

TREATMENT INFORMATION GROUP

*thinking about AIDS drugs*

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Dr Olive Shisana  
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And to cc list

Dear Dr Shisana

**South African National HIV Prevalence, HIV Incidence,  
Behaviour and Communication Survey, 2005**

I have some troubling questions for you as lead author of your HSRC's recently published *South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005*, but more particularly for you as a 'daughter of Africa and a hero in the

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

HIV/AIDS struggle', as your HSRC's website bills you, in a country which you claim in the 'Executive Summary' of your report has 'the largest number of people living with HIV/AIDS in the world'.

The chief findings of your report concerning what you call 'HIV prevalence' in South Africa are based (you tell us on page xxii) on 'HIV antibody testing'. I was greatly surprised to see this, because as far as I know HIV antibody tests are made for screening blood and not for diagnosing infections – which is to say these tests don't tell you whether a person is living with the virus or not.

So it seems to me that your report to the nation and to the world on how many people in our country have the virus in them is so grossly and fundamentally flawed that it's fit only for the shredder.

But if I'm wrong about that, and you *can* tell whether a person is living with the virus on the basis of antibody test results, you still messed it up:

You say on the same page that 'All samples were first tested with the Vironostika HIV-1 Uni-form II Plus O assay (bioMerieux). All HIV positive samples were retested with a second ELISA test (Vitros ECI, Ortho Clinical Diagnostics).' This sounds tremendously scientific and impressive. The trouble is when you read the instruction manual for the first test, the most a 'reactive result indicates', says the manufacturer bioMerieux, is that 'the sample tested either contains anti-HIV-1, anti-HIV-2 and/or anti-HIV-1 group O or contains a non-specifically reacting factor'.

What this means in plain talk is that the test has detected HIV antibodies but then again maybe not: it may equally have detected

other antibodies (a 'non-specifically reacting factor'). Because the test is not specific. Not at all. All sorts of things can cause it to light up. Including the simple state of being a mother. This is why its 'Intended use', according to the instruction manual is 'for the screening of donated blood', i.e. to exclude possibly risky blood from the combined pool at blood banks, and no more. Not for diagnosing whether a person is infected or not. (BioMerieux also indicates a second limited (non-diagnostic) clinical application, but it's irrelevant here.)

The instruction manual goes on to require that 'Specimens that show an initially reactive result should be retested in duplicate. ... Because all highly sensitive immunoassay systems have a potential for non-specific reactions, repeatably reactive specimens must be verified using an appropriate test method. Due to the high sensitivity of Vironostika HIV Uni-form *Plus O* in early seroconversion samples, it is recommended to include a sensitive HIV antigen assay in confirmatory testing.'

In other words, if a specimen is reactive, it should be retested. By stipulating 'retested in duplicate', bioMerieux implies doing it again with the same test. You didn't. Instead, according to your report, you 'retested ... HIV positive samples ... with a second ELISA test (Vitros ECI Ortho Clinical Diagnostics)' and left it at that – failing to comply with bioMerieux's requirement that if still reactive upon repeat testing the specimen should be subjected to 'confirmatory testing' with 'an appropriate test method'. The 'appropriate test method' that bioMerieux recommends includes the use of an 'HIV antigen assay' in the 'confirmatory testing' procedure.

Clever AIDS experts know that the 'appropriate test method' for 'confirmatory testing' of specimens that are repeatedly reactive to an ELISA antibody test conventionally entails the use of a Western Blot test. Indeed, bioMerieux says so in the instruction manual for another of its ELISA tests, its substantially similar Vironostika HIV-1 Plus O Microelisa System: 'specimens reactive with the Vironostika HIV-1 Plus O Microelisa System assay should be confirmed with a confirmatory test, e.g., Western Blot testing.'

Out of the question is simply using another ELISA test to confirm the result of the first. Obviously so, because as bioMerieux points out, '*all* highly sensitive immunoassay systems have a potential for non-specific reactions'. (My emphasis.) The reason for this should be obvious: you can't confirm one reactive ELISA antibody test with another one because whatever 'non-specifically reacting factor' caused the first test to react can just as well do the same to the second. So it makes no difference whether you retest with the same brand of ELISA test or with a different brand of the same type of test.

It was therefore incompetent of your researchers to have retested the initially positive specimen with another antibody test kit made by a different manufacturer, and then to have counted the person contributing the twice-reactive specimen as HIV infected in your report of 'HIV prevalence' in our country.

Your submission of these invalidly 'confirmed ELISA-positive' specimens for 'HIV incidence testing' by the National Institute for Communicable Diseases corrupted that whole exercise too. (This spares us having to deal with the scientific vacancy of 'HIV

incidence testing' here.) So your report on 'HIV incidence' in our country is completely worthless as well.

Why didn't you do what bioMerieux told you to do, and perform 'confirmatory testing' on repeatedly antibody reactive specimens with another sort of 'appropriate test method', namely a 'Western Blot' and an 'HIV antigen assay'?

Why did you disregard bioMerieux's explicit instructions concerning the manner in which initially reactive results should be verified, and then pretend to everyone that you duly confirmed the first reactive ELISA – with a second ELISA test made by another manufacturer?

Especially since Ortho Clinical Diagnostics does not indicate the use of its Vitros ECI test (an ELISA test substantially identical to bioMerieux's) for confirmatory purposes; in fact, *no* ELISA test kit manufacturer does.

Consider the analogy of an apartheid Race Classification Board inspector applying the pencil test to detect indigenous ancestry in South Africans of doubtfully pure European descent. The pencil stays in, but he knows that it's not a very reliable indication for coloured hair, for coloured blood, so he repeats the test using a different pencil made by another factory. That would be ridiculous, you'll agree. But it's no different in principle from treating a second reactive ELISA as confirmation of a first. It's like seeing an opacity on a chest x-ray using a Siemens machine which appears the same using an EMI machine and saying the opacity is lung cancer.

On what basis did you report antibody test results as an indication of 'HIV prevalence', i.e. infection, when not a single antibody test kit manufacturer claims that HIV-positive, even repeatedly, means HIV infected?

I should tell you that in making these elementary observations, I'm only scratching the surface. The trouble with HIV antibody testing, be it ELISA or Western Blot, (and 'HIV antigen' testing too) goes much further; but it seems idle to go into all that given the fatal defects in the design and conduct of your research into 'HIV prevalence' in South Africa that I've mentioned.

But supposing your survey of 'HIV prevalence' was splendidly performed and not totally botched as I've shown you, and that it means what it claims:

Since, according to your report, '24.4% of African females in this age group ['aged 15-49 years'] were found to be HIV positive', do I understand correctly that when I walk down the street in this country, about every fourth African woman I pass has the killer sex-virus teeming in her vagina, even if she looks beautiful, bright-eyed and in fine health?

And if I'm mingling among young African women of between 25 and 29 years of age, just about every second one of them has HIV lurking under her panties ('37.9%', according to your report), and likewise nearly one in three of those aged between 30 and 34 years ('31.7%')? Just waiting to jump out and give me AIDS.

Do you think I should stay away from my home province KwaZulu-Natal until things improve, until the Zulus start acting more

civilized, since just about every second woman there is 'living with HIV/AIDS': '40.7%', according to your report?

You can't be serious.

But if you really are, and you're not trying to be funny: now that you tell me that African women are fifty times more likely to give me AIDS than white women – 'HIV prevalence among whites' is '0.6%', you say – do you reckon it was it a dreadful mistake for me to have had a Xhosa sweetheart a couple of years ago?

Particularly since you claim African women aged between 25 and 35 are the most diseased group, so the risk of them infecting their men is even higher.

Do you think that having regard to your scientific findings I should telephone my subsequent white and Indian girlfriends and urge them to rush out and get tested, since I possibly exposed them to HIV, having been intimate with an exceptionally high-risk person of the most dangerous sort prior to my relationships with them?

Would you advise that in future it would be best for me to follow a whites-only romantic policy, and that African men should too, if we don't want to get infected with HIV and die of AIDS, because white women as bedfellows are much cleaner and almost disease-free (according to your report), whereas Bantu females are heavily infected with the virus and so will be coming down in droves with full-blown AIDS all over the place in a few years? Especially younger ones with all their pistons firing.

As a 'daughter of Africa', would you also attribute the tragic calamity of our having 'the largest number of people living with

HIV/AIDS in the world' (according your report) to what your fellow 'hero in the HIV/AIDS struggle' Professor Jerry Coovadia describes as the 'unbridled sexuality' of 'newly liberated people ... especially the promiscuity of men' that has led to 'AIDS ... ripping through millions of our people'? (He wasn't referring to whites like me, apparently.)

Would you heartily agree with Supreme Court of Appeal Judge Edwin Cameron (another prominent 'hero in the HIV/AIDS struggle') that Africans are rife with HIV (according to your report) on account of 'sexual practice among African men', being what he identifies as having chiefly 'contributed to its spread'.

To put a point on His Lordship's brightly percipient but rather obliquely expressed analysis: would you also say that the root cause of the AIDS epidemic in South Africa – and here I'm quoting President Mbeki in Parliament on 21 October 2004, citing the heavy irony of Professor Edward Rhymes of the University of Massachusetts-Dartmouth – is that African men such as he are 'rampant sexual beasts, unable to control our urges, unable to keep our legs crossed, unable to keep it in our pants'?

And – to quote President Mbeki again, from the same Parliamentary session, now citing the sarcasm of Professor Keith Wailoo at the University of North Carolina-Chapel Hill – that African people are basically 'a social menace whose collective superstitions, ignorance and carefree demeanour [stand] as a stubborn affront to modern notions of hygiene and advancing scientific understanding ... [a people best understood as] a disease vector'?



Having regard to your research findings that ‘The overall HIV prevalence among African respondents [(male and female) is] 13.3%’ – versus an insignificant ‘0.6%’ among whites – would it be scientifically correct for white people, especially in the US, to conclude that Africans generally should properly be considered ‘a disease vector’ in our country?

Do you share the American view that ‘aggressive, effective action’ is needed to deal with them, to quote former US ambassador to South Africa Cameron Hume, in the form of good, strong AIDS drugs?

Which I see you’re busy pushing already: Rehle, T. & Shisana, O. (2005) *The impact of antiretroviral treatment on AIDS mortality: a study focusing on educators in South African public schools*. Cape Town: HSRC Press: ‘This report estimates the extent to which the provision of antiretroviral treatment might reduce AIDS mortality among our educators.’

Never mind the criminal truth of the matter, stated by President Mbeki in Parliament on 28 October 1999: ‘There ... exists a large volume of scientific literature alleging that, among other things [*it doesn’t work*], the toxicity of this drug [AZT] is such that it is in fact a danger to health. These are matters of great concern to the Government as it would be irresponsible for us not to heed the dire warnings which medical researchers have been making.’

As a ‘hero in the HIV/AIDS struggle’, do you know better than President Mbeki does? Do you really swallow the line as put out by the TAC and all its friends in the newspapers that exceptionally toxic AIDS drugs are ‘life-saving’? That swallowing poisonous

chemicals every day actually makes you live longer? That they 'reduce AIDS mortality', as you say? Such as the cell-poison AZT, a failed experimental cancer chemotherapy – labelled with a deadly skull and crossbones hazard icon when supplied in tiny amounts for research use, along with the warning: 'Toxic to inhalation, in contact with skin and if swallowed. Target organ(s): Blood Bone marrow. ... Wear suitable protective clothing.' Not forgetting that other judicial favourite, nevirapine, not licensed in any First World industrial country for administration to blue-eyed, fair-haired mothers and babies, and forbidden in the US for doctors and nurses suffering needle-stick injuries, because it's so very toxic. Causing total liver failure and death after just two weeks in some cases.

Do you share the view of our country's most famous and widely admired 'hero in the HIV/AIDS struggle' Dr Zackie Achmat LID (*honoris causa*) that what chiefly ails the fight against AIDS in South Africa is that, as evinced by his scepticism in wryly quoting the two insolent professors cited above, 'The President doesn't want to believe people in Africa have a lot of sex'? Like he, Dr Achmat, used to at the Observatory station in Cape Town: 'I had sex at the toilets every day, sometimes twice or three times a day. I had sex with anyone who wanted to: old, young, black or white, fat or thin, it did not matter.' (What mattered was getting paid.) As a 'daughter of Africa', could you tell me: Is this how African people behave? Explaining why (according to your report) Africans are riddled with HIV.

Is Dr Achmat right in saying 'people in Africa have a lot of sex'? With everyone who comes along? Even if the 'President doesn't

want to believe' it. Do you? In the light of your assertion that 'the most common mode of HIV transmission in South Africa is heterosexual intercourse', would you agree that your finding of an extraordinarily widespread '13.3% HIV prevalence in Africans' provides all the scientific proof we need that the Native is extremely sexually promiscuous?

In other words, that Africa is 'naturally prone to ... an AIDS pandemic caused, it is said, by rampant sexual promiscuity and endemic amorality' – to quote President Mbeki speaking at the Third African Renaissance Festival in Durban on 31 March 2001?

And that your report scientifically shows that Africans are 'germ carriers, and human beings of a lower order that cannot subject its passions to reason ... a depraved and diseased people ... perishing from self-inflicted disease ... natural-born, promiscuous carriers of germs, unique in the world ... doomed to an inevitable mortal end because of our unconquerable devotion to the sin of lust' – to quote President Mbeki again, this time delivering the inaugural ZK Mathews Memorial Lecture at the University of Fort Hare on 12 October 2001?

Conversely, would it be scientific to deduce from the almost negligible '0.6% HIV prevalence among whites' that you found that they are much less interested in sex than the indigenes? That they don't like it nearly so much? Alternatively, that they are by and large an admirably chaste and faithful race, and that, unlike the aboriginals, the white man knows how to 'keep it in [his] pants'? With white women judiciously good at keeping it out theirs?

Borne out further by the UK Health Protection Agency's 'HIV and AIDS in the United Kingdom quarterly update: data to the end of March 2005' published in *Communicable Disease Report Weekly (CDR Weekly)* on 26 May 2005 (Vol. 15, No. 20):

Since the counting started in 1982, by March 2005 a cumulative total of 10 544 men and 16 109 women had 'diagnosed and reported ... HIV infection' in the UK, thought to have been acquired through 'Sex between men and women' – amounting to an 'HIV prevalence', to use your language, of a grand 0.04% of 60 million people (of whom a most alarming 39 reportedly died of it between January and March 2005).

Strangely enough, though, the UK National Health Service reports that 'Teenage birth rates in the UK are the highest in Western Europe.' (In the US the rate is twice as high as the British one – right on top of the world.) Which means they're not shy to drop their drawers that side. Not big into condoms either.

But anyway you needn't worry about catching it on your next holiday in Mother England because the risk is even lower if you stick to whites. Who don't like blacks:

According to a preceding 'quarterly update' published in *CDR Weekly*, Vol. 15 No. 8, 'During 2004, 5016 new diagnoses of HIV infection were diagnosed and reported' in the entire UK.

Concerning 'infections acquired through sex between men and women ... 76% ... were probably infected abroad ... 89% [of whom] had been exposed in Africa'. So you can see, it's those darkies who are bringing it in.

Or is the better conclusion to be drawn from a cursory look at your report not rather that it's a complete load of rubbish, a grotesque and obscene calumny against Africans based on the worst sort of American junk science, and a monumental waste of time and money, showing that none of the clowns who designed your useless study – mostly white professional AIDS experts, it appears from your 'Acknowledgements' – have the faintest idea of what they're doing? And so should all be sacked on the turn.

Before I go, I have a couple more basic questions to ask you.

Proceeding from your stated premise that 'the most common mode of HIV transmission in South Africa is heterosexual intercourse', you spend a hell of a lot of time pruriently poking and probing the sexual habits and attitudes of our country's people for the 'Behaviour and Communications' part of your report: their 'sexual debut' and so on. (White researchers seem to especially enjoy this kind of thing.) After which, sounding like some po-faced pastor in his Sunday pulpit, you issue a series of hilarious, finger-wagging sex mandates about when and how and with whom.

You even have the cheek to propose in your report that we all be tithed to pay for the dissemination of these moral lessons (and of course your nice houses, cars and clothes). But why should we pay another tax for this, when the Americans are already funding it? You'll surely recall that on the eve of the vote in the House of Representatives on 1 May 2004 to approve President Bush's \$15 billion PEPFAR fund to fight AIDS in Africa, Vice President Dick Cheney successfully lobbied House members to pass an amendment requiring that a third of the grant go to sexual

abstinence programmes, in tune with a White House statement that it wished the legislation to 'prioritize the abstinence component of the ABC approach ... "A" for abstinence, "B" for being faithful and "C" for condom use when appropriate.' That's a cool \$5 billion to teach Africans to 'keep it in [their] pants'. Congressman Mike Pence explained afterwards: 'It's important that we not just send them money, but we send them values that work.' As a 'daughter of Africa', do you also think Africans need to be taught American 'values that work'? To protect them from the virus.

I know this sounds very foolish to even ask, but could you possibly refer me to the study or studies establishing that HIV is sexually transmitted? Or are you just assuming this?

I ask because according to what they described as 'the largest and longest study of the heterosexual transmission of HIV in the United States', epidemiologist Dr Nancy Padian PhD and her colleagues reported in 'Heterosexual transmission of human immunodeficiency virus (HIV) in Northern California', a ten-year study funded by the US National Institutes of Health and published in the *American Journal of Epidemiology* 1997 Aug 15;146(4):350-7, that 'male-to-female per contact infectivity was estimated to be 0.0009'.

Of a 'total of 82 infected women and their male partners and 360 infected men and their female partners ... no seroconversions [were observed] after entry into the study'. Which is to say, in the decade during which the study was conducted, nobody was seen to infect anyone. The minute risk reported for a woman to become HIV-positive after sex with an HIV-positive man (and it's eight

times lower vice versa) was inferred by Padian et al. from the small number of couples who entered the study both HIV-positive – on the assumption that one had infected the other. And nothing else.

In sum, ‘the largest and longest study of the heterosexual transmission of HIV in the United States’ provides no evidence that HIV is sexually transmitted – instead, it adduces evidence that it isn’t.

Two years earlier, Dr Stuart Brody PhD noted in *Archives of Sexual Behavior* 1995 Aug;24(4):383-93 that ‘there has been the assumption in both scientific and lay communities that vaginal HIV transmission commonly [occurs. But] the basis for this assumption rests on data that are unacceptably weak or flawed. The need for sexual behavior change that has been claimed by public health and other authorities is not supported by the scientific data.’

But let’s allow for argument’s sake that the Padian study definitively determined the risk of catching HIV from lovemaking, and that you can. In their letter to the *British Medical Journal* 2002 April 27; 324(7344):1035, under the title ‘Heterosexual transmission of HIV in Africa is no higher than anywhere else’, Papadopoulos-Eleopoulos et al. pointed out that at such an extraordinarily low transmission rate, ‘it would take 770 or 3333 sexual contacts [male to female] ... to reach a 50% or 95% probability of becoming infected. If sexual contact were to take place repeatedly every three days this would require a period of 6.3 and 27.4 years respectively. Based on the estimate of female to male transmission by Padian et al. it would require 6200 and 27000 contacts and a period of 51 and 222 years, respectively.’

Which reduces the very idea of heterosexual transmission of HIV to a joke. If you get it. (If that's what it takes to get HIV, I'm all for it.)

And not as if Africans are somehow different from whites in this regard: Gray et al., reporting the 'Probability of HIV-1 transmission per coital act in monogamous heterosexual, HIV-1 discordant couples in Rakai, Uganda' at the 8<sup>th</sup> Conference on Retroviruses and Opportunistic Infections in Chicago 2001, and later that year in *Lancet* 357(9263):1149-53, refuted any suggestion that Africans might infect one another with HIV more readily than whites.

Papadopoulos-Eleopoulos et al. summed up in their letter: 'The probability of transmission per sexual contact was 0.0009 for male to female and 0.0013 for female to male respectively ... The authors concluded that the probability of HIV transmission per sex act in Uganda is comparable to that in other populations.'

Since the science shows we have no or virtually no chance of catching HIV from having sex, whatever our colour, why all the fuss about abstinence, condoms and everything?

Especially in view of the findings of Kamali et al. reported in their paper, 'Syndromic management of sexually-transmitted infections and behaviour change interventions on transmission of HIV-1 in rural Uganda: a community randomised trial' in *Lancet* 2003;361:645-52.

In an awkward comment that *Lancet* didn't want to publish (online at [www.thepertgroup.com](http://www.thepertgroup.com)), Papadopoulos-Eleopoulos et al. noted that in this 'large, well designed and executed study on the effect of sexual behaviour intervention on transmission of HIV-1 in



Uganda, the authors reported a reduced incidence of herpes simplex virus type 2 (“HSV2- a proxy measure of unprotected sexual contact”), as well as a significant reduction in acute syphilis, gonorrhoea, and unprotected casual sex in the intervention group. But there was no effect on HIV incidence.’

This was notwithstanding a full-bore safe sex education campaign, described by other commentators as an ‘apparently appropriate intervention that reduced other STDs and was implemented on a huge scale with great care and commitment’ (Stephenson JM, Cowan FM. ‘Evaluating interventions for HIV prevention in Africa’ *Lancet* 2003;361:633-4). Meaning that the safe sex campaigns that you go on and on about in your report are entirely ineffective in reducing what you call ‘HIV prevalence’.

All of which calls for a big rethink, you’ll agree, even if it’s rather embarrassing for you and your colleagues ‘in the HIV/AIDS struggle’. All the more in the light of ‘Mounting anomalies in the epidemiology of AIDS in Africa: Cry the beloved paradigm’ by Brewer et al. in the *International Journal of STD and AIDS* 2003 March; 14(3):144-7, in which the authors made the point that ‘There is substantial dissonance between much of the epidemiologic evidence and the current orthodoxy that nearly all of the HIV burden in sub-Saharan Africa can be accounted for by heterosexual transmission and the sexual behaviour of Africans. ... We propose that the existing data can no longer be reconciled with the received wisdom about the exceptional role of sex in the African AIDS epidemic. ... Dispassionate assessment of our conclusions admittedly depends on a willing suspension of disbelief, since the current paradigm is deeply embedded.’

Of course, this is doubly hard when your reputation and career are built on 'the current paradigm' (i.e. that you can die from making love with someone) and there's the real danger for you that once it's exposed as a mass delusion, like witches behind every tree, everyone will be bursting out laughing.

Finally – and again I know this sounds like a terribly silly question – but with all this talk of HIV everywhere in your report and in our country (among Africans), could you maybe show me a photo of this virus? On its own, duly isolated, and looking like the dramatic artists' pictures we see in magazines and on posters at AIDS conferences: scary round objects covered in sucker-like protuberances. (Nondescript blobs or spots near cell walls or in a soup of cellular debris won't do for me, particularly when they're the wrong size and the wrong shape.)

I must tell you that I've been at this for nearly ten years now, and I've yet to see such an electron photomicrograph of HIV. And I've really searched.

This has me wondering whether HIV isn't like the Devil, if you know what I mean – the evidence of his existence being overwhelming, when you just consider the terrible things people do.

Have *you* ever seen this virus? This virus that jumps between our genitals, you experts solemnly warn us, but not our mouths, which are 100% safe to kiss, you say, and for as long as we like. Even African ones.

In conclusion, I'd like to ask you as 'a daughter of Africa' how you consider your role as Executive Director of our Human Sciences Research Council and lead author of the *South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005* keys into the imperative articulated by then Deputy President Mbeki in his *African Renaissance Statement* on 13 August 1998? Africa, he said, 'can and must be its own liberator from the condition which seeks to describe our continent and our people as the poverty-stricken and disease-ridden primitives in a world riding the crest of a wave of progress and human upliftment'. How do you suppose your sort of faux scientific research advances this endeavour?

I propose that you issue a statement forthwith, withdrawing your report with its revolting, grossly racist aspersions and insinuations, and apologising to the African people of our country – who've had centuries of being told they're dirty and diseased and sex-crazed and inferior and less than human, and just when they thought it was over, you and your comrades 'in the HIV/AIDS struggle' come along.

Because if you don't, next the Americans will be citing your report to justify ever more aggressive intervention in domestic policy in our country to open the markets here for the pharmaceutical corporations that gave so generously to both of President Bush's election campaigns. The White House has been calling AIDS in Africa a threat to the national security of the United States since 29 April 2000, and I'm sure you know the liberties this gives the CIA, the NSC and all those unpleasant people. (In low-intensity subversion of independent states, the trick nowadays is to make

use of 'human rights' NGOs.) We've already had Colin Powell calling AIDS in Africa 'a weapon of mass destruction', so anything's possible with these guys. And when they want to make the world safe for democracy, they don't play.

By the way, why do you persist in referring to and relying on your 2002 'national HIV prevalence' survey for comparison purposes when I told you at the time that it was all nonsense? An annexed excerpt from a book I'm writing will remind you of why.

Yours sincerely

ADV ANTHONY BRINK  
CONVENER AND NATIONAL CHAIRMAN: TREATMENT  
INFORMATION GROUP

CC: President Thabo Mbeki

Deputy President Phumzile Mlambo-Ngcuka

Minister of Health, Dr Manto Tshabalala-Msimang

Deputy Minister of Health, Nozizwe Madlala-Routledge

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

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Mr Willie Madisha, President, Cosatu

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Other interested parties: academia, NGOs and individuals

And online at [www.tig.org.za](http://www.tig.org.za)

## Re: NELSON MANDELA HSRC STUDY OF HIV/AIDS 2002

On 6 December, at the Sandton Convention Centre in Johannesburg, Mandela released a study by the Human Sciences Research Council, which he'd commissioned to investigate public opinion regarding the government's handling of the 'AIDS epidemic'.

[...]

The other purpose of the study was to 'determine HIV prevalence in the population ... using linked anonymous HIV saliva tests'. According to press reports, eight and a half thousand respondents submitted saliva samples for testing, on the basis of which four and a half million South Africans were thereupon reported infected: 11.4 per cent of us, and twice as many blacks as whites. But the big surprise in the report of the study was how many children were reported infected: 'The observation that the estimated HIV prevalence among children aged 2-14 years is 5.6% ... was unexpected.'

In conducting their research the researchers employed a single ELISA test. The novelty was that instead of collecting blood samples for testing with a hypodermic syringe, as usual, they used a new gadget called the OraSure® HIV-1 Oral Specimen Collection Device, described on its manufacturer's website as a 'specially treated cotton fiber pad that is attached to a nylon stick. This collection pad draws antibodies from the tissues of the gum and cheek into the mouth and into the pad. The collection pad ... is placed between the lower cheek and gum for 2-5 minutes.' The idea is to collect the ooze – oral mucosal transudate – exuded from the capillary blood vessel walls in your gums and inner cheeks into their surface mucus. Not saliva. 'The OraSure® HIV-1 pad is then placed in a vial with preservative and sent to a clinical laboratory for testing with an initial "screening" assay (ELISA).' (Note that Orasure Technologies Inc. correctly refers to an ELISA test as a screening assay – for excluding possibly tainted blood, not determining infection.) If reactive, 'a supplementary test, the OraSure® HIV-1 Western blot assay, is performed to verify the result of the screening assay'. But Mandela's researchers at the HSRC didn't get around to that. And treated the 'unconfirmed' result of a single screening essay as proof of HIV infection.

Another thing: whether the researchers collected OMT samples or mere spit for testing is doubtful. According to the just-mentioned description of one of the study's aims, the researchers thought they were using 'saliva tests'. And the report mentions that 'all

children between 2 and 14 years of age were asked for their verbal consent to take a saliva sample'. Not an OMT sample. Apart from their failure to employ 'a supplementary test, the OraSure® HIV-1 Western blot assay', there's a further indication that the researchers never read the collection device manufacturer's instructions. Which reads: 'Important Information: OraSure® HIV-1 Oral Specimen Collection Device is intended for use in the collection of oral fluid specimens for testing for antibodies to the Human Immunodeficiency Virus-Type 1 (HIV-1) in subjects 13 years of age and older.' Mandela's clever researchers didn't spot that. Before testing the children 'between 2 and 14 years of age' with it. And then announcing that an 'unexpected' 5.6 per cent of them were infected.

All of which reduces the value of the HSRC figures on the South African infection rate to Monopoly money. Unaware of this, and making a terrible fool of himself, along with the bumbling incompetents in the HSRC who designed the study, Mandela said the study was a 'watershed'; it provided data for the country to fight AIDS 'even more vigorously'. To be helped by his own redoubled war-effort: he was pitching in ten megs from his foundation to fund the South African Medical Association's scheme to provide free antiretroviral drugs at eighteen sites across the country. The Department of Health responded to the report by promising to increase funding for the fight against AIDS by R3.3 billion over the next three years. While people go hungry everywhere.

I pointed out the basic flaws in the study to Olive Shisana, the principal investigator. She ignored my letter and in May announced a new study based squarely on the findings of the old. Four thousand children in the Free State province would be examined, she said, to determine 'the role of the healthcare system, sexual abuse and other non-healthcare related events, for instance traditional circumcision ceremonies' in how they got their HIV infections. Assuming that they were infected – according to the prohibited, improperly used and unconfirmed OraSure® HIV-1 Oral Specimen Collection Device-based test.