THE HIV/AIDS BLUNDER:
HIV is not sexually transmitted, and it didn't cause AIDS;
What ever happened to self-correcting science?

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Historians and sociologists of science and other scholars in science & technology studies (STS) can look forward to many busy years, trying to understand how this blunder came about and why it remained uncorrected for so long. Two decades of HIV tests on 10s of millions of Americans prove that HIV is not an infection. HIV/AIDS theory entails blatantly racist interpretations of the facts. Yet all mainstream institutions, scientific and non-scientific, international and national, continue to adhere dogmatically to this failed theory whose application brings iatrogenic harm to innumerable people.

I appreciate deeply this opportunity to talk about something that's been weighing heavily for many months. What I have to say will at first seem unbelievable. If so, I hope you will check my facts and references, which are fully documented in 3 manuscripts posted at http://hivnotaids.homestead.com

I had contemplated as a title for this talk, "Why does HIV discriminate by race?", but finally decided that might be too provocative. HIV/AIDS and race are both topics on which the taking of offence can hinder rational discussion. So let me pledge at the outset that my ultimate conclusions are not pejorative with respect to gay sex and they are not pejorative with respect to racial differences. Quite the contrary: the conventional wisdom, the mainstream view about HIV/AIDS, mandates blatantly racist interpretation of the facts.

I came to the topic of HIV/AIDS because my chief interest has been in scientific unorthodoxies, how to distinguish good from bad science, genuine science from pseudo-science; and although most people don't know it, an appreciable number of competent people have been arguing from the beginning that the orthodox view of HIV/AIDS is wrong.

I had trained and worked as a chemist before learning, here at Virginia Tech, some rudiments of history, philosophy, and sociology of science, and the other disciplines that comprise STS, Science & Technology Studies. I learned that old theories continue to dominate until there is a revolutionary shift after sufficient anomalous observations have accumulated; yet theories are never discarded until better ones are available. Still, I maintained a certain level of naivety--I can't help thinking that when the facts are plain enough, science will draw the obvious conclusions.

I've also long maintained that STS is a very good thing for taking a broader view, for giving guidance to science & technology policy, and as the best way to educate non-scientists about what science is and what it can do and what it should not be asked to do. But I kept insisting that when it comes to the ***substance*** of science, STS must defer to those who are actually doing the stuff.

So now I have to eat my own words. The facts are plain, but science does not draw the obvious conclusions. The insiders are wrong about the substance of their own work. All official institutions, international as well as national, all mainstream scientific and medical organizations, journals, and funding sources, insist that HIV unquestionably is the cause of AIDS. I have no credentials in molecular biology or virology or immunology or epidemiology, and yet I can see that the data demonstrate, without doubt and quite conclusively, that HIV doesn't cause AIDS.

I am not, of course, the only person who believes HIV doesn't cause AIDS. As already mentioned, well qualified virologists and epidemiologists and others have been arguing that all along. But those arguments feature intricate technicalities of virology and immunology, which not many non-specialists feel comfortable with or can judge properly. What I'm claiming is that no expert knowledge is needed to see that readily available evidence plainly shows that HIV is not sexually transmitted.

I think the best approach is to retrace the steps that led me to this heretical conclusion.

It began early last year, when I read a scientific biography of Peter Duesberg, who has long argued that HIV cannot be harmful. At page 184, I came across something that just couldn't be right:

> the U.S. Armed Forces find that, just as in Africa, the distribution of HIV antibody is gender-neutral among the presumably fit adolescents wanting to enlist.

I checked the original reference: It does indeed say that. In fact, it underscored that something was wrong, because it says that in the years ***between 1985 and 1989***, among teenage potential recruits, females were infected at the same rate as males.

Do you see what's wrong with that? I suspect that many of you don't. That's quite a big part of my problem in talking about all this. AIDS first appeared 25 years ago. Only people who are now older than 40 or so experienced the hysteria and panic of those years and recall what it seemed to be about.

What's wrong with that statement is that when AIDS appeared in the 1980s, 90--95% of victims were gay men in a few large cities. How could female teenagers, all around the country, already have been infected in those years at the same rate as males? HIV is supposed to have spread from gay and bisexual men and drug users through chains of sexual partners. How long would it take to get across the country and into the general teenage population from a few fairly closed communities in major cities?

I thought this was a decisive disproof of HIV as a cause of AIDS--provided that one research article was reliable. So I looked for other information about HIV infection, especially in the 1980s--the tests only became available around 1985. I found quite a lot of data.

A natural question is whether the facts I'm relying on are representative or whether they are selected with possible bias. I draw on reports of 60 million or more tests (Table 1), most of them on groups of people not regarded as at risk. "High-risk" refers to IDU, people who inject drugs, and MSM, gay men; and sexual partners of those; other groups are "low-risk".

DESCRIPTION OF GROUP	*DATES OF STUDY*	*NUMBERS OF TESTS*
MILITARY GROUPS		
Active-duty	1985--2004	6,500,000
Military applicants	1985--2004	6,900,000
---teenage	1985--89	1,100,000
National Guard	1985--2004	2,600,000
Army Reserve	1985--2004	1,600,000
Navy & Marine Corps	1986--88	1,100,000
BLOOD DONORS	1985--2002	~11,000,000
(first-time)	1993--2001	~10,000.000
JOB CORPS	1987--97	~500,000
OTHER LOW-RISK		
New mothers	1994--95	4,600,000
Family planning clinics (public sites)	1995--98	1,220,000
Prenatal clinics (public sites)	1995--98	740,000
Marriage-licensees	1985--88	>100,000
University students	1988--89	17,000
INDETERMINATE RISK		
Publicly funded sites	1989--98	22,000,000
---including STD clinics	1995--98	2,560,000
Drug clinics	1995--98	470,000
Prisons	1995--98	427,000
TB clinics	1995--98	89,000
Teenagers at clinics	1990--97	104,000
STD clinic patients	1991--96	180,000
HIGH RISK		
HIV counseling sites	1995--98	2,590,000
Young MSM	1994--1998	3,500
MSM	1998--2000	2,900
MSM at STD clinics	1993--97	200,000
IDU in treatment	1993--97	37,000

TABLE 1: Some of the data base from which generalizations have been drawn

Full documentation is on the hivnotaids website. I would be delighted if all of you would search the literature for yourselves, because I suspect that no one could believe what the facts are without seeing paper after paper after paper saying the same things. For many weeks, I couldn't believe what I was seeing. I have

found no significant contradictions anywhere to the sweeping assertions I'll be making. I cite more than 100 references and I looked at maybe another hundred that just confirm what I cite. I scanned all the publications by the Centers for Disease Control (the CDC), the weekly ***Morbidity and Mortality*** reports as well as the special HIV/AIDS reports that came out at least annually.

The first result of gathering all these data was an unhappy one. I realized that the female-to-male infection ratio can ***not*** serve as rhetorically as well as substantively decisive proof, as I'd thought initially it could. Over the years, the male-to-female ratio for ***AIDS*** has dropped from about 10 or more to 1 down to about 3 to 1; and the ***HIV infection*** ratio overall in all groups isn't much lower than that, maybe about 2 (Figure 1). The male-to-female discrepancy between AIDS victims and HIV infection has dissipated over the years.

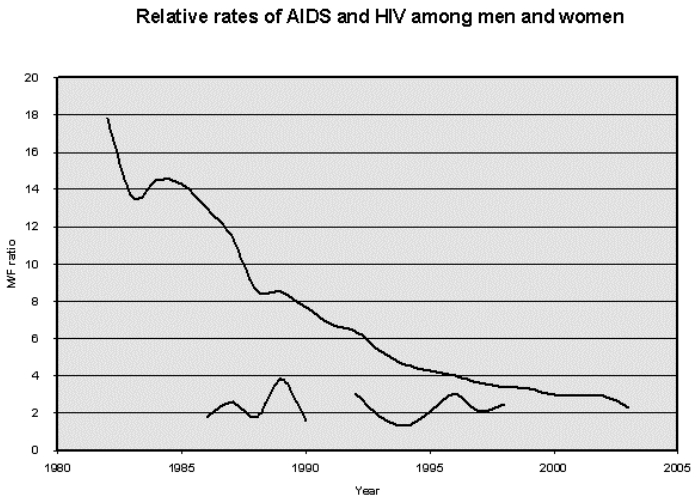

FIGURE 1: Male-to-female ratio of AIDS cases (upper curve) and HIV infection rates (lower curve)

The changing ratio for AIDS came about because the definition of AIDS, the criterion for a diagnosis of AIDS, has been altered several times, to the extent that AIDS nowadays is actually nothing like 1980s AIDS. That becomes a long and complicated story, maybe just as intricate as the arguments about virology and molecular biology. It's not straightforward enough to serve as a rhetorical tool for questioning the entrenched dogma and conventional wisdom.

But as I was gathering all those data, I couldn't help noticing quite a lot of strange facts and trends that are constantly present. Please remember that from now on I'm talking about ***HIV infection*** and not about visible illness in the form of AIDS:

- The rate of infection changes with age in remarkable ways (Figure 2):

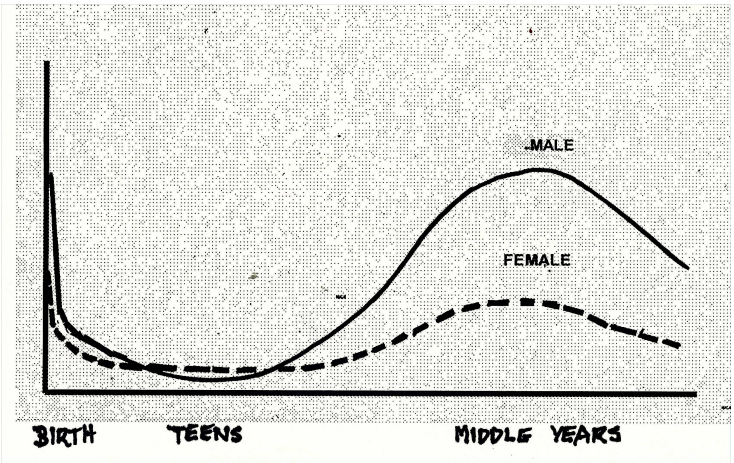

FIGURE 2: Frequency of positive HIV tests varies with age, qualitatively in the same manner in all groups, but the variations are more pronounced among males than among females

Babies are infected at about the highest level found among adults who appear to be in good health. Infection rates drop sharply in the first year after birth, and begin to rise again in or after the teens. Males are always infected more than females, except in the low teens when females are more infected than males.

Now please recognize that I'm not talking about one study, or one group. These regularities are seen among members of all racial categories, in every tested group--applicants for military service, active-duty soldiers, sailors, and Marines, members of the Job Corps, blood donors, new mothers, and in Africa as well as in the United States.

- There's also something quite peculiar about the geographic distribution of HIV. Again in every tested group, high-risk as well as low-risk and unchanging over twenty years, the rate of infection is highest along the Atlantic coast, and in the South, especially the South-East. Figure 3 is the average of a dozen separate studies.

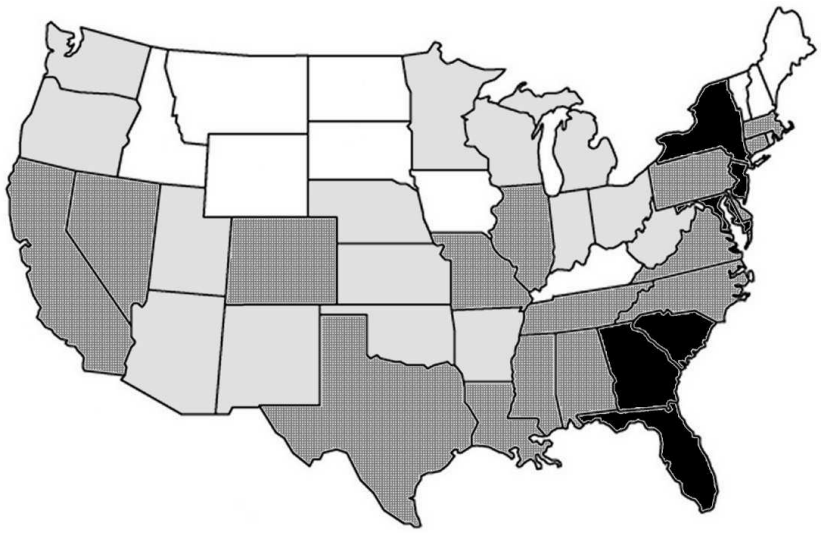

FIGURE 3: Observed geographic distribution of HIV, similar in all social groups and unchanging over time

- In every low-risk group tested, there are always a few people infected, typically on the order of 1 per 1000.

These regular trends surely make it obvious that HIV is not a sexually transmitted infection or disease, STD. The incidence of an STD does not show such regular variation with age, sex, and geography. Syphilis or gonorrhea does not infect about 1 in 1000 people in every demographic group of apparently healthy people who are tested. Rates of infection by syphilis or gonorrhea do not uniformly, in every group, increase with age from the teens into middle age and then decrease again, still less are the infection rates of babies so high. There are outbreaks of syphilis and gonorrhea in different parts of the country, and in different social groups, at different times in different places; those diseases are not always more prevalent in the Atlantic regions and the South.

And then there's the question of race.

Just about every study reports rates of infection by racial category, and in every tested group there is always this same sequence:

white < Hispanic < black

When the numbers of tests are large enough to report separately for Asians, it is always

Asians < white < Hispanic < black

And the differences are large. With 1 as reference for white, the proportions are roughly

Asian ~0.6 < white 1.00 < Hispanic ~2.8 < black ~5.5
(~1.5--9) (~3--14)

Though the ranges for Hispanics and blacks are fairly wide and overlap, the same sequence is seen in all groups; in only a handful of cases, a few percent, are Hispanics reported as infected more than blacks. Black people are more frequently HIV-positive than others, by a significant amount, no matter whether the tested group comprises blood donors or drug users, Marines or new mothers, hospital patients or soldiers or reservists or members of the Job Corps; and whether they are babies or teenagers or adults; and whether they are male or female. Race influences being HIV-positive as an independent variable, just as age and sex do.

To me, it seems quite obvious that this demonstrates, just as the other data do, that HIV is not a sexually transmitted infection, that whatever the HIV tests are measuring is something purely physical, like skin or hair or eye color. Surely no one could believe that a propensity to practice unsafe sex promiscuously, or to inject drugs with dirty, infected needles, would be so constantly correlated with racial ancestry, even among babies and children.

Again it seems that I was naïve. When I sent my data analysis to the Centers for Disease Control for comment, they responded,

> The 'characteristic differentiation by race' that you note **is compatible** [emphasis in original] with a behavioral explanation

Of course, they had already said as much in official publications:

> The marked racial and ethnic differences in HIV prevalence, even among persons treated in the same clinic, suggests that ***both behavioral norms and complex social mixing patterns within racial and ethnic groups*** are important determinants of HIV transmission risk [emphasis added]

In plain words: Standard accepted behavior in black and Hispanic communities is said to bring significant numbers of people in those communities into frequent sexual contact, or needle-sharing contact, with HIV-infected people; and the origin of every chain of such contacts is an infected gay man or drug addict. Ubiquitous promiscuity is supposed to be much more common among black and Hispanic people than among white people--who, however, are 50% more likely to behave like that than Asians are.

I would have expected such a view to be expressed by extremists of the right, and by extremists of the left, but not by people speaking for a government agency that is supposedly science-based. Extremists of the right--one might call them paleo-Darwinian sociobiologists--believe that skin color predicts sexual behavior, just as they believe that it predicts intelligence and the tendency to criminal behavior. Extremists of the left one might call paleo-Lamarckian sociobiologists, for they believe that a few centuries of extreme social deprivation have so shaped the victims that their offspring unto many generations inevitably behave irresponsibly, and that therefore skin color predicts sexual behavior.

By contrast, it seems to me, the only intellectually respectable view is this:

If some characteristic is always, in every group and sub-group, distributed in the same relative fashion between racial categories, then that characteristic is not a behavioral one. It is something like blood groups, or sickle-cell anemia.

Whether or not you find this abstract argument convincing, the data inescapably support it. You see, the same racial disparities in HIV infection are seen in other countries as well. In Europe, people of African descent test HIV-positive significantly more often than Caucasians. In South Africa, blood donors show the same disparities as in the United States (Table 2):

Classification by South African Blood Service	*Racial categories of blood donors*	*HIV per 100,000*
Category 1 ("safe")	regular donors, white or Indian	1.12
Category 2	coloreds, & first-time Indian and white	2.2
Category 3	first-time coloreds, & blacks	25.8
Category 4	blacks, first-time)	58.97

TABLE 2: South African National Blood Service classification and corresponding HIV prevalence

These data came into public view in 2004, when word leaked out that the South African Blood Service was not using blood donated by blacks, because it was so much more frequently HIV-positive.

Under the official view, one has to conclude that Indians behave as circumspectly as white people. As to coloreds (people of mixed ancestry), the official view again has to presume that the same genes that determine racial classification also determine behavior.

But what can this official view do about the fact that Hispanics in the United States show up differently in the East than in the West?

> In the Western states, HIV seroprevalence was similar among Hispanics and whites, while in states along the Atlantic Coast, seroprevalence was higher among Hispanics than among whites

For example, here are the relative infection rates for white and for Hispanic women who have just had babies (Table 3):

State	*Region*	*Hispanic-to-white infection ratio*
NY	Atlantic	9.7
CT	Atlantic	6.8
MI	Mid-West	5.0
NJ	Atlantic	4.8
KS	Mid-West	3.6
CA	West	1.4
TX	South-West	1.0

TABLE 3: Eastern Hispanics are like blacks, Western Hispanics like whites

Are we to conclude, as the CDC apparently does, that in the West, Hispanics are somehow able to behave almost as responsibly as white people, while in the North-East, they are at least as irresponsible as blacks?

It occurred to me that there is available an objective test to decide the question, whether racial disparities in HIV infection in the United States follow lines of social or cultural or economic deprivation or discrimination or whether they follow lines of purely physical, genomic, correlates of racial category.

Native Americans offer a test case.

If it's a matter of social deprivation, Native Americans should show up comparably to blacks. If it's a matter of genomes, then Native Americans should fall with Asians and whites.

That, ***of course***, is where they do fall (Table 4):

	Civilian applicants to military	*Job Corps*	*Public sites*	***Average***
sample size	5,300,000	250,000	9,000,000	
Asian	0.59	0.4	0.63	**0.54**
White	1.00	1.00	1.00	**1.00**
Native American	**1.47**	**1.6**	**1.23**	**1.43**
Hispanic	2.25	1.6	2.37	**2.1**
Black	6.25	6.4	2.76	**5.1**

TABLE 4: HIV infection rates relative to whites. Native Americans are closer to whites than to blacks

Obviously, a positive HIV test reflects something physical that correlates with racial genomic patterns.

Why are Hispanics in the Western US more like white Americans, and in the East more like black Americans? Simply because that's what they actually ***are***. "Hispanic" is an ethnic category, not a racial one; for some purposes the Census Bureau distinguishes between black and non-black Hispanics. In the West, Hispanics are largely Mexican, with little African ancestry on average, whereas in the East they are heavily of Caribbean origin with considerable African ancestry.

If yet further proof were needed, that HIV is not an infection, just look at the published data from actual studies of the rate of transmission: They are invariably on the order of about 1 per 1000 acts of unprotected intercourse. For syphilis or gonorrhea, the rates are a hundred times greater than that, tens of percent instead of parts per thousand (Table 5).

Observed rate of transmission <u>by unprotected intercourse</u>	***Year of study***
<1/1000 M ---> F, <0.5/1000 F ---> M	1986
0.8--1/1000 M ---> F	1987
0.5--2.3/1000	1988
0.8--1/1000	1989
0.6--2.6/1000 M ---> F	1994
0.5--1.2/1000 M ---> F	1996
1/1000	1997
0.9/1000 M ---> F, 0.11/1000 F ---> M	1997
0.6--0.9/1000 M ---> F	1998
0.6--0.8/1000 M ---> F	1998
7% per year = 1/1000 at 70 acts/year	1999 Haiti
10/100 person-years M ---> F, 5/100 person-years F ---> M = 1/1000 /for M ---> F, 5/10,000 for F ---> M at 100 acts/year	2002 Africa
8.2/1000 within ~2.5 months after seroconversion; 1.5/1000 within 6--15 months after seroconversion; 2.8/1000 in the 6--25 months before the death of the infected partner	2005 Africa

TABLE 5: Observed rates of transmission of HIV are ~1/1000 acts of unprotected intercourse in all countries

If you find this hard to believe, do please check the original sources and try to find contradictions anywhere in the literature. Why this is not common knowledge, or why its significance has not been broadcast, is another question for STS to take up. A review of such studies in 2001, by people at the CDC itself, concluded that

> the transmission probabilities presented are so low that it becomes difficult to understand the magnitude of the HIV-1 pandemic.

In fact, of course, these results in themselves already ***falsify*** the hypothesis of sexual transmission. The studies cover two decades, a variety of investigators, and subjects in North America, Europe, Haiti, and Africa. Yet apparently the mainstream researchers who published these data, and the reviewers of their manuscripts, have not asked:

"What, by the way, is the evidence ***for*** sexual transmission?"

The answer to that is, "There never was much, if any". Look through the literature. You won't find it.

The literature also has no reports of transmission via infected needles. It's another shibboleth without substantive basis.

So if it's not an infection, why has it been spreading?

Well, of course, it ***hasn't*** been spreading. You may recall that in June 2005, the CDC announced that "***for the first time***" more than a million Americans were infected. Nowhere did I see or hear mentioned, that the official estimate has remained about the same for 20 years (Table 6):

Estimated number of infected Americans (millions)	***Year***	***Authority***
> 1 "*for the first time*"	2005	CDC
> 1	2003	CDC, *JAMA*
> 1	1993	*Science*
~ 1	1989	CDC
1.5--2	1988	NIAID & CA Health Dept.
0.945--1.41	1987	CDC
1--1.5	1986	CDC

TABLE 6: Official estimates of infected Americans have been the same for 20 years

For Haiti, too, the estimate has remained the same for 20 years, at about 5% of the population. In the US, 1 million represents about 0.3%; but Haitians are Caribbeans and largely of African ancestry and therefore test HIV-positive more frequently.

All sorts of evidence, then, shows that HIV isn't an infection and hasn't been spreading. Therefore, HIV cannot have been the cause of AIDS. HIV has been around as long as we've tested for it, its distribution has not changed, so it was not what suddenly caused clusters of deaths of gay men in a few cities in the 1980s.

So, what then is HIV, and what is AIDS?

Before I suggest some answers, let me point out that these two questions are red herrings so far as what I am claiming as beyond doubt. ***It is absolutely definite, based on an unbiased collection of official data, that HIV is not an infection***.

It is an inference from there, but a short, easy and I think certain one, to the claim that HIV didn't cause AIDS.

Case closed.

So there's no onus on me to also explain what HIV is and what AIDS is. But the data do offer some clues, and they support convincing answers already given by others.

One clue is the manner in which the level of so-called infection varies by tested group (Figure 4).

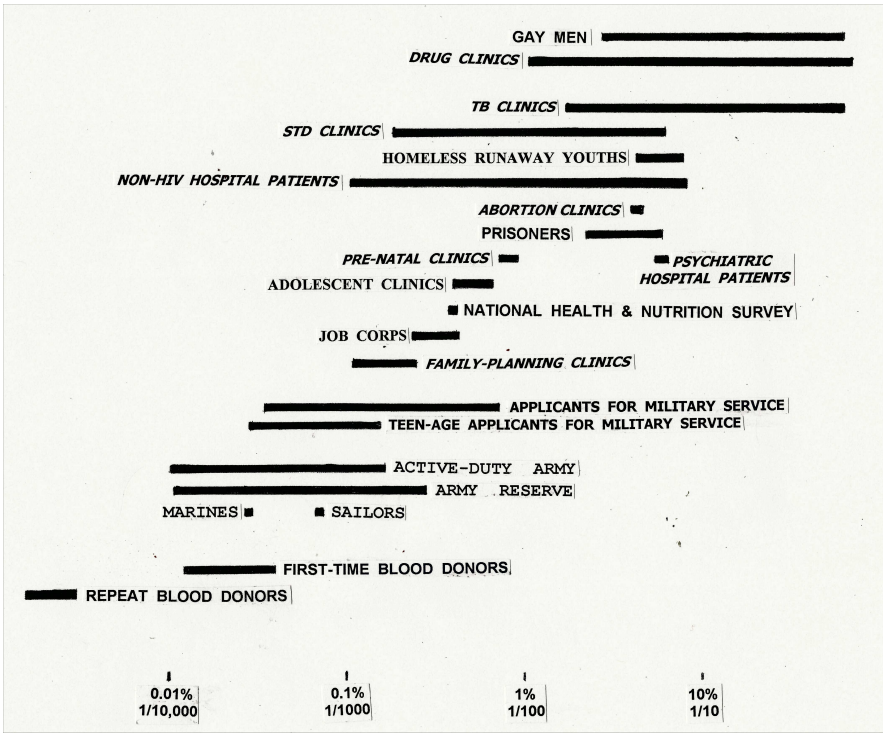

FIGURE 4: How the frequency of positive HIV tests varies among different groups. Logarithmic scale covers 5 orders of magnitude.

There is a correlation between the frequency of positive HIV tests and the expected average relative level of health of members of the group, health having nothing to do with venereal disease. Blood donors healthiest, repeat donors more so than first-timers. Prisoners, non-HIV hospital patients, TB patients, significantly less healthy. Note the situation of psychiatric patients; no reason why they should be infected by a venereal disease as much as, or even more than, patients at STD clinics, is there? Women at abortion clinics test positive more frequently than women at pre-natal clinics, who test positive more often than women at family planning clinics--just the variations you would expect of something that indicates physical stress. Drug injectors tend to be very unhealthy, of course.

So the frequency of positive HIV tests is a bit like the frequency of fever. Both just show that the body, or the immune system, is reacting to some sort of health challenge. A group of scientists and physicians in Perth, Australia, has long argued that HIV tests measure oxidative physiological stress. Many instances demonstrate that testing HIV positive is not necessarily a permanent condition, which fits with the notion of a reversible physiological stress.

Like a fever, a positive HIV test is a quite non-specific indication that the body is reacting to something. As with a fever, the cause may be something serious or something trivial that will take care of itself.

The only possible anomaly might be, why gay men would so frequently test positive. One reason is that those gay men who get tested for HIV are the ones who were enrolled for study at the places where gay subjects can readily be identified--bath-houses, bars, HIV and STD clinics, and so on. Those are also places where unhealthy lifestyles tend to be common. The so-called "fast-lane" life-style practiced by this minority of gay men, notably in the years following gay liberation, has been described by a number of insiders, for example:

Larry Kramer, *Faggots*, Random House, 1978
Michael Callen, *Surviving AIDS*, HarperCollins, 1990
John Lauritsen, *The AIDS War*, ASKLEPIOS, 1993
Richard Berkowitz, *Stayin' Alive: The Invention of Safe Sex*, Westview, 2003

Josef Sonnabend had a medical practice in New York from the 1970s, with many gay patients. Before AIDS even appeared, he had already been warning his patients that their lifestyle would kill them. Those who listened to him lived much longer than others, and two of them (Callen and Berkowitz) literally wrote the manual of safe sex.

It's fairly common knowledge that AIDS never spread into the general population in the United States, but it's not widely remarked that it never spread into the general ***homosexual*** population either. Moreover, the initial correlation between AIDS and gay appears to have been a mistaken one, through a failure to appreciate that the gay victims of AIDS had been heavy users of recreational drugs as well as antibiotics and other medications used to treat or guard against frequent and recurring infections by various venereal and other diseases. This was pointed out long ago by Lauritsen, and has recently been documented in considerable detail by Michelle Cochrane (*How AIDS Began*) specifically for San Francisco.

As to what AIDS is, most of the cases in the 1980s were probably owing to drug abuse, multiple recurring infections, excessive resort to antibiotics, and generally burning the candle at both ends. I can't spare the time to say more on that, plenty has been written about it by Robert Root-Bernstein and Peter Duesberg, among others. But I do want to suggest why HIV--not AIDS, HIV--discriminates by race.

It makes sense that Africans should have particularly strong immune responses, just as it makes sense that they have dark skin. In the tropics, the sun is fierce, and it needs to be filtered by the skin to avoid too much vitamin D being produced. As humans migrated out of Africa, their skins lightened because they needed more of the available sunshine to make enough vitamin D. Nowadays in non-tropical regions, people with dark skin are at significantly higher risk for vitamin D deficiency.

The tropics not only have fierce sun, they have fierce health challenges as well: parasitic, microbial, fungal, and viral diseases abound there. "Tropical medicine" has accordingly been a recognized specialty for a long time. I suggest that as humans evolved in Africa, they developed extraordinarily strong immune systems as protection against all these challenges. Humans who migrated out of Africa progressively lost some of that as the environmental challenges became less. So people of African ancestry have a more pronounced tendency to display the positive HIV-test response to a health challenge.

In about a year of data gathering and rumination, I have so far found nothing that contradicts this view of HIV/AIDS, that HIV-positive is an indicator of oxidative stress, not necessarily serious, and definitely not signifying the ***cause*** of any illness. On the other hand, the more one digs into the data about HIV, and also that about AIDS, the more contradictions one finds of the mainstream conventional wisdom about "HIV, the virus that causes AIDS". That paradigm is ready to fall, and all that supports the house of cards are these few things:

- All national and international institutions: the World Health Organization, the World Bank, UNAIDS, the Centers for Disease Control and Prevention, the National Institutes of Health, and more
- All mainstream scientific and medical journals, which reject on sight any manuscript that questions the orthodoxy
- Innumerable charities sponsored by prominent people: Bill Clinton, Princess Diana, Elton John, Nelson Mandela, Arthur Ashe, Bill Gates, and more
- Enormous profits for drug companies; total sales of anti-retrovirals are ~ $20 billion per year
- Research grants and employment for many thousands of scientists
- Employment for innumerable HIV counselors, social workers, and more
- Many misguided gay activist groups: that a virus should cause AIDS is, in their view, less threatening than that AIDS should have been the result of the lifestyle practiced by a minority of gay men.

I would appreciate your help in persuading all concerned that they are wrong.

That flippant note and other earlier ones should not distract from how serious all this is. Lives are quite literally at stake. Anyone who tests HIV-positive is advised, urged--sometimes even forced--to take treatment with anti-retrovirals. All of those are toxic and debilitating, yet they are being fed to perfectly healthy people including pregnant women and newborns; disproportionately, of course, to those of African ancestry, because they test HIV-positive much more frequently than others.

I certainly don't subscribe to any of the conspiracy theories as to the genesis of HIV and AIDS, some of which have alleged a genocidal purpose. Still, we are presently committing something like unwitting genocide; after all, there is incessant propaganda urging that we provide Africans with more and more of these poisons.