rhea, fever, significant weight loss, and asthenia, as well as other minor symptoms. These are also the symptoms of most non-AIDS diseases, including malnutrition, malaria, and parasitic infections, in Africa. In 1994 Bangui was finally updated to suggest the use of an HIV test, but in practice, they are prohibitively expensive.

The reality is that, in Africa, estimates of the HIV-positive population are estimated using the results from a limited number of HIV tests. But as many critics have tried, in vain, to point out, this is another reason why the projected picture is so utterly distorted: the HIV test itself is unreliable.

A group of researchers based in Perth Australia, headed by the nuclear physicist Eleni Eleopolis-Papadopoulis, have for years been publishing blistering, detailed critiques on the very interface between AIDS projections and AIDS realities. Their main target is the HIV test—and the Western Blot test in particular—which they say is the very gateway to a series of Escher-like stairways of presumptions leading nowhere except to each other. The so-called "Perth Group" has argued in several meticulously documented papers, read and studied chiefly by so-called AIDS dissidents, that HIV is not a coherent, gold-standardized, *purified* retroviral entity, but rather a series of proteins which are not unique constituents of HIV, and can appear wherever certain immune stressors, microbes, and antigens congregate at high concentrations. Eleopolis-Papadopolis and her colleague Dr. Valendar Turner, an Oxford educated heart surgeon at the Royal Perth Hospital, have documented up to seventy proteins that can cause a false positive result on a Western Blot test, including those for malaria, TB, and even pregnancy itself. HIV is not an "it" in the way that we imagine it—unlike other viral infections, it is extremely hard to test for because, as Peter Duesberg has pointed out, "it's barely there"—it

can only be detected with generously broad antibody tests and highly sensitive DNA tests, like PCR, which can find a needle in a haystack.

HIV was never isolated in a way that would have provided a so-called Gold Standard to test for its presence or absence. From the outset, it was inferred by laboratory identifications. If you have this, this, and this protein, it *means* HIV, on the theory that those protein combinations are unique to HIV and not found elsewhere. It is like the difference between footprints of a tiger and the tiger itself. If you see the footprints, you assume the tiger has passed through. But what if the footprints, as the Perth Group has argued, are not those of a tiger? Their research has shown that the proteins said to be unique to HIV, and which signal HIV on the antibody test, are not at all unique to HIV.

The two proteins considered most specific to and indicative of HIV's presence are p24 and p41. (Written as such because the proteins correspond to a particular molecular weight.) In the early years of AIDS, a number of people were told they were infected with HIV based *only* on the presence of p24 or p41. The U.S. Multicenter AIDS Cohort Study (MACS), began in the early 1980s, testing and studying 5,000 gay men. All of them were told they were HIV-positive, and presumably most of them began taking AIDS drugs. One band was considered sufficient proof of HIV infection in the United States until 1990. One third of people transfused with HIV-free blood later developed antibodies to p24. Fifty percent of 144 dogs tested for HIV in 1990 were found to have antibodies to one or more HIV proteins.

In 1988, the U.S. Army tested over a million soldiers with the ELISA AIDS test and found 12,000 were positive. Half were negative on a repeat ELISA. Two thirds failed to react on a first

Western Blot test, and some of those failed to react on a repeat Western Blot. The point is that all 12,000 would have been called "HIV infected" in Africa but very few would have been called that in the West.

In another disturbing study, HIV-free mice tested positive for HIV when they were injected with cells from other HIV-free mice.

One quarter of HIV-free blood donors in the West were found to have reactive bands on the HIV Western Blot test. The HIV Reference Laboratory admitted to Turner and Eleopoulis, when pressed, that these were caused by cross-reacting non-HIV antibodies. In a 1997 interview in the now defunct AIDS journal *Continuum*, Turner explained: "Now, the way you get your cross-reacting, non-HIV induced antibodies is to give your immune system a few belts. And the more belts, and the more closely spaced, the more likely a person tested will have cross reacting antibodies. But we know in places like Africa this kind of thing is happening all the time. And it happens across all the AIDS risk groups. The very people you're testing for HIV are those with the greatest chance of non-specifically induced antibodies. So we have this grotesque paradox. One quarter of pristine, well-fed Australian blood donors have one or more HIV Western Blot bands, and that might include four bands, but they're not infected with HIV. But in Africa, poverty stricken, malnourished, Ugandan subsistence farmers with malaria or tuberculosis, or repeated attacks of dysentery, have buckets of cross reacting antibodies but if they've got just two bands on the Western Blot, not four, they *are* infected with HIV. Do you know anyone who can explain this?"

Whether or not people ought to submit to taking an "AIDS test" has long been the subject of furious debate. The impact on the life or lives of the people who do take the test—if it comes

back positive—is incalculable, since HIV is still largely associated with surefire death. The debate about the HIV antibody test has been long, complex, and anguished. No single diagnostic test in the history of modern medicine has had such a momentous impact on the lives of the individuals who rely on it. Since the beginning of the AIDS crisis, people have had very dramatic reactions to receiving positive test results—lapsing into chronic depression and anxiety, quitting, or losing their jobs, taking very toxic medications, getting divorced, having abortions, taking their lives and sometimes even other people's lives—all based, not on diagnosis of AIDS, but merely a positive antibody test. Given that the test holds such power, its flaws and shortcomings are extremely significant. Unfortunately, it is only since the early '90s that this immensely important subject has been investigated.

In addition to the Perth group's critique of the Western Blot test, significant criticisms have also been directed at the ELISA, which was the first test developed for HIV in 1985, developed specificly to screen out HIV from the blood supply. The test is highly sensitive and very nonspecific, which means it gives a positive result easily even when there is no HIV present. At one time, as many as four out of five ELISA tests could not be confirmed by the Western Blot.

One of the most important problems with overstating HIV infection in Africa is that overestimation muddles the reality of the epidemic in other parts of the world. At the dawn of the AIDS epidemic, doomsday figures were announced for the U.S. and the world—some held out the possibility of human extinction. But, as Valendar Turner notes, the African AIDS "epidemic," no matter its supposed magnitude, is useless in predicting the

spread of the disease elsewhere, especially in the West. "Under such diagnostic rigor," Turner writes about assumptions of HIV infection in Africa, "the example of thousands of African men and women, who are essentially suffering from symptoms and diseases all called other names before 1981, is held up as proof that the West is menaced by the threat of heterosexually transmitted AIDS."

Turner is referring to the by now discarded notion—on the scrapheap of so many discarded AIDS fictions—that an unchecked AIDS epidemic in the West can be predicted by the African epidemic, where "AIDS," as we were relentlessly told, "spreads heterosexually." The long and complicated history of the AIDS epidemic in the U.S., however, shows that this is a supremely misguided notion. Indeed, the first heterosexual AIDS epidemic predicted for the U.S. simply never happened. That a heterosexual AIDS epidemic was ever predicted in the West is simply never mentioned anymore, rather like Y2K.

A vast array of epidemiological indicators came to light during the '90s during investigations of the threat posed by heterosexual transmission of AIDS. In 1991, a study published in the medical journal *Fertility and Sterility* addressed a very basic question: Can HIV be found in the semen of HIV-positive men? The results were deeply perplexing. Semen samples of twenty-five HIV-positive men were studied, and it was discovered that only four showed any trace of HIV. While epidemiological reports indicate quite clearly that AIDS is spread two ways—through blood and semen—the findings placed considerable doubt on the role HIV plays in relation to the spread of the disease. The authors of the study acknowledged, in a rather understated way, that "very little information exists regarding [HIV's] prevalence in semen and mechanisms underlying its sexual transmission."