

TREATMENT INFORMATION GROUP

thinking about AIDS drugs

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Professor Anthon Heyns

CEO: South African National Blood Service

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And to cc list

Dear Professor Heyns

HSRC 'HIV PREVALENCE' SURVEY 2005

I write to draw your attention to the findings of the Human Sciences Research Council published last month in its report, 'The South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005', and their serious implications for the safety of our national blood supply.

The **Treatment Information Group** is a public interest initiative to promote *research-based* debate of antiretroviral drug policy, alternative non-toxic treatment approaches to AIDS, and HIV testing issues in South Africa. The TIG has entered into a strategic alliance with the **Dr. Rath Health Foundation Africa** to achieve this.

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Propaganda is to democracies what violence is to dictatorships.
Noam Chomsky

According to the HSRC report:

‘The overall HIV prevalence among African respondents’ in South Africa is 13.3% – meaning that about one in seven of them is living with HIV, the virus that causes AIDS.

‘24.4% of African women [‘aged 15-49’] were found to be HIV positive’ – which is one in four.

Of African women aged between 30 and 34, the infection rate is ‘31.7%’ – about one in three.

And just about every second young African woman you see between 25 and 29 years old has HIV, the virus that causes AIDS – ‘37.9%’ of them.

Fortunately, ‘HIV prevalence among whites’ is a mere ‘0,6%’, which is to say only one of every 167 Europeans is infected with the virus.

Using a ‘pioneering’ experimental American technology called the ‘BED assay’ to determine the ‘Number HIV+ with recent infections (past 180 days)’ in ‘confirmed infections’ (‘confirmed ELISA-positive’), the HSRC reported that ‘In the African race group, an incidence of 3.4% was found.’ The recent infection rate ‘in females aged 15-49 years was 6.3% ... with a peak incidence of 7.1% in the band 25-34 years’.

You can be sure that at this hot rate plenty more cases of ‘recent infection’ would have gone undetected in ‘the window period’, about which you explain in your advisory, ‘Safe blood starts with me’, that in ‘the window period ... the H I virus is undetectable in the blood for a period of time after infection ... about four weeks to three months, or even longer’, and state that ‘there are no

technological methods that can entirely eliminate the risk of infection'. In your 'DONOR FORM' you issue the further warning that 'During the window period, laboratory tests are negative, but the person is still capable of infecting others.'

Quoted in the *Mail&Guardian* on 20 January HSRC director and lead co-author of the 'HIV Prevalence' report, Professor Thomas Rehle, emphasized that his findings were extremely scientific: 'The research can no longer be denied – and the less confusion you have, the better,' he said, adding that 'The consensus is definitely significant' – namely the agreement by all the AIDS experts that HIV, the virus that causes AIDS, is rampant among the Natives in our country.

In view of your undertaking in your 'MISSION' statement 'to provide all patients with ... safe ... blood products', please let me know whether you intend revising your 'NEW RISK MANAGEMENT MODEL' to absolutely prohibit Africans, younger women especially, from donating their blood, given that a world-famous AIDS expert of Professor Rehle's calibre emphasizes that it 'can no longer be denied' that they're heavily infected with HIV, the virus that causes AIDS – and undetectably so in a significant number of cases – so the risk is very high that they will pollute the blood supply with their deadly germs.

In other words, will you be reverting to your former national policy of keeping donated blood separate but equal, which you clearly quite sensibly applied right up until the end of September last year when you introduced your new liberal policy of mixing it?

In your 'Blood donation and ethnicity' advisory, you now say, 'The donor questionnaire will continue to ask donors to voluntarily state

their ethnic group, but the Service will not reject a donor who chooses not to reveal his or her ethnicity.' I'm sure you'll agree that the HSRC's report about the sky-high 'HIV Prevalence' rate in 'the African race group' is a pressing reason to urgently reverse your new approach and to go back to your traditional apartheid policy, according to which people who won't say will have their blood flushed out with the sewerage – like President Mbeki's in December 2004. As you mentioned at the time, racial discrimination is 'an internationally accepted method of ensuring blood safety'. It's also the 'most logical, medical, ethical and legally defensible system available', your medical director Dr Robert Crookes rightly pointed out. And obviously, as your chairman Reverend John Pender-Smith put it, it's the only 'equitable and cost-effective' route there is to protecting the blood supply, and also the only sustainable and capacity-building way.

And with the HSRC's findings about 'HIV Prevalence' now backing you up, you won't have any trouble sacking any irresponsible nurse who, like Poppie Bereng, refuses to lie to her sort by pretending with a fake smile that the blood they've come to donate is going to be used to save lives, instead of telling them straight out that it's no good, it's probably septic with HIV, the virus that causes AIDS, and is going to be thrown away. Who can fault you now, if, as your spokesman Marika Champion said, you 'use risk to determine risk'. Never mind Dr Tshabalala-Msimang's claim that racial profiling 'smacks of racism' – the HSRC study confirms exactly who's posing the 'risk', and it can't be said often and loudly enough that it's her people not ours. The point is that if we don't

want our fine country going to the dogs in the war against AIDS, then they mustn't expect us to drop our standards.

Since you're rightly concerned to keep 'the blood supply as safe as possible', shouldn't you be banning Indians and Coloureds from giving blood as well? According to the HSRC the infection rate with HIV, the virus that causes AIDS, is three to four times higher among those people than among whites, namely 1.6% and 1.9% respectively, which is to say their blood is not nearly as pure as ours. One just can't be too careful when there's an incurable virus going around that's always fatal and causes people to die an early, lingering, painful and lonely death.

Who can forget the terrible scene right out of Edgar Allan Poe sketched by the *Mail&Guardian* in its unforgettable editorial on 9 July 2000, entitled 'The death sentence has been brought back', describing the plight of those afflicted with the scourge as they 'struggle to draw breath, puke and ache, their skins festered, their mouths filled with ulcers, their bodies racked with disease – living skeletons as they approach a suffocating death'? The reverend justices of our Constitutional Court, no less, have also lamented 'the nature of the suffering so grave'. So as I said we can't be taking any chances with carelessly spreading the virus around, more particularly since their learned Lordships say the 'prospects of ... surviving if infected are so slim'. Certainly those lucky enough to receive the best healthcare that medicine has to offer tend to die young, because it's well-known that AIDS drugs, although very strong medicines, are not strong enough to save them from the virus. Even when taken every day until the day they die.

If my proposals seem rather incorrect in the present political climate, with our DA having reduced itself to a spluttering comical irrelevance, what about Professor Nicoli Nattrass's idea? She's that AIDS activist academic at UCT who directs the AIDS and Society Research Unit there, and tells people at dinner parties that she votes for Tony Leon's DA now because, unlike President Mbeki, he's in favour of giving AIDS drugs to the blacks.

Commenting on the expert consensus that they're riddled with HIV, the virus that causes AIDS, she noted: 'If the South African government successfully intervenes with anti-retroviral drugs, you will see a higher prevalence of people living with AIDS, which looks bad but is actually a good thing.'

Would you also consider it a 'good thing' that on toxic AIDS drugs the prevalence of serious disease among Africans will naturally increase? (Doctors brightly call it 'Immune Reconstitution Syndrome'.) Even if it 'looks bad' as they fall dangerously ill on the drugs? 'For one thing people aren't dying, and for another, people on anti-retroviral drugs are less likely to infect others,' Professor Nattrass says. Is this perhaps the solution: forcing the government to put as many Africans on AIDS drugs as possible to make them 'less likely' to foul our blood supply? Or do you think it's more a case of George Orwell's observation that 'the slovenliness of our language makes it easier for us to have foolish thoughts'? During her 'many long dog-walks on the mountain' taken to 'sharpen my arguments' – her brilliant moral and economic ones to drum the government into doing trade with pharmaceutical corporations.

I was a bit concerned by your promise in the 'DECLARATION' section following the 'SELF EXCLUSION QUESTIONNAIRE' in

your 'DONOR FORM' to set lawyers and/or the police on me if I make any 'wilful misrepresentation of the facts' in declaring that 'I do not consider myself to be a person at risk of spreading HIV/AIDS', so I'm not sure whether I should I go ahead and sign the 'DECLARATION' if I've had steady African and Indian girlfriends in the past couple of years, in the light of the HSRC's findings about the 'alarming' prevalence of HIV, the virus that causes AIDS, among the non-whites. Especially since one was a surgeon with her hands stuck in other people's bloody guts all day. You ask me at the beginning of the 'DONOR FORM' to 'Help keep the blood supply as safe as possible by looking HONESTLY at your lifestyle and answering the questions truthfully', and as you can see I'm really trying to be honest about this. Naturally your 'blood transfusion service has to check the lifestyle of all those who wish to donate', and I'm being completely open about my 'lifestyle' with you.

Since you very properly warn in your 'DONOR FORM' that blood donations by people engaging in an unchristian 'lifestyle', such as being friendly with fast women and unusually friendly men, will be 'putting the lives of people who receive your blood at risk', and you stress accordingly, 'DO NOT DONATE BLOOD IF YOU MAY HAVE BEEN EXPOSED TO HIV/AIDS', would you say that my 'lifestyle' in mixing with non-Europeans negatively affects my 'donor status' – in other words has put me 'in a situation where [I] could have been exposed to HIV/AIDS', so I shouldn't be donating my blood?

I'm sure you'll understand that the last thing I want is to be 'endangering someone's life' and getting sued or put in jail over this. Please advise.

Finally, I attach for your information a letter that I sent HSRC CEO Dr Olive Shisana about her HSRC's 'HIV Prevalence' report, in which I posed some awkward questions. It seems to have left her speechless because she hasn't even acknowledged it, and I sent it weeks ago. But I know you'll be interested in it, because, as I said in the beginning, the scientific integrity of the HSRC report has immense ramifications for your business every day over at the blood bank.

Please note though that top AIDS expert Professor Rob Dorrington, director of UCT's Centre for Actuarial Research, has independently confirmed HSRC's findings: about 11% of South Africans, one in nine, are living with the virus, he says, the one that causes AIDS. Make no mistake, this is an expert who knows what he's doing and on whom you can rely with complete confidence. He treats *one* positive ELISA HIV antibody test result in *pregnant women* as proof of infection with HIV, the virus that causes AIDS, and then churns the numbers, among others, with those returned by the HSRC in its first HIV prevalence survey in 2002 (about which you can read at the end of the annexed letter).

A funny thing about that first HSRC survey in 2002 is that it reported that 6.2% of whites were infected with HIV, the virus that causes AIDS, but three years later the HSRC found that only 0.6% of them are. Do you have any idea what happened to the 5.6% of our fellow whites once infected but now seemingly cured of the disease that doctors say is incurable? Is it possible that in three

years 351,232 infected white people died off unnoticed? Could they have emigrated?

The *M&G* quoted Professor Rehle saying how pleased he was by Professor Dorrington's validation of his scientific research: 'It's reassuring that our results have been confirmed by other approaches.' Even Yale University reportedly praised Professor Dorrington's high-class methodology in having based his findings on 'an excellent model, probably the most sophisticated in the world, because it incorporates data from a wide range of sources'. So there's definitely no one better than Professor Dorrington to crunch the numbers on his computer with all those sophisticated computer programmes of his, and to scientifically verify that the HSRC is spot-on in reporting that HIV, the virus that causes AIDS, is raging completely out of control among the blacks.

In conclusion, I just want to say that it's a great comfort to me to know that we still have so many competent white men in positions of power and authority in our country's universities and scientific institutions, seeing to it that scientific standards are upheld and keeping interfering politicians engaging in pseudo-science out of medicine where they don't belong.

As a token of my appreciation for the special care that you take to 'keep the blood supply truly safe', I'd like make a small donation to your funds. Please accept my cheque for R10-00, which you'll find enclosed.

Yours sincerely

ADV ANTHONY BRINK
CONVENER AND NATIONAL CHAIRMAN:
TREATMENT INFORMATION GROUP

Encl: Copy of unacknowledged letter dd 6.1.06 to HSRC CEO Dr Olive Shisana concerning 'The South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005'

CC: President Thabo Mbeki

Deputy President Phumzile Mlambo-Ngcuka

Minister of Health, Dr Manto Tshabalala-Msimang

Deputy Minister of Health, Nozizwe Madlala-Routledge

All other members of Cabinet

Mr James Ngculu MP, Chairman, Parliamentary Health Portfolio Committee, and all ANC Committee members

Mr Thami Mseleku, Director-General, Department of Health

Mr Manala Manzini, Acting Director-General, NIA

All Provincial Health MECs and D-Gs

Dr Kgalema Motlanthe, Secretary General, ANC

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All ANC NEC members

Ms Nosiviwe Mapisa-Nqakula, President, ANC Women's League

Mr Fikile Mbalula, President, ANC Youth League

Mr Charles Nqakula, National Chairperson, SACP

Mr Willie Madisha, President, Cosatu

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Mr John Samuel, CEO, Nelson Mandela Foundation

The Director, South African office, Swiss Agency for Development and Cooperation, Swiss Foreign Ministry

Mr Snuki Zikalala, MD, News and Current Affairs, SABC

Noseweek, Special Assignment, 3rd Degree, Carte Blanche, other media

Rev John Pender-Smith, chairman SANBS

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Professor Thomas Rehle, Director, Social Aspects of HIV/AIDS and Health Programme, HSRC, and principal co-author of the 'HIV Prevalence' 2005 report

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Professor Rob Dorrington, director, Centre for Actuarial Research, UCT

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Other interested parties: academia, NGOs and individuals

And online at www.tig.org.za