DAVID RASNICK

What are the statistics regarding AIDS and HIV infection in Africa?

> *"I think it is time to start questioning some of the claims made by the Aids lobby. Their certainties are so fanatical, the powers they claim so far-reaching. Their authority is ultimately derived from computer-generated estimates, which they wield like weapons, overwhelming any resistance with dumbfounding atom bombs of hypothetical human misery. Give them their head, and they will commandeer all resources to fight just one disease.*
> Rian Malan, 2003 [1]

Decline of AIDS and Genesis of HIV/AIDS

When the term HIV/AIDS replaced AIDS in the late 1990s, it completely muddied the water. The rationale for transmuting AIDS into HIV/AIDS was never formally articulated.

This change was facilitated when the US Centers for Disease Control (CDC) elevated the status of two laboratory results in its 1993 definition of AIDS to allow an otherwise healthy American with antibodies to HIV and fewer than 200 CD4 cells per microliter of blood to be defined as an AIDS case [2]. Solely on the basis of this provision of the 1993 definition, the number of new AIDS cases increased three-fold, literally overnight. (Figure 1) [3]. This new category, which was to become HIV/AIDS, destroyed the distinction between HIV and AIDS.

The equation HIV=AIDS=disease=death that has been drilled into the public psyche since 1984 also made it easy for the AIDS orthodoxy to promote the new label HIV/AIDS. But why was there a need to replace AIDS with HIV/AIDS?

When AIDS (defined by real diseases) is tracked and reported, the epidemic is shown to have essentially burned itself out throughout the world, including Africa (Figure 2), by the beginning of the new millennium. Instead of publicizing the good news, the CDC stopped reporting actual AIDS cases after 1997. The number of new cases had been dropping steadily since 1993 (Figure 3) [3]. Ever since, computer models have been cranking out apocalyptic numbers of an exploding pandemic of HIV/AIDS.

The CDC keeps track of the number of new AIDS cases according to three definition categories, each of which expanded what constitutes AIDS: pre-1987, 1987 and 1993. The CDC's rule is that the diagnosis of AIDS must be made according to the earliest definition that qualifies. This rule makes the dramatic increase in the proportion of new AIDS cases (now called HIV/AIDS) based on the 1993 definition even more striking. From 1994 to 1997 the proportions rose from 49 to 68% (Table 11, from page 17 of reference [3]).

Manufacturing the African HIV/AIDS Pandemic

The current HIV/AIDS pandemic is solely dependent on divining how many people around the world have antibodies that react with the so-called HIV tests. I say divining because over 95% of the computer-generated 40+ million people with "HIV/AIDS" have never been tested for antibodies to HIV, as most are poor Africans. Therefore, in order to generate the colossal African HIV/AIDS numbers, the AIDS orthodoxy extrapolates from results for HIV-antibodies in pregnant Africans [4-6]. These extrapolations are absolutely necessary to generating an ever-growing virtual pandemic of HIV/AIDS.

It is generally accepted that South Africa has the best statistics in sub-Saharan Africa. Before 1998, two HIV-antibody tests had been performed for the South African surveys: one screening test and a confirmation test on the positive samples. The second test was skipped from 1998 onwards (except in Western Cape) even though richer countries usually require four tests to define someone as HIV-positive: an initial positive ELISA, at least one of two follow-up ELISA tests being positive followed by a positive Western Blot.

The manufacturer of the HIV-antibody test that was used in these (see reference [4]) and earlier surveys, specifically warns that, "at present there is no recognized standard for establishing the presence or absence of HIV-1 antibody in human blood." Furthermore, it also warns that "non-specific reactions may be seen in samples from some people who, for example, due to prior pregnancy...have antibodies to the human cells or media in which HIV-1 is grown for manufacture of the EIA" [7]. [EIA stands for "Enzyme-Linked Immunassay"; the abbreviation "ELISA" is also used (NdE)]

In other words the test, which may show false positive reactions in women with "prior pregnancy", is being used in pregnant women without further confirmation or adjustment.

This can explain why "Studies from seven African countries over the last 15 years show rates of HIV incidence during antenatal and/or post-partum periods exceeding what could be expected solely from sexual transmission" [8]. Yet, these problematic, unconfirmed results from pregnant women are then used to estimate the frequency of HIV in the general population [5] and eventually the whole of sub-Saharan Africa [6].

Reality Check

Ultimately, any real pandemic, regardless of its name, would at some point be made obvious by a surge in disease and death, well-above normal levels. The question, then, is: is there evidence, independent of extrapolations and computer-generated numbers, showing extraordinary increases of disease and death? An ability to keep track of the annual number of deaths, irrespective of cause, is all that is needed to determine if something unusual is going on.

Statistics South Africa (Stats SA) reports a constant growth in the population of South Africa from 38 million in 1994 to 43 million in 2001 [9, 10]. Furthermore, the rise in the number of deaths from all causes during the same period was also constant, growing as the population grows—but no faster (Figure 4).

The latest antenatal screening survey in South Africa also failed to support the hypothesis that HIV is sexually transmitted [4] but instead confirms the conclusion of Brewer et al. that, "HIV is not transmitted by 'sex'" [11]. The survey included testing pregnant women for syphilis and antibodies to HIV in order to see how the two diseases were correlated by geographical location and over time. But, there was no correlation.

On the contrary, in 2000, KwaZulu-Natal, which is leading when it comes to HIV, has the lowest rate of syphilis in all provinces. Western Cape, on the other hand, had the highest rate of syphilis but the lowest HIV prevalence. Paradoxically, there is an inverse geographical correlation between syphilis and HIV (Figure 5) although both are said to be transmitted by heterosexual intercourse.

An even more extraordinary result is the divergence over time between an increasing prevalence of antibodies to HIV and a declining rate of syphilis (Figure 6) [4]. This is also difficult to understand given the assumption that both are sexually transmitted.

A 1999 study in Uganda produced similar results. The intention of the study had been to reduce HIV incidence by mass treatment of STD [Sexually Transmitted Disease]s with conventional antibiotics. The rationale behind the study was that reducing STDs (which was assumed to be a co-factor in the transmission of HIV) should reduce the transmission of HIV. However, the result of the study was paradoxical. While the investigators were very successful in significantly reducing STDs, their intervention had "no [effect] on incidence of HIV-1 infection..." [12].

The data from Thailand show that these inconsistent results are not peculiar to Africa. Even though Thailand is said to be severely hit by a heterosexually transmitted HIV-epidemic, we find, yet again, the same scenario presented by South Africa and Uganda. Bangkok has the highest rate of STDs but low HIV prevalence. Conversely, the so called Golden Triangle of northern Thailand has the highest rate of HIV but the second lowest STD morbidity of all regions. And, even within the different provinces of the Northern Region there is a negative correlation between HIV and syphilis [13]. The conclusion from these observations is obvious: HIV cannot be heterosexually transmitted.

Given these and other impossibilities surrounding AIDS, President Thabo Mbeki convened the Presidential AIDS Advisory Panel in Pretoria, South Africa in May 2000 to answer basic questions. Many of the panelists were excited by the prospect of obtaining the very latest and best information and statistics on AIDS in South Africa. However, this was not to be. As stated in the Interim Report of the meeting released in March 2001:

> "The deliberations of the panel were at all times bedevilled by the absence of accurate and reliable data and statistics on the magnitude of the AIDS problem or even HIV

> prevalence in South Africa. Repeated requests for such data and statistics, failed to result in the provision of such data by either South African panellists or the officials of the Department of Health." [14]

So, where does one find the best statistics on AIDS in Africa, if not South Africa?

Something Doesn't Compute

A perusal of the World Health Organization Global Health Atlas website (http://globalatlas.who.int/globalatlas/dataQuery/default.asp) allows one to query for the actual number of annual AIDS cases (not HIV/AIDS) from 1979 through 2001 for 167 countries. You can also ask for cumulative numbers for years 2001 and 2003 for 210 countries.

You will find many curious bits of information in the WHO database. For example, the cumulative number of AIDS cases in the USA for 2001 and 2003 were identical: 806,157. If one is to believe this result, then there were no new AIDS cases in the USA between 2001 and 2003. The USA is not the only country so privileged. Robert Gallo's four African countries all had unchanging totals —Kenya: 81,492, Botswana:10,178, Uganda:55,861and South Africa:12,825.

Globally, the cumulative total number of AIDS cases as of March 27, 2006, reported on the WHO Global Health Atlas website was 2,965,292. The WHO has not updated this figure since 2003, which is interesting in itself. A likely reason for not keeping the database up to date is revealed by a simple plot of the annual number of globally reported AIDS cases for the period 1979-2001 (Figure 2A). Such a graph shows AIDS cases rising from insignificant numbers through the mid 1980s to a peak in 1995 (analogous with the CDC's 1993 peak for the USA (Figure 3), followed by a precipitous decline through 2001. The cumulative total for the entire world produced by this graph is 2.8 million through 2001. The cumulative total for sub-Saharan Africa is 1.1 million AIDS cases (Figure 2B). By the end of 2003, the total had climbed to only 1,15 million. According to the WHO database, Africa gained an average of just under 23,000 new AIDS cases per year.

To get a feeling for the meaningfulness of these AIDS numbers, one must compare them to the population explosion Africa experienced during the quarter-century of AIDS. From 1980 through 2005, the sub-Saharan Africa gained 358 million people [15], equivalent to 1.3 times the population of the USA. However, as of March 2006, the WHO reported, as described above, a total of only 1.15 million AIDS cases (not HIV or HIV/AIDS). Even if all of those 1.15 million peopled died, their deaths due to AIDS would be difficult to detect in a background of 358 million new sub-Saharan Africans. It also needs to be mentioned that African AIDS-defining diseases are indistinguishable from conventional African morbidity and mortality [16].

The WHO's tally of just under 3 million global AIDS cases spread over a quarter-century is much less alarming and useful to the AIDS orthodoxy than its computer generated 24

million to 48 million cases of HIV/AIDS for 2003 alone (figures obtained from the same WHO website above).

The complete disconnect between the number of actual AIDS deaths compared to computer-generated numbers based on the HIV/AIDS model was eloquently documented by the revered South African author Rian Malan in his 2001 article "AIDS in Africa: in search of truth" [17]. Malan is not alone in his criticism of what he calls the AIDS lobby. Because of the many epidemiological and clinical differences between African AIDS and its American/European namesake, and because of the many uncertainties about the statistics on African AIDS [18] both the novelty of African AIDS and its relationship to American/European AIDS have recently been called into question by a number of others [18-25].

In conclusion, the computer generated cases of HIV/AIDS has transformed a disappearing AIDS epidemic, the real diseases and actual deaths, into a new global pandemic of hypothetical infections and virtual corpses.

References

1. Malan R. **Africa isn't dying of Aids**. *The Spectator* 2003 December 13.
2. Centers for Disease Control and Prevention. **1993 revised classification system for HIV infection and expanded surveillance case definition for AIDS among adolescents and adults**. *Morb Mort Weekly Rep* 1992,41(No. RR17):1-19.
3. Centers for Disease Control and Prevention. **U.S. HIV and AIDS cases reported through December 1997, Year-end edition**. *HIV AIDS Surveillance Report* 1997,9:1-43.
4. Makubalo LE, Netshidzivhani PM, Mulumba R*, et al.* **Summary Report:NATIONAL HIV AND SYPHILIS SERO-PREVALENCE SURVEY IN SOUTH AFRICA**. In. Pretoria, South Africa: Directorate: Health Systems Research, Research Coordination and Epidemiology; 2001.
5. Ntsaluba A. **National HIV and Syphilis Sero-Prevalence Surveyof women attending Public Antenatal Clinics in South Africa 2000**. In. Pretoria, South Africa: Ministry of Health, Director-General for Health; 2000:13 pages.
6. UNAIDS. **2004 report on the global HIV/AIDS epidemic: 4th global report**. In: *Joint United Nations Programme on HIV/AIDS*. Geneva; 2004.
7. Abbott Laboratories Diagnostics Division. **Human Immunodeficiency virus type 1 HIVAB HIV-1 EIA**. In. Abbott Park, IL: Abbott Laboratories; 1997.
8. Gisselquist D, Rothenberg R, Potterat J, Drucker E. **HIV infections in sub-Saharan Africa not explained by sexual or vertical transmission**. *Int J STD AIDS* 2002,13:657-666.
9. Statistics South Africa. **Causes of death in South Africa 1997-2001**. In; 2002.
10. Statistics South Africa. **South African Statistics 2000**. In; 2000.
11. Brewer DD, Brody S, Drucker E*, et al.* **Mounting anomalies in the epidemiology of HIV in Africa: cry the beloved paradigm**. *International Journal of STD & AIDS* 2003,14:144-147.
12. Wawer MJ, Sewankambo NK, Serwadda D*, et al.* **Control of sexually transmitted diseases for AIDS prevention in Uganda: a randomised community trial. Rakai Project Study Group**. *Lancet* 1999,353:525-535.
13. Chitwarakorn Aea. **Sexually Transmitted Diseases in Asia and the Pacific**. Region 10, Chiang Mai, Thailand: Ministry of Public Health, AIDS Division, HIV/AIDS Situation in Thailand; 1998.
14. Secretariat for Thabo Mbeki. **Presidential AIDS Advisory Panel Report**. In. Johannesburg; 2001.
15. Bureau of the Census. **World population by region and development category: 1950-2025**. In. Washington, DC: U.S. Department of Commerce; 2001.
16. World Health Organization. **Provisional WHO clinical case definition for AIDS**. *Weekly Epidemiological Records* 1986,March, 7, (10):72-73.
17. Malan R. **AIDS in Africa in search of the truth**. *Rolling Stone* 2001 November 22:70-72, 74-78, 80, 82, 100, 102.
18. Fiala C. **AIDS in Africa: dirty tricks**. *New African* 1998:36-38.
19. Shenton J. **Positively False: exposing the myths around HIV and AIDS**. London/New York: I. B. Tauris; 1998.

20. Stewart GT, Mhlongo S, de Harven E*, et al.* **The Durban Declaration is not accepted by all**. *Nature* 2000,407:286.
21. Gellman B. **S. African President Escalates AIDS Feud**. *Washington Post* 2000:Sect. A01.
22. Fiala C, de Harven E, Herxheimer A, Kohnlein C, Mhlongo S, Stewart GT. **HIV/AIDS data in South Africa**. *Lancet* 2002,359:1782.
23. Ross E. **Sub-Saharan Africa, Kenyia and the Malthusian paradigm in contemporary development thinking**. In: *Reclaiming Knowledge for Diversity*. Edited by Pimbert M: Routledge or Earthscan; 2003:in press.
24. Gisselquist D, Rothenberg R, Potterat J, Drucker E. **HIV infections in sub-Saharan Africa not explained by sexual or vertical transmission**. *Int J STD AIDS* 2002,13:657-666.
25. Hodgkinson N. **AIDS: the failure of contemporary science**. London, UK: Fourth Estate; 1996.

Posted: April 12, 2006
Scienza e Democrazia/Science and Democracy
www.dipmat.unipg.it/~mamone/sci-dem