RethinkingAIDS

Volume 8, Number 3 March 2000

MBEKI TAKES ON THE AIDS INDUSTRY
South African president queries epidemic, AZT

by Tom Bethell

SOUTH AFRICAN PRESIDENT Thabo Mbeki stunned the AIDS industry and its critics in February by announcing that he would host an international panel of experts to examine the science of AIDS, its treatment, and the role of the pharmaceutical companies. News of the panel, scheduled to meet in Pretoria May 6 and 7 and to include supporters and critics of the HIV-causes-AIDS model, elicited the expected response: HIV-AIDS critics embraced the chance to participate in an open exchange of scientific ideas, while HIV-AIDS proponents expressed indignation, not-so-veiled threats, and insults.

Mbeki, the first head of state to rethink the HIV-AIDS issue, has been suspicious of the received wisdom for some time. Last October, he requested a safety review of the "anti-HIV" drug AZT, saying that "a large volume of scientific literature" claimed that its toxicity made it "a danger to health." It would be "irresponsible" not to heed such warnings, he said.

In January, Mbeki sent RA Group board member David Rasnick a list of questions. To assist with the reply, Rasnick enlisted African History professor Charles Geshekter of California State University, Chico, who last December met Mbeki's health minister in South Africa, and has spent extensive time throughout the continent. Their letter to Mbeki suggested a non-HIV explanation for Africans diagnosed as having "AIDS": the clinical symptoms of diseases traditionally caused by poverty, malnutrition, poor sanitation, and parasitic infections were being blamed on a retrovirus and given a new name, AIDS. "There are billions of dollars available for AZT and condoms but hardly a penny for food, school, education, clean water and jobs," they said.

Two days later, Mbeki phoned Rasnick and asked for his support in reassessing AIDS and AZT. Rasnick gave it, and also committed the Group for the Scientific Reappraisal of AIDS (which publishes RA) and the International Coalition for Medical Justice to the same goal. Then came the official call for the panel.

According to the South African News Agency (SAPA), Mbeki's actions "met with a storm of protest from doctors, AIDS activists and the media, who said the dissident arguments had been discredited years ago, and that South Africa risked becoming the laughing-stock of the world." Mail & Guardian editor Philip van Niekerk, a vehement defender of the orthodoxy, asked why South Africans are being sidetracked "by a group of very fringe people sitting in California." He added that these California-sitters "are actually quite reactionary politically, in the sense that they come originally out of an almost anti-gay kind of position. Why are we wasting our time with that?"

Johannesburg's Sunday Independent quoted Dr. John Moore of the Aaron Diamond AIDS Research Center in New York as saying that he was "flabbergasted." Mbeki had "given lifeblood to a dead cause," he said. Moore said that the matter would be brought to the attention of people at "very serious levels in the US government. [Mbeki] needs to get proper advice, from his peers." Questioning AIDS was "tantamount to Holocaust denial because the implications are so serious," he added. Dr. Seth Berkley of the International AIDS Vaccine Initiative has also likened the skeptics "to those who believe the Holocaust did not occur."

Not only was "reappraising AIDS" as untenable as "reappraising the Holocaust," it was dangerous enough to constitute a holocaust: "A charge of genocide would not be inappropriate," Moore warned Newsday's Laurie Garrett.

The head of South Africa's Medical Research Council, Professor Malegapuru Makgoba, told the Mail & Guardian that the AIDS dissidents are "failures in their own countries," and "out to get famous." Warning that South Africa is becoming "fertile ground for pseudo-science," he described President Mbeki as "medically and scientifically naive."

Mbeki himself has been taking it calmly. Replying to the chairperson of the Durban conference, Professor Jerry Coovadia, Mbeki said he was surprised to find how many people claiming to be scientists "are determined that scientific discourse and inquiry should cease, because 'most of the world' is of one mind." He added: "By resorting to the use of the magic wand at the disposal of modern propaganda machines, an entire regiment of eminent 'dissident' scientists is wiped out from the public view, leaving a solitary Peter Duesberg alone on the battlefield." (Duesberg is engaged in cancer research at UC Berkeley and has not commented on the recent furor about African AIDS.)

This summer, over ten thousand AIDS researchers will gather for the 13th International AIDS Conference in Durban, South Africa (July 9 to 14). The following companies are major sponsors of the conference: DuPont Pharmaceuticals, Pharmacia & Upjohn, Glaxo Wellcome, Bristol Myers Squibb, Merck, Hoffman LaRoche, Abbott Laboratories, and Boehringer Ingelheim.

In resisting the AIDS orthodoxy in Africa, dissidents are joined by science journalist Michael Fumento, author of The Myth of Heterosexual AIDS (Regnery, 1993). Fumento believes that HIV

causes AIDS, but does not believe that the African epidemic is real. He thinks the AIDS-in-Africa propaganda campaign has been driven by the budget concerns of the existing beneficiaries of AIDS spending. The failure of American AIDS to "explode" into the general population led the authorities to look for the phenomenon elsewhere. New AIDS cases in the US began falling before the introduction of "protease inhibitor" therapy, and from 1997 to 1998 dropped from about 60,000 to 48,000. Of teenagers diagnosed in 1998, only 68 were classified as "heterosexual contact." Among women, AIDS diagnoses fell from 13,000 in 1997 to 11,000 in 1998.

If the very high AIDS spending by the US government is to be sustained, the emergency would have to be drummed up elsewhere. Prof. Geshekter, who has made 15 trips to Africa, sees things in much the same way. "AIDS is dwindling away in the US," he said. "The numbers are down. What are the AIDS educators to do? Africa beckons."

The director of research of the Statistical Assessment Service in Washington, D.C., has also shown skepticism. He points out that in its latest disease rankings WHO dropped TB down the list and moved AIDS up. The best explanation, David Murray told Michael Fumento for an article in the journal Philanthropy, is that both the TB and AIDS figures are guesses, and that WHO simply shifted a huge chunk of deaths out of the TB category into AIDS. Murray was unable to get anyone from the World Health Organization to comment on this highly probable scenario.

Journalists covering Mbeki's "AIDS reappraisal" might write about the topic more intelligently, accurately, and sensibly if they considered the following key points:

1. AIDS in Africa may be diagnosed without HIV test

This alone is sufficient to cast doubt on all claims about AIDS on the continent. AIDS is a new name for 30-odd diseases found in conjunction with a positive test for antibodies to HIV. Being "HIV-positive," then, is the unifying and defining condition of AIDS. But in Africa the HIV test does not have to be conducted. This means that doctors and health authorities can attribute disease and death to AIDS with no fear of contradiction.

The decision to dispense with the HIV test was made in October 1985 by American public health officials at a conference in Bangui, in the Central African Republic. The organizer, Joseph McCormick of the Centers for Disease Control, wanted a diagnostic definition of AIDS for countries lacking the equipment to perform blood tests. He also convinced representatives from the World Health Organization in Geneva to set up their own AIDS program. Observing sick people in Zaire hospitals persuaded the Americans that AIDS now existed in Africa — this before HIV tests had even been conducted. They "found" that slightly more women than men were affected. Back in America, reporter Laurie Garrett wrote in The Coming Plague (1994), McCormick told an assistant secretary of Health and Human Services that "there's a one-to-one sex ratio of AIDS cases in Zaire." Public health officials now had what they wanted: heterosexual transmission. Suddenly we were all at risk. AIDS budgets would soar. Even though she devoted several pages to the Bangui meeting, Garrett failed to make the key point that the HIV test had been abandoned.

Deceptive labeling is central to an understanding of AIDS in Africa. The HIV test-free "Bangui definition" of AIDS, reached "by consensus," included these major components: "prolonged fevers (a month or more), weight loss of 10 percent or greater, and prolonged diarrhea." Now many traditional African diseases, pandemic in poverty-stricken areas with tropical climates, open latrines, and contaminated drinking water, had a unifying, simple new umbrella term: AIDS. And an attractive one, as it qualified diagnosing physicians and patients for new sources of funds from the West.

The Bangui definition was published in WHO's Weekly Epidemiological Record (1986: 61: 69-76), and in Science magazine (21 November 1986). But it seems not to have been published in US newspapers, of which the leader has been the New York Times. The paper's main AIDS reporter, Lawrence K. Altman, is himself a former public health officer, and like McCormick worked for the CDC's Epidemic Intelligence Service. In November 1985 Altman wrote two extensive stories for the Times on African AIDS, one including a section on the Bangui meeting. But like Newsday's Garrett, Altman omitted the fact that, in Africa, AIDS can be, and usually is, diagnosed without an HIV test. (Aaltman did not return phone messages requesting his comments for this article.)

2. The HIV test is not specific to HIV

When they are used, HIV tests detect antibodies with an assortment of proteins that are not unique to HIV. Neither the HIV Western Blot nor ELISA antibody tests respond exclusively to antibodies generated by exposure to HIV. Other microbes that can trigger these same antibodies include some that are epidemic in Africa: those responsible for tuberculosis, malaria, and leprosy. In 1994, an article in the Journal of Infectious Diseases concluded that HIV tests were useless in central Africa, where these microbes are so prevalent that they cause a 70 percent false-positive rate. Tests may be positive if immune systems are compromised for many reasons, including chronic parasitic infection and anemia. In South Africa, tests are mostly conducted on pregnant women, yet pregnancy itself is a condition that may yield a false positive. The packet insert in the ELISA test kit from Abbott Labs contains the disclaimer: "There is no recognized standard for establishing the presence or absence of HIV-1 antibody in human blood." All the claims that AZT reduces the maternal transmission of HIV run afoul of this difficulty. The tests are non-specific. We don't really know whether the mothers are infected in the first place.

Mark Schoofs, who recently won the Pulitzer Prize for his eight-part series on African AIDS in the Village Voice, contracted malaria during his six-month stay in Africa. Had he taken an HIV test, he might easily have tested positive. Even without the test, he probably qualified as an "AIDS" patient by the Bangui definition. Despite the unlimited page-space at his disposal, Schoofs, too, failed to explain that the official definition allows almost anything, including his own illness, to be called AIDS in Africa.

3. AZT is more toxic, less effective than initially thought

AZT was designed in 1964 as cancer chemotherapy but never approved for that use because it was considered too toxic. The

"double-blind, placebo-controlled" trials of the drug in 1986 that led to FDA approval were paid for by the drug's manufacturer, Burroughs Wellcome (today, Glaxo Wellcome). Approval came only after several thousand AIDS activists demonstrated in the grounds and corridors of the FDA building in Rockville, Maryland. The safety and efficacy trials became unblinded and were prematurely terminated. Patients figured out who was receiving drug and who placebo, and they swapped doses in mid-trial. Trials were ended after only four months, before the adverse effects appeared. A later European investigation called the "Concorde study" showed that AZT conferred no benefit. Since the drug was first approved, its toxicity has caused so much concern that its recommended dosage level has been sharply reduced.

Many more unflattering details about AZT can be gleaned from these "approved" sources: "Imminent Marketing of AZT Raises Problems," by Gina Kolata, Science, March 20, 1987; "Doctors Stretch Rules on AIDS Drug: Some Give Possibly Toxic AZT Before Symptoms Develop," by Gina Kolata, New York Times, Dec 21, 1987. "The Return of AZT," by Terence Monmaney, Discover, January 1990. "AZT and AIDS: The Doubts Persist," by Phyllida Brown, New Scientist, 26 October 1991. "After 5 Years of Use, Doubt Still Clouds Leading AIDS Drug," by Gina Kolata, New York Times, June 2, 1992. "Toxic Hope," by Linda Marsa, Los Angeles Times Magazine, June 20, 1993. "New Study Questions Use of AZT in Early Treatment of AIDS Virus," by Lawrence K. Altman, New York Times, April 2, 1993. "The Doctor's World: AIDS Study Casts Doubt on Hastened Drug Approval in US" by Lawrence K. Altman, New York Times, April 6, 1993. "Benefits of Often-Used AIDS Drug Are Questioned," Associated Press, New York Times, March 17, 1994. "Children's AIDS Study Finds AZT Ineffective," by Lawrence K. Altman, New York Times, February 14, 1995.

4. HIV-AIDS model slanders African sexual mores

No one alleges that HIV spreads in Africa by homosexual contact or by intravenous drug use. This leaves heterosexual transmission. But Nancy Padian and associates showed in the August 15, 1997 issue of the American Journal of Epidemiology that male-to-female transmission of HIV is extremely difficult, requiring on average one thousand unprotected sexual contacts. Female-to-male requires on average eight times as many.

The claim of a vast heterosexual epidemic in Africa therefore obliges Western health experts and "educators" to impute gross promiscuity to Africans en masse. This amounts to attributing Hollywood-style morals on African villagers. Absurd and undocumented tales of African truck drivers have been invented and duly accepted. Gullible reporters such as ABC's David Marash and Ted Koppel, on a special three-night edition of "Nightline" March 8-10, 2000 ("AIDS in Africa: The Disappearing Society") have shown themselves true believers in this cause. Even good liberals like Nobel Prize winner Nadine Gordimer, have been willing to impugn African morals. (Though in her April 11, 2000 New York Times essay, "Africa's Plague, and Everyone's," she sugar-coated it. African promiscuity, she wrote, "is difficult to condemn when sex is the cheapest or only available satisfaction for people society leaves to live on the street.")

But the rest of us are entitled to a little skepticism. It is understandable and justifiable that African leaders should question and even reject these ethnic fictions and racial slanders.

5. The political economy of AIDS

HIV/AIDS has developed into a vast international aid program in which the recipients are identifiable and the donors (taxpayers) are anonymous. Benefits are focused, costs are diffused. Governments, pharmaceutical companies, AIDS activists and educators, retrovirologists, scientific publications, and people with AIDS work together symbiotically, budgets are fattened, and taxpayers worldwide (but mainly in the US) pay up willy-nilly. US Federal spending on AIDS increases at about 10 percent a year, even as case loads fall, topping $10 billion in the last budget cycle. Much of the money is sent to the National Institutes of Health, and to health-care and housing programs. The states add on billions of their own. All this pays for the lion's share of the drugs, and relieves the pharmaceutical companies of worrying about whether their customers can afford their products. For AIDS patients, health-care is gold-plated.

The NIH-funded investigators will fiercely uphold the consensus in favor of the received science. Now and then, the Centers for Disease Control and Prevention will report discernible "progress," but always with the caution that the problem has not gone away. Then, every year or so, "sobering realities" will be reported. The virus will have "mutated," weakening the drugs. A vaccine trial didn't pan out. In a far away country (currently, South Africa and Zimbabwe are in fashion), HIV infection rates of 25 or 30 percent are suddenly "discovered." Or fully two-thirds of the South African army will be "infected!" Now, once more, we have a full-blown crisis. Showing no concern that they are being used, good soldiers Laurie Garrett (Newsday) and Lawrence Altman (NYT) will play their appointed role, without a trace of skepticism, and be rewarded with front-page headlines. "Plagues" are more urgent and scary than dysentery or malaria, after all. Science magazine's coverage will be scarcely any different.

The message conveyed never changes: More funding is urgently needed! The drug companies fear the activist organizations and their shakedowns. For protection, therefore, their contributions are generous. Project Inform gets to pay its bills. The remunerated activists call off the demos and redirect their members to get in touch with their congressmen: more money must be spent on AIDS! Perennial NIH lab-funder Anthony Fauci wisely befriends gay activist Larry Kramer. It's a cozy relationship, beneath the contrived contretemps. PWA's get their health care paid for, go-along scientists get their labs fully funded, public health officials get big annual budget increases and the resources to hire more assistants. As for the drug companies, they have been making so much money that they can afford to underwrite these huge biennial AIDS jamborees — such as the one upcoming at Durban — which invariably help fan the flames for more of the funding that inevitably finds its way back into their laps.

Peter Piot, the head of UNAIDS, saw what was going on. In a revealing comment in the June 19, 1998 Science he wrote: "Unlike any health problem before, there has been a uniquely close involvement of and pressure from individuals and groups infected with or affected by HIV." These were "mainly gay men in the industrialized world." He might well have added that retrovirologists were also

among the "affected." Anyway, the infected and the affected were "setting the agenda for AIDS research," Piot wrote, "pressing for the immediate application of results," "lobbying for increased funds," "setting the research agenda in clinical trial committees, boards of foundations, advisory boards of pharmaceutical companies, and scientific conferences." It would be hard to improve on that.

AIDS "provides a new paradigm for the interaction between science and society," he saw, and "between public health departments and affected communities." More plainly, science had at last been subordinated to politics. And public health departments had found themselves an influential, placard-bearing, media-savvy constituency—a potent lobby for funding increases. Piot was probably correct in saying that this was something new. Cancer researchers and patients have since begun to form the same symbiotic coupling.

6. Politics, not science, guides AIDS policies

AIDS wisdom involves a realization that political rather than scientific considerations drive corporate and government AIDS policies. When activists confronted Pfizer's chief executive in March, the company swiftly agreed to give away its "AIDS" drug Diflucan in South Africa. The activists did not appreciate the implications of prescribing this antifungal medication to treat patients supposedly ill from a retroviral infection.

"The drug makers are coming under increasing pressure to provide help to the developing nations," Michael Waldholz wrote in the Wall Street Journal, "especially because the AIDS conference this year will be held in Durban, South Africa, where world-wide media attention will focus on the lack of access to the drugs in the developing world."

Several months earlier, the Bristol-Myers Squibb Foundation shelled out $100 million to five African countries. One must imagine that Squibb would prefer the recipient countries to apply that money to HIV-based AIDS programs, which would involve purchasing and administering anti-HIV drugs, but not to anti-poverty programs, which would alleviate the health-destroying factors of African poverty.

Late last summer, AIDS activists began disrupting Vice President Al Gore's early campaign appearances. Gore met privately with Mbeki to discuss ways the US could help South Africa obtain cheaper AZT.

But in October, Mbeki in a speech to provincial leaders questioned the drug's safety. A few weeks later, in Seattle, President Clinton promised that the US would help countries like South Africa obtain HIV-based AIDS drugs. In January, Gore pledged support for a Congressional bill to supply the UN $350 million for HIV-based AIDS programs.

None of this money is intended to assist targeted countries in evaluating for themselves the cause or causes of illness in their residents who receive "AIDS" diagnoses.

This sits poorly with Mbeki, who has found no convincing scientific justification for devoting South Africa's anti-AIDS resources exclusively to HIV-based programs. Those resources, some scientists think, belong in anti-poverty programs, not the anti-HIV and safe sex programs intended by Clinton, Gore, and UN officials. Mbeki wants to hear first hand what those dissenting scientists have to say, and in a dialog that involves scientists who advocate the HIV model.

Will Mbeki manage to withstand the the hysteria, name calling, and vilification that has exclusively composed the response so far from the HIV scientists, who are pressuring him to cancel the May 6 panel? If Mbeki resists their relentless campaign and stages his proposed panel, he would have taken another unprecedented step in constructing the first national AIDS policy based on a thoughtful and open examination of the facts.

Bethell writes for the American Spectator and the National Review.

Rethinking AIDS

is the monthly publication of the Group for the Scientific Reappraisal of AIDS, also known as the Rethinking AIDS Group.

Submitting articles

The Directors welcome concise and appropriately referenced contributions.

Supporting the Group

You can support our efforts in many ways: scrutinize the HIV/AIDS hypothesis in discussions with friends, classmates, and professors; make photocopies of this journal and distribute them to associates or leave them where free publications are displayed in book and health stores. Currently the Group survives on tax-deductible donations.

Annual subscriptions

$25 ($35 US cash foreign) individual, $50 ($60 US cash foreign) institutional.

Contact information

1354 East Ave., Suite R-120, Chico, CA 95926-7385
toll free 877-256-6406 Los Angeles / fax 508-526-5944 Detroit
www.rethinkingaids.com (editor@rethinkingaids.com)

Mission Statement of the Rethinking AIDS Group

1. To develop, articulate, and promote rational scientific discourse on the subject of HIV and AIDS.
2. To advocate the absolute right of students, professors, physicians, scientists, government officials, and everyone else to think freely and speak openly on the subject of HIV and AIDS without fear of professional, social, political, economic, or criminal penalties.
3. To assemble scientists, physicians, and other informed people who support these views, and make those persons available for commentary and consultation to interested social groups, media outlets, government agencies, professional organizations, and individuals.