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500% Black-White HIV+ Disparity Belies "3% Epidemic" in Washington

Anomalies from 30-year-old AIDS theory

by Terry Michael

A recent report from an observational study of sexual behavior of 35 gay and bi-sexual African American males is the latest attempt to explain away the huge 500% disparity between blacks and whites testing "positive" for HIV, a difference so great it belies the oft-repeated claim of a "3% generalized and severe epidemic" of "HIV-AIDS" in the heavily black District of Columbia. That unexplainable disproportion raises serious questions, lingering for the past quarter century, about the single pathogen theory of the immune deficiency syndrome first observed by the CDC 30 years ago this month, when the Centers for Disease Control, in a June 5, 1981 surveillance report, noticed curious cases of pneumonia in five gay men in Los Angeles.

Between 2001 and 2006, black males aged 18 to 24 were interviewed by Dr. Errol L. Fields, as a graduate student at Johns Hopkins. A university press release, written from an abstract of a paper by Fields presented at the Pediatric Academic Societies conference in Denver, May 2, 2011, begins: "Young black men who have sex with men (MSM) get infected with HIV nearly five times more often than MSM from other races, even though they don't have more unprotected sex. The discrepancy has long mystified public health experts but a new study...offers a possible explanation for it."

Indeed, it has been a mystery of HIV and AIDS theory that black skin equates to five times greater likelihood, than white, for testing reactive to "HIV tests," but that difference is usually disregarded or ignored, in the U.S and Africa, because it suggests a racist conclusion that blacks are hyper-sexually promiscuous.

Dismissed is the probability that those of African descent have a greater propensity, perhaps of genetic or environmental causation, to test reactive for a set of proteins in their blood--proteins expressed from sources other than those claimed as specific to HIV anti-bodies. Test kit manufacturers acknowledge seventy or more factors--like flu shots, pregnancy, herpes simplex, and Hemophilia--that can cause "positive" reactions to the blood proteins assayed. And proteins are what the tests actually detect, not an active viral pathogen. The manufacturers of the tests and physicians will claim the proteins probably reflect "HIV anti-bodies" if one is in a "high risk category." Read that as gay, or intravenous drug user, or black heterosexual female, or maybe some combination of the three. If hosts are straight and Caucasian, physicians often give them a pass, and claim the proteins must be caused by something else--because there never has been an epidemic of AIDS in the white Western heterosexual population.

More from the Johns Hopkins press release: "These men show a clear preference for

masculine men...equating masculinity with lower HIV risk. This dynamic...can help explain why young black MSM contract HIV more often than their counterparts from other races."

Why would a black male be any more likely than a Caucasian to choose a "macho" insertive partner in anal sex-- and then let that partner decide on condom use? The study doesn't tell us about Caucasians, because none were studied, Fields acknowledged in an email interview for this article.

This "study" comprises still another HIV-equals-AIDS orthodoxy attempt to brush aside racial differences in testing. "The test"--not actual disease--is at root of the claim of a "3% epidemic" in the District of Columbia. The 3% claim conflates "cases" of "positive" tests for HIV (not a disease) with "cases" of AIDS (a syndrome, not a disease.) And the vast majority of AIDS "cases" (up to two-thirds; see below) are diagnosed just by T-cell counts of 200 or below, without presenting illness.

There is no evidence of an epidemic of presenting illness of any kind from immune deficiency in Washington, DC. There is an epidemic of testing, for blood proteins. Why? Because, in 2006, Washington became the first city in the U.S. to implement a policy of routine "opt out" HIV testing in many medical settings (get the test unless you say “no”), and that change yielded a major increase in "positive" tests, not disease.

If you reduced the 16,513 so-called "HIV-AIDS cases" claimed by DC as of Dec. 31, 2008 to just the "AIDS cases," of which the city claimed 9,352 in a document released by the director of the Dept. of Health, Pierre N.D. Vigilance in March 2010 ("District of Columbia, HIV/AIDS, Hepatitis, STD and TB Epidemiology, Annual Report 2009 Update"), there would be 7,161 "cases" of nothing more than individuals whose blood samples included proteins believed to be associated with HIV anti-bodies--but with no progression to AIDS. The same report also noted that "the overall number of cases defined as AIDS based on the presence of an OI [opportunistic illness] has decreased over time, from 76% to 35%," which means the remainder would be defined only by the surrogate marker of less-than-200 T-cells, with no presenting illness. Thus, if you reduced the claimed 9,352 so-called AIDS cases to that 35% defined by OI's, there would be a total of 3,273 cumulative living (over the past two-and-a-half-decades) AIDS cases in DC defined by actual presenting illness.

Take those 3,273 “cases” and divide by the population of DC for the end of 2008 (510,640, according to the report cited above) and you would get not a 3% epidemic, but six-tenths of one percent of the population that might be said to be ill from an immune deficiency. Or, just sick from the disease with which they presented. Read further into that report released in March 2010, and you will find that only 133 people died of AIDS-defining opportunistic illnesses in 2007 (last year figures available.) But the same table (P. 48, Annual Report Update 2009) claims a total of 274 deaths in 2007. Reading the footnotes, you will find that the other 141 (over half) died of things having absolutely nothing to do with AIDS: homicide, suicide, accidents, substance abuse, non-AIDS defining cancers, cardiovascular disease, etc. In other words, get an HIV test,

get hit by a truck the next day, and you died of AIDS!

Blood tests are aggressively promoted by the city's HIV-AIDS administration, which gets federal funding (about 90% of its HIV agency budget) based on HIV-conflated-with-AIDS "cases," most of which "AIDS cases" show no presenting illness on diagnosis, as noted above.

Much of that federal money goes to HIV-AIDS non-profits established in the metro area in the past 25 years. The Washington Post exposed in October 2009, as unaccounted for, grants totaling $25 million to these "service organizations" between 2004 and 2008. The HIV-AIDS Industry is a big and lucrative business in the Washington area. For example, the director of Food & Friends, one of almost one hundred metro area HIV-AIDS non-profits, was compensated an average of $333,000 per year from 2004-2009, according to the corporation's IRS informational tax Form 990. Metro TeenAIDS received a $100,000 grant this year from Gilead Sciences, the largest purveyor ($6.2 billion in 2010) of so-called "anti-retrovirals." Gilead promotes its chemotherapy, with highly toxic side effects, widely in America's gay press--much as manufacturers of nitrite inhalents (“poppers”) were major streams of revenue for the gay press in the late 1970's and early 1980's. The DC HIV-AIDS administration itself is a large enterprise, employing 150, with a budget for FY 2012 of about $89 million.

If those thousands of "AIDS cases" in Washington, DC, defined only by T-cell counts, went to Canada, they wouldn't have AIDS. In Canada, and the rest of the western world, actual illness is required for an AIDS diagnosis. Corrected for population, Canada reported 2,100 percent fewer new cases of AIDS for 2007 than did our Centers for Disease Control--238 in all of Canada (population about 34 million) vs. 44,084 in the U.S. (population in 2007 a little over 300 million.)

To learn more about anomalies from HIV-equals-AIDS; the mysteries of the so-called "HIV" test; what AIDS really is in Africa; and the iatrogenic (doctor induced) illness being caused by toxic "anti-retrovirals," begin with a "special report" you'll see at my web site: www.terrymichael.net. Ask yourself, particularly if you're African American: do you want to risk the psychological impact of a bogus HIV+ result, followed by "treatment" with highly toxic chemotherapy for life--if you're not actually ill?

A 36-year resident of Capitol Hill, Terry Michael is an independent journalist, whose "day job" is teaching journalism students about politics. Email: terrymichael@terrymichael.net

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DOCUMENTATION:

Abstract for researchers' presentation at Pediatric Academic Societies conference in Denver May 2, 2011:

http://www.abstracts2view.com/pas/view.php?nu=PAS11L1_3243&terms=

Hopkins press release of May 2, 2011:

http://www.hopkinschildrens.org/Higher-HIV-Risk-in-Black-Gay-Men.aspx

Citations for Canada vs. U.S. data, 2007:
Corrected for population, Canada's Centre for Infectious Disease Prevention and Control (CIDPC) r HIV/AIDS, Hepatitis, STD and TB Epidemiology 2009* reported about two thousand one hundred percent fewer new cases of AIDS in 2007 than did the U.S. Centers for Disease Control (CDC) for 2007 (last year for which comparable statistics were available.) CIDPC reported just 238 new cases...
http://www.phac-aspc.gc.ca/aids-sida/publication/survreport/pdf/survrep1207.pdf
...(.7/hundred thousand) in all of Canada in 2007, with a population of 34,000,000 (Table 16A in Section 3 of the report.) The CDC claimed 44,084...
http://www.cdc.gov/hiv/surveillance/resources/reports/2007report/table1.htm
....new cases (14.7/hundred thousand) in the U.S. in 2007, out of a population of about 302,000,000 that year. Put into context, 238 new cases of acquired immune deficiency syndrome in Canada in 2007 is a level of incidence that comes close to the number of people struck by lightning and hit by trucks each year in a country of 34 million. (14.7 is 21 times, or 2,100%, greater than .7)

HIV/AIDS, Hepatitis, STD and TB Epidemiology Annual Report 2009 Update
http://doh.dc.gov/doh/frames.asp?doc=/doh/lib/doh/services/administration_offices/hiv_aids/pdf/annual_report_hahsta_march_2010.pdf