

Challenging the Culture of Fear in Africa: Rethinking AIDS and Sexual Scares

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**“Nothing in life is to be feared. It is only to be understood.”
Madam Marie Curie**

This paper challenges the basic assumptions that causally link sexual behavior to AIDS cases in Africa. It suggests that conceptual flaws, dubious statistics, western stereotypes, poorly designed research, and racist claims about African sexuality have created untenable conclusions now proliferating across Africa.

As a master narrative rooted in sexual fears, the AIDS in Africa discourse has been a brilliant success as political theater, but is one of the great medical fallacies of our times. Discussions about AIDS in Africa often devolve into a series of rhetorical gimmicks and political slogans, not a coherent strategy for public health improvements.

Why do African Studies academics, most of whom are critical thinkers on all other topics - Bush's policies against terrorism, the nature of Islamic fundamentalism, the origins of apartheid, the impact of colonialism, the roots of poverty – submit so willingly to a set of claims organized around a sex panic?

A generation of researchers, policy-makers, activists and pharmaceutical industry representatives, with a great stake in defending the infectious viral theory of AIDS, become unhinged at the prospect of new thinking. Even posing questions is often deemed impermissible and anyone who raises them usually evokes dismissive name-calling, vilification, delegitimizing, or worse. Mundane facts, the scientific method, second thoughts or even confidence in the powers of our own common sense seem to matter little to social crusaders whose quasi-religious

sense of certainty has them hunting for improper sexual behavior. In such a morally righteous world, critics deserve no voice.

The confusion that prevents us from thinking carefully about AIDS in Africa is borne of several factors: 1) racist claims regarding African sexuality and fanciful assumptions about truck drivers and prostitutes that have achieved the status of "urban legends;" 2) conjured up statistics that evaporate whenever one tries to pin them down specifically to a metropolitan area or the province of any country; 3) an inability to distinguish the unreliability of HIV antibody tests from the clinical symptoms of an "AIDS" case; and 4) an unfamiliarity with the nature of political economies of African states since the late 1970s.

In other ways, AIDS has become a great diversion. The belief that behavior modification will cure poverty overlooks the endemic conditions that cause the appearance of the "symptoms" in the first place. Many AIDS activists and researchers ignore the historical forces that propelled parts of Africa into a downward economic spiral beginning in the late 1970s and set the stage for the appearance of "AIDS."

During the Reagan Era, a "Washington Consensus" dominated official thinking about economic development in the U.S. government, the IMF, the World Bank and private banks and foundations. It called for sharp cutbacks in government spending, financial liberalization, privatization of state-owned enterprises, deregulation and the supremacy of the market over all other values, policies that contributed mightily to the demise of Africa. According to Joseph Stiglitz, an economist formerly with the World Bank, during the 1990s, the number of people living in extreme poverty (less than \$2 per day) increased by nearly 100 million, world-wide, with the disproportionate amount being found in Africa.

Countries in east and southern Africa became so indebted to and dependent on international financial institutions that they were no longer free to make basic

decisions about which goods and services could be allocated.ⁱ Beginning in the late 1970s, corruption and decay in the public health field, sharp decreases in the prices of exported commodities, severe restrictions on social services due to the IMF and World Bank strictures of "structural adjustment," savage civil wars, declining rates of immunization, and crowded refugee camps were among the major forces afflicting Africa as the 20th century ended. None of these forces were related to sexual promiscuity.

One African leader who was troubled by the many contentious aspects of the orthodox view of AIDS was South Africa's President Thabo Mbeki, himself an economist. In early 2000, Mbeki appointed an AIDS Advisory Panel that consisted of 52 researchers, scholars and activists (including this author) who held widely opposing views on the definition, causation, prevention and treatment of AIDS cases. Mbeki sought evidence-based answers to three basic questions: 1) what causes the immune deficiency that leads to death from AIDS; 2) what is the most effective response to this cause or causes; and 3) why is HIV/AIDS in sub-Saharan Africa heterosexually transmitted while in the western world it is said to be largely homosexually transmitted?

Mbeki applied the principle of "Occam's razor" to AIDS, the scientific rule that the simplest of competing theories is preferred to the more complex, that explanations of unknown phenomena are to be sought first in terms of known quantities. The essence of the scientific method is to frame and operationalize a hypothesis "whose predictions comport with observable results in a consistent manner. If the hypothesis is valid and testable, its result should be generally reproducible, rather than unique to a particular experiment."ⁱⁱ

The AIDS orthodoxy has long stifled what ought to have been a lively, inclusive debate on issues ranging from statistics and epidemiology to science, economic history, and notions about African sexuality. Averse to second thoughts and unable to be self-critical, they contend that anyone who questions their core

beliefs or challenges the infectious viral theory of AIDS is not an honorable scholar with different views, but is someone who commits great evil. This is not something they can prove or explain rationally -- it is simply an article of faith.

Since the clinical symptoms that define an AIDS case are widespread in the general African population, if it transmits heterosexually it should also become widespread in other general populations, such as Americans, in which hundreds of thousands of heterosexuals annually contract venereal diseases. Instead, 25 years after it was first described in the medical literature in the United States, AIDS remains confined to special risk groups. Of the 40,000 annual American AIDS patients, nearly 90% are either drug users or homosexuals and fewer than 10,000 have ever been identified as heterosexual cases.ⁱⁱⁱ

For example, among the actors and actresses of the adult film industry (centered in Los Angeles) who perform prodigious amounts of condomless sex for money, between 1998-2004 approximately 81,000 HIV tests were administered to those pornographic stars. Of that amount (at \$50 per test), a grand total of eleven registered a positive result, or one in 8,000 in a cohort of 20-35 year olds that surely engages in more sex than almost anyone else in the USA.^{iv}

Even at my own university, California State University, Chico, America's former #1 Party School (according to *Playboy*, January 1987) a considerable amount of sexual activity occurs as demonstrated by the large number of cases of chlamydia, genital warts and herpes simplex seen at the Student Health Services Center. Yet, from 1989 to 2004, the Health Center administered 17,000 HIV tests; only one came back positive.^v

By dogmatic repetition, the notion has been pounded into the public's mind that HIV tests are reliable and empirically valid. Those who start with the concept of HIV as a transmissible retrovirus that causes AIDS, seize on any decline or increase in HIV rates as evidence that AIDS cases are either receding or growing.

The term "HIV" describes a collection of non-specific, cross-reactive cellular material. HIV tests are not standardized, but are arbitrarily interpreted or "read" by different laboratories. Because HIV tests are antibody tests, they produce many false-positive results. This is crucial to keep in mind whenever one reads about "rates" or percentages.

All antibodies tend to cross-react. Humans constantly produce antibodies in response to stress, malnutrition, drug use, vaccination, certain foods, a cut, a cold, intestinal worms, tuberculosis, or even pregnancy. All of these antibodies are known to make HIV tests come up as positive.

The packet insert in an HIV/ELISA test from Abbott Laboratories contains this prudent disclaimer: "At present there is no recognized standard for establishing the presence or absence of antibodies to HIV-1 in human blood." Yet the cornerstone surveillance study for HIV seroprevalence in Africa rests on administering a single ELISA test to pregnant women attending antenatal clinics, never acknowledging that the ELISA test is notoriously unreliable in those circumstances since pregnancy is one of 70 conditions known to trigger a "false positive" result.

The medical literature lists dozens of reasons for positive HIV test results. One study included "transfusions, transplantation, or pregnancy, autoimmune disorders, malignancies, alcoholic liver disease, or for reasons that are unclear..."

^{vi} Another cited "liver diseases, parenteral substance abuse, hemodialysis, or vaccinations for hepatitis B, rabies, or influenza..."^{vii}

Pregnancy is consistently listed as a cause of positive test results, even by the test manufacturers themselves: "[false positives can be caused by] prior pregnancy, blood transfusions... and other potential nonspecific reactions." (Vironostika HIV Test, 2003).

These clarifications and disclaimers are critical for any discussion about alleged HIV rates in any African country, because national HIV estimates are drawn almost exclusively from tests done on groups of pregnant women.

Sexual transmission cannot explain the differences in alleged rates of HIV positivity between African heterosexuals (about five per 100) and American ones (about one per 7000). When the HIV/AIDS paradigm debuted in 1984, its proponents assumed that HIV was easily transmitted coitally. When scientists actually tested this idea ten years later, they arrived at extremely low coital transmission frequencies. Researchers routinely classify HIV infection as a sexually transmitted disease (STD) without acknowledging the extraordinary difficulty of the sexual transmission of HIV.

Studies by Nancy Padian and her associates demonstrate that the infectivity rate for male-to-female transmission is extremely low.^{viii} An HIV-negative woman may convert to positive on average only after *one thousand* unprotected contacts with an HIV-positive man. An HIV-negative man may become positive on average only after *eight thousand* contacts with an HIV-positive woman. These data suggest two mutually exclusive conclusions. Either HIV is not a sexually transmitted microbe at all and other factors must account for HIV seroprevalence, or else African heterosexuals are more promiscuous than American heterosexuals, an unproven assumption rooted in racist stereotypes.

With this in mind, why did so many public health professionals and officials come to view the diseases of poverty in Africa as sexually contagious? How can one virus cause twenty-nine heterogeneous AIDS indicator diseases almost entirely among males in Europe and America but afflict African men and women in nearly equal numbers?^{ix} The answer is that the World Health Organization uses a definition of AIDS in Africa that differs decisively from the one used in the West. The origins of this definition of African AIDS are quite illuminating.

Joseph McCormick and Susan Fisher-Hoch, physicians from the U.S. Centers for Disease Control (CDC), were instrumental in convening the WHO conference in the Central African Republic in 1985 that produced the "Bangui Definition" of AIDS in Africa. The CDC had just adopted the HIV/AIDS model to explain immune disorders found among American drug injectors, transfusion recipients, and a small cohort of very promiscuous urban gay men. There was a tendency for HIV antibodies to react with plasma from some of these patients. The same was apparently true of blood from Africans afflicted with the diseases of poverty. The infectious viral model of AIDS assumed that immune deficiency would spread via HIV to a much larger fraction of Africans than those who tested positive for the antibodies.

McCormick and Fisher-Hoch accepted this model. Here is how they explained their motivation for the Bangui Conference and the rationale behind the AIDS definition that resulted from it:

"We still had an urgent need to begin to estimate the size of the AIDS problem in Africa....But we had a peculiar problem with AIDS. Few AIDS cases in Africa receive any medical care at all. No diagnostic tests, suited to widespread use, yet existed....In the absence of any of these markers [e.g., diagnostic T4/T8 white cell tests], we needed a clinical case definition....a set of guidelines a clinician could follow in order to decide whether a certain person had AIDS or not. [If we] could get everyone at the WHO meeting in Bangui to agree on a single, simple definition of what an AIDS case was in Africa, then, *imperfect as the definition might be*, we could actually start to count the cases, and we would all be counting roughly the same thing. [emphasis added]

The definition was reached by consensus, based mostly on the delegates' experience in treating AIDS patients. It has proven a useful tool in determining the extent of the AIDS epidemic in Africa, especially in areas

where no testing is available. Its major components were prolonged fevers (for a month or more), weight loss of 10 percent or greater, and prolonged diarrhea..."^x

The doctors recalled that:

"experts in STDs continued to regale us with tales of the excessive and often bizarre sexual practices associated with HIV in the West...we were also beginning to see a direct correlation between the number of sexual partners and the rate of infection...Compared to the West, heterosexual contacts in Africa are frequent, and relatively free of social constraints - at least for the men....There was every reason to believe that, having found heterosexually transmitted AIDS in Kinshasa, we were likely to find it everywhere else in the world."^{xi}

It was upon these unsubstantiated claims, clinical generalizations, western notions of sexual morality, and stereotypes about Africans that AIDS became a disease by definition. Africa was assigned a central role in the premise that *AIDS was everywhere* and everyone was at risk. By 1986, "people were falling over one another to get involved in AIDS research," recalled the physicians. "They realized that AIDS represented an opportunity for grant money, training, and the possibility of professional advancement....A certain bandwagon mentality took hold. Careers and reputations were riding on the outcome."^{xii}

As proof that these AIDS symptoms were sexually transmitted, McCormick and Fisher-Hoch relied on a narrow survey conducted by Kevin DeCock, another CDC epidemiologist. DeCock examined stored blood samples taken in 1976 (for Ebola virus testing) from 600 residents of the small town of Yambuku, in northern Zaire. Samples from five patients (0.8%) tested positive for HIV antibodies.

DeCock wanted to know what happened to those five people during the

intervening ten years. According to McCormick and Fisher-Hoch:

“three of the five were dead. To determine if their deaths were attributable to AIDS, Kevin interviewed people who had known them. The friends and relatives of the deceased described an illness marked by severe weight loss and other ailments that *left little doubt* in Kevin’s mind that they had succumbed to AIDS [emphasis added].”^{xiii}

DeCock concluded from these interviews that the subjects had died from AIDS, and that HIV had caused their death. He reached this conclusion without matching the five HIV-positive patients with peers from among the 595 HIV-negative subjects and without collecting mortality data and morbidity information about them. Had he done this, perhaps he would have discovered that numerous HIV-negative Africans also die of severe weight loss and other so-called AIDS conditions.

DeCock further noted that antibody tests conducted in 1986 showed that the HIV prevalence in Yambuku had remained constant at 0.8% during the ten years since 1976. As far as he was concerned, this meant that HIV - and thus AIDS - really originated in Africa where it had existed for years in small numbers of rural inhabitants whom he imagined had contracted it from primates. He speculated that once some of those people in the late 1970s migrated to what he assumed were sexually promiscuous urban areas, an epidemic of HIV and AIDS exploded. DeCock did not consider that these same data could have been interpreted as indicating that HIV is a mild virus and difficult to transmit. Neither did McCormick and Fisher-Hoch.

The presumptive diagnosis employed by DeCock is known as a “verbal autopsy.” It is widely accepted in Africa, where “no country has a vital registration system that captures a sufficient number of deaths to provide meaningful death rates.”^{xiv} While medically certified information is available for less than 30% of the

estimated 51 million deaths that occur each year worldwide, the Global Burden of Disease Study (GBD) found that sub-Saharan Africa had the greatest uncertainty for the causes of mortality and morbidity since its vital registration figures were the lowest of any region in the world - a microscopic **1.1%**.^{xv}

When the mainstream media use the term "AIDS-related illness," they accept the sweepingly wide set of clinical symptoms that suddenly came to "define" an AIDS case anywhere in Africa in October 1985 and has remained in place ever since.

Whereas acquired immune deficiency in the industrialized countries is almost exclusively a disease of a tiny percentage of homosexuals, intravenous drug users and recipients of tainted blood transfusions, AIDS cases in Africa are said to be as general and indiscriminate as such long-time African scourges as malaria, tuberculosis, schistosomiasis, and sleeping sickness (trypanosomiasis).

AIDS researchers and activists have created an image of sexual behavior in Africa to explain this "heterosexual paradox" of AIDS in Africa when compared to the United States or western Europe. Some researchers consider the paradox to be temporary. They speculate that HIV evolved or emerged first in Africa and that, in time, AIDS will be just as rampant in the West. However, they have said this for twenty-five years and nothing of the sort has occurred.^{xvi}

Other researchers account for a "permanent paradox" by suggesting that Africans are somehow different from Westerners, are substantially more promiscuous, and hence more likely to have genital ulcers. How else can they explain the widespread distribution of a virus whose transmission requires, for non-ulcerated genitals, a thousand heterosexual acts? Such insinuations warrant the closest scrutiny since generalizations about African sexual practices are analytically useless on an internally diversified continent of 650 million people.

At the 10th International AIDS Conference in Yokohama (August 1994), Dr. Yuichi

Shiokawa claimed that AIDS would be brought under control only if Africans restrained their sexual cravings. Professor Nathan Clumeck of the Université Libre in Brussels was skeptical that Africans will ever do so. In an interview with *Le Monde*, Clumeck claimed that "sex, love, and disease do not mean the same thing to Africans as they do to West Europeans [because] the notion of guilt doesn't exist in the same way as it does in the Judeo-Christian culture of the West."^{xvii} AIDS educators try to counter this purported lack of guilt in African sexuality through conservative appeals to restraint, negotiating safe sex and a nearly evangelical insistence on condom use.

Many orthodox AIDS researchers perpetuate racist stereotypes of libidinous black men and women. The myths about the sexual excesses of Africans are old indeed. Early European travelers returned from the continent with tales of black men performing carnal feats with unbridled athleticism with black women who were themselves sexually insatiable. These affronts to Victorian sensibilities were cited, alongside tribal conflicts and other "uncivilized" behavior, as justification for colonial social control.^{xviii}

AIDS researchers added new twists to this old repertoire: stories of Zairians who rub monkeys' blood into cuts as an aphrodisiac or philandering truck drivers who get AIDS from prostitutes and then go home to infect their wives.^{xix} A facetious letter in *The Lancet* even cited a passage from Lili Palmer's memoirs as evidence for how a large male chimpanzee's "anatomically unmistakable signs of its passion for [Johnny] Weismuller" on the Tarzan set in 1946 "may provide an explanation for the inter-species jump" of HIV infection.^{xx}

Some researchers assert that many African men prefer "dry sex" whereby women, particularly prostitutes, are said to "insert substances, such as household detergents or antiseptics, in their vagina prior to intercourse in order to prevent wetness." According to a study in *The Lancet*, this practice allegedly produces a "hot, tight, and dry" environment, which men find more pleasurable but which

may "increase the risk of HIV-1 transmission, since the substances could cause the disruption of the membranes lining the vaginal and uterine wall."^{xxi}

Another theory attributed the origin of HIV to the "repeated radiation exposure of chimpanzees and mangabey monkeys in equatorial Africa" to strontium-90 from uranium mining in the former Belgian Congo and to radiation from atmospheric nuclear tests in the equatorial Pacific Ocean in the 1950s and 1960s after "radioactive fallout from them circled the globe around that latitude."^{xxii}

The latest speculation by Edward Hooper traced the origins of AIDS cases to oral polio vaccines that were accidentally contaminated in the Congo, allegedly with tissues from a primate version of HIV.^{xxiii} As an example of how absurdly far-fetched this speculation can become, one reviewer of Hooper's book (Helen Epstein in *New York Review of Books*) imagined that the subsequent linkages might have proceeded as follows: "*Perhaps* a hunter or butcher carrying a benign monkey virus gave blood at a blood bank or had an injection. *Perhaps* someone was transfused with his blood, or *perhaps* the needle used to inject him was used to inject someone else without being sterilized. *Perhaps*, a few weeks later, the virus was transferred to a third person through another injection or transfusion. This *might* have been enough to 'kick-start' the virus. It *might* have evolved through such 'passaging' to become able to grow vigorously in human cells. It *might* have been able to infect new people through means other than needles or blood transfusions. It *might* have become sexually transmitted, and it *might* have become deadly. [all italics added]"^{xxiv}

Aside from the lack of verification to corroborate these claims, no one has ever shown that people in Rwanda, Uganda, Zaire, and Kenya - the so-called "AIDS belt" - are more sexually active than people in Nigeria which has reported a cumulative total of only 26,276 AIDS cases out of a population of 120 million or Cameroon which reported 18,986 cases in 14 million.^{xxv} No continent-wide sex surveys have ever been carried out in Africa. Nevertheless, conventional

researchers perpetuate stereotypes about insatiable sexual appetites and carnal exotica.^{xxvi} They assume that AIDS cases in Africa are driven by a sexual promiscuity similar to what produced - in combination with recreational drugs, sexual stimulants, venereal disease, and the over-use of antibiotics - the early epidemic of immunological dysfunction among a small sub-culture of urban gay men in the West.^{xxvii}

Case studies from Africa suggest nothing of the sort. In 1991 researchers from Médecins Sans Frontières and the Harvard School of Public Health surveyed sexual behavior in Moyo district of northwest Uganda. Their findings revealed behavior that was not very different from that of the West. On average, women had their first sex at age 17, men at 19. Eighteen per cent of women and 50% of men reported premarital sex; 1.6% of the women and 4.1% of the men had casual sex in the month preceding the study, while 2% of women and 15% of men had done so in the preceding year.^{xxviii}

The media misrepresentations that link sexuality to AIDS have spawned inordinate anxieties in regions of Africa already afflicted with extreme poverty, ravaged by war, and deprived of primary health care delivery systems. The disaster voyeurism of tabloid journalism enables the media to use AIDS to sell "more newspapers than any other disease in history. It is a sensational disease - with its elements of sex, blood and death it has proved irresistible to editors across the world."^{xxix} In recent years, western media have used unrelentingly melancholy metaphors to portray Africans as helpless wretches, which may only homogenize complex situations and contribute to public apathy and "compassion fatigue."^{xxx}

In this age of globalization, public health seems to require more salesmanship than skepticism. The media's appetite for scare tactics and its disdain for alternative perspectives enable them to treat Africa in apocalyptic terms.^{xxxi} Doomsday scenarios compare AIDS in Africa to the great epidemics in history like

the Black Death of the Middle Ages that killed 20 million people.^{xxxii} *USA Today* warned about “a time bomb ticking south of the Sahara” and UNICEF called AIDS “the modern incarnation of Dante’s *Inferno*.” U.S. Senator Diane Feinstein of California said, “I truly believe that the AIDS crisis is worse than the bubonic plague...this crisis can wipe out sub-Saharan Africa as we know it today. It is mega in its impact on the world...”^{xxxiii} In 2004, Professor Richard Feachem, Director of the Global Fund to Fight AIDS, TB, and Malaria, somberly pronounced it “the worst disaster in recorded history.”^{xxxiv}

At the 15th International AIDS Conference in Bangkok (July 2004), these images of HIV/AIDS-ravaged Africa were taken as indisputable. Convinced that a strange mutant retrovirus was somehow unleashed on Africa from the Congo rainforest to cause AIDS, spread by promiscuous truck drivers and prostitutes, activists and researchers ignore the socio-economic history of modern Africa when waging war on AIDS. Their preferred weapons are the endless preaching of abstinence, sexual behavior modification schemes and condom use (the ABCs), and the prescribing of drugs of demonstrated toxicity.

The marketing of anxiety is supposed to promote the sexual behavior modification that will help “save Africa.” Some writers even feel that the manufacture of fear is a good way to increase social awareness. For conservatives who want to see “the notion of sexual responsibility [shake] off its puritanical image,” the subsequent “public anxiety about AIDS is seen as an important sentiment for popularizing a more restrictive and puritanical sexual ethos.”^{xxxv}

Oblivious to the morbidity and mortality data from the *Global Burden of Disease Study*, journalists reflexively maintain that “AIDS is by far the most serious threat to life in Africa.”^{xxxvi} Given the momentum behind this assumption, few scientists question the infectious AIDS hypothesis, leaving little reason for the media to scrutinize the reliability of AIDS research.^{xxxvii} Scott Adams, the cartoonist who draws *Dilbert*, put it succinctly: “Reporters are faced with a daily choice. They can

either painstakingly research stories or they can write whatever people tell them. Both approaches pay the same.”

The claims that millions of Africans are threatened by AIDS or are already HIV-positive make it politically acceptable to use the continent as a laboratory for vaccine trials^{xxxviii} and for the distribution of toxic drugs of disputed effectiveness like AZT.^{xxxix} For instance, AZT is a toxic chemical whose primary biochemical action is the random termination of DNA synthesis, the central molecule of life. It is frightening to recommend giving such a carcinogenic drug to pregnant women because fetuses cannot develop into babies without DNA synthesis.^{xi}

Moreover, media claims that safe sex is the only way to avoid AIDS inadvertently scare Africans from visiting public health clinics for fear of receiving an AIDS diagnosis.^{xii} Even Africans “with treatable medical conditions (such as tuberculosis) who perceive themselves as having HIV infection fail to seek medical attention because they think that they have an untreatable disease.”^{xiii}

Biomedical funds that used to fight malaria, tuberculosis and leprosy are now diverted into sex counseling and condom distribution, while social scientists shift their attention to behavior modification programs and AIDS awareness surveys.^{xiiii}

One such initiative – the Summertown HIV-Prevention Project - lasted three years in an impoverished South African township. It was described as a “mixed bag of disappointments and achievements...[as] many proposed activities [were] yet to be implemented, consistent and widespread condom use remains low...and the most damning lack of Project success over the three-year research period is the lack of evidence for any reduction in STI [sexually transmitted infection] levels.”^{xliv} The analysis by its Director uses such impenetrable prose that one is not surprised by the Project’s admitted lack of effect on either sexual behavior, HIV rates, or AIDS cases. As she states in her conclusion:

“In the interests of contributing to the development of a critical social

psychology of sexuality, the research has illustrated the way in which sexual behaviour, and the possibility of sexual behaviour change, are determined by an interlocking series of multi-level processes, which are often not under the control of an individual person's rational conscious choice. Sexualities are constructed and reconstructed at the intersection of a kaleidoscopic array of interlocking multi-level processes, ranging from the intra-psychological to the macro-social."^{xlv}

The researchers of the Summertown project honestly believed that sexual behavior changes would make people unsick and enable them to stay well. They never imagined that their project failed because its core construct was erroneous and incapable of correction. Did they ever consider that the production of HIV antibodies was environmentally induced, and had little or nothing to do with sexuality?

In Africa, where women contract so-called "Slim Disease" in numbers roughly equal to males, there is no evidence to link the onset of immune deficiency with engagement in promiscuous homosexual intercourse. Intravenous drug use seems uncommon among villagers and city dwellers. Does this mean that in Africa heterosexual intercourse itself puts everyone at risk for AIDS? Does the "AIDS epidemic" in Africa portend the future of the developed world? Many scientists, bio-medical researchers and AIDS experts still believe this is the case.^{xlvi}

As anyone who attended the International AIDS Conference in South Africa (July 2000), can attest, there were more signs of an openly assertive "sexual culture" of surfers, casual drug users, semi-nudity, porn and sex shops, and beautiful prostitutes within one square mile of any hotel at South Beach in Durban than one ever sees in 1000 square miles of Zululand and Maputaland. If AIDS in South Africa is linked to heterosexual behavior or condomless sex, then its epicenter should be found amidst the white oceanfront culture of the north Durban coast, or

the leafy suburbs of north Johannesburg, or the international swingers' scene around Sea Point in Cape Town. But those areas are, of course, the last places one finds AIDS cases in South Africa.

This takes us back to Thabo Mbeki. After the distinguished Harvard physician Paul Farmer found himself at conferences where professional colleagues went "practically purple with rage discussing Mbeki," even accusing him of genocide, he decided to look dispassionate at the controversy. Farmer concluded, quite sensibly, that Mbeki's message was that "poverty and social inequality serve as HIV's most potent co-factors, and any effort to address this disease in Africa must embrace a broader conception of disease causation." Farmer acknowledged, "this is precisely the point many of us have tried to make....and we haven't been branded as AIDS heretics."^{xlvii}

AIDS researchers in Africa assume there is a correlation between clinical symptoms (weight loss, chronic diarrhea, fever, a persistent dry cough) and sexual activity. Correlation - whether one phenomenon is found in tandem with another - is not causation. Proof of causation requires that we control all variables in order to isolate one variable as a cause, not merely as an associated factor. The clinical symptoms that define an AIDS case in Africa are expressed in roughly equal numbers among men and women, not because of alleged heterosexual transmission, but because the socio-economic conditions that give rise to the gender equity in the distribution of these widespread symptoms are caused by environmental risk factors to which many Africans are regularly exposed.

Moreover, there may be a correlation between having those clinical symptoms, which attend to an absence of good health, and the likelihood that the patient will generate a positive antibody test result. This does not prove that it was the antibodies (or "HIV") which caused those symptoms. Anyone who has those symptoms, which are due to environmental insults, may cause a positive test result, indicating simply that the patient is likely to be in poor health.

To put it another way, the presentation of the clinical AIDS symptoms is likely to predict a positive HIV-antibody result on a single ELISA test. Thus, these AIDS symptoms could be said to "cause" a positive test result.^{xlviii}

Poverty-stricken, malnourished subsistence farmers with malaria, tuberculosis or repeated attacks of dysentery are likely to have a considerable amount of cross-reacting antibodies in their systems. Dr. F.J.C. Millard, a physician at a small mission hospital in South Africa's North Province (formerly Northern Transvaal), described the local conditions in which the incidence of tuberculosis and AIDS were rising: "the area had suffered from neglect during the *apartheid* years. There is poverty, malnutrition, violence, unemployment, overpopulation, and, most important of all, a lack of education."^{xlix}

Statistics on AIDS cases in Africa remain marred by the careless use of sources, questionable mathematics and a refusal by those who accept that data to engage in discussions with their critics. Throughout the July 2000 sessions of President Mbeki's AIDS Advisory Panel, purported AIDS cases in South Africa were routinely conflated with the results from a single ELISA HIV-antibody test derived from sentinel surveys performed on 18,000 pregnant (mostly African) women at antenatal clinics. This sleight-of-hand led adherents to the orthodox view on HIV/AIDS to accept "high counters" whose uncritical treatment of sources dismissed any attempt at verification and validation.

During the past twenty years, as the external financing of HIV-based AIDS programs in Africa dramatically increased, money for studying other health sectors remained static, even though deaths from malaria, tuberculosis, neo-natal tetanus, respiratory diseases and diarrhea grew at alarming rates.¹

While western health leaders fixate on HIV, approximately 52% of sub-Saharan Africans lack access to safe water, 62% have no proper sanitation, almost half

live on less than one dollar a day, and an estimated 50 million pre-school children suffer from protein malnutrition.ⁱⁱ Poor harvests, rural poverty, migratory labor systems, urban crowding, ecological degradation, the collapse of state structures, and the sadistic violence of civil wars are the primary threats to African lives.ⁱⁱⁱ When essential services for water, power, and transport break down, public sanitation deteriorates and the risks of cholera, tuberculosis, dysentery, and respiratory infection increase.

Historian Randall Packard documented attempts made by the South African government to control the spread of tuberculosis and to lower its morbidity and mortality rates. Even though tuberculosis is curable and the available control measures are sufficient to combat it effectively with antitubercular drugs, the *apartheid* government made little impact on the overall prevalence of the disease. Packard showed that the South African government refused “to address the foundations of black poverty, malnutrition, and disease upon which the current [1980s] epidemic of tuberculosis is based...[and] placed their faith in the ability of medical science to solve health problems in the face of adverse social and economic conditions.”ⁱⁱⁱⁱ

AIDS researchers and policy makers confuse correlation with causation as they conflate tuberculosis incidence and the reactivation of dormant TB with a person’s HIV-antibody status. This co-mingling enables conventional AIDS programs to link efforts to reduce the infectiousness and severity of tuberculosis with family planning, safe sex messages and behavior modification proposals.^{liv}

In August 1998, the *New York Times* reported that Zimbabwe had become the center of the world’s AIDS epidemic. It claimed that as many as 25 percent of all adult Zimbabweans were infected with HIV, the highest infection rate on earth. Although it provided no figures for previous years, the article acknowledged that the presumed increase in HIV incidence had occurred when increasing poverty, food shortages and instability had “begun to overcome the country. Tuberculosis,

hepatitis, malaria, measles and cholera...have surged mercilessly. So have infant mortality, stillbirths and sexually transmitted diseases." Malarial deaths had risen from 100 in 1989 to 2,800 in 1997 and tuberculosis cases jumped from 5,000 in 1986 to 35,000 in 1997. The reporter admitted that all of these diseases indicated deepening social deprivation, with tuberculosis as "the sentinel illness of poverty and social decline."^{lv}

Subsequent reports showed that rural suffering in Zimbabwe was caused by government corruption, a savage drought and the breakdown of civil society under the harsh regime of Robert Mugabe. Zimbabwean misery over the past fifteen years was also the result of local mismanagement and gross inequities in the region that were accelerated by strictures imposed by the World Bank's structural adjustment programs. In such dire straits, people were hurting because of food shortages and untreated illnesses, not because of sexual promiscuity. Once again, it was no accident that the clinical symptoms that define a case of AIDS in Zimbabwe (fever, diarrhea, weight loss, and persistent cough) were actually manifestations of protein anemia, unsanitary drinking water and parasitic infections in a country "with one of the fastest-shrinking economies on earth."^{lvi}

Other articles in the macabre series, entitled "Dead Zones," illustrated fundamental flaws in the HIV/AIDS model. Among sick or dying Africans, clinicians cannot distinguish which patients would test antibody-positive even if test kits were available. People were presumptively diagnosed as "having AIDS" simply by having the clinical conditions that HIV is *said to cause*, such as tuberculosis or the symptoms of malaria (persistent night sweats, fever, wasting) or that of cholera (diarrhea, fever, wasting).

Former WHO Director General Hiroshi Nakajima warned emphatically that "poverty is the world's deadliest disease."^{lvii} Indeed, the leading causes of immunodeficiency and the best predictors for clinical AIDS symptoms in Africa are impoverished living conditions, economic deprivation and protein anemia, **not**

extraordinary sexual behavior or the trace measurements of antibodies for a retrovirus that has proved difficult to isolate directly.

The AIDS epidemic in Africa has been used to justify the medicalization of sub-Saharan poverty. Rather than treat the clinical symptoms of AIDS as the manifestations of impoverished living conditions, researchers like Dr. David Alnwick, UNICEF's health chief, invert this cause-and-effect relationship to allege that "all our efforts at providing safe water and other protections for children have been undermined, undone, by the AIDS epidemic."^{lviii}

Western medical intervention has taken the form of vaccine trials, drug testing and demands for behavior modification.^{lix} In 1997, the Division of AIDS at the National Institute of Allergy and Infectious Diseases concluded that there was "not enough evidence that a live attenuated HIV-1 vaccine [was] safe - or effective." Nonetheless, the International Association of Physicians in AIDS Care (IAPAC) insisted that a vaccine should not be required to meet U.S. safety and efficacy standards because the alleged number of AIDS cases rendered "further delay unethical."^{lx}

AIDS scientists and public health planners should recognize the roles of malnutrition, poor sanitation, and parasitic and endemic infections in producing the clinical AIDS symptoms that are manifestations of non-HIV insults.^{lxi} The data strongly suggest that socio-economic development, not sexual restraint, is the key to improving the health of Africans. Wherever one projects high rates of HIV-antibodies in Africans, one also finds high rates for all germs indicative of sanitation problems which generally indicate abject poverty, destitution and a high disease burden.

Phillipe and Evelyn Krynen, medically trained charity workers employed by the French group Partage in Kagera Province (Tanzania), report that when "appropriate treatment was given to villagers who became ill with complaints such

as pneumonia and fungal infections that might have contributed to an AIDS diagnosis, they usually recovered."^{lxii} Father Angelo D'Agostino, a former surgeon who founded Nyumbani, a hospice for abandoned and orphaned HIV-positive children in Kenya came to a similar conclusion:

"People think a positive test means no hope, so the children are relegated to the back wards of hospitals which have no resources and they die. They are very sick when they come to us. Usually they are depressed, withdrawn, and silent....But as a result of their care here, they put on weight, recover from their infections, and thrive. Hygiene is excellent [and] nutrition is very good; they get vitamin supplements, cod liver oil, greens every day, plenty of protein. They are really flourishing."^{lxiii}

Finally, a 1998 study of pregnant, HIV antibody-positive women in Tanzania showed that simply providing them with inexpensive micronutrient supplements produced beneficial effects and decreased adverse pregnancy outcomes. The researchers found that women who received prenatal multivitamins had heavier placentas, gave birth to healthier babies and showed a noticeable "improvement in fetal nutritional status, enhancement of fetal immunity, and decreased risk of infections." Their commitment to the belief that AIDS was caused by a viral infection obliged the researchers to conclude that "how the individual vitamins produce these effects is not fully understood."^{lxiv}

Once scholars consider the non-contagious, indigenous-disease explanations for what are called AIDS, they may begin to see things differently. The problem is that dysentery and malaria do not yield headlines or fatten public-health budgets. "Plagues" and infectious diseases do.

Inadequate libraries, poorly paved roads, a dearth of teachers, insufficient childhood immunizations, poor harvests, an excess of rinderpest or locusts, domestic abuse, awful public transportation systems, growing numbers of

orphans, packs of wild dogs, disruptive regime transitions, unwanted sexual advances..... you name it and HIV/AIDS is somehow, ultimately behind it.^{lxv}

Given the erratic and unreliable keeping of vital statistics across Africa and the vague symptomology that constitutes an "AIDS" case to begin with, it sometimes seems that unless an African was killed by gunshot wounds or had died from injuries sustained in a traffic accident, then almost any decedent can safely be alleged, without any death certificate or an autopsy, to have died from "AIDS" or an "AIDS-related illness."

The 2005 meeting of the African Studies Association was organized around the general theme of "Health, Knowledge, and the Body Politic." Yet one found almost no papers that dealt with the real killers that afflict Africans or compromise their health: malaria, tuberculosis, protein anemia, respiratory diseases, childhood diarrhea, measles, tetanus or the immunosuppression that comes from malnutrition.

If the term "panacea" refers to something that is a "cure-all," then I propose the invention of a neologism to describe the all-encompassing power now attributed to HIV and AIDS in Africa. The new term combines "pan" (all-inclusive) with "pathogen" (disease-causing agent) to form "panopathogen." AIDS has become the African panopathogen, the cause of all that is debilitating or life-threatening.

Is this an exaggeration? Perhaps. But a 2004 report, *Downward Spiral: HIV/AIDS, State Capacity, and Political Conflict in Zimbabwe* exemplifies the all-inclusive nature of the HIV/AIDS hypothesis.^{lxvi} One is astonished to learn about the diversity of economic maladies in Zimbabwe that the authors claim are either

directly caused or indirectly induced by the HIV/AIDS epidemic and HIV disease, which they call "debilitation and mortality as the virus increasingly colonizes the work force." These include:

- 1) reduction of the labor supply
- 2) declining productivity of workers
- 3) decline in remittance income
- 4) current food shortage
- 5) decline in life expectancy
- 6) increased infant mortality
- 7) decline in personal savings
- 8) increased national debt
- 9) increased orphans
- 10) criminal behavior and general disenchantment
- 11) opportunities for terrorists
- 12) accentuated social class differences
- 13) reduction in the accumulation of knowledge and skills
- 14) increased violence against women
- 15) government collapse

People can be encouraged to behave thoughtfully in their sexual lives if they are provided with reliable information about contraception, family planning and venereal diseases. Rather than spend billions of dollars on behavior modification schemes or in pursuit of an illusory AIDS vaccine, multilateral aid should be earmarked to subsidize inexpensive but effective medicines to treat the specific symptoms of common illnesses that are a byproduct of impoverished living conditions.

That money can purchase antibiotics to treat syphilis or gonorrhea, rehydration tablets for diarrhea, directly observed therapy (DOTS) with anti-microbial medicine for tuberculosis sufferers, and micronutrients and vitamin supplements

for pregnant women and breastfeeding mothers, regardless of their alleged HIV status. These measures may not be sexy, but they will save lives.^{lxvii}

Over the past century, infectious diseases have been controlled through such successful measures

as improved sanitation, cleaner drinking water, eradication of mosquitoes, isolation of genuinely contagious individuals, vaccinations, and the prudent use of antibiotics. Nowad throughout

the AIDS community, the enemies of public health are said to come from within individuals themselves, especially those given to inappropriate or promiscuous sexual behavior.

Multilateral institutions and African scientists should familiarize themselves with the body of literature that demonstrates the contradictions, anomalies and inconsistencies in the orthodox view that the symptoms of AIDS are caused by a single viral infection.^{lxviii} Once they consider the non-contagious explanations for AIDS cases in Africa, they can help stop the proliferation of terrifying misinformation and tendentious projections that associate sexuality with death.

The inadequate empirical basis for the “ABCDs” of AIDS policies (abstinence, behavior modification, condoms, drugs) replicates policy errors made to justify environmental interventions thirty years ago. Both propose that western researchers, funding agencies and drug (or chemical) manufacturers provide a self-righteous service to rescue a helpless, ravaged continent. In the case of AIDS, it has meant the medicalization of poverty, the infantilization of African behavior, and the sexualization of everyday life.

A fruitful methodological approach for enlightened skepticism about AIDS in Africa may be found in the scholarship that refutes comparably “self-evident” truths about environmental crises.^{lxix} These studies show how scientists, development agencies and governments benefit from a crisis mentality by inventing, exaggerating and upholding assumptions (i.e., desertification, overgrazing,

deforestation) long after the evidence for them had been overturned. As Bassett and Crummey explain, “the degree of urgency which accompanies so many calls for intervention is far too often directly proportional to the ignorance out of which it arises. Outsiders have been constructing Africa according to their own will for far too long.”

The value of local knowledge remains greater than ever as a basis for challenging external constructions about African reproductive health or ecological integrity. If we tap into that knowledge we may finally recognize that the “cure” for AIDS is as near at hand as an alternative explanation for what is making Africans sick in the first place.

ENDNOTES

ⁱ This is amply demonstrated in Joseph E. Stiglitz, *Globalization and Its Discontents* (New York: Norton, 2002) and William K. Tabb, *Unequal Partners: A Primer on Globalization* (New York: New Press, 2002), especially Chapter Three, “Debt, AIDS, and Today’s Colonialism,” pp. 86-120.

ⁱⁱ Nicholas Eberstadt and Sally Satel, “Health, Inequality and the Scholars,” *The Public Interest* (Fall 2004), p.116.

ⁱⁱⁱ Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report*, 1997, Vol. 9, #2, Tables #3-#5, pp. 10-12.

^{iv} Centers for Disease Control, “HIV Transmission in the Adult Film Industry: Los Angeles, California, 2004,” *Mortality and Morbidity Weekly Report* (Vol. 54, #37), pp. 923-926; and Nick Madigan, “Voice of Health in a Pornographic World,” *New York Times* (10 May 2004).

^v Ari Cohn, “Cases of Genital Warts on the Rise at Chico State,” *Chico Enterprise-Record* (20 October 2005); and Diana Flannery, et. al., “Anal Intercourse and Sexual Risk Factors Among College Women, 1993-2000,” *American Journal of Health Behavior*, Vol. 27, #3 (2003), pp. 228-234.

^{vi} Terence I. Doran and Ernesto Parra, “False-Positive and Indeterminate Human Immunodeficiency Virus Test Results in Pregnant Women,” *Archives of Family Medicine*, Vol. 9 (2000), pp. 924-929.

^{vii} Eleftherios Mylonakis, et. al., “Report of a False Positive HIV Test Result and the Potential Use of Additional Tests in Establishing HIV Serostatus,” *Archives of Internal Medicine*, Vol. 160 (August 2000), pp. 2386-2388.

^{viii} Nancy Padian, et. al., "Heterosexual Transmission of Human Immunodeficiency Virus (HIV) in Northern California: Results from a Ten-Year Study," *American Journal of Epidemiology*, Vol. 146, #4 (August 15, 1997), pp. 350-57.

^{ix} Recent research among African populations suggests that a person with an over-active immune system that is constantly assaulted by various pathogens or burdened with chronic infections is more susceptible to a positive HIV antibody test result. Zvi Bentwich, et. al., "Immune Activation is a Dominant Factor in the Pathogenesis of African AIDS," *Immunology Today*, Vol. 16, #4 (1995), pp. 187-91.

^x Joseph B. McCormick and Susan Fisher-Hoch, *Level 4: Virus Hunters of the CDC* (Atlanta: Turner Publishing, 1996), pp. 188-90.

^{xi} *Ibid.*, pp. 173-74.

^{xii} *Ibid.*, pp. 179-80.

^{xiii} *Ibid.*, p. 193.

^{xiv} Henry M. Kitange, et. al., "Outlook for Survivors of Childhood in Sub-Saharan Africa: Adult Mortality in Tanzania," *British Medical Journal*, Vol. 312 (January 27, 1997), pp. 216-17. The authors report that "a network of people was established in each of the [Tanzanian] study areas whose responsibility it was to inform a field supervisor of all deaths occurring in their areas. Locally known and respected people were selected...when a death was reported, the field supervisor in that area visited the home of the deceased and carried out a 'verbal autopsy.' This entailed interviewing the family by using a standard proforma with the aim of determining the cause of death."

^{xv} Christopher Murray and Alan Lopez, "Mortality by Cause for Eight Regions of the World: Global Burden of Disease Study," *The Lancet*, Vol. 349 (May 3, 1997), pp. 1269-1276. The authors advise that "the system of collecting cause of death data via 'verbal autopsies' needs to be assessed and improved to provide reliable data on broad categories of causes of death at low cost." See also, "From What Will We Die in 2020?" *The Lancet*, Vol. 349 (May 3, 1997), p. 1263.

^{xvi} For instance, California has a population of nearly 34 million of whom at least 95% are heterosexuals. Between 1981 and 2003, a cumulative total of 134,852 cases of AIDS (approximately 6120 per year) were reported by county health departments. But only 5,956 cases (4.4% of the total or roughly 260 per year) were attributed to heterosexual transmission.

^{xvii} Jean-Yves Nau, "AIDS Epidemic Far Worse Than Expected," *Le Monde* section in *Manchester Guardian Weekly* (December 14, 1993). Anthropologist Jack Goody claims that love is a consequence of modernity and a written culture. Thus, when literate people are separated by a social barrier or absence they write to each other using precise words that lead them to be analytical and reflexive, eventually coming to act as they write. Goody claims that African oral cultures had little elaboration of romantic love in art, discourse or actuality. Perhaps, AIDS researchers like Klumeck accept Goody's analysis to insinuate why Africans are more disposed to spread AIDS through heterosexual activity. Jack Goody, *Food and Love: A Cultural History of East and West* (London: Verso, 1999).

^{xviii} A recent study investigated the history of Sarah (Saartjie) Bartmann, an early 19th century African woman from Cape Colony whose unusually sized buttocks made her the object of popular caricatures in Britain and France. The book analyzed the centrality and paranoia that sexualized images of black people such as the "Hottentot Venus" played in 19th century European culture. T. Denean Sharpley-Whiting, *Black Venus: Sexualized Savages, Primal Fears and Primitive Narratives* (Durham: Duke University Press, 1999)

^{xix} For an example of anecdotes and impressionistic tales presented as facts about East African truck drivers and AIDS, see Ted Conover, "Trucking Through the AIDS Belt," *The New Yorker* (August 16, 1993).

^{xx} Raul Sebastian, "Did AIDS Start in the Jungle?" *The Lancet*, Vol. 348 (November 16, 1996), p. 1392.

^{xxi} Adele Baleta, "Concern Voiced Over 'Dry Sex' Practices in South Africa," *The Lancet*, Vol. 352, No. 9136 (October 17, 1998), p. 1292.

^{xxii} Brandon P. Reines, "Radiation, Chimpanzees and the Origin of AIDS," *Perspectives in Biology and Medicine*, Vol. 39, #2 (Winter 1996), pp. 187-92.

^{xxiii} Edward Hooper, *The River: A Journey to the Source of HIV and AIDS* (Boston: Little, Brown Publishers, 1999).

^{xxiv} Helen Epstein, "Something Happened," *New York Review of Books* (December 2, 1999), p. 18.

^{xxv} World Health Organization, *Weekly Epidemiological Record*, Vol. 74, #48 (November 26, 1999), p. 401.

^{xxvi} For a compendium of these assumptions, see John C. Caldwell, et. al. (eds.), *Resistances to Behavioural Change to Reduce HIV/AIDS Infection in Predominantly Heterosexual Epidemics in Third World Countries* (Canberra: National Centre for Epidemiology and Population Health, Australian National University, 1999). An investigation into the role of anal intercourse in Africa as a contributing factor to AIDS concluded that the "behaviors most relevant to [AIDS] transmission there (and probably in much of the Third World) seem less likely to be sexual than a consequence of unhygienic practices and medical care." Stuart Brody and John J. Potterat, "Assessing the Role of Anal Intercourse in the Epidemiology of AIDS in Africa," *International Journal of STD and AIDS*, Vol. 14 (July 2003), p. 434.

^{xxvii} In a review of *Sexual Ecology: AIDS and the Destiny of Gay Men* by Gabriel Rotello (New York: Dutton, 1997) and *Life Outside: The Signorile Report on Gay Men* by Michelangelo Signorile (New York: HarperCollins, 1997), historian Daniel Kevles notes that with the advent of gay liberation, "bathhouses, while offering a communitarian haven from homophobia, also institutionalized part of the liberation movement, providing sexual opportunities in private cubicles, showers, hallways, and dimly lit 'orgy rooms' devoted to anonymous encounters...Tens of thousands were habitués of the 'circuit' - a series of large gay dance parties held in different places where they used one kind of drug to heighten their sexual energies and another to relax their sphincter muscles." Daniel J. Kevles, "A Culture of Risk," *New York Times Book Review* (May 25, 1997), p. 8. John Lauritsen and Dr. Joseph Sonnabend have described the unhealthy lifestyle of this very specific cohort of urban gay men in the United States who had unprecedented opportunities for sexual contacts with hundreds, even thousands of partners. It was a ghettoized sub-culture of promiscuous gay men who habitually abused alcohol and drugs that

produced the epidemic levels of chronic infection and immunological breakdown that allowed opportunistic infections to take over bodies that had been repeatedly exposed to a wide range of microbes such as gonorrhea, cytomegalovirus, hepatitis, syphilis, non-specific viral infections, bacterial pathogens, and parasitic infections. Without addressing these underlying socio-economic and environmental causes, the commitment of researchers to lump together the diverse cases of immune-deficiency that began appearing in this small sub-culture led them uncritically to accept the unifying hypothesis of a single viral cause based on the similarities of the disease manifestations. See Joseph Sonnabend, "Fact and Speculation About the Cause of AIDS," *AIDS Forum*, Vol. 2, #1 (May 1989), pp. 2-12; John Lauritsen, *The AIDS War* (New York: Asklepios Press, 1993); and John Lauritsen and Ian Young (eds.) *The AIDS Cult: Essays on the Gay Health Crisis* (Provincetown, Massachusetts: Asklepios Press, 1997). Frank Bruni, "Drugs Taint Annual Gay Revels," *New York Times* (September 8, 1998) chronicled the abundant array of drugs like cocaine, Ecstasy, ketamine ("special K") and a liquid anesthetic called gamma hydroxybutyrate (GHB) that were widely consumed at an August 1998 fund-raiser for AIDS at Fire Island, New York.

^{xxviii} Doris Schopper, Serge Doussantousse, and John Orav, "Sexual Behaviors Relevant to HIV Transmission in a Rural African Population," *Social Science and Medicine*, Vol. 37, #3 (August 1993), pp. 401-12.

^{xxix} James Deane, "The Role of the Media in the Fight Against AIDS," *SIDAfrique*, #8/9 (1996), p. 29.

^{xxx} Susan D. Moeller, *Compassion Fatigue: How the Media Sell Disease, Famine, War and Death* (New York: Routledge, 1998) and Jonathan Benthall, *Disasters, Relief and the Media* (New York: St. Martins Press, 1993). For a demonstration of how U.S. officials manipulated statistics and public fears to mobilize billions of dollars in a futile effort to halt the illicit international drug trade, see Mike Gray, *Drug Crazy* (New York: Random House, 1999).

^{xxxi} A typical example is Lawrence K. Altman, "Parts of Africa Showing HIV in 1 in 4 Adults," *New York Times* (June 24, 1998).

^{xxxii} A scholarly attempt to analogize AIDS with the Black Death is David Herlihy, *The Black Death and the Transformation of the West* (Cambridge: Harvard University Press, 1997), pp. 5-6.

^{xxxiii} Zachary Coile, "Bill Would Enhance Access to AIDS Drugs," *San Francisco Chronicle* (March 7, 2001), p. A7.

^{xxxiv} Cited in Alex de Waal, "Sex in Summertown," *Times Literary Supplement* (6 August 2004), p. 5.

^{xxxv} Frank Furedi, *Culture of Fear* (London: Cassell, 1997), p. 48. American novelist Philip Roth's recent work, *The Human Stain* (New York: Houghton Mifflin, 2000), refers to the "ecstasy of sanctimony" that defines the current epoch of shrill moral hysteria about sexuality.

^{xxxvi} "No End of Plagues," *The Economist* (September 7, 1996), p. 38. A recent study found that 40% of American journalists rarely or never seek independent verification for a science story they are writing, and that 82% of the scientists polled felt that journalists did not understand statistics well enough to explain new findings. Jim Hartz and Rick Chappell, *Worlds Apart: How the Distance Between Science and Journalism Threatens America's Future* (Nashville: First Amendment Center at Vanderbilt University, 1998). Media coverage of AIDS resembles the kind of writing that Australian journalist

John Pilger describes as “repetitious, safe and limited by invisible boundaries.” Thus, as Will Rogers once quipped, it’s not ignorance that causes all the trouble in this world, “it’s the things people know that ain’t so.”

^{xxxvii} Nowhere is this more evident than at the biennial “International AIDS Conferences” which resemble pharmaceutical trade shows for commodities of the AIDS industry. At the XII AIDS Conference (Geneva, June 1998), journalists and researchers referred to AIDS as a “runaway epidemic” and a “collective failure of the world,” demanding that it be made a “global public health priority.” Lawrence Altman, “At AIDS Conference, a Call to Arms Against ‘Runaway Epidemic’,” *New York Times* (June 29, 1998).

^{xxxviii} In a candid review of the fruitless vaccine trials, Richard Horton admitted that “until the gravity of this scientific failure is openly acknowledged, a serious debate about how to end HIV’s lethal grip...cannot take place.” Horton noted that many AIDS scientists fear that their inability to find a “single-dose, safe, affordable, oral vaccine that gives lifelong protection against all subtypes of HIV” will erode public confidence in other aspects of the “war on AIDS.” Their fears are justified. “AIDS: The Elusive Vaccine,” *New York Review of Books* (September 23, 2004), pp. 53-57. Several recent studies demonstrate how large numbers of people and many advocacy organizations profit from fear-mongering about dangers that are blown way out of proportion to their real risks. David Ropeik, *Risk: A Practical Guide for Deciding What’s Really Safe and Really Dangerous* (Harvard University Press, 2002); Barry Glassner, *The Culture of Fear* (New York: Basic Books, 1999); Frank Furedi, *Culture of Fear* (London: Cassell, 1997); Laura Lee, *100 Most Dangerous Things in Everyday Life and What You Can Do About Them* (New York: Broadway Books, 2004); and Marc Siegel, *False Alarm: The Truth About the Epidemic of Fear* (New York: John Wiley, 2005).

^{xxxix} In 1999-2000, several major companies offered to discount the cost of drugs to Africans. Glaxo Wellcome cut the price of AZT and 3TC to \$200 a month for sale in Uganda and Ivory Coast where the annual per capita income is less than the price of the drug. Urging African governments to subsidize the costs, UN official Joseph Saba said his agency had to “show them that AIDS justifies investing public funds.” Associated Press, “Firms Cut AIDS Drug Prices to 3rd World,” *San Francisco Chronicle* (June 24, 1998)

^{xl} An important analysis of AZT, its properties and effects, is Anthony Brink, *Debating AZT: Mbeki and the AIDS Drug Controversy* (Pietermaritzburg: Open Books, 2000, ISBN #0-620-26177-3).

^{xli} For instance, a 31-year old man in Kagera Province (Tanzania) was said to be dying of AIDS. Emaciated and despondent, he worked as a fisherman until he became sick in 1992 with diarrhea, chest pains, muscle weakness, and a severe cough. The man stayed with an aunt because his brother and sister refused to see him. “Since I became sick,” he told a reporter, “I have not made an effort to go to the hospital because I have no money and my aunt is not able to pay.” Susan Okie, “Tanzania Village Devastated by AIDS Deaths,” *Washington Post* (March 15, 1992)

^{xlii} “False-Positive Self-Reports of HIV Infection,” letter from Chifumbe Chintu, et. al., *The Lancet*, Vol. 349 (March 1, 1997), p. 649.

^{xliii} Some Western scientists, including Dr. Luc Montagnier the French virologist who discovered HIV, claim that the practice of female circumcision facilitates the spread of AIDS. Yet Djibouti, Somalia, Egypt and Sudan, where female genital mutilation is the most widespread, are among the countries with

the lowest incidence of AIDS cases. Thomas Bass, *Reinventing the Future: Conversations with the World's Leading Scientists* (Reading, Massachusetts: Addison-Wesley, 1994), p. 40. See also the analysis by a Sudanese anthropologist, Rogaia Mustafa Abusharaf, "Unmasking Tradition," *The Sciences* (March/April 1998), p. 24.

^{xliv} Catherine Campbell, *'Letting Them Die: Why HIV/AIDS Prevention Programmes Fail* (Oxford: James Currey, 2003), p. 185.

^{xlv} *Ibid.*, p. 183. Despite the stunning failures of the Project, one reviewer, who was also the Series Editor for its publisher, called it "the best book yet written on the struggle to control HIV." De Waal, *op. cit.*, p. 5.

^{xlvi} By 2000, the theory that an infectious virus causes AIDS had become a "doctrinal system" whose adherents could dismiss impertinent historical facts by simply labeling them as "lies." As Noam Chomsky once observed, "if you're following the party line you don't need to document anything; you can say anything you feel like...That's one of the privileges you get for obedience. On the other hand, if you're critical of received opinion, you have to document every phrase." Cited in Donald Macedo (ed.), *Chomsky on Miseducation* (New York: Rowman and Littlefield, 2000), p. 173.

^{xlvii} Paul Farmer, "AIDS Heretic," *New Internationalist*, #331 (January/February 2001), p. 15.

^{xlviii} Throughout my work as a member of Mbeki's AIDS Advisory Panel, I sat next to Barry Schoub, a prominent virologist from the University of Witwatersrand. We chatted amiably about topics besides AIDS. During one casual conversation, when I suggested this reversal of the standard HIV=AIDS equation, Schoub agreed that the correlation between a person having those symptoms and then testing positive might exceed 99%. It was a classic reversal (or confusion) of the difference between causation and correlation. Having "AIDS" symptoms could easily predispose someone to test HIV-antibody positive, hence "having AIDS" could be said to cause "HIV."

^{xliv} F.J.C. Millard, "South Africa: A Physician's View," *The Lancet*, Vol. 351 (March 7, 1998), p. 748.

¹ World Health Organization, *Bridging the Gaps: The World Health Report 1995* (Geneva: WHO, 1995), Table 5 (p. 18) and Table A3 (p. 110); and World Health Organization, *Fighting Disease, Fostering Development: The World Health Report 1996* (Geneva: WHO, 1996), Table 4 (p. 24) and Table A3 (p. 127).

^{li} "A Good Turn for Africa, Please," *The Lancet* (January 11, 1997), p. 69. The continent seems to grow poorer with every passing decade, leading some analysts to suggest that, "even if Africa's aggregate growth doubles over the next nine years, its per capita income in 2006 would still be five percent lower than it was in 1974." Dan Connell and Frank Smyth, "Africa's New Bloc," *Foreign Affairs*, Vol. 77, #2 (March/April 1998), p. 89. In Uganda, the expenditure on debt servicing (\$15 per head annually) is six times the spending on health and nearly one in two children is undernourished. Derek Summerfield, "The Politics of Apology," *The Lancet*, Vol. 354 (July 31, 1999), p. 421.

^{lii} According to the *Global Burden of Disease Study*, 1.02 million Africans died of injuries (intentional and unintentional) in 1990. For South Africa, see Jeanelle de Gruchy and Laurel Baldwin-Ragaven, "Poverty and the South African Health Professions: A Commentary," *Health Systems Trust Update* (#39, January 1999).

^{liii} Randall M. Packard, "Industrialization, Rural Poverty, and Tuberculosis in South Africa, 1850-1950," in Steven Feierman and John M. Janzen (eds.), *The Social Basis of Health and Healing in Africa* (Berkeley: University of California Press, 1992), p. 129. In 1989, Packard observed that a "new resurgence of TB is surfacing in the urban areas of the country as thousands of workers and their families attempt to escape the poverty of the Bantustans. Once again, industrial capital and the state have combined to lay the groundwork for a major upsurge in urban-based TB... [will the state and local authorities] once again apply their time-honored policies of exclusion to solve this growing problem....[or] will they at long last recognize the futility of this policy and begin to deal with the underlying causes of TB?" Randall M. Packard, *White Plague, Black Labor: Tuberculosis and the Political Economy of Health and Disease in South Africa* (London: James Currey Publishers, 1989), pp. 318-19.

^{liv} For examples, see USAID/Bureau for Africa, *A Strategic Framework for Setting Priorities for Research, Analysis, and Information Dissemination on HIV/AIDS, STIs, and Tuberculosis in Africa* (Washington: USAID, June 1995).

^{lv} Michael Specter, "Doctors Powerless as AIDS Rakes Africa," *The New York Times* (August 6, 1998). The article omitted any reference to the combined effects on Zimbabwe of the World Bank's structural adjustment programs in the 1990s coupled with poor harvests, drought, long-term food deficiencies, a 70% inflation, an unemployment rate of 50%, and the cost of its 1998 military involvement in the Congo left the average Zimbabwean poorer by one-third than at independence in 1980. For a study of the serious economic degradation in rural and urban areas, see Leon Bijlmakers, Mary Basset and David Sanders, *Health and Structural Adjustment in Rural and Urban Zimbabwe* (Uppsala: Nordiska Afrikainstitutet Research Report, No. 101, 1996) which one reviewer termed, "an extensive survey of health, economic and demographic characteristics [that] monitored and documented the deterioration that occurred under the World Bank's structural adjustment program. It confirms what is widely believed, that charges for the use of health services, introduced at the behest of the Bank, deter the patients at greatest risk of disabling and fatal illnesses, the very patients for whom medicine has developed preventive, curative and cost effective interventions." Meredith Turshen in *African Studies Review*, Vol. 41, #1 (April 1998), p. 182. See also, Ken Owen, "Bloody Mugabe," *New Republic* (March 8, 1999), pp. 21-23. In her latest study as part of an annual re-survey, Mary Basset suggests that the impact of SAP on Zimbabwean households has been pernicious -- people are eating one meal a day, not seeking health care but saving money (for funerals?), there are more women headed households and hints of more child-headed households (orphans and children of a parent away at work). Stefano Ponte, "The World Bank and 'Adjustment in Africa'," *Review of African Political Economy*, #66 (December 1995), pp. 539-58 provides data showing that several countries which UNAIDS claims are threatened with a "plague of HIV (Tanzania, Uganda, Zambia and Zimbabwe) have been hard hit by Bank policies in terms of limited debt reduction and poor institutional capacity building." The enormous expansion of debt, the globalization of poverty and its impact on public health sectors since the 1980s are the context within which AIDS developed. See, Michel Chossudovsky, *The Globalisation of Poverty: Impacts of the IMF and World Bank Reforms* (New York: Zed Books, Inc., 1997).

^{lvi} Philip Gourevitch, "Wasteland: Letter From Zimbabwe," *The New Yorker* (June 3, 2002), p. 61. See also Michael Wines, "In Zimbabwe, Even the Farmers Are Going Hungry," *New York Times* (February 29, 2004), p. A6; Gabrielle Menezes, "Letter From Zimbabwe," *The Nation*, (May 12, 2003), pp. 12-14; and Samantha Power, "How to Kill a Country," *Atlantic Monthly* (December 2003), pp. 86-98.

^{lvii} WHO, *The World Health Report 1995*, v. Furthermore, the 1996 UNICEF report, *The Progress of Nations*, sensibly warns that “classifying deaths by disease hides the fact that death is not usually an event with one cause but a process with many causes. In particular, it is the conspiracy between malnutrition and infection which pulls many children into the downward spiral of poor growth and early death.”

^{lviii} Quoted in David Perlman, “UN Moves to Prevent AIDS Babies,” *San Francisco Chronicle* (June 30, 1998).

^{lix} A steady stream of AIDS researchers from the United State and Europe has converged on Africa, convinced that their work is humane and benevolent just as 19th century missionaries came to cure and train. Jonathan Falla sees this impulse towards charity as another form of social control. “What Do They Think They Are Doing?,” *Times Literary Supplement* (July 18, 1997).

^{lx} Michael McCarthy, “AIDS Doctors Push for Live-Virus Vaccine Trails,” *The Lancet*, Vol. 350 (October 11, 1997), p. 1082.

^{lxi} This is elaborated in Charles Gesheker, “Outbreak? AIDS, Africa, and the Medicalization of Poverty,” *Transition*, #67 (Fall 1995), pp. 4-14; Gesheker, “The Plague That Isn’t,” *Toronto Globe and Mail* (14 March 2000), and Cindy Patton, *Inventing AIDS* (New York: Routledge, 1990), especially Chapter 4, “Inventing African AIDS.” In 1997, Glaxo-Wellcome negotiated with the South African Department of Health to have the government subsidize the cost of importing AZT. As part of this “bouquet of assistance” to provide HIV positive women with AZT, the difference in cost between the actual and discounted price would be used to fund training for “AIDS counselors.” *The Weekly Mail and Guardian* (Johannesburg), August 22, 1997. Some pharmaceutical companies now urge pregnant African women who test HIV-antibody positive to take these powerful drugs and to stop breast-feeding their infants.

^{lxii} Cited in Neville Hodgkinson, “Cry, Beloved Country: How Africa Became the Victim of a Non-existent Epidemic of HIV/AIDS,” in P. H. Duesberg (ed.), *AIDS: Virus- or Drug-Induced?* (Dordrecht: Kluwer Academic Publishers, 1996), p. 353.

^{lxiii} Hodgkinson, *op. cit.*, pp. 350-51.

^{lxiv} Wafaie W. Fawzi, et. al., “Randomized Trial of Effects of Vitamin Supplements on Pregnancy Outcomes and T Cell Counts in HIV-1 Infected Women in Tanzania,” *The Lancet*, Vol. 351 (May 16, 1998), pp. 1477-82. The absence of prenatal health care and adequate nutrition remain major factors in pediatric AIDS cases in the United States where 80% of HIV-infected babies are born to drug-addicted mothers who suffer from a host of vitamin deficiencies.

^{lxv} See, Tamar Kahn, “Dogs Roam Wild as AIDS Kills Owners,” *Business Day* (4 February 2005).

^{lxvi} Andrew T. Price-Smith and John L. Daly, *Downward Spiral: HIV/AIDS, State Capacity and Political Conflict in Zimbabwe* (Washington: U.S. Institute of Peace, #53, July 2004).

^{lxvii} For example, for about \$20, one can acquire a six-month supply of rifampin, isoniazid, pyrazinamide and ethambutol that will cure an African of tuberculosis. The regimen is a simple, proven, effective remedy for one of the real scourges of Africa.

lxviii Neville Hodgkinson, *AIDS: The Failure of Contemporary Science* (London: 4th Press, 1996); Elinor Burkett, *The Gravest Show on Earth* (Boston: Houghton Mifflin, 1995); Hiram Caton, *The AIDS Mirage* (Sydney: University of New South Wales Press, 1994); Robert Root-Bernstein, *Rethinking AIDS: The Tragic Cost of Premature Consensus* (New York: Free Press, 1993); Peter Duesberg, *Infectious AIDS: Have We Been Misled?* (Berkeley: North Atlantic Books, 1996); Joan Shenton, *Positively False: Exposing the Myths Around HIV and AIDS* (New York: St. Martins Press, 1998); Stuart Brody, *Sex at Risk: Lifetime Number of Partners, Frequency of Intercourse, and the Low AIDS Risk of Vaginal Intercourse* (New Brunswick: Transaction Publishers, 1997); Christine Maggiore, *What If Everything You Thought You Knew About AIDS Was Wrong?* (Los Angeles: American Foundation for AIDS Alternatives, 1999); Christian Fiala, "Dirty Tricks: How the WHO Gets Its AIDS Figures," *New African* (April 1998), pp. 36-38; Gordon Stewart, "A Paradigm Under Pressure," *Index on Censorship*, Vol. 28, #3 (May/June 1999), pp. 68-72; Huw Christie, "Rethinking AIDS," *Index on Censorship*, Vol. 28, #3 (May/June 1999), pp. 73-78; Peter Duesberg, et. al., "The Chemical Bases of the Various AIDS Epidemics: Recreational Drugs, Anti-Viral Chemotherapy and Malnutrition," *Journal of the Biosciences*, Vol. 28, #4 (June 2003), pp. 383-412; and John Crewdson, *Science Fictions: A Scientific Mystery, A Massive Cover-Up, and the Dark Legacy of Robert Gallo* (Boston: Back Bay Books, 2003).

For an exposé of the CDC's misleading campaign in the United States, see Amanda Bennett and Anita Sharpe, "AIDS Fight is Skewed by Federal Campaign Exaggerating Risks," *Wall Street Journal* (May 1, 1996) and David R. Boldt, "Aiding AIDS: The Story of a Media Virus," *Forbes Media Critic* (Fall 1996). The CDC believed that exaggerating the risks to the American people was the only way to enlist widespread support for funds to combat AIDS. Thus, the theme of its public service ad campaign launched in 1987 was, "If I can get AIDS, anyone can." But from 1990 to 1992, the proportion of heterosexuals (aged 18-49) in high risk American cities who reported multiple sexual partners **increased** from 15% to 19%, while condom sales **decreased** by 1%, and 65% of respondents admitted they used condoms either sporadically or not all. Americans were not practicing safe sex and teen pregnancies and venereal diseases were on the rise. Yet AIDS cases continued to decrease sharply. Even the fraction of Americans assumed to be HIV-antibody positive declined from an estimated 1 million in 1985 to 700,000 in 1996. Joseph A. Catania, et. al., "Risk Factors for HIV and Other Sexually Transmitted Diseases and Prevention Practices Among U.S. Heterosexual Adults: Changes from 1990 to 1992," *American Journal of Public Health*, Vol. 85, #11 (November 1995), pp. 1492-99.

There were similar distortions in Canadian reports. By December 31, 1998 there had been a cumulative total of 16,236 cases of AIDS reported in Canada since 1981. In 1995 alone, 2009 adult cases of AIDS were reported. 1834 (91.2%) were males and 175 (8.8%) females. In 1996, there were 1385 adult cases of AIDS reported in Canada, a decrease of nearly 30% in one year. Of the 1385 adult cases, 1220 were males (88%) and 165 were females (12%). In 1997, there were just 573 adult cases, 485 males (84.6%) and 88 females (15.4%). In 1998, there were only 279 cases - 241 males (86.3%) and 38 females (13.7%), a total decrease of almost 90% in three years.

The actual number of adult female AIDS cases reported in Canada had decreased by 50% from 1995 to 1997. In a country of 32 million people, 15.1 million of them women, there were only 38 female AIDS cases in 1998. Yet because the **percentage** of women with AIDS went from 8.2% in 1995 to 13.7% in 1998 even though the actual number sharply decreased, the *Annual HIV and AIDS in Canada Surveillance Report* (April 1999) from the Bureau of HIV/AIDS and STD at the Canadian Laboratory Centre for Disease Control issued an alarmist warning that the risk of AIDS among Canadian women

had *dramatically increased* by 25% to now comprise nearly 14% of all diagnosed cases, “the highest proportion observed since monitoring of the epidemic began,” re-affirming how statistics are easily misrepresented to advance claims of an ever-expanding AIDS epidemic.

By 2003, the total number of AIDS cases annually reported in Canada had shrunk to 218, of whom 164 were males and 54 were females. Women now account for 25% of all AIDS cases in Canada, but the latest report drew little attention to the fact that the total number of female AIDS cases in Canada had actually **dropped 82%** from 1996 to 2003. *HIV and AIDS in Canada: Surveillance Report to December 31, 2003* (April 2004), pp. 28-30.

^{lxix} Melissa Leach and Robin Mearns (eds.), *The Lie of the Land: Challenging Received Wisdom on the African Environment* (Oxford: James Currey, 1996); Thomas J. Bassett and Donald Crummey (eds.), *African Savannas: Global Narratives and Local Knowledge of Environmental Change* (Oxford: James Currey, 2003); and Vigdis Broch-Due and Richard Schroeder (eds.), *Producing Nature and Poverty in Africa* (Stockholm: Nordic African Institute, 2000)