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# **The Deadly Fallacy of the HIV-AIDS-Death Hypothesis: Exposing the Epidemic that Is Not**

by

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*"We cannot live without sex," .... "What else is there, where is the enjoyment? We might as well be dead."*

- National Geographic, April 1988.

- a man in a village living a hard existence of daily physical chores in Rakai in Uganda when told that the AIDS epidemic was contracted through sex.

## **INTRODUCTION**

The "HIV-AIDS-caused-by-sex-equals-to-death" disease is one of the most compelling and sensational to have been discovered and widely publicized in recent times. It has penetrated the deepest sinews and fibers of the American society and some of the remotest sectors of the international community. It is even an accepted part of the lexicon of disease today. "The emergence and spread of this lethal new disease in the past decade has had a dramatic impact on virtually every facet of American life. AIDS is now a household word."(Flanders and Flanders, 1991:3)

The disease is perhaps as sensational as the European Black Death and may be the worldwide influenza epidemic of 1918 (Fettner, 1990; Ziegler, 1969). Both these plagues wiped out millions of humans. The HIV-AIDS "plague" or "epidemic", however, lacks the merit of millions of dead even after ten to fifteen years of dire predictions from the dominant medical community that infections and deaths would escalate. What has gone wrong? Does the HIV-AIDS disease exist? Does the virus exist? Is HIV really infectious? How many humans may be needlessly dying or being subjected to severe emotional stress all over the world today because of possible continuous relaying of erroneous information and use of possible flawed HIV tests? Is there a possible cover-up, and are human greed, selfishness and just plain carelessness and negligence the culprits? How much of this can be explained by political correctness and desire for tolerance in a multicultural world? How much of this is explained by the possible excesses of the explosion of sophisticated medical technological advances? How much of this is the out

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come of the excesses of the electronic information super highway and cyberspace? In spite the possible compromising of basic scientific principles and ethics in the process, can science still come to the rescue from the possible harm that public health and science are perhaps being subjected to? This paper has four main objectives.

First, the paper will describe the basic tenet of the HIV-AIDS-equals-to-death hypothesis and the major controversy surrounding the disease. Second, the paper will challenge the validity and reliability of the HIV-AIDS-equals-to-death hypothesis. This possible erroneous hypothesis has been maintained and in some cases ruthlessly protected and used as the impetus or lynch pin for driving national and international public health policy. The third objective will explore the positive and negative real life implications and outcomes for science and public health in Western and non-Western societies in clinging on to and promoting a possibly severely flawed HIV-AIDS-equals-to-death hypothesis. Lastly, recommendations on what science, Africans and perhaps the public should do to investigate, counteract, correct, and if possible remove the illegitimate and perhaps scandalous influence of the HIV-AIDS orthodoxy.

### ***HIV-AIDS-death Hypothesis***

The basic tenet behind the HIV-AIDS-death hypothesis is that once the human body contracts the Human Immunodeficiency Virus (HIV), it evades the immune system defenses and attacks it, rendering the body defenseless. Because of the compromised and weakened immune system, the body becomes vulnerable to opportunistic infections such as diarrhea, encephalitis with dementia (HIV infection of the brain), toxoplasmosis of the brain (a protozoan infection), Kaposi Sarcoma, herpes simplex, herpes zoster, cytomegalovirus(CMV), Candida albicans infections (oral thrash), pneumocystis carinii pneumonia (PCP), toxoplasma gondii and other lower respiratory infections such as tuberculosis or a persistent cough. Such symptoms as fever, muscle ache, exhaustion, fatigue, loss of appetite, night sweats, swollen lymph glands and weight loss accompany many of the illnesses. This condition is known as the Acquired Immunity Deficiency Syndrome. Some of the group of the numerous opportunistic infections that the patient becomes victim of are known as AIDS-Related complex (ARC). There is believed to be an incubation period between HIV infection and the onset of AIDS. This period may range from a few months to as many as thirty years (Shenton, 1998: p.10) The infected person dies of complications from the massive attacks from many opportunistic infections. (Root-Bernstein, 1993; Mukonde, 1992; Agadzi, 1989; Flanders and Flanders, 1991; www.planetrx.com). What is the controversy surrounding the HIV-AIDS hypothesis?

The controversy today is centered on a number of contradictory epidemiological findings and evidence that have been gathered over the last eighteen years. The evidence strongly suggests that some of the most central and emphasized assumptions and generalizations that are the cornerstones of the etiology of HIV-AIDS, might be right out wrong. If this is the case, then science and the public are not only being misled with possible erroneous information, but thousands if not millions are needlessly harmed or even dying because of the bad and alarmist public health policies and programs. These programs are generated and buttressed on the basis of this possible erroneous information. The HIV-AIDS disease has been portrayed as very complex covering an incredible number of

pathologies. The disease is said to be caused by an equally cunning and complex virus. It is no wonder that the disease has numerous corollaries. These corollaries of the HIV-AIDS hypothesis include its origins, transmission (sexual activity, intravenous drug use, blood products and hemophilia, pregnant women and breast feeding babies, contaminated needles), diagnosis, prognosis, cure, community management and response, moral implications and financial lucrativeness of the HIV-AIDS industry (drugs, research, testing kits, public campaigns), and the virus' national and international or cross-cultural ramifications. A paper of this limited scope cannot adequately explore all of these corollaries in detail. Instead, it will explore what might be the major flaw in the central foundation of HIV-AIDS hypothesis. The flaw effectively creates grave doubts or even collapses most of the adjoining theories about origins, transmission, diagnosis, prognosis, and cure. There is a very simple test that the HIV-AIDS-equals-to-death hypothesis has largely failed.

### ***Koch' Postulates***

Koch was a German microbiologist who first discovered the cause of tuberculosis. He also was the first scientist who laid down the criteria that has to be used to determine whether there is an infectious agent causing a particular disease. His four postulates are incredibly simple and HIV-AIDS research suggests that none of these have been met to an acceptable degree.

- *The particular germ must be found in all patients and in enough quantities to cause the disease.* The HIV virus germ must be found in all the patients who have the AIDS disease and the germ or virus must be found in enough quantities to cause the illness. It is estimated that the HIV virus cannot be isolated or found in an estimated 10 to 20 percent of AIDS patients.(Root-Bernstein, 1993:94-100; Shenton, 1998:96-100) For the amount of devastation that HIV is said to cause in AIDS patients, there is so little HIV found in AIDS patients that detection is done indirectly. The procedure is that the scientists take a huge amount of cells from the AIDS patient and through a complex laboratory process reactivate the virus. "If HIV were a powerful pathogen, it could reasonably be expected that high levels of virus would be found in people with AIDS. Given the attention HIV has received, it might be expected that laboratories would be testing the levels of virus in the blood of AIDS patients and healthy carriers night and day. .... In general, people have not been able to detect any substantial levels of virus in AIDS patients and that has been one of the most puzzling aspects of the viral infection."(Adams, 1989:72). The logical question to ask is, "if the virus is this inactive, undetectable or perhaps even dead in severely sick patients, how can it cause so much pathology or harm?" In the majority of diseases, enough active virus or germ is found to be isolated directly from the patient's blood or affected tissue. For example, at the height of viral infections when the patient is really sick, one million to ten thousand million units can be found in every millilitre of blood. This is not the case with HIV-AIDS patients however as less than five units and never more than a few thousand units of the virus are found per millilitre of blood plasma.(Adams, 1989) The United Nations recently published very alarming statistics about the estimated number people who are HIV positive all over the world. It is estimated that Sub-Saharan Africa has twenty-six million people who are HIV positive. If HIV

cannot be isolated from 20% of infected individuals, wouldn't it be likely that as many as 5.2 million Africans may not in reality have the HIV virus at all? (Ankomah, 1998) Where the HIV virus has been found, it has been in such small quantities that it is unlikely to have caused the great damage that is attributed to the virus.

- *The germ that is the culprit in a particular disease must be separated from other germs and must be isolated from the patient or host's body.* The HIV virus must be differentiated or distinguished from other germs and it must be isolated from the patient's body (Shenton, 1998). This criteria has not been met. The two HIV tests that are used merely detect the presence of HIV antibodies. They supposedly determine whether the individual has been exposed to the HIV. As will be discussed later, these tests have serious flaws one of which is high levels of false positives. But the most intriguing aspect about this criteria is that even when some of the most advanced and sophisticated indirect tests are used, HIV is detected in very low levels. When the molecular hybridisation is used, "One HIV gene can be detected in ten or one hundred and a cell contains a million genes. To put it another way: the quest for the genetic material of HIV material must be sensitive enough to detect less than one gene in a million to ten million genes. With these tests, the genetic material of the virus (proviral DNA, to be specific) has been found in only fifteen percent of patients. If it is not detected in the other eighty-five percent, that means there is less of it or it is not there. The latent virus - not replicating, just existing - can be found in fifty percent of AIDS patients." (Adams, 1989:75) Adams (1989) further says that another advanced test known as the PCR (polymerase chain reaction), for isolating the virus also yields similar unfavorable results suggesting that even these indirect tests for detecting the HIV cannot find it with any high levels of certainty.
- *When the germ is introduced in a new host or person, it must cause illness.* The HIV virus must cause the AIDS sickness when injected into a healthy person or other hosts (Shenton, 1998). Experiments have been conducted over the last ten to fifteen years in which chimpanzees have been injected with the HIV have never developed AIDS. Health care workers who have been accidentally injected with HIV have not developed AIDS.
- *The HIV virus must be isolated again from the newly infected or diseased person or host* (Shenton, 1998). Since all the above have not been satisfactorily met, especially the third one of the postulates, the HIV is far from meeting this criteria.

It must be emphasized that these criteria should not really be used to simply silence the HIV-AIDS orthodoxy or to settle the argument once for all. But rather it should be used to open new avenues for finding what must really be killing people. According to Shenton (1998), these criteria can be used to differentiate between whether an infectious or toxic agent is killing people. The evidence so far strongly suggests that HIV might not be an infectious agent because it does not meet any of these criteria. In fact, many HIV-AIDS investigators have asserted that HIV does not behave like a typical infectious agent because it is very difficult to transmit between healthy heterosexual individuals who are the vast majority of the population (Root-Bernstein, 1993: 220-258; Shenton, 1998:69-73). Confirming this difficulty, Plumley, Chair of the Society of Actuaries Task Force, is quoted as saying:

“...since the vast majority of people have neither high-risk behavior nor a high-risk partner, their risk of HIV infection from normal (genital) sexual intercourse is so

remote as to be almost non-existent - generally considered less than one chance in a million per episode, about the same as winning a state lottery or being struck by lightning. ....it is now clear that HIV is very hard to transmit to healthy people. ...statistics demonstrate that most Aids victims are homosexual men or drug abusers who have a lifestyle that creates immune system disorders.”(Hodgkinson, 1996:127)  
*(Underline and brackets mine)*

### **Diagnosis of HIV-AIDS**

The standard diagnostic tool used to test HIV is whether an individual's blood tests positive or negative for the virus. For the vast majority of the public, the negative result means one is free of the virus but the positive one has dire emotional and physical consequences. This may include being ostracized in the community, sometimes suicide (Shenton, 1998: 62-65), with the likelihood of inevitable death. But what is the HIV test testing for and what should it mean for one's health if the test is positive or negative?

The HIV test does not directly detect the presence of the virus because viruses technically can never and have never been isolated in their pure culture form in the laboratory(Root-Bernstein, 1993:99). But rather it determines whether the immune system has been exposed to HIV by determining whether or not HIV antibodies are present in the blood. There are two kinds of tests used: the Elisa (enzyme-linked immunosorbent assay) and the Western blot test.

The tests use a variety of selected proteins that are believed to belong to the HIV virus. These are separated and isolated by the test manufacturer and inserted on a strip of nitrocellulose paper. The blood sample to be tested is then incubated with these strips. If the antibodies to the particular HIV virus proteins are present, they will bind with certain of the proteins on the strip. The two tests use identical procedures. The major difference is that in the Elisa test the variety of antibody proteins bind to the strip as a group. In the Western blot test the antibody proteins bind in separate individual bands making the test more specific and accurate (Hodgkinson, 1996:233).

Hodgkinson (1996) examines the scientific basis for these tests and studies that have been made to test the validity and reliability of these HIV tests. Due to its high rate of false positives, the Elisa is used by the Center for Disease Control as a screening tool to initially examine any suspicious blood samples. The Western blot test is regarded as being more reliable and therefore used as the confirmatory test. A Bio/Technology review article published in June 1993, however, suggested that both tests have questionable validity and reliability as testing procedures and the results are based on possible erroneous assumptions. The study “not only presented evidence confirming the Elisa test's unreliability, but demonstrated that the western blot was also incapable of determining whether people were really infected with HIV. ....a positive HIV status has such profound implications that no one should be required to bear the burden without solid guarantees of the verity of the test and its interpretation.”(Hodgkinson, 1996:234)

Three criteria must be met in order for the HIV test to be declared valid and reliable. First, *the material used in the test must be identifiable and reliable*. The source of the HIV-specific antigen, or the protein components to which antibodies bind, is unreliable. Since the HIV virus has never been isolated in a pure form, mere assumptions have been

made about the testing process. For example, the assumption that some material that bands at a density of 1.16 grams per milliliter when spun in a centrifuge represents “pure” HIV and RNA proteins is just an assumption. But then these bands are the same ones used to manufacture the proteins for HIV tests. Many of the protein bands that are supposed to react to HIV antibody proteins have been shown to react positively to just mere immune system activation without the HIV virus. (Hodgkinson, 1996:234)

*Second, the test must be standardized.* The HIV tests lack standardization such that a positive Western blot test should have the same meaning and interpretation in all patients, in all laboratories, and in all countries. As things stand now, the proteins that are numbered according to their molecular weight that have been considered most important in triggering antibodies to HIV are p120, p41/45, p55, p31/32, p24/25 and p17/18. “An FDA-licensed western blot kit, used by a minority of laboratories, required a positive result on three different bands, p24,p31, and either p41, p120 or p160. When these stringent criteria were used, less than 50% of AIDS patients tested HIV-positive. The Consortium for Retroviruses Serology Standardization, however, defined a positive western blot as the presence of antibodies to at least p24 or p31/32, and p41 or p120/160. Using these criteria, the proportion of Aids patients testing positive increased to 79%.”(Hodgkinson, 1996:236) Hodgkinson further says that other laboratories and organizations use different standards.

Lack of standardization alone, which is known as the gold standard as the crucial scientific proof of validity, makes the HIV-AIDS-sex-equals-to-death hypothesis more questionable. When these same HIV tests are used internationally in societies where economic, health, environmental and epidemiological conditions may be remarkably different from the Western or American society, the life and death conclusions that are based on the tests are even more alarming.

*Third, a valid test must be reproducible.* In other words, in the case of the HIV, given the same or identical samples of blood, laboratories should come up with the same results be they negative or positive. Again, according to Hodgkinson(1996), the HIV test has repeatedly failed this criteria. To illustrate how the Western blot HIV test is irreproducible, the Transfusion Safety Study conducted a study in the US. Four samples of blood were subjected to the Elisa and the Western blot test. Two were found HIV positive and the other two negative. These samples of blood were then sent to three different laboratories to be tested sometimes as many as seventy times. The results showed astounding differences. Some of the negative results came out positive several times. Some of the blood was HIV negative on some or a few of the bands but not on other protein bands. These variations mean that: “In Australia, for example, atleast four protein bands are required, in Canada and much of the USA three or more and across Africa two will do. So all an African has to do is to be retested in Australia where he or she might be found negative.”(Shenton, 1998:229)

All this means is that the diagnosis of HIV positive ness and negative ness based on the tests is very unreliable. It is therefore, unconscionable and immoral that the HIV-AIDS orthodoxy does not confront this issue so that thousands and perhaps millions of people in the US and the world can be relieved of the death sentence that is often the HIV positive blood test result. At least, a moratorium can be issued on the wide use of these tests until their true meaning can be determined beyond all this confusion.

The HIV diagnosis has another confounding aspect. The unreliability of the test and its lack of specificity, which is an outcome lack of standardization, are serious flaws. But the question to ask is: 'How did HIV-AIDS achieve this high profile medical status in the first place?' The origins of HIV-AIDS may have been ignored or largely forgotten by now. But when the AIDS epidemic first became known in 1981, it was exclusively associated with homosexual men in the US. It was known as Gay-Related Immune Deficiency (GRID). The majority of the sick men had not only used drugs but they had had sex with anywhere from three thousand to twenty thousand different partners(Shiltz, 1987:131-132; Hodgkinson, 1996:15). During this early period, the HIV positive test and the AIDS diagnosis was associated with a limited number of diseases especially Kaposi Sarcoma, oral thrush, dysentery, cytomegalovirus (CMV), Epstein-Barr Virus, herpes simplex I and II, venereal warts, and fever.

But as the HIV test's use has been expanded and extended nationally and internationally, more and more clusters of disease may be erroneously diagnosed as HIV-AIDS related. For example, in Africa diseases and symptoms that may be associated with malaria, TB, and other infections may be misdiagnosed as HIV-AIDS related. "...there are abundant scientific publications warning that there are more than 70 different conditions that make the current HIV test show positive reading when in fact the person is not infected with HIV at all. It is interesting to note that most of these 70 conditions are present in the majority of people who live in developing countries"(Giraldo,1998:41; Ankomah,1998:40)

The point to keep in mind is that an unreliable HIV test combined with an expanded list of clinical diagnosis of AIDS has probably led to thousands if not millions of misdiagnoses. It should be emphasized that this is putting a death sentence on people who may be innocent. African and other Third World countries have inadequate resources for medical treatment and prevention of such endemic diseases as malaria, TB and other respiratory infections, yellow fever, elephantiasis, sleeping sickness, whooping cough, childhood dysentery, kwashiorkor and marasmus child malnutrition diseases. "In tropical Africa, AIDS and HIV-seropositivity are virtually synonymous with regions in which malaria is endemic. ....Studies in Africa and Venezuela have found that malaria often results in false-positive HIV tests and may be a risk factor for HIV infection independent of blood transfusion."(Root-Bernstein, 1993:304-5) Hodgkinson confirms these assertions when he says: "In the third world, it was very difficult and in some situations impossible to disentangle Aids from malnutrition, and from epidemics of sexually transmitted diseases and other infections in what were often chronically diseased populations .....concerned that HIV testing, whose reliability was particularly questionable in third world conditions, might itself be causing widespread loss of life, apart from enormous unwarranted distress."(Hodgkinson, 1996:128) These countries can ill afford to use the expensive ELISA let alone the Western blot HIV tests on their population. It is too expensive for both Western researchers who travel to these countries and the indigenous government medical establishments. Therefore, with the rising pressure to show figures of an expanding HIV-AIDS epidemic, (Ankomah, 1998:36) Western researchers resort to what can only be characterized as wild estimates of HIV cases based on very limited perhaps ill-gotten statistics based on sometimes hastily collected skewed observations. These are then used to generalize about the entire continent of Africa. "I found in Kenya as elsewhere that these statistics were founded on

small clinical surveys, with the results then writ large by computer to form an estimate for the country and continent as a whole - and all this using a non-specific test.”(Hodgkinson, 1996:264).(Underline mine) In addition to erroneous statistics, a false HIV positive result can have severe life consequences. "In some African countries, the stigma attached to a positive test result was so great that victims were at risk of losing their jobs, of being denied hospital treatment, and even, in the case of some mothers and children, of being thrown out of their home."(Hodgkinson, 1996:129; Shenton, 1998:166-67)

Region	Epidemic started	Adults & children living With HIV/AIDS	Adults & children newly infected with HIV	Adult prevalence rate	Percent of HIV-positive adults who are women	Main mode(s) of transmission for adults living with HIV/AIDS
Sub-Saharan Africa	Late '70 - early '80s	22.5 million	4.0 million	8.0%	50%	Hetero
North Africa & Middle East	Late '80s	210,000	19,000.00	0.13%	20%	IDU, Hetero
South & South-East Asia	Late '80s	6.7 million	1.2 million	0.69%	25%	Hetero
East Asia & Pacific	Late '80s	560,000	200,000.00	0.068%	15%	IDU, Hetero, MSM
Latin America	Late '70s - early '80s	1.4 million	160,000.00	0.57%	20%	MSM, IDU, Hetero
Caribbean	Late '70s - early '80s	330,000	45,000.00	1.96%	35%	Hetero, MSM
Eastern Europe & Central Asia	Early '90s	270,000	80,000	0.14%	20%	IDU, MSM
Western Europe	Late '70s - Early '80s	500,000	30,000	0.25%	20%	MSM, IDU, Hetero
North America	Late '70s - early '80s	890,000	44,000	0.56%	20%	MSM, IDU, Hetero
Australia & New Zealand	Late '70s & early '80s	12,000	600	0.1%	5%	MSM, IDU
<b>TOTAL</b>		<b>33.4 million</b>	<b>5.8 million</b>	<b>1.1%</b>	<b>43%</b>	

MSM - (sexual transmission among men who have sex with men), IDU - (transmission through injecting drug use), Hetero - (heterosexual transmission)

**Source:** UNAIDS

Table 1: Regional HIV/AIDS statistics and features, December 1998.

Country	Total Population	Estimated Aids cases: 1980 - 1997	Estimated Aids deaths: 1980 - 1997	Aids deaths in 1997
United Kingdom	58.2 million	18,000	13,000	-
Zambia	8.5 million	630,000	590,000	97,000
Uganda	20.8 million	1,900,000	1,800,000	160,000
Kenya	28.4 million	660,000	600,000	140,000
Tanzania	31.5million	1,000,000	940,000	150,000
South Africa	43.3 Million	420,000	360,000	140,000
Nigeria	118.3million	590,000	530,000	150,000
Liberia	2.4 million	26,000	24,000	4,600
Ghana	18.3 million	180,000	170,000	24,000
Cote d'Ivoire	14.3 million	450,000	420,000	72,000

**Source:** UNAIDS

Table 2: Estimated number of AIDS deaths in a selected number of African countries compared to UK - a European Country.

Tables 1 and 2 show estimated HIV/AIDS in regions of the world and a selected number of African countries. If there is so much unreliability, poor validity, and the high cost of the HIV tests, what do these numbers mean? Are they exhibiting genuine medical statistics or merely reflect serious biases? How and why is Sub-Saharan Africa given the incredibly high estimate of twenty million cases of HIV cases with an eight percent infection rate?

Some scholars have rightly suggested other alternative explanations for the reported high HIV-AIDS infection rates in Africa and especially Haiti in the 1980s - racism. Chirimuuta (1989) explains that a number of diseases tend to be more prevalent in tropical countries including those of Sub-Saharan Africa. These are such diseases as visceral leishmaniasis (Kala Azar) and African trypanosomiasis, which is known as sleeping sickness. These diseases cause fever, weight loss, skin rashes and lymphadenopathy which are also common symptoms of clinical AIDS. Uganda is one of the many African countries where the health conditions have deteriorated. For example, "The health of people in Rakai is generally poor - nutrition is inadequate, malaria is endemic, and so are a host of other parasitic diseases. There is no hospital in the district, and the single clinic seldom has drugs. People's immune systems are constantly under assault, making them susceptible to new infections." (Caputo, 1988:487) Patients in these African countries like Uganda used to die of opportunistic infections long before HIV-AIDS were discovered in the early 1980s. These bad conditions may contrast very sharply with the excellent ones that exist in the majority of the Western countries. These are the countries from which the authors who describe HIV-AIDS conditions in African countries come from.

“Thus chronic wasting diseases such as advanced tuberculosis that may be clinically similar to AIDS are uncommon in well nourished and well housed white American communities, but endemic in poor immigrant Haitians. ....The circumstances mentioned above may not be the only explanation for possible misdiagnosis of AIDS in black people, whether Haitian or African. There is no reason to believe that doctors are immune from racism that is such an integral part of western culture, and indeed the medical text books

and journals are littered with examples of classic racist thought.”(Chirimuuta, 1979:46-47)

### ***Transmission and Cure of HIV-AIDS***

Since the onset of Aids in 1981, the medical community and other researchers have had eighteen years to observe, examine, and revise some of the original fundamental elements about the nature of the relationship between HIV and AIDS, its transmission and prognosis. During this same period most of the major modes of transmission have been explored. The HIV virus is transmitted through: “... potentially infectious sexual and reproductive activities, including heterosexual and homosexual practices, artificial insemination, pregnancy, and childbirth; medical procedures, such as blood transfusions, organ transplants, and “traditional” medical practices from other cultures; accidents in the medical work place; and intravenous drug use.”(Vargo, 1992:19)

As mentioned earlier, the paper has a limited scope and cannot explore all these issues in detail. But the main issue which will be explored is: given the many grave doubts about the HIV itself as the only cause of AIDS and the questions about the validity and reliability of the HIV test, what should the reader be concerned about its transmission and cure?

This part of the discussion of HIV-AIDS generates the most passionate disagreement. This is where the dominant and powerful HIV-AIDS orthodoxy sometimes smears its opponents during the vitriolic disagreement. It accuses anyone who disagrees with these issues as expressing fringe views, accused of being dangerous, opposing what is already obvious or an open and shut case, needlessly opposing popularly accepted scientific findings, about which there is already consensus of opinion. And at worst the dissenters are labeled as loony or irresponsible as they may cause thousands of deaths in their careless talk. The HIV-AIDS orthodoxy supporters believe themselves to be saving lives by educating the public about HIV, encouraging HIV testing, use of condoms during sexual intercourse, encouraging single sex partners and for people to engage responsible safe sex(Hodgkinson, 1996:195; Shenton, 1998:76) The scientific arguments are never really confronted.

During the emergence of HIV-AIDS disease and the hysteria, panic and confusion that surrounded the epidemic in the early 1980s, science truly begun to identify, investigate, and pursue many alternative hypotheses to explain why people were dying of this new mysterious disease. But genuine investigative science fell victim to such political pressure that perhaps no other epidemic disease has experienced before. This was because HIV was primarily identified as transmitted through sex. Sexual orientation and avoiding imposing of sexual practices, styles and morality became issues that may have partly prevented not only the pursuing of all alternative medical leads, but also pursuing a public health policy that was going to achieve the most public safety.

Today, it is an accepted principle or idea that the Human Immunodeficiency Virus (HIV) causes the destruction of the immune system causing Acquired Immunity Deficiency Syndrome (AIDS). According to Hidgkinson (1996), it is difficult for us to grasp the idea that when the syndrome was discovered primarily in the gay community in the early 1980s, there were two schools of thought or alternative hypotheses.

The first idea was that there was a new germ, microbe, or possibly a virus that came out of the blue. Although its victims were mainly gay, it was transmitted through sexual contact. Perhaps even one sexual contact with an infected person was enough for anyone to contract HIV and eventually AIDS. “Many doctors and scientists, especially if they were already working with viruses, naturally warmed to this theory. It gave them a clear-cut aim that brought the fight against Aids right into their territory. They could track down the virus, then prepare drugs and vaccines against it, just as they had done so successfully with polio and small pox,...”(Hodgkinson, 1996:14)

So that when Robert Gallo (1991) declared in 1984 that HIV may be the cause of the new syndrome, many in the scientific community were relieved as now they could go to the lab, track down the virus, find drugs to cure it, and find a vaccine to prevent its transmission. “World-wide, the single-virus theory became the basis for research and public health efforts to curb the spread of the infection and thus, it was thought, to fight the disease.”(Hodgkinson, 1996:14)

The second school of thought or alternative was that the new disease was a logical outcome of any continuous, lengthy, and relentless exposure of the human immune system to massive numbers of different microbes that exist. Michael Callen was one of the early exponents of this theory who was diagnosed with full-blown AIDS in 1982. He spent the next twelve years articulating, advocating, and trying to convince the scientific medical community about this perspective. Asked if it was not HIV, what had caused his immune system to breakdown? His reply was shocking. “You try having three thousand men up your butt by the age of twenty-six and NOT get sick, ....And I was a baby! I knew the first wave of people with Aids: they were founders of what was called the ten thousand club; they had had ten thousand or more different sexual partners.”(Hodgkinson, 1996:15)

Callen emphasized that it was not just having too many different partners in rectal intercourse exposing the individual to many different secretions, “There was also a hazard from the cumulative effects of drugs used habitually to drive this sexual merry-go-round. But the main problem, he believed, was that the men who had become a part of this fast-lane gay life, which operated on an international basis, had concentrated among themselves just about every sexually transmitted microbe available.”(Hodgkinson, 1996:15)

A New York City doctor, Joe Sonnabend, is believed to be one of the first doctors to identify the new syndrome. In an early study of his gay patients, he found that those who were monogamous had a normal immune system, and those who occasionally had more than a couple of sexual partners had minor problems with their immune system, “and those such as Michael Callen with a long history of sexually transmitted disease were profoundly immune-deficient. He believed Aids probably developed in other groups through a similar multi-factorial process, although the specific infections and other immune-suppressing factors might be different from those seen in gay men.”(Hodgkinson, 1996:16) This might also be known as “the multifactorial and synergistic disease models of AIDS”(Root-Bernstein, 1993:104)

The abandonment of the cofactor or multifactorial perspective in the investigation of HIV-AIDS may have been the impact of normal political pressure combined with the

human inclination to pursue what seems easy, simple, familiar and obvious. The abandonment of the multifactorial perspective can also be attributed not only to just to politics, but to a much more compelling political force in America and the World of the 1980s 90s,- political correctness.(Tembo,1993). Hodgkinson alludes to it when he explains that having sex with thousands of partners by some gays in the 1970s and 80s could not be called "promiscuous". What may be called "promiscuous" may be a form of individual expression and radical social liberation and transformation for just liberated gay and lesbian women. The lifestyles of gays and lesbians as a minority group may historically have been victims of prejudice, violence, and political persecution. "Promiscuous is a dangerous, emotive word that touches sensitive buttons in most of us. It is especially dangerous used in relation to a group of people who have suffered greatly from 'inhuman stereotypes', .....dumped on them by a society in which guilt over sex is near-universal, although far from universally acknowledged."(Hodgkinson, 1996:17)

Political correctness (Tembo,1993:51)<sup>2</sup> and the drive toward multiculturalism may have been indirectly responsible for steering the HIV-AIDS perspective in a less productive direction. Callen and Berkowitz wrote a letter to the Native newspaper. They used themselves as examples in trying to advocate the link between sexual promiscuity and HIV-AIDS and the collapse of the immune system. Their article provoked a ferocious response suggesting that the authors were showing "panic and paranoia", exhibiting excessive "morality", and were "blaming-the-victim". A medical doctor even linked them with "the right which in our time has been strongly associated with religious fundamentalism".(Hodgkinson, 1996:24) Joan Shenton (1998) supports this point when she says: "But political correctness has been a further obstacle in the path towards opening up the AIDS debate. Pointing a finger at the lifestyle of some gay men and drug users has raised sensitivities. Better to stick to the 'virus from hell' or Africa hypothesis than to focus on a group that had suffered discrimination for so many years and was now emerging into a world of gay liberation. Any arguments that singled out these groups were immediately labelled as homophobic and belonging to the far right of the political spectrum."(xxxii) (Underline mine)

Although the immune overload theory may be the more useful in finding better solutions or prevention of HIV-AIDS in many different risk groups all over the world, political correctness will prevent its full investigation. The immune overload or multifactorial theory is less favorable than the monolithic "new germ theory".(Hodgkinson, 1996:25) As will be discussed later, the immune overload theory may in fact be the most useful in understanding the so-called explosion of heterosexual aids in Sub-Saharan Africa by identifying not just one specific risk factor, but a wider variety and range of potential risk factors which when combined may cause AIDS.

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<sup>2</sup> This article summarizes the multiculturalism debate that raged on college campuses in the late 1980s and early 90s. The HIV-AIDS is not discussed. But the political correctness may have been relevant in understanding the path the HIV-AIDS debate took. In the article, political correctness is defined as: "a pejorative term for a pattern of behavior in which discourse, argument, and good sense are stifled by an imposed conformity that places maximum value on giving no offense to such 'marginalized' groups as women, people of color, gays and lesbians, Jews, Muslims, and the poor."(Mackenzie,B1-B2). Tembo, M.S., "Being Oversensitive about nothing: the Potential Impact of "political correctness" and Multiculturalism on Knowledge." Proteus: a Journal of Ideas, Vol. 10, No. 1, Spring 1993.

What does the pursuing of either one of these lines of investigation suggest? The reality is that the scientific and political community chose the easier, more expedient, and more financially lucrative one-germ theory or "one-microbe-one disease-one drug"(Root-Bernstein) theory. This may cost society lives and time before perhaps the true cause(s) of HIV-AIDS disease are/is found.

### **HIV-AIDS in Zambia<sup>3</sup>**

This author had a relative who was working as a nurse at the University Teaching Hospital which is Zambia's largest hospital located in the Capital City of Lusaka. This author was visiting her at her home one day in April of 1988 and conversation turned to the unusually high rates of illnesses and deaths among relatives and close friends. The author had just attended a burial at the City's Leopards Hill Cemetery of the many close work mates and friends who were to die in the following years. He was lamenting about malaria and AIDS killing people suddenly when she replied:

*No !!! yamene AIDS na malaria yavuta. Sure imwe munthu akadwala malaria basi mwaziba azankhala positive ku AIDS. Bati imwe!! I don't believe mwe.*

"No!! this AIDS disease and malaria are very troublesome. How come that if someone becomes sick with malaria fever they automatically become positive for AIDS? How is this possible!? This is incredulous!"

This is the closest translation into English of what she had said in Lusaka Nyanja lingua franca. The translation, however, does not reflect her incredulous tone, that also reflected her astoundment, befuddlement, helplessness, and skepticism. She was asking: 'how was it that nearly everyone who was coming down with malaria was automatically also found positive for HIV?!'

For reasons that will become evident soon, this anecdotal statement has rung in the author's head since that day in 1988 as he has observed alleged HIV-AIDS deaths in Zambia and read the scientific literature over the years about "the epidemic in Africa". It seems to reflect the contradictions and the puzzles that are far from being resolved about what ever might be killing people in Zambia and perhaps elsewhere in Africa. This anecdote also demonstrates that some of the most informed people who may hold the key to explaining the puzzle (as far as this author is concerned) of HIV-AIDS in Zambia, may be ordinary people and local experts and doctors who are directly involved in everyday lives of the people. They may have a better grasp of the indigenous disease etiology.

But the views of most of these indigenous people and experts are either ignored or relegated to a minor role when Western medical experts and journalists conduct research and investigations. Dr. Francis Kasolo is the head of Virology, Dr. Nkandu Luo is the

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<sup>3</sup> The use of Zambia instead of Africa has been done deliberately and for a purpose. The use of "Africa" in discussing cases of HIV-AIDS in Uganda and Zambia, for example, only reinforces the stereotype which is unfortunately very prevalent in the West; that Africa is just one small country. This very persistent stereotype leads to the often ridiculous conclusions that if there are high "estimated" cases of HIV positive individuals in Kampala in Uganda or Lusaka in Zambia, then the whole of Africa has high HIV positive rates. Africa today is very heterogeneous and complex.

head of pathology and microbiology, and Dr. Sitali Maswenyeho is a paediatrician. They are all at Zambia Lusaka's University Teaching Hospital. They all expressed serious reservations about many of the elements and aspects of HIV-AIDS and that the HIV testing kits were unreliable. The views and experiences of these indigenous Zambian experts would never be taken seriously in the current atmosphere created by the HIV-AIDS orthodoxy. "Despite concerns over the validity of the HIV test, the presence of a severe form of immune system failure, affecting mainly sexually active people, was widely acknowledged. But there was argument over its causes. Kasolo maintained that a variety of sexually transmitted infections might be responsible, a view shared by many older Zambians. Others felt it might be associated with over-use of aphrodisiac drugs, made from plant sources."(Hodgkinson, 1996:271) It is very counter productive when Western scientists bring Western one-germ theory or model of HIV-AIDS and impose it on Zambia or Africa. The results may be the diversion in the indigenous medical priorities and at worst the possible catastrophic deaths due possible misdiagnoses.

Although the zeal with which Western donor agencies have responded to the AIDS crisis is commendable and shows their humanitarian intentions, investing so much scarce resource into a possible misdiagnosed disease will be harmful in the long run. The numerous AIDS agencies in the field may have disruptive impacts on the social fabric of those African societies. There may actually be evidence that the donor agency campaigns and policies may be misdirected and achieving the wrong results. They may be diverting meager funding from health policies that could truly make a difference in African lives to focus on the exciting, sensational, and high profile HIV-AIDS campaign. This author warned about this possibility including a critique of what appeared at the time to be racially motivated claims that AIDS originated from Africa and was therefore spread by Africans. In the 1991 book review of Chirimuuta's AIDS, Africa, and Racism, this author warned: "The real dangers of these persistent racially motivated claims is that too much money and effort is being devoted to fighting AIDS in Africa when too many people might be dying of malaria, malnutrition, and lack of basic health care. Secondly, when Western AIDS researchers limit themselves to racist agenda, thereby needlessly politicizing the deadly disease, they close the door to lines of investigation that might yield real solutions to the problem of AIDS".(Tembo, 1991:373)

After close to two decades of the intensive campaign involving billions of US dollars, the possible negative impact on the African social fabric and dignity of the international HIV-AIDS campaign may already be apparent. For example, there are a reported over seven hundred non-governmental organizations in Uganda alone involved in the campaign to fight HIV-AIDS. According to Makumbi, the country's Minister of Health, a few of the organizations do a good job. But his government has not way of knowing, monitoring, and evaluating what the rest of the organizations are doing. "Unfortunately, a good number of them do rush in, collect data and go away with it, and the next we hear about it is when it is being printed in journals. And we have not had any input. Some of the work has been done in very limited areas, not reflecting the rest of the country."(Ankomah, 1998:42) The possible outcome of this ill-gotten data may be further circulation of skewed erroneous data that further distorts the prevalence of HIV-AIDS not only in Uganda but "Africa" as the Western media prefers to characterize these reports. There is also evidence in rural areas where these AIDS agencies have been operating that people (both villagers and indigenous Aids workers) are beginning to exaggerate the

reports of the incidence of AIDS with the full knowledge that higher numbers of reported Aids with generate more goodies, assistance, money or funding from foreign donor agencies.(Shenton, 1998:165)

There is additional evidence that donor agencies may ignore addressing the obvious traditional less glamorous causes of ill health like lack of clean water, poverty, malnutrition, and bad hygiene such as lack of pit latrines in poor rural African countries. Instead they may focus on distribution of condoms and conducting sex counseling, and perhaps the giving out of clean needles. (Shenton, 1998: 167) The point is not that promoting safe sex through use of condoms is bad in itself, but rather that having clean water, fighting poverty and malnutrition perhaps has a wider impact and therefore should have a higher priority. May be both should be conducted simultaneously.

### **Strategy for Explaining HIV-AIDS**

Tropical Africa has been known to be the possible origin of many epidemics. But this doesn't mean that every epidemic that is mysterious has to be somehow attributed to Africa or everyone of African origin. The HIV-AIDS origin and the apparent prejudices which continue to be associated with it is a classic.

An objective discussion of disease in tropical Africa cannot skirt the issue that there is historically a legitimate reason to believe that most epidemics may have originated in tropical parts of the world in the process of human evolution(Lappe, 1994:13; McNeill, 1977; Karlen, 1995). However, today this evolutionary reality is mitigated by the fact that other dramatic changes in the environment, medicine, travel and global social networks no longer make tropical Africa the obvious and prime source of disease. There are now drug resistant bacteria, pollutants, carcinogens, and ecological insults to ground water.

"Epidemics are again a regular part of the news. The genital herpes virus infects half the people in the United States. Chlamydia, virtually unknown until twenty years ago, has become the country's most common infectious disease after the common cold. Germs that used to attack cats, rats, sheep, and monkeys have sickened people from Albuquerque to Moscow. Many forms of cancer are more common, and viruses are implicated in helping to cause several types. Viruses are also suspected of playing roles in chronic fatigue syndrome, Alzheimer's disease, rheumatoid arthritis, systemic lupus, and multiple sclerosis. In recent years, syphilis, tuberculosis, measles, whooping cough, and diphtheria have surfaced not only in poor but in developed nations."(Karlen, 1995:5)

This quote suggests that when science, spearheaded by the Western media, continues to promote the one-germ-model, in the light of all the other contradictory factors and evidence, this may be not only wrong, but makes it difficult to find the real cause(s) of the HIV-AIDS epidemic. This may also result into the promotion of injurious public health policies and campaigns especially in Third World countries like those in Africa.

One of the biggest errors in the HIV-AIDS epidemic is the original claim (since then still unsubstantiated claim) that HIV came from Africa transmitted through green monkeys that are believed to have bitten a human in the jungles of Africa.(Sabatier, 1988) This was compounded by a sensational story that spread like the proverbial wild fire in the

early 1990s; that the AIDS epidemic had core-infected areas in Kenya, Uganda, Tanzania, Zambia and Zimbabwe. Phillippe and Evelyne Krynen are a couple sponsored by the French charity, Partage, who originally broke the sensational AIDS story to the world. At that time in the early 1990s, the news about whole villages being wiped out and leaving orphans garnered so much sympathy and alarm in the West. Huge resources including manpower were diverted to fight AIDS in this part of Africa. Since that time, major international organizations like WHO, UNICEF, European Commission's Global Fight Against Aids, and thousands of agencies have been involved.(Ankomah, 1993:8)

But after they had worked in Northern Tanzania for four years in what was considered the AIDS epicenter, the Kryenens discovered that they may have been wrong. Asked about AIDS in the region, their reply was: "There is no aids. It is something that has been invented. There is no epidemiological grounds for it; it doesn't exist for us."(Ankomah, 1993:8) The Kryenens had investigated Aids for four years and now were confessing that they had made a mistake in their original story. When this story broke in the Sunday Times Newspaper in UK, it was like a bomb going off. Doctors, organizations, and other Aids agencies vilified the Kryenens and the investigative reporter. "What nonsense! Was the general verdict. Everyone knows that Africa is crawling with Aids! Tests prove that millions of Africans are HIV-positive and HIV leads inevitably to full-blown Aids. Who are the Kryens to tell the experts that there is no Aids epidemic in Africa?"(Ankomah, 1993:8)

This reaction typically reflects what has been happening in the investigation of the HIV-AIDS epidemic. The Kryenens, reporters, and perhaps other indigenous people and experts may have a better grasp about what might be really happening in the field in Africa. But the experts in London, Paris, and New York, who create the news and drive the health policies, may be the ones who know the least about what is really happening on the grass roots in Africa.

The Kryenes' explanation about their error might reflect what may be happening now in the HIV-AIDS diagnosis in Africa. Based on the information they had been given prior to coming to Tanzania, at first they assumed that most deaths were due to Aids. But after some research, they were faced with some cases that did not make medical sense. They discovered that when HIV positive patients were treated for their diseases like TB or pneumonia, they recovered just as quickly as those patients that were HIV-negative. "They carried out mass testing and were surprised to find that a far smaller percentage of the population had positive results than earlier research had indicated. They began to suspect that there was either something wrong with the test procedure or that (HIV) positive results were being triggered off by other bacteriological infections."(Ankomah, 1993:10)

After living in the area for a long time, the Kryenens began to realize that the "orphans" were not really orphans. Their parents had left to work elsewhere and sometimes sent some money back to the village. But the extended family, including grand parents, were raising the children. This was an apparent cross-cultural misinterpretation of the significance of the extended family in child rearing in African societies. But all these children were and continue to be frequently mistakenly reported in a sensational way in the Western press as "Aids orphans". Most Western researchers rarely recognize or acknowledge that the structure and endurance of the African family may be remarkably

different from the nuclear Western monogamous family. Infact African scholars like Mazrui (1986) have asserted that the African family might be the only enduring, resilient, indigenous, and authentic African social institution.

### **Implications for Medical Science**

In this part of the paper, the author will argue that the most productive, logical, and scientifically legitimate is the co-factor or the multifactorial approach to HIV-AIDS.

What may be the premature driving to a consensus to the "HIV-AIDS-equals-to-death-hypothesis" by the dominant medical community may cost science its integrity and genuine progress. A great deal of money (Shenton, 1998:31) seems now to be driving both the HIV-AIDS debate (if there is any at all) and health policies. This has resulted into the strong possibility that many scientists have compromised the integrity of their work in abandoning honest debate and pursuing lines of scientific investigation that are least likely to displease or contradict the HIV-AIDS orthodoxy.

A case in point is that of a Dr. Marie Deschamps who was a bright doctor who was to shortly publish a paper in the *Lancet*. She described an eight-year study in Haiti of 920 sexually active couples; 475 of these couple had one of them HIV negative and the other positive. The couples were not using condoms. After those eight years, only thirty-six couples both became positive and the other 439 couples did not infect each other. In normal scientific investigation, this finding was begging for numerous alternative explanations including challenging some aspects of the HIV-AIDS hypothesis. When asked about the surprising findings, Dr. Deschamps exhibited unwillingness to explore the possibility of a wide variety of explanations. She seemed unwilling to challenge the accepted orthodox view.

"The closed mind, rooted in the accepted wisdom on HIV and AIDS, had to look for explanations within her own hypthesis. Where was the scientist's curiosity, we again wondered, that might have yielded explanations other than the accepted wisdom? Where was the inclination at least to listen to those who doubted the infectivity of HIV? What had happened to doubt and questioning among scientists?"(Shenton, 1998:199)

In the HIV-AIDS discourse to day, disagreement based on logical reasoning, analysis and exposing inconsistencies in the research is simply either smothered or excluded from the mainstream debate in journals, AIDS conferences, and electronic media. The classic case of an opposing view in the HIV-AIDS research being smothered and excluded from the mainstream or HIV-AIDS orthodoxy is that of a distinguished molecular biologist Peter Duesburg. (Shenton, 1998; Hodgkinson, 1996). He and several other scientists constitute a small and less powerful but consistent number of critiques of the HIV-AIDS-equals-to-death hypothesis.

The scientific medical community is perhaps experiencing the normal frustrations of a revolutionary shift in the medical diagnostic and epidemiological paradigm. What is happening in the HIV-AIDS controversy may have parallels to the shift that happened in medicine when the pellagra epidemic was common in

communities in Europe. Pellagra is a niacin (vitamin B) deficiency induced disease that was common in poor communities in Europe whose staple food consisted of processed maize or corn flour. "Although pellagra did not spread beyond its risk groups, a classic indicator of a non-infectious disease, and never affected nursing staff, many doctors pronounced it a contagious bacterial disease. Patients with the disease developed terrible skin lesions, nerve damage, dementia, diarrhea, wasting syndrome and finally died."(Shenton, 1998: xxix)

Pellagra infections were confined to the risk groups of the poor and sailors. For 15 years from the 1920s, Dr. Joseph Goldberger alone battled the mainstream medical establishment at the time that believed pellagra was caused by a bacteria. Goldberger went as far as infecting himself with patients' blood to prove to his adversaries that pellagra was a non-infectious disease. Many people continued to die until niacin was isolated in the 1930s. Are we witnessing a similar scenario with HIV-AIDS ? The infections have been confined to risk groups for the last eighteen years. Alternative hypotheses are neither seriously endorsed nor investigated while the one-germ- or virus theory is the accepted one. Instead of focussing, almost to a point of obsession, on Africans, chimpanzees and monkeys in jungles in Africa as being the source of HIV,(Ankomah, 1999) scientists should be seriously exploring other alternative explanations. Besides numerous other factors, some African countries in Southern Africa, for example, have maize as their staple food. As a follow up to the example just discussed, could African urban dwellers be partial victims of pellagra and poverty especially if the maize is processed without vitamin fortifications and nutritious food supplements more easily available to their rural counterparts?

Given all the ambiguity, cross-cultural complexities, and the unknowns, the HIV-AIDS research should expand and focus beyond the narrow confines of the HIV-AIDS-equals-to-death hypothesis. The scientists should focus on the following:

- Seriously investigate all major alternative hypotheses in the relationship between HIV-AIDS
- Seriously investigate the possible multifactorial or co-factors in the relationship between HIV and AIDS: malnutrition, environmental pollution, the impact of chemical food contamination, chronic drug abuse including alcoholism, the role of extreme physical and emotional stress in contemporary life styles.
- Explore the role of extreme sexual promiscuity or liberalism and all exotic sexual practices (anal and oral sex, prostitution, drug use especially chronic alcohol abuse, numbers of sex partners, frequency of travel and location of sex partners) in sexually transmitted diseases (STDs) among some heterosexuals, homosexuals, and international travelers and tourists. This should not just mean scrutinizing the health status of all immigrants and travelers from poor Third World countries to developed countries. But also equally exploring seriously that travelers and the elite from rich and poor countries may transmit lethal pathogens to vulnerable Third World populations who may not have the resistance to drug resistance microbes. Racial and cultural superiority complex

leads Western society to believe that because of advanced medical technology, the Western has less STDs than developing countries. "The claim of such supporters in the developed world does not appear 100 percent correct, because the incidence of venereal disease is much higher in spite of their positive claims. Even after the cure the incidence of reinfection is much advanced. Although the people are conscious about sexually transmitted diseases, they are reluctant to adopt precautionary measures, even in the developed countries."(Garg, 1987:63)

- Seriously consider the possibility that there may be a third obvious simple factor or factors that cause(s) AIDS that is being ignored because research in HIV, testing, and cure lends itself more easily to the use of sophisticated, fancy, financially lucrative and seductive modern bio-chemical equipment in the expanding field of microbiology and bio-technology. This author could not resist use of the analogy of the man who lost his keys on a dark part of the street. He was observed erroneously looking for the keys under a well-lit street lamp fifty yards away. Asked why he was looking for his keys clearly in a wrong place, his reply was that this is where the light was.
- All scientists should take the difficulties, obstacles, and sometimes barriers involved in cross-cultural research very seriously if the pursuit of reliable and valid scientific knowledge is the objective of many of the HIV-AIDS studies. Africa, for example, is a giant or huge continent which has a total area of 11.7 million Sq. Miles (30.3 M. Sq. Kms). Table 1 shows the size of four countries and Europe compared to Africa. It is more than 3 times the size of the United States.

Country	Area (Sq. Mi)
China	3,705,390
United States	3,618,770
India	1,266,595
Europe	1,905,000
Argentina	1,065,189
New Zealand	<u>103,736</u>
TOTAL	11,664,680 Sq. Mi.
	Or
	30,211,551 Sq. Km.
Africa's area:	11,707,000 sq. mi
	Or
	30,321,130 Sq. Kms.

Source: AFIM (Africa Interactive Maps, 1998)

Table 3: Size of Africa compared to four countries and Europe

- In addition, the continent has 54 mostly sparsely populated countries with tremendous geographic, physical, climatic, linguistic, ethnic, religious, historical, economic and cultural diversity and complexity.(AFIM, 1998) Some of the highly sensational HIV-AIDS research findings, most of it

qualifies as conjecture and speculation, are discussed in terms of such broad generalizations as..."African paediatric AIDS" ...."HIV originated in the African jungle" ..... "the HIV-AIDS epicenters of Africa". These gross generalizations and distortions prevent any clarity in the investigation of the problem.

### **What Should Zambians/Africans do?**

The ambivalent use of "Zambia" and "Africa" is deliberate in the paper. But more importantly it reflects the kind of ambivalence that all serious scholars of HIV-AIDS in Africa should exhibit. A discussion of HIV-AIDS in "Africa" may ignore the fact that many countries in Africa are reported not to have high incidence of HIV-AIDS. Some of the countries, like Zambia, Uganda, and Tanzania have been targeted and identified as HIV-AIDS epicenters. How does one meaningfully discuss the subject as relating to "Africa" when there may be such marked differences between the African countries? The countries differ in terms of levels of urbanization, prevalence of migration and civil war and unrest, political stability, cleavage and conflict, medical infrastructure, volume of tourism, levels of formal education in the population, ease of transportation and travel, and the existence of international and national communication, exposure to Western television, languages, provision of food and development of agriculture.

This is why this author argues that with regards to the HIV-AIDS disease investigation, it would make more sense to first explore the etiology and pattern of the disease (if it exists at all) in the West, and then in each African country and then later for investigators to compare notes. The current strategy of employing, adopting, and imposing the monolithic single-germ theory developed by Western medicine on the entire African continent, while for the most part disregarding all other factors, will only yield sensational, meaningless and predictably confounding results. The frequent statement of befuddlement you hear through the Western media is: "HIV-AIDS is mainly a homosexual or gay disease in the US but it is a heterosexual disease in Africa". The current research strategy will never yield valid answers to this question and many others so long as the focus is on just "Africa". This author proposes that all serious Zambians and Africanists should do the following in the HIV-AIDS research:

- Investigate and determine whether HIV-AIDS does exist in relation to the history and etiology of diseases that are indigenous to their individual countries. Many of these diseases that today may be clinically classified as new and HIV-AIDS related, may have existed before. Exploring the African traditional diseases through examining folklore may be one strategy.
- Compare death rates in the individual countries prior to the 1980s and after the 1980s to see whether HIV-AIDS may have claimed as many lives or contributed to an epidemic rise in the death rates. Has there in fact been a population growth? Did deaths and displacement due to civil war severely reduce the population?

- Seriously investigate the multifactorial or co-factor explanation of HIV-AIDS. Special attention should be paid to the role of indigenous diseases including malaria fever, tuberculosis, elephantiasis, sleeping sickness, leprosy, river blindness, schistosomiasis, yellow fever, cholera, marasmus and kwashiorkor malnutrition diseases, other parasites, viruses and bacteria. A combination of these might in themselves explain cases of the incidence of AIDS disease without HIV (Root-Bernstein, 1993) especially in testing the synergistic model of disease or the immune system stress overload theory of HIV positivity and negativity.
- Seriously investigate levels of hygiene especially in overcrowded poverty stricken shanty compounds of major cities as this may be the key co-factor in the AIDS symptoms even without HIV.
- Determine the levels and impact of drug abuse (cocaine, heroine, marijuana, heroine, mandrax, sexual stimulants and others) including alcohol.
- The area of sexuality may have experienced the most dramatic change in individual African countries. There should be a serious and honest investigation of the nature, volume or magnitude of sexual activity in each country. A calamitous break down of the more restrictive African traditional sexual morals combined with exposure to Westernization and the sexual revolution that occurred in the West in the 1960s and 70s may have increased the prevalence of Sexually Transmitted Diseases to a level before unknown in the country. An increased access to pornographic videos, internet, magazines, alcohol, and drugs may further fuel excessive sexual activity. "In higher species, copulation offers germs many ways to spread, by the contact of skin, mucous membranes, body fluids, and breath. .... Humans are an especially fertile field for such germs, because our eroticism is unmatched in nature. ....No other mammals couple in as many nonproductive times and ways - orally, anally, homosexually, during pregnancy and lactation, sometimes before fertility starts and after it ends....One consequence has been an explosion in the incidence and variety of STDs."(Karlen, 1995:122) Mcilhaney (1990) and Garg (1987) have identified more than twenty sexually transmitted diseases that exist to day that include gonorrhea, syphilis, Human Papilloma Virus (HPV) infections or Venereal Warts, AIDS, hepatitis B, vaginitis, chlamydia, herpes, public lice, molloscum contagiosum, mycoplasma infections, amebiasis, giardiasis, and gay-bowel syndrome. If many of these STDs exist in large numbers of the population combined with malnutrition and many other indigenous diseases and emotional and physical stress due to, for example to massive urban poverty and economic hardship, would not all these factors not cause the immune system to be overloaded and therefore to result into symptoms such as AIDS? The HIV-AIDS orthodoxy have largely ignored the cases where people show AIDS symptoms while they remain HIV negative.(Root-Bernstein, 1993; Shenton, 1998; Adams, 1989) What if elite of African countries brought the STDs from the Western countries where these may have been already drug resistant, would this,

combined with other factors, not cause massive immune breakdowns in the African victims exhibiting itself in the AIDS symptoms and death?

- African countries should embark on a serious scientific exploration, investigation, and documentation of the indigenous or traditional etiology of disease. Traditional diagnostic and healing methods may become very valuable in the near future. The West and Westernized Africans have erroneously been confusing the so called "witchcraft", "witchdoctor", "voodoo" with the African traditional legitimate healing methods and the African traditional healer.(Tembo, 1993) They have successfully induced a certain shame and inferiority complex among Africans about African indigenous methods of healing and use of herbs. Some of these same methods that are known as being primitive and showing backwardness are now being incorporated into medicine to day in the West as "alternative medicine" or "healing"(Tembo, 1993; Clark, 1993; Christy,1994) This negative attitude of inferiority complex among Zambians/Africans will be very difficult to reverse.
- Lastly, Africa and Africans are vulnerable and badly need to defend themselves. Anybody to day can make the most unfounded, scurrilous or preposterous very negative assertions about Africa and Africans, there is often no one to defend the continent and the people. As a result, most people to day believe that HIV-AIDS came from a monkey that bit an African in the African jungle when there has never been any evidence to support this assertion or speculation. This hypothesis was expressed during the early days of the HIV-AIDS epidemic in the mid 1980s. Many of these and similar assertions are made in the name of "science" and "scientific" investigation and findings. When such clearly reckless assertions are made, most with racist undertones, Africans and African experts everywhere should be willing to step forward where possible and rationally challenge such harmful remarks.

## **Conclusion**

Since the HIV-AIDS was discovered in the 1980s, the information about the deadly disease has been spread far and wide in the whole world. Appropriate private and public health care institutions and organizations have been mobilized to fight the "epidemic" costing resources in billions of US dollars. The controversy about the possible serious flaws in the diagnosis of the disease has been largely kept out of the mainstream scientific debate and the public. It is hoped that this paper has not given the impression that readers should deny the possible existence of HIV-AIDS or killer disease. But rather that people might be dying of a new disease or a group of old diseases and that all the possible explanations and hypothesis should be open to investigation in line with logic and genuine scientific procedure.

This paper recognizes that the HIV-AIDS disease has generated large volumes of information in its collateralies including origin or history, diagnosis, prognosis, cure, prevention, and public healthy policy. In the context of its limited

objectives, the paper has focussed on a number of key flaws in the hypothesis. It is hoped that readers will realize that if the basic foundation and premises of the HIV-AIDS hypothesis are themselves extremely weak and questionable, what is the logic of vigorously searching for the cure and generating to what amounts to massive fear, anxiety, and hysteria and possible deaths in what might turn out to be a possible misguided public campaign to eliminate the disease? It is hoped that even if the paper does not change anyone's mind, that atleast it will encourage the readers to open their eyes and begin to ask questions of their doctors, medical establishments, pharmaceutical companies, the media, government, researchers, co-workers, neighbors, relatives and friends. This quote from Hodgkinson probably best summarizes the status of the HIV-AIDS disease to day.

"It was and is wrong to tell people they are carrying a deadly new virus on the basis of an unvalidated test, beset with technical problems and pitfalls in interpretation, vulnerable to shipping, climatic and storage conditions, and subject to unmeasured and probably immeasurable cross-reactivities and hence false positive results. It is very hard for doctors, scientists, politicians, the World Health Organization, gay leaders, Aids charities and even journalists to admit to this today, since they have all been instrumental in bringing about the climate of opinion in which this unvalidated test was inflicted on millions. But those are the facts. Regardless of whether or not the test has any relevance to a retrovirus, there are so many other possible causes of a positive result that on present knowledge, no one should be diagnosed as suffering from 'HIV' infection or disease. No one cognizant of these facts will ever wish to allow themselves to be tested. The sooner the error is acknowledged and the test relegated to history, the quicker we may see a return to sanity in Aids science."(Hodgkinson, 1996:262)

**Post Script:** *This paper was written in 1999 and has not been revised since. Like many other Africans and Zambians this author has lost many relatives and friends to the HIV-AIDS epidemic. It appears the antiviral drugs have saved many lives and improved the lives of many victims. This author is still surprised that apparently many of the scientific questions that he and many others have raised have never been adequately answered. Those who express either some curiosity or are skeptical of the HIV-AIDS hypothesis are called pejoratively as HIV-AIDS deniers. If the some of the questions have been answered through credible scientific investigation, kindly let this author know.*

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