the popular imagination (mostly non-African) – the juridical one too, apparently.

297. Instead of bandying about distasteful, derogatory epithets in regard to those who don't share his belief in the magical medical dogmas he propounds and applies for his good living, it would have been more informative and helpful to this court had Dr Venter rather stated matter-of-factly and truthfully that there are

scientists who publish and present scientific data and arguments in peer-reviewed medical and scientific journals of high repute questioning whether a retrovirus is the cause of AIDS.

298. What is striking about these papers is that are unanswered. In an ordinary scientific atmosphere allegedly bad theories, critiques and other scientific ideas are challenged and the issues thrashed out in rebutting letters and/or articles, followed by the authors' replies. But none of the several published papers by Papadopulos-Eleopulos et al., for instance, delineating the fundamental fallacies of the HIV theory of AIDS have ever been faulted, much less rebutted.

299. It is so that 'There is no consensus amongst this group regarding their theories. For example, some do not believe HIV exists, some believe it's a harmless passenger virus, some do not believe ARVs are effective, and some even believe that ARVs cause AIDS' – except that there's unanimous agreement among the dissidents in the two camps first mentioned in regard to the latter two propositions. This negative assessment of ARVs is based upon and is amply supported by the research literature, to which I'll refer below.

300. The absence of consensus among critics of the HIV theory of AIDS well illustrates that science does work by consensus. Indeed, notwithstanding the appearance of unanimity in the orthodox camp there's considerable confusion and disagreement over even the fundamentals. There's no agreement over what sort of virus 'HIV' is supposed to be (a latent, slow lentivirus or a virulently aggressive, immediately pathogenic one), how it is supposed to destroy the immune system (numerous distinct, incompatible models have been hypothesized), and so on. So that as estimable an AIDS expert as Harvard Medical School professor of immunology Paul Johnson can state without a twinge of embarrassment: 'We are still very confused about the mechanisms that lead to CD4 depletion, but at least now we are confused at a higher level of understanding.' (Quoted by Balter in 'How does HIV overcome the body's T cell bodyguards?' *Science*. 1997 Nov 21;278(5342):1399-400.)

301. **Ad 38 and 39.** Concerning Dr Venter's statement that 'There is no credible scientific institution that shares or reflects AIDS

denialist views', it's difficult to understand what he means by 'credible' and 'denialist'. In the first place, scientific institutions are staffed by credible people of his professional calibre, none of whom have ever presented any evidence proving the existence of 'HIV' particles, 'HIV' proteins and 'HIV' RNA – in short, the existence of 'HIV'. In the second, it's arguable that the very discoverer of 'HIV' (by reputation anyway), Professor Montagnier of the Pasteur Institute in Paris, is now a 'denialist' on two counts: he has long – since the International AIDS Conference at San Francisco in 1990 – not considered 'HIV' to be pathogenic without the presence of 'co-factors', and he has more recently expressed his support for the oxidative stress theory of AIDS (detail below).

302. No credible astronomer from that profession accepted Galileo's announcement that Jupiter is circled by moons; and his claim to have seen them through his telescope was violently condemned by his credible professional peers as 'demonic visions'. And of course Galileo's rejection of the geocentric model of planetary motion, contradicting all conventional wisdom based on the overwhelming, credible evidence of the sun's apparent movement across the sky, was a 'denialist' position in the face of the seemingly obvious, and was therefore censored and punished.

303. It's in the nature of things that critics of widely accepted paradigms are always initially incredible, more especially when money and careers ride on them. It was once incredible, for instance, to suggest that an odourless, unseen gas later called oxygen caused combustion at a time when it was universally believed that an innate substance called phlogiston was being given off and accounted for the phenomenon. Like HIV, phlogiston wasn't ever seen, but to subscribers of the phlogiston theory proposed in the late 17th century – then considered one of the most important discoveries in science – the sight of an object burning was overwhelming evidence of its existence. Other examples abound.

304. Were scientific facts decided on the basis of appeals to respectability, it could be mentioned that among the many 'credible' scientists who find the HIV theory of AIDS unpersuasive and unconvincing, and who have said so, are professors emeriti such as Richard Strohman (molecular biology,

University of California at Berkeley), Etienne de Harven (pathology, University of Toronto), Gordon Stewart (epidemiology and public health, Glasgow University), and Professor Walter Gilbert (molecular biology, Harvard University); and Dr Kary Mullis PhD (now a full-time science writer and public speaker), chemistry Nobel Laureates in 1980 and 1993 for their inventions of genetic sequencing and genetic amplification techniques respectively. It would obviously be idle to imply that scientists of this rank are non-entities in their fields, who are not 'credible'. (I have numerous interviews of all of them on video, which I can screen on request.)

305. In support of his allegation that 'Scientific evidence refutes the views of the AIDS denialists', Dr Venter puts up 'a detailed rebuttal of the AIDS denialist viewpoint written for the layperson … published by the National Institutes of Health, an authoritative public research institution in the United States.'

306. I attach marked 'AB63' a crisp rejoinder by Papadopulos-Eleopulos et al., which entirely demolishes this so-called 'detailed rebuttal'. And it is no more meaningful to speak of an 'AIDS denialist viewpoint' as it is to talk about a non-Christian viewpoint.

307. **Ad 40.** I dispute Dr Venter's claim on oath that he is 'familiar with the principal argument of some AIDS denialists, particularly Anthony Brink and David Rasnick'.

308. In the first instance, although we're at one that the contemporary HIV theory of AIDS is bad, and that AZT and other ARVs are both useless and deadly, my colleague Dr Rasnick and I have fundamental friendly disagreements about the sufficiency of the scientific evidence for the existence of HIV, and about the pharmacology of AZT at the molecular level that accounts for its profound cellular toxicity, i.e. whether it's a DNA chain terminator strictu sensu or a potent oxidizing agent.

309. Secondly, I do not believe and accept that Dr Venter is telling the truth when claiming to be 'familiar with' my work, which has nearly all focussed on the ARVs AZT and nevirapine, and I should relish the opportunity to cross-examine him, should this matter be referred to trial, to test the veracity of his implication that he has read it and so is 'familiar with' it. It would also be

revealing to cross-examine him on which of Dr Rasnick's published papers he's 'familiar with', and on what scores he thinks Dr Rasnick is wrong and why.

310. **Ad 41.** Nearly every one of Dr Venter's following statements is wrong and it demonstrates that in truth he has no personal knowledge of what he deposes to: 'Mr Brink produced AIDS denialist arguments about the toxicity of AZT in paragraphs 6 to 22 of an affidavit in the Pietermaritzburg High Court in 2002. His claims were refuted in detailed affidavits by Professor Robin Wood (University of Cape Town), Professor Brian Gazzard (President of the British HIV Association) and Professor David Back (Head of the Pharmacology Department, University of Liverpool, UK).'

311. No 'argument' was 'produced' in any 'affidavit'; facts were averred in a pleading: a set of particulars of claim attached to a combined summons commencing a dependent's action for damages brought by a widow whose husband was killed by AZT. (Annexure 'AB64'.) And the action was instituted in June 2001, not in 2002.

312. The sharp point of the case from the defendant GlaxoSmithKline's angle was never the potentially fatal 'toxicity of AZT', which is freely admitted in the package insert for the drug. The commercial danger for the company, which it hired Professor Back in England to meet, was that the plaintiff impeached its claims concerning its drug's alleged pharmacological action. In her particulars of claim, the plaintiff pointed out that AZT is not triphosphorylated to its inhibition concentration within the cells of people taking it and that it therefore cannot have the pharmacological action GlaxoSmithKline claims for it, and that indeed by all conventional measures it does not. Since AZT is admittedly very toxic, and admittedly potentially fatally so, the risk/benefit ratio is accordingly infinite and AZT is therefore defective as a medicine.

313. Having regard to the foregoing, it's evident that Dr Venter either didn't read the claim and the expert reports filed in the case as he implies, or he lacks the scientific expertise to have made sense of them.

314. No expert hired by GlaxoSmithKline disputed that AZT is very poisonous, and that for some people it may be lethal.

315. Professor Back provided the single expert statement purporting to answer and refute the gist of the claim, namely that AZT is not sufficiently triphosphorylated intracellularly to act a chain terminator of pro-viral DNA and thereby exert the virustatic action that GlaxoSmithKline falsely alleges. His expert summary is annexed marked 'AB65'. (The 'Introductory Primer', 'Annex 1' promised in paragraphs 1.2 and 3.2 of his expert summary was never delivered.)

316. Annexed marked 'AB66' is the rebuttal that Papadopulos-Eleopulos et al. drew to Professor Back's statement, which points the direction that cross-examination of him would have taken. Reference to 'our paper' in the rebuttal is to Papadopulos-Eleopulos E, Turner VF, Papadimitriou JM, Causer D, Alphonso H, Miller T. 'A critical analysis of the pharmacology of AZT and its use in AIDS'. *Current Medical Research and Opinion* 1999; 15:1s-45s. I annex this seminally important, unanswered paper marked 'AB67'. The crux of the claim, mentioned in the preceding paragraph, namely that AZT is not activated to its inhibition concentration in vivo, is finely discussed in this paper. I have all the nearly twenty papers published to date reporting findings showing the insignificant extent to which AZT is triphosphorylated in the body and I can make them available on request.

317. The triphosphorylation problem – fatal to GlaxoSmithKline's fraudulent marketing claim that AZT has antiviral activity as a medicine – has also been noted and discussed in other leading medical journals in print and online: Lavie and colleagues of the Max Planck Institute described it in their paper, 'The bottleneck in AZT activation' *Nature Medicine* 3, 922 - 924 (1997) doi:10.1038/nm0897-922. (Annexure 'AB67A') And Dr Dennis Blakeslee PhD commented on this paper on Newsline, HIV/AIDS Resource Center, an internet service of the *Journal of the American Medical Association* ('JAMA'), under the pointed title, 'The Failure of AZT – An Enzyme Bottleneck'. (Annexure 'AB67B')

318. Cross-examination of Professor Back (on his claim that AZT is not a failure; it really works) would have commenced by laying out his financial conflict of interest in the case arising from his many rich and varied sponsorships by the pharmaceutical industry, including one of his most generous benefactors, 'Glaxo Wellcome' (now GlaxoSmithKline), in the form of 'Grants obtained from pharmaceutical industry (Total value approximately £3,000,000)' between 1995 and 2001 – matters announced in his accompanying Curriculum Vitae. (Excerpt, annexure 'AB68'). Professor Back would have been asked what he thought would happen to his enormous funding stream were he to make any fundamental, fatal concessions adverse to his sponsor's product and commercial interests.

319. Papadopulos-Eleopulos's et al. answer to Professor Back's disgraceful report is a stark illustration of how massive pharmaceutical industry funding has corrupted academic science and how it has succeeded in buying off professional opinion.

320. 'The plaintiff, represented by Brink, did not proceed with that case', not because, as Dr Venter misleadingly implies, the case was no good on the merits, but on account of a number of unforeseeable practical obstacles.

321. **Ad 42.** It is transparently meaningless to lump together the scores of peer-reviewed scientific papers by different scientists and clinicians around the globe, published in some of the world's leading medical and scientific journals, that critique the HIV/AIDS hypothesis by presenting or reviewing data in relation to different aspects of the hypothesis, and to glibly dismiss them all as 'characterized by poor logic, misleading statements, and outright falsehoods'. I further specifically deny this characterization to the extent that it might be intended to slate my own work, which has been positively appraised by scientists of the highest rank.

322. The statement, however, is revealing of the quality of its author's intellect: By attempting to make his case by providing 'one illustrative example', Dr Venter commits the elementary logical fallacy of attempting to prove his point by way of selected instance; and what's worse, his selected instance doesn't sustain his case and backfires on him instead:

323. **Ad 43.** Dr Venter picks on Dr Rasnick's 'commonly made argument' that 'ARVs have not been shown to be clinically effective in controlled clinical trials'. This 'commonly made argument' is actually a perfectly true fact and, as will appear below, Dr Venter's various attempts to escape its negative ramifications in his following subparagraphs all fall down:

324. **Ad 43.1.** Dr Venter admits that 'most clinical trials examining ARVs have examined surrogate endpoints of clinical outcomes as opposed to clinical outcomes themselves'. Indeed, and this is itself most informative, for if ARVs restored the sick to health, or kept the well from falling sick, as medical drugs are supposed to do, there would be clinical trial evidence showing this. There isn't.

325. Dr Venter contends that 'some trials including the trial on which the US registration of AZT was based have shown dramatic clinical benefit'. Certainly BW002, the Phase II clinical trial preceding the licensing of AZT by the FDA and drug regulatory authorities in other countries including ours, was on its face a spectacular success in showing that AZT is a life-saving medicine for severely ill AIDS patients. Except that in reality the trial was an abject fraud. I've closely detailed this in my article *Licensing AZT* (annexure 'AB59').

326. Even by the dismal standards and expectations set by the rest of his affidavit, Dr Venter's citation and reliance on this clinical trial as showing AZT to have 'dramatic clinical benefits' is a remarkable display of professional ignorance. Nobody in the know today considers that the fraudulent AZT licensing trial to which Dr Venter refers is worth the paper it was written on – i.e. that it established that AZT really does rescue the lives of gravely sick people, as was claimed at the time – or it would still be prescribed to mortally ill AIDS patients on its own as a life-saving treatment today. On the contrary, there was no dissension from the ranks of the orthodoxy when Dr Rasnick estimated on the record at the first meeting of President Mbeki's AIDS Advisory Panel in 2000 that AZT had probably killed tens of thousands of people. AZT monotherapy is now universally regarded as having been a deadly mistake, just like its successor, the 'hit early, hit hard' approach with multiple ARVs, officially

abandoned in the US on 5 February 2001 because of its formally acknowledged harmfulness (discussed above).

327. Dr Venter doesn't identify any other trials in which 'dramatic clinical benefits' were shown for AZT and other ARV drugs, so I don't know what he's referring to. In *Licensing AZT* (annexure 'AB59'), however, I also debunk the claims made in regard to another early AZT trial, ACGT 019, and I cite a published reanalysis of the trial by Professor William Lenderking of the Harvard School of Public Health and his associates that drew much darker conclusions, having regard to the data reported in the trial concerning the extreme toxicity of AZT, found to be 'life-threatening' for some people even at the lowest dose used.

328. No manufacturer of any other ARV(s) claims that 'dramatic clinical benefits' have ever been demonstrated for any of them, and none have claimed 'dramatic clinical benefits' as the basis of their licensing applications. None have conducted placebo controlled clinical trials showing 'dramatic clinical benefits'.

329. **Ad 43.3.** Dr Venter claims that 'There is sufficient evidence that surrogate endpoints for clinical trials, namely CD4 and viral load measurements, are predictors of clinical outcome.' The claim is fatuous on numerous scores:

330. In the first place, the central myth of the HIV theory of AIDS that 'HIV' (whatever the experts mean by this) kills T4 (CD4) cells, though attractively elegant, is unsupported by any in vivo or in vitro studies. (And certainly not 'in the very earliest papers on the isolation of HIV dating from 1983-1984', as the TAC propounds in its propaganda; I have all these papers and can make them available to this court for verification if needs be.) Secondly, for more than a decade many AIDS experts, including the Nobel Laureate David Baltimore, have claimed that the decrease in T4 cells is due to the down regulation of the CD4 molecule on the cell surface and not to cell death. (Annexures 'AB68A', 'AB68B' and 'AB68C') This is discussed in depth by Papadopulos-Eleopulos et al. in their pivotal paper 'A critical analysis of the HIV-T4-cell-AIDS-hypothesis' *Genetica* 1995. 95:25-50, annexed marked 'AB69', which concluded following a review of the case for it: 'The available data do not support the presently accepted hypothesis that HIV is either necessary or sufficient for

the pathogenesis of AIDS, and thus it would seem logical to consider alternative theories.' (Unfortunately for the public, scientific logic is trumped by the logic of the market.)

331. Professor Montagnier now considers that what he considers to be the apoptosis of T4 cells is caused by cellular oxidation; and at least in Africa the major cause of such oxidation is malnutrition. This is discussed in annexure 'AB70', a letter accepted and in press for publication in a major medical journal, which I'll identify at the hearing if it's in print by then as I expect.

332. Certainly there's no evidence whatsoever for the popular myth that 'HIV' attacks and kills off CD4 cells in the blood, thereby weakening the immune system and leading to the onset of certain opportunistic diseases or malignancies. This enduring fable central to the mythology of AIDS was dismantled years ago by Papadopulos-Eleopulos et al. in their just-cited paper (annexure 'AB69'), and after reading this paper anyone who still thinks AIDS is caused by a virus, HIV, that knocks out the CD4 cells of the immune system leading to the onset of opportunistic infections and cancers seriously needs new batteries.

333. At the beginning of the AIDS era it was claimed that CD4 depletion is the hallmark of HIV/AIDS, i.e. that HIV infection leads to CD4 killing which leads to the clinical syndrome. Now there's ample scientific evidence that this is not the case: for some healthy people, abnormally low CD4 cell counts may be quite normal for them, and some people can live a healthy life for many years with zero CD4 cells (annexure 'AB71'); conversely, people with normal CD4 cell counts develop the clinical syndrome (the reported data to this effect are reviewed in annexure 'AB69'). This is best exemplified by so-called 'immune reconstitution' diseases, which Dr Venter himself demonstrated in his own research paper, mentioned in his affidavit. These facts alone are sufficient for anybody with a matric to question and abandon the HIV theory of AIDS.

334. Furthermore, AZT raises the CD4 count in people who are not 'HIV' infected. For example, in their paper 'CD4+ lymphocyte count variations in HIV-negative subjects treated with zidovudine' *AIDS* 1996; 10:1444-5, Milazzo et al. reported huge

increases of up to 84.5%: 774 to 1428 cells per microlitre. (Annexure 'AB72')

335. Leading American AIDS expert Jay Levy and colleagues discuss this phenomenon of AZT causing CD4 cell counts to rise independently of any supposedly virustatic action in 'Plasma viral load, CD4+ cell count and HIV-1 production by cells' *Science* 1996; 271:670-671. (Annexure 'AB73') The authors also (superficially) discuss the limitations of relying on 'viral load' readings.

336. Despite these reports, it has never occurred to any AIDS expert to research and report the effect of other ARVs on the CD4 counts of HIV-negative individuals. Probably because no one would be pleased by the results and so there'd be no money in it.

337. AIDS experts merely assume that the modulation of CD4 cell counts by these chemicals is due to an antiviral action, inhibiting HIV replication and thereby leading to an improvement in the cell count. However, the modulation of CD4 cell counts by AZT in HIV-negative people is an obviously compelling reason to dismiss this measure as a 'surrogate marker' for the efficacy of ARVs.

338. More than ten years ago, having employed CD4 cell counts as a surrogate marker for drug efficacy, in line with conventional wisdom at the time, in the largest, best conducted AZT clinical trial yet conducted, the Concorde trial (which found AZT to be no good, and on an extended analysis a killer), the researchers pointed up the irrelevance of this laboratory measure, and its lack of a correlation to clinical health, in noting that the results of the study 'call into question the uncritical use of CD4 cell counts as a surrogate endpoint for assessment of benefit from long-term antiretroviral therapy'. I annex their report marked 'AB74', and reference to the extended results marked 'AB74A'.

339. In their review 'Surrogate End Points in Clinical Trials: Are We Being Misled?' published on 1 October 1996 in *Annals of Internal Medicine* 125; 7:605-13, Fleming and DeMets pointed out that CD4 cell counts are 'as uninformative as a toss of a coin … Effects on surrogate end points often do not predict the true clinical effects of interventions. … Three … trials, including the Concorde Trial showed an inverse relation between survival and

improved CD4 cell counts.' (Annexure 'AB75') So the better you were getting on AZT according to AIDS experts such as Dr Venter telling you how nicely your CD4 cell count was rising, the faster you died.

340. In the abstract of his latest paper, published in January 2005 in *Health Affairs* 24;1:67-78 under the title 'Surrogate Endpoints And FDA's Accelerated Approval Process', Fleming delicately made the point that 'To use surrogate endpoints and the accelerated-approval process, challenging issues must be addressed to avoid compromising what is truly in the best interest of public health: the reliable as well as timely evaluation of an intervention's safety and efficacy.' (Annexure 'AB76') The 'challenging issue' concerning ARV researchers' reliance on CD4 cell counts as a marker for ARV efficacy, instead of looking at whether the drugs actually make ill people better or keep healthy people from falling sick, is that, as Fleming himself had noted nine years earlier, the popular medical practice in the AIDS era of doing CD4 cell counts, though lucrative, is 'as uninformative as a toss of a coin'.

341. It's a common fallacy among AIDS experts such as Dr Venter, newspaper journalists and their readers that a CD4 cell count reflects an absolute value, like the number of policemen in a city to keep criminals (infectious pathogens) at bay. It doesn't. An individual's CD4 cell count can vary in the course of the day, and from day to day, and increase and decrease for many reasons that have nothing to do with 'HIV infection' or ARV drug treatment. Furthermore the same cells simply change their spots, so to speak: depending on the molecular markers on its surface, a T cell can be counted as a CD4 in the morning and as a CD8 in the afternoon, and one's CD4 cell count may change after a suntan or a cigarette (discussed in annexure 'AB69').

342. The hopeless futility of 'viral load' readings is canvassed in annexure 'AB38' at page 8ff, which decisively explodes the exercise as utterly worthless, and shows it to be no more scientific than the mediaeval practice of diagnosing disease by assaying urine: sniffing and tasting it, ascertaining its specific gravity, and reading its colour by the light of the sun and the moon. It's a widespread misunderstanding among AIDS doctors, activists, journalists and newspaper readers that such tests 'show the

presence of HIV in infected people', and show that 'HIV is active in people with HIV antibodies' (per TAC propaganda). On the contrary, such tests are so unreliable, so non-specific that they are not even permitted for screening blood, let alone diagnosing or confirming 'infections'. For instance, the manufacturer of the leading 'viral load' test, Roche Diagnostic Systems, Inc., expressly warns (as do other such test manufacturers Organon Teknika and Versant in the same FDA-mandated terms) at the top of the first page of its HIV-1 Monitor test manual: 'The Amplicor HIV-1 Monitor test is not intended to be used as a screening test for HIV or as a diagnostic test to confirm the presence of HIV infection.' (Excerpt, annexure 'AB76A') This is because, contrary to popular belief, it does not 'test for the virus itself' as the commonly heard phrase goes, i.e. the test is not specific for 'HIV'. And as the unfortunate popular misnomer 'viral load' misleadingly implies, the test certainly doesn't tell you how many viruses you've got in you per unit of your blood. It merely copies and amplifies ribonucleic acid (RNA) assumed, but never actually proven, to be viral.

343. **Ad 43.4.** Dr Venter states magisterially that 'A clinical meta-analysis is an accepted scientific technique for evaluating the results of a health intervention by grouping together all clinical trials to determine whether a statistically significant effect occurs.' Among informed scientists and statisticians, on the other hand, it's trite that such meta-analyses have serious limitations and numerous fundamental problems, inter alia, their potential for subjectivity of inclusion/exclusion criteria, issues concerning the combinability of studies, and controversy concerning statistical analysis and single summary estimate of the effect of the intervention. Moreover, a meta-analysis can only be as good as the studies upon which it's based. Combining a number of defective trials doesn't unflaw them, and if the trials do not individually prove clinical benefits (because they were not conducted according to the normal requirements for a valid clinical trial), they can't be relied upon to prove such benefits when grouped. This is elementary to people with research qualifications. Dr Venter doesn't have any.

344. Dr Venter states: 'The AIDS denialist argument is refuted by meta-analysis of antiretroviral clinical trials: An analysis by

Rachel Jordan and colleagues in the British Medical Journal in 2002 found AIDS or death with AZT was 70% of placebo (BMJ 2002;324:757) … death or AIDS for patients using two ARVs was 60% of those using one ARV … death or AIDS for patients using using three ARVs was 60% of those using two ARVs. This alone constitutes convincing evidence that the benefits of ARV treatment extend life and reduce illness.' The fact Dr Venter needs to rely on a meta-analysis to attempt to demonstrate that ARVs are good for people, after many hundreds of trials and nearly two decades of their use, points to the obvious fact that the individual clinical trials included in the meta-analysis have not themselves provided the evidence that Dr Venter strains after.

345. Ms Jordan's paper is a signal example of the dross that typically passes for research in the AIDS era, appositely chosen by Dr Venter as the high water mark of his case on ARV efficacy. The paper is beset with many glaring basic problems, none of which seem to have struck its peer-reviewers before publication, much less Dr Venter:

346. Out of 2000 papers, only 90 were considered suitable for Ms Jordan's objective (to show ARVs save lives, and the more the merrier), i.e. just 4.5% of all the reported papers on the clinical effects of taking ARVs.

347. She included studies that were not double-blinded and randomised.

348. She included reports of studies of the clinical effects of double and triple combinations of ARVs that had no placebo arm.

349. The 'dropout rate' in the studies that she included was 'large', signifying unendurable toxicity for a high proportion of trial subjects.

350. She did not 'exclude publication bias', which she defined as the tendency that studies are more likely to be published if they have positive results. Consequently, any systematic review that does not take into account unpublished studies (in which the intervention failed) will overestimate the true value of the intervention. Publication bias results in unrepresentative publication of research reports concerning a given intervention, not necessarily due to the quality of the research but to such other

factors as the tendency of investigators to submit, and publishers to accept, only positive research reports showing a beneficial treatment effect of a new intervention, not the negative ones showing the intervention to be a dud. This obviously distorts any meta-analysis of large numbers of published studies.

351. She included such well-known junk as Fischl MA et al. 'The efficacy of azidothymidine (AZT) in the treatment of patients with AIDS and AIDS-related complex. A double-blind, placebo-controlled trial' *New England Journal of Medicine* 1987; 317: 185-191 (sponsored by Burroughs Wellcome; and laid bare in *Licensing AZT*, annexure 'AB59'); and Cooper DA et al. 'Zidovudine in persons with asymptomatic HIV infection and CD4+ cell counts greater than 400 per cubic millimeter'. The European-Australian collaborative group' *New England Journal of Medicine* 1993; 329: 297-303 (sponsored by the Wellcome Foundation). The gross procedural and statistical blunders in this study were exposed in a series of critical letters in the journal (329:1895 and 330:1758); and the positive conclusions, 'Treatment with zidovudine benefits HIV-infected persons with CD4+ cell counts above 400 per cubic millimeter' and 'Severe hematologic or clinical side effects were rare', were accordingly both rejected by the FDA in June the following year.

352. There was extreme heterogeneity in regard to T4 cell numbers and viral load endpoints, showing inconsistency in the manner in which the individual trials making up the meta-analysis were designed and interpreted. Because of this, Ms Jordan's meta-analysis could not be usefully performed in the first place and her claims based upon it are both misleading and worthless.

353. According to AIDS experts, having a T4 CD4 cell number lower than 500 is abnormal and is an augury of future illness with AIDS; and less than 250 portends a high probability of the appearance of the clinical syndrome and death, they say. Ms Jordan reported that monotherapy with AZT versus placebo led to a difference in CD4 count of 47 cells per microlitre. The difference in the CD4 count between double and monotherapy was 58 or 10 depending on which drugs were used in the double therapy. The difference in the CD4 count between double and triple therapy was 41. These differences may be statistically significant, but the increase in CD4 numbers with any therapy is

actually very small. This means (if the HIV theory of AIDS is correct) that there cannot be any difference in the clinical benefit obtained with any combination of ARVs because to date nobody has presented any evidence that an increase in CD4 counts of 50, 100 or even 200 will decrease the probability of developing an AIDS disease. Whereas, on the other hand, there's evidence that people with zero CD4 counts can lead normal lives, and people with high counts develop AIDS illnesses.

354. Another way of explaining this is as follows: Assume it's true, as the learned AIDS experts claim, that having a CD4 cell count of more than 250 really does mean that you are less likely to die from an AIDS defining illness compared to someone whose count is below 250. If the starting CD4 count is zero and it increases by 58, 10 or 41 you are still in the high risk group of dying from AIDS. This means you can have any starting number up to 192, and raising it by 58 cells (the maximum observed) will still not get you above 250. To get out of the high risk group you have to start with at least 193 cells. Be this as it may, there remains no evidence whatsoever supporting the contemporary medical mythology that if, by whatever means, you raise the CD4 cell counts of a group of HIV-positive individuals from less than 250 to more than that number they fare any better, that they are less likely to fall ill and more likely to stay healthy.

355. According to the British HIV Association's Guidelines for Antiretroviral Treatment of HIV Seropositive Individuals published in *Lancet* 1997; 349:1086-1092, 'if the viral load has not fallen by about 1 log 8-12 weeks after treatment initiation consideration should be given to modify therapy'. (Annexure 'AB77')

356. According to leading American AIDS experts Saag, Shaw, Coombs and their associates, in their paper, HIV viral load markers in clinical practice *Nature Medicine* 1996;2:625-9, 'a three-fold or greater sustained reduction (>0.5 log) of the plasma HIV RNA levels is the minimal response indicative of an antiviral effect ... return of HIV RNA levels to pretreatment values (or to within 0.3 - 0.5 log of the pretreatment value), confirmed by at least two measurements, is indicative of drug failure'. (Annexure 'AB78')

357. On this basis Ms Jordan shows AZT to be a 'treatment failure'. Since AZT is given as a pro-drug, i.e. in an unphosphorylated form, intracellular triphosphorylation is necessary for the drug to have an antiretroviral action. But no triphosphorylation takes place in vivo to any significant extent, which explains why AZT could not reportedly reduce the viral load by even 0.65 log. In fact no AZT study has ever been published in which the drug reduced the viral load by 1 log. In short, AZT is not antiretroviral.

358. Ms Jordan recorded that the difference in viral load between mono and double therapy was 0.65 log and between double and triple therapy 0.54 log. Again, although these may be statistically significant, according to the British and American authorities, namely the British HIV Association and Professor Saag and his associates respectively, they do not signify clinically significant differences.

359. Well this court might wonder then what the point of Ms Jordan's meta-analysis was. The insignificantly small reduction in 'viral load' reported following AZT administration obviously calls for an alternative explanation to a putative virustatic action of the drug, as discussed in annexure 'AB67'.

360. Since ARVs have a very small effect on CD4 count and a wholly insignificant effect on 'viral load', if there are any clinical benefits, i.e the treatment prevents the appearance of AIDS or death, and the more drugs used the larger the benefits, as Dr Venter claims, then 'viral load' and CD4 cell counts cannot be used as surrogate markers for the clinical outcome. That is to say, the HIV theory of AIDS – HIV (high viral load) leads to low CD4 cell count; low CD4 count (AID) leads to S (the clinical syndrome) – is wrong. But, on the other hand, if the theory is correct and viral load and CD4 counts can be used as surrogate markers for the clinical syndrome, then there can be no clinical benefits for ARVs as claimed in the paper by Ms Jordan and by Dr Venter. It's a lose lose situation.

361. As is plain from the above discussion, Dr Venter's claim that 'The AIDS denialist argument is refuted by [Ms Jordan's] meta-analysis of antiretroviral clinical trials' is rather feeble.

362. **Ad 44.** 'In summary,' alleges Dr Venter, 'ARVs have been tested sufficiently in clinical trials to demonstrate that they reduce

mortality and morbidity in people with advanced HIV disease and that they prevent transmission from mother-to-child.' As discussed, this 'summary' is not supported by the presently available data. So Dr Venter's statement is untrue.

363. Apropos of Dr Venter's claim concerning the perinatal use of ARVs for prophylactic purposes, it's refuted in annexure 'AB38' in detail. A submission to the MCC by Professor Mhlongo and me (pages 22-34 of annexure 'AB4'), concerning the futility of the HIVNET 012 nevirapine regimen, also refutes the magic bullet single-pill-to-the-mother-and-a-squirt-of-drug-syrup-down-the-baby's-throat approach. A slide-show presentation, 'A Critical Analysis of the Evidence Considered Proof that Nevirapine Prevents Mother-To-Child Transmission of HIV', prepared by Papadopulos-Eleopulos et al. was presented by Professor Mhlongo at a meeting of the South African Association of Professionals in Health Care on 7 February 2002; it further elaborates the radical flaws of HIVNET 012. (The TAC's Mark Heywood, who attended the meeting, told Professor Mhlongo afterwards: 'The time for science is gone; people are dying.') Since it's bulky, I've not annexed it, but it's posted on my group's website at http://www.tig.org.za/pdf-files/nevppsn1.pdf. (I'm an honorary co-author of this critique as well.)

364. Moreover, the findings reported by the HIVNET 012 researchers couldn't be repeated when the regimen was tried out outside the control of researchers biased to show positive results for their novel treatment hypothesis: In 'Low efficacy of nevirapine (HIVNET012) in preventing perinatal HIV-1 transmission in a real-life situation', *AIDS* 2004 Sep 3;18:1854-1856, Quaghebeur et al. found that when 'in a real-life situation in Kenya' they tried the HIVNET 012 regimen it was a failure: 'Since 2001, the unrestricted use of HIVNET012 has been recommended for the prevention of mother-to-child transmission in low-resource settings, despite the lack of validated efficacy data outside research settings. We implemented the nevirapine regimen in a real-life situation in Kenya. The perinatal HIV-1 transmission rate at 14 weeks was 18.1%, similar to the 21.7% before the intervention. … Our findings question the usefulness of the current prevention of mother-to-child transmission recommendations based on HIVNET012, which have been

implemented in resource-poor settings, based on just one observation in a clinical research setting. … These data, suggesting a rather limited effect of the widely recommended HIVNET012 intervention, call for further research on the long-term efficacy of the HIVNET012 regimen in a field setting. Taking into account the low coverage of the nevirapine regimen, the lack of benefit for maternal health, the concerns about resistance, the enormous deployment of resources needed to provide nevirapine within the current voluntary counselling and testing paradigm, and the reported lack of efficacy in real-life conditions, the true health gains of the intervention should be reconsidered.' (Annexure 'AB79') Dr Venter obviously missed this paper.

365. Dr Venter's following claims are untrue: 'Clinical trial findings have been supported from cohort data published in many countries and in numerous communities. My colleagues and I have published such cohort study findings.' No properly conducted clinical trials have ever been carried out in which cogent clinical findings have been reported in regard to the effect of ARVs in keeping people alive and well; and as for Dr Venter's own 'cohort study findings', I'll expose the shockingly inept quality of his published research work below.

366. **Ad 45.** Concerning Dr Venter's claim that 'ARVs can cause serious side-effects', a less partisan witness, who makes his living dealing these drugs, would frankly state that all ARVs are so exceptionally toxic that conventionally prescribed doses can kill you. The ARVs that are the subject of the TAC's complaints are AZT and nevirapine; annexed marked 'AB80' and 'AB81' are the first pages of 'Prescribing Information' advisories for these drugs issued by their manufacturers that set out these grave caveats concerning their potentially lethal effects in prominent black-box warning notices at the top of the page. The question is why Dr Venter conceals this deadly information; although it may be that he simply doesn't know about it, because he's never bothered to read the AZT and nevirapine package inserts containing these warnings.

367. **Ad 46.** Dr Venter's claims that 'the benefits of ARV treatment far outweigh the risks' and 'Without ARV treatment, nearly all patients with HIV progress to death from AIDS' are not true;

there's currently no consensus among orthodox AIDS experts how long an HIV-positive person will survive, with or without ARV treatment. This is because there's no supporting epidemiological data for Dr Venter's invented propositions. There are plenty of reports in the medical literature of people living long and healthy lives without ARVs, a collection of which is posted online at http://rethinkingaids.com/quotes/progression.html.

368. No one less than Professor Montagnier himself contradicts Dr Venter's false allegation that 'Without ARV treatment, nearly all patients with HIV progress to death from AIDS': I have a copy of a videotaped interview conducted at the Pasteur Institute in Paris in 1997 by the French investigative journalist Djamel Tahi, in which Professor Montagnier stated (translated from French): 'AIDS does not inevitably lead to death, especially if you suppress the co-factors that support the disease. It is very important to tell this to people who are infected. I think we should put the same weight now on the co-factors as we have on HIV. Psychological factors are critical in supporting immune function. If you suppress this psychological support by telling someone he's condemned to die, your words alone will have condemned him.' A translated transcription of the interview in English is annexed hereto marked 'AB82', with a crucial commentary on it by Papadopulos-Eleopulos et al. annexed marked 'AB83'. I can screen the interview (in French) on request.

369. In the course of the interview Professor Montagnier conceded that he never in fact isolated any new retrovirus (later dubbed 'HIV') by purification as he'd claimed in his paper in *Science* in 1983. (Annexure 'AB84') The obviously fatal implications of this at root for the HIV theory of AIDS are canvassed in the commentary.

370. Professor Montagnier pointed out in the interview that Dr Robert Gallo, who claimed to have isolated the same virus in four papers in the same journal the following year, did not in his opinion do so either.

371. Dr Venter's claims that: 'Once patients have developed AIDS, approximately 50% will die within 12 months in the absence of ARV therapy. ARV treatment decreases progression to AIDS and reduces mortality of AIDS patients by approximately 90%.'

Neither of these claims is supported in the medical and scientific literature. If they were, ARV manufacturers would obviously tout them in the marketing of their goods. But no pharmaceutical corporation claims that half of any given group of HIV-positive people, e.g. attending a particular clinic, presenting with an AIDS indicator disease such as TB, will be dead of it within a year, unless they buy and use their ARV(s), and that the drugs are guaranteed to save their lives in all but an unlucky 10% of them. Although his evidence is sworn, Dr Venter just makes it up as he goes along.

372. Dr Venter's false statement to this court that 'Without ARV treatment, nearly all patients with HIV progress to death from AIDS' is easily exposed as such. I mentioned earlier that the HSRC released its 'South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005' in December last year. The principal object of the survey was to determine and report the supposed HIV infection rate in South Africa, and the HSRC's methodology in going about this was more stringent (two ELISA tests) than any previous investigation by either the Department of Health (estimating the national HIV infection rate by extrapolating the results of single ELISA tests of pregnant women attending antenatal clinics) and the HSRC itself previously in 2002 (applying single rapid 'saliva' tests to a representative sample of the general population).

373. Since, as at the date of signature of this affidavit neither the lead author of the report, HSRC CEO Dr Olive Shisana nor any of the 25 other contributory authors to whom I copied my queries to her concerning the scientific integrity of the study had responded to them, I assume that the HSRC stands by its findings. Indeed, 'The numbers are real,' insisted Dr Shisana to the news service PlusNews on 27 February 2006 on learning that President Mbeki had rightly 'dismissed the findings of the HRSC as highly speculative' and not factual. (Plusnews report, annexure 'AB85')

374. I'll also assume that Dr Venter accepts the HSRC's HIV prevalence findings as scientifically sound, and shall treat them as such for present purposes. (If, however, Dr Venter agrees with me that the HSRC's findings are total garbage for the reasons I've set out in my letter to its lead author, or for any other reason(s), he is invited to say so in reply.)

375. The HSRC reported that 40.7% of women living in KwaZulu-Natal are infected with HIV. According to AIDS experts, most HIV-positive people progress to AIDS and die within five to ten years.

376. Senior South African AIDS journalist Tamar Kahn, Science and Health Editor of *Business Day*, who presumably relies on the AIDS expert scientists she cites for her information and does not merely dream up what she writes, in other words fabricates her reports to titillate her readers and editors, claimed in *Business Day* on 16 February 2006 that it's 'within three to five years'. (Annexure 'AB86') I asked her for a reference but to date she hasn't given me one. (Annexure 'AB87') (The annexures to my enquiry to her concerning the Judith Miller Award 2005 – granted to Health-e editor Kerry Cullinan – are insufficiently relevant to these proceedings to append, but they may be read on the www.tig.org.za website at the foot of the page.)

377. It's a notorious fact that several million people live in KwaZulu-Natal. By September 2005, according to a statement by the Director-General of Health, mentioned in paragraph 21 of Dr Venter's affidavit, about 61 000 people were being treated with ARVs in the public health sector in all nine provinces (the number is now reportedly about double). It follows that relative to the number reportedly infected, the fraction of HIV-positive women on ARVs in KwaZulu-Natal is minute. This is to say most HIV-positive people in KZN are not on the drugs.

378. If most infections occurred in recent years, following the classic pattern of a ballooning infectious epidemic, and only a quarter of the HIV-positive women, or even say ten percent of them, were infected more than five years ago, one would expect to see a huge rise in the death rate from AIDS-defining diseases in KwaZulu by now. But there isn't any.

379. Similarly: if, as the HSRC reports, '24.4% of African females in this age group ['15-49 years'] were found to be HIV positive' in South Africa, 31.7% of them between 30 and 34, and 37.9% of them between 25 and 29, then, applying the same principles, the deadly plague should be evident everywhere in the streets and in the fields. It isn't.

380. In an interview with *City Press* published on 26 February 2006, President Mbeki wryly mocked the professional AIDS alarmists, who were claiming that the country's teachers were being wiped out by AIDS, by pointing out that he hadn't noticed any sudden rise in the death rate among the staff in his office, and noting that he didn't think that a disease would affect civil servants in various departments differently. (Annexure 'AB88')

381. Dr Venter's claims about the life-saving benefits of ARVs are contradicted by some of the leading AIDS experts on the use of these drugs: Professor Michael Saag at the University of Alabama, Birmingham, US, runs a major cutting-edge experimental AIDS treatment clinic sought after by pharmaceutical companies to try out their newest compounds. He was interviewed for an article in the March 1999 issue of *Esquire*: 'In one year, 157 of Saag's patients collectively took 189 different drug formulas, with only three patients taking the same mix of HAART drugs … despite such rigorous, individualized medical attention, Saag says, the HAART "dam" is already leaking and there is high danger of it collapsing altogether ... Failures are occurring right and left. … As physicians venture into even wilder frontiers of HIV treatment, the grand experiment with combination therapies, called Highly Active Anti-Retroviral Therapy, or HAART, is rushing forward without any data. No-one is keeping track. … Perhaps the biggest difference between the cure paradigm and whatever paradigm we're in now is, we now should expect failure with whatever [ARV cocktails] we first use. We should plan on it. We should prepare for it. Clinicians should expect failure.' Saag complained that the death rate of his patients on ARV combinations was rising: 'They aren't dying of a traditionally defined AIDS illness … I don't know what they're dying of, but they are dying. They're just wasting and dying. … It is sobering,' Saag continued, 'while we are making good guesses, they are just guesses. We don't know what we are doing.' (Excerpt, annexure 'AB89'.)

382. Furthermore, in regard to Dr Venter's claim that 'Once patients have developed AIDS, approximately 50% will die within 12 months in the absence of ARV therapy. … ARV treatment decreases progression to AIDS and reduces mortality of AIDS patients by approximately 90%', perhaps he knows something

about ARVs that GlaxoSmithKline Senior Vice-President of Genetics Research Dr Allen Roses MD doesn't: In December 2003 he stated that 'more than 90% of drugs work only in 30 to 50% of people'. (Annexure 'AB89A')

383. It appears from Dr Venter's assertion that he considers AZT and other ARVs to belong to that special 10% of wonder drugs that always work for everybody, even though this optimistic appraisal is not shared by top AIDS treatment expert Professor Saag, who says 'Clinicians should expect failure' with them. If Dr Venter possesses such data, he might like to share it with this court in reply. (It could even make him rich.) If he doesn't have such data, it behoves him to admit either that he lied or that he simply doesn't know what he's doing, like Professor Saag and his AIDS expert colleagues.

384. According to the American case definition of AIDS, 'patients have developed AIDS' (Dr Venter's phrase) if their CD4 cell count is under 200/μL. But there's no evidence in the medical literature supporting Dr Venter's false claim that 'approximately 50%' of these 'AIDS patients … will die within 12 months in the absence of ARV therapy'. The claim is as factual as a priest's threat of eternally frying over fire and brimstone in the hereafter unless you buy the hocus pocus he's selling (payable every week), except that Dr Venter's lies are told under oath.

385. **Ad 47.** In claiming that cancer 'Chemotherapy is much more likely than ARV therapy to result in serious toxicity', Dr Venter appears to be unaware that ARV drugs such as AZT, 3TC, ddI, ddC, and d4T are nucleoside analogues closely similar in chemical composition to such purpose-designed cell-killing drugs as fludarabine, cladribine and pentostatin, discussed in *Nucleoside Analogs in Cancer Therapy* (op cit). I'll make my copy of this textbook, discussing the use and general toxicity of these drugs, available on request.

386. Dr Venter is well aware that the 'serious toxicity' of nucleoside analogues, which he and his colleagues prescribe to Africans as a remedy for AIDS, is currently crippling and killing them; and he has privately admitted this to his AIDS doctor colleagues. On 2 September 2005 Dr Janet Giddy, working at the ART (ARV) clinic at McCord's Hospital in KwaZulu-Natal, reported to an

internet medical discussion forum, 'Doctor's [sic] Dialogue', that 'we are becoming increasing [sic] concerned about the problem of lactic acidosis in our patients on HAART … the mortality appears to be around 40% … The concern we feel about D4T [sic] as a drug is shared by other clinicians – we discussed this at the National AIDS conference [sic] with people like Francois Venter … Apart from lactic acidosis, we see a lot of peripheral neuropathy, some hepatitis as well as some lipodystrophy. Of all these conditions, lactic acidosis concerns us the most as it is the most unpredictable and often fatal. … We are concerned about any extra adverse publicity about ART, considering all the panic in South Africa about toxicity. … In the long run, I think the Dept of Health is going to have to make more ARV's [sic] available (e.g. tenofovir) and probbly [sic] restrict the use of D4T [sic]. I hope this is of help to those of you in the ART business.' (Annexure 'AB89B')

387. Dr Venter responded by having a 'first stab' at a poster to alert doctors to the deadly problem, entitled, 'LACTIC ACIDOSIS (LA) CAN BE FATAL! Spot the symptoms early LACTIC ACIDOSIS CARRIES A HIGH MORTALITY (>50%) IF NOT IDENTIFIED EARLY'. In a covering post to the same internet forum he admitted: 'I think we are all seeing cases aplenty (and several deaths)', adding (like Professor Saag: 'We don't know what we are doing'), 'I know the post LA choices are controversial, but I think most of us are doing what I've put down. It's hardly an evidence-based field, and we have far more experience between us than anyone else in the world.' (Annexure 'AB89C')

388. As is evident from this concession, Dr Venter and his mostly white colleagues 'in the ART business' are performing an open-ended, uncontrolled trial-and-error experiment with deadly drugs on impoverished Africans in South Africa, without any scientific 'evidence-based' foundation for it. And as for those killed, bereaved and orphaned by the drugs, the attitude of the AIDS experts seems to be: whatever, they had the Devil in them and were going to die anyway.

389. Dr Giddy's post to 'Doctor's Dialogue' and Dr Venter's response to it was forwarded to me by a public health researcher appalled both by the ongoing reckless killing of the African poor with the

toxic treatment, and Dr Giddy's concern to keep the scandal from the newspapers, rather than going public about the deadly hazards of the medicine, and as widely as possible before any more people were killed or injured. My informant has asked to remain anonymous so as not to jeopardise her employment.

390. It's stupefyingly ignorant for a physician to refer to a cancer chemotherapy drug's 'serious toxicity' as something that might possibly 'result' – when the very point of giving a person diagnosed with cancer a chemotherapeutic drug is to kill his cells off deliberately. It's precisely the 'serious toxicity' of the drug that provides the rationale for prescribing it for short periods, the intention being to poison off the patient's unwanted cancer cells before fatally poisoning off the patient.

391. In the current context, I decline to be drawn into further irrelevant debate about the sense, the merits and all the physical consequences of this brutal, extremely harmful and frequently fatal, half-century-old, failed treatment modality.

392. Dr Venter appears to be alluding to the myth propounded by implication by pharmaceutical corporations in the ARV business that when these drugs are given to HIV-positive people at recommended doses they target the putative virus, HIV, specifically and leave our cells unscathed, i.e. the drugs are specific. In its AZT package insert for AZT, for example (annexure 'A1' to annexure 'AB64'), GlaxoSmithKline claims: 'Competition by zidovudine-TP for HIV reverse transcriptase is approximately 100-fold greater than for cellular DNA polymerase alpha.' (Actually, there's no such thing as 'HIV reverse transcriptase', any more than there was 'the ether' suspending the heavenly orbs, or 'phlogiston' emanating from burning objects; this is discussed in depth at the start of 'AB67'.) But the incontestable, admitted life-threatening toxicity of AZT and similar drugs at ordinarily prescribed doses readily refutes this false claim. Hence the pressing appeal by Hayakawa et al., in *Biochemical and Biophysical Research Communications* (1991) 176:87-93 that 'for AIDS patients, it is urgently necessary to develop a remedy substituting this toxic substance, AZT'. (Annexure 'AB90')

393. Dr Venter claims that ‘There is not a single recorded adverse event associated with the single-dose nevirapine regimen, which is used in most South African hospitals to prevent transmission of HIV from mother to child.’ In making this claim, not only is Dr Venter is woefully incorrect, he also has no reasonable excuse for his dangerous ignorance: even the general public knows that the safety data reported in the HIVNET 012 trial were corrupt and that innumerable serious adverse events, some fatal, were not recorded and reported by the principal investigators:

394. A series of reports by investigative journalist John Solomon of Associated Press were published in the mass media worldwide, including our own, from mid-December 2004 onward, in which Dr Jonathan Fishbein MD, Director of the Office for Policy in Research Operations in the Division of AIDS (DAIDS), in the US National Institute of Allergies and Infectious Diseases (NIAID), went public on the fact that DAIDS director Dr Edmund Tramont had suppressed a crucial, detailed negative safety report by drug safety experts in his division and had substituted it with a positive one that he’d himself written, so as to fraudulently conceal ‘thousands’ of unrecorded serious adverse events during the trial, some fatal.

395. This quoted figure (‘thousands’) was given by one of the two principal investigators of the HIVNET 012 single-dose nevirapine trial, Dr Laura Guay, during interrogation by Westat, a private, independent contract research organization, hired by NIAID inter alia to audit the HIVNET 012 trial records. Given that only 645 pregnant mothers were inducted into the trial, the figure is obviously hyperbole, but it reflects her appreciation of the scale of the problem of unreported serious adverse events.

396. Made available by Dr Fishbein, I annex hereto copies of (a) a conference minute recording a discussion on 3 January 2002 by DAIDS officials of the failure by the trial investigators to monitor and report serious adverse events and deaths; (b) the report of an audit by Boehringer Ingelheim dated 24 January 2002, finding the same; and (c) Westat’s audit report finding likewise, marked ‘AB91’, ‘AB92’ and ‘AB93’ respectively.

397. I’ll serially highlight their findings in regard to adverse events, serious adverse events and fatalities among African mothers and

babies given AZT and nevirapine by the American researchers conducting the HIVNET 012 trial.

398. The DAIDS minute (annexure 'AB91') noted under 'SAFETY' that 'there were more deaths that were not on the CRFs [*clinical report files*] and this was found on only a sample of forms – At least 16 deaths—possibly 5 others or more … 11 NVP grp [*in the nevirapine group*] & 5 AZT grp – and 19 missed SAEs [*unrecorded serious adverse events*]'. Furthermore 'there are differences in #s [*numbers*] of SAEs & deaths … site used their own criteria for grading SAEs, No lab normal values, & serious under-reporting of SAEs … no Med Officer involved, no MO [*medical officer*] AE [*adverse event*] over-sight @ the site. Etc, etc. Other Problems – Data Integrity: Are deaths Drug related – it was felt it was too early to tell. There is a murky picture of what happened at the site. Dr. Mike Hensley is still there & feels with some work it may be possible to salvage study??' Under 'Efficacy Issues/Ops issues' the DAIDS officials noted: '3-4 databases not reconciled, pharmacy issues, drug repackaging, storage & access issues. Randomization procedure unclear etc. … No master log, stolen file cab with IC docs—lost IRB [*institutional review board*] docs etc. Not reported to DAIDS … How much is salvageable? Unknown at present time.'

399. The findings recorded by nevirapine manufacturer Boehringer Ingelheim's clinical trial auditors, recorded in their report (annexure 'AB92'), were so appalling, so compromising, that the company ('BI') fraudulently contrived to keep them from coming to the knowledge of the FDA – telefaxing the report to DAIDS's FDA liaison chief Dr Mary Anne Luzar on 24 January 2002 with a furtive appeal: 'Controlled distribution from BI. BI stated not to copy.' This request, recorded by Dr Luzar in a hand-written memo on the face of the report, was coupled to an even graver one, also duly annotated by her: 'Sensitive information. Asked for it to be destroyed when audit is upon us.'

400. Passing Boehringer Ingelheim's report about the serious trouble with HIVNET 012 on to DAIDS director Tramont, Dr Luzar noted on its cover-page: 'Ed – Here is B.I. summary of their audit. M.A. Has a lot of problems uncovered too.'

401. Since our MCC was later to reject HIVNET 012, despite Dr Tramont's attempt to deceive it about the reliability of HIVNET 012 and the data indicating that nevirapine is unsafe for mostly African, mostly poor South African mothers and their babies (detail below), I'll enumerate the 'lot of problems' found by Boehringer Ingelheim's audit team in relation to drug safety only:

402. 'Information describing adverse events was most thoroughly collected during the first eight weeks after delivery.' After that 'the safety data are incomplete'. Among the 'fatal and life-threatening' adverse events experienced by babies exposed to the trial drugs nevirapine or AZT that 'were reported late' were 'pneumonia … worsening' three days later when the baby was readmitted to hospital, but not recorded and reported as a serious adverse event. The serious adverse events, some 'life-threatening', some 'fatal', included 'Grunting respiration … Pre-eclampsia … Neonatal sepsis, vomiting …Intrauterine fetal death … Hemorrhagic disease of newborn … Hypertension … Respiratory distress, cephalohematoma … Transient tachypnea of newborn … Infectious dermatitis … Birth asphyxia … Fresh stillbirth … Severe anemia'. There were also 'two serious, unexpected SAEs, where the relationship is stated as unable to determine … diarrhea and … pneumonia' which 'should [have been] reported as IND [*investigational new drug*] reports'.

403. Even where the data were recorded, 'The primary difficulty with these data are [sic] the arbitrary definitions of seriousness and severity that were employed.' Again it was noted that 'the sub-investigators and PI' (the principal investigator, Dr Guay) were 'not actually seeing the patients whose events they are evaluating'. The dismal state of the record-keeping in HIVNET 012 was synopsized in the report: 'A core issue for the Mulago site is an absence of documented internal procedures. Reliance on memory and precedent is useful but likely to be associated with inconsistencies in data collection.'

404. That is to say, the missing data aside, even the reported data, including the data relevant to assessing the safety of the drugs for babies, was useless.

405. On 8 March 2002, following its audit of the HIVNET 012 records, Westat filed its report about the mess it found in the

record-keeping and the poor conduct of the trial generally (annexure 'AB93'). Again I'll confine myself to exposing the falsehood of Dr Venter's claims about how safe the extraordinarily toxic drug nevirapine has proven to be when given African mothers in labour and injected as a syrup down their babies's throats a few hours after birth by recounting only the evidence of harmful drug toxicity found and reported by Westat:

406. 'Looking at the examination for discharge, for Mothers, more than 1/3 were marked abnormal. … On a similar note, looking at infant weights, it was apparent that a weight of less than 7Kg at 12-month follow-up was not an uncommon finding, despite the generally robust size of most infants at that visit. It was thought likely that some, perhaps many, of these infants have serious health problems. A sample of 43 such infants from the larger sample of 93, showed adverse events at 12 months. Of these 43, only 11 were HIV positive, suggesting that upon audit of the site files we would find more pathology than had been reported. More to the point, most of the SAEs reported for infants were in the newborn period, which was incompatible with the large number of infants with apparent Failure to Thrive past six months of age. Additionally, there was the matter of the Lancet paper, which mentioned 59 Serious Adverse Events in infants less than two months of age. Both the data sample described above, and the Lancet report, suggested more serious adverse events in infants than had been reported to FDA under the IND [*investigational new drug report*]. Taken together, it appeared likely in fact, that many adverse events and perhaps a significant number of serious adverse events, for both mother and infant, may not have been collected and reported in a timely manner to the FDA, under the IND. … Safety reporting therefore became a primary focus for the site audit team.'

407. Again it was noted that 'For the most part, neither the Principal Investigator nor any sub-investigator actually saw the patient experiencing an AE or SAE. Completion of this form, as well as decisions on seriousness, causality, relation to study drug and severity were made on the basis of second hand information.'

408. Cases where mothers brought their ailing babies back to hospital in unscheduled visits for treatment within six weeks of nevirapine or AZT exposure, or any time after that, were not routinely

recorded as severe adverse events and were generally inappropriately classed as 'non-serious' adverse events instead.

409. Where serious adverse events were noted, there was no follow-up of the patient to clinical resolution – a basic FDA requirement – creating the possibility of fatal outcomes not being recorded.

410. The high number of 'Failure to Thrive' cases among treated babies speaks to irrecoverable toxic shock at birth, manifesting many months later – not taken into account, and never reported by the HIVNET 012 researchers in their glowing reports of the study in the medical journals.

411. The Westat auditors found and described numerous other serious anomalies in the records of adverse events, and uncovered 'deaths not reported to the FDA' in notes kept by visiting nurses.

412. The auditors reported that Dr Guay 'was surprised, however, [that] any death might have been missed. … Although initially Dr. Guay described strict adherence to protocol specified endpoints for collection of safety data, interpretations of seriousness and severity were not actually made according to the protocol or according to 21CRF. … On several occasions Dr. Guay stated that there were probably "thousands" of such missing [*unrecorded serious adverse*] events. … Taking into consideration the decision by Dr. Jackson, Dr. Guay, et al., to coin their own local definitions of seriousness and severity, and keeping in mind the under-reporting of SAEs which resulted from that ("thousands"), then the entire safety reporting system can be seen to have been significantly different from that expected in an IND study. In explanation, Dr. Jackson and Dr. Guay cited a need for consistency in a somewhat chaotic and very busy clinic system. Regarding the definition of "Serious" they cited ignorance of the 1997 safety reporting regulation, although the protocol, as amended in 2000, included a clear statement of the new rule. They also reported that they had never had "GCP" [*good clinical practice*] training, and had never attempted a Phase III trial.' Which is to say, they'd cut their teeth as novice drug researchers experimenting on African mothers and babies, not knowing the first thing about how to conduct a clinical trial.

413. In their 'Summary of Discussions with PI and Sub-investigators', the Westat auditors noted that 'All acknowledged the [*audit*]

findings as generally correct. … Both Dr. Guay and Dr. Jackson expressed concern regarding statements made regarding safety and efficacy in the Lancet paper, and resolved to review the data.' This is to say Drs Guay and Jackson conceded that their claims in *Lancet* in September 1999 that nevirapine had been shown to be safe and effective were insupportable. (Despite their undertaking to the Westat auditors to correct their misrepresentations in *Lancet*, they were silent about it in their second HIVNET 012 report in the *New England Journal of Medicine* in September 2003.)

414. Faced with the embarrassing political implications of the negative findings made by his own staff, by Boehringer Ingelheim and by Westat concerning inter alia the incidence of adverse events, severe adverse events and fatalities in the HIVNET 012 trial among African babies experimentally exposed to nevirapine or AZT, DAIDS director Tramont sent another team of DAIDS staffers over to Mulago Hospital in Kampala, Uganda to draw a third report, with the corrupt intention to paper over the problems with the trial that had led to the withdrawal of Boehringer Ingelheim's license application to the FDA.

415. In a private note to me, Dr Fishbein explained the purpose of DAIDS's 'Remonitoring Report': 'Well before the remonitoring was done, the NIAID had already decided that the data, the results, and the conclusions of the 1999 *Lancet* paper were valid. Too much was at stake to have ever let that be questioned, so what the report stated was a foregone conclusion.' In other words the premeditated, fraudulent object of Dr Tramont's 'remonitoring' exercise had been to deceive the South African MCC, which was reviewing its provisional registration of nevirapine for perinatal administration on the strength of the HIVNET 012 results reported in *Lancet*, in the light of the grave trouble with the study found by the FDA leading to the withdrawal of Boehringer Ingelheim's special license application.

416. What was 'at stake' was the institutional prestige of the National Institutes of Health, which had funded the HIVNET 012 study, on the basis of which the WHO had recommended the perinatal use of nevirapine, and South Africa and many other countries in the Developing World had registered the drug for this indication; but more importantly, national prestige was 'at stake', inasmuch as

US President Bush had announced with much fanfare a federal budget allocation of $500 million to supply nevirapine to pregnant women and newborn babies in Africa on the strength of the reported trial results. To show how much Americans care for Africans.

417. But to Dr Tramont's dismay, his staff on the 'HIVNET 012 Safety Review Panel' noted inter alia in a ten-page report: 'Acceptable or required timeframes for reporting SAEs and deaths were not followed. … The safety reporting quality for the HIVNET 012 study does not meet levels expected in perinatal trials sponsored by DAIDS. … The supervision or monitoring of the willing and capable Ugandan site personnel in all aspects of safety, including subject information regarding treatment risks, verification of eligibility criteria for mothers and infants as well as safety reporting does not appear to have been in place and raises concerns about the study conduct. … Site records for safety monitoring and subject visits were of poor quality and make safety statements very difficult from the perspective of a review process. … Monitoring during the trial for safety and clinical trial management was not in evidence. … Safety reporting did not follow DAIDS reporting requirements during the conduct of HIVNET 012. Safety conclusions from this trial should be very conservative.' (Annexure 'AB94')

418. In view of these damning findings Dr Tramont suppressed the Safety Review Panel's report and slipped a positive one to the FDA instead, which he'd written himself: 'There was some concern expressed by one of the American physician monitors about the adequacy of standards of clinical care in Uganda. … During the full review of 80 mother-infant charts, the reporting of AEs was found to be generally complete. The discrepancies that were found between the database and the source documentation were due to some missing information in the adverse event report. … The remonitoring of review process undertaken by the safety review panel has shown that there was a consistent attempt throughout the study to document AEs and SAEs as evidenced by the large numbers of such reports … and the small numbers of missed events in the remonitoring process. … HIVNET 012 has demonstrated the safety of single dose nevirapine for the prevention of maternal to child transmission of HIV infections.

Although discrepancies were found in the database and some unreported AEs were discovered during the remonitoring process, these were not clinically important in determining the safety profile.' (Annexure 'AB95')

419. Associated Press quoted Dr Tramont later explaining his motivation being that 'Africans in the midst of an AIDS crisis deserved some leniency in meeting U.S. safety standards'. (Annexure 'AB96')

420. When Dr Elizabeth Smith and her expert paediatric drug safety team saw that Dr Tramont had omitted their adverse safety findings recorded in 'The HIVNET 012 Safety Review: Findings and Summary: Final Report_3 April 2003' (annexure 'AB94') from the doctored Remonitoring Report, they passed it on to Dr Luzar, who delivered it to the FDA. It included mention of hyperbilirubinaemia among drug-exposed babies – evidence that they had suffered liver damage or red blood cell poisoning: 'The results of the bilirubin review by treatment, approximately 310 infants on each treatment arm, show that on day 7 post treatment, the number of infants on ZDV [*AZT*] with grade 3 was 132 (44 with other concurrent AEs, 40 without). The number of infants on NVP with grade 3 was 64 (24 with additional concurrent AEs and 90 without) and with grade 4 was 28 (9 with additional concurrent AEs and 19 without). … The infants who had the grade 4 bilirubins have not been followed up to determine if any difference in morbidity [*disease*] and mortality was conferred by the difference in the risk of grade 4 bilirubin levels.'

421. Under a mandatory interdict granted by the Constitutional Court at the instance of the TAC, the South African government is currently being forced to provide nevirapine to mostly poor African women in labour and their newborn babies, against its better judgement, despite the MCC's subsequent rejection of the clinical trial that had founded the registration of nevirapine for perinatal administration, the absence of any basis for the MCC's continued registration of the nevirapine for this special indication in the form of any randomized, double-blind, placebo-controlled clinical trial establishing the efficacy and safety of the drug for use in maternity wards, and most importantly, the existence of a considerable body of data that the drug is harmful to newborn babies.

422. It seems most unlikely that any member of the MCC has bothered himself to read the DAIDS minute, the Boehringer Ingelheim audit (which the company asked to be destroyed before it fell into the hands of the FDA), the Westat audit, and DAIDS's 'HIVNET 012 Safety Review Panel' report (that DAIDS director Tramont fraudulently suppressed), because there has been no action taken by the MCC to deregister nevirapine for administration to mostly African, mostly poor women and their newborn babies, or even suspend it pending an enquiry into this criminal scandal.

423. In view of the MCC's rank professional indolence and incompetence disclosed by this episode, I respectfully request that this court issue an order in such terms as it deems suitable for the protection of our country's young, born mostly to poor African mothers, to protect them from being needlessly harmed by nevirapine exposure after birth as the data uncovered in the HIVNET 012 trial predict.

424. I should mention that a panel of the US Institute of Medicine ('IOM'), many of whose members were major grant recipients from the very agency about whose internal corruption Dr Fishbein had blown the whistle, subsequently concluded, in a very narrowly framed enquiry, that the conclusions of HIVNET 012 were actually fine (for developing countries), but noted crucially that the under-reporting of severe adverse reactions 'may limit the generalizability' of the study's conclusions – ruling out nevirapine being given to American babies. The superficial IOM enquiry never came close to considering any of the fundamental defects in the design of HIVNET 012 that Professor Mhlongo and I raised in our 100-point submission to the MCC. And to this day, the study remains totally unacceptable to the FDA as the basis for a licence application to sell nevirapine for administration to mothers and babies in the US. But it's OK for us in South Africa according to the American IOM, notwithstanding the 'The HIVNET 012 Safety Review: Findings and Summary: Final Report_3 April 2003' that Dr Tramont didn't want the FDA to see, but which thanks to the honesty and integrity of Dr Luzar it did – decisively killing nevirapine's prospects of ever being licensed in the US for giving to pregnant women and their newborn babies.

425. Given the quality of the fixed, boxed, stultified thinking patterns on exhibit in his affidavit, it's certain that when, as the findings of the various auditors of the HIVNET 012 trial predict, Dr Venter sees newborn babies falling ill after being exposed to a dose of a general metabolic poison as potent as nevirapine, he'll ascribe this to the march of AIDS, to the work of the virus – just as doctors in the first half of the 20th century who injected pregnant women with arsenic during their pregnancies to treat their 'syphilis' blamed the consequent severe congenital and other serious diseases among their babies on 'congenital syphilis', a disease construct that has virtually disappeared with the abandonment of arsenic treatment for 'syphilis' by Western doctors. Hence Dr Venter's claim that 'There is not a single recorded adverse event associated with the single-dose nevirapine regime' – when the principal investigators of the HIVNET 012 perinatal nevirapine trial in Uganda confessed under investigation that among just a few hundred mother-child pairs there'd actually been 'thousands'. Of serious ones.

426. If Dr Venter has a reasonable excuse for his ignorance of the scale of the problem regarding serious adverse events in the HIVNET 012 trial later uncovered – because accessing and studying this information takes time and trouble, and as the country's top AIDS doctor he's too busy saving lives – he has none for not knowing the incidence of serious adverse events reported in the popular medical press (which are now known to be unreliably low): Even before the dirt on HIVNET 012 emerged, i.e. that numerous severe toxic reactions, including fatalities, had gone unrecorded and unreported, the original report of the study in *Lancet* in September 1999 reflected that 'The rate of serious adverse events in the two groups [*of AZT- and nevirapine-exposed babies*] was similar up to the 18-month visit (19·8% in the zidovudine group, 20·5% in the nevirapine group), with the median age at last visit being 183 days (IQR 102–276).' (Excerpt from a review of HIVNET 012 by the National Academy of Sciences of the United States of America, annexure 'AB96A'; I have the full paper and can make it available if necessary.)

427. **Ad 49.** If by his statement, 'Side-effects are more common with multiple dosing', Dr Venter means that the higher the total daily dose of ARVs the higher the incidence of toxic side effects, i.e.

the more poison you take, the more poisoned you become, I've no quarrel with it. But if Dr Venter means that of a given daily dose, multiple small doses are more prone to result in toxic side effects than a couple of large doses, I deny that there's any foundation in the research literature for this.

428. Dr Venter starts by claiming that 'Side-effects are more common with … ARV combination therapies'. Then he says that notwithstanding that they cause more 'side-effects' (although he provides no reference for this allegation – there isn't one), 'These more complex regimens (frequently including AZT and/or nevirapine) are more effective for mother-to-child transmission prevention than single dose nevirapine.' Then he concludes by saying 'Recommended regimens are chosen for their tolerability and safety.' So on his bright medical logic as an AIDS expert, ARV combination treatments are given to pregnant women because they 'are more effective' and also because 'Side-effects are more common with … ARV combination therapies'.

429. I dispute Dr Venter's claim that 'These more complex regimens (frequently including AZT and/or nevirapine) are more effective for mother to child transmission prevention than single dose nevirapine.' There's no evidence that any of these drugs have the activity he alleges, alone or in combination, and Dr Venter's fallacious claims that they do are analysed and refuted in annexure 'AB38' and annexure 'AB4' at pages 22-34. As will be clear to this court after reading these critiques, the entire mother to child transmission of HIV story, around which so much moral energy has been generated and reactionary political ground won, is scientific nonsense.

430. Dr Venter states that the 'Side effects of ARVs commonly include short term effects, such as rash, hepatitis, headache, gastrointestinal disturbances, fatigue, sleep disturbances, and dizziness. Longer term effects can include anaemia, lipoatrophy, peripheral neuropathy and metabolic disturbances. There are a large number of rarer side effects, including life-threatening conditions such as pancreatitis and lactic acidosis.' Dr Venter's deceptively emollient presentation of the potentially dangerous consequences of taking ARVs, on account of their potent general metabolic toxicity, is inconsistent with the way in which their manufacturers, mandated by the FDA, highlight in black-box

warning notices at the top of their package inserts that these drugs are so exceptionally toxic that they can kill you. And it's inconsistent with Reisler's et al. findings, mentioned above, that on ARVs one's chances of falling seriously ill with ARV-induced 'serious or life-threatening (grade 4) events', of which liver damage is the 'most common', and 'Cardiovascular events' are 'associated with the greatest risk of death', are greater than the prospect of developing an AIDS indicator disease (quite predictably after broad-spectrum cellular poisoning by ARVs).

431. Dr Venter states: 'My colleagues and I published the results of one of our cohorts of patients in 2004 (S Afr J Epidemiol Infect 2004; 19:48-51). Out of 352 patients receiving ARV treatment followed up from 2 April 2004 to 11 June 2004, seven were lost to follow-up and five died. In other words a maximum of 12 died (3.5%). All 352 patients presented with AIDS. Nearly all would likely have been dead by the end of the period if they had not received ARV treatment. Side-effects were recorded in 44% of patients. However, only 10 patients (2.8%) required a change in ARV regimen by week 10 of the programme. Sixteen (4.5%) were hospitalized, 11 (3.1%) experienced immune reconstitution syndrome, 7 were lost to follow-up and 5 (1.4%) died.'

432. In the first instance, there's no foundation for the assertion that Dr Venter's patients would probably have died without his allegedly life-saving intervention in their lives by dosing them with ARVs. This self-aggrandizing claim is pure invention. Not a single properly conducted clinical study has ever shown that ARVs save lives and that people diagnosed by doctors as having AIDS will die without them. Dr Venter's claim that 'Nearly all ['352 patients … with AIDS'] would likely have been dead by the end of the period ['2 April 2004 to 11 June 2004'] if they had not received ARV treatment' beggars belief. It's a novelty even in the endlessly surprising world of AIDS medicine, and will be news to Dr Venter's AIDS expert colleagues, because no other AIDS expert claims that if you've been diagnosed with AIDS, you'll be dead in a few weeks unless you take his ARVs.

433. Annexed hereto marked 'AB97' is a copy of the paper by Hudspeth et al., to which Dr Venter refers, and of which he's co-author. The paper is a testament to Dr Venter and his colleagues's deadly incompetence for all to see:

434. According to the report, patients were followed for an average of 6 weeks (1-10 weeks). Patients were given triple ARV therapy upon HIV diagnosis at the Johannesburg ARV clinic. The only ever mention of any clinical presentation is that 9.9% of the patients had current and 23.6% previous tuberculosis. Dr Venter and his associates appear not to have heard that mycobacterial diseases such as TB are classic cross-reacting conditions causing what AIDS doctors call 'false positives' to HIV antibody tests, which means merely having a mycobacterial disease such as TB may result in HIV-antibody tests showing up positive. I annex pertinent excerpts from the leading paper on this by prominent AIDS expert Professor Max Essex of Harvard University and others, marked 'AB98'. I have the full paper – Kashala et al. *Journal of Infectious Diseases* 1994;169: 296-304 – and can make it available if required.

435. Moreover, it never occurred to Dr Venter to state the evidence in his paper for claiming that his patients were HIV infected, that is, by what testing method/protocol he diagnosed them.

436. Other than to record that 9.9% of patients were receiving treatment for 'active TB', there's no mention in the report whether any of the patients, or what percent of them if any, were sick with AIDS defining diseases. It appears then that people were inducted into the study and treated with ARVs on the basis that they were HIV-positive and had low CD4 counts (average 123) irrespective of whether they were sick or not. Dr Venter and his associates presumably applied the definition of AIDS favoured by American doctors, in terms of which you can be perfectly healthy and still be diagnosed as having AIDS if you register HIV-positive and have a low CD4 cell count. Yet there are no published data on the survival of patients whose AIDS diagnosis is made purely on the basis of an positive antibody test and a low CD4 count in the absence of any indicator disease; there's no basis in the literature for assuming that such people are diseased and are doomed to fall grievously ill and die, even less that giving them ARVs will prevent this and save their lives.

437. I pause to mention that marginally more sensible Canadian AIDS experts don't go for the American idea that you've got AIDS, even if you're feeling fine, merely because your CD4 cell count is low on a given day – so that whether or not you've got AIDS, and

are going to die in a few years time, possibly extended by a few more by buying ARVs, they say, all depends on which side of the border you're on. So if you've been diagnosed with AIDS by an American AIDS doctor because your CD4 cell count is low, all you have to do is hop over the border and a Canadian doctor will tell you don't have AIDS anymore. You're instantly cured of your AIDS by the guy stamping your passport at the border post. (Excerpts, 'Annual Report on AIDS in Canada: December 1996', annexure 'AB98A')

438. And by the way, according to the US CDC's case definition of AIDS, if your young child has lymphoid interstitial pneumonitis or recurrent bacterial infections and he's also HIV-positive, he's got AIDS; but on the day he turns thirteen he doesn't have AIDS any longer, he just has one of the said diseases. He just outgrows having AIDS, like pimples. These diseases are only AIDS-defining if you're under thirteen, according to American AIDS experts, and not if you're older than that.

439. This circus in the diagnosis of AIDS extends to the diagnosis of HIV infection too. Whereas nearly all AIDS experts everywhere – but not in England – consider a positive Western blot antibody test result to mean you've definitely got the AIDS virus in you, whether you're actually living with the virus or not all depends on what country you live in, and even on what medical laboratory your blood is sent to in your city: Western blot test results for so-called HIV antibodies (in fact these antibodies are entirely non-specific) are interpreted by AIDS experts according to completely different criteria from one country to the next, one laboratory to another. This farce – if it wasn't a tragic holocaust for the millions being terrorized, robbed and poisoned by AIDS doctors and the pharmaceutical industry – is discussed in annexure 'AB38'.

440. To return to Dr Venter's paper: After an average of just six weeks of treatment with his ARVs, 4.5% of patients needed to be hospitalized, 3.1% otherwise became seriously ill on the drugs (described by Dr Venter as 'immune reconstitution syndrome'), and 'a maximum of … 3.5%' died.

441. If the death rate remained constant, this means that after one year approximately 30% would have died. (If we start with 100

patients, after the first six weeks, 3.5 will be dead, leaving 96.5 patients. After the second six weeks 3.5% of those 96.5 patients will also be dead, that is, 3.7 more dead patients. After nine lots of six weeks, just over a year, almost 30% will be dead.) This is a very high mortality rate, and if, as it appears from the report, the patients in Dr Venter's study were diagnosed as having AIDS on the basis only of the US laboratory test definition (low CD4 cell count) the first thing any reasonable person would conclude is that he was poisoning and killing them with his toxic ARV treatment. Even if all the patients inducted into the study were clinically ill with AIDS indicator diseases (which the report didn't claim), the 30% annual mortality rate is still breathtakingly high.

442. Considering the extent to which the trial subjects needed hospitalization, and the incidence of 'immune reconstitution diseases' setting in after just a few weeks of ARV treatment, the only intelligent interpretation of the findings reported by Dr Venter in his paper is that ARVs have no benefit to the patient, but that instead they are dangerously hazardous to health and life.

443. Not only was there no placebo arm in the study, and no non-treatment arm, it was not randomized either. It was also retrospective; and for some unknown reason Dr Venter had to obtain his data from two sources, the pharmacy and the patient file. And 'furthermore, the data represented summarised the experience of the first ten weeks of the clinic only, resulting in a variable duration of follow up of the patients and the absence of virological outcome data', according to the report.

444. That is, Dr Venter didn't report a tally of 'viral load', conventionally read by AIDS experts such as him as an index of treatment efficacy.

445. Dr Venter gives the baseline average CD4 cell count in the total patient population, male and female, which means he was measuring their CD4s. Yet for unknown reasons no mention is made in his paper of these putative immunological data at the end of the trial.

446. Dr Venter's failure to report these parameters suggests that the data recorded disappointed him, i.e. that CD4 cell counts didn't climb and 'viral loads' didn't plummet with the administration of his strong medicines as he'd expected.

447. His failure to monitor the people he was treating means they may have fallen grievously ill or died of ARV poisoning outside the brief period of 'follow up' and consequently not have been counted as casualties of his experiment on them.

448. Having regard to the low quality of his research, it will not surprise this court to read at the foot of his paper that while doing his ARV experiments on Africans in South African ('95%' of study subjects) Dr Venter is in the pay of the American government. (Much less trouble if they're killed or injured here than in the US.)

449. **Ad 54.** Dr Venter states that 'From this we can conclude that ARV treatment, despite its side-effects, is beneficial to patients in a large scale hospital setting in SA.' However, from the data reported by Dr Venter it's impossible for anyone who understands the meanings of the concepts of evidence and proof to draw such a conclusion. To the contrary, the data support the conclusion that ARVs are lethally harmful.

450. **Ad 55.** Concerning Dr Venter's claim that 'preliminary data are similarly reassuring regarding side effects', I point out that, in contradistinction, competent investigators who have performed properly conducted investigations have found the incidence and severity of ARV 'side effects' anything but 'reassuring' (Fellay et al., Reisler et al. cited above).

451. **Ad 56.** Without presenting any data, Dr Venter's statement that other 'Successful cohort results have also been reported from ARV sites in other South African settings' is worthless, particularly if the 'cohort studies' were conducted to the same abysmal standard as his.

452. **Ad 57.** Dr Venter's claim that 'Regardless of the side effects of ARVs, if patients with advanced HIV disease did not take them, they would likely die prematurely of AIDS' is pure medical mythology, unsupported in the medical literature, and certainly not by his study, given that it was retrospective, open label, not randomized and devoid of placebo and non-treatment arms.

453. **Ad 71.1-2.** Dr Venter's claims that 'Hyperbole is used in [Brink's] statement [that] "AZT is profoundly toxic to all cells of the human body". It will mislead people who do not have access

to or the background to understand the scientific data pertaining to zidovudine (AZT). While AZT has side effects, some of which can be serious in some individuals, there is no scientific evidence that it is "profoundly toxic to all cells of the human body". (Dr Venter's emphasis.) I invite Dr Venter to state in reply, with reference to the research literature, which cells of the human body AZT is not toxic to, or to which cells it's only mildly toxic – otherwise to confess his endeavour to misdirect this court.

454. In this regard, it's to be hoped that Dr Venter will be able to come up with a better informed authority than his AIDS expert colleague, Professor Robin Wood, co-director of the Desmond Tutu HIV Centre at the University of Cape Town, who passed the memorable remark reported by Health-e News on 13 May 2005 that 'the toxicity of these drugs [*AZT and similar*] is very low indeed'. (Annexure 'AB98B') Likewise Joseph Perriens, the equally ignorant buffoon in charge of the Care and Support Division of UNAIDS in Geneva, quoted by the *New York Times* on 25 November 1999, in reference to AZT, saying that 'To combat a fatal disease, it is perfectly acceptable to use drugs slightly more toxic than an aspirin.' (Annexure 'AB98C')

455. Especially since Brinkman et al. had just reported in *Lancet* 1999 Sep 25;354(9184):1112-5 that AZT-class drugs 'are much more toxic than we considered previously. … The layer of fat-storing cells directly beneath the skin, which wastes away … is loaded with mitochondria … other common side effects of [AZT and similar drugs are] nerve and muscle damage, pancreatitis and decreased production of blood cells … all resemble conditions caused by inherited mitochondrial diseases.' (Abstract, annexure 'AB98D')

456. The literature on the profound general cellular toxicity of AZT is vast. The principal reason why AZT is so toxic to all human cells is because it destroys the energy-generating mitochondria inside them, and it inhibits DNA synthesis inter alia by decreasing the cellular triphosphorylated nucleotide pool from which DNA is made; indeed, it was specifically designed to kill cells by stopping the synthesis of DNA. The toxic pharmacology of AZT is reviewed in annexure 'AB67'. Annexed is a collection of citations and excerpts from leading research reports in regard to the cellular toxicity of AZT, marked 'AB99', and in regard to

other ARVs in combination (which AIDS doctors call 'HAART', i.e. 'Highly Active Combination Therapy') marked 'AB100'. I have many of these papers in full and can make them available to this court or any other authority on request.

457. To Achmat, however, President Mbeki's appreciation that this data shows 'antiretrovirals like AZT are toxic and destroy the immune system' is the only 'explanation for the paranoia that's going on', that is to say, to Achmat's mind AZT isn't toxic and doesn't destroy the immune system, and anyone thinking it is and it does is nuts. (These are the brains behind a R38 million a year propaganda organ for the pharmaceutical industry in South Africa – described by *Rapport* on 10 February 2002 as the 'mastermind' ('*meesterbrein*') behind the TAC.)

458. With submission, any doctor such as Dr Venter who, unlike Achmat, has 'access to or the background to understand the scientific data pertaining to zidovudine (AZT)', and who gives AZT to his patients, telling them not to worry, it's is not profoundly toxic to all cells of their body as hundreds of research papers have reported, is a professional disgrace and a grave menace to the public.

459. **Ad 71.3.** I deny Dr Venter's claim that 'Presenting the fact that AZT is toxic, without informing readers that scientific studies have found its benefits to outweigh its risks, is misleading', because no properly conducted large scale, randomized, placebo controlled double blind scientific study has ever demonstrated that swallowing as poisonous a chemical as AZT has any clinical health benefits.

460. **Ad 71.4.** Dr Venter's claim that 'AZT has been shown in clinical studies to reduce transmission of HIV from mother to child' is scientifically debunked in Popadopulos-Eleopulos's et al. monograph on the subject, annexure 'AB38'. There's no evidence that AZT prevents this. Nor can any be obtained because no tests exist to prove 'transmission of HIV from mother to child' – as is specifically treated in Appendix X of the monograph. This extensive refutation of Dr Venter's claim shows that contrary to his assertion, in truth there's no 'scientific consensus that for such infants exposed to HIV, the benefit of not contracting HIV outweighs the risks that AZT may present to them'.

461. There's no evidence in the medical literature that babies exposed to AZT and/or nevirapine and/or other ARVs in the womb or after birth live longer and are less prone to fall ill than unexposed children. It's abundantly established in this literature, on the other hand, that unborn and newly born babies may be severely harmed by exposure to AZT and similar drugs in utero, and, in some cases, for several days after birth. This is comprehensively detailed in my correspondence with the MCC, and in my afterword, which canvasses the latest research findings (annexure 'AB4'). (Indications of the harm to babies caused by nevirapine exposure immediately after birth are detailed above.)

462. In sum, what these studies show is that babies exposed to AZT, pre-, peri- and post-natally, have a much higher incidence of serious disease and death – as one might reasonably expect from exposing them to a mitochondrial toxin and inhibitor of DNA synthesis at so vulnerable an age.

463. For the reasons mentioned earlier, I deny that the expressions 'exposed to HIV' and 'contracting HIV' have any more empirical content than possession by the Devil, even if they are just as exciting.

464. If as kingpin of his HIV/AIDS Clinicians Society Dr Venter is 'unaware of studies that show that AZT is definitely teratogenic in doses used to prevent transmission of HIV from mother to child', it seems likely that the rest of his society's members are just as ignorant. In the circumstances I respectfully request that this court consider issuing a directive in such terms as it deems suitable that Dr Venter and his society acquaint themselves with the scores of studies in this regard immediately so that the mostly African pregnant women whom they push this drug on can be properly consented first. The studies are canvassed in my letters to the MCC (annexure 'AB4').

465. It appears that by 'teratogenic' Dr Venter has the popular meaning of the word in mind, in the sense of liable to cause the sort of monster-births that resulted from the use of thalidomide in pregnancy between 1958 and 1961 in the West (a tragedy still continuing today out of Western sight in Developing World countries where the drug's manufacturer Chemie Grunenthal has turned its criminal energy to selling it as a treatment for leprosy).

But in the medical sense of a chemical that permanently and seriously damages growing human foetuses, the literature is replete with studies reporting this, which I cited in my correspondence with the MCC.

466. Mostly white AIDS doctors such as Dr Venter, treating mostly African pregnant women with AZT, have simply looked the other way as these reports have been published in the medical and scientific press – just as their medical predecessors did in regard to the accumulating mountain of literature that the manifestations of 'syphilis', involving inter alia skin eruptions, loss of teeth, gangrenous rotting of the face and extremities, heart, kidney, liver and other organ failure, blindness, deafness, progressive brain and other neurological deterioration resulting in general physical paralysis and dementia, presenting in slobbering and shambling, were the result of medical treatment with arsenic and mercury, and not the work of some sexually-transmitted germ, that by the strangest coincidence was able to cause the very same wide range of symptoms that poisoning by these deadly heavy metal poisons have been observed to cause for centuries.

467. **Ad 72.** It's indeed so that AZT supplied by Sigma-Aldrich 'for experimental work in the laboratory' is 'not formulated for oral intake'. In fact the company warns on the label that the chemical is so exceptionally toxic that researchers working with it should take the utmost care when handling it, because AZT is 'Toxic to inhalation, in contact with skin and if swallowed. Target organs: Blood, bone marrow. … Wear suitable protective clothing.' So not only should they on no account swallow it, they should not even sniff it or let it touch their skin. And to ensure this, they should cover themselves up completely before opening the bottle.

468. Dr Venter does not state on what basis it's 'misleading to compare this product with that formulated for oral intake' by GlaxoSmithKline and generic drug producers such as Aspen Pharmacare in South Africa. Whether supplied by Sigma-Aldrich for research use, or sold by pharmaceutical corporations as a medicine, the chemical is exactly the same; it's pure AZT: 3'-azido-3'-deoxythymidine – formerly called azidothymidine, now zidovudine.

469. I invite Dr Venter to elucidate in reply what the difference between AZT supplied by GlaxoSmithKline and Sigma-Aldrich is – other than that '600mg [daily] doses' of AZT which are 'recommended' by doctors such him to be swallowed on purpose, are twenty-four times the quantity that Sigma-Aldrich warns is a deadly toxic hazard upon a single accidental contact.

470. Even a lesser daily dose of AZT than the quantity 'recommended' by Dr Venter and his AIDS expert colleagues, namely 500 mg of AZT given daily to 'asymptomatic patients', was reported by Lenderking et al. in the *New England Journal of Medicine* 1994 Mar 17; 330(11):738-43 to cause 'severe side effects' that are 'life threatening in some cases'. (Abstract, annexure 'AB101')

471. Unlike Dr Venter, who has apparently come to appreciate that higher doses of AZT knock his patients down very quickly and so now prescribes '600mg doses' daily, GlaxoSmithKline still nonchalantly recommends in its package insert for the drug: 'A broad range of dosages (between 500mg and 1500 mg/day) have been used.' That's between 20 and 60 times the quantity in the 25mg Sigma phial. (Annexure 'A1' to 'AB64')

472. **Ad 73.1.** Dr Venter claims that it's misleading to describe 'AIDS drugs such as AZT' as 'extremely toxic' and state that they can 'kill people'. Since the research literature reports that nucleoside analogues such as AZT inhibit cellular DNA synthesis and destroy mitochondria, and hundreds of published papers have reported the clinical consequences of this form of poisoning (a sample of them in annexure 'AB99'), there's no foundation in the scientific literature for Dr Venter's denial that nucleoside analogue drugs in the AZT class drugs are 'extremely toxic' and can 'kill people'. Dr Venter's denial is a false denial, and his only defence to a perjury charge on this score is disgraceful ignorance of his professional literature for which he ought by rights to be struck off.

473. Assuming that Supreme Court of Appeal Judge Edwin Cameron is a reliable source in this regard, which I do, the TAC's leaders have themselves admitted – to him, it appears – that the drugs they earn their living promoting have killed some of their own members. The Canadian *Globe and Mail* quoted Judge Cameron on 13 Sept 2003: '"On the 28th of October, 1999, the President

gave a speech in which he said AZT was toxic," said Edwin Cameron, the shock of it still fresh. "This signalled the start of an apparent courting of the AIDS denialists. … Of course the drugs are toxic," said Mr. Cameron, almost trembling with exasperation. TAC recently lost three prominent activists whose bodies could not withstand the drugs.' (Annexure 'AB101A')

474. That is to say, three prominent, highly visible TAC activists, whose deaths would not have been missed, were killed by ARVs. It's an open question how many people out of public sight, persuaded by the TAC to take ARVs, have been poisoned and killed by them too. Some grimly instructive figures in this regard were released to local journalist Anita Allen on 6 October 2005 by Department of Health Media Liaison Officer Maupi Monyemangene in response to some questions she posed the month before. 'Reporting of adverse events is very poor between both private and public sectors not only in South Africa but also in other countries,' noted Ms Monyemangene, and no national figures exist on how many people have died on ARVs provided by the public health service. But 'The Western Cape report showed that: – Out of a total of 4251 patients enrolled in 3 months, a total of 207 (4.8%) patients died. Out of the total of 2715 patients enrolled in 6 months, a total of 196 (7.2%) patients died. Out of the 914 patients enrolled in 12 months, a total of 114 patients (12.2%) patients died.' (Annexure 'AB102')

475. Plotted on a graph as X and Y values, these data reveal a perfect linear relationship between the death rate of people taking ARVs and the duration of their treatment; and they predict that within seven years everyone on ARVs will be dead. That is to say, the data show the life expectancy of people taking ARVs to be lower than the (medically imagined) life expectancy of untreated people, which is five to ten years according to the AIDS experts. So rather than prolonging life, ARVs demonstrably shorten it. They are killing mostly African, mostly poor people in our country. This is the fruit of the TAC's work in getting these drugs into the public health system.

476. **Ad 73.2.** Although Dr Venter has 'explained above' that 'the benefits of AZT outweigh its risks', he has nowhere adduced any evidence that ingesting AZT has any clinical benefits for the

people he encourages to swallow it. There isn't any in the form of any properly conducted trial.

477. Dr Venter concedes that 'in rare cases patients on ARVs die as a result of the medicines'. The only basis for this concession is that the statement he has just falsely repudiated ('AIDS drugs such as AZT are extremely toxic and kill people') is actually quite true. Dr Venter doesn't quantify the 'rare' number of people he kills by prescribing them frank cell poisons to swallow, so his assertion that they are 'rare', albeit nice propaganda, is scientifically meaningless.

478. Dr Venter's ex cathedra assertion that 'many more would die if they did not take ARVs', has no foundation in the form of any duly conducted, large-scale, placebo-controlled, double-blind clinical trial showing that ARVs save the lives of people diagnosed HIV-positive or with AIDS. The allegation is accordingly manufactured from nothing and is false.

479. Dr Venter claims that 'Local research has demonstrated that ARVs, using regimens that include AZT, reduce the risk of tuberculosis.' I presume that the 'Local research' to which Dr Venter refers is of a similar quality to his own, discussed above, which accounts for why it hasn't been published in any reputable journal, and furthermore why the ARV manufacturers, including AZT producer GlaxoSmithKline, haven't seized upon these allegedly break-though discoveries regarding the supposed anti-TB prophylactic activity of AZT and other ARVs. Contrary to Dr Venter's claim, many reports have been published in medical journals that as people start ingesting these toxic drugs they develop TB and other serious illnesses. Even the TAC recognises this in its pamphlet on 'Immune Reconstitution Syndrome' (annexure 'AB18'): 'I got sick with TB after starting ARV treatment…'

480. Annexed marked 'AB103' is a list of some thirty reports in the medical literature concerning ARV treatment causing people to become very sick with 'Immune Reconstitution Syndrome' – seen through Dr Venter's glasses as a good sign that they are actually getting better, since as the doctor he knows better than the people he treats whether they are sick or not. I have the full texts of all these listed papers, and about twenty more on the same theme,

and I can make them available to this court or any other authority if required.

481. **Ad 73.4.** As to Dr Venter's claims that 'ARVs improve immune reconstitution … They do not worsen immune deficiency', for two decades we have been told by AIDS experts that (a) a virus HIV causes immune deficiency, which in turn leads to the appearance of many diseases and thus to death, and (b) ARVs reverse this immune deficiency by fighting the virus, thus preventing the appearance of the many AIDS defining diseases and death. Now, with the recent invention of 'Immune Reconstitution Syndrome' as a brand new medical construct devised by AIDS doctors to rationalize the onset of serious diseases caused by the toxic ARVs that they prescribe, we are told that ARVs reverse immune deficiency ('Immune Reconstitution'), but patients continue to develop the same diseases and die from them. To prevent this, the patients are treated with more of the same agents that themselves cause immune deficiency, that is, with immunosuppressant ARV drugs. As George Orwell once observed, 'Only a member of the intelligentsia would believe such a thing. No ordinary man would be such a fool.'

482. The clinical presentation of 'Immune Reconstitution Syndrome' ('IRS') in the form of deadly diseases developing among people treated with ARVs is as good evidence as one can get that the HIV theory of AIDS is wrong, and that the conventional treatment of AIDS with ARVs is a colossal medical blunder. It's palpably obvious to any intelligent person that IRS is a self-serving medical contrivance calculated to prolong the life of the two-decades old HIV theory of AIDS and protect the professional esteem, privileges and riches of AIDS experts, who are irrevocably professionally committed to this theory and the use of ARVs, in the face the most glaring mounting anomalies. Obviously, no good for the patient comes of being told by Dr Venter and his professional fellows that as they fall very sick on the toxic drugs being prescribed to them they shouldn't mind, and they should continue swallowing them, because actually, even as they are physically deteriorating, they are getting better according to the laboratory tests. The invention of IRS as a manifestly ludicrous new medical construct shows how AIDS science is

ideologically and not scientifically driven: rather than being a self-correcting system of knowledge grounded in and responsive to empirical observation, it's founded on deeply sunk grand abstract theoretical conceptions in the Lysenkoist mould, with disruptive, anomalous facts either absurdly rationalized, or suppressed and opposed – and the more obviously incongruent and fundamentally awkward they are, the more hotly they're resisted. Anything to avoid the embarrassment of having to abandon the extant, entrenched model of understanding as completely mistaken, even as it reaps honours and riches for those propounding it.

483. **Ad 74.** I have nothing further to add about the toxicity of nevirapine for newborn babies, except to observe that, considering that it's contraindicated for even short term use by the US CDC for administration to doctors and nurses suffering needlestick injuries, because it has been found to be so acutely and severely poisonous – to the liver particularly – and babies with immature organs are much less capable than adults of metabolizing and eliminating toxic chemicals, and so are much more vulnerable to being permanently harmed by them, the bovine obduracy of doctors who continue to champion this pharmaceutical product (AZT too) brings to mind the playwright Chekov's thoughts about doctors in Tsarist Russia, likening their 'dull wittedness and tyranny' with that of the secret police. (Particulars in annexure 'AB56')

484. **Ad 75.** Dr Venter and I agree at last that '"AIDS drugs" do not cure HIV/AIDS'. We agree further that 'Currently, antiretrovirals are a lifelong chronic treatment for HIV/AIDS', just as from 1909 until the nineteen-fifties the 'current treatment' for syphilis was repeated injections with arsenic until the patient died. (A photograph of arsenic ampoules is annexed marked 'AB104'; if required, I can exhibit my box of this formerly popular medicine to this court.) However, ARVs are extremely toxic chemicals, and Fellay et al. have found that more than two thirds of people prescribed these drugs are unable to take them because of this, with half of them reporting clinical problems such as vomiting, diarrhoea, nausea, fat growth, mood swings, insomnia and fatigue, and a quarter suffering 'potentially serious' metabolic abnormalities indicated by blood tests. The researchers described

a ‘significant proportion’ of the adverse events as ‘serious or severe’. That is to say, the findings of a formal investigation to quantify the incidence of toxic ill effects predict that for the majority of his mostly African, mostly poor patients Dr Venter’s dream that they will be swallowing his medicines until their dying day, so he can go their funerals and celebrate himself (detail below), is unlikely to be realized.

485. The burden of Dr Venter’s statement that ARVs ‘do not cure HIV/AIDS’ is that the patient under his control is led to believe by him that he is incurably and permanently diseased and will die prematurely, and is not permitted to believe that he or she can be completely well again. Clearly it’s Dr Venter’s medical ideology that is very sick.

486. **Ad 75.2.** It will be obvious to this court by now that Dr Venter’s explanation – ‘As I have explained, it is false that AIDS drugs “make people even more sick”’ – is not a very good one. That the toxicity of AZT can ‘make people even more sick’ when they are already sick with AIDS defining diseases, and that such ill people are especially vulnerable to the toxicity of AZT, has been pertinently warned against by AIDS experts (cited in annexure ‘AB67’).

487. Even Dr Venter knows this, and declared so at the funeral of a woman he killed – it’s common cause – by the ARVs that he’d prescribed her. Speaking at her grave in April 2002, he ‘explained that toxic reactions to the drugs can occur, particularly when the patients’ immune systems are severely weakened’ (per Judge Edwin Cameron’s paraphrase in *Witness to AIDS* (Cape Town: Tafelberg, 2005). Dr Venter seems to have felt it necessary to pitch up at the funeral of his former patient to make excuses to her family for having killed her with his poisonous treatment, a practical illustration of the aphorism that doctors bury their mistakes. There’s no indication that Dr Venter proceeded to account to his victim’s family for his fatal medical negligence in giving her ‘toxic’ ARVs despite her ‘severely weakened … immune system’ and his knowledge, shared at her graveside, that she was therefore at high risk of being killed by his treatment.

488. It defies rational comprehension that AIDS doctors such as Dr Venter should encourage people with low CD4 cell counts

(believed to indicate 'immune systems' that 'are 'severely weakened') to take ARV drugs such as AZT and similar.

489. In his book just cited, Cameron JA also mentions that a few months after commencing treatment with ARV drugs in the AZT class (d4T and ddI) in October 2002, TAC campaigner Charlene Wilson was killed by lactic acidosis, 'a side effect of stavudine [d4T] and didanosine [ddI]'. It's a well-established 'side effect' of AZT too, as is borne out by the reports cited in annexure 'AB99'.

490. **Ad 76-80.** The references to ARVs in these paragraphs are repetitious, and I've disposed of them already.

491. I respectfully seek a finding by this Honourable Court that, reckless of his ordinary obligations to depose to 'the truth, the whole truth and nothing but the truth' to which he swore, and of his special obligations to this court as an expert witness, Dr Venter has, to quote his own words, uttered numerous 'misleading statements, and outright falsehoods'. Where I've shown his statements to be false – either contradicted by the research literature or made without any foundation in it – I ask that they be referred to the Director of Public Prosecutions for the investigation of a charge of perjury. Where, on the other hand, Dr Venter's evidence has repeatedly been 'characterized by poor logic', to quote him again, the very purpose of high-pressure rote-tutoring of physicians in supposed medical facts, without any rounding education in history, philosophy, politics, literature and cultural studies, let alone the basics of the philosophy of science and the problems of medical epistemology, appears contrived to ensure that they emerge from their medical colleges as dependable, robotic, wholly uncritical, loyal delivery mechanisms for pharmaceutical industry merchandise, criticism of which invariably imperils their careers and leads to professional ostracism. I therefore concede that Dr Venter cannot fairly be held accountable for his deficient education insofar as this goes to the development of thinking skills. Concerning Dr Venter's dangerous professional incompetence, disclosed in his affidavit, including evidence that he is slaughtering African people with the sort of American medicine he plies, I ask for no special order, because any charge in this regard is unlikely to be sustained by his medical colleagues or by a criminal court, given that his

professional conduct is entirely within the accepted norms of contemporary medical practice, of which he's an outstanding, highly respected and exemplary exponent.

492. Concerning the costs of this application, I've been informed by a concerned physician, a member of the second applicant, who told me that she'd prefer to remain anonymous to prevent victimisation, that when the second applicant was solicited by the TAC to join forces and lend the weight of its name to the first applicant's case, it only agreed to do so against an undertaking by the TAC to pay all its legal costs and to indemnify it for costs should the application fail. This is to say, the entire case against the respondents, including the South African government, is being maintained by the TAC's foreign funders, notwithstanding the appearance of domestic support for it. Since this may have a bearing on the question of costs liability at the end of the case, I request that the second applicant confirm or deny this in reply

493. I invite Professor Dorrington and Dr Venter to declare in reply how much money the TAC paid them, if it did, for their contributions to this application.

494. Should the TAC or any of its expert witnesses improperly try slipping some new studies or data into their replying papers to rebuild their collapsed case (e.g. allege the fallacies that 'HIV' has been genetically sequenced, or that its existence is proved by transfection or cloning phenomena), I'll apply for leave to rebut them by way of a further affidavit and supporting annexures before the issues in question are determined.

495. In the situation, I respectfully seek an order dismissing the application against me and my group, the sixth and seventh respondents, with costs.

496. Since the TAC has not shown that my group and I are involved in any wrongdoing at all, and accordingly makes no case for interdictory relief against us in its founding papers whatsoever, I submit that its misjoinder of us in this application by including us in the spray of the case was manifestly malicious and intended to oppress us financially with a view to silencing us as political enemies; and I accordingly respectfully request the that this court mark its disapproval of the TAC's gross abuse of the legal process for this self-serving, male fide purpose by granting a costs

order on a punitive scale. Otherwise, as our group's information campaign concerning the toxicity and inefficacy of ARVs grows and gains ground in future, thereby jeopardizing the TAC's massive foreign funding and political hegemony, it can be expected that the TAC will again employ this abusive gambit to harass us in a bid to suppress our opposition to its claims and activities as lobbyists for the useless and very dangerous medicine for AIDS currently being marketed by the multinational pharmaceutical industry in South Africa, wastefully clogging the courts as it does so.

497. That Achmat and his TAC well appreciate that there never was any case against my group and me is indicated by his omission of us from those he accuses in his rant at the Microbiocides 2006 conference mentioned earlier (annexure 'AB62A').

498. In conclusion, as this court will appreciate from this affidavit, thousands of people in our country, mostly African, mostly poor, are currently being terrorized into submitting to treatment with harmful chemicals, and are being killed and injured by them, to the benefit only of the shareholders invested in the mostly American and English corporations that manufacture them and their local pimps, peddlers and other hangers-on. Since the MCC has shown itself to be entirely ineffectual in preventing this, I respectfully ask that this court direct that a copy of these papers be forwarded to the president of the South African Medical Research Council, Professor Anthony Mbewu, and that he be requested to coordinate, without further delay, the conduct of a simple, absolutely decisive scientific experiment – one agreed by orthodox and dissident scientists in my presence at the second meeting of President Mbeki's International AIDS Advisory Panel in Johannesburg in July 2000, and formally minuted as 'Proposal 5' in Chapter 9.6.1 of the report that followed – namely that the HIV theory of AIDS be tested directly by determining whether HIV-positive people really are infected with this retrovirus. (Excerpt, annexure 'AB105')

499. My enquiries over the years have established that the experiment has been deliberately blocked by officials and scientists who believe in the HIV theory of AIDS (both of whom have since moved on from their offices), notwithstanding President Mbeki's strong wish that the experiment be performed, as he stated during

an interview on e.tv on 25 April 2001: 'I am very keen that this panel should do these scientific experiments', because 'The panel said one of things we have got to do is to determine when you do an HIV test what is the test testing.' (Annexure 'AB106')

500. The method long ago devised by virologists for finding out this most basic fact is purification, a procedure described in section 9.6.2.2 of the Panel's report. It's a relatively simple matter to perform this experiment, and everything turns on it, because if it shows, like Iraq's fabled Weapons of Mass Destruction, that there's no retrovirus to be found when the researchers conducting the experiment finally look under the bed, as it were, an immediate reappraisal and redirection of government AIDS policy and over R3 billion a year in associated expenditure will be called for. Hundreds of thousands of South Africans, mostly African, mostly poor, will have hope restored to their shattered lives as the false curse of their fatal medical diagnosis is dispelled when the news gets out that the whole thing has been a money making hoax; and no longer will they needlessly be poisoned with ARVs, suffering horribly and in some cases dying as a result.

ANTHONY ROBIN BRINK

SIGNED AND AFFIRMED BEFORE ME IN THE PRESCRIBED MANNER AT CAPE TOWN ON THIS DAY OF MAY 2006, THE DEPONENT HAVING STATED THAT HE HAS CONSCIENTIOUS OBJECTIONS TO TAKING THE OATH AND THAT HE REGARDS THE AFFIRMATION AS BINDING ON HIS CONSCIENCE.

COMMISSIONER OF OATHS

All annexures to this affidavit can be accessed via the electronic version online to which they are hyperlinked at www.tig.org.za.