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Book Review
HIV/AIDS: The Facts and the Fiction

by Anna Rabin, East Africa Analyst: Anna Rabin has a Masters in African Politics from the School of Oriental and African Studies (SOAS), University of London. She has a particular interest in East Africa and demography.

Although short on solutions, biologist Chris Jennings persuasively argues that AIDS did not originate in Africa and that its spread is vastly overestimated.

When a book's statement of purpose is to "reconfigure the conceptual paradigm of the HIV/AIDS epidemic, such that resource allocations and health care interventions better serve the populations at need – both those with and without HIV/AIDS – worldwide", expectations are high. Although successful in making waves within the realm of HIV/AIDS research, Jennings' efforts largely fail to step outside this research paradigm and address the issue of resource allocation and healthcare priorities.

Nevertheless, the overall message Chris Jennings is trying to convey is never lost, despite the Harvard-educated biologist's attempts at writing for laypeople being sometimes overshadowed by large sections of scientific jargon.

HIV/AIDS: The Facts and The Fiction argues that the AIDS epidemic first began in New York City, that the HIV virus was not discovered in an African green monkey, and that the media alongside international and national bodies have grossly overestimated how many AIDS victims there have been.

Jennings's accompanying book, *HIV/AIDS in South Africa: The Facts and The Fiction* further highlights the dangers of estimating the number of HIV/AIDS victims in the country reported to be home to the largest HIV/AIDS epidemic in the world.

Where did it all begin?

Contrary to the widely held belief that AIDS originated in Africa, Jennings makes a convincing case that the first 'legitimate' cases of AIDS were in the United States – specifically New York City, then in Los Angeles. 72% of these first one thousand victims were gay men. And, although the first ever AIDS victim in the US was an African-American man, Jennings is quick to point out that the next 25 victims were Caucasian.

Jennings goes on to argue that the first connection between Africa and AIDS was made shortly after its initial outbreak in the US. One third of early sufferers were also infected with Kaposi's sarcoma, an opportunistic virus which takes advantage of the weakened immune system. And in 1981 – just two years after the first ever AIDS patient was diagnosed in New York City – the Morbidity and Mortality Week Report published an article stating that although Kaposi's sarcoma was very rare in the US, it accounted "for up to 9% of all cancers" in an " endemic belt" across equatorial Africa. Jennings asserts that the reiteration of this point by the New York Times planted the seed for future misconceptions about the links between Africa and AIDS.

The spread of AIDS

Jennings's portrayal of how AIDS spread to become a global epidemic is also unorthodox. Contrary to the widely held assumption that AIDS travelled from the African jungle to urban centres from which it permeated the Western world, Jennings argues that the spread of AIDS exemplifies his theory that "disease follows trade routes". He claims the first cases of AIDS were seen in the US, before the disease appeared throughout Europe, with the majority of the early victims having had homosexual relations in the US or with an American citizen. Jennings also highlights the fact that the first two confirmed AIDS victims in South Africa were two gay men who had travelled to the US.

Nevertheless, throughout this section of the book, Jennings fails to properly investigate the possibility that the virus existed in Africa but was not widely acknowledged for reasons such as traditional medical practices, the lack of central HIV reporting databases, and the possibility of diseases common to developing countries including tuberculosis, being diagnosed in place of the AIDS virus.

This shortcoming aside, his argument that the disease followed trade routes carries some weight. The fact that, as the virus began to ripple through the Caribbean and Europe, there was a virtual absence of the disease in

Cuba and the Soviet Union, seems to confirm linkages between disease and trade routes, or a lack thereof, during the Cold War era.

Monkey business

Further to Jennings's version of the spread of AIDS, he goes on to clarify that an AIDS-like virus was not in fact located in an African green monkey in 1985, as initially reported by a group of researchers from the School of Public Health at Harvard. He explains that the scientists' findings came as a result of lab contamination and suggests that the lack of media coverage surrounding the researchers' retraction of their initial findings was just another incident of the media propagating a one-sided story that AIDS originated in Africa.

Indeed, the role of the media in supporting what Jennings refers to as the 'African fallacy' is a common theme throughout the book. On numerous occasions, Jennings refers to specific newspaper headlines to give examples of the media both propagating and inflating the idea of AIDS originating from, and decimating, the African continent. New York Times headlines such as "AIDS in Africa: A Killer Rages On" and "AIDS Is Everywhere, but Africa Looks Away" are provided as examples of such alarmist journalism. While Jennings makes mention of similar coverage appearing on the BBC and the Chicago Tribune, his overarching focus on the New York Times (a whole page of the book is dedicated to listing the publication's headlines) is quite puzzling and skewed at times.

Statistical searching

Jennings's investigation into the statistics that surround HIV/AIDS prevalence in Africa is nothing short of alarming. In particular, *HIV/AIDS in South Africa* provides a provocative and compelling analysis into a country he believes is the "principal exemplar of the discrepancy between modelled HIV/AIDS estimates, surveillance data, and death counts". His analysis questions both the methods used for diagnosing HIV/AIDS and the validity of country-wide estimates made by international organisations and South Africa's Department of Health.

Jennings is quick to point out the belief that South Africa has "the largest [HIV/AIDS epidemic] in the world" is based on estimates, not actual data. Before 1996, South Africa calculated the number of people living with HIV/AIDS using actual surveillance data. 12,825 cases were reported in 1996.

In estimates for 1997, however, the World Health Organisation (WHO) published figures suggesting there were 2.9 million people living with HIV/AIDS in South Africa and that 140,000 had died from the disease in 1997 – a marked difference from the 6,235 deaths reported.

In 1992, African countries reported 211,032 cumulative AIDS cases; WHO's estimate was 7.5 million. Throughout his statistical review, Jennings gives adequate weight to potential reasons for underreporting, but claims this alone cannot justify such an extreme difference in the data. Throughout *HIV/AIDS in South Africa*, Jennings provides an interesting and well-presented statistical summary that will leave readers questioning the validity of internationally-approved estimates.

Jennings also argues that the rate of false-positive HIV/AIDS tests in South Africa is absurdly high. The inappropriate use of diagnostic assays used to confirm cases of HIV/AIDS in a patient exhibiting signs of suffering from an opportunistic infection are being used on larger populations to test for the disease. Jennings asserts that this method of testing can be highly inaccurate, saying: "it is generally understood that medical assays are likely to generate more false-positives than true-positives in a large healthy asymptomatic population". As testing mechanisms become more sensitive, they are also more susceptible to producing false-positive readings.

Who is tested is also of concern. Instead of using the highly sensitive diagnostic assays on a random sample of the population, South African estimates are based on a survey of approximately 30,000 women who are pregnant for the first time; a group not representative of the population at large.

Jennings argues that such high rates of incorrect readings can be detrimental to fighting curable diseases because a large portion of health budgets in African countries is being spent on treating HIV/AIDS, when many presumed to suffer from the disease may in fact have other, more easily combated, illnesses.

An insight into AIDS

HIV/AIDS: The Facts and The Fiction and *HIV/AIDS in South Africa: The Facts and The Fiction* provide interesting insights into the myths and realities of the origins and scale of the HIV/AIDS epidemic. Jennings's discussion surrounding the origins of the disease is controversial, yet quite plausible. Although his analysis of the media coverage may be slightly flawed, his overall argument never wavers. When read one after the other, the two books can become quite repetitive, but his country specific analysis on South Africa effectively reinforces Jennings's hypothesis and is persuasively argued.

However, besides fleeting references to the fact that government budgets to treat HIV/AIDS patients in African countries dwarf those to treat curable diseases such as malaria and tuberculosis, Jennings does not succeed in providing alternatives. A discussion into more appropriate resource allocation would have both broadened the scope of his studies and enhanced their practical purposes.

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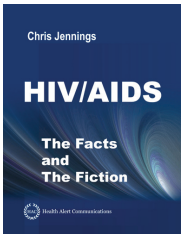
Communication in Life Sciences

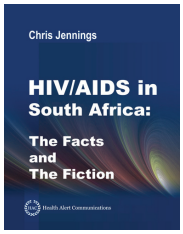
"UNAIDS estimated that the Republic of South Africa had 350,000 HIV/AIDS deaths in 2007. After tabulating all deaths for 2007, the Republic of South Africa attributed only 13,521 deaths to HIV/AIDS."

In the same year ● 76,761 TB deaths ● 49,722 pneumonia deaths ● 37,398 deaths from intestinal infections.

By 2009, an estimated **900,000 South Africans** were receiving rather toxic anti-HIV medications, the majority of whom probably lacked HIV infection – while other curable diseases likely went untreated and/or undiagnosed.



HIV/AIDS - The Facts and the Fiction
Chris Jennings
Health Alert Communications
ISBN: 978-0-936571-11-9
Paperback
$45.00



HIV/AIDS in South Africa - The Facts and the Fiction
Chris Jennings
Health Alert Communications
ISBN: 978-0-936571-08-9
Paperback
$25.00

Unfortunately, the health authorities in the Republic of South Africa grant more validity to the computer-generated estimates than to their own empirical death counts. ***HIV/AIDS in South Africa - The Facts and the Fiction*** discusses why these mathematically modeled estimates, and the HIV sero-prevalence surveys upon which they are based, are simply implausible.

"The theory that AIDS originated in African monkeys arose from an incident of laboratory contamination."

Two new books dispel the prevailing myths and misconceptions about HIV/AIDS and the HIV/AIDS epidemic – by accurately reporting the contents of the scientific and medical literature. Based on a forensic review of over 3000 scientific and medical journal articles and fully referenced, ***HIV/AIDS – The Facts and the Fiction*** and ***HIV/AIDS in South Africa - The Facts and the Fiction*** redefine global concepts for the prevalence and distribution of HIV infection, and have powerful implications for HIV/AIDS funding, research prerogatives, and global health care interventions.

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The scientific literature is clear: (1) New York City is the epicenter of the AIDS epidemic; (2) the theory that HIV came from monkeys is a fallacy – the theory that AIDS originated in African monkeys arose from an incident of laboratory contamination; and (3) the African AIDS epidemic-as-holocaust never manifested.

"The first Africans diagnosed with AIDS were residents of Belgium."

View the Tables of Contents, and learn more about these books at **Amazon.com**. Buy the books today and join the growing consensus calling for more appropriate action on third world health.

HIV/AIDS – The Facts and the Fiction:
http://www.amazon.com/gp/product/093657111X/

HIV/AIDS in South Africa - The Facts and the Fiction:
http://www.amazon.com/gp/product/093657108X/

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About the Author: Chris Jennings (Harvard, B.A., Biology 1976) excels at writing scientific books that fulfill the needs of professionals while rendering the science accessible and easy to read. His prior book, **Understanding and Preventing AIDS: A Book for Everyone**, was favorably reviewed by the ***New England Journal of Medicine*** ● adopted for staff education by Massachusetts General Hospital – the hospital affiliated with Harvard Medical School; the U.S. Department of Health and Human Services (HHS); the National Institutes of Allergy and Infectious Diseases (NIAID); and Walter Reed Army Medical Institute ● sold in medical bookstores ● purchased by innumerable city and state health agencies ● and utilized as a textbook at colleges, nursing schools, and public health schools.

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In addition to conducting investigative research of the scientific and medical literature, Chris Jennings provides writing services to the pharmaceutical, medical, and diagnostic industries. He has written HIV assay (HIV antibody test) specification sheets, articles about the juxtaposition of the HIV assay in the diagnosis and clinical management of HIV infection, articles about diagnostic assay architecture, and clinical trial reports for submission to the U.S. Food and Drug Administration (FDA) on several antiretroviral drugs and drugs versus AIDS-related opportunistic infections.

The Implications

- Only a tiny fraction of the 6.6 million people in Africa who are receiving anti-retroviral drugs actually have HIV infection. Not only are the anti-retroviral drugs potentially toxic, "the frightening scenario looms that widespread, but curable, diseases are wrongly classified as AIDS-related complex, thereby foregoing appropriate treatment." *

- The goals of health care interventions in Africa include: voluntary circumcision of up to seventy percent of all 18- to 49-year-old adult males not infected with HIV; antiretroviral therapy > 90% of HIV-infected adults; and antiretroviral therapy to 95% of HIV-infected pregnant women (the majority "diagnosed" by HIV antibody tests that evidently generate avalanches of false-positives in tropical, indigent populations).

- AIDS/HIV research consumes 42% of government, corporate, and philanthropic research funding while the two largest killers in the third-world (pneumonia and diarrhea) receive less than 6 per cent combined; tuberculosis remains the biggest killer in the third world.

- Critics of HIV/AIDS interventional policies say that such monies and parallel healthcare infrastructures injected into third world countries undermines the development of domestic health care and sanitation systems attuned to domestic health requirements.

* quote by Derbyshire SW, *AIDS Anal Afr*. Dec 1995

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The Fallacy of HIV's African Origin

As principal investigator at the Harvard School of Public Health, **Max Essex, was recently awarded $20 million to study HIV prevention in Botswana** – a meagre reward for the man who played a pivotal role in creating the current conceptual model of the HIV/AIDS epidemic, compared to the billions distributed annually.

Essex's erroneous research spawned the theory that HIV originated in African monkeys. This misconception is critical because the concept is a pillar for the fallacy that HIV/AIDS is endemic in Africa.

In 1985, it was Essex and his team of investigators that "discovered" an "AIDS-like" virus in the blood sample of wild-caught **African green monkeys** (AGM). This "AIDS-like" virus eventually came to be called SIV, the Simian Immunodeficiency Virus; even though it did not cause immunodeficiency in African green monkeys.

Yet, in 1988 – only 3 years later – the truth came out! SIV was not from Africa! SIV was not a new virus! Rather, what was thought to be SIV was actually another virus, which had contaminated the blood samples of the African Green monkeys.

This contaminating virus originally came from Rhesus macaque monkeys. As a species, Rhesus macaques originated in Asia, but these particular Rhesus macaques were residents of the United States, and lived at the New England Regional Primate Research Center (NEPRC) in Southborough, Massachusetts, where various species of primates were housed and bred for the purpose of medical experimentation.

Several months prior to the discovery of "SIV," a researcher at NEPRC, **Phyllis Kanki**, had isolated the virus from 4 sick Rhesus macaques monkeys. She then gave Max Essex a sample. Three years later, another group of investigators compared the genetic structures of SIV ("discovered" by Essex) and the virus from Rhesus macaques. Genetically, the two viruses were 99% identical; meaning they were the same virus. The viruses Kanki had given Essex had contaminated the blood samples of the wild-caught AGMs in the team Essex laboratory (the blood samples but not the monkeys were brought over from Africa).

In 1988, ***Nature***, the leading interdisciplinary scientific journal, published a letter by Essex admitting this contamination and its source. Nature also published the genetic analysis that exposed the contamination. However, both the admission and the genetic analysis seemed to pass unnoticed by the medical and scientific community at large – even though Nature followed up several months later with a short editorial entitled "Human AIDS Virus Not From Monkeys".

Nonetheless, 6 months after Essex's letter of admission was published in Nature, ***Scientific American*** – a magazine of far greater distribution – published an article co-written by Essex and Kanki entitled "The Origins of the AIDS Virus" which featured a full-page, color photo of the African green monkey.

About Charles Geshekter:

Charles Geshekter is a Professor Emeritus of African History at University of California, Chico. He lived in Africa for 3 years, visited Africa 20 times on professional excursions, served as advisor to the American Ambassador of Somalia, and served as a member of the South African AIDS Advisory Council.

Charles Geshekter is the author of the following newspaper article and another journal article, located further below.

Charles Geshekter is what is commonly called an "HIV dissenter" or and "AIDS dissenter." He belongs to a community of people who believe HIV is not the cause of AIDS. Rather, they believe AIDS is caused by other health and/or lifestyle issues.

Chris Jennings does NOT support this view.

However, given Professor Geshekter's expertise and experience in African affairs, Geshekter's contributes valuable, first-hand information regarding the purported devastating HIV/AIDS epidemic in Africa.

From Chris Jennings' point of view, HIV/AIDS undoubtedly exists in Africa (and throughout the world), the purported levels of HIV prevalence in Africa (up to 25% of some countries), and the number of African deaths attributed to HIV/AIDS (millions annually) are entirely implausible. In essence, the hyperbolic statistics for HIV/AIDS prevalence and deaths belie the recognized rates of sexual HIV transmission, and belie the basic tenets of blood-borne disease. A blind belief in the outcomes of HIV antibody testing surveys perpetuates this erroneous conceptual paradigm.

The plague that isn't

Poverty is killing Africans, not an alleged AIDS pandemic, says U.S. policy adviser

Charles Geshekter

The United Nations calls it the "worst infectious disease catastrophe since bubonic plague." U.S. Senator Barbara Boxer advocates spending $3-billion to "fight AIDS." And delegates at last month's National Summit on Africa in Washington pleaded for more money to wage war on AIDS. But the scientific data do not support these claims. The whole subject needs a healthy dose of skepticism.

I recently made my 15th trip to Africa to find out more. Let's start with a few basic facts about HIV, AIDS, African record-keeping and socio-economic realities. What are we counting? The World Health Organization defines an AIDS case in Africa as a combination of fever, persistent cough, diarrhea and a 10-per-cent loss of body weight in two months. No HIV test is needed. It is impossible to distinguish these common symptoms — all of which I've had while working in Somalia — from those of malaria, tuberculosis or the indigenous diseases of impoverished lands.

By contrast, in North America and Europe, AIDS is defined as 30 odd diseases in the presence of HIV (as shown by a positive HIV test). The lack of any requirement for such a test in Africa means that, in practice, many traditional African diseases can be and are reclassified as AIDS. Since 1994, tuberculosis itself has been considered an AIDS-indicator disease in Africa.

Dressed up as HIV/AIDS, a variety of old sicknesses have been reclassified. Post mortems are seldom performed in Africa to determine the actual cause of death. According to the Global Burden of Disease Study, Africa maintains the lowest levels of reliable vital statistics for any continent — a microscopic 1.1 per cent. "Verbal autopsies" are widely used because death certificates are rarely issued. When AIDS experts are asked to prove actual cases of AIDS, terrifying numbers dissolve into vague estimates of HIV infection.

The most reliable statistics on AIDS in Africa are found in the WHO's Weekly Epidemiological Record. The total cumulative number of AIDS cases reported in Africa since 1982, when AIDS record-keeping began, is 794,444 — a number starkly at odds with the latest scare figures, which claim 2.3 million AIDS deaths throughout Africa for 1999 alone.

More reliable, locally based statistics rarely exist. In December, I interviewed Alan Whiteside of the University of Natal, a top AIDS researcher in South Africa and asked for details of the alleged 100,000 AIDS deaths in South Africa in the last year. He laughed aloud. "We don't keep any of those statistics in this country," he said. "They don't exist."

And South Africa is more advanced than most African countries in that it conducts HIV tests in surveys of about 18,000 pregnant Africans annually. The HIV-positive numbers are then extrapolated. But there are two problems with this: The women are given a blood test known as ELISA, which frequently gives a "false positive" result (one condition that can trigger a false alarm is pregnancy). Even the packet insert in the ELISA-test kit from Abbott Labs contains the disclaimer: "There is no recognized standard for establishing the presence or absence of HIV-1 antibody in human blood."

Secondly, it's well understood that many endemic infections will produce so much cross-contamination that a single ELISA test is virtually useless. When I asked Thuli Nxege, a 28-year-old domestic worker from a rural Zulu township, what made her neighbours sick, she cited tuberculosis, and added that the lack of sanitary facilities and having open latrine pits adjacent to village homes made it difficult to prepare clean food.

Beauty Nongila, principal of a rural school in north Zululand, insisted that building more toilets would improve the health of her 408 students (her sparsely-equipped elementary school has four). She struggled to provide her underfed kids with a spartan lunch on an allowance of 8 cents a day. When I inquired about the AIDS crisis, she laughed and said that dental problems, respiratory illnesses, diarrhea and chronic hunger were far more vexing.

The World Health Organization defines an AIDS case in Africa as a combination of fever, persistent cough, diarrhea and a 10-per-cent loss of body weight in two months. No HIV test is needed. It is impossible to distinguish these common symptoms from those of malaria, tuberculosis or the indigenous diseases of impoverished lands. WILLIAM SAVAGE/Daily Mirror/Morning News

Figures about children orphaned by AIDS also bear closer examination. The average fertility rate among African women is 5.8 and the risk of death in childbirth is one in three. The African life span is not long — 50 for women and 47 for men — so it would not be surprising, on a continent of 650 million people, if there were not even more than 10 million children whose mothers had died before they reached high-school age.

The scandal is that long-standing ailments that are largely the product of poverty are being blamed on a sexually transmitted virus. With missionary-like zeal, but without evidence, condom manufacturers and AIDS fund-raisers attribute those symptoms to an "African sexual culture." Rev. Eugene Rivers of Boston has launched a crusade to change African sexual practices — a crusade reminiscent of Victorian voyeurs whose racist constructs equated black people with sexual promiscuity.

In South Africa, which will host the International AIDS Conference in July, criticism is on the rise. Some journalists and physicians are challenging the marketing of anxieties and questioning the epidemic.

Late last year, South African President Thabo Mbeki launched an investigation into the safety and benefits of AZT, a toxic and expensive drug that produces abnormalities in laboratory animals; its life-extending benefits remain unproved. South Africa's Minister of Health, Manto Tshabalala-Msimang (a physician herself), told South African television audiences in December that she would not recommend AZT, advice echoed on the same program by Dr. Sam Mhlongo of the National Medical University in Pretoria.

I'd argue that wearing red ribbons or issuing calls to condomize the continent will do little for the health of Africans. By contrast, a 1998 study of pregnant, HIV-positive women in Tanzania showed that simply providing them with inexpensive micronutrient supplements produced beneficial effects during and after pregnancy. The researchers found that women who received prenatal multivitamins had heavier placentas, gave birth to healthier babies and showed a noticeable "improvement in fetal nutritional status, enhancement of fetal immunity and decreased risk of infections."

Once AIDS activists consider the non-contagious, indigenous-disease explanations for what are called AIDS, they may see things differently. The problem is that dysentery and malaria do not yield headlines or fatten public-health budgets. "Plagues" and infectious diseases do.

This means that those who question AIDS in Africa put their own funding at risk. I saw this at first-hand when I visited Swaziland in mid-December at the invitation of their HIV/AIDS Crisis Management Committee. I was driven from the airport to the hotel in a late model 4-wheel drive vehicle. It had been donated by UNICEF and was covered with AIDS posters urging Swazis to "use a condom, save a life." The committee included representatives of the major government ministries, as well as church and women's groups.

After my presentation, an attorney named Teresa Mlangeni acknowledged that she could easily see how malnutrition, tuberculosis, malaria and other parasitic infections — not sexual behaviour — were making her fellow Swazis ill. But other committee members confided that if they voiced public doubts, they risked losing their international funding. And I realized that the vested interests of the international AIDS orthodoxy would discourage further inquiries.

Traditional public-health approaches, clean water and improved sanitation above all can tackle the underlying health problems in Africa. They may not be sexy, but they will save lives, and they will surely stop terrorizing an entire continent.

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Charles L. Geshekter is a three-time Fulbright scholar who teaches African history at California State University in Chico. He has served as an adviser to the U.S. State Department and several African governments.

Full marks for Mike

A recent high-school grad applauds the Ontario Premier's tough stand with teachers

LYDIA LOVRIC

Premier Mike Harris recently announced that Ontario's teachers will supervise extracurricular activities before and after school starting this fall, whether they want to or not. As a recent high-school graduate, I applaud the Premier for his efforts to ensure that high-school students receive access to a well-rounded education that includes sports and academic clubs or organizations.

Unfortunately, some secondary-school teachers, upset with changes made by the provincial government, have decided to protest by punishing students. Ever since the introduction of Bill 160 three years ago — a bill that requires teachers to teach seven instead of six classes a day — certain teachers have simply refused to supervise extracurricular activities.

Although teachers in Ontario currently spend four hours and 10 minutes in the classroom each day, they claim that additional time is required to plan and prepare lessons and mark students' work. As someone who has only recently completed high school, I know that teachers do spend time preparing lessons. But I also know that many secondary-school teachers are responsible for the same courses year after year, greatly reducing the preparation needed.

An example: One math teacher at my high school put all his lessons on overheads and brought these to each of his classes. He taught the same math courses year after year and simply used the overheads again and again. English teachers teach the same texts and therefore have much less to prepare. They don't have to study *Julius Caesar* or *A Tale of Two Cities* from scratch if they covered both the year before. I fail to see why all this prep time is needed.

I also don't understand why so much marking time is required. Nearly every teacher I had in high school marked papers and tests during class time. Many actually had the students mark. It was common for us to exchange quizzes and tests with fellow classmates so the teacher wouldn't have to mark each one individually. In any event, I don't believe that teachers spend such an incredible amount of time grading papers at home when so much is done in class.

Obviously, there are exceptions. I've had some incredible teachers who are extremely dedicated and work very hard, both in and out of the classroom. But they seem to be the exception at the high-school level and not the rule.

Before the introduction of Bill 160, Ontario teachers spent the least amount of time in the classroom compared with teachers in other provinces. Now Ontario teachers are at the national average — yet teachers outside the province still seem to find time for the extracurriculars that are currently a problem in Ontario. Requiring our teachers to be in the classroom for a little more than four hours a day and spend some time supervising extracurricular activities is not outrageous — especially when one factors in the two months of summer vacation teachers enjoy.

There are many other professions that require 10- to 12-hour workdays, and even then, employees still bring work home, and work the occasional weekend, to ensure that the job gets done. Why then, do teachers seem to be so out of touch?

Extracurricular activities are an integral part of a well-rounded education. I've probably benefited more from extracurricular activities than I have from actual classes. Sports ensure good physical fitness and teach strategy and sportsmanship. Academic clubs, such as debating, serve to strengthen one's mind and ability to communicate with others intelligently. Studies also indicate that students who participate in extracurricular activities are less likely to become involved in risky behaviour. Clearly, these activities benefit not only the students, but society as a whole. Teachers need to stop taking students hostage by withholding extracurricular activities. Nobody wins from such bully tactics.

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Lydia Lovric is a freelance writer and a student at McMaster University. She has served as a member of the provincial delegation at the Forum for Young Canadians in Ottawa.

THE GLOBE AND MAIL

Comment

The plague that isn't
Poverty is killing Africans, not an alleged AIDS pandemic, says U.S. policy adviser Charles Geshekter

Charles Geshekter
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Beauty Nongila, principal of a rural school in north Zululand, insisted that having more toilets would improve the health of her 408 students (her sparsely-equipped elementary school has four). She struggled to provide her underfed kids with a spartan lunch on an allowance of 8 cents a day. When I inquired about the AIDS crisis, she laughed and said that dental problems, respiratory illnesses, diarrhea and chronic hunger were far more vexing.

Figures about children orphaned by AIDS also bear closer examination. The average fertility rate among African women is 5.8 and the risk of death in childbirth is one in three. The African life span is not long -- 50 for women and 47 for men -- so it would not be surprising, on a continent of 650 million people, if there were not even more than 10 million children whose mothers had died before they reached high-school age.

The scandal is that long-standing ailments that are largely the product of poverty are being blamed on a sexually transmitted virus. With missionary-like zeal, but without evidence, condom manufacturers and AIDS fund-raisers attribute those symptoms to an "African sexual culture." Rev. Eugene Rivers of Boston has launched a crusade to change African sexual practices -- a crusade reminiscent of Victorian voyeurs whose racist constructs equated black people with sexual promiscuity.

In South Africa, which will host the International AIDS Conference in July, criticism is on the rise. Some journalists and physicians are challenging the marketing of anxieties and questioning the epidemic.

Late last year, South African President Thabo Mbeki launched an investigation into the safety and benefits of AZT, a toxic and expensive drug that produces abnormalities in laboratory animals; its life-extending benefits remain unproved. South Africa's Minister of Health, Manto Tshabalala-Msimang (a physician herself), told South African television audiences in December that she would not recommend AZT, advice echoed on the same program by Dr. Sam Mhlongo of the National Medical University in Pretoria.

I'd argue that wearing red ribbons or issuing calls to condomize the continent will do little for the health of Africans. By contrast, a 1998 study of pregnant, HIV-positive women in Tanzania showed that simply providing them with inexpensive micronutrient supplements produced beneficial effects during and after pregnancy. The researchers found that women who received prenatal multivitamins had heavier placentas, gave birth to healthier babies and showed a noticeable "improvement in fetal nutritional status, enhancement of fetal immunity and decreased risk of infections."

Once AIDS activists consider the non-contagious, indigenous-disease explanations for what are called AIDS, they may see things differently. The problem is that dysentery and malaria do not yield headlines or fatten public-health budgets. "Plagues" and infectious diseases do.

This means that those who question AIDS in Africa put their own funding at risk. I saw this at first-hand when I visited Swaziland in mid-December at the invitation of their HIV/AIDS Crisis Management Committee. I was driven from the airport to the hotel in a late model 4-wheel drive vehicle. It had been donated by UNICEF and was covered with AIDS posters urging Swazis to "use a condom, save a life." The committee included representatives of the major government ministries, as well as church and women's groups.

After my presentation, an attorney named Teresa Mlangeni acknowledged that she could easily see how malnutrition, tuberculosis, malaria and other parasitic infections -- not sexual behaviour -- were making her fellow Swazis ill. But other committee members confided that if they voiced public doubts, they risked losing their international funding. And I realized that the vested interests of the international AIDS orthodoxy would discourage further inquiries.

Traditional public-health approaches, clean water and improved sanitation above all can tackle the underlying health problems in Africa. They may not be sexy, but they will save lives. And they will surely stop terrorizing an entire continent.

Charles L. Geshekter is a three-time Fulbright scholar who teaches African history at California State University in Chico. He has served as an adviser to the U.S. State Department and several African governments.

Illustration

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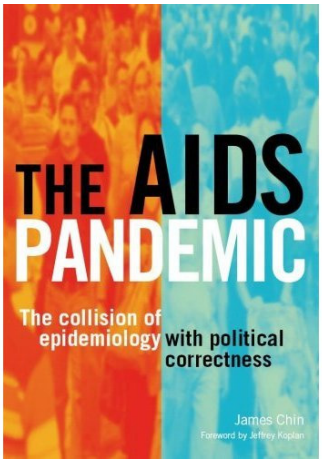
The AIDS Pandemic: The Collision of Epidemiology With Political Correctness

by James Chin

Dr. Chin was former Chief of the Surveillance, Forecasting, and Impact Assessment (SFI) unit of the Global Programme on AIDS (GPA), of the World Health Organization (WHO), Geneva, Switzerland. He was instrumental in developing the computer model used by the World Health Organization to estimate HIV prevalence in Africa. Reportedly, Dr. James Chin quit in protest over the WHO's consistent use of the most hyperbolic computer estimates, and then wrote this book.

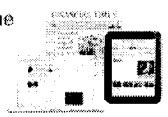
Radcliffe Publishing, 2007



This book exposes the extent AIDS programs developed by international agencies and faith-based organizations are more socially, politically, and moralistically correct than epidemiologically accurate or relevant. This is the first book to provide an objective assessment of the AIDS pandemic, offering clear and rational conclusions drawn to challenge the position of UNAIDS and most AIDS activists (*Amazon.com*).

About the Author:

- Clinical Professor of Epidemiology, School of Public Health, University of California, Berkeley



Disease research funds neglect big killers

By Andrew Jack in London
Published: February 4 2009 19:00 | Last updated: February 4 2009 19:00

Three quarters of funding to find treatments for "neglected diseases" goes to just three big killers, according to a pioneering attempt to track support to health research by governments, companies and philanthropists.

HIV/Aids, malaria and tuberculosis consume respectively 42 per cent, 18 per cent and 16 per cent of the estimated $2.6bn given for research and development in 2007, while less than 6 per cent goes to pneumonia and diarrhoeal illness, the two largest killers in the developing world.

EDITOR'S CHOICE

US boosted by Human Genome Project - May-11

US apologises for Guatemala STD study - Oct-01

Opinion: Don't write off the Republicans' pledge - Sep-23

Editorial: Limits to genetics - Aug-12

Editorial Comment: Health and safety - Dec-21

Trials dash prostate cancer vitamin hope - Dec-09

The figures highlight mismatches between disease impact and funding, as well as heavy reliance on a handful of donors. They will help fuel a debate about where to allocate resources likely to become increasingly scarce in the next few years as a result of the global financial crisis squeezing public and private donors alike.

The study, conducted by the George Institute for International Health in Australia, and funded by the Bill & Melinda Gates Foundation, showed that 60 per cent of funding came from just two entities – the US National Institutes of Health and the Gates Foundation.

The European Commission, the US Department of Defense and the US Agency for International Development were the next most important, while the pharmaceutical industry contributed 9 per cent.

Mary Moran, the study leader, said: "The good news is that neglected diseases are on the global agenda. The bad news is that some of the biggest killers have few advocates."

At the launch of the report in London on Wednesday, John Worley from the Department for International Development, called for "better priority setting mechanisms", while stressing that the UK government remained committed to health as part of its pledge to raise development funding to 0.7 per cent of gross national income by 2013.

Chris Hentschel, head of the Medicines for Malaria Venture, a product development partnership which raises and allocates funds for the development of new malaria treatments, stressed the difficulties of how to allocate funding in order to ensure the maximum improvement in health.

Andrew Farlow, from Oriel College at Oxford University, cautioned that most current funding came from large industrialised countries running substantial budget deficits, and argued that for sustainability, more should come instead from emerging economies with budget surpluses such as China.

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The HPTN 052 trial results on the effect of treatment on the sexual transmission of HIV[1] should help transform the fight against HIV. They should pave the way for the development of normative guidance by international technical agencies to inform investments. The Global Fund is finalising its 5-year strategy for 2012–16, with an ambitious target to accelerate the scale-up of antiretroviral treatment (ART). At present, more than half of the 6 million people who receive ART in low-income and middle-income countries do so through programmes supported by the Global Fund.[2]

As suggested in the new HIV investment framework proposed by experts from UNAIDS and other key institutions,[3] ART needs to be combined with targeted behaviour-change programmes to develop an integrated response to the HIV epidemic that will support change at the individual and community levels, develop community responses, reduce stigma, and ensure the optimum uptake of biomedical and other services.[4] These basic programme activities need to be underpinned by crucial programme enablers such as targeted communication interventions[5] to achieve an optimum comprehensive response.

As we celebrate the game-changing results from the HPTN 052 trial about the effects of treatment on HIV transmission, we should not hastily abandon non-biomedical elements of HIV prevention but support a comprehensive and integrated response guided by the new proposed investment framework to ensure an effective response.

We declare that we have no conflicts of interest.

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The Global Fund to Fight AIDS, Tuberculosis and Malaria, 1214 Vernier, Swtizerland

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2 The Global Fund to Fight AIDS, Tuberculosis and Malaria. Making a difference: Global Fund results report 2011. Geneva: The Global Fund, 2011.
3 Schwartländer B, Stover J, Hallett T, et al. Towards an improved investment approach for an effective response to HIV/AIDS. *Lancet* 2011; **377:** 2031–41.
4 WHO, UNAIDS, UNICEF. Towards universal access: scaling up priority HIV/AIDS interventions in the health sector. Geneva: World Health Organization, 2010.
5 Bertrand JT, O'Reilly K, Denison J, Anhang R, Sweat M. Systematic review of the effectiveness of mass communication programs to change HIV/AIDS-related behaviors in developing countries. *Health Educ Res* 2006; **21:** 567–97.

A strategic revolution in HIV and global health

Your Editorial (June 18, p 2055)[1] sees a new leadership role for UNAIDS in global health, with AIDS at the leading edge of a new movement for integrating health responses to disease. This Editorial is obviously based on the self-serving press releases and reports of UNAIDS. The UNAIDS Strategic Plan[2] on which these are based was itself prepared by consultants charged with saving UNAIDS in the light of rapidly increasing awareness of its irrelevance to global health. Only when the writing was so clearly on the wall for UNAIDS did the organisation commission this work to try to reposition UNAIDS given that international funding is shifting from HIV to health systems development.

This play for leadership based on strengthening health systems and integrating vertical programmes now being promoted by UNAIDS is, of course, an admission that the organisation was ill-founded in the first place: it has been the main promoter of the biggest vertical programme in history. So UNAIDS is now to assume "a potentially new leadership role in global health"?[1] The idea is farcical. It should be closed and *The Lancet*'s Editor has said as much in an earlier Comment.[3]

UNAIDS tops a significant list of self-serving UN organisations existing mainly to keep international bureaucrats and their technocrats in jobs—an aim *The Lancet* seems keen to support in this case. If *The Lancet* does not have the time to critique properly this UNAIDS spin on reality, then it should at least decline to promote it. If more integrated and efficient health systems are to materialise, they will be achieved at country level by those who for a decade have been fighting the disease-dedicated funding fads of international agencies—led of course by funding for HIV. That this is now changing is good. That it needs global leadership is debatable. That this leadership could be provided by UNAIDS is ridiculous.

I declare that I have no conflicts of interest.

Roger England
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Health Systems Workshop, Box 1350, Grande Anse, St George's, Grenada

1 The Lancet. A strategic revolution in HIV and global health. *Lancet* 2011; **377:** 2055.
2 UNAIDS. Getting to zero: 2011–2015 UNAIDS strategy. http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/20101221_JC2034E_UNAIDS-Strategy_en.pdf (accessed June 29, 2011).
3 Horton R. Offline: Revising our expectations. *Lancet* 2011; **377:** 14.

Body-mass index, abdominal adiposity, and cardiovascular risk

The conclusion of the Emerging Risk Factors Collaboration (March 26, p 1085),[1] that measures of abdominal obesity do not add to the association of body-mass index (BMI) with cardiovascular disease, is not supported by the data in the paper or those from several independent studies.

First, after adjustment for systolic blood pressure, diabetes, and total and HDL cholesterol, the waist-to-hip ratio had a hazard ratio that was significantly greater (1·12, 95% CI 1·08–1·15) than that of BMI (1·07, 1·03–1·11; p for heterogeneity=0·028; assuming the two regression coefficients are correlated at ≥0·4,

Etica & Politica / Ethics & Politics, IX, 2007, 2, pp. 330-370

Myths and Misconceptions of the Orthodox View of AIDS in Africa

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"Nothing in life is to be feared. It is only to be understood."
Marie Curie

"To kill an error is as good a service as,
and sometimes even better than, establishing a new truth or fact."
Charles Darwin

ABSTRACT

This article rebuts conventional claims that AIDS in Africa is a microbial problem to be controlled through sexual abstinence, behavior modification, condoms, and drugs. The orthodox view mistakenly attributes to sexual activities the common symptoms that define an AIDS case in Africa - diarrhea, high fever, weight loss and dry cough. What has really made Africans increasingly sick over the past 25 years are deteriorating political economies, not people's sexual behavior. The establishment view on AIDS turned poverty into a medical issue and made everyday life an obsession about safe sex. While the vast, self-perpetuating AIDS industry invented such aggressive phrases as "the war on AIDS" and "fighting stigma," it viciously denounced any physician, scientist, journalist or citizen who exposed the inconsistencies, contradictions and errors in their campaigns. Thus, fighting AIDS in Africa degenerated into an intolerant religious crusade. Poverty and social inequality are the most potent co-factors for an AIDS diagnosis. In South Africa, racial inequalities rooted in *apartheid* mandated rigid segregation of health facilities and disproportionate spending on the health of whites, compared to blacks. *Apartheid* policies ignored the diseases that primarily afflicted Africans - malaria, tuberculosis, respiratory infections and protein anemia. Even after the end of *apartheid*, the absence of basic sanitation and clean water supplies still affects many Africans in the former homelands and townships. The article argues that the billions of dollars squandered on fighting AIDS should be diverted to poverty relief, job creation, the provision of better sanitation, better drinking water, and financial help for drought-stricken farmers. The cure for AIDS in Africa is as near at hand as an alternative explanation for what is making Africans sick in the first place.

AIDS Anal Afr. 1995 Dec;5(6):4-5.

WHO criticised for "inflating" AIDS figures.

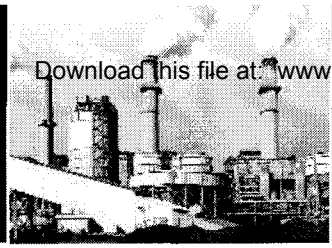
Derbyshire SW.

Abstract

The World Health Organization (WHO) has issued exaggerated projections about AIDS deaths that the press picked up to paint an apocalyptic future for Africa. Computer models used by WHO estimate that 2-3 million people in Africa are suffering or have died from AIDS since the early 1980s and another 10 million are carrying HIV. WHO surveys during 1987 indicated HIV seroprevalence rates from 5% to 30%. The Global Program on AIDS (GPA) utilized these data to predict 6.5 million new AIDS deaths annually by 1997, which would reduce population growth in urban areas by over 30%. This projection seems to be an exaggeration. The same 1987 figures were used to predict AIDS deaths for 1992. **Using the highest seroprevalence rate of 30%, the WHO model predicted a high scenario of 6 million new AIDS deaths in 1992, when in fact the cumulative cases were only 331,376 in 1994.** Even the low scenario of a 5% seroprevalence rate predicted 750,000 new AIDS cases for 1992, whereas the 1% rate suggested 500,000 new AIDS cases. Another projection made in 1994 estimated only 350,000 new AIDS cases for Africa in 1994. The discrepancies between projections and recorded figures are attributable to lack of statistical data and reliable reporting of mortality. National estimates are derived from censuses and surveys which are overextrapolated. **Since 1985, AIDS has been defined in Africa on the basis of clinical observation (chronic diarrhea or prolonged fever and persistent cough or herpes) because of lack of HIV testing facilities.** However, it is impossible to tell whether someone who develops malaria does so because of AIDS or because of normal impaired immunity. This definition has inflated the estimated AIDS figures. **The danger of the AIDS epidemic is dwarfed by 3.5 million deaths from tuberculosis and 16.8 million deaths from malaria since the beginning of the AIDS epidemic. The frightening scenario looms that widespread, but curable, diseases are wrongly classified as AIDS-related complex, thereby foregoing appropriate treatment**. [Bold added]

PMID: 12319962

http://www.ncbi.nlm.nih.gov/pubmed?term=12319962



Capturing carbon 184

Autism and the synapse 190

slowed, the nuclei may never be accelerated to 40 EeV, he says.

Whatever its cause, the fall-off leads some to question the need to build a bigger array, as the Auger team hopes to do in the Northern Hemisphere. "Once you see the cutoff—even if you disagree about what it is—then building a bigger detector hardly gets you anything," because there are so few higher energy particles to capture, says Gordon Thomson, a Hi-Res member from Rutgers University in Piscataway, New Jersey. Members of the Hi-Res and AGASA teams are building a detector in Utah called the Telescope Array, which will be three-eighths the size of Auger. That may be just the right size, Thomson says.

Others say that only a bigger array can amass enough data to trace the fall-off in detail. "Now we understand that above the GZK cutoff there are ten times less cosmic rays than we thought 10 years ago, so we may need a detector ten times as big as Auger," says Masahiro Teshima of the Max Planck Institute for Physics in Munich, Germany, who worked on AGASA and is working on the Telescope Array.

The few highest energy, straightest flying particles will be crucial for determining whether high-energy cosmic rays emanate from particular points or patches in the sky, says James Cronin of the University of Chicago, Illinois, who, with Watson, dreamed up the Auger array in the early 1990s. Such "anisotropy" might reveal the rays' origins, and "if we can show an anisotropy, then that's a brilliant breakthrough," he says. Mapping the sky could take a decade—although Cronin and Watson hint they may have already seen something exciting that's not yet ready for release. **–ADRIAN CHO**

HIV/AIDS

India Slashes Estimate of HIV-Infected People

Contrary to previous estimates, India does not have more HIV-infected people than any country in the world, says a new analysis by government health officials. Improved and widened surveys of the country's massive population has led India's National AIDS Control Organization (NACO) to slash by more than half the estimated number of people infected, from 5.7 million to 2.5 million. NACO, which announced the new figures on 6 July, says HIV thus infects 0.36% of the country's adults, rather than 0.9%. "The figures are now much more realistic," says N. K. Ganguly, the head of the Indian Council of Medical Research in New Delhi who chaired a meeting that reviewed the new NACO numbers. Ganguly, who long worried that epidemiologists had exaggerated the scale of India's epidemic, adds that he was "very happy" that a look back analysis also found that HIV was not gaining ground in this huge country.

The Joint United Nations Programme on HIV/AIDS (UNAIDS), which advised NACO and earlier issued the higher estimate, supports the new figures. "We're much more confident that the estimates being put out are as accurate as they can be," says epidemiologist Peter Ghys, who heads the UNAIDS branch that produces the oft-cited estimates for most countries.

In the past, India's HIV estimates have relied heavily on a limited number of "sentinel" surveillance sites, like clinics for pregnant women. But such analyses capture more data from urban than rural areas and miss many high-risk groups such as injecting drug users or men who have sex with men. The new analysis includes data from 400 new sentinel sites added since 2006—there were just 764 in 2005—as well as voluntary blood samples taken from more than 100,000 people in a national household survey.

NACO's estimates of HIV-infected people still are far from exact, ranging from 2 million to 3.1 million. But that's more certainty than portrayed by UNAIDS in 2006, which estimated India's HIV-infected population at 3.4 million to 9.4 million. The range is "some indication that at the time we were not as confident as we are today about the estimates," says UNAIDS's Ghys.

The lowered estimates and the reanalysis of data back to 2002 indicate that the country has had a stable epidemic with a "marginal decline" last year, NACO says. This challenges the idea that India is on an "African trajectory"—with the virus moving from concentrated risk groups such as sex workers and truck drivers to ▸

Country	HIV/AIDS cases (millions)	Adult prevalence (%)	Population (millions)
South Africa	5.5	18.6	44
Nigeria	2.9	3.9	135
India	2.5	0.3	1,129
Mozambique	1.8	16.1	21
Swaziland	0.22	33.4	1.1
United States	1.2	0.6	301

No longer number one. Much wider sampling, including a national household survey that goes well beyond the "sentinel" surveillance sites, like the clinic above in Kolkata, has led to new, lower estimates of size of the AIDS epidemic in India.

CREDITS: MALCOLM LINTON (PHOTO); UNAIDS/CIA/NACO (DATA)

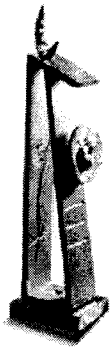
the general population—a controversial assertion made by epidemiologist Richard Feachem, former head of the Global Fund to Fight AIDS, Tuberculosis and Malaria (*Science*, 23 April 2004, p. 504). India expert and epidemiologist Robert Bollinger of Johns Hopkins University in Baltimore, Maryland, co-authored a 9 October 2004 *Lancet* article with Indian colleagues that explicitly criticized Feachem's prediction. "Frankly, I wouldn't be surprised if there were 6.1 million or 5 million or 2.5 million infected people, but the point is the epidemic is different in India," says Bollinger. A key distinction, he says, is outside of commercial sex workers, Indian women rarely have more than one sexual partner at the same time, a major driver of epidemics.

Suniti Solomon, who runs a private clinic in Chennai, YRG Care, stresses that India still faces a formidable challenge. "Whatever the numbers, if we are complacent ... the virus will spread faster," says Solomon. And she says many infected people still do not have access to anti-HIV drugs. The country is also seeing "worrying" rates of people who fail to respond to treatment and need more expensive second-line drugs, she says.

According to an April report issued by UNAIDS, the World Health Organization, and UNICEF, India had just over 55,000 people receiving anti-HIV drugs as of November 2006. The report, which relied on the old calculations of HIV prevalence, estimated that the number of people in need of immediate treatment ranged from 627,000 to 1.6 million. The new numbers mean "fewer people need treatment today and will need treatment in the future," says Ghys. Yet he, too, cautions that this doesn't suddenly make scaling up treatment simple.

UNAIDS's latest figures estimate that 39.5 million people worldwide are infected with HIV, which the revised Indian numbers would lower to 36.3 million. South Africa now has the unfortunate distinction of having more HIV-infected people—5.5 million as of 2005—than any country in the world.

–JON COHEN



AWARDS

Science Wins Communication Award

Science and *Nature* have jointly been named recipients of the prestigious 2007 Prince of Asturias Award for Communication and Humanities.

The award is made annually by Spain's Prince of Asturias Foundation, formed in 1980 under the presidency of His Royal Highness Prince Felipe de Borbón, heir to the throne of Spain. The foundation honors accomplishments by individuals, groups, or organizations in eight categories: communication and humanities, social sciences, arts, letters, scientific and technical research, international cooperation, concord, and sports.

In a statement, the foundation noted: "Some of the most important and innovative work of the last 150 years has appeared on the pages of *Science* and *Nature*, thus contributing to the birth and development of many disciplines, including Electromagnetism, Relativity, Quantum Theory, Genetics, Biochemistry and Astronomy. ... In 2001, the international community learned of the description of the human genome from the pages of both publications."

This year's awardees in other categories are former Vice President Al Gore (international cooperation), Bob Dylan (arts), developmental geneticists Ginés Morata of the Spanish National Research Council and Peter Lawrence of Cambridge University in the United Kingdom (scientific and technical research), and Hebrew writer and professor Amos Oz of the Ben-Gurion University in Israel (letters). Awards for social sciences, sports, and concord have not yet been announced.

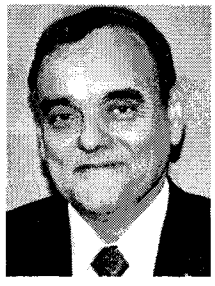
"We are delighted and deeply honored that our journal's contributions to public discourse on science and technology have been recognized by Spain's Crown Prince Foundation," said *Science*'s Editor-in-Chief Donald Kennedy.

The awards will be presented at a ceremony in Oviedo, Spain, in October.

CREDITS (TOP TO BOTTOM): NOAA; 2007 PRINCE OF ASTURIAS FOUNDATION

SCIENCESCOPE

Winds of Change



The head of the U.S. National Hurricane Center in Miami, Florida, has been placed on leave after a rebellion by fellow forecasters and staff. William Proenza (left), a longtime National Weather Service official and forecaster, has publicly complained about the center's budget since becoming director 7 months ago. One gripe was that its parent agency, the National Oceanic and Atmospheric Administration (NOAA), hadn't prepared to replace the aging QuikSCAT, a NASA satellite. Proenza had warned that its loss could worsen 3-day hurricane track forecasts by 16%.

But prominent center staff questioned the satellite's importance. And, in an unusually public letter last week, 23 of 50 center staff called for Proenza's removal, lamenting the "unfortunate public debate" over the center's forecasting ability. In May, NOAA chief Conrad Lautenbacher called Proenza's bluntness "one reason why we love him," but in a letter this week to center staff, he said there was "anxiety and disruption" at the center and that Proenza was leaving. Officials, who aren't saying why the move was made, have put center deputy Edward Rappaport in charge.

–ELI KINTISCH

Space Probes Add Side Trips

NASA is sending two decorated veterans out to collect more scientific data. After already having traveled 3.2 billion kilometers to pick up 1 microgram of dust from comet Wild 2 and having dropped it back to Earth for analysis, NASA's Stardust spacecraft will be visiting comet Tempel 1 in 2011. NASA's Deep Impact spacecraft fired a massive copper projectile at the comet on 4 July 2005, and researchers want Stardust to image the resulting impact crater to learn about the structure and porosity of the comet's nucleus. "A revisit is always a good idea," says Gerhard Schwehm, head of solar system science at the European Space Agency, although he warns that "Stardust's hardware was designed for a different purpose."

Meanwhile, Deep Impact also has been given a new assignment. It plans to fly past comet Boethin on 5 December 2008 after looking for transiting planets around other stars. NASA science chief Alan Stern says the new missions get "more from our budget."

–GOVERT SCHILLING

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South Africa: Deaths From AIDS Grossly Distorted

A new report by Health Alert has recalculated AIDS associated death estimates in South Africa- suggesting a significant inconsistency with presupposed numbers.

The country's AIDS prevalence is widely considered to be of epidemic proportions. WHO/UNAIDS statistics suggest hundreds of thousands of deaths each year in the state alone, so it follows that substantial research funding is being pumped into drug development by corporations, governments and philanthropic bodies alike.

Health Alert's new report *Where are the Bodies? — HIV/AIDS Statistics in South Africa*, however may turn existing policy towards the treatment of the disease on its head. The report challenges the assumptions underlying global estimates for the prevalence and distribution of HIV; raising further questions as to the actual market size for products related to treating infection.

Estimates from UNAIDS abound that the Republic of South Africa had 360,000 HIV/AIDS deaths in 1997, new tabulated surveillance data indicates only 6,635 deaths were actually attributed to HIV/AIDS.

UNAIDS also estimated that the country had 2.9 million people living with HIV/AIDS (PLWH) in the same year. Even given the 11-year survival period a substantial cluster of those individuals should have died by 2008; however the county tabulated a total of 136,000 HIV/AIDS deaths for the 11 years 1997-2008 inclusive, a figure far less than estimates would lead us to expect.

Report author Chris Jennings said 'One problem is that epidemiological models incorporate a misconception about the HIV incubation period.

'At the outset of the AIDS epidemic, the Centers for Disease Control actively tracked and

Contents

'At the outset of the AIDS epidemic, the Centers for Disease Control actively tracked and interviewed patients, and determined that HIV incubation averaged 8- 18 months. Fifty percent (50%) of these patients died within 12 months of manifesting opportunistic infection. Therefore the first AIDS deaths occur 20 months after infection, not 10 years as currently conceived; changing the distribution curve'.

The surveillance data has been inputted into Computer models using specific algorithm's to generate the results.

Health Alert report that pharmaceutical companies invest $300 million into developing anti-retroviral drugs thanks to an over-estimated market, but the most threatening diseases to mortality in the third-world; pneumonia, diarrhoea and tuberculosis, receive only marginal funding by comparison.

The organisation is not alone in its claim that the disease has been lent a disproportionate weight in terms of global policy and attention.

In establishing its own off-shoot agency UNAIDS, the UN has treated HIV 'like an economic sector rather than a disease', Roger England, chair of small Grenada-based think tank Health Systems Workshop, commented.

Health Alert challenges the common statistics oft cited by the UN with regards the epidemic in the country;

'The supposed HIV seroprevalence rates in the Republic of South Africa exceed all plausible limits of heterosexual HIV transmission,' states Jennings.

He continues that the 'scale and scope of the epidemic have been grossly distorted in the RSA and other indigent, tropical settings', suggesting that 'theoretically, the heterosexual African black men of the Republic of South Africa would have to sleep with 5 – 20 times as many sex partners as the gay men of NYC in order to instigate a geometrical AIDS growth pattern equalling that in the United States at the start of the AIDS epidemic', re-iterating that the global epicentre for the disease remains New York City.

Whilst it is hugely important to maintain an accurate grasp on seropravalance, there is also the risk that these explicit statements may feed the arguements of 'AIDS denialists' in the country. For many years under Thabo Mbeki's presidency, the prevalence of HIV was widely disputed at high levels of government, with dietary remedies recommended over anti-retroviral drugs. Accurate data is crucial in the successful treatment of the disease and healthcare provision in the county, so it is hoped any policy changes following this research will serve to benefit the sufferers.

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"Sexual concurrency" does NOT drive the African HIV/AIDS epidemic

One of the primary beliefs regarding the scope of the purported HIV/AIDS epidemic is the belief that many Africans persist in the practice of polygamy (multiple wives) and that Africans, as a general rule, are highly sexually active.

In current "scientific" lingo, the term "sexual concurrency" is used to describe the purported African practice of having "multiple simultaneous sex partners.

Although this belief has been widely accepted and promulgated, several researchers are now coming forth with studies suggesting the alternative view, i.e., sexual concurrency is not driving the African HIV/AIDS epidemic.

One such study is entitled: ***"Concurrent sexual partnerships do not explain the HIV epidemics in Africa: a systematic review of the evidence."*** It is available free online at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3161340/pdf/1758-2652-13-34.pdf

Here's a quote from the top of Page 19:

"It is customary to end the presentation of research with calls for still more research. This paper, however, calls for an end (or at least a moratorium) to research on sexual behavior in Africa of the kind discussed in this article. The continued use of financial and human resources to prove Western preconceptions about African sexuality cannot be justified."

The first page of the study follows.

Several other authors have pointed out that the evidence "remains lacking" for the belief that "sexual concurrency drives" the African HIV/AIDS epidemic. Unfortunately, the authors cited here, among several other authors, remain true believers in the African HIV/AIDS epidemic as holocaust. Despite their own findings, they persist in the implausible belief that up to 25% of populations in various African countries are infected with HIV.

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REVIEW Open Access

Concurrent sexual partnerships do not explain the HIV epidemics in Africa: a systematic review of the evidence

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Abstract

The notion that concurrent sexual partnerships are especially common in sub-Saharan Africa and explain the region's high HIV prevalence is accepted by many as conventional wisdom. In this paper, we evaluate the quantitative and qualitative evidence offered by the principal proponents of the concurrency hypothesis and analyze the mathematical model they use to establish the plausibility of the hypothesis.

We find that research seeking to establish a statistical correlation between concurrency and HIV prevalence either finds no correlation or has important limitations. Furthermore, in order to simulate rapid spread of HIV, mathematical models require unrealistic assumptions about frequency of sexual contact, gender symmetry, levels of concurrency, and per-act transmission rates. Moreover, quantitative evidence cited by proponents of the concurrency hypothesis is unconvincing since they exclude Demographic and Health Surveys and other data showing that concurrency in Africa is low, make broad statements about non-African concurrency based on very few surveys, report data incorrectly, report data from studies that have no information about concurrency as though they supported the hypothesis, report incomparable data and cite unpublished or unavailable studies. Qualitative evidence offered by proponents of the hypothesis is irrelevant since, among other reasons, there is no comparison of Africa with other regions.

Promoters of the concurrency hypothesis have failed to establish that concurrency is unusually prevalent in Africa or that the kinds of concurrent partnerships found in Africa produce more rapid spread of HIV than other forms of sexual behaviour. Policy makers should turn attention to drivers of African HIV epidemics that are policy sensitive and for which there is substantial epidemiological evidence.

Introduction

Prevalence of HIV in some countries of sub-Saharan Africa is up to 50 times higher than the average for countries outside Africa. In the 1990s, it was widely accepted in policy and scholarly discourse that higher rates of risky sexual behaviour in Africa explained the difference in HIV prevalence. That conventional wisdom was repeated in hundreds of articles, books and policy documents, as well as in popular media. Careful examination of empirical evidence, however, compelled social scientists and policy makers alike to acknowledge that most kinds of risky sexual behaviours are not exceptionally common in sub-Saharan Africa [1-5]. On the contrary, rates of risky behaviours are considerably higher in affluent and middle-income countries with low HIV prevalence, including early initiation of sex, number of sexual partners, and premarital and extramarital sexual relations [5-18]. Confronted with that evidence, defenders of the notion that some form of risky sexual behaviour must explain the high HIV prevalence in sub-Saharan Africa narrowed their argument to a single kind of sexual behaviour: concurrency, which they define as long-term, overlapping partnerships.

The concurrency hypothesis consists of two claims: that concurrency leads to more rapid spread of HIV than other forms of heterosexual partnering and that concurrency is more prevalent in eastern and southern Africa than in the rest of the world. The concurrency hypothesis is about the difference between Africa and the rest of the world. The focus of the concurrency

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