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THE MYSTERY OF HIV/AIDS



TENS OF MILLIONS of HIV tests accumulated over twenty years of testing show that HIV is not a sexually transmitted infection.

That conclusion is diametrically opposed to “what everyone knows”. But the data pointing to the conclusion are in the public domain. The website of the Centers for Disease Control and Prevention (CDC) offers—and permits downloading of—a number of special reports as well as full sets of the *Morbidity and Mortality Weekly Report* and the *HIV/AIDS Surveillance Report*. Those include summaries of data from blood banks, surveillance of military personnel, and results from a wide variety of published sources as well as data obtained under the auspices of the CDC itself. All applicants for military service, and all active-duty and reserve personnel, have been routinely tested, and the results are publicly available from the website of the Army Medical Surveillance Activity. Scores of peer-reviewed articles in *JAMA* (formerly *Journal of the American Medical Association*), the *New England Journal of Medicine* and similar periodicals contain results and analyses of HIV tests on a wide range of various sub-groups of the American population.

Between one quarter and a half of the population of the United States has been tested for HIV at least once. Most of the tests have been on individuals regarded as being at low risk of AIDS. (Those at high risk form a very small proportion of the population—people who abuse drugs, and promiscuous drug-abusing gay men. Though everyone knows that AIDS first struck in gay communities, it is not widely appreciated that AIDS has struck only those gay men who have had heavy recourse to drugs of one sort or another—“recreational”, antibiotics, chemotherapeutics, antiretrovirals.)

This mass of data, then, tells about HIV in the general population. Across the country and across all social sectors, a small but steady fraction of a per cent of seemingly healthy people test HIV-positive. Soon after testing began in 1985, the CDC estimated that about 1

million Americans were infected. The same estimate was arrived at year after year during the 1980s, and the latest estimate, announced in a press release in June 2005, again was that about 1 million Americans are infected. That million corresponds to about 0.3 per cent, in other words it is consistent with the data from tests on low-risk groups.

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Proportions as small as fractions of a per cent raise the question of whether false positives or some other artefact might be confounding the data. There are several reasons

why that cannot be the case here. First, all the data come from official reports and peer-reviewed publications; if these data cannot be relied upon, then nothing said about HIV could be believed, as all of it is based on tests performed in this manner. Second, I submitted my data analysis to the CDC and was rewarded with a letter stating that the data are correct and that the trends I note are real and not artefacts. Third, HIV-positive tests on all groups show uniform trends by age, sex, race and geographic distribution, at levels of HIV ranging from fractions of a per cent to 10 per cent or more; false positives would then either be in negligible proportion or would vary with age, sex and race in precisely the same way as HIV infection—an incredible eventuality which, even if it were true, would not vitiate conclusions drawn from those variations by age, sex, race and geography.

But could not the positive tests on low-risk groups merely reflect the occasional inclusion of a few high-risk individuals? Definitely not. AIDS victims—who define the high-risk category—were 95 per cent males throughout and beyond the 1980s, whereas the ratio of HIV-positive men to women is much less in all tested groups; indeed, among young teenagers, females are more frequently HIV-positive than are males. Moreover, the observed uniform trends by age, sex, race and geography would mean, if high-risk individuals had significantly contaminated low-risk groups, that high-risk and low-risk individuals have identical demographic characteristics, which is evidently not so with regard to sex.

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Many reports, sometimes illustrated by maps, describe the geographic distribution of HIV in the United States. That geographic distribution has been the same since 1985, and it is the same for every population sub-group: blood donors; military personnel—separately for active-duty and potential recruits; members of the Job Corps; people tested at public sites; women who have just had babies. But the distribution is not uniform across the country. In every case, the prevalence of HIV is greatest along the Atlantic coast and in the South, especially the South-East and North-East; Washington DC and Puerto Rico are typically highest in HIV prevalence, and they are almost always among the top five out of fifty-two (the fifty states plus DC and Puerto Rico). Something whose distribution has remained unchanged over a period of two decades, and which is distributed all across the country in a characteristically non-uniform fashion, is not a sexually transmitted infectious agent.

That the national average of HIV-positive individuals is about 0.3 per cent tells only a small part of the story. Between one and two decades of continuous data are available on four separate and large sectors of the population: military personnel (on the order of 10 million tests over twenty years); the Job Corps (about 50,000 tests per year for more than ten years); blood donors (about 1 million tests a year); people tested at a variety of public testing sites (2 million tests per year over ten years). All four groups show a *decline* in HIV prevalence since 1985, indicating that the constant estimate for the nation as a whole may not be reliable. But whether constant or declining, this is certainly not a spreading infection.

As a matter of fact, there is even direct evidence that HIV is not infectious, that it is not readily transmitted. At least four independent studies in different countries have shown that HIV is transmitted by unprotected sexual intercourse with an efficiency that is well below 1 per cent, more like 1 in 1000 acts of unprotected intercourse. (How could such studies be carried out? Is it not unethical to observe, in effect to encourage, unprotected intercourse between an HIV-infected person and a non-infected one? That is a separate issue. The fact is, the studies were done.) By contrast, gonorrhea or syphilis are transmitted with efficiencies well over 10 per cent.

HIV is not even passed on via inadvertent punctures with infected needles. Medical personnel, even in the military, are not at risk of infection. By 2001, about 800,000 cases of AIDS had been reported in the United States; over that period, the CDC found only 57 possi-

ble—not proven—instances of HIV infection of health-care workers through accidental needle-stick. Even more striking: two studies at separate drug-treatment clinics—in two different countries—revealed higher rates of HIV infection among drug users who did not share needles than among those who did.

But if HIV has been endemic and invariant in the United States for at least two decades, then it was also not the cause of the AIDS outbreaks around 1980 in New York, Los Angeles and San Francisco. The geographic distribution of HIV does not indicate a spread from those cities. And since HIV is transmitted so inefficiently, it could not have covered the whole country, in all social groups, by the time testing began in 1985. (The official view is that there is a latent period of about ten years between HIV infection and symptoms of AIDS. Thus HIV is supposed to have arrived in those three cities around 1970. Transmitted at a rate of about 1 per 1000, and starting among gay men and drug users, it could not have become widespread in the general population across the country in fifteen years. Even in the AIDS epicentre of San Francisco, women giving birth to children test HIV-positive only a few

per thousand, just as in other low-risk groups; yet there could hardly be a locality where a sexually transmitted infection would be more likely to pass from gay men into the general population.)

BUT HOW COULD everyone have been so wrong for so long? And what, then, did cause AIDS? And how about AIDS in Africa?

Everyone has not in fact been wrong; it is just that the popular media have made it appear that there is no doubt about HIV causing AIDS. One of the world's leading retrovirologists, Peter Duesberg, has argued for two decades that no retrovirus could do what HIV was supposed to. Kary Mullis, the Nobel laureate who invented the technique everyone uses to detect and measure DNA, has repeated over and over again that no proof has been published that HIV causes AIDS, and that the use of his technique to measure "viral load" of HIV is erroneous. Robert Root-Bernstein, MacArthur ("genius award") fellow and physiologist, has explained in detail why HIV cannot be the sole cause of AIDS. Other competent and eminent people are among many hundreds who have signed petitions asking that HIV/AIDS theory be re-examined.

Those arguments entail complex technical matters of molecular biology, and it is understandable that journal-

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ists sidestep the technicalities argued by a few individuals and simply accept official words from the CDC, the World Health Organisation, the World Bank, UNAIDS, and the like. There has been a lack of sustained investigative reporting. As a result, no one seems as yet to have realised that HIV/AIDS theory fails to explain the mass of available data on HIV tests: the apparently endemic presence of HIV in the United States, its unchanging geographic distribution, and the fact that the prevalence since 1985 has declined rather than increased.

Once one begins to doubt HIV/AIDS theory, however, other instances of the failure of that theory are not hard to come by. For example: Kaposi's sarcoma (KS)—a very rare cancer that produces purple patches on the skin—was so common in the first outbreaks of AIDS that it became a sort of logo of AIDS; yet for at least a decade it has been widely known that HIV cannot be found in most victims of KS, and that KS is hardly ever now seen among people diagnosed with AIDS; indeed it is now generally accepted that something other than HIV causes KS. Even the autobiographies of Luc Montagnier and Robert Gallo, the co-discoverers of HIV, remark on that; and moreover both admit—albeit in passing and without emphasis—that something in addition to HIV is needed to produce AIDS. The real experts know that HIV does not cause AIDS; it is popularisers and bureaucracies that have not yet realised it.

The HIV data display fascinating other aspects beside the unchanging geographic distribution. HIV prevalence depends in characteristic and constant fashion, among all tested groups, on age, sex and race, in ways that are quite different from what is found with gonorrhea, syphilis and other sexually transmitted infections. Further exploration of those trends will doubtless lead to better understanding of what HIV tests actually detect.

WHAT IS AIDS? Most likely, immune systems ravaged by abuse of a variety of drugs. As already remarked, it was drug-using gay men who first came down with AIDS. It is happenstance that AIDS was first noted in gay communities; it is not an inevitable concomitant of gay sex. Those who abuse different drugs get different opportunistic infections.

So what is HIV? It appears that HIV tests detect a physiological response, perhaps specifically by certain parts of the immune system, to a variety of health challenges. That has long been proposed by researchers in Western Australia, the so-called Perth Group. Some HIV data support that view quite strongly. For example,

reformed drug addicts test HIV-positive less often than those still using drugs, and the longer they have been away from drugs, the less frequently do they test HIV-positive. (By contrast, HIV/AIDS theory sees a positive HIV-test as marking *permanent*, irreversible infection.) Again, groups not at particular risk of AIDS but certainly ill in some way often test HIV-positive: about 5 per cent of psychiatric patients, for instance, have tested HIV-positive, as have hospital patients admitted for reasons having nothing to do with AIDS. The better the average health of a given group, the lower is the prevalence of positive HIV tests: repeat blood donors test HIV-positive a few times per 100,000 but first-time donors test positive about ten times more often; military personnel test positive a few times in a thousand, but members of the Job Corps—disadvantaged, unemployed youth—test positive about ten times more often than that.

As to Africa, that's another story. From the earliest times of AIDS in the 1980s, no HIV tests were regarded as necessary to diagnose someone in Africa as having AIDS; in 1986 it had been agreed (the so-called Bangui definition) that continuing weight loss, persistent fever, and persistent diarrhea justified a diagnosis of AIDS. Yet those symptoms do not differentiate from malaria and many other common tropical ailments. African "AIDS" victims do not display the same opportunistic infections as characterised AIDS in the United States (and other developed countries). AIDS in Africa has little to do with AIDS in America—except among some of the more affluent Africans who indulge in drugs.

All this is so contrary to "what everyone knows" that it seems incredible. No one should take anyone's word for it. The only cure for the disbelief is to look at the copious available data on HIV tests in the United States. I have scanned every relevant CDC report and many scores of other publications. All support and none contradict the view that HIV has always been in the United States in its present distribution and at about its present rate. My suggestions as to what HIV is, and what AIDS is, are just that, suggestions; but the conclusion that HIV is not a sexually transmitted infection, and that it did not cause the AIDS outbreaks of the 1980s, is no suggestion or inference of mine—it follows directly and inevitably from the publicly available data.

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