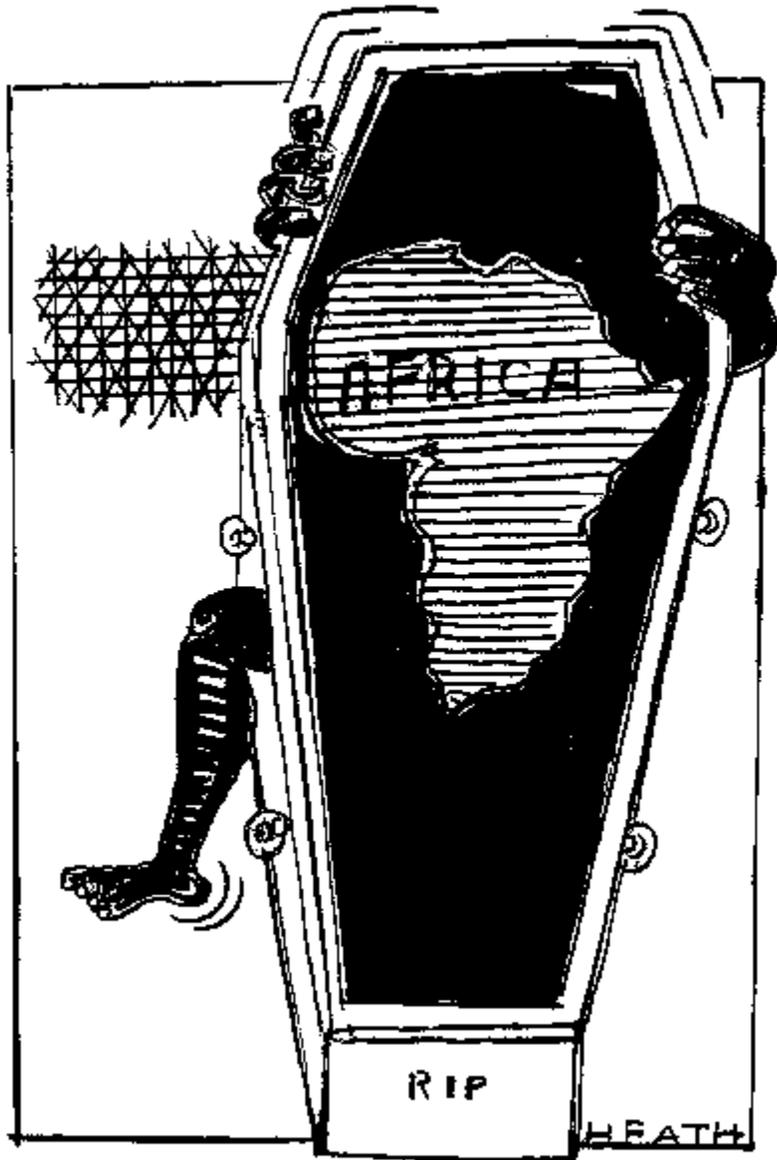


Source: [The Spectator](#), 14 December, 2003.

Africa isn't dying of Aids

*The headline figures are horrible: almost 30 million Africans have HIV/Aids. But, says **Rian Malan**, the figures are computer-generated estimates and they appear grotesquely exaggerated when set against population statistics*



Cape Town

It was the eve of Aids Day here. Rock stars like Bono and Bob Geldof were jetting in for a fundraising concert with Nelson Mandela, and the airwaves were full of dark talk about

megadeath and the armies of feral orphans who would surely ransack South Africa's cities in 2017 unless funds were made available to take care of them. My neighbour came up the garden path with a press cutting. 'Read this,' said Capt. David Price, ex-Royal Air Force flyboy. 'Bloody awful.'

It was an article from The Spectator describing the bizarre sex practices that contribute to HIV's rampage across the continent. 'One in five of us here in Zambia is HIV positive,' said the report. 'In 1993 our neighbour Botswana had an estimated population of 1.4 million. Today that figure is under a million and heading downwards. Doom merchants predict that Botswana may soon become the first nation in modern times literally to die out. This is Aids in Africa.'

Really? Botswana has just concluded a census that shows population growing at about 2.7 per cent a year, in spite of what is usually described as the worst Aids problem on the planet. Total population has risen to 1.7 million in just a decade. If anything, Botswana is experiencing a minor population explosion.

There is similar bad news for the doomsayers in Tanzania's new census, which shows population growing at 2.9 per cent a year. Professional pessimists will be particularly discomfited by developments in the swamplands west of Lake Victoria, where HIV first emerged, and where the depopulated villages of popular mythology are supposedly located. Here, in the district of Kagera, population grew at 2.7 per cent a year before 1988, only to accelerate to 3.1 per cent even as the Aids epidemic was supposedly peaking. Uganda's latest census tells a broadly similar story, as does South Africa's.

Some might think it good news that the impact of Aids is less devastating than most laymen imagine, but they are wrong. In Africa, the only good news about Aids is bad news, and anyone who tells you otherwise is branded a moral leper, bent on sowing confusion and derailing 100,000 worthy fundraising drives. I know this, because several years ago I acquired what was generally regarded as a leprous obsession with the dumbfounding Aids numbers in my daily papers. They told me that Aids had claimed 250,000 South African lives in 1999, and I kept saying, this can't possibly be true. What followed was very ugly — ruined dinner parties, broken friendships, ridicule from those who knew better, bitter fights with my wife. After a year or so, she put her foot down. Choose, she said. Aids or me. So I dropped the subject, put my papers in the garage, and kept my mouth shut.

As I write, madam is standing behind me with hands on hips, hugely irked by this reversion to bad habits. But looking around, it seems to me that Aids fever is nearing the danger level, and that some calming thoughts are called for. Bear with me while I explain.

We all know, thanks to Mark Twain, that statistics are often the lowest form of lie, but when it comes to HIV/Aids, we suspend all scepticism. Why? Aids is the most political disease ever. We have been fighting about it since the day it was identified. The key battleground is public perception, and the most deadly weapon is the estimate. When the virus first emerged, I was living in America, where HIV incidence was estimated to be doubling every year or so. Every time I turned on the TV, Madonna popped up to warn me that 'Aids is an equal-opportunity killer', poised to break out of the drug and gay subcultures and slaughter heterosexuals. In 1985, a science journal estimated that 1.7 million Americans were already infected, with 'three to five million' soon likely to follow suit. Oprah Winfrey told the nation

that by 1990 'one in five heterosexuals will be dead of Aids'.

We now know that these estimates were vastly and indeed deliberately exaggerated, but they achieved the desired end: Aids was catapulted to the top of the West's spending agenda, and the estimators turned their attention elsewhere. India's epidemic was likened to 'a volcano waiting to explode'. Africa faced 'a tidal wave of death'. By 1992 they were estimating that 'Aids could clear the whole planet'.

Who were they, these estimators? For the most part, they worked in Geneva for WHO or UNAIDS, using a computer simulator called Epimodel. Every year, all over Africa, blood would be taken from a small sample of pregnant women and screened for signs of HIV infection. The results would be programmed into Epimodel, which transmuted them into estimates. If so many women were infected, it followed that a similar proportion of their husbands and lovers must be infected, too. These numbers would be extrapolated out into the general population, enabling the computer modellers to arrive at seemingly precise tallies of the doomed, the dying and the orphans left behind.

Because Africa is disorganised and, in some parts, unknowable, we had little choice other than to accept these projections. ('We' always expect the worst of Africa anyway.) Reporting on Aids in Africa became a quest for anecdotes to support Geneva's estimates, and the estimates grew ever more terrible: 9.6 million cumulative Aids deaths by 1997, rising to 17 million three years later.

Or so we were told. When I visited the worst affected parts of Tanzania and Uganda in 2001, I was overwhelmed with stories about the horrors of what locals called 'Slims', but statistical corroboration was hard to come by. According to government census bureaux, death rates in these areas had been in decline since the second world war. Aids-era mortality studies yielded some of the lowest overall death rates ever measured. Populations seemed to have exploded even as the epidemic was peaking.

Ask Aids experts about this, and they say, this is Africa, chaos reigns, the historical data is too uncertain to make valid comparisons. But these same experts will tell you that South Africa is vastly different: 'The only country in sub-Saharan Africa where sufficient deaths are routinely registered to attempt to produce national estimates of mortality,' says Professor Ian Timaeus of the London School of Hygiene and Tropical Medicine. According to Timaeus, upwards of 80 per cent of deaths are registered here, which makes us unique: the only corner of Africa where it is possible to judge computer-generated Aids estimates against objective reality.

In the year 2000, Timaeus joined a team of South African researchers bent on eliminating all doubts about the magnitude of Aids' impact on South African mortality. Sponsored by the Medical Research Council, the team's mission was to validate (for the first time ever) the output of Aids computer models against actual death registration in an African setting. Towards this end, the MRC team was granted privileged access to death reports as they streamed into Pretoria. The first results became available in 2001, and they ran thus: 339,000 adult deaths in 1998, 375,000 in 1999 and 410,000 in 2000.

This was grimly consistent with predictions of rising mortality, but the scale was problematic. Epimodel estimated 250,000 Aids deaths in 1999, but there were only 375,000 adult deaths in

total that year — far too few to accommodate the UN's claims on behalf of the HIV virus. In short, Epimodel had failed its reality check. It was quietly shelved in favour of a more sophisticated local model, ASSA 600, which yielded a 'more realistic' death toll from Aids of 143,000 for the calendar year 1999.

At this level, Aids deaths were about 40 per cent of the total — still a bit high, considering there were only 232,000 deaths left to distribute among all other causes. The MRC team solved the problem by stating that deaths from ordinary disease had declined at the cumulatively massive rate of nearly 3 per cent per annum since 1985. This seemed very odd. How could deaths decrease in the face of new cholera and malaria epidemics, mounting poverty, the widespread emergence of drug-resistant killer microbes, and a state health system reported to be in 'terminal decline'?

But anyway, these researchers were experts, and their tinkering achieved the desired end: modelled Aids deaths and real deaths were reconciled, the books balanced, truth revealed. The fruit of the MRC's ground-breaking labour was published in June 2001, and my hash appeared to have been settled. To be sure, I carped about curious adjustments and overall magnitude, but fell silent in the face of graphs showing huge changes in the pattern of death, with more and more people dying at sexually active ages. 'How can you argue with this?' cried my wife, eyes flashing angrily. I couldn't. I put my Aids papers in the garage and ate my hat.

But I couldn't help sneaking the odd look at science websites to see how the drama was developing. Towards the end of 2001, the vaunted ASSA 600 model was replaced by ASSA 2000, which produced estimates even lower than its predecessor: for the calendar year 1999, only 92,000 Aids deaths in total. This was just more than a third of the original UN figure, but no matter; the boffins claimed ASSA 2000 was so accurate that further reference to actual death reports 'will be of limited usefulness'. A bit eerie, I thought, being told that virtual reality was about to render the real thing superfluous, but if these experts said the new model was infallible, it surely was infallible.

Only it wasn't. Last December ASSA 2000 was retired, too. A note on the MRC website explained that modelling was an inexact science, and that 'the number of people dying of Aids has only now started to increase'. Furthermore, said the MRC, there was a new model in the works, one that would 'probably' produce estimates 'about 10 per cent lower' than those presently on the table. The exercise was not strictly valid, but I persuaded my scientist pal Rodney Richards to run the revised data on his own simulator and see what he came up with for 1999. The answer, very crudely, was an Aids death toll somewhere around 65,000 — a far cry indeed from the 250,000 initially put forth by UNAIDS.

The wife has just read this, and she is not impressed. 'It's obscene,' she says. 'You're treating this as if it's just a computer game. People are dying out there.'

Well, yes. I concede that. People are dying, but this doesn't spare us from the fact that Aids in Africa is indeed something of a computer game. When you read that 29.4 million Africans are 'living with HIV/Aids', it doesn't mean that millions of living people have been tested. It means that modellers assume that 29.4 million Africans are linked via enormously complicated mathematical and sexual networks to one of those women who tested HIV positive in those annual pregnancy-clinic surveys. Modellers are the first to admit that this

exercise is subject to uncertainties and large margins of error. Larger than expected, in some cases.

A year or so back, modellers produced estimates that portrayed South African universities as crucibles of rampant HIV infection, with one in four undergraduates doomed to die within ten years. Prevalence shifted according to racial composition and region, with Kwazulu-Natal institutions worst affected and Rand Afrikaans University (still 70 per cent white) coming in at 9.5 per cent. Real-life tests on a random sample of 1,188 RAU students rendered a startlingly different conclusion: on-campus prevalence was 1.1 per cent, barely a ninth of the modelled figure. 'Doubt is cast on present estimates,' said the RAU report, 'and further research is strongly advocated.'

A similar anomaly emerged when South Africa's major banks ran HIV tests on 29,000 staff earlier this year. A modelling exercise put HIV prevalence as high as 12 per cent; real-life tests produced a figure closer to 3 per cent. Elsewhere, actuaries are scratching their heads over a puzzling lack of interest in programs set up by medical-insurance companies to handle an anticipated flood of middle-class HIV cases. Old Mutual, the insurance giant, estimates that as many as 570,000 people are eligible, but only 22,500 have thus far signed up.

In Grahamstown, district surgeon Dr Stuart Dyer is contemplating an equally perplexing dearth of HIV cases in the local jail. 'Sexually transmitted diseases are common in the prison where I work,' he wrote to the Lancet, 'and all prisoners who have any such disease are tested for HIV. Prisoners with any other illnesses that do not resolve rapidly (within one to two weeks) are also tested for HIV. As a result, a large number of HIV tests are done every week. This prison, which holds 550 inmates and is always full or overfull, has an HIV infection rate of 2 to 4 per cent and has had only two deaths from Aids in the seven years I have been working there.' Dyer goes on to express a dim view of statistics that give the impression that 'the whole of South Africa will be depopulated within 24 months', and concludes by stating, 'HIV infection in SA prisons is currently 2.3 per cent.' According to the newspapers, it should be closer to 60 per cent.

On the face of it, these developments suggest that miracles are happening in South Africa, unreported by anyone save a brave little magazine called Noseweek. If the anomalies described above are typical, computer models are seriously overstating HIV prevalence. A similar picture emerges on the national level, where our estimated annual Aids death toll has halved since we eased UNAIDS out of the picture, with further reductions likely when the new MRC model appears. Could the same thing be happening in the rest of Africa?

Most estimates for countries north of the Limpopo are issued by UNAIDS, using methods similar to those discredited here in South Africa. According to Paul Bennell, a health-policy analyst associated with Sussex University's Institute for Development Studies, there is an 'extraordinary' lack of evidence from other sources. 'Most countries do not even collect data on deaths,' he writes. 'There is virtually no population-based survey data in most high-prevalence countries.'

Bennell was able, however, to gather information about Africa's schoolteachers, usually described as a high-risk HIV group on account of their steady income, which enables them to drink and party more than others. Last year the World Bank claimed that Aids was killing Africa's teachers 'faster than they can be replaced'. The BBC reported that 'one in seven'

Malawian teachers would die in 2002 alone.

Bennell looked at the available evidence and found actual teacher mortality to be 'much lower than expected'. In Malawi, for instance, the all-causes death rate among schoolteachers was under 3 per cent, not over 14 per cent. In Botswana, it was about three times lower than computer-generated estimates. In Zimbabwe, it was four times lower. Bennell believes that Aids continues to present a serious threat to educators, but concludes that 'overall impact will not be as catastrophic as suggested'. What's more, teacher deaths appear to be declining in six of the eight countries he has studied closely. 'This is quite unexpected,' he remarks, 'and suggests that, in terms of teacher deaths, the worst may be over.'

In the past year or so, similar mutterings have been heard throughout southern Africa — the epidemic is levelling off or even declining in the worst-affected countries. UNAIDS has been at great pains to rebut such ideas, describing them as 'dangerous myths', even though the data on UNAIDS' own website shows they are nothing of the sort. 'The epidemic is not growing in most countries,' insists Bennell. 'HIV prevalence is not increasing as is usually stated or implied.'

Bennell raises an interesting point here. Why would UNAIDS and its massive alliance of pharmaceutical companies, NGOs, scientists and charities insist that the epidemic is worsening if it isn't? A possible explanation comes from New York physician Joe Sonnabend, one of the pioneers of Aids research. Sonnabend was working in a New York clap clinic when the syndrome first appeared, and went on to found the American Foundation for Aids Research, only to quit in protest when colleagues started exaggerating the threat of a generalised pandemic with a view to increasing Aids' visibility and adding urgency to their grant applications. The Aids establishment, says Sonnabend, is extremely skilled at 'the manipulation of fear for advancement in terms of money and power'.

With such thoughts in the back of my mind, South Africa's Aids Day 'celebrations' cast me into a deeply leprous mood. Please don't get me wrong here. I believe that Aids is a real problem in Africa. Governments and sober medical professionals should be heeded when they express deep concerns about it. But there are breeds of Aids activist and Aids journalist who sound hysterical to me. On Aids Day, they came forth like loonies drawn by a full moon, chanting that Aids was getting worse and worse, 'spinning out of control', crippling economies, causing famines, killing millions, contributing to the oppression of women, and 'undermining democracy' by sapping the will of the poor to resist dictators.

To hear them talk, Aids is the only problem in Africa, and the only solution is to continue the agitprop until free access to Aids drugs is defined as a 'basic human right' for everyone. They are saying, in effect, that because Mr Mhlangu of rural Zambia has a disease they find more compelling than any other, someone must spend upwards of \$400 a year to provide Mr Mhlangu with life-extending Aids medication — a noble idea, on its face, but completely demented when you consider that Mr Mhlangu's neighbours are likely to be dying in much larger numbers of diseases that could be cured for a few cents if medicines were only available. About 350 million Africans — nearly half the population — get malaria every year, but malaria medication is not a basic human right. Two million get TB, but last time I checked, spending on Aids research exceeded spending on TB by a crushing factor of 90 to one. As for pneumonia, cancer, dysentery or diabetes, let them take aspirin, or grub in the bush for medicinal herbs.

I think it is time to start questioning some of the claims made by the Aids lobby. Their certainties are so fanatical, the powers they claim so far-reaching. Their authority is ultimately derived from computer-generated estimates, which they wield like weapons, overwhelming any resistance with dumbfounding atom bombs of hypothetical human misery. Give them their head, and they will commandeer all resources to fight just one disease. Who knows, they may defeat Aids, but what if we wake up five years hence to discover that the problem has been blown up out of all proportion by unsound estimates, causing upwards of \$20 billion to be wasted?