# Abstracts by CDC Authors Submitted to the 12th World AIDS Conference

Geneva, Switzerland
June 28-July 3, 1998

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

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12th World AIDS Conference Geneva
June 28 – July 3 1998

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Choice 1: Track/Category C 4  Choice 2: Track/Category A 9  Serial No.

# HIV-1 dual infections and recombinants are an integral part of the HIV epidemic in Brazil

**Background:** Although dual infections and recombinants involving sequences of different HIV-1 subtypes have been previously reported, their prevalence has not been evaluated.
**Objective:** To estimate the proportion of dual infections and recombinants among HIV-1 infected persons living in Rio de Janeiro, an area where HIV-1 subtypes B and F are common.
**Methods:** Peripheral blood mononuclear cells collected in 1993-1994 from 107 HIV-1-infected persons were used for nested-PCR amplification of viral gag (p24 region), pol (protease), and env (C2-V3 domain). Potential dual infections and recombinants were selected for further sequence analysis by using a combination of restriction fragment length polymorphism and heteroduplex mobility screening assays.
**Results:** Of the 107 specimens tested, 87 were infected with HIV-1 subtype B, 5 were infected with subtype F, 15 were potential dual infections caused by two distinct viral strains, and 5 were recombinants of various subtypes. Phylogenetic analysis of sequence data revealed that 7 dual infections were heterogeneous and comprised subtypes B and F (1), F and D (2), B and D (1), and B and C (3 cases of familial clustering). The remaining 8 specimens from this group represented false dual infections due to hypermutated sequences (3) or point mutation in the restriction site (5). In contrast to the heterogenous nature of heterotypic dual infections, all 5 recombinants included HIV-1 genomes of subtypes B and F only. The recombinant patterns based on gag, pol, and env included BFF (1), BFB (1), B/Fgag/FF (2), and B/Fgag FB (1). Taken together, these data suggest that while dual infections with multiple subtypes are common in Rio de Janeiro, recombinant viruses comprise sequences of subtypes B and F only.

**Conclusion:** Our data indicate that dual infections (6.5%) and recombinants (4.7 %) are an integral part of the HIV-1 epidemic in Brazil. This knowledge is vital to our understanding of the relevance of dual infections as a prerequisite for recombination, and is immediately applicable for current vaccine research.

**Name and full address of contact author**

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## Does measured behavior change reflect change in STD/HIV risk?


**Objective:** Changes in risk behavior are often used as the outcome in STD and HIV prevention studies, but it is not clear how well they predict disease incidence. We studied the association between behavior change and STD incidence.

**Methods:** Participants in a multicenter randomized trial (Project RESPECT) were analyzed to compare incidence of STD (gonorrhea, chlamydia, syphilis, HIV) among persons whose STD/HIV risk behavior changed from baseline to 6 months or 6 months to 12 months. Behaviors were categorized in four levels for each variable. Multivariate analysis was done using logistic regression for repeated measures.

**Results:** Of 4328 participants, 3282 had 6136 six-monthly STD exams and follow-up interviews. 8.5% had a new infection during a 6 month period. STD incidence was associated with center, race, and age. After adjusting for these, risk was also associated with number of partners in the interval (no partners OR=0.93; one=referent; two=1.2; three+=1.9. An unexpected finding (consistent regardless of number and types of partners) was that the highest risk for STD was in persons with 1-5 episodes of unprotected sex (OR=1.4); the incidence was similar for persons with no episodes and >20 episodes. After controlling for behavior during the interval, STD incidence was unrelated to behavior before the interval. There was no association with gender, having a new partner, or having an occasional partner. Many variables had paradoxical associations with STD incidence. We could not develop a risk score that effectively distinguished infected from uninfected persons.

**Conclusion:** Although Project RESPECT has clearly shown that a behavioral intervention can reduce the incidence of STD, our findings suggest a need for caution in using behavior change as a surrogate for a change in STD/HIV risk. Measured variables were only weakly associated (if at all) with STD risk and the risk was highest for persons with 1-5 episodes of unprotected sex in the preceding 3 months.


**Name and full address of contact author**


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Choice 1: Track/Category C 3 3 Choice 2: Track/Category C 2 3 Serial No.

## Tolerability of Antiretroviral Agents Used by Health-Care Workers (HCWs) as Postexposure Prophylaxis (PEP) for Occupational Exposures to HIV.


**Background:** In June 1996, the US Public Health Service recommended the use of combinations of antiretroviral agents (ARVs) as PEP following certain occupational HIV exposures. Except for zidovudine (ZDV), there is little information on the tolerability of ARVs in persons not infected with HIV.

**Methods:** Data collected on occupational exposures to HIV and reported to the National Surveillance System for Hospital Health Care Workers were analyzed to assess the tolerability of ARVs used as PEP.

**Results:** From June 1995 through December 1997, 188 HCWs reported occupational exposures to HIV. Of the 114 HCWs for whom at least one follow-up was available, 58 took PEP, 53 did not, and 3 had missing PEP information. Of the 58 HCWs who took PEP, 16 (28 %) took ZDV alone; 20 (34 %), ZDV and one other ARV; 20 (34%), a combination of three ARVs; and two (4%), four ARVs. Nineteen HCWs completed their PEP regimens as prescribed, 21 stopped prematurely, four modified their regimens, and 14 had missing information. Of the 21 HCWs who stopped their PEP prematurely, 16 (76 %) did so because of symptoms; three (14%), due to HCW choice; and two (10%), for other reasons. Forty-one (71%) of 58 HCWs taking PEP reported one or more symptoms. The most commonly reported symptoms were nausea, reported by 24% of HCWs; fatigue or malaise, 22%; emotional distress, 13%; headache, 9%; and loss of appetite, 6%. While HCWs not taking PEP also reported symptoms, they reported them less frequently, with symptoms being reported by 13 of 53 not taking PEP vs. 41 of 58 (relative risk 2.88, and 95% confidence interval 1.75-4.75) taking PEP.

**Conclusion:** A large proportion of HCWs taking PEP experienced at least one symptom while on PEP. This often was the reason for discontinuation of PEP. Counseling of HCWs about potential side effects of PEP along with symptomatic treatment may help ensure compliance with PEP regimens.


**Name and full address of contact author**


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Choice 1: Track/Category D28 Choice 2: Track/Category D16 Serial No.

1 **A Critical Assessment of HIV/AIDS Prevention Interventions for People on the Move in Sub-Saharan Africa**

2 **Issue:** The widespread occurrence of mobile livelihoods (including but not limited to migrations) in Sub-Saharan Africa (a) contributes to the spread of HIV/AIDS as people on the move engage in sexual networking in destination areas that exposes them and their sexual partners in destinations and their families at home to HIV infection and (b) creates challenges for HIV/AIDS prevention.
**Objectives:** Assess HIV/AIDS prevention interventions for people on the move in Sub-Saharan Africa by (a) highlighting key issues in this kind of HIV/AIDS prevention (b) review approaches used and reported results, and (c ) discuss implications for improving interventions.
**Method:** A review of intervention project reports and publications presenting information on strategies, operational approaches and results of 16 country-based and trans-border HIV/AIDS interventions in 12 Sub-Saharan African countries.
**Results:** Country-based interventions are more common than trans-border interventions even though most initiatives aim to address target groups involved in trans-border mobility and associated HIV risk taking; interventions provide little evidence of successfully integrating relevant multidisciplinary perspectives and findings from studies in the social and health sciences; interventions are not establishing linkages with "community-based" social support structures that frequently occur among people on the move, particularly in destination areas.

3 **Conclusion:** HIV/AIDS prevention interventions among people on the move must (a) broaden their geographic scope, (b) increase levels of trans-border coordination by different country-based HIV/AIDS prevention programs, (c ) ensure internal capacity to assess and integrate relevant perspectives and findings from studies in social and health sciences and (d) assess the potential benefits of developing linkages with social support organizations that occur among communities of people on the move.

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Choice 1: Track/Category C 4 9 Choice 2: Track/Category D 1 7 Serial No.

# Sexual HIV Transmission Risk Among HIV-Seropositive Men who have Sex with Men Recruited from Three Venue Types in Two US Cities


**Objectives:** Few behavioral interventions have been specifically designed to reduce sexual HIV transmission risk among HIV+ individuals. The present study sought to identify effective strategies for recruiting high-risk men into a study of sexual risk to inform a planned intervention trial, the SUMS .

**Methods:** Participants were recruited in New York City and San Francisco, from AIDS service organizations (ASOs) (N=69), mainstream gay venues (MGVs) such as bars and pride events (N=53), and public sex environments (PSEs) (N=73). They completed questionnaires regarding their sexual behavior in the previous three months, connections to community services, internalized homophobia, and sexual orientation. We hypothesized that PSE men would be the least connected to services, least likely to identify as gay, highest in homophobia, and at highest sexual transmission risk.,

**Results:** Men recruited from PSEs reported significantly more sex partners in the previous 90days than men from the other two venues, Ms = 19.3 vs. 12.0 and 12.8, $p < .03$. No differences were observed in reports of any unprotected anal intercourse with negative or unknown HIV-serostatus partner in the previous three months, M = 37%. However, men reporting this risk behavior reported significantly more frequent visits to sex clubs (1.48 vs. .97 times/month, $p > .05$) and cruising areas (1.68 vs. 1.27 times/month, $p < .05$) to find new sex partners. PSE men were significantly less connected to gay activities and health services. Near-significant differences suggest that PSE men are more likely to report being bisexual, and have higher levels of internalized homophobia, than men from the other venues. Data on effort needed to recruit participants from the three venues will also be reported.

**Conclusions:** Results are suggestive of some differences between men who frequent PSEs and those who do not, or who do so less frequently. Further research on specific risk patterns of individuals recruited from different types of settings and with different behavioral risk criteria is needed in order to target interventions to those at highest-risk of transmitting HIV.



**Name and full address of contact author**

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## Synthesis of HIV Prevention Intervention Research for Heterosexual Populations


**Background:** This study examines the effects of behavioral and social interventions on the sexual behaviors of persons at risk for HIV through heterosexual transmission, using data from studies identified by the new database of HIV prevention studies developed by the U.S. Centers for Disease Control and Prevention.

**Methods:** The CDC Prevention Research Synthesis database includes 82 studies, from 1988 to the present and around the world, that meet pre-established criteria for relevance (e.g., behavioral or HIV/STD outcomes) and methods (e.g., inclusion of control or comparison groups). Of the 82, 26 (32%) address heterosexual populations and are the focus of this presentation. We synthesized results descriptively and meta-analytically; calculating weighted average effect sizes (WA), and 95% confidence intervals (CI) for studies with safer sex outcomes.

**Results:** Synthesis of the 26 studies reveals their most common characteristics. Intervention designs include: clinic settings (62%); single short sessions (46%); and delivery by counselors (50%). Study populations were youth (46%), women (23%), clinic patients (19%), general public (4%), persons who are mentally ill (4%), and HIV-infected persons (4%). The median sample size was 150. Meta-analysis was performed on the 10 studies, to date, which report sufficient data on safer sex outcomes. The analysis showed positive (indicating effectiveness) and significant (CI did not include zero) protective effects of the interventions [n=10, WA=0.37, CI=(0.26 to 0.47)]. Similar positive and significant effects were obtained when analyses were done by sub-groups of youth and adult subjects; clinic and non-clinic settings; and no treatment and minimal care comparison groups.

**Conclusions:** Synthesis of HIV prevention studies for heterosexuals reveals diversity among intervention features, six study populations, reliance on health care settings for intervention delivery, but no intervention studies specifically for heterosexual men. The 0.37 weighted average effect size found by meta-analysis is equivalent to an 18% reduction in sexual risk behavior. This indicates that science-based prevention programs may be helpful in reducing HIV incidence among populations at risk through heterosexual transmission.


**Name and full address of contact author**


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Presenting author's signature Mary Neumann

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# Pocket Programme

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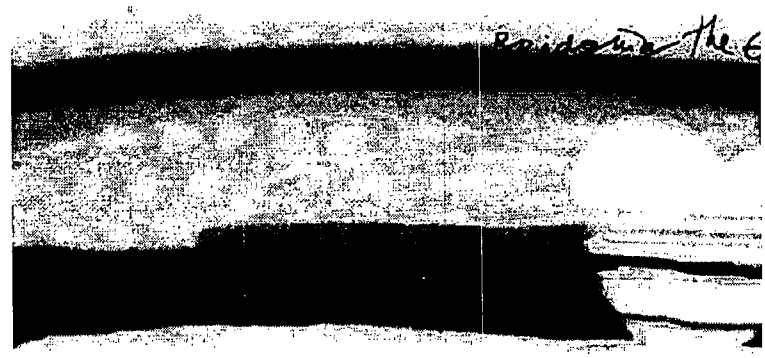

LAST UPDATE: Tuesday, 30 June, 1998 23:13 GMT

ONLINE NEWS

...all the ne happens

# Condom use soars after intervention, China

Efforts to increase knowledge and awareness of AIDS and STDs and increase the rate of condom use among female sex workers in Yunan, China have been extremely successful.

In an oral presentation yesterday, Dr. Zunyou Wu of the Yunan AIDS Centre said these results were achieved after repeated discussions with female sex workers, production of video and audio tapes, and distribution of educational materials and condoms in the towns of Chengjiang, Ruili and Longchuan.

Among 297 sex workers taking part in Wu's research, knowledge about the routes of HIV transmission increased from 18% to 98% in Chengjiang, from 44% to 80% in Ruili, and from 0% to 59% in Longchuan.

Awareness that condoms reduce the risk of HIV/S infection skyrocketed from 58% to 99% in Cheng to 91% in Ruili, and 55 to 90% in Longchuan. Th was that condom use by sex workers increased fr 77% in Chengjiang, 51% to 75% in Ruili and 39 t Longchuan.

Wu explains that the Yunan AIDS Centre prefers health workers and establishment (brothel) owner conduct awareness programmes because of the "h mobility and low respectability" of female sex wo Female sex workers tend to migrate from town to stays of between two days to two months, and it i to enlist them in peer education programmes.

**this story can also be found in The Bridge, the onsite print newspaper**

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12th World AIDS Conference

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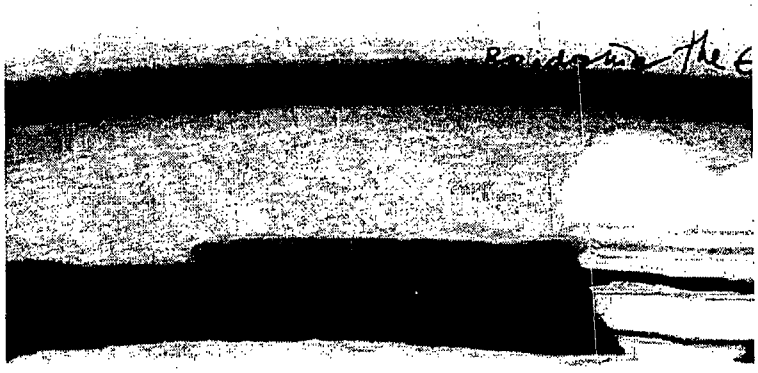
back to today's front page



LAST UPDATE: Monday, 30 June, 1998 21:13 GMT

BAD POLITICS

*...all the ne happens*

## India: Bad Politics Form Bad Policies

In government documents the AIDS epidemic in India is referred to as being in its early stages, but Radhika Ramasubban disagrees. "This, I believe, is a euphemistic description of an epidemic whose real epidemiological and social dimensions are still inadequately understood 12 years after the first case of AIDS was isolated in India, " she said at a session on the role of politics in policy making.

What does this position of a country with three million people living with HIV have to do with politics? Quite a lot, at least where implementation of programmes concerning HIV prevention is concerned, she says.

In her work at India's Centre for Social and Technological Change, Ramasubban is frustrated that AIDS has not received recognition as a priority problem from the Indian government.

"In the 1980's when Africa was [the centra AIDS, India on the other hand took refuge postures of denial on the grounds that AID foreign disease," she said.

"Until 1992, AIDS was considered a probl vigilance by law and order agencies, throu deportation of sex workers to their respecti and suspicion of foreigners." The real issu human rights and access to treatment were she said. "Change is needed."

**this story can also be found i The Bridge, the onsite print newspaper**

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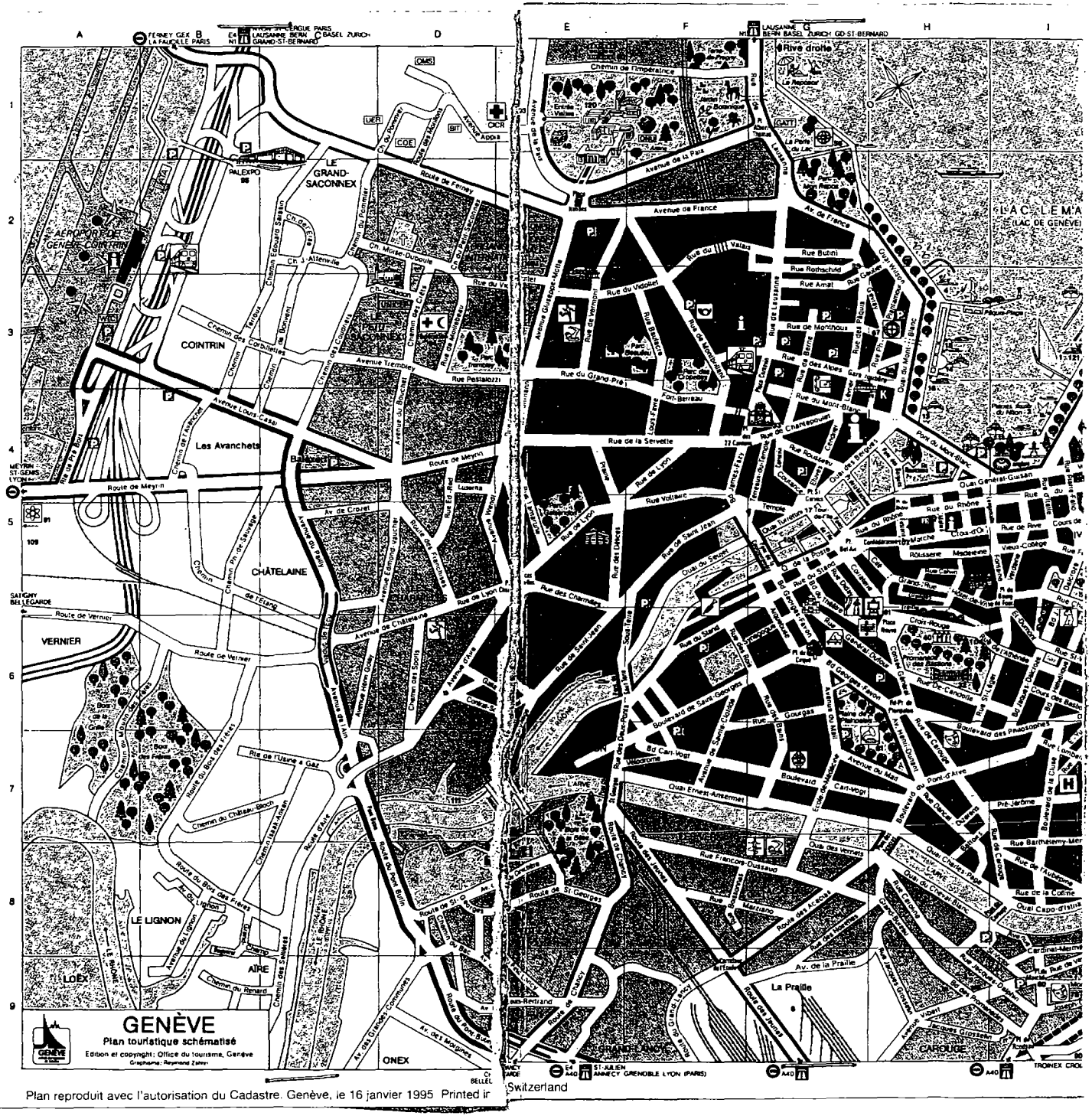


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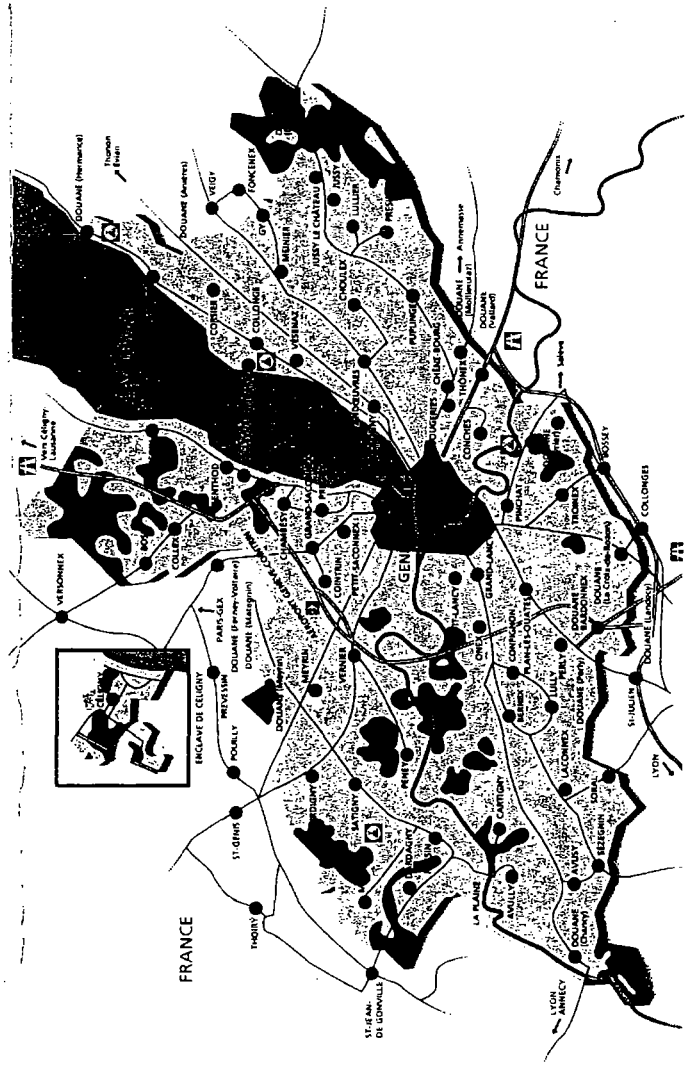

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| | | | **Satellite:** Cedars-Sinai Medical Center | | | | |
| | **Room F** | **Room G** | **Room H** | **Room I** | **Room K** | **Hotel Noga-Hilton** | |
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| | | Summary Session | | | | | |
| | | **PL 3** (P) Care/Treatment in '98 | | | | | |
| mmunity | **B32** Clinical Immunology in HIV-1 Infection | **B33** (P) Current Limits and Future of ART | **C31** Forecasting and Determinants | **C32** (P) Local Policies, Nat. Issues, Global Impact | **C33** (H) IDUs: Identification and Response | **D31** (G) Women-Centered Prevention | **D32** (P) Community in Prevention and Care |
| | **Room F** | **Room G** | **Room H** | **Room I** | **Room K** | | |
| | **SB 30** Programas de la nutrición | **SB 31** (P) Influencing Leaders in Asia | **SB 32** Basic Evaluation Techniques | **SB 33** (P) Influencer les décideurs en Afrique | **SB 34** Electronic Network Training | | |
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| (G) e of h HIV | **A33** Viral Reservoirs | **B35** Adherence to ART: New Research | **C34** Implementing STD Prevention and Care | **C35** (G) (H) Culture and Community: MSM | **C36** Harm Reduction Programmes for IDUs | **D33** (H) (P) Stigma and Discrimination | **D34** (P) (Y) Support for Orphans |
| gy | **B36** (H) Effects and Use of ART | **B37** TB: Prevention and Management | **C37** (P) (Y) Mother-to-Child HIV Transmission | **C38** (G) Male and Female Condoms | **B38** IAS – USA New Treatment Guideline | **D35** (H) (P) (Y) Ethics and Science | **D36** (P) Resource Allocation |
| n | **Room F** | **Room G** | **Room H** | **Room I** | **Room K** | | |
| | **SB 36** Building Strategic Alliances | **SB 37** (Y) Orphan Responses | **SB 38** Harm Reduction for IDUs in Eastern Europe | **SB 39** Gestión sindrómica de las ETS | **SB 40** Electronic Network Training (en español) | | |
| II IV | **Session Hall VII** | **Arena** | **Session Hall V** | **Session Hall VI** | **Satellite Hall 2000** | **Session Hall I** | **Session Hall II** |
| vention: revention | | | **Satellite:** UK Coalition | | **Satellite:** Gilead Sciences | **CS 11** Alternative and Traditional Therapies | **CS 12** (H) AIDS, Human Rights and Activism |
| | **Satellite:** MATEP 18.15–22.00 | | **Satellite:** Positive Action 20.30–22.30 | | | | |

(P) Policy (Y) Youth and Children

ry Session. SB = Skills Building Workshops

Track A Track B Track C Track D

## THURSDAY, JULY 2

| Time | | Session Hall III | Session Hall IV | Session Hall VII | Arena | Session Hall V | Session Hall VI | Satellite Hall 2000 | Session Hall I | Session Hall II |
|---|---|---|---|---|---|---|---|---|---|---|
| 06.30–08.30 | | **Satellite:** Genentech | **Satellite:** Immune Response Corporation | | | | | | | |
| | | **Room D** | **Room E** | **Room F** | **Room G** | **Room H** | **Room I** | **Room K** | | |
| 06.30–08.45 | | **Satellite:** (G) US Dept. of Health 07.45–08.45 | **Satellite:** ROW Sciences 06.30–08.30 | | | | | | | |
| | | **Session Hall III** | **Session Hall IV** | **Session Hall VII** | **Arena** | **Session Hall V** | **Session Hall VI** | **Satellite Hall 2000** | **Session Hall I** | **Session Hall II** |
| 08.00–08.50 | | | | | Summary Session | | | | | |
| 09.00–10.30 | | | | | **PL 4** Biomedical Advances | | | | **PPL 4** (H) (P) Epidemiologic Evolution: Consequences | |
| 11.00–12.30 | Poster Sessions 08.00–18.00 | **B41** Care in Special Populations | **B42** (Y) Predictors of Response to ART | **A41** (P) Vaccine Trials in Humans | **B43** (Y) HIV Infection in Children | **C41** (Y) Trends and Patterns of HIV Epidemics | **C42** (G) STD/HIV Interaction | **C43** Rapid Assessment for Intervention Development | **D41** (G) (H) Human Rights and Legal Challenges | **D42** Workplace – Prevention, Promotion, Protection |
| | | **Room D** | **Room E** | **Room F** | **Room G** | **Room H** | **Room I** | **Room K** | | |
| 11.00–14.30 | | **IAS General Meeting:** 12.00–13.00 | **SB 41** Gestión clínica de recursos limitados | **SB 42** Building Strategic Alliances | **SB 43** Programmes de diététique | **SB 44** Clinical Management in Poor Settings | **SB 45** Basic Evaluation Techniques | **SB 46** E-mail (in English) 11.00–12.30 | **SB 47** E-mail (en français) 13.00–14.30 | |
| | | **Session Hall III** | **Session Hall IV** | **Session Hall VII** | **Arena** | **Session Hall V** | **Session Hall VI** | **Satellite Hall 2000** | **Session Hall I** | **Session Hall II** |
| 13.00–14.30 | | **A42** Animal Models for Vaccine Development | **B44** Neurological Complications of HIV | **A43** Pre-Clinical Drug Development | **B45** (P) Issues in Clinical Trial Design | **C44** (G) Transgender Issues | **C45** Model-Based Evaluation | **C46** (G) HIV and Drug Injection | **D43** Media Response and Transformation | **D44** (G) Mental Health and HIV |
| 15.00–17.00 | | **A44** (G) Cellular Immunity | **C47** TB and HIV in Developing Countries | **B46** (G) HIV-Associated Neoplasia | **B47** Grand Rounds: Clinical Case Studies | **C48** (G) (P) Microbicides: Towards a New Paradigm | **A45** Vaccines: Animal Models | | **D45** (G) Implications of New Treatments | **D46** (P) Resource Mobilisation |
| 17.30–20.30 | | | **Satellite:** (G) Joint Meeting ICW and IAS Women's Caucus | | | | | **Satellite:** Abbott International | | |
| 18.30–20.00 | | | | | | | | | **CRV** Closing Plenary | |
| | | **Room D** | **Room E** | **Room F** | **Room G** | **Room H** | **Room I** | **Room K** | **Perle du Lac, Geneva** | |
| 18.30–22.30 | | **Satellite:** (G) US Dept. of Health 18.30–20.00 | | | | | | | **CRV** Closing Ritual 21.00–22.30 | |

## FRIDAY, JULY 3

| Time | Arena | Session Hall VII |
|---|---|---|
| 08.30–10.30 | **Late Breakers:** Tracks A and B | **Late Breakers:** Tracks C and D |
| 11.00–12.45 | **Closing Ceremony:** Includes Rapporteur Session, Special Awards and Closing Speech | |

Pathway Symbols: (G) Gender (H) Human Rights (P) Policy (Y) Youth and Children

Abbreviations: **CRV** = Community Rendez-Vous, **PL, PPL** = Plenary Session, Parallel Plenary Session
**SB** = Skills Building Workshops

Track A Track B Track C Track D

**12th World AIDS Conference Geneva June 28–July 3 1998**

# Schedule at a Glance

## FRIDAY, JUNE 26

| Time | Session Hall I | Palais Eynard, Geneva |
|---|---|---|
| 16.30–18.30 | **CRV** Opening Plenary | |
| 19.30–21.30 | | **CRV** Reception |

## SATURDAY, JUNE 27

| Hotel Intercontinental | Centre Médical Universitaire | Swissair Centre | Hotel Noga-Hilton | Hotel Holiday Inn | Cercle de l'Espérance | Pont des Bergues, Geneva | | |
|---|---|---|---|---|---|---|---|---|
| **Satellite:** American Medical Association 08.00–15.30 | **Satellite:** Association Nurse 98 08.00–18.00 | **Satellite:** Community Treatment and Science Workshop 08.00–18.00 | **Satellite:** Swiss AIDS Federation 08.30–18.00 | **Satellite:** Universities of Nairobi and Manitoba 08.30–16.30 | **Satellite:** Groupe Sida Genève (Y) 09.30–14.00 | Quilt Ceremony 16.00–19.00 | | |
| **Session Halls I and II Rooms D,E,F, I** | **Session Hall III** | **Session Hall IV** | **Session Hall V** | **Session Hall VI** | **Session Hall VII** | **Room G** | **Room H** | **Room K** |
| **CRV** Regional Meetings: 09.00–12.00 Session Halls I, II and Rooms D, E, F<br><br>**CRV** Network Meetings: 13.00–17.00 Session Halls I , II and Rooms D, E, F, I | **Satellite:** International Christian AIDS Network 18.00–20.00 | **Satellites:** Friends and Family AIDS Panel Workshop 09.30–11.00<br><br>Indian Health Organisation 14.30–17.30 | **Satellite:** University of California 08.30–17.00 | **Satellite:** International Fed. of Red Cross and Red Crescent Societies 08.30–15.00 | **Satellite:** NIAID (G) 08.45–16.30 | **SB 2** Producing a Newsletter 13.00–17.00 | **SB 1** Drama in AIDS Prevention 13.00–17.00 | **SB 3.1** E-mail (in English) 13.00–14.30<br><br>**SB 3.2** E-mail (en français) 15.00–16.30 |

## SUNDAY, JUNE 28

| Session Hall I | Session Hall II | Rooms D and E | Session Hall III | Session Hall IV | Session Hall V | Session Hall VI | Session Hall VII | Satellite Hall 2000 | In Geneva |
|---|---|---|---|---|---|---|---|---|---|
| Orientation Sessions 10.00–11.00 11.30–12.30 13.00–14.00 14.30–15.30 | Séances d'orientation 10.00–11.00 13.00–14.00<br><br>Sesiones de orientación 11.30–12.30 14.30–15.30 | **Satellites:** Joint Meeting (G) ICW and IAS Women's Caucus 09.00–12.00 Room D<br><br>Harvard AIDS Institute 09.00–12.00 Room E<br><br>ICW Meeting 13.00–16.00 Room E | **Satellites:** George Meany Center 09.00–11.00<br><br>IAS – Caucus for (G) Lesbian, Gay, Bisexual Concerns 12.00–14.00<br><br>International Forum for Accessible Science 20.00–22.00 | **Satellites:** UNDP 09.30–12.30<br><br>International DNCB Foundation 20.00–22.00 | **Satellites:** ULACETS 08.00–12.00<br><br>European Immunomodulation Interest Group 20.30–22.30 | **Satellites:** MSD 09.00–11.30<br><br>F. Hoffmann-La Roche 15.00–17.30 | **Satellite:** University of (G) Alabama School of Medicine 09.00–13.00<br><br>**Arena**: **Opening Ceremony:** 17.30–19.00 | **Satellite:** Glaxo Wellcome 12.30–15.00<br><br>**Hall 7**: **Welcoming Reception:** 19.00–20.00 | **Satellites:** Swiss AIDS Federation 08.30–12.00 Hotel Noga-Hilton<br><br>University of Southern California 09.00–16.00 Swissair Centre |

Pathway Symbols: (G) Gender (Y) Youth and Children

Abbreviations: **CRV** = Community Rendez-Vous, **SB** = Skills Building Workshops

## MONDAY, JUNE 29

| Time | | Session Hall III | Session Hall IV | Session Hall VII | Arena | Session Hall V | Session Hall VI | Satellite Hall 2000 | Session Hall I | Session Hall II |
|---|---|---|---|---|---|---|---|---|---|---|
| 06.30–08.30 | | | | | | | | **Satellite:** Agouron | | |
| 09.00–10.30 | | | | | **PL1** Prevention (Y) | | | | | |
| 11.00–12.30 | | **A11** Regulation of HIV Replication | **A12** (G) (Y) Chemokines and Receptors I | **B11** CMV and HCV | **B12** ART: Issues in Clinical Management | **C11** (G) (Y) Gay Men: Risks and Community Response | **C12** (Y) Mother-to-Child HIV Transmission | **C13** (Y) Youth: Prevention Programmes | **D11** (Y) End of Life Issues | **D12** (P) Policy and Programme Evaluation |
| 11.00–14.30 | | **Room D** | **Room E** | **Room F** | **Room G** | **Room H** | **Room I** | **Room K** | | |
| | | | **SB 4** (H) Ethical and Human Rights Issues | **SB 5** Developing Nutrition Programmes | **SB 6** Gestion clinique avec ressources limitès | **SB 7** Vaccine Basics | **SB 8** Harm Reduction for IDU in Asia | **SB 9** E-mail 11.00–12.30 (en español) | **SB 10** E-mail 13.00–14.30 (in English) | |
| 13.00–14.30 | Poster Sessions 08.00–18.00 | **Session Hall III** | **Session Hall IV** | **Session Hall VII** | **Arena** | **Session Hall V** | **Session Hall VI** | **Satellite Hall 2000** | **Session Hall I** | **Session Hall II** |
| | | **B13** Nursing Care | **A13** Chemokines and Receptors II | **B14** Care in Resource-Limited Settings | **B15** Opportunistic Infections | **C14** (G) Access to STD Diagnosis and Treatment | **C15** (H) (P) (Y) Mother-to-Child HIV Transmission | **C16** Determinants of HIV Transmission | **D13** (G) Male Sexuality | **D14** (H) (P) Overcoming Obstacles |
| 15.00–17.00 | | **A14** Immune Reconstitution Following ART | **A15** Early Events in HIV Cycle | **B16** (Y) Nursing Care: Hospital to Home | **B17** ART I: Clinical Trials | **C17** Counselling and Testing | **C18** (H) Human Rights and Public Health | | **D15** (P) Politics Behind AIDS Policies | **D16** (G) (Y) Youth and Vulnerability |
| 15.00–18.30 | | **Room D** | **Room E** | **Room F** | **Room G** | **Room H** | **Room I** | **Room K** | | |
| | | **Satellite:** Family Health International 18.30–20.30 | **SB 11** Técnicas de evalución | **SB 12** Peer Education Programmes | **SB 13** Community-Based Research | **SB 14** Interactive Training Methods | **SB 15** Practical Epidemiology | **SB 16** El acceso a Internet | | |
| 17.30–20.00 | | **Session Hall III** | **Session Hall IV** | **Session Hall VII** | **Arena** | **Session Hall V** | **Session Hall VI** | **Satellite Hall 2000** | **Session Hall I** | **Session Hall II** |
| | | **CS 3** Facing a Future: Long-Term Survival | **CS 4** (P) Commercial Sex and Health | **Satellite:** Hong Kong AIDS Foundation 18.00–21.00 | | | **CS 5** The Need for Nutritional Interventions | **Satellite:** (P) Bristol-Myers Squibb | **CS 1** (P) Strategic Lobbying | **CS 2** HIV and Religion |
| 20.00–22.30 | | | | | | **Satellite:** Essex Chemie AG/ Schering Plough | | | | |

Pathway Symbols: (G) Gender (H) Human Rights (P) Policy (Y) Youth and Children

Abbreviations: **CS** = Community Symposia, **PL** = Plenary Session, **SB** = Skills Building Workshops

Track A Track B Track C Track D

## TUESDAY, JUNE 30

| Time | | Session Hall III | Session Hall IV |
|---|---|---|---|
| 06.30–08.30 | | | |
| 07.45–08.45 | | **Room D** **Satellite:** (G) US Dept. of Health | |
| 08.00–08.50 | | Session Hall III | Session Hall IV |
| 09.00–10.30 | | | |
| 11.00–12.30 | | **B21** (Y) Paediatric Care and Treatment | **A21** Viral Assays and Diagnostics |
| 11.00–14.30 | Poster Sessions 08.00–18.00 | **Room D** | **Room E** **SB 17** Ethique, droits de la personne |
| 13.00–14.30 | | **Session Hall III** **A23** (Y) Mother-to-Child HIV Transmission | **Session Hall IV** **A24** Cytokines |
| 15.00–17.00 | | **A25** Viral and T-Cell Dynamics | **A26** HIV Pathogenesis |
| 15.00–18.30 | | **Room D** | **Room E** **SB 23** Orphan Response |
| 17.30–20.00 | | **Session Hall III** **CS 8** Community Development and Private Sector | **Session Hall IV** **CS 9** Personal Tales of PWA |
| 17.30–21.30 | | **Room D** **Satellite:** Population Services Int'l 18.30–20.30 | **Room E** **Satellite:** NCIH/USAID 19.30–21.30 |
| 20.00–22.00 | | **Session Hall III** | **Session Hall IV** |

Pathway Symbols: (G) Gender (H) Human Rights (P) P

Abbreviations: **CS** = Community Symposia, **PL** = Plenary Ses

12th World AIDS Conference
Thursday July 2

**Report from Constellation** - *Tony Murdoch*

Addition to morning Press conference

Documentation from the **International Forum for Accessible Science**
- Press release
- Clipping from The European

Press Conference - Afternoon

See next page for participants

Very few journalists in attendance -
This could be explained by the fact that ActUp was busy putting tape all around the Schering-Plough booth and shortly before had pulled the European Community stand almost to pieces.

Each participant gave a very brief overview of their presentations.

Of note...

**Edwin Cameron** stated his clear belief that Human Rights abuse creates vulnerability to HIV (quotes Jonathan Mann on this)
There is a need for effective activism to force political leaders to act to do what is right from a public health viewpoint.

**Marina Mahathir** emphasized her view that in the aftermath of the economic and now social crisis in South and South-East Asia which sees rapid and often random cuts in public funding that the most hopeful path forward is the privatization of this funding.

**Maria Wawer** talked of her work through intensive STD campaigns to control HIV. The results do lower STD but the impact on HIV is not significant (it is better in mother/child situations)

**Marie Laga** who has done similar work and confirmed that HIV people with STD have much higher concentrations of HIV in their secretions.

When asked how well HIV can be controlled by lowering the incidence of STDs, she replied that this was possible but that it is a complicated (and perhaps not conclusive) path.

**Helen Gayle** and **Larry Corey** briefly introduced their work on post-exposure prophylaxis.

## *Thursday, July 2nd, 15:00. Moderator: Robin Gorna*

*Topics: Consequences of the HIV epidemic, Vaccine trials in humans, HIV infection in children, STDs and HIV, Transgender issues,Hhuman rights and legal challenges*

| Name | Affilation | Session and Topic |
|---|---|---|
| Belocq, Javier | SPES Foundation Buenos Aires | Plenary: from personal to global survival |
| Cameron, Edwin | Judge, High Court of South Africa | Plenary: Refugees and Human Rights: Causes of and Consequences for HIV |
| Mahathir, Marina | Malaysian AIDS Council | Plenary: Priorities for public funds: crises in national leadership |
| Mainadet, Nais | Women Fighting AIDS in Kenya | Plenary: from personal to global survival |
| Ojwok, Omwony | Uganda AIDS Commission | Plenary: Priorities for public funds: crises in national leadership |
| Corey, Larry | University of Washington | A41: Vaccine Trials in Humans |
| Osborne, Connie | Zambia | B43: HIV Infection in Children |
| Wawer, Maria | Columbia School of Public Health | STDs not linked to HIV (Rakai study, LB 14) |
| Laga, Marie | Institute for Tropical Medicine | |
| Cabral, Camille | | C44: Transgender |
| Maluwa, Miriam | UNAIDS | LB 12473: LHuman Rights and Legal Challenges |

***Please note: all participants are subject to change***

# International Forum for Accessible Science (IFAS)

Secretary General: Michael Baumgartner, Switzerland

*Chair Board of Scientists*
Eleni Papadopulos-Eleopulos
Biophysicist
Perth, Australia

*Chair Public Access Board*
Karen Parker
Human Rights Attorney
California, USA


## ***press-communique***press-communique***

At the IFAS Satellite Meeting held at PALEXPO, in the evening of Sunday June 28th a team of scientists in Perth, Australia, led by Eleni Papadopulos, bio-physicist and chairwomen of the Board of Scientists of IFAS demonstrated that to date there has been no isolation of the "human immunodeficiency virus" ("hiv"), according to the scientifically approved standards and steps for retroviral isolation: a) Purification through density gradient banding, b) Identification of the banded material using electron microscopy and c) Introduction of pure particles into a virgin culture and, by repeating the above steps, showing that identical particles are produced.

None of the so-called "hiv-markers", biomedical or genetic, seen in human subjects labelled "hiv positive" and/or having "aids" has been known to be specific for "hiv".

The existence of the "human immunodeficiency virus" must therefore, be called into question.

Due to lack of evidence of "hiv" having been isolated, and due to the fact that after 15 years' work there is still no sound demonstration in the medical literature proving that a retrovirus named "hiv" is the cause of what is called "aids", the "hiv-aids hypothesis" has failed.

Epidemiological data does not support the predictions made in 1984 that the conditions labelled "aids" were caused by a new specific retrovirus, transmissible by sexual intercourse, inevitably fatal and spreading uncontrollably in the general population, cumulating in a global pandemic. Independent epidemiological research together with the passage of time has since shown that this hypothesis and the ensuing predictions are wrong.

P.O.Box 486, CH-3000 Bern 22, Switzerland, phone: +41 31 332 93 73, fax: +41 31 348 16 36

Toxic treatments directed against an ill-defined and possibly non-existing agent pose a serious risk to human health.

Until there is a full reappraisal of the "hiv-aids-hypothesis" by an international independent scientific committee, IFAS places the following request before the World Health Organisation and national health authorities:

- Use of all "hiv" antibody and "viral-load" tests to be suspended, pending an international inquiry into the alleged non-specific nature of these test.

- Studies to be carried out evaluating the relationship between a false "hiv positive" diagnosis and higher risk of illnesses.

- All "anti-viral" drug approaches of the treatment of the conditions labelled as "aids" and "hiv disease" to be suspended, unless it can be shown that they have beneficial clinical effects which outweigh any deleterious effect on humans and that the same clinical effects cannot be obtained by less toxic agents

  If the international establishment which propagates the belief that "hiv" is the cause of the conditions called "aids" as if it were a scientific fact and as if "hiv" had been isolated, continues to ignore all the data telling otherwise, it would expose itself to legal action on the grounds of several human rights violations.

# CIENCE ■ Experts meeting in eneva will hear some startling ew evidence on what causes Aids

# HIV: IS

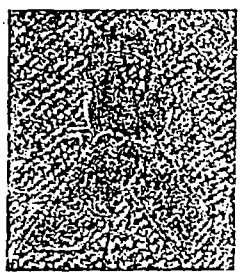
lle Hodgkinson

N 28 June scientists at the 12th World Aids Conference in Geneva will hear arguments that a modern dogma, almost universally accepted, is flawed in a mental and dangerous way. This is the first propounded at an international press rence in the United States in April 1984 dopted almost immediately worldwide, he cause of Aids is a deadly virus, HIV an immunodeficiency virus).

e theory seemed validated scientifically Dr Robert Gallo, of the US National ites of Health, published four long papers ingle issue of the journal *Science* pur- g to have identi- he new virus as rimary cause of nd to have pro- d a diagnostic test . The hypothesis ne the basis of an ry that has since ed tens of billions llars for research reatment in Eur- nd North Amer- with more than n contributed by axpayers alone. 's apparent dis- y was hailed as g "another mira- the long honour f American medi- and science", ugh it was to her- worldwide panic sex, with predic- that millions d die as the virus pitiously spread. according to a of scientists who or the first time given an oppor- to put their ideas e the world Aids munity, basic s needed to establish the nature and even distence of such a virus were never com- d. Evidence accumulated by these crit- dicates that genetic and biochemical ls that gave rise to the HIV theory are understood as arising from within the 's immune cells, rather than as a conse- e of invasion by a deadly new microbe. ious prolonged stresses on the body can these signals to appear. They include ion by a range of known germs; exposure ner people's bodily fluids such as blood emen; and assaults on the body by some cal and recreational drugs. Malnutrition plays a part, especially in parts of Asia Africa, because it greatly increases rability to chronic infections such as rculosis and leprosy that also cause a n to test "HIV" positive.

cording to this view, antibodies detected e blood with the "HIV" test are non-specific: they do not mean a person is infected with a particular virus that is slowly destroying their immune system. The test should therefore be scrapped. The same is true of so-called "viral counts", technology that picks up altered levels of certain genetic sequences in the body. This genetic activity is connected with immune system activation but has never been shown to relate to a specific virus. The multi-billion-dollar effort to develop drugs or a vaccine targeting "HIV" should be reappraised, as it is unlikely to get to the root of the problem of Aids and may have been adding to the suffering of victims.

In short, "HIV" is a myth, along with many of the beliefs accompanying the theory. The pictures of the virus that have appeared around the world are artists' impressions and computer simulations, based on indirect observations by molecular biologists, not isolation of the virus itself.



In short, 'HIV' is a myth, along with many of the beliefs accompanying the theory

The scientist at the centre of this amazing critique is Eleni Eleopulos, of the department of medical physics, Royal Perth Hospital, in Western Australia. An expert on cell oxidation, she recognised 14 years ago that the phenomena claimed to show the presence of a new virus in Aids might instead be arising from mechanisms of cell stress. She has been researching the issue ever since.

Eleopulos is supported by Dr Valendar Turner, an emergency physician who has also dedicated years of work to an analysis of Aids science; Dr David Causer, Eleopulos's head of department; and Dr John Papadimitriou, professor of pathology at the University of Western Australia, an internationally renowned expert on electron microscopy. All four are to present their case, via a satellite link-up from Perth, in a two-hour symposium at the world conference entitled "HIV Testing: Open Questions Regarding Specificity".

Dr Etienne de Harven, former professor of pathology at the University of Toronto, who pioneered a method of purifying viruses during 25 years' work at the Sloan Kettering Institute in New York, is also taking part in the symposium. Now based in France, he agrees with Eleopulos's dramatic claim that HIV researchers have failed to demonstrate the existence of "HIV" in Aids patients. Recent attempts to make good this omission, with electron microscope studies that should have been done 15 years ago, produced "disastrous" results, he says, suggesting "billions of research dollars gone up in smoke".

Other participants will include Dr Stefan Lanka, a German virologist who has also argued against the HIV hypothesis; Huw Christie, editor of *Continuum*, a UK-based Aids magazine which has offered a £1,000 "missing virus" award to the first person finding a scientific paper establishing actual isolation of HIV; and science journalist Joan Shenton, author of *Positively False*, a recent book about controversies surrounding HIV and Aids.

The session is hosted by the Geneva-based International Forum for Accessible Science (Ifas), an umbrella group which has brought together scientists, gay health activists and human rights workers seeking to highlight radical challenges to current Aids research, diagnosis and treatment strategies.

Michael Baumgartner, the organisation's founder and secretary, who used to serve as an Aids chaplain at San Francisco General Hospital, said that voices of dissent on the HIV hypothesis have been growing stronger from within the scientific community. The dissidents had presented more and more "conclusive" work. In addition, he said, organisations of people living with the label of either "HIV" or Aids were irritated by the failure of the latest treatment approaches and losing faith in the orthodox views. The decision to allow the claimed flaws in HIV science to be examined at the conference was "historic".

Basic checks to establish the existence or the nature of such a virus were never completed

The conference's scientific programme coordinators turned down a request for a full plenary session. However, Ifas has been granted free facilities for the two-hour symposium as a complement to the official programme. The decision was made by the conference executive after support from the Global Network of People Living With Aids and the International Community of Women Living with HIV/Aids, two of the five co-sponsors of the conference. Baumgartner says Dr Bernard Hirschel, the conference chairman, also indicated that he sees the importance of clarifying the issues raised by Ifas.

The implications of the challenge are enormous, in commercial as well as human terms. The US Patent and Trademark Office has awarded more than 1,500 patents based on the belief that HIV is both real and dangerous. Companies producing tests that screen blood for evidence of HIV and its purported effects on immune system cells make millions of dollars yearly. New tests are now being marketed for estimating levels of genetic activity attributed to HIV – so-called "viral load" assays. The latest thinking is that an "HIV-positive" person should be tested in this way four times a year.

Although Aids cases are plummeting in many parts of the world, sales growth is anticipated in this area of managing what has come to be known as "HIV disease". Sales of diag nostic and monitoring kits totalled $186m i 1995 in the US alone and were predicted t rise by 50 per cent within five years.

Still more lucrative is the rapidly growin market for combination of expensive drug claimed to be therapeuti in "HIV disease", such a Glaxo Wellcome's Com bivir, approved by th European Commission thi year. Sales are not jus directed towards Aid patients but to the muc larger groups who, accord ing to the orthodox view are in the grip of a virc illness that is slowly wear ing down their immun system years before symp toms develop. By last yea cumulative worldwid sales of Glaxo Wellcome' AZT, the first "anti-HI therapy", had exceede $2.5bn, despite sever concerns about its toxicity Aids grew into a multi-bil lion-dollar business whe it was claimed in the mid 1980s that the virus "doe not discriminate" and tha it would be only a matte of time before it swep through the world's sexu ally active populations The huge investment o money and energy mad it difficult for ideas about the nature of the il ness to change. Government and industr scientists, as well as public health officials Aids advocacy groups, journal editors an specialist correspondents became defensive

The response to the first major critique c the HIV theory, by Dr Peter Duesberg, profes sor of molecular biology at the University c California at Berkeley, was bewilderment followed by fury. Duesberg had been vote Californian Scientist of the Year for hi discoveries in the field of retroviruses (of whic HIV is supposed to be one). He argued in 198 that HIV could not be doing the damag attributed to it, because it was so difficult t find in the body, even in a person dying o Aids. He postulated that an explosion in th use of recreational drugs during the 1970 was probably the main cause of Aids. He wa first ignored and then pilloried for persistin with his views. He lost a $350,000 "out standing investigator" award and became an embarrassment to his university, which, whil unable to fire him, reduced him to chairing it annual picnic committee.

The past 10 years have shown Duesberg t have been right on several counts. He state that HIV could not kill immune cells, that Aid would not become a heterosexual epidemi and that the anti-viral drug AZT would kil rather than cure. On all three issues, th evidence has gone his way.

The Perth group's still more fundamenta

# ybody positive

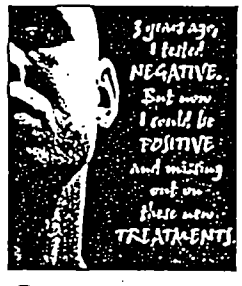
challenge to the HIV theory, despite its almost incredible contradiction to received wisdom, fits the facts even better than Duesberg's. It bypasses one of the principal objections to Duesberg's position: the close relationship, confirmed in numerous studies, between testing HIV-positive and risk of illness. According to Eleopulos, the relationship is real, even though HIV is not. When antibodies are present in the blood at levels that cause a person to test positive, this may well indicate an abnormal immune system state. However, the abnormalities are not caused by "HIV" but by factors in patients' lives that overstimulate their immune cells. These factors may be either toxic or infectious in nature. Sometimes the stimuli are only temporary – even a dose of flu, or a course of flu jabs, can cause a positive result. Longer-lasting assaults are the ones that may trigger a process leading to Aids.

In a huge review article published in *Bio/Technology*, a sister journal to *Nature*, Eleopulos and her colleagues argued that none of the HIV tests marketed was ever properly validated by showing that protein reagents used to detect "HIV" antibodies really were connected to the virus. The reason this validation was never performed, they say, is that it proved impossible to isolate the virus from patients. The main means of attempting to confirm the usefulness of the tests was to show that antibodies which react with the test proteins were much more likely to be found in Aids patients and people at risk of Aids than in healthy people. However, all of those so-called "HIV" markers have been shown to have other sources within the body, so even if HIV existed the antibodies could not be said to signify its presence.

Huge confusion has been created by this situation. One review of the medical literature found no fewer than 70 different disease conditions, often involving an auto-immune response, documented as capable of triggering a positive result with the test.

If the scientists who maintain that "HIV" is a myth are right, their analysis holds a crucial message of hope for people who have tested positive. It means that, depending on how much damage has been caused, a person's immune system may return to a normal, healthy state providing the compromising factors are removed. This explains why millions of "positive" people have stayed well for years, especially in poor countries unable to afford the anti-viral drugs, contrary to predictions based on the "deadly virus" view.

Even Africa, subjected by western scientists, Aids agencies and the media to years of stories of impending doom because of HIV, may be beginning to emerge from the nightmare as it becomes widely understood that the predictions were wrong. A recent *Time* cover story, "Africa Rising", acknowledged that "after decades of famine and war, life is finally looking up for many Africans." In 11 pages, there was not one mention of HIV or Aids. *New African* magazine, which circulates across the continent, has called for an international inquiry to establish the truth about Aids. It says "alarmist and exaggerated" forecasts made by western experts, supported by the World Health Organisation, have done immeasurable harm to African confidence and the way Africans are seen abroad.




Contrary to impressions given by the media, there are now thousands of dissenters

Tragically, there is much evidence that the "HIV" diagnosis itself has killed many. Apart from causing suicides and other deaths related to the psychological stress involved, the diagnosis led doctors to prescribe highly toxic drugs to try to defeat the virus. Some of the most experienced physicians, such as Dr Donald Abrams, professor of medicine and director of the Aids programme at San Francisco General Hospital, have begun to awaken to the disaster. In a lecture to medical students of the University of California at San Francisco, reported in their magazine, *Synapse*, Abrams said: "People who have chosen not to take any antiretrovirals ... watched all of their friends go on the antiviral bandwagon and die."

For the most part, the Aids mainstream has maintained silence about these and many other findings that undermine the "HIV" beliefs. When pressed, the typical response has been to assert that only a handful of "maverick" scientists are questioning the orthodoxy. Most professionals have had little opportunity to know any different, because the main journals refused access to their pages. Professor Gordon Stewart, a British public health expert and former World Health Organisation adviser, concluded as far back as 1985 that lifestyle and behaviour factors were probably central to Aids. His predictions about the pattern of the epidemic proved more accurate than those based on the virus theory. However, years of efforts to persuade *Nature* and the Royal Society, the national academy of science for the UK, to publish his analyses came to nothing.

In fact, thousands of scientists and Aids experts around the world have concluded that the "lethal virus" theory of Aids is inadequate. Several hundred of these, including two Nobel prize winners, have gone public on the issue. Through an organisation called the Group for the Scientific Reappraisal of the HIV/Aids Hypothesis, set up six years ago, they have been pressing the scientific community to re-examine the cause or causes of Aids. Support for this call is growing as a result of the construction of two dissident websites. One of these (http://www.virusmyth.com) contains more than 250 articles.

The webmaster is Robert Laarhoven, a Dutch Aids analyst who four years ago was ejected from the 10th World Aids Conference in Berlin after he persisted in setting out literature concerning the dissident case on an unused table. He was threatened with arrest and expulsion from Germany if he returned. Gay activists who set fire to some of the literature were left unimpeded. Will it be different this time, in Geneva? While the conference executive's decision to allow Ifas a platform is welcome, much will depend on whether both lay and scientific delegates are sufficiently wearied by the failings of the HIV theory to contemplate an alternative.

Unease over the state of Aids science is certainly growing. The last World Aids Conference, two years ago in Vancouver, Canada, was dominated by jubilant claims that new pharmaceutical cocktails, including a class of drugs called protease inhibitors, were dramatically beneficial in some cases of Aids. A "Lazarus effect" was reported, in which patients were said to be rising from their sickbeds and returning to productive life. There were hopes that these aggressive combination therapies, costing around $20,000 a year (including the cost of the "viral counts" that accompany them), could eliminate HIV from some patients.

Last year, a different story was emerging. HIV, it was now stated, mutated so fast that it was evading the pharmaceutical onslaught. It also had "hiding places" in the body. "Despite new Aids drugs, many still lose the battle", the *New York Times* reported in August. From Germany, doctors stated that "... the favourable results from controlled studies with antiretroviral drugs containing protease inhibitors cannot simply be translated into everyday clinical practice". Even the most passionate advocates of the new approaches have admitted there is "one dark cloud on the horizon", as a report in *The Lancet* put it: human behaviour. Up to a half of patients find it impossible to swallow all their pills as prescribed, becoming "treatment failures". This is not just because of the complicated regimen, involving t 20 tablets a day. Bizarre and dan effects are beginning to emerge. "I tell us that protease inhibitors ar cific in their effects on the virus as said Dr John Mellors, of the Unive burgh, at a conference in Febru "They also hit the patient."

Recent claims in the *New Engl of Medicine* that rapid falls in Ai deaths are attributable to the use intensive drug treatments were r a scientific trial but on a study w bias. Besides, the falls began we new treatments were introduced

Aids doctors earnestly want tc thing to show for the billions of into the HIV theory, but their de clouding their judgment, accord scientists. Dr David Rasnick, a bio US Aids researcher who worked w inhibitors for 20 years, pointed c that none of the recently lauded c class approved by the US Fooc Administration had completed a trial. Instead, trials are stopped b tial problems emerge. For examp person trial was halted prem February last year because the deaths in a gr ing two anti-v compared wit deaths in a gr ing three, inclu tease inhibitor was presented the protease cocktail reduce half but ever leader admitte 1,200 people ied, the differe reached statist cance. Much happened wit first alleged " dard" of Aids tr a four-year An study it was sh bringing a 25 p in deaths in th ing the drug with those given


As soon as it was claimed that the virus does not discriminate, Aids became big business

Contrary to t sion given by t there are now of dissenters t theory. It took medical mind years ago but o more than 100,( have been p Much courage a ity will be needed by the medical to look at it afresh. The longer the a over virus isolation and the validity remain unacknowledged, the gr potential crisis for medical science.

Will Geneva rise to this challeng it insist, as a former editor of *Nature* of the HIV hypothesis, that "there i and thus no choice"?