

09 August 2006

Mr. Nathan Geffen
Treatment Action Campaign
Policy Co-ordinator
Per email

And to CC list

Dear Mr. Geffen,

“What do South Africa’s AIDS statistics mean?”

Being in a position where information on matters of health is of paramount importance to my functioning I pride myself on keeping abreast of the latest news. In doing so I came across your article (referred to above) on the TAC website and I foresee being asked questions on it: so I’m really hoping you can help me get my facts straight before I make a terrible mess in reply. I would be much obliged if you could detail a response to the hereunder.

You state that “...the quality of South Africa’s HIV/AIDS statistics is actually very good.” Please tell me how you know this, and on whose authority I should take this statement. When referring to quality one generally uses the concepts of validity (does the said thing refer to what it is supposed to, and only to what it is supposed to?) and reliability (will the same results be obtained if the study is repeated?). Both validity and

reliability are in question in AID\$ statistics as reported in the general media as you are about to discover.

From the hypothesis that you depart (i.e. that HIV is the cause of AID\$) then valid AID\$ statistics would require that reported AID\$ deaths be due to HIV and nothing else, and since you state clearly in your article that “many people die of AIDS without being tested for HIV”, the validity of the statistics has to be questioned from the very beginning. Especially since the AID\$ defining diseases (such as TB, pneumonia, and diarrhea) have many other recognized causes and can be identified in their own right. How, for example, do the statisticians decide that a death from pneumonia is an AID\$ death or simply a case of bad luck after having caught a ‘routine’ chest infection-especially when there is no HIV antibody test result to correlate it with? I’m asking this because I’ve seen many death certificates (which you hold in esteemed value in your article in determining AID\$ deaths) and they are not very detailed as to the patient’s complete medical history and contain no information about the deceased’s socio-economic status. Is it fair to assume that stereotyping is generally relied upon, since we all know-and you confirm-that it’s the indigenous people of our country who are most afflicted? So all things being unequal, will Mr. Q from Kagiso township, getting progressively more ill and dying at home of TB be counted as an AID\$ death; while Mrs. A from the Northern Suburbs with exactly the same problem will not-especially since neither knew their “HIV status”?

Even if we did know the “HIV status” of those thought to have died of AID\$ it would still skew the validity curve since HIV has never been duly isolated according to the viral isolation methods described at the Pastuer

Institute in 1973; nor is there any epidemiological evidence in the scientific literature where it is established with any certainty that those who register positive on an HIV antibody test will definitely go on to develop AIDS at some point. And so such people could have died from causes other than the virus doctors generally tell us is incurable. Should you disagree, I invite you to provide me with references to **peer-reviewed published papers in the scientific literature** where the contrary is established.

On the same point of statistical validity, please explain to me how “we know that AIDS [here I assume you mean preceding HIV infection] is the only cause that can explain the massive increase in the number of deaths since 1997” when immune deficiency (i.e. “AIDS”) has other recognized causes beyond HIV, including poor social conditions, lack of sensible and wholesome nutrition, etc? Who are the “we” that you refer to and how do “we know”?

You even admit in your article that the black people living in informal settlements have a higher prevalence (and incidence?) of HIV than others in more sophisticated settings. Is your brain ever going to connect the dots and get a picture other than HIV as the cause of immune suppression? Or, as Shakespeare put it, are you “in blood in stepped in so far that, should [you] wade no more, returning were as tedious as go o’er” [Macbeth Act III, Scene IV] and it would therefore be too embarrassing for you and your sheep to admit that your hands are bloody? Perhaps you have “nothing but vaulting ambition” [Macbeth Act I, Scene VII] and the funds would dry up as soon as you “return”- then you’d have to actually find a real job.

Referring to why the African population (read black people in poor living conditions) has a higher incidence of positive results from an HIV antibody test, please see the Perth Group's analysis (published in *International Journal of STD & AIDS* 2003; 14: 426-430) and archived on their website at www.theperthgroup.com . You may like to peruse the following too, archived on the same site: AIDS in Africa: Distinguishing fact from fiction (World Journal of Microbiology & Biotechnology (1995) Vol. 11); Is a positive Western Blot Proof of infection? (Bio/Technology June 1993, Vol. 11); HIV antibodies: further questions and a plea for clarification (Current Medical Research and Opinion (Vol. 13: 1997). Anyone who tells you after reading those papers that registering HIV positive on an antibody test means you're infected with some killer virus is, to quote John Lauritsen, "either ignorant, lazy or stupid."

I'm also interested to see that, according to your article, "the epidemic has reached epidemic [sic-tautology] proportions in other population groups". Please tell me to which population groups you are referring, since the totally flawed HSRC's latest HIV prevalence survey findings show that a mere 0,6% of whites are infected with HIV (down from 6,2% in 2002: showing just how unreliable the statistics really are-unless 5,6% died off, or immigrated in the last 3 years). In choosing my partners your answer to this question will be very useful as I would hate to associate too closely with a high risk group when arranging dates.

Apropos the antenatal surveys, it is incompetent of researchers to take the results of one rapid ELISA test as evidence for HIV infection-which is what they do. This therefore renders the statistics obtained via this method invalid.

One of the many reasons for a false positive on an HIV antibody test is current or past pregnancy-reported in at least five different research papers and as a warning from Abbott laboratories in their test kits. The p24 antigen is often circulating in the blood of a gravid woman and hence causes this marker in the test kit to register positive. Whether pregnant or not, relying on an ELISA (or even an ELISA repeated a 100 times) is simply not a good enough reason to include a person as an HIV statistic. There are no tests currently licensed by any authority (including the FDA) for use in diagnosing HIV infection. This is made clear in the test kit instructions of all HIV antibody tests, including the one I currently have in front of me which reads:

“The test for the existence of antibodies against AIDS-associated virus is not diagnostic of AIDS and AIDS-like diseases. Negative tests do not exclude the possibility of contact or infection with AIDS-associated virus. Positive tests do not prove AIDS or pre-AIDS disease status nor that these diseases will be acquired.”

You see, these tests were developed to screen blood, not diagnose infection-doing so demonstrates the incompetence and lack of understanding that continues to be supported by organizations such as yours with masses of funding and middle-class moral panic as fuel.

The HSRC has been made aware of their flawed methods in obtaining data for their latest HIV prevalence report but choose to ignore the commentary. President Mbeki dismisses their findings as “highly speculative”- many concur.

Even if we take the numbers in your article into consideration, the sample group included in the antenatal survey is hopelessly dismal. For one, as you rightly state, this is not a randomized sample, and so the results cannot reliably be extrapolated into the general population. Secondly, you state that the antenatal survey includes approximately 16 000 participants per year-this is therefore a mere 1,4% sample of your estimated 1,1 million pregnancies annually. This does not equate to 1 out of every 45 people in the general population as you cleverly try to sell in your article, but in fact a pitiful 16 000 out of the entire population (or 0,035%)-hardly a large enough sample for any significant survey. Yet, it's still the extrapolations from these antenatal surveys that are **most** relied upon to crunch the numbers and determine our HIV prevalence in this country. But hey, as long as the figures are good, who cares how they were obtained?

Any sensible person with undergraduate training in research should be able pick up the many flaws described so far; and the many more we can't even go into in this letter. But when you have someone of your calibre, for example, explaining the numbers with such authority, why bother to question them? As long as it brings in the dough.

Some clever person is one day going to do research on **healthy** teenage children in poor African communities and find that a percentage of them who have never been exposed to "HIV risk factors" test positive on an antibody test... This would mean that they have been living with the dreaded killer virus since birth as a consequence of their normal genetic code thus confirming Peter Duesberg's assertion that HIV is nothing more than a "harmless passenger retro-virus". Professor Luc Montagnier (co-discoverer

of “HIV”) would probably agree seeing as he points out himself that p24 (employed in HIV antibody tests) is not unique to HIV and can demonstrably form retroviral sequences of up to 2% of the human genome.

Your stated prevalence of 15-16% in the under 20 age category may well be a good demonstration of this possibility and that is why it remains constant. Like the American AID\$ epidemic that never happened: since testing began the prevalence of HIV has remained constant at around one million with no explosion into the general population. AID\$ still remains almost exclusively confined to the originally identified risk groups. Are you connecting dots?

Lastly, a word on mathematical modelling... You might do well to read Rebecca Culshaw’s articles regarding HIV and statistics on www.rethinkingaids.com . She has a “sophisticated mathematical” background having completed her Ph.D in mathematical modelling (specifically on HIV) and has come to realize how flawed the number crunching relating to this disease actually is. I’m sure she is far better qualified to advise people on what South African AIDS statistics really mean-and I’m sure you won’t like what she has to say about your attempt to justify the numbers.

Forgive me but your article reads like it was written to convince yourself of your own cause. Nobody is attacking the models as your article states-we’re just asking questions (isn’t that what “good science should be”?)—questions that people like you find difficult and mostly impossible to answer.

A reply to this letter with your thoughts would be most welcome but I shall not hold my breath-seeing as my last letter to you went unacknowledged.

Yours faithfully,

Darren