

## Part 1: bad Science, bad Journalism: Africa and AIDS

(The Portland Alliance, July 2002)

Portlanders came together for a series of conferences in early June to discuss the plight of Africa, including the toll AIDS is taking on that continent. While everyone agrees Africans are suffering and dying, some question the diagnosis. The following is part of an Alliance series looking at AIDS.

The problem with the truth is that it is mainly uncomfortable and often dull.

-H. L. Mencken

By Kim Stephenson

If HIV is transmitted easily through heterosexual sex, as the enormous South African HIV/AIDS figures declare, why have United States heterosexual transmission numbers always remained minuscule? Maybe Africans have sex differently and have lots more of it-those savage beasts!

This racist and offensive notion is all that we have to ponder when comparing the current figures of heterosexual HIV infection: 28 million South Africans to 3,678 Americans. Doesn't it seem a little odd in comparison? Mainstream AIDS scientists, administrators and journalists give us no explanation nor do they seem to question why the epidemiology of Sub-Saharan Africa (and what about the rest of Africa?) is so drastically different from the United States or any other country.

Statistics pouring out of the Center for Disease Control, UNAIDS and the World Health Organization are never questioned and they appear to be the cause of the chasm. In Africa you do not need to be HIV infected or tested to be classified as having HIV or AIDS. You need only suffer from diarrhea or fevers for more than one month, and weight loss of ten percent or greater. It is poverty that is killing Africans, not sex.

Africa and the purported heterosexual AIDS epidemic is just one piece to a giant jigsaw puzzle of unproven, slippery science and cowardly, unchallenging journalism that has produced and sustained a multi-billion dollar infrastructure known as the AIDS epidemic.

This is the first in a series of articles for The Alliance that briefly outline the myriad questions, issues, statistics and theories regarding the AIDS epidemic. This first article will address AIDS and Africa. Subsequent articles will discuss the scientific specifics and statistics of HIV sexual transmission; describe to the best of our ability what HIV is, how it was discovered and the validity of HIV testing; discuss the phenomenon of court seizure of "HIV positive" children from their mothers after women refuse to give AZT to their children, and discuss long-term, non-drug-taking AIDS survivors. The final article will give voice to dissident scientific theories about the cause of AIDS.

Portland recently hosted several South African speakers from June 12-14 to discuss how the enormous debt Africa owes to the United States for past "humanitarian help" is contributing to the AIDS crisis. Like other Third World countries, the World Bank and the International Monetary Fund have Africa bound and buried in debt it can never repay.

"Africa owes \$380 billion to multinational corporations," said Nunu Kidane, program director for International Development Exchange in San Francisco. "These are debts that were made illegitimately and under murky circumstances. We want what is rightfully ours!" Kidane said passionately. "We want to reclaim the land that is ours!"

The speakers stressed that it is difficult to gain headway in African healthcare when one-third of Africa's gross national product leaves the country to service debts, one of which was "humanitarian" aid for the 1984 famine. The General Secretary of the South African Council of Churches, Molefe Samuel Tsele, vented his frustration with American drug companies.

"We are held hostage to the drug companies who hold the licenses to the drugs people need. AIDS policy is strengthening drug companies; the stock goes as high as the number of people with AIDS in Africa."

An audience member asked if anyone had looked into the connection between drug companies promoting anti-AIDS drugs and the groups generating the AIDS statistics, and the idea that Africans could be suffering from diseases other than AIDS. Kidane replied that it didn't matter, that people were dying and that AIDS must be a new disease.

But the way HIV/AIDS is defined in Africa, it most assuredly is not a new disease(s). The result is that we are treating malaria, tuberculosis, parasitic infections and the effects of malnutrition, unclean drinking and bathing water with multi-million dollar condom campaigns.

African AIDS statistics are coming from UNAIDS, a massive umbrella organization that includes The World Bank, the United Nations Drug Control Program, the World Health Organization (WHO) and five other large international organizations. It seems a conflict of interest to have the same organization both produce HIV/AIDS statistics and receive billions of dollars to "fight the disease."

The BBC recently reported UNAIDS figures that AIDS will kill one in two Africans, and the United Nations has therefore called for a "massive increase in funding." The World Bank AIDS website states there are 25 million Africans currently living with AIDS, with 15,000 new infections daily; therefore the World Bank is "giving \$500 billion of no interest loans to developing countries."

When astounding figures such as 25-28 million current South African HIV infections (organizational estimates usually differ by the millions), 40 million current HIV infections worldwide and 100 million expected deaths from AIDS in the next decade, one would assume and hope such horrifying figures are derived from reliable methods, but they are not. For instance, health officials have not performed 28 million ELISA or Western Blot tests in Africa in the past year.

HIV/AIDS statistics in Africa are derived from guess-timates the WHO compiles using the "Bangui Definition" of AIDS and a handful of HIV positive tests from pregnant African women that are exponentially exploded.

The Bangui Definition was created in 1985 at the WHO conference in the Central African Republic because doctors felt an urgent need to begin to estimate the size and spread of HIV/AIDS. There was no diagnostic test for widespread use at the time but doctors needed a clinical case definition. Two physicians, Joseph McCor-mick and Susan Fisher-Hoch, produced what is called the "Bangui Definiton" of AIDS in Africa, which says an adult or adolescent 12 years old or greater is considered to have AIDS if he or she exhibits two or more major signs plus one minor sign. Major signs include 1) weight loss of at least ten percent of body weight; 2) diarrhea for at least one month; 3) fever for at least one month (intermittent or constant). Minor signs are 1) oropharyngeal candidiasis; 2) pruritic skin rash; 3) a history of herpes zoster; 4) generalized lymphadenopathy; 5) cough for at least one month (without TB); 6) chronic ulcerated herpes simplex; 7) tuberculosis.

In a country ravaged by imperialism, drought, civil wars, dictators and widespread destitution these symptoms are not unusual, which is why many Africans say AIDS stands for the "American Idea for Discouraging Sex."

Any type of health statistic is difficult to come by in a country where there is little-to no health care and HIV tests are expensive. The "known" HIV positives coming from the WHO are taken from a small sampling of leftover blood samples drawn from pregnant women who visit STD clinics. This blood is given only one ELISA test and often it results in a false positive because when a person's immune system is low, the antibodies produced in response also react with HIV proteins. (HIV tests recognize HIV proteins, which is the closest science can come to the virus itself.) In the United States, if a person tests positive for one

ELISA test, at least one or two more ELISA tests are done and also a Western Blot test, which is more reliable and expensive.

These “known African positives” are then put into a Geneva-based machine that grinds the number through “a complicated formula that explodes out the number.” There are many assumptions in the formula including the sexual behavior of the pregnant woman and the “well-known natural course of HIV infection.”

Even death statistics are hard to come by in Africa, and when someone does dig them up country by country, as South African journalist Rian Malan did, numbers do not jive. He found that African deaths have actually dropped in the era of AIDS.

The near impossibility to get medical information combined with the ambiguous definition of AIDS made Africa ripe to destroy the stigma that AIDS was only a disease of homosexual men. Doctors wanted to refute the ugly moralism of the early 80s, and they wanted financial and political support to fight AIDS. Africa was and is assigned a central role in the premise that “AIDS is an equal opportunity destroyer” and that “AIDS does not discriminate” by making it a heterosexually transmitted disease.

There are two camps devoted to the explanation of why HIV/AIDS remains confined to relatively small groups of homosexual men and intravenous drug users everywhere else but Africa. One camp says Africa is our future and the epidemic hasn’t hit yet, even though we have been waiting 20 years. The other camp says Africans are substantially more promiscuous and are more likely to have genital ulcers, but it doesn’t make sense when researching the studies of heterosexual transmission (the next article).

Racist myths about the sexual excesses of Africans are as old as imperialism, and affronts to our Victorian sensibilities are penalized with Western sexual mores that translate into social control. During International AIDS Conferences doctors claim AIDS could be brought under control if Africans could only restrain their sexual cravings. Billions of taxpayer dollars are being channeled through white, Western infrastructures to promote condoms, abstinence and monogamy in a culture that is not based in Judeo-Christian guilt. Even homo-hating Senator Jesse Helms approves of the campaign and recently rushed \$200 million overseas as part of an anti-terrorism package. Last April the United States government declared AIDS a threat to national security, which means more governmental/political control in the realm of science.

Africa has long suffered from malaria and tuberculosis, and the diseases have grown resistant to conventional drugs. Malaria kills about two million people per year, roughly the same as alleged AIDS deaths per year, yet malaria receives a fraction of the funding. Tuberculosis kills about 1.7 million people per year and is also brushed aside to the extent no new TB drugs have been developed for four years.

The AIDS epidemic is built on the holy trinity of journalism: blood, sex and money. Until Sept. 11, levels of AIDS funding grew daily as foundations and philanthropists rushed to ease the “merciless plague of biblical virulence.” America’s heartstrings are pulled daily with stories of millions of orphans and whole families slowly wasting away, but if we want to help Africa, are condom campaigns the best pursuit?

**Kim Stephenson is a freelance writer and regular contributor to the Alliance**

---end-- part 1

## Part 2: Transmitting the Problem

### How America made AIDS a heterosexual disease

(The Portland Alliance, August 2002)

By Kim Stephenson

For a number of years HIV/AIDS has been presented as an equal opportunity destroyer that is thwarted by condom use for every type of sexual encounter and a clean syringe for every intravenous drug use. Through a high-powered media campaign America has repeatedly received the message that "AIDS does not discriminate." Locally, we have seen the image of a middle class white woman with the ominous tag line of the sponsoring agency, The Cascade AIDS Project, below : "IT'S NOT OVER." The subtext clearly reading: "Beware white, heterosexual America!"

Yet statistics and scientific studies concerning the transmission of HIV/AIDS say otherwise. Last year marked the twentieth anniversary of AIDS and the demographics have roughly remained the same throughout the two decades: The disease affects mostly men (93 percent in Oregon) and mostly white gay men. To say this is considered to be homophobic, and therein lies the problem.

The campaign making AIDS everyone's problem was a public relations event that was a desperate response to the disinterest and prejudices of the American public and government. The disinterest was to such an extent virtually no prevention or research dollars could be approved. After all, fags and junkies were dying, who cared?

In the mid-1980s, when the "AIDS Does Not Discriminate" campaign began, the Centers for Disease Control (CDC) was aware HIV was not spreading heterosexually. Now, as in the past 20 years, AIDS has remained confined to homosexual men, intravenous drug users and their sex partners. Then, as now, the chances of heterosexual transmission through one sexual encounter is lower than the risk of being struck by lightning. To understand why our public health and AIDS organizations have misled us, you need to look at the social environment in which AIDS was born.

Just eight years prior to the first cases of what will be defined as AIDS, the American Psychiatric Association removed homosexuality from its list of mental disorders. In December of 1973 the Association declared that "homosexuals were able to function effectively in society, and when they sought treatment, it was for reasons other than their homosexuality." The "Gay Liberation Movement" was in its infancy and young Americans of all persuasions were enjoying sexual freedom.

In June 1981, the CDC reported on "five young men, all active homosexuals" who had turned up in Los Angeles hospitals with a rare lung infection called pneumocystis carinii. A month later the CDC reported on 26 cases of young gay men diagnosed with Kaposi's sarcoma, a rare skin cancer. Kaposi's sarcoma is characterized by bluish-red nodules on the skin, usually on the lower extremities, that is endemic to equatorial Africa. These are thought to be the first cases of AIDS. Although the diseases were previously known, they were thought to point to an immune deficiency, which will soon be defined as AIDS.

Another deadly agent made himself known that very same year: Ronald Reagan. Reagan and his conservative administration set-up house in 1981 and remained throughout the next crucial decade. Deaths rapidly increased and there was widespread panic. No one knew how the disease was being transmitted. Top health officials were trying wildly to retain funding for research into AIDS but Reagan and his administration refused to utter the word AIDS let alone give it a dime.

AIDS became moral politics. Reagan's domestic policy staff thought a discussion of AIDS would involve debates over sexual practices and drug use and therefore it would alienate mainstream voters. Religious conservatives held signs saying "Praise God for AIDS" and public health officials made remarks to reporters like "Why are you making such a big deal of it? If it kills a few of them, society will be better for it."

Top health officials at the Centers for Disease Control knew the way to battle the disease was to target the populations hardest hit, but all AIDS material had to be cleared by the Reagan White House and they refused “pro-condom” messages on moral grounds.

The CDC then hired a high-powered advertising agency to receive advice on how best to market a prevention and education program. The advertising giant Ogilvy and Mather ran focus groups in several cities to gauge American attitudes toward AIDS. The results proved what gay activists already knew: Americans thought AIDS was someone else’s problem, that it was a disease that affected gay men and drug users and therefore they were not concerned. A Gallup Poll at the time showed one half of America thought AIDS was a punishment for moral decline and one fourth of Americans thought employers had the right to fire employees thought to have AIDS.

The CDC wanted to get people talking about AIDS and reduce the stigma. After much debate and in-fighting, the CDC decided their best bet was to present AIDS as everyone’s problem and so began the concerted effort making AIDS a heterosexual problem. Dr. Walter Cowdle, a CDC virologist and veteran of the war on herpes, at first fought for a targeted campaign but was beaten down by the Reagan administration and his CDC colleagues. “As long as this was seen as a gay disease or, even worse, a disease of drug abusers, that pushed the disease way down the ladder of people’s priorities,” he said.

Randy Shilts, a journalist who has since died of AIDS, told a reporter about the heterosexual shift: “A lot of gay men in AIDS organizations have spent years watching friends and lovers die,” and were convinced that research money was not available because AIDS was not perceived to be a general threat. He said there was a “concerted effort to create a heterosexual panic by gays, public health officials and scientists who want research dollars.”

The CDC’s award-winning campaign to democratize AIDS was launched in October of 1987 and featured 38 television spots, eight radio announcements and six print ads. The first ads focused on the universality of the disease and steered clear of specific transmission information. The campaign was highly effective. As a Wall Street Journal article says: “Millions of people were thus sold and resold on the message: Though AIDS started in the homosexual population, it was inexorably spreading, stalking high school students, middle-class housewives, doctors, dentists and even their unwitting patients.”

In 1991 Magic Johnson gave the heterosexual scare a boost when he announced he had acquired AIDS through promiscuous heterosexual behavior. (A dream come true for American moralists!) Mainstream talk shows and magazines, especially women’s magazines, pursued the subject relentlessly. Meanwhile, the CDC itself was producing research that made it clear the heterosexual fears were exaggerated. Some CDC scientists tried once again to refocus the AIDS campaign toward those most in need, but were drowned out by the mass media campaign.

The CDC well knew the images it represented in the media campaign were a misleading impression about who was likely to get the disease. The blonde middle-aged woman in the brochure was an intravenous drug user but was not identified as such. The television spot starring the morally elevated Baptist minister’s son who said: “If I can get AIDS, anyone can,” did not mention he was gay.

This sort of omission of information and misrepresentation continues to this day. Now that AIDS is a politically correct universal problem, billions of dollars are flowing, hence everyone in the “business” is invested in the propaganda. But as an excellent article in the Wall Street Journal points out, “AIDS Fight is Skewed by Federal Campaign Exaggerating Risks” (May 1, 1990) the shift in focus has created a perverse effect: Dollars are not necessarily going where they are needed.

Also new discriminations are unjustly created, like presenting female prostitutes as the AIDS assassins, even though the odds are about one to 8,000 of female-to-male transmission. Similar to the conclusion of the The Alliance article last month about AIDS in Africa, the intentional misleading campaign to make AIDS a heterosexual problem is not helping the thousands of Americans who are suffering from immune system destruction (AIDS).  
--end-- part 2

## Part 3: The paradoxical skinny on sex

(The Portland Alliance, September 2002)

by Kim Stephenson

The science of AIDS and HIV-related behavior is paradoxical and enigmatic. How can someone be HIV-antibody positive for a decade or more and never develop AIDS? Why do people who have died of AIDS appear not to have HIV in their bodies? Why does HIV not behave like other sexually transmitted pathogens? How can one individual have thousands of high-risk sexual encounters with an HIV-positive person and never become HIV infected or develop AIDS and why is it that another individual can have a single sexual encounter and acquire HIV?

It was my curiosity about the specifics of sexual transmission that plunged me into this series of stories on AIDS. My effort to understand sexual transmission and statistics represents the circling enigmas and paradoxes found within this scientific religion. In this article I want to share with you information I found on my journey.

Two years ago I read a local article that said more women were dying of AIDS, more than men, the percentage said. The article also said there was a large percentage increase of Oregon women contracting HIV heterosexually. I was alarmed. I also read national articles proclaiming AIDS in Africa was increasing by the tens of millions and that it was all heterosexually transmitted. Women prostitutes were allegedly responsible for transmitting HIV to many different men, each of whom then took HIV home to infect their wives, who then infected their babies. I was even more alarmed and curious as to how women could transmit HIV to men sexually, by the tens of millions. I thought I would gather information about a story on women and AIDS, with the classic journalism formula of profiling some local women and organizations and then stretch the issues out to show global and national trends.

My first stop was a visit with Thomas Bruner, the executive director of the Cascade AIDS Project (CAP). I asked him about sexual transmission and what's new in Oregon.

"Absolutely women can give HIV to men!" he said with enthusiastic conviction. "How exactly?" I asked. "If a man has cuts and lacerations on his penis it can happen," he said, adding that it was uncommon. Huh, I thought. If it's uncommon, how can African women be spreading HIV by the millions? This method of bumping sores or harboring cuts seemed similar to woman-to-woman transmission, I thought. It seemed a contradiction since ALL health agencies and experts say woman-to-woman transmission is nil, since it is common knowledge we (the author is a lesbian) are God's Chosen Ones, using the logic of the Religious Right.

I asked more specific transmission questions and Bruner repeated the two-pronged party line several times throughout our conversation: "I think everyone contracts HIV the same way: Through unprotected sex and sharing needles." He said AIDS is a fatal disease that is not gender-specific. He went on to emphasize that we need to stop looking at the epidemic in broad, all-encompassing categories like white gay men. I thought that category sounded pretty specific and that it's a category needing attention since about 87 percent of Oregon AIDS cases are white gay men.

He discouraged me from writing a story about local women with AIDS and instead had three other developed story ideas for me. Although CAP's media packet and citywide billboards were filled with the faces of white women and heterosexual families, I was shocked to learn CAP had no staff or programs for women. Bruner gave me the names and numbers for two women in the prevention department who act as CAP's women and AIDS contacts.

I first called Sonali Balajee and asked her about the number of Oregon women who had HIV or AIDS. She didn't know the numbers and encouraged me to contact the Women's Intercommunity AIDS Resource, a very small Portland nonprofit that is specifically for women. I said I will do that, but I would

still like the numbers from her. She referred me to the other CAP woman contact, Allison Goldstein. Ms. Goldstein also did not know the specific numbers of the “changing epidemic” and told me to look at the websites of the Centers for Disease Control and Prevention and the Oregon Health Department. I said I’ll do that, but since CAP keeps talking about the “changing epidemic,” I thought CAP could give me some statistics showing that. I called back several times. At one point she said she had her staff working on it and then said CAP was busy moving. I left more messages and finally she didn’t return my last call asking if there was someone else at CAP who might be able to answer my questions.

My next stop was Mark Loveless, the head AIDS/HIV epidemiologist for the Oregon Health Division. He said epidemiology would say receptive penile-anal sex would constitute the highest risk of HIV transmission and coming up second and third would be penile-vaginal intercourse and oral sex.

It still seemed vague to me. I was curious about the direction HIV was going in the vaginal and oral sex categories. I asked: “When you say vaginal intercourse, does that mean men are getting it from women’s vaginas, or men are giving it to women through their vaginas? And the same questions for oral sex, with the added variables of who is giving or receiving oral sex?”

Dr. Loveless appeared angry and curtly said “Again! I would have to do some significant research on good studies about women getting HIV!” (Dr. Loveless said prior to this question he was going to have to “do some significant research!” when I asked him about how much money the state of Oregon spends on AIDS, hence, “Again!”) I asked Dr. Loveless if he could refer me to any good studies about sexual transmission, and he said: “How could we do that! How could we study that?! How could we study of efficiency of male-to female or female-to male transmission?!” I was shocked, he was the expert, and didn’t know what to say.

Oregon’s head AIDS/HIV statistician said percentages are very misleading figures if they are very low and depending on what’s in the numerator and denominator. That clarified some confusion.

When I looked at the Oregon Health Division’s (OHD) Surveillance Report for 1990, I found 36 Oregon women had AIDS. In 1999’s report, the most recent annual report, I found there were 24 women AIDS cases in Oregon. I was shocked again. By reading The Oregonian and CAP’s material, I thought the epidemic was huge among women, instead I find AIDS cases have actually decreased in Oregon by one-third!

Blood, sex and money, we want drama and when we convert low numbers to percentages, they dramatically become big. With ALL AIDS cases in the denominator, in 1990 women made up 4 percent of all AIDS cases and in 1999 women jumped up to 11 percent, thereby showing a 7 percent increase! The change is due to the fact AIDS cases and deaths among white gay men have flattened out. The heterosexual woman increase that CAP and other organizations are fond of talking about is from 13 Oregon women with AIDS in 1990 to 14 women in 1999. Again, the 13 women in 1990 made up 36 percent of all AIDS cases among women and the 14 women in 1999 made up 58 percent, showing a 22 percent increase. Mainstream media do nothing but regurgitate misleading statistics that are fed them by AIDS organizations and health officials to continue private and public alarm and funding. Another big jump in women’s numbers occurred in the mid-90s when the definition of AIDS changed (for the third time) to include cervical cancer.

## **The scientific study of sex**

Next I went to the vast library of Oregon Health Science University and found what Dr. Loveless thought impossible: Hundreds of studies dryly and perversely detailing the efficiency of male-to female, female-to male, male-to male and female-to female HIV sexual transmission! The study of gay male sex was by far the most popular since that is where most HIV infection is purported to be, and far, far fewer heterosexual transmission studies were available, by comparison.

I found that although sexual transmission is studied and studied and studied, doctors do not like to come to clear conclusions. They like to say things like “male-to female transmission is eight to ten times more likely than female-to male transmission,” which would be dandy if they said what female-to male

transmission is, but they do not, because it is so small it is statistically impossible to calculate, they say. Another dizzying circle. I have seen over and over again the statistic that male-to female infectivity per contact is 0.0009, which means the likelihood of transmission is once every 9,000 sexual contacts. Yet I also saw the figure once per 1,000 sexual contacts for male-to female transmission and once per 8,000 contacts for female-to male transmission several times. Take your pick.

To contract HIV once every 1,000 to 9,000 contacts is really different from any other sexually transmitted disease, like syphilis or gonorrhea, for example. It takes on average only two or three unprotected sexual contacts to infect most people with most sexually transmitted diseases. And except for HIV, sexually transmitted diseases affect people in a pretty gender-balanced way. For instance, syphilis infects at a ratio of 60 percent female to 40 percent male, whereas the ratio for HIV infection is purported to be 10 percent female to 90 percent male in the US.

Studies often detail the "rugged vagina, fragile anus" idea to explain HIV transmission because studies have concluded the number one risk factor that is independent of all risk factors is receptive penile-anal intercourse with HIV antibody positive semen. Anal sex is risky, they say, because it is almost like shooting drugs. Semen goes directly into the bloodstream because the anal canal is thin, easily torn and quick to absorb liquids. The vagina is tougher and not as friendly to HIV. The vagina is elastic and is designed to stretch, lubricate, deal with punctures and be discerning about what it lets in. Also, the acidity of the vagina inactivates HIV, thereby making vaginal secretions not very contagious. Semen, on the other hand, has high pH levels and makes a favorable environment for HIV.

This makes sense, but statistically more heterosexuals engage in anal sex than gay men, so why are heterosexual women not affected to the same degree? Sexual behavior studies say more than 10 percent of heterosexuals engage in anal sex, and 10 percent of American heterosexuals far out number all gay men.

Many doctors and studies have questioned how present HIV is in semen. The first study to demonstrate the presence of HIV antibodies in semen was done by the doctor who co-discovered HIV, Dr. Robert Gallo. He found HIV in some semen and not in others and where he could find HIV, it was in extremely low amounts and transient. Another anomaly is that if semen is loaded with HIV, as the generalized message dictates, why has there not been significant infection via artificial insemination? Artificial insemination should be the gold standard of proof for heterosexual infectivity since semen is shot directly onto the cervix. In conventional terms, this would be a very high-risk activity, yet of the 80,000 women in this country who are artificially inseminated per year, only two have become HIV positive and no case of infant AIDS exists from this method.

Mothers are said to transmit HIV to their fetuses, but mothers give everything to their child (just ask any mother!) including her immune system. Babies pick-up Mom's HIV antibodies through the placenta but within the course of six months they shed it. Babies ride on Mom's immune system (and catch everything Mom has) until they build their own immune systems. The HIV test tests for HIV antibodies--if mom tests positive so will baby because baby has the same antibodies--if you test within the first six months. Most of the statistics we see about women and their HIV antibody positive babies are from intravenous drug using moms at public hospitals that test the babies right away.

I am two years along my journey and still I am swimming and circling through the puzzle of HIV and AIDS. These sexual transmission issues bring into question the true contagiousness of the HIV retrovirus and again we ponder if resources are being used properly. Maybe CAP could share some of its \$3+ million budget on chlamydia, for example, which newly infected 6,200 Oregonians in 1999, compared to 260 new infections of HIV for the same year. But government-funded health care isn't really interested in prevention anyway.

--- end-- part 3

## Part 4: Bad science, Bad Journalism

### The HIV retrovirus: Discovery or invention

#### What is HIV Virus and how was it discovered?

by Kim Stephenson

Have you seen “The Truman Show” starring Jim Carrey? Carrey plays Truman, who is the unknowing star of a reality television show transmitted throughout the world. Truman is happily living his perfect life in a perfect suburb with a perfect wife until he begins to catch some clues that something just isn't right. The film is about his process of discovering his entire life, and all of his physical surroundings, are fabricated. The island he lives on is the world's largest television set, viewable from space. Everyone is in on it; Truman is monumentally deceived. His wife, mother, best friend, co-workers and thousands of townspeople are nothing but actors.

When Truman realizes what's going on, he breaks out of his home and hops into a sailboat to get away. After surviving a brutal storm induced by the show's creator, the water is calm and his boat abruptly hits the side of the dome that looks like the sky. Truman is stunned and slowly he touches the wall. As he touches it, he lets out a sigh of relief. Finally, he knows and feels reality! He is angry and beats the wall with his fists; then he collapses and cries.

While researching the subjects of this article, I felt like Truman as he touched that wall. For years I reported on HIV/AIDS for the Seattle Gay News with energy and empathy. I have done a lot of what I consider to be promotional writing to bring attention to countless AIDS events and fundraisers. I edited a minimum of five obituaries per week of young gay men who were said to die of AIDS. I never once questioned, nor did I hear anybody else question, the science behind the discovery of HIV and its connection to AIDS - it was all steadfastly assumed. “HIV/AIDS facts and figures” were fed to us at the gay press by AIDS organizations that were on the front lines of the bloody battle. They were articulate and repetitive about the sexual transmission of HIV. To question the science behind the new retrovirus HIV and its causation to AIDS would be like questioning if the sky was really blue. Or maybe our reality had been constructed, like Truman's.

### Defining AIDS: a collection of known diseases

AIDS is not a disease. It is not one disease but a collection of 29 known diseases; which include “signs” of bodily distress, like unexplained weight loss. If you deconstruct the acronym, Acquired Immune Deficiency Syndrome, you can see it hinted AIDS is a group of symptoms that characterize immune system breakdown. Media presents AIDS as being a disease (“AIDS is a disease of poverty, AIDS is sexually transmitted;”) but the nation's official AIDS registry, the Centers for Disease Control and Prevention (CDC), has always said AIDS is a bunch of diseases, none of which are new. All media representatives seem to fall into non-questioning guilty stupors when AIDS is involved and fail to ask such questions as: “What did the patient actually die of?”

If they did, the answer would be: pneumonia, Kaposi's sarcoma, lymphoma, tuberculosis, herpes simplex, the “wasting syndrome,” chronic intestinal isosporiasis, candidiasis of the bronchi, invasive cervical cancer, recurrent salmonella, esophageal candidiasis and 19 other known diseases. These are now “opportunistic infections of AIDS” - if you test HIV antibody positive.

Currently we are at 29 known diseases that are defined as AIDS and we are always anxiously awaiting more. The definition of AIDS has changed at least five times since its invention in 1982. Maybe you noticed a lot of stories about the increase of women with AIDS around 1993 or a little after? The news stories forgot to tell readers the CDC added cervical cancer, along with several other female-specific conditions, to the definition of AIDS that year.

Some of the most important and absurd definition expansions were in 1987 and 1992. In 1987 the

CDC said that even if a patient's immune suppression disorder was already known, like from chemotherapy or born with a congenital immune deficiency, the patient should be counted and regarded as an AIDS patient. In 1992 the CDC said anyone having a low T-cell count has AIDS, even if the individual is not sick, has no symptoms or "opportunistic infections," and has not taken an HIV antibody test. The flu really should be considered to be part of AIDS, because if you receive a flu shot or have the flu, you would test positive on the HIV antibody tests (Enzyme-linked Immunosorbent Assay and Western Blot).

AIDS is the first disease in history that no one can survive by definition, thereby delivering a hopeless and demoralizing message to those diagnosed HIV antibody positive. Once someone is diagnosed with AIDS, he or she stays in that category forever, regardless of improvement or cause of death. There are no criteria listed in any definition that allow a person to fight, and beat AIDS, unlike cancer or heart disease or any other illness.

The difference between hope and certain doom (by official definition) is how you do on the HIV antibody test. It all comes down to the test. The difference between having AIDS or pneumonia is the test. The difference between having tuberculosis or AIDS is the antibody test. Here's the equation: pneumonia + HIV antibody = AIDS; pneumonia - HIV antibody = pneumonia. Tuberculosis + HIV antibody = AIDS; tuberculosis - HIV antibody = tuberculosis. So, the crucial subject worthy of investigation is: what is HIV and how do you test for its existence?

## **Retroviruses and HIV**

AIDS orthodoxy says HIV is an infectious retrovirus that hijacks the genetic structure of the body's cells, creating more and more of itself to overpower the immune system and make the individual succumb to one of the 29 diseases.

The discovery of retroviruses came about 1970, when Nixon declared a war on cancer and hundreds of millions of dollars were thrown toward research into a viral cause of cancer. The research seemed promising at first because retroviruses do not kill infected cells but integrate into the cell's cancer-causing agents. A retrovirus raids a host cell with the help of an enzyme that catalyzes the synthesis of the host's DNA from RNA. This is called "reverse transcriptase activity" and it may be a clue a retrovirus is there, but not definite identification. Cells without retroviruses also have this activity.

A contradiction surfaces at this base level because if HIV is a retrovirus, how can it kill T-cells? Killing T-cells (immune-helpers) is a cornerstone of AIDS. Retroviruses replicate like crazy, which is a cornerstone of viruses. [Head-scratcher #1.]

The viral war on cancer failed and in 1977 the National Cancer Institute Virus Cancer Program was abruptly closed. But seven years of money and time allowed scientists to thoroughly research and explore retroviruses. Out of that research came protocols for identifying and isolating retroviruses. It was agreed among scientists that an alleged retrovirus must be completely isolated in order to identify its proteins, nucleic acids and RNA/DNA structure, so it is not confused with other confounding cellular matter, which also has its own proteins, nucleic acids and RNA/DNA. Scientists need to identify the thing itself before they can make assumptions about its components, which are the basis for tests and cures.

"Proof for the existence of a virus is unconditionally contingent upon finding a right looking particle (virus-like) that is able to faithfully replicate," says Val Turner, emergency physician at the Royal Perth Hospital in Australia. Turner goes on to explain the virus identification process. "Merely seeing a particle, even viral-like, is not sufficient proof because multiplication is the name of the game with viruses. The method of convincing oneself, or the whole world, that a virus exists is: 1) to grow whatever cells are thought to contain the virus 2) purify the particles, so they are not confused with the cells in which they were grown or constituent proteins or acids 3) document these chemical constituents 4) introduce pure particles into a virgin cell culture and prove what comes out is exactly the same as what went in."

Number two and four seem to be especially challenging to HIV. An accepted fact in retrovirology is to

use the original Pasteur Institute virus isolation protocol. Scientists do this by spinning virus-like particles around real fast and particles fall down the test tube in accordance to their density. Retrovirologists agree retroviruses should band at the 1.16 gm/ml density band and that this protocol should be able to be replicated by anyone in the world.

Although knowledge of retroviruses became solid through the 1970s, there was no solid evidence retroviruses played a role in cancer. One good try was by a National Institute of Health (NIH) virologist, Dr. Robert Gallo, when in 1975 he said he had isolated the first human retrovirus from a leukaemia patient. It turned out his samples were contaminated with retroviruses from a monkey, a gibbon and a baboon and therefore his retrovirus connection to human leukaemia was not valid.

## **Gallo's HTLVs = HIV**

Gallo was heavily involved and committed to finding a viral cause to cancer and leukaemia during the 70s. Gallo's sister had died of leukaemia at a young age and it had a darkly profound affect on Gallo and his family. Gallo was also an exceedingly ambitious and competitive personality and those close to him said only his ego challenged the size and fury of his competitiveness and ambition. Imagine the prestige of being the scientist to discover the cause of AIDS - the touted "disease(s)" of the twentieth century," expected to surpass the Black Plague in deaths. This man or woman would surely be awarded God-like status and the Nobel Prize would be a given. Why has the Nobel Prize not been given for discovery of "the cause of AIDS?"[Head scratcher #2].

Gallo's retrovirus money was drying up and he desperately needed a breakthrough. He thought he found one when he grew cells of a leukaemia patient and saw reverse transcriptase activity. Gallo claimed it was a retrovirus because he saw transcriptase activity, but he did not isolate the virus with the aforementioned process. He called his new retrovirus Human T-cell leukaemia virus or HTLV-I. (Then came HTLV-II and HTLV-III became what is now known as the HIV retrovirus.)

There were some now-familiar contradictions right away (that Gallo admitted) like why is HTLV readily found in perfectly healthy people, and how could it be that only one percent of those "infected" with HTLV ever develop leukaemia? [Head-scratcher #3]

## **Fast track to the "AIDS virus"**

In 1982 Gallo presented the hypothesis that the cause of AIDS is a retrovirus. A year later, colleagues of Gallo claimed they found antibodies to HTLV-I in AIDS patients and Gallo made the same claim at about the same time. However, while HTLV-I was accepted to cause T-cell proliferation and cause leukaemia, the hallmark of leukaemia, the hallmark of AIDS was T-cell depletion. [Head-scratcher #4] Gallo noticed the contradiction and easily fixed it by simply replacing the "L" in HTLV from "leukaemia" to "lymphotropic" and later the messy "L" was dropped altogether for HIV. Wha la! Isn't science easy?

In the same month, Dr. Luc Montagnier of the Pasteur Institute in France described the isolation of a retrovirus from the lymph nodes of a homosexual man with lymphadenopathy. Samples of this virus, called Lymphadenopathy Associated Virus (LAV) were sent to Gallo's laboratory on several occasions. Montagnier had not written a paper yet and Gallo offered to look through the draft before publication. Gallo offered to write an abstract for Montagnier's paper and read it to him over the phone. Gallo's last sentence read: "The virus appears to be a member of the human T-cell leukaemia virus (HTLV) family," thereby linking the two in history. Montagnier said he never would have agreed to that statement but he didn't understand Gallo's English. This is important because conventional HIV science is based on these discoveries of Montagnier and Gallo.

Gallo was desperately trying to find a solid connection to his retrovirus family and AIDS, and in 1984 his team was testing the blood of people with AIDS. They had a hard time finding any HTLV, so they used hothouse techniques and pooled together a brew of selected, cancerous cell lines from ten different patients. Gallo said he found another retrovirus in the blood of these samples and called this one HTLV-III, which would later be abbreviated to HIV. Needless to say, pooling together several blood samples is very

bad science and is far, far removed from actually isolating and proving a retrovirus is there. But it was good enough for Gallo and the US government, who wanted an answer to this embarrassing, deadly problem without discourse.

On April 23, 1984 Health and Human Services Secretary Margaret Heckler, with Dr. Gallo by her side, announced that Gallo and his co-workers “had found the probable cause of AIDS” and they had developed a sensitive test to show whether the “AIDS virus” was present in the blood. Gallo filed for a US blood test patent, which he had developed, the same day. It was a public relations event that will forever reverberate in history.

It is important to note this announcement was made before any scientific papers of Gallo’s were published that shared an experiment and findings claiming HIV isolation and its link to AIDS. What was probably most damaging was when The New York Times splashed the announcement on the front page, saying the cause of AIDS had been found and it’s the “AIDS virus.” Science is a community based on a sportsman-like premise that says, “You come up with an idea, and we - the rest of the community - will see if we can tear you down or replicate your findings.” Normally, papers are published and other scientists mimic the experiment and publish their findings in the form of confirmations or disproofs. This never happened with the “discovery” of HIV. The next month Gallo and colleagues did publish four papers in Science, but those papers did not isolate HIV by identifying it under electron microscope nor was isolation at the 1.16 gm/ml band achieved.

It turned out Gallo actually stole Montagnier’s LAV sample and photograph when they were sent to his lab. Gallo used Montagnier’s stolen sample for his published papers making the claim to have found HIV, the cause of AIDS. He needed to steal the sample, because he was having a hard time finding what he wanted to find. A big battle ensued because now the stakes were very high if LAV a la HTLV-III (HIV) was “known to cause AIDS.” Just imagine the royalties on the HIV test! The discoveries, inventions and subsequent patents of scientists are profoundly lucrative for their employer. In Gallo’s case, it was the US government’s National Institute of Health (NIH). Gallo’s inventions provided over half of the organization’s enormous income.

The Pasteur Institute alleged that Gallo had misappropriated LAV in developing the HIV blood test. The conflict ran through American courts and ended when President Reagan and French Premier Francois Mitterand got together to cut the pie down the middle and agreed both Gallo and Montagnier could claim to be the “co-discoverers of HIV” and, most importantly, both would share royalties.

This conflict caught the attention of investigative journalist John Crewdson and he published a lengthy article in the Chicago Tribune. The article caught the attention of a US senator and three formal inquiries followed. One inquiry was done by the NIH, and (big surprise) they thought Gallo’s actions did not meet the formal definition of misconduct. Then the case was kicked to the Office of Research Integrity and Gallo was found guilty of scientific misconduct. (If you would like to read in detail about this fiasco, check out Crewdson’s book *Science Fictions*, available at Multnomah County library.)

Although the “co-discoverer” of HIV was found guilty of scientific misconduct because he “created and fostered conditions that give rise to falsified/fabricated data and falsified reports,” all HIV/AIDS information, statistics and treatments are based on his science. [Head-scratcher #5]

The four Gallo papers published in Science in 1984 and Montagnier’s first paper are the reference and proof of HIV and its causation to AIDS. Montagnier never thought his LAV was related to Gallo’s HIV family and later he said he thought HIV alone is harmless. For a detailed analysis of these papers, please use the internet and go to: [Virusmyth.net](http://Virusmyth.net) - Find - Papadopoulos et al Eleni (Eleni Papadopoulos) or The Perth Group. (Also see attached resource list sidebar.)

We, the public, who are concerned with HIV infection and AIDS, play Truman in this reality show. The creator, the man in “The Truman Show” who manipulates the drama from a fake sun, is not Gallo, but the

large, nebulous health organizations that are fused with government. Gallo, and present day rhetoric-with-no-evidence shouting orthodox scientists, health care providers and AIDS organizations are simply our best friends, mothers and spouses.

Kim Stephenson is a freelance writer and regular contributor to the Alliance.

---end-- part 4

## **Resources**

***AIDS: The Failure of Contemporary Science: How a Virus That Never Was Deceived the World*, by Neville Hodgkins**

***Rethinking AIDS: The Tragic Cost of a Premature Consensus* by Dr. Robert Root-Bernstein.**

***Positively False: Exposing the Myths Around HIV and AIDS*, by Joan Shenton**

***Prescription For Profit: How the Pharmaceutical Industry Bankrolled the Unholy Marriage Between Science and Business*, by Linda Marsa**

**The AIDS War: Propaganda, Profiteering and Genocide from the Medical-Industrial Complex, by John Lauritsen**

***AIDS: The HIV Myth*, by Jad Adams**

***The Gravest Show on Earth: America in the Age of AIDS*, by Elinor Burkett**

***Inventing the AIDS Virus*, by Dr. Peter Duesberg**

***Science Fictions* by John Crewdson**

***What if Everything You Knew About AIDS Was Wrong?*  
by “long-term HIV survivor” Christine Maggiore**

## Part 5

### bad Science, bad Journalism

#### How accurate are the HIV tests and a talk with a long-term thriver

(The Portland Alliance, November 2002)

By Kim Stephenson

I consider myself a long-term thriver," says Garland Perry, a Portlander who has tested HIV antibody-positive for more than 18 years. "I never did like that 'survivor' stuff. In 1984 when the test was first announced by Gallo at a press conference, I dutifully ran down like other active gay males and got tested. I tested positive then and have every year since.

"I was skeptical from the beginning," Perry continues. "I was suspicious that a single agent caused AIDS and I thought conservatives would just love to say all gay sex is dangerous. I had come to not believe everything the government said was true because of my political awareness about Central America. I personally don't believe HIV can make anybody sick and my last three boyfriends have come to believe that also.

"I have never been deathly ill and I have never taken any HIV drugs. It's not to say I don't have health problems; I do, but I think HIV is only one minor thing my body has to deal with, if it is there at all. I have migraines, but I think it is because I stared at a computer for 15 years and I have carpal tunnel because I typed so much. I do have a fragile immune system, but I always have, since I was a kid. I have to really support myself, eat right, stay active, etc."

Perry says he has seen the best HIV doctors in Portland and they have not exactly helped him create a vision of vitality and hope. "Marcia Coodley of Fanno Clinic told me the image I should think of is that my health is like a train that is headed for a cliff, and that I may feel fine now, but I am going to reach that cliff and I had better get on drugs. I have been to all the doctors that the gay community thinks are good, have good bedside manners and are warm and understanding. But they give me the cursory look-over and tell me I should go on cocktails."

"Cocktails" is the gay camp term for protease inhibitors, the newer combination drug therapy that is supposed to be superior to its patient-killing precursor AZT, a liquid chemotherapy.

Perry attends classes and functions at Project Quest and The Immune Enhancement Project and has seen his fellow HIV-positives who are on cocktail therapies. "They talk about the side effects a lot — nausea, diarrhea and the protease paunch — and they look puffy and gaunt at the same time, and I find it very disturbing. They (doctors) attribute the drugs to the decline of AIDS, but I wonder if it's because they stopped AZT and have decreased the dosages of cocktails.

"I think the reductionist view to look to a test tube to explain peoples' health is wrong. Health is not a single thing. Do people have community? Joy? Proper food and shelter? Many, many things contribute to health," Perry says.

Western medicine has been stuck on the "magic bullet" theory for some time. One disease, one cause — and lucky for those drug companies — one cure. Perry is a moving, thriving example of one HIV/AIDS paradox: how can someone so consistently be "loaded" with HIV yet never succumb to the 29 diseases known as AIDS?

The Centers for Disease Control and Prevention (CDCP) takes care of it by throwing Perry and thousands like him into the category: HIV positives who have not yet acquired any "opportunistic infections." This "latency period" has curiously gotten longer and longer since its first creation. About 17

years ago it was two to four years, then it doubled to eight years and now “experts” are telling us a lethal virus may be innocently lying dormant in our bodies for 15 years to a lifetime. This fantasy creation of a “latency period” just adds more fear to the sexually active general public. Conventional HIV/AIDS theory cannot explain why thousands of people like Perry exist so they made-up the latency period; there is no scientific evidence for it.

The paradox of Perry points to three possible things, alone or in combination: 1. HIV does not exist (it has never been properly isolated); 2. HIV is a harmless passenger retrovirus like other retroviruses; or 3. the tests to identify HIV are not accurate.

The Alliance has covered number one and two in previous issues. The HIV retrovirus and the flawed science behind its “discovery” were the subjects discussed last month. As was noted, AIDS is defined by an HIV antibody-positive status. The difference between having pneumonia, for example, or having AIDS is the outcome of an HIV antibody test. Here’s the equation: pneumonia + HIV antibody positive test = AIDS; pneumonia — HIV antibody positive result = plain ol’ pneumonia.

## **Virus isolation and the tests**

It was also discussed last month that HIV has proven impossible to obtain directly from patient tissue and it has eluded standard retrovirology techniques to achieve isolation. To isolate an alleged new virus is a tenet of virology. How can you know what is really there and identify its elements, like proteins and RNA/DNA, if you do not see it all by itself? Because test manufacturers do not have a sample of HIV to see under an electron microscope, they use another technique of spinning the alleged virus around real fast and its proteins fall in accordance to their density. When these proteins are exposed to “AIDS” blood, the antibodies that attach to them become the basis for the ELISA and Western Blot tests.

Since AIDS is not one disease, but any one of 29 known diseases, there is not an “AIDS test.” What is commonly known as the “AIDS test” in the U.S. is the ELISA (enzyme-linked immunosorbent assay) and the Western Blot. These identify antibodies that react to proteins that are allegedly proteins of HIV. There is also a lesser-used, expensive test that reads genetic fragments of what is believed to be the RNA/DNA of HIV called the PCR (polymerase chain reaction) test. In the U.S., two ELISA tests and one Western Blot test confirms an HIV-positive status. Confirmation of an HIV status differs throughout the world. There are no standards for what constitutes a HIV-positive status in the U.S. or anywhere in the world.

## **Depends on where you test....**

As was noted in the July issue of The Alliance, African HIV/AIDS statistics are based on estimates, and when a handful of pregnant women are tested, only one test is administered and it is the most unreliable (the ELISA). The World Health Organization and the CDCP admit that if someone has or has had malaria or tuberculosis they test positive on an ELISA test. Britain has ceased using the Western Blot test because experts there agree it is unreliable, yet U.S. experts say the Western Blot is highly specific to HIV and boasts it is 99 percent accurate when used with an ELISA. Britain uses the ELISA test, which the Centers the CDCP says is not accurate (4 out of 5 ELISA positives are Western Blot negative) and should only be used for screening. Who or what is right? It’s only our lives that are at stake.

## **The ELISA**

Having antibodies to an illness used to be a good thing until AIDS came along. Creating antibodies is the idea behind vaccines such as those for polio. A vaccine is a small dose of the alleged cause itself, so the immune system can develop its strategy and army needed to ward off the foreign invader. In AIDS science, however, antibodies are the kiss of death and evidence to begin taking highly potent pharmaceutical “cocktail” treatments.

The ELISA test was developed in 1985 and it is thought to be highly sensitive but extremely non-

specific. The ELISA detects antibodies to groups of proteins thought to be HIV proteins. They are specified “p” for protein and a number that represents their molecular weight. HIV is recognized by p24, p17, p41, p120 and others, and it wasn’t until the early 90s that researchers thought to look into how ubiquitous these proteins might be.

A group of Australian researchers (known as the Perth Group) reported finding the proteins are not specific to a unique retrovirus but are due to the immune system being activated by a variety of reasons. P24, which was the only protein thought to be truly specific to HIV, was found in more than 40 percent of patients with multiple sclerosis and about 13 percent of people with generalized warts, for instance. And they pointed out that p24 was not found in all AIDS patients and over one-half of those testing p24-positive later tested negative.

In fact, it is common someone can test positive on the ELISA and when time passes and they retest, they test negative. The U.S. Army has a policy to test and wait a couple of months to retest because of all the false positives. Four out of five ELISA positives are Western Blot negative.

The Perth Group argues maybe all positives are false positives because the main AIDS risk groups — gay men, drug users and hemophiliacs — are all exposed to foreign substances known to cause immune dysfunction and antibody reaction, such as semen in the bloodstream, recreational drugs and Factor 8 (for blood clotting).

The CDCP states in its 1993 test guidance report that ELISA results “should never be used alone to report a final positive result” and should only be used for screening purposes. The 1994 edition of “AIDS Testing,” a 400-page text edited by CDC experts, even admits that “the virus cannot be detected directly by conventional molecular biology techniques,” and that HIV is highly inactive, which should have put HIV in a very different category from other infectious viruses.

All of this means the ELISA often gives a false positive result, yet it remains the most widely used test in the Third World. Scientific literature has documented at least 70 conditions that trigger a false positive result on the ELISA, including pregnancy, autoimmune disorders, fever, the flu and flu shots. The U.S. Army has a policy to not test soldiers if they have had a flu shot in the last six months. The Army has found flu shots almost always give false positive results.

## **The Western Blot test**

The Western Blot test also identifies a selection of proteins but they are thought to be more specific because the proteins are separated. A strip of nitrocellulose paper is incubated with a dilution of a blood sample. If antibodies to those proteins are present, one is said to be positive.

The Perth Group took a hard look at the Western Blot and ELISA tests in a 1993 Bio/Technology paper entitled “Is a Positive Western Blot Proof of HIV Infection?” They say both tests are seriously flawed because: 1. They are not standardized; 2. The tests are not reproducible; — and back to the original science — 3. HIV lacks the gold standard of science, virus isolation.

Any antibody test only becomes meaningful when it is standardized, which means a test result has the same meaning in all patients, in all laboratories, in all countries. This sure ain’t the case with HIV. In the study, one blood sample was sent 89 times to three different labs. It was positive 64 times, indeterminate 23 times and negative once. I could literally fill The Alliance with instances of varying test results and wild inconsistencies.

From the first antigen-antibody reactions performed by Montagnier and Gallo (co-discoverers of HIV), it was found that not all of the “HIV proteins” react with all blood sera from AIDS patients. Even sera from the same patients obtained at different times did not react in the same way to the same tests. Also, they noted that sera from AIDS patients may react with proteins other than those considered to be HIV

antigens. This is what you call cross-reaction and there is lots of it with HIV.

Laboratory definitions of what constitute a positive result are all over the map. In the beginning, most laboratories used the CDCP criteria that said the presence of either the p24 and p41 protein means a positive result. But by 1987 it became apparent these proteins were not specific to HIV. There is still no nationally agreed upon criteria among major U.S. labs for Western Blot interpretation! Laboratories have their own differing criteria about a positive result but agree a negative result requires the absence of any and all protein bands including those that do not represent "HIV proteins." (Do they want us to be positive?)

Because there are no standards for the ELISA or Western Blot tests, even first-class labs produce differing conclusions, thereby being unable to reproduce the same results. Since the beginning of the epidemic, many AIDS patients do not test HIV-positive and many who do test positive never get sick. The CDCP has relaxed its criteria for the Western Blot to get over the embarrassing fact that fewer than half of all AIDS patients test positive for HIV!

If all this isn't enough, human bias also exists to throw off the reliability of HIV tests. Journalist John Lauritsen sent the same blood sample to a lab under different risk categories. He found the same sample of blood tested positive when the lab thought it came from a gay man and negative when technicians thought it came from a heterosexual.

## **PCR**

The polymerase chain reaction (PCR) test was invented by Dr. Kary Mullis who won the 1993 Nobel Prize in chemistry for it. Dr. Mullis is a leading AIDS "dissident" and says if you have to use his test to see anything, it is biologically insignificant. The PCR test is used by AIDS orthodoxy to monitor "AIDS patients" who are on drug treatments. The PCR measures the famous "viral load," which dissidents affectionately call a "viral load of crap."

PCR technology amplifies the tiniest amount of any DNA sequence, to find the proverbial needle of HIV in a haystack of DNA. Dr. Eric Barklis, Associate Professor of the Department of Molecular Microbiology and Immunology at OHSU, explains it simply: "The PCR test detects an essential part of a virus, but not the virus itself. An analogy would be that if you had a way of detecting car engines, you could be confident a working car is there. But of course, some car engines are in factories and others are in cars but no longer work."

The PCR test costs a couple of hundred dollars, so only the privileged who have submitted themselves to conventional drug therapy generally receive it.

## **Betting our lives**

It seems clear there are serious questions about the reliability of HIV tests and it is a crime against humanity since so many people bet their life on it. Perry is lucky. He did not feel the need to commit suicide upon hearing of his HIV status, nor did his partner come home to murder him and his children. This happens frequently around the world. In the U.S., people like Perry live with the pressure of possible death, looming and waiting, and others begin taking toxic drug treatments out of fear and misinformation.

"I am resentful if it is a big illusion, a big lie, which I think it is," says Perry. "Our community was torn apart by this. AIDS came to nip our growing gay rights movement in the bud, which I think could have helped the rights of all people. It was stopped by a fundamentalist belief system that said gay sex (or even all sex) is evil and therefore it kills people."

Kim Stephenson is a freelance writer and regular contributor to The Portland Alliance.

---end-- part 5

## **Resources:**

AIDS: The Failure of Contemporary Science: How a Virus That Never Was Deceived the World,  
by Neville Hodgkins

Rethinking AIDS: The Tragic Cost of a Premature Consensus,  
by Dr. Robert Root-Bernstein.

Positively False: Exposing the Myths Around HIV and AIDS,  
by Joan Shenton

Prescription For Profit: How the Pharmaceutical Industry Bankrolled the Unholy Marriage Between  
Science and Business, by Linda Marsa

The AIDS War: Propaganda, Profiteering and Genocide from the Medical-Industrial Complex,  
by John Lauritsen

AIDS: The HIV Myth,  
by Jad Adams

The Gravest Show on Earth: America in the Age of AIDS,  
by Elinor Burkett

Inventing the AIDS Virus,  
by Dr. Peter Duesberg

Science Fictions,  
by John Crewdson