THE CASE AGAINST HIV

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Additions and corrections are welcomed,
indeed solicited, at our comments page.

That HIV causes AIDS has been the officially sanctioned view for about 3 decades, believed almost universally but questioned openly by thousands of people, some of whom are expert in relevant sciences 1,2,3. These dissidents point out that a comprehensive reading of the mainstream literature together with analysis of mainstream data demonstrates conclusively that HIV is neither a necessary nor a sufficient cause of AIDS.

An annotated bibliography of dissident books and other writings was published in 1993 4; dissident books not listed there or published since that time include Bauer 5, Bialy 6, Crewdson 7, Culshaw 8, De Harven 9, Duesberg 10, Farber 11, Fiala 12, Hodgkinson 13, Konotey 14, Kremer 15, Lauritsen 16, Lauritsen & Young 17, Leitner 18, Maggiore 19, Root-Bernstein 20, Shenton 21.

The Immunity Resource Foundation (IRF) offers important archival material including many documentary films and videos; many issues of Continuum magazine; many links to other AIDS-Rethinking or HIV-Skeptical websites; and a blog and newspage. The 2013 award-winning film, “Positively False — Birth of a Heresy” can be rented or bought at the IRF website. Another award-winning documentary is "House of Numbers."

At first sight, that HIV does not cause AIDS must seem unbelievable in light of the officially promulgated view that has so thoroughly pervaded the media and the public sphere. How could medical science be so wrong for so long about something so important? Moreover, haven’t the miracle antiretroviral drugs (ARVs) saved countless lives and changed AIDS from an invariably fatal death sentence into a chronic, manageable, condition? Aren’t Africans dying in hordes from AIDS only because they can’t get enough of those drugs?

Those questions can all be answered, but not in any brief way. The comprehensive case against HIV has to be made along several mutually reinforcing lines:

8. How could such a massive blunder come about and persist?
9. FAQs: Questions — sometimes rhetorical only — posed by adherents to HIV/AIDS theory.

Just how inconceivable most people find it, that HIV/AIDS theory could be so wrong, that official medicine and science could be so wrong in this day and age, may be illustrated by my own experience 514. I had read enough — many of the books listed above — to become open to the possibility, but it took my own digging into "HIV" epidemiology to convince me p.7 & chapter 1 in 5, and that was about 10 years after I first became aware that there exist dissidents from orthodox HIV/AIDS belief. And it has taken me further years to understand that "HIV" may not even exist, and that "HIV" tests are perhaps the central issue in the whole business. My long-standing interest in Loch Ness Monsters and the like testifies that I am significantly more open to unorthodox views than are most people, so my own difficulty in recognizing the errors of HIV/AIDS theory might serve as a warning, that the task of bringing others to that understanding is an extraordinarily difficult one.

(The Footnotes include many URLs. Those beginning with "http://wp.me" refer to the blog by Henry Bauer at hivskeptic.wordpress.com; the blog posts include further citations to the mainstream literature. URLs that were not active when this document was drafted show the date when that URL was last accessed directly; such broken links can often still be found indirectly via the Wayback Machine 22, or sometimes a copy of the source can be found via a Google search on the article's title.)

1. HIV DOES NOT CAUSE AIDS

1.1 It was never established in the first place, nor later proved, that HIV causes AIDS.

1.1.1Kary Mullis has described his unsuccessful quest — including asking the discoverer of HIV — for citations to the scientific articles that prove HIV to be the cause of AIDS 23.

1.1.2The "fact sheets" issued by the National Institutes of Health are not scientific articles, and their claims of proof have been refuted in full detail 24,25. Those refutations have been ignored or misrepresented but never effectively challenged.

1.1.3The issue is complicated by progressive re-definitions of AIDS, see section 2.

1.1.4Luc Montagnier, credited with the discovery of HIV, reported that AIDS seemed to be caused by a mycoplasma and not by HIV 26,27,28,29,30,31.

1.1.5By 1993 so many cases of "HIV-negative" "AIDS" had been reported 32,33,34,35 that the condition was pronounced a new disease, "idiopathic CD4 T-cell lymphopenia" (ICL) 36,37,38,39,40,41,42,43 (also "HIV-negative adult-onset immunodeficiency" 44): immune deficiency of unknown cause with low CD4 counts; but this is precisely the same as the original definition of AIDS.

1.1.6"HIV-positive" individuals do not necessarily ever progress to AIDS in absence of any treatment 45.

1.1.7Specific Italian data illustrate that HIV does not cause AIDS 46,47,48.

1.2HIV and AIDS are not even correlated.

1.2.1The seminal papers claimed to have found the putative retrovirus in only “18 of 21 patients with pre-AIDS … [and] 26 of 72 adult and juvenile patients with AIDS” 49. This did not even establish that HIV is correlated with AIDS 50, let alone causes it. The principal author, Robert Gallo, may have committed scientific misconduct as well 7,51,648.

1.2.1.1Most of those who refer to the discovery of HIV credit Montagnier, not Gallo 52.

1.2.2Kaposi’s sarcoma (KS) was one of the three originally iconic AIDS diseases, yet HIV-negative cases of KS had been noted at the very beginning 53 and turned out to be quite common 54.

1.2.2.1KS is now ascribed not to HIV but to something else 64, perhaps KSHV (Kaposi’s sarcoma herpes virus) or HHV-8 (human herpes virus 8) 55,56,57,58.

1.2.2.2 AIDS-1 (section 2.1) KS was probably caused by the widespread use of nitrite “poppers” by many gay men 59,60,61,62,63,64. Although described as a cancer (sarcoma), it may actually be non-malignant damage to blood vessels.

1.2.3HIV and AIDS are not correlated with respect to geography chapter 9 in 5,80.

1.2.4HIV and AIDS are not correlated with respect to race chapter 9 in 5.

1.2.5HIV and AIDS are not correlated with respect to the sexes chapter 9 in 5.

1.3HIV does not even cause illness, let alone death 66,45.

1.3.1The mortality of “HIV-positive” individuals and of “People with AIDS” (PWAs) is independent of age whereas mortality increases very significantly with age in every (other) illness 67,68,69,70,71.

1.3.2About 50% of people testing “HIV-positive” never experience illness associated with “HIV” 72,73,74.

1.3.3It remains mysterious, in what way or by what mechanism HIV could cause illness of any kind; a number of mechanisms have been bruited, none has been demonstrated or accepted as satisfactory 75.

1.3.3.1“HIV” is found in only a tiny proportion (<1%) of the T-cells that it supposedly kills, so the decrease in CD4 counts supposedly characteristic of AIDS or “HIV disease” is ascribed to an unspecified “bystander mechanism” 833,866,867,868.

1.3.3.2Duesberg long ago argued that no retrovirus could act as claimed for HIV 76.

2. THE PLAIN EVIDENCE ABOUT AIDS

Which AIDS?

AIDS has been defined in at least three distinctly different ways at different times and in different places. To avoid confusion, it is necessary to distinguish among them as AIDS-1, AIDS-2, and AIDS-Africa.

2.1The first definition of AIDS, therefore AIDS-1: A supposedly unprecedented syndrome characterized by immune deficiency (specifically, low CD4 counts) of unknown cause presumed responsible for the presence of manifest opportunistic infections, chiefly Kaposi's sarcoma, Pneumocystis carinii pneumonia (PCP), or candidiasis (fungal: thrush, yeast infection) 77,78.

2.1.1Designating AIDS-1 as a new medical phenomenon was an error because

2.1.1.1None of the "AIDS-1" diseases was previously unknown. They occur in HIV-negative individuals for a wide range of reasons 79.

2.1.1.2A great many conditions and infections induce immune deficiency, even specifically the low counts of CD4 cells purported to be characteristic of AIDS — non-specific conditions like oxidative stress 80,15 (see also sections 3.2.2, 4.3.2.4, 5.3.3.1, 5.3.3.11, 7.3.3.4) or such specific diseases as tuberculosis 82,83.

2.1.1.3The initial diagnosis 103 was by a young physician early in his career who also had access to the relatively new technique of counting CD4 cells 84.

2.1.1.4 In particular, "recreational" drugs 85,86,87,88,89,90 including nitrites ("poppers") 91,92 cause the same conditions as are said to be characteristic of AIDS, including loss of CD4 cells 93, and drug addicts display the same manifest symptoms as were ascribed to AIDS-1 13.

2.1.1.5The first AIDS-1 patients were indeed typically users of "recreational" drugs p. 191 ff. in 16, pursuing a "fast-lane" lifestyle 99,100 conducive to ill health. They were on average in their mid-to-late thirties with histories of many bouts of syphilis, gonorrhea, and other infections 95,96,97,98.

2.1.1.6The Centers for Disease Control & Prevention used a unique, bizarre, misleading statistical classification scheme that obfuscated the fact that drug abuse was the primary common feature among victims of AIDS chapter 1 in 16.

2.1.1.7"AIDS" was a new social phenomenon, irrational exuberance by a proportion of gay men following "liberation", expressed in an impossibly unhealthy lifestyle pp. 119-20 in 5,99,100,101,102. It had first been designated more correctly as GRID: Gay-Related Immune Deficiency; though since it was only a small proportion of gay men who practiced the "fast-lane" lifestyle, most correct would have been FLLRID.

2.1.2The first AIDS-1 patients had not been in sexual contact with one another 103. AIDS-1 came to be regarded as infectious only after the mistaken conclusion that HIV causes AIDS.

2.2Following the mistaken identification of "HIV" as cause of AIDS-1, an increasing number of diseases have come to be labeled "AIDS" just because in their presence an "HIV" test is fairly often positive. That defines AIDS-2: "HIV-positive" by definition, as in the now-common usage "HIV/AIDS", which masks the fact that AIDS-1 was not HIV-caused. Recently the term "HIV disease" has become common.

By subliminal definition creep, “HIV disease” has come to include dozens of ailments, many of which are not opportunistic infections and all of which are previously known conditions, for example tuberculosis, weight loss or wasting, dementia 104.

2.2.11985 definition (AIDS-2a): “HIV-positive” and additional opportunistic infections beyond KS, PCP, or candidiasis 105.

2.2.21986 definition (AIDS-2b): “HIV-positive” and low CD4 counts and opportunistic infections 105.

2.2.31987 definition (AIDS-2c): “HIV-positive” “[r]egardless of the presence of other causes of immunodeficiency” [emphasis in original] and in presence of more than a dozen diseases 106.

2.2.41993 definition (AIDS-2d): Re-definition increased number of “AIDS” cases in that year by 75% 107.

2.3AIDS in Africa (henceforth AIDS-Africa) is neither AIDS-1 nor AIDS-2 108.

2.3.1Although AIDS-2 had been defined as caused by HIV, the lack of HIV-testing facilities in Africa led to defining AIDS via the Bangui definition 109: chronic or persistent weight loss, diarrhea, fever — entirely non-specific symptoms consistent with any number of endemic African diseases.

2.3.1.1Africans dying from “AIDS” are succumbing to diseases that have ravaged Africans for centuries 108,110.

2.3.1.2Since the criterion for AIDS diagnosis in Africa is independent of “HIV”, one cannot know how many African “AIDS” patients are HIV-negative 32.

3. THE PLAIN EVIDENCE ABOUT HIV

3.1“HIV tests” have never been shown to detect “HIV”, namely an exogenous retrovirus 111,112,113,114,115,116. Therefore the term HIV denotes only whatever it is that produces a positive HIV test, and this should be indicated by always writing “HIV” or F(HIV) chapter 9 in 5 or something similar.

3.1.1That a retrovirus could be found in AIDS patients had been inferred from the presence of reverse transcriptase 117,p. 1259 in 118, an enzyme used by retroviruses to infiltrate the DNA genomes of the cells they invade. But reverse transcriptase turned out to be present in all mammalian cells and is not a valid marker for the presence of “HIV” 119 or any other retrovirus.

3.1.2The mistaken claim to have found a retrovirus in AIDS patients became a claim, announced at a press conference 120, that it was the probable 121,122,123 cause of AIDS, discovered by Robert Gallo. The articles later published by Gallo 49,124,125,126 did not establish that claim (see section 1.2.1).

3.1.3“HIV” tests have never been validated against a gold standard 127, namely, authentic pure virions (virus particles).

3.1.3.1Actual virions of “HIV” have never been isolated from an AIDS-1 patient nor from an “HIV-positive” individual 50,111,128,129,130,131.

3.1.3.2“Isolation of HIV” in the mainstream HIV/AIDS literature does not carry the usual meaning of isolation, namely, separating out and purifying; instead, the so-called “isolation” of HIV involves a complex culturing technique without subsequent purification; it amounts to a self-fulfilling prophecy 132.

3.1.3.3The only published electron micrographs of “isolated” “HIV” show a motley mixture of particles and debris that may not even include any retrovirus particles pp. 127-9 in 119,129,133.

3.1.3.4A reward of $100,000 for an electron micrograph of isolated pure HIV virions was offered in 2002 and has never been claimed 134.

3.1.3.5Montagnier has acknowledged that his laboratory never isolated pure HIV 135,136,137.

3.1.3.6Gallo acknowledged that his laboratory had not isolated HIV; he even claimed that copious production of HIV in culture was superior to isolation and purification and that it had made purification unnecessary pp. 1257-8 in 118.

3.1.3.7Synthetic “HIV”, a “molecular clone”, contained only between 1 in 10,000 and 1 in 10 million actually infective virions and they were unstable, self-destructing quickly 138.

3.1.4“Validation” of “HIV” tests is a self-fulfilling tautology 139,140,141.

3.1.5The instructions in test kits acknowledge that the tests are not approved for detecting infection 142,143.

3.1.6The first “HIV” test — “ELISA” (enzyme-linked immunosorbent assay) — detects antibodies 144,145 that are presumed to characterize “HIV” proteins, but these and later tests react “positive” to many kinds of antibodies, other proteins, or bits of RNA or DNA. “HIV” tests are not specific, see section 3.2.

3.1.6.1That the tests detect active virus infections came to be believed without the benefit of evidence 146.

3.1.6.2That belief, that detection of antibodies demonstrates presence of active virus, is an unprecedented and unwarranted inference: antibodies indicate earlier exposure, not infection, and in absence of manifest symptoms of illness antibodies are regarded — except only with HIV — as a priori evidence of established immunity to the respective infection.

3.1.7Measurement by PCR of so-called “viral load” (the purported amount of HIV particles in “HIV-positive” individuals) has been criticized as inherently invalid by the inventor of PCR, Nobelist Kary Mullis 147.

3.1.7.1“Viral load” measurements may not be specific to the presumed “HIV” genome 148.

3.1.7.2“Viral load” measurements yield appreciable numbers of false negatives 149.

3.1.7.3“Viral load” measurements yield appreciable numbers of false positives 149,150.

3.1.7.4“Viral load” measurements suffer from poor reproducibility 149,151,152.

3.1.7.5“Viral load” is not a marker for risk of death or progression to disease 153,154,155.

3.1.7.6“Viral load” does not measure amount of virus, since virus could not be cultured from some people with significant “viral loads” 156,157.

3.1.7.7“Viral” genes can be found in “HIV-negative” individuals 158,159,160,161.

3.1.8There are no valid “confirmatory” tests. Although Western Blot is routinely referred to in that way, its criteria have never been standardized or validated 127,162,163,164 and it is itself also liable to false positives 165.

3.1.9The initial “HIV” test was based on blood drawn from gay men who were manifestly ill “with AIDS”. No surprise, then, that a wide range of illnesses or degrees of ill health conduce to testing “HIV-positive”: for example, TB patients and drug addicts are as likely to test “HIV-positive” as are gay men, who were the very first purported “risk” group for “AIDS” 166.

3.2False-positive “HIV” tests are common 165,167,168,169,170,171,172,173. For consequent misinterpretations and their consequences, see sections 4.3 & 6.1 respectively.

3.2.1Rates of false-positive “HIV” test-results depend on the prevalence of positive-testing substances in the tested population. At the prevalence of “HIV-positive” (<1%) typical in populations outside southern Africa, the rate of false positives is likely to be quite high 127.

3.2.2Dozens of physiological conditions — normal, in disease, or owing to medical treatment — conduce to false-positive “HIV” tests 110,145,175,176,177,178,179 — possibly because “HIV-positive” correlates with oxidative stress 180,181,182,183,184,185,186 (more about oxidative stress in sections 2.1.1.2, 4.3.2.4, 4.3.2.8, 5.3.3.1, 5.3.3.11, 7.3.3.4).

3.2.2.1 Auto-Immune Diseases and antibodies to many stimuli 187,188,189,190,191,192,193,194,195,196,197,198,199,200,201; anti-carbohydrate antibodies 178,202,203; anti-collagen 204; anti- lymphocyte 204,205; anti-phospholipid (“sticky blood”) 80,206; HLA antibodies 178,179,187,188,189,197,207,208,209,210; mother’s antibodies transferred to babies 211; normally occurring antibodies 203,212,213; antibodies to components of test kits 196,214; lupus 215,216.

3.2.2.2Illnesses that are not infectious: Cancers (cervical cancer 217,218); cardiovascular, atherosclerosis 219,220; chronic obstructive pulmonary disease (COPD) 221; cutaneous T-cell lymphoma 232; cystic fibrosis 222,231; diabetes 197; hemophilia 187,188; kidney failure and dialysis treatment 178,179,187,188,205,216,223,224,225,226,227,228; leprosy 229,230; multiple myeloma 187,189,210; multiple sclerosis 231,232; periodontal disease233; rheumatoid arthritis 238.

3.2.2.3Infections and toxins: Aflatoxin 234; cytomegalovirus infection 235; Epstein-Barr virus 236,237; flu (and flu vaccination) 178,189,238,239,240,241,242,243,244,245,250; hepatitis

179,187,188,210,225,246,247,248; herpes 249,250,251,252,253,254,255,256,258; HTLV p. 248 in 257; malaria 258,259,260,261,262,263,264,265,274,266; Mycobacterium avium 230; paramyxovirus 199; schistosoma 267; syphilis 179,187,188,197,268,269,287,320; Trichomonas vaginalis parasites 270,271; Trypanosoma parasites (Chagas disease) 272,273,274; tuberculosis 230,258,275,276; visceral leishmaniasis 277,278.

3.2.2.4Medical procedures: Blood transfusion 178,188,189,209,24,238,279; globulins, in sick people or given as prophylaxis 110,178,189,262,280,281,282.283,284,285,286,287; hormonal contraception 288,289,290; organ transplants 178,179,205,238,291,292,293.

3.2.2.5Natural conditions, not unhealthy: Pregnancy Fig. 22 p. 83 in 5,178,189,210,238,294,295,296,297,298,299,300,301,302,303,304,305; receptive anal sex 111.

3.2.2.6Normal components of human cells: HIV-like genetic sequences occur in HIV-negative human genomes 306,307,308 and can generate immune responses to “HIV” proteins 309,310,311; supposedly “HIV” proteins occur normally in many human cells 178,179,172,313,111,315; normal human extravillous trophoblast cells express “HIV-1” antigens 316.

3.2.2.7“Recreational” drugs: 231 Alcohol 317; cocaine 317; crack cocaine 317,318; crystal meth 319; methamphetamine 320.

3.2.2.8Vaccinations: Experimental HIV vaccines 321; flu 322 (also see above under infections); globulins (also see above under medical procedures); hepatitis B vaccination 189,323,324; rabies 190; rubella 325; tetanus 326,327,328.

3.2.3False positives are especially common in emergency rooms since the probability of a positive “HIV” test increases with degree of ill-health Fig. 22, p. 83 in 5, and associated text.

3.2.3.1In Cincinnati with a population “HIV-positive” rate of 1.7 (per 100,000), the emergency-room rate was 7.8 329.

3.2.3.2Only 9 of 26 “HIV-positive” test results in an emergency room were positive on a later test 329.

3.3HIV — rather “HIV-positive” — has never been shown to be infectious or transmissible.

3.3.1Prospective studies to detect sexual transmission of “HIV” seropositivity have not observed transmission 330,331.

3.3.2The often-cited rates of transmission are calculated by making unprovable assumptions, including about when individuals became “HIV-positive”.

3.3.3Those often-cited rates of transmission are ~1 per 1000 acts of unprotected intercourse for male-to-female transmission and an order of magnitude less for female-to-male transmission 330, hundreds of times less than with STDs — gonorrhea, syphilis, herpes.

3.3.4Mother-to-child transmission has not been shown to occur.

3.3.4.1Definitely transferred are substances that produce positive “HIV” tests, in particular “HIV” antibodies. Those dissipate within a year and “HIV-positive” babies then revert to “HIV”- negative without medication Fig. 2 and Tables 25-27 in 5,332.

3.3.4.2“[T]here is no proof that HIV, even if it is assumed to be present in pregnant women, is perinatally transmitted to their offspring” 333.

3.3.4.3The presently available data do not prove that HIV can be transmitted by breastfeeding 333. Babies breast-fed exclusively by “HIV-positive” mothers become “HIV-positive” less frequently than those not fed solely from the breast 334,335,336. The research about mortality and “HIV” transmission associated with breast-feeding has brought inconsistent and confusing results 337,338.

3.3.4.4A large percentage of “HIV-positive” babies had “HIV”-negative mothers 339,340.

3.3.5“HIV” varies in regular fashion and independently with age, sex, race, and geography, unlike the stochastic patterns seen in infectious diseases 5,341,342 — see also section 3.4 below.

3.3.5.1The median age-range for testing “HIV-positive” is 35-45 Fig. 2, p. 26 in 5, comparable to the median age-range for diagnoses of AIDS and for deaths from AIDS 343,344,345,346,347. These have remained unchanged throughout the AIDS era and are the same in almost every tested group.

3.3.6The Office of Medical and Scientific Justice has successfully defended dozens of “HIV-positive” people (52nd case in June 2013) charged with endangering others by exposing them to possible transmission of “HIV”: OMSJ forces the prosecution to acknowledge — at least implicitly by altering charges or dropping prosecutions — that positive “HIV” tests do not prove infection 348.

3.3.7Innumerable attempts to create a vaccine against “HIV” infection have all failed 349,350,351,352,353 during the nearly 3 decades since Robert Gallo in 1984 envisaged a vaccine being ready within a couple of years 354,355,356, despite continuing pronouncements of optimism and announcements of promising “breakthroughs” 357.

3.3.8Drug addicts supposedly become “HIV-positive” through re-use of infected needles, yet use of fresh new needles increases rather than decreases the incidence of “HIV-positive” tests 358,359.

3.3.8.1Successfully rehabilitated drug addicts can revert from “HIV-positive” to “HIV”-negative 360.

3.3.8.2There was little difference in risk behaviors between HIV-negative and HIV-positive drug- injecting gay men 361.

3.3.8.3Drug use and venereal disease but not sexual behavior were risk factors for being “HIV-positive” among gay men 362.

3.3.9Medical personnel are extraordinarily unlikely to be infected by “HIV” or “AIDS” whereas they run appreciable risk with hepatitis, for example 88. An “HIV-positive” surgeon

performed many open-heart surgeries without any patient becoming “HIV-positive” 364. “There is no recorded case of transmission of HIV from an infected health care worker to a patient in the UK [as of November 2006]” 365.

3.3.10Condoms do not decrease the incidence of “HIV-positive” 366,367,368.

3.3.11HIV and AIDS are almost unknown in the porn industry 369,370,371 even though chlamydia and gonorrhea infection and re-infection are common 372.

3.3.12The claimed rate of “HIV-positive” in sub-Saharan Africa can only be explained by postulating an impossible rate of promiscuity: 20-40% of adults having 10 or more sexual partners at any one time and changing them frequently pp. 63-5 in 373.

3.3.13Thus there are no demonstrated epidemics of heterosexually transmitted “HIV” 374.

3.3.14Racial disparities in prevalence of “HIV-positive” do not correlate with respective sexual behavior 375,376 and thereby seem inexplicable on HIV/AIDS theory.

3.3.15The incidence of “HIV” does not parallel the incidence of known STDs (chlamydia, gonorrhea, syphilis) pp. 35 & 109 in 5,377,378.

3.3.16Married women are more at risk for becoming “HIV-positive” than are prostitutes or widows, incongruous for any sexually transmitted disease 379,380.

3.3.17That pregnancy is a risk factor for testing “HIV-positive” (section 3.2.2.5) is incongruous for any sexually transmitted disease.

3.3.18Prostitutes do not become “HIV-positive” unless they are drug addicts 12,pp. 41-2 in 20,381,382.

3.3.19Drug addicts tend to test “HIV-positive” to different degrees from different drugs 360.

3.4“HIV” tests are racially biased.

3.4.1In any group, black people (people of relatively recent sub-Saharan ancestry) test “HIV-positive” about 7 times (males) or 20 times (females) more often than Caucasians. Asians test “HIV-positive” about 2/3 as often as Caucasians. Native Americans and Mexicans test “HIV-positive” perhaps 10-20% more frequently than Caucasians chapters 5 & 6 & passim in 5,383,384,385.

3.4.1.1The supposedly “HIV” protein p24 generates a stronger response in black people than in others 386.

3.4.1.2Higher levels of “HIV-1 RNA” were found in Malawians than in Swiss or USA men 387.

3.4.1.3Africans and Caucasians differ genetically with respect to the human T-cell antigen receptor 388.

4. FAILINGS OF HIV/AIDS THEORY

HIV/AIDS theory has persistently led to wrong predictions and to inadequate or totally missing, and not infrequently absurd, explanations.

4.1Predictions have invariably been wrong.

4.1.1“Generalized” epidemics leading to “HIV-positive” population levels of more than 1% have never eventuated outside populations of African ancestry, namely sub-Saharan Africa and the Caribbean 389.

4.1.2Even in sub-Saharan Africa, “HIV-positive” levels are “explained” by postulating an impossible level of promiscuity pp. 63-5 in 373 (see also sections 3.3.12 & 6.1.4).

4.1.3Predicted Philippines epidemic did not happen 390.

4.1.4Forewarned epidemic in porn industry 391 never eventuated despite lack of condom use.

4.1.5Predicted Asian epidemics never eventuated 392.

4.1.6Predicted decimation of populations did not occur in Africa. Instead, there has been robust population growth 110: “Recent [2007] reports from Uganda, Kenya and Burkina Faso show . . . concern over rapid population growth” 393.

4.1.7Vaccines were predicted within a couple of years of 1985 and have never been achieved 357.

4.1.8“Breakthroughs” in preventing or treating infection are announced — and then never live up to their promise 394,395,396,397,398,399,400,401,402,403,404,405,406,407,408,409,410,411,412,413,414,415,416,417,418,419.

4.2Public statements emphasize how much is known about HIV/AIDS, yet researchers do not understand many practical as well as theoretical aspects.

4.2.1“We probably know more about how HIV produces its pathology than about the pathological mechanism of virtually any other microbe” 420.

4.2.2“[I]dentification of immune correlates of protection from HIV infection is still lacking” 421. In other words, no clue (by 2013!) about how to make a vaccine.

4.2.3“35 top British and US scientists . . . predicted this week [29 April 2008] that a vaccine would be at least 10 years and maybe even 20 years away” 422 (see also sections 3.2.2.8, 3.3.7, 4.1.7).

4.2.4The recommended treatments are revised several times a year (section 5.4), including when to begin treatment 421.

4.2.5Characteristics of the purported “acute viral syndrome” postulated to accompany initial infection — sometimes — are speculative: “diagnosis of acute HIV-1 infection remains problematic” 423.

4.2.5.1Seeking manifest signs accompanying infection by “HIV”, a correlation has sometimes (e.g. in 20% of cases 424) been suggested with transient “flu-like” or mononucleosis-like 425,426 symptoms that are entirely non-specific 427: fevers, sweats, malaise, lethargy, anorexia, nausea, myalgia, arthralgia, headaches, sore throat, diarrhoea, generalised lymphadenopathy, rash 428 (sometimes “macular erythematous truncal eruption”), thrombocytopenia. Since those symptoms as well as “HIV-positive” can result from a large number of different conditions, fleeting as well as chronic, the phenomenon of “acute viral syndrome” cannot be regarded as established.

4.2.5.2Such symptoms could only be potentially connected to “HIV” or “AIDS” by some sort of prior assumption, which makes the purported correlation a self-fulfilling presumption. Why were such symptoms not only noticed but also suspected of being associated with “HIV” rather than with flu, mononucleosis, or the many other possibilities? So “[d]iagnosis of primary HIV infection remains a relatively infrequent occurrence [in 2008]” 429, and generalizations currently accepted may well be mistaken.

4.2.5.3It is assumed that such symptoms indicate high levels of viremia 430 — but since “HIV” tests are generally not carried out concurrently with the “acute viral syndrome” 431, this is mere presumption.

4.2.5.4The postulate of “acute viral syndrome” with HIV/AIDS was made already in the early 1980s 432 and has subsisted by inertia without serious reconsideration.

4.2.5.5“Clinical signs and symptoms of acute human immunodeficiency virus (HIV) infection in infants are not well characterized” 433.

4.2.6How “HIV” could damage the immune system remains a mystery 434,435,436,437,864.

4.2.7When and how HIV appeared in humans remains controversial 438.

4.3Treatment of “HIV-positive” individuals and HIV/AIDS research are misguided through misinterpretation of positive “HIV” tests.

4.3.1Genetic, race-correlated tendencies to test “HIV-positive” are misinterpreted.

4.3.1.3Race-correlated genes are postulated to drive mutation of HIV 439.

4.3.2Conditions that conduce to positive “HIV” tests are misinterpreted as susceptibility to “HIV” infection; see the list of false-positive possibilities, section 3.2.

4.3.2.1The unhealthy “fast-lane” lifestyle (drug abuse, alcohol abuse, promiscuity with frequent infections and courses of antibiotics) conduces to testing “HIV-positive”.

4.3.2.2Drug addicts who test “HIV-positive” are presumed to have been infected with “HIV”.

4.3.2.3Damage to gut bacteria and mucosa (intestinal dysbiosis) is attributed to “HIV” 437,440,441 whereas strong evidence indicates the opposite, that testing “HIV-positive” is a result of damage to the gut (see sections 6.1.5.3, 9.3.1). Probiotics increase CD4 counts 442.

4.3.2.4“AIDS” may reflect oxidative stress rather than a viral infection 80 (see also sections 2.1.1.2, 3.2.2, 4.3.2.8, 5.3.3.1, 5.3.3.11, 7.3.3.4) but “HIV” is held responsible for causing oxidative stress 454.

4.3.2.5In several Central Asian countries, inexplicable cases of “HIV-positive” are ascribed to infection in some unknown manner by needles supposedly infected from some unknown source instead of to birth stress and other conditions that can produce positive “HIV” tests 443,444.

4.3.2.6Probiotic treatment against bacterial vaginosis is misinterpreted as acting against “HIV” 445,446.

4.3.2.7Hemophiliacs who test “HIV-positive” are assumed to have been infected by blood transfusion or blood-clotting factor 447,Appendix A in 10,passim in 20.

4.3.2.8Psychiatric problems are attributed to “HIV” 448,449 instead of realizing that stress, including psychological stress, can induce testing “HIV-positive” Fig. 22 & p. 80 ff. in 5 (re oxidative stress, see sections 2.1.1.2, 3.2.2, 4.3.2.4, 5.3.3.1, 5.3.3.11, 7.3.3.4)

4.3.2.9Intracranial aneurisms are attributed to “HIV” 450,451.

4.3.4Iatrogenic ailments caused by ARVs are legion (section 5.3), but they are often misattributed as “HIV-associated”:

4.3.4.1Lipodystrophy, which is caused by protease inhibitors in particular 452.

4.3.4.2“HIV-associated” arthritis, said to include reactive arthritis, psoriatic arthritis, osteomyelitis, polymyositis, vasculitis, infected joints and fibromyalgia 453.

4.3.4.3Age-related conditions (cancer. dementia, heart disease) 454.

4.3.4.4“HIV-associated” mania 455,456,457.

4.3.4.5Heart attacks 458,459.

4.3.4.6Neuropathy 460,461,462.

4.3.4.7Kidney disease 463.

4.3.5Three decades of efforts to find a vaccine against “HIV” have failed (sections 3.3.7, 4.1.7, 4.1.8, 4.2.2, 4.2.3) even though quite a number of people with natural immunity against “HIV” have been identified and studied 464,465,466,467,468,469,470,471,472,473,474,475,476.

4.3.6Decades of efforts to find a microbicide have also failed 477,478,479,480.

4.3.6.1“The trial did not demonstrate that Carraguard is effective in preventing male-to-female HIV transmission” 481.

4.4A number of basic aspects of HIV/AIDS theory are known to be wrong.

4.4.1The so-called “latent period” between infection and illness, an essential component of the original labeling of HIV as a lentivirus (slow virus), doesn’t exist 482,483.

4.4.2KS was the iconic AIDS disease, recognized by the purple blotches on the skin and affecting 25-40% of AIDS patients in the early 1980s. But since the early 1990s 484 and thereafter only about 5% of AIDS cases have manifested KS. Furthermore, Kaposi’s sarcoma is now said to be caused primarily pp. 125-9 in 5,485,486,487 by HHV-8 (human herpes virus 8) or KSHV (Kaposi’s sarcoma herpes virus) — and “HIV-associated” KS may not even be a cancer 488.

4.4.3Cervical cancer had been declared to be an AIDS disease 489, i.e. caused by “HIV”, but now it is said to be caused by HPV, human papilloma virus 490.

4.4.3.1It is a mystery, why cervical cancer was ever declared an AIDS disease, given that its incidence had been declining steadily throughout the AIDS era 490,491.

4.4.4HIV is supposed to kill CD4 cells, but there is no correlation between CD4 levels and the purported amount of “HIV” (“viral load”) or even the patient’s clinical condition 154,493,494,495,496.

4.4.5“HIV-positive” is not permanent; people sometimes spontaneously become “HIV-negative”, a phenomenon known as seroreversion 497,498,499,500,501,502.

4.4.6Low T-cell counts are a predictor for becoming “HIV-positive”, they are not a consequence of “HIV” 503,504.

4.4.7The theoretical basis for Highly Active AntiRetroviral Treatment, HAART, was that there was very rapid turnover of T-cells 505,506. That model has been shown to be wrong 507,508,509,510.

4.5HIV/AIDS statistics are unreliable 511,512.

4.5.1UNAIDS 513 inflates estimates in order to dramatize the situation 373.

4.5.2For more than a decade, official data for “HIV” and “AIDS” have come from computer models and not actual counts pp. 114 & 135-6 & 203-10 & 221-5 in 5,515,516.

4.5.3The computer models have needed perpetual correction 517,518; for example, estimates of new infections were reduced by 40% in 2007, and totals reduced from 40 million to 33 million 519.

4.5.4Estimates of deaths by the Division of HIV/AIDS of the Centers for Disease Control and Prevention (CDC) differ from the counts of death certificates by the CDC’s own Center for Health Statistics 520,521,522.

4.5.5Peer-reviewed , published, and widely publicized assertions about AIDS deaths in South Africa 523,524,525 are based on computer models whose estimates are more than on order of magnitude greater than the published data from South Africa Statistics 74.

4.5.6The World Health Organization claimed 85,000 “HIV-positive” Pakistanis when only 3200 were actually known from tests 527.

4.5.7HIV/AIDS numbers asserted for Liberia during the 2000s varied between 1.5% and 8.2% 528.

4.5.8Circumcision is reported as both decreasing the risk of becoming “HIV-positive” and as not decreasing the risk 529,530,531,532,533,534, 535,536,537,538,539,540,541,542,543,544.

4.5.8.1Circumcision increased the rate of “HIV-positive” among virgins 545.

4.5.9Absurd numbers are promulgated (sections 4.7.16, 4.7.18).

4.5.9.1Zimbabwe claimed reduction in “HIV-positive” rate from 34% to 18.1% between 2002 and 2005-6 — implying that 15.9% of the population had died in five years if there were no new “HIV-positive” cases, or else the population had grown at 3% per year with no new infections 546,547. Or the rate was said to have dropped from 22.1% to 20.1% in just two months 548.

4.5.9.2Similarly absurd claims have come from Uganda 304,549.

4.6The origin and spread of HIV have found no satisfactory explanation.

4.6.1AIDS was first named and recognized as characteristically affecting gay men in a few large cities in the United States, but HIV is held to have infected humans for the first time in West Africa at least a decade earlier and perhaps several decades earlier 14,550.

4.6.1.1In 1985, “HIV” in Southern Africa was found only in gay men who had been in the USA or in contact with Americans 551,552.

4.6.1.2PCP was the chief opportunistic infection characterizing the original AIDS-1. In AIDS-Africa it apparently affected only young children 553,554.

4.7Self-contradictions and absurdities of HIV/AIDS theory and practice.

4.7.1That pregnancy (section 3.2.2.5, 3.3.17, 6.1.1.4) is a risk factor for acquiring this sexually transmitted disease.

4.7.2HIV/AIDS activists insist that no stigma should be attached to those who become “HIV-positive” even as HIV/AIDS theory asserts that “HIV” is contracted through behavior that is appropriately frowned upon: careless promiscuity or drug abuse and injecting drugs with dirty needles.

4.7.3HIV/AIDS activists urge that drug abusers be given new needles so that they can “safely” inject heroin and other “recreational” drugs. In every circumstance except HIV/AIDS, use of illegal injected drugs is regarded as criminal behavior 555,556, and it is recognized that drug addicts harm their families as well as themselves. Moreover, clean needles are associated with greater incidence of “HIV-positive” (section 3.3.8), owing to the ill-health brought about by the drugs.

4.7.4“HIV” is supposed to spread by different mechanisms in different parts of the world 557,558,559.

4.7.5Those who are most susceptible to becoming “HIV-positive” nevertheless live longer 560.

4.7.6Poverty is supposed to conduce to “HIV-positive” by increasing risk factors, but in Africa it is wealth that conduces to being “HIV-positive” 561.

4.7.7An “HIV-positive” man who did not infect his wife despite intercourse with her must have nevertheless infected his child by biting her finger 562.

4.7.8Babies infected by dirty needles are supposed to have transmitted “HIV” to their mothers by biting their nipples 563.

4.7.9Breast-feeding by “HIV-positive” mothers is said to risk transmitting HIV to the babies, yet exclusive breast-feeding brings the lowest risk that babies will become “HIV-positive” 334 (section 3.3.4.3).

4.7.10Tuberculosis (TB) patients test positive as often as do gay men and drug addicts Fig. 22 p. 83 in 5,564 so, irrationally, TB is sometimes said to be an AIDS disease rather than just TB.

4.7.11Cervical cancer was said to be an “AIDS disease”, i.e. caused by “HIV”, in 1993 489. Yet nowadays it is said to be caused by human papillomavirus (HPV), again on the basis of a mere correlation.

4.7.12Increased obesity is attributed to desire to show that one is not “HIV-positive” 565.

4.7.13When malnourished Africans test “HIV-positive”, their ill-health is attributed to “HIV” rather than lack of food 110,566.

4.7.14“Washing the penis minutes after sex increased the risk of acquiring H.I.V. in uncircumcised men. The sooner the washing, the greater the risk of becoming infected” 567.

4.7.15When ARVs appeared to work against “HIV” but patients nevertheless became more ill, this was ascribed to the newly invented “immune restoration syndrome”: recovery or re-activation of the immune system supposedly caused inflammation and illness 568,312.

4.7.16Official numbers just don’t compute 569. Estimates have perhaps one in four 570of “HIV-positive” Americans unaware of their status — up to 75% of gay men 571, even 93% of young gay black men 572 (and about a third of “HIV-positive” people in Britain 573,574). Now, about 1 million Americans have been “HIV-positive” throughout 3 decades pp. 1-2 in 5. By 2 decades ago, therefore, assuming the 10-year “latent period” (which doesn’t actually exist 482,483), at least 250,000 “HIV-positive” people should have been coming down with AIDS and dying within a year or two, being replaced by the ~55,000 new annual infections 575 to somehow keep the total number of infected at about 1 million. But reported HIV/AIDS deaths rose to a peak of 42,000 in 1994 and then declined steadily to <16,000 576.

4.7.17 Measles virus slows progression of HIV infection 577,578,579,580,581.

4.7.18 “HIV” tests are sometimes said to be 100% sensitive and 100% specific 582.

4.7.19 Sleeplessness and not taking ARVs are correlated [big surprise] 583.

5. WHAT ANTIRETROVIRAL DRUGS DO 584,585,586,587,588

The criterion for effectivenss of ARVs is action in reducing “HIV-positive” or “viral load” or increasing CD4 counts, judged initially by in vitro experiments. But this does not necessarily correlate with clinical improvement of the patient 154. This is a real-life illustration of the old saw that an operation may be judged by the experts to have been successful even if the patient died.

5.1 There is no evidence that ARVs prolong life 68,589,590 or improve the quality of life 591,592,593,594,595,596,597.

5.1.1Despite FDA warnings, manufacturers advertise ARVs misleadingly as though they allow a completely healthy life 598,599,600.

5.1.1.1 Some people become manifestly more ill as soon as they start taking ARVs. This happens so often that it has been given a name, "immune restoration syndrome" 312.

5.1.2“Virological response after starting HAART improved over calendar years, but such improvement has not translated into a decrease in mortality” 601.

5.1.2.1Mortality of 25-year-old “HIV-positive” people responding successfully to HAART was 5.3 and 10.4 times greater than in the general population, for men and women respectively 602.

5.1.3No life-prolonging benefit is claimed for AZT in a review that attempts to calculate the supposed benefits of ARVs 603.

5.1.4Deaths from “AIDS” continued to increase after the introduction of AZT treatment. The proportion of AIDS patients surviving for even one year was not increased by AZT plus prophylaxis against PCP 604.

5.1.5AZT actually killed about 150,000 “HIV-positive” people between the mid-1980s and the mid- 1990s 68.

5.1.5.1Side effects unpleasant enough to report were experienced by 50-75% of healthy medical personnel treated for possible exposure to HIV, and the side effects were severe enough that 24-36% discontinued the therapy 605.

5.1.6When AZT was replaced by “cocktails” [Highly Active AntiRetroviral Treatment (HAART) or Combination AntiRetroviral Therapy (CART)] the death rate of “AIDS” patients almost instantly declined solely because the new treatment was less toxic 68,604.

5.2The very concept of ARVs was misguided.

5.2.1Bacterial and parasitic infections can be successfully treated with antibiotics because those can kill bacteria and parasites without killing the human patient: the physiology of the invading agents is sufficiently different from that of the patient. By contrast, viruses use the host’s biochemical machinery, so preventing virus replication means disabling some of the body’s essential mechanisms.

5.2.2Nevertheless, social hysteria over the putatively fatal, sexually transmitted “HIV” led to a trial- and-error search for virus-killers.

5.2.3The initial clinical trial of AZT 606,607 — interpreted as showing that AZT extended by a few months the lives of AIDS-1 patients who were at death’s door — was badly flawed 608,609, as was 610 the later, much larger “Concorde” trial 611.

5.2.4AZT (Retrovir), renamed zidovudine (ZDV), is a nucleoside reverse transcriptase inhibitor (NRTI). Nowadays it is acknowledged that these drugs are not effective “HIV”-killers: “Single-NRTI therapy does not demonstrate potent and sustained antiviral activity and should not be used (AII). For prevention of mother-to-child transmission (PMTCT), zidovudine (ZDV) monotherapy is not recommended but might be considered in certain unusual circumstances . . . .” [emphasis added] 612.

5.2.4.1Yet AZT monotherapy for PMTCT had been introduced in 1994 and later, in the HAART era and until at least 2007, “[d]uring pregnancy, HIV-1-infected women in industrialized nations . . . commonly receive[d] highly active antiretroviral therapy . . . that generally consist[ed] of three or more drugs, including two . . . NRTIs . . . . most frequently. . . AZT and lamivudine [3TC]” 613.

5.2.5Mainstream data should have made it obvious long ago that AZT therapy is too carcinogenic 614 (section 5.3.3.4) as well as toxic (in particular to mitochondria, sections 5.2.6, 5.3.3.1, 7.1.3.1) to use in humans and moreover could not defeat “HIV” 615 (sections 5.1, 5.2.4).

5.2.6Nevertheless, NRTIs including AZT/ZDV remain a component of most combination therapies, despite lack of effectiveness and considerable toxicity: “ZDV can cause bone marrow suppression, myopathy, lipoatrophy, and rarely lactic acidosis with hepatic steatosis” 616; “Bone marrow suppression, manifested by macrocytic anemia and/or neutropenia, is seen in some patients. ZDV also is associated with GI [gastrointestinal] toxicity, fatigue, and possibly mitochondrial toxicity 613,617, including lactic acidosis/hepatic steatosis and lipoatrophy” 618. The manufacturer’s own pamphlet included a dozen pages detailing adverse reactions 619.

5.2.7Combination antiretroviral treatments are less obviously and speedily toxic than monotherapy because the dosages of each of the toxic substances are smaller and some of the components are somewhat less toxic than AZT.

5.3Toxic side-effects of ARVs are legion 620,621,622,623,624.

5.3.1“[A] growing proportion of patients receiving long-term antiretroviral therapy are experiencing treatment failure, drug toxicities, side effects, and drug resistance. . . . an increased incidence of malignancies, cardiovascular and metabolic complications, and premature aging associated with long-term HIV disease or antiretroviral therapy” 625.

5.3.1.1Toxicity of stavudine increased with dose and over time 626.

5.3.1.2In December 2011, activists asked the Gates Foundation to cancel a clinical trial comparing stavudine to tenofovir because the former is so toxic 627.

5.3.2The side-effects are so intolerable that patients' non-adherence to treatment is a perpetual theme in the literature 628,629,630,631,632,633,634.

5.3.2.1NIH Treatment Guidelines are replete with references to non-adherence 635, e.g. "Adverse effects have been reported with use of all antiretroviral (ARV) drugs; they are among the most common reasons for switching or discontinuing therapy and for medication nonadherence" 636.

5.3.2.2"Not surprisingly, nonadherence to prescribed medications is common in teens" 637.

5.3.3Specific side-effects impinge on every part of the body.

5.3.3.1Aging prematurely 454,638,639; damage to mitochondria 613,617,640,641,642,643,644,645,646,647,649,650,651,690 could be a reason for this and for muscle deterioration 655 and oxidative stress 652 (re oxidative stress, see also sections 2.1.1.2, 3.2.2, 4.3.2.4, 4.3.2.8, 5.3.3.1, 7.3.3.4).

5.3.3.2Allergic reactions including rash and skin death 653,654,655;

5.3.3.3Bleeding, spontaneous, with all protease inhibitors 655.

5.3.3.4Cancer 613,656,657,658,659,660,661,662,663,664.

5.3.3.5Central nervous system effects 665,666 including psychosis 655,667: neuromuscular weakness, somnolence, insomnia, abnormal dreams, dizziness, impaired concentration, depression, suicidal ideation, depression 655.

5.3.3.6 Functional and physiological disturbances: headaches 607; insomnia 607;

5.3.3.6 Gallstones, apparently inevitable with protease inhibitors: "Median time to onset is 42 months (range 1–90 months)" 655.

5.3.3.7Gastrointestinal: vomiting, nausea, diarrhea 607,655,668,669.

5.3.3.8Metabolic syndrome 670,678 and metabolic dysfunctions 671: diabetes, insulin resistance 655,672,673,674,675,676,677,678,679,680; dyslipidemia (dysfunctional blood lipids) 655,672,674,675,676,677,678,680,681,682,683,684,685; lactic acidosis 655 ; lipodystrophy 655,672,674,675,676,677,678,680,683,684,686,687,688,689,690,691,692,693,694,695.

5.3.3.9Organ deterioration and failure: anemia and bone-marrow suppression 607,655; heart disease including heart attacks 655,673,678,696,697,698,699,700,701,702,703,704,705,706,869; kidney disease, kidney stones 655,707,708,709,710; liver damage 655,711,712,713,714,715,716; neutropenia 717; pancreatitis 718; stroke 719.

5.3.3.10Osteoporosis 655,720,721.

5.3.3.11Oxidative stress 722 (see also sections 2.1.1.2, 3.2.2, 4.3.2.4, 4.3.2.8, 5.3.3.1, 7.3.3.4).

5.3.3.13Peripheral neuropathy 460,461,462,655.

5.3.3.14T-cell killing 607,723.

5.4The official Treatment Guidelines 724 are perpetually revised, and once-recommended treatments become not recommended or to be avoided 725,726,727,728,729. Innumerable changes can be identified in successive versions of the Guidelines.

5.4.1Bear in mind that these revisions are based on knowledge gained through already observed severe damage in a significant number of cases (sections 5.1.5, 5.2.5, 5.3).

5.5Some physicians have successfully treated AIDS patients without resort to ARVs 730,731,732, though they sometimes resort to very short courses of ARVs, which are potent antimicrobials, to eliminate possibly occult bacterial infections.

5.5.1Juliane Sacher has had better success treating AIDS patients than other German physicians who use standard anti-“HIV” treatment 733,734,735.

5.5.2Claus Köhnlein has successfully treated AIDS patients without the anti-“HIV” approach 736.

5.5.3A decrease in opportunistic infections in “HIV-positive” individuals may not be due to killing “HIV” but to direct suppression of fungal infections 737,738.

6. DAMAGE DONE BY HIV/AIDS THEORY AND PRACTICE

6.1To individuals, through misinterpretation of positive “HIV” tests.

6.1.1Everyone who is ill for any reason is likely to be subjected to an “HIV” test and damaged (sections 6.1.2 and 6.1.3).

6.1.1.1The greatest human tragedy of HIV/AIDS theory is that “HIV-positive” individuals who become ill for any reason at all — and sometimes who are not ill at all but tested “positive” because of a life-insurance examination or something similar — are classed as “having HIV/AIDS”.

6.1.1.2So long as HIV/AIDS theory remains in force, there is a crying need for authoritative information for people who are told they “have HIV/AIDS”, many of them knowing with certainty that they could not have become infected in any of the ways that HIV/AIDS theory says they must have been.

6.1.1.3There is a crying need for doctors to learn how to deal with laboratory results claiming “HIV-positive”: that none of the tests are approved for actually identifying infection; that there are any number of false positives; that there are no valid confirmatory tests; and that they should use every diagnostic tool available to determine whether there is any reason at all to think the person might actually have an illness.

6.1.1.4There is a crying need for doctors to learn that a very common reason for an “HIV-positive” result is pregnancy (section 3.2.2.5).

6.1.1.5There is a crying need for doctors to learn that there are genetic, race-correlated factors that conduce to testing “HIV-positive” and that the tests are thereby severely racially biased pp. 100-2 & 171 in 5.

6.1.2Everyone who tests “HIV-positive” is thereby at risk of psychological and social harm.

6.1.2.1Individuals are not properly informed about the high probability of false-positive ”HIV” tests, particularly with low-risk individuals 739.

6.1.2.2Promiscuity is inferred with no further ado, and relationships are broken 740.

6.1.2.3“HIV-positive” individuals who engage in sex may be sent to prison for allegedly endangering their partners 741.

6.1.2.4“HIV-positive” individuals have been sent to prison even for spitting on someone 742,743,744.

6.1.2.5“Veteran who was WRONGLY treated as HIV positive for nine years sues hospital after being ‘emotionally and mentally destroyed’” 745.

6.1.2.6Boxer Tommy Morrison lost his career because of inconsistent “HIV” test-results 746.

6.1.2.7“HIV-positive” Asian women have been driven from their marital homes 747.

6.1.2.8“HIV-positive” women in Chile have been forcibly sterilized 748.

6.1.3Everyone who tests “HIV-positive” is at risk of bodily harm from toxic (section 5.3) ARVs.

6.1.3.1ARVs have been tested on foster children 749,750 and orphans 751,752,753,754 without proper safeguards.

6.1.4Black people are at particular risk because they test “HIV-positive” much more often than others; black women seem to be particularly at risk — see 3.4.1

6.1.4.1African ancestry is misinterpreted as behavioral risk of infection even though blacks test “HIV-positive” more often than others irrespective of behavior 755,756,757,758,759,760,761.

6.1.4.2Extraordinarily promiscuous “concurrency” is postulated to explain the uniquely high sub- Saharan prevalence of “HIV-positive” 373,762,763,764 even though actually observed sexual behavior does not support the postulate of high levels of concurrency p. 78 in 5,375.

6.1.4.3Black people are presumed to be not only more promiscuous but also more likely to inject illegal drugs 765.

6.1.4.4“HIV-positive” black men are immediately assumed to be on “the down low” 766,767 — behavior that may be far less common than is now widely presumed 768,769.

6.1.5Gay men are at particular risk because something about the lifestyle seems to conduce to testing “HIV-positive”.

6.1.5.1Probably only those gay men who practice the “fast-line” lifestyle, but data are lacking to reach firm conclusions.

6.1.5.2Extraordinary promiscuity is inferred from dubious data: “exactly the same strain of HIV can be shown to have infected all five of these people. . . . [and] transmission probably occurred from a single person to these various partners within just a few hours” [emphasis added] 770.

6.1.5.3Intestinal dysbiosis theory 735,771 suggests that deliberately responsible behavior like anal douching may actually conduce to becoming “HIV-positive” and even ill.

6.2To social institutions

6.2.1When finally it becomes universally recognized that HIV/AIDS theory is wrong, trust in the institutions of medicine and science will take a very severe blow.

6.2.2In the meantime, individual institutions may be sued for damages when positive “HIV” tests were mistakenly taken as proof of permanent “HIV-positive” status 745,772.

6.2.3Law enforcement gets egg on its face when prosecutions fail because they cannot prove the transmissibility of “HIV” 348,773.

6.3To society as a whole: Huge sums of money have been and continue to be wasted on anti-“HIV” and anti-“AIDS” activities.

6.3.1The United Nations HIV/AIDS program 774 and National Institutes of Health 775,776 spend disproportionate amounts on “HIV/AIDS” compared to other health concerns.

6.3.2In Africa, billions of dollars are spent on ARVs and associated activities when far smaller amounts could improve health and save lives immediately 110,777,778,779, for example by providing:
a. means for water purification;
b. minimal amounts of decent food 777;
c. treated anti-mosquito nets to prevent malaria;
d. $35 oxygen valves for hospitals 777.

6.3.3Billions of dollars continue to be spent on attempts to find an anti-“HIV” vaccine despite 3 decades of evidence that it cannot be done (sections 3.3.7, 4.1.7, 4.1.8, 4.2.2, 4.2.3, 4.3.5).

6.3.4Well-intentioned “education” programs reinforce the hegemony of HIV/AIDS theory.

6.3.4.1The Bill and Melinda Gates Foundation actually paid for entertainment programs to present the mainstream viewpoint about HIV/AIDS 780.

7. HINDRANCES TO MAKING THE CASE AGAINST HIV

One difficulty is the massive misunderstanding of science that makes it seemingly inconceivable that it could go so massively wrong for so long (section 8). In addition:

7.1Misinformation is ingrained in the public sphere, in the conventional wisdom, about the discovery of “HIV” and the histories of HIV and of AIDS 781.

7.1.1That AIDS-1 first appeared among “young, previously healthy, gay men”. In reality they were not particularly young (average age mid- to late 30s) and far from healthy 95, characterized primarily by heavy drug abuse and a “fast-lane” lifestyle rather than by being gay 16.

7.1.2“HIV” tests are taken as showing infection, and “confirmatory” tests (typically Western Blot) are taken as validating that. In reality, neither presumption is correct, there are no valid tests for infection (sections 3.1, 3.2) and so-called “confirmatory” Western Blot itself is liable to false-positives 165.

7.1.3Antiretroviral therapy is not “life-saving”, as it’s often described 589 (section 5.1). The false claim is sustained in part by attributing toxic side-effects of ARVs to “HIV” rather than to the drugs 782,783,784,785,786,787 (section 4.3.4).

7.1.3.1Premature aging is attributed to ARVs keeping people alive longer and supposedly suffering long-term damage from “HIV”, when actually ARVs are known to damage mitochondria (sections 5.2.5, 5.2.6, 5.3.3.1), and damage to mitochondria happens to be a direct cause of aging 788,789,790,791,792,793.

7.1.4References in fiction and on television 794,795,796,797,798,799 reinforce the hegemony of HIV/AIDS theory.

7.1.4.1That “HIV” is readily spread by sexual intercourse 800,801.

7.1.4.2That one could be infected by “HIV”-tainted blood splashed into one’s eye 802.

7.1.4.3That HIV can be transmitted by saliva on a baseball 803.

7.1.4.4That AZT is a powerful ARV 804.

7.1.4.5However, Daniel Easterman correctly noted in 1990 805 that some individuals could overcome AIDS by making lifestyle changes, possibly reflecting the experience of Michael Callen 101.

7.1.4.6 That an HIV-infected needle on a chair seat can be used to assassinate someone, death following in 5 months 862.

7.1.4.7 That smoking crack cocaine avoids worrying "about needles and AIDS" 863.

7.1.4.8 That getting a tattoo risks getting AIDS from an infected needle 865.

7.2Fresh misinformation about “HIV” and AIDS continually enters and pervades the public sphere 806.

7.2.1“News” items incessantly reinforce mistaken views by reiterating “HIV/AIDS”; “HIV, the virus that causes AIDS”; “life-saving” ARVs; etc.

7.2.1.1The media typically broadcast “breaking news” about science and medicine but fail to revisit the topic when the original claim turns out to need modification or complete withdrawal, which is the usual circumstance with the latest from the research front 807 — for example, 30 years of promises and promising breakthroughs toward an “HIV” vaccine without any genuine, perceptible progress (sections 3.3.7, 4.1.7, 4.1.8, 4.2.2, 4.2.3, 4.3.5).

7.2.1.2Governmental and non-governmental agencies continually urge the media to campaign for awareness of HIV/AIDS theory 808.

7.2.2It takes longer to demonstrate the errors in a claim than to make the mistaken assertion.

7.2.2.1The flaws in any new mainstream claim about “HIV” and “AIDS” can only be explained once it is recognized that HIV/AIDS theory is wrong.

7.2.2.2For example, “antiretroviral drugs can forestall long-term health risks of the disease and cut the risk of transmission by as much as 96 percent” 809.

To debunk that sentence requires presenting the copious but circumstantial proof that “HIV” entails no “long-term health risks”, as well as surveying the copious data on toxicity of ARVs, not to speak of demonstrating the faulty statistics underlying that “96%”: since the claimed transmissibility is already so low (section 3.3.3), the reported “96%” cut could only be observed in a clinical trial of immense proportions and duration. Everything based on “HIV” tests is likely to be wrong and should not be accepted at face value, but to make the case with any specific claim requires debunking the whole basis and edifice of HIV/AIDS theory.

7.3The dissenters from HIV/AIDS theory do not agree among themselves about how to discredit HIV/AIDS theory or about what the correct explanations are for “AIDS” and “HIV”.

In addition, it is notoriously difficult to prove a negative case, and the case against HIV is in some sense a negative case. Science does not abandon an hypothesis just because it has flaws and cannot accommodate all known facts, nor because there are facts that apparently disprove it: Hypotheses or theories are abandoned only when there is sufficient acceptance of a plausible and evidently better alternative. In the present instance, there is no obviously salient alternative because the HIV/AIDS dissenters do not agree on a single explanation of what “HIV” and “AIDS” are.

7.3.1There is no monolithic association of “HIV skeptics”, “AIDS Rethinkers”, or as the mainstream would have it, “AIDS denialists”. The only view held in common by all dissenters from HIV/AIDS theory is that “HIV” — no matter what it is or isn’t — doesn’t cause “AIDS”, no matter how that is defined.

7.3.1.1This is typical for people in opposition to mainstream views. Internal disagreements and organizational schisms are common among such “single-issue” groups whose members are not also bound together for other strong overarching and self-interested reasons 810,811.

7.3.2There are specific disagreements over what “HIV” is. Different dissenters hold that:

7.3.2.1HIV has never been proven to cause AIDS.

7.3.2.2HIV has never been proven to exist 812.

7.3.2.3HIV does not exist 812.

7.3.2.4HIV is a harmless “passenger” virus that opportunistically infects AIDS patients.

7.3.3There is a considerable variety of suggestions about what AIDS is.

7.3.3.1AIDS-1 was a multifactorial syndrome caused by a combination of insults 20.

7.3.3.2More specifically, AIDS-1 resulted from the “fast-lane” lifestyle common among a proportion of gay men during the early years of gay liberation: promiscuous consumption of “recreational” drugs 16, promiscuous sex, frequent infections by gonorrhea, syphilis, etc., indiscriminate consumption of antibiotics even as prophylactics 100, generally unhealthy behavior.

Such behavior damages the intestinal microflora, the immune system’s first line of defense, specifically against the fungal infections that were common in AIDS-1. Such damage brings illness as well as positive “HIV” tests 813,814,815, and explains some of AIDS-2 as well as AIDS-1.

7.3.3.3AIDS-1 was caused specifically by drugs, including ARVs 736,816. So is a proportion of AIDS-2.

7.3.3.4AIDS-1 was and is, and a proportion of AIDS-2 & AIDS-Africa are, a syndrome associated with oxidative stress 80, which can result from a wide range of physical (and even mental) insults (see also sections 2.1.1.2, 3.2.2, 4.3.2.4, 4.3.2.8, 5.3.3.1, 5.3.3.11).

7.4HIV/AIDS theorists and advocates, and therefore the media and the public, lump together indiscriminately everyone who does not accept the mainstream view in toto, so they do not distinguish between “AIDS Rethinkers” or “HIV Skeptics” who just deny that “HIV” causes “AIDS” by contrast with charlatans and conspiracy theorists 817,818, for example:

7.4.1Peddlers of fake remedies 819.

7.4.2Claims that HIV was man-made 820,821.

7.4.2.1Deliberately or accidentally in research on biological warfare 822,823,824.

7.4.2.2To damage certain social groups 825,826,827 — “to depopulate vulnerable target groups, including blacks and other minorities, homosexuals, and perceived ‘decadent’ sexually active individuals” 828, or that condoms sent to Africa were spiked with “HIV” 829.

7.4.3Claims that HIV originated in unrelated cancer 830 or vaccine research or practice 831,832.

7.5The mainstream refuses to engage the evidence or to debate substantively with dissenters.

7.5.1Dissenters are ignored, not answered, boycotted, black-listed, maligned.

7.5.1.1Not answered: Duesberg’s seminal article 833 never answered p. 233 in 5; p. 147 in 6; p. 198 in 10; p. 139 ff. in 13; Kary Mullis, request for published proof that HIV causes AIDS pp.

171-4 in 23; Gary Null, asking Robert Gallo to cite publications proving HIV causes AIDS p. 39 in 834

7.5.1.2Excluded from professional meetings: Peter Duesberg p. 147 in 13

7.5.1.3Hindered or excluded from professional publications: Peter Duesberg pp. 229-30 in 5; pp. 147-52 in 13; Gordon Stewart pp. 100-31 in 13; pp. 230-1 in 5

7.5.1.4Not permitted to reply to published criticism: Peter Duesberg p. 229 in 5; chapter 3 in 834

7.5.1.5Research no longer funded: Peter Duesberg p. 229 in 5

7.5.1.6Misrepresented: Various HIV/AIDS skeptics p. 234 in 5

7.5.1.7Scheduled public events canceled: Showing of House of Numbers to be followed by debate 835

7.5.1.8Disinvited at the last moment: Peter Duesberg & Celia Farber, from appearing at Congressional hearing 836

7.5.1.9Personally maligned: Various people, as “flat-earthers” pp. 212 & 233-4 in 5

7.5.1.10Journalists warned against covering dissenting views 837,838,839

7.5.2Where mainstream and dissenters do publicly address the same points, they do not engage with one another.

7.5.2.1Dissenters were accused of complicity in deaths in South Africa on the basis of computer-modeled estimates of deaths 523,524,525 that are contrary to the official South Africa Statistics data 74.

7.5.2.2The progressively modified NIH “fact sheet” 840 (most recent revision 14 January 2010) fails to address the specific criticism 25,841 made of its arguments.

7.6The mainstream tries to discredit dissenters via ad hominem polemics 839, not by substantive argument pp. 212 & 233-4 in 5; pp. 49 & 80 in 834.

7.6.1Because the dissenters have never themselves done HIV/AIDS research.

7.6.1.1This is a non sequitur.

Informed individuals are perfectly capable of critiquing the work of others. Peer review of manuscripts and grant proposals is often done by supposedly informed individuals who have not themselves worked on exactly the same topic. Indeed, the advantage of freedom from conflicts of interest makes it desirable that critiques come from other than insiders, be they colleagues or competitors.

7.6.1.2Many supporters of the mainstream view and critics of the dissenters — indeed some of the most prominent and vociferous HIV/AIDS proponents — have themselves done no

HIV/AIDS research and may not even have any scientific credentials at all 842,843,844: Jeanne Bergman 845 (lawyer) 843,844; Nathan Geffen 846,847 (activist) 848,849; Seth Kalichman 850 (social psychologist) 851; Nicoli Nattrass 523,524,852 (social scientist, economist) 853,854,855. As to the many physicians among public proponents of HIV/AIDS theory, it should be remembered that physicians, doctors, MDs, are not scientists, were not trained to do or to understand research, have no preparation for doing scientific research 856,857.

7.6.1.3The mainstream refers queries to official sources like the NIH "Evidence" 840, but such in- house writings for public consumption are not scientific publications, they are public-relations pieces; they have never been peer-reviewed and are often written by PR personnel, not by scientists. Many official reports are not only not scientific writings, they may be demonstrably incompetent Chapter 8 in 834.

7.6.2Dissenters are labeled denialists 839,850

7.6.2.1The deliberate analogy with Holocaust deniers is emotionally fraught and is used because the mainstream cannot answer the dissidents' substantive points 858.

7.6.2.2They're "flat-earthers" p. 297 in 257.

7.7The media do not cover dissenting views.

7.7.1They fail even to discuss, let alone expose, the improper tactics of those who malign dissenters.

8. HOW COULD SUCH A MASSIVE BLUNDER COME ABOUT AND PERSIST?

8.1The general context of medical science permits this sort of blunder Chapters 11-13 in 5; 834.

8.1.1Theories once accepted are then not perpetually questioned.

8.1.1.1Observations that contradict the accepted view are ignored for as long as possible 65,94,859,860,861.

8.1.1.2Boat-rockers are not appreciated. There is no career role in science for inveterate questioners of accepted practices; if possible there is even less room in medical practice for transgressing established practice.

8.1.1.3Peer review is almost universal as a purported safeguard of quality. In reality, it serves to enshrine whatever the mainstream consensus happens to be 81,526: "Peer review … is simply a way to collect opinions from experts in the field. Peer review tells us about the acceptability, not the credibility, of a new finding" 363.

8.1.2There is no organized coordination of specialized research areas.

8.1.2.1Virologists don't concern themselves with epidemiology. Clinicians simply accept what the virologists and the drug designers tell them. If data in one specialty are relevant to another specialty, that may not be realized quickly or efficiently. Specialists feel unqualified to critique the specialties of others.

8.1.2.2So much is published that researchers find it difficult to keep up with what everyone is doing even within their own very narrow specialty.

8.2This particular blunder came about via specific identifiable steps Chapters 14 & 15 in 5.

8.2.1Mis-classification of characteristics of AIDS patients: they were primarily drug addicts rather than gay men Chapter 1 & p. 191 ff. in 16.

8.2.2 Mistaking a social phenomenon for a medical one (section 2.1.1).

8.2.3 Accepting inadequate evidence for the presence and activity of a retrovirus (sections 1-3).

8.2.4Once Gallo, with the imprimatur of the Department of Health and Human Services, had been credited with discovery of the probable cause of AIDS, researchers framed their subsequent grant requests and consequent research on the virus hypothesis.

The overwhelming majority of funding of biological research comes from the National Institutes of Health, which is an agency within the Department of Health and Human Services.

8.2.5Alternatives to the retrovirus hypothesis ceased to be discussed by mainstream researchers.

8.2.6Minority views and those of outside observers were peremptorily dismissed.

8.2.7The media did not attend in neutral fashion to dissenting views.

8.3How science and medicine are communicated to the general public entrenches such blunders 314,Chapter 7 in 834.

8.3.1“a politics dominated by experts and mass persuaders” 174.

9. FAQS: QUESTIONS (SOMETIMES RHETORICAL ONLY) POSED BY ADHERENTS TO HIV/AIDS THEORY

9.1If HIV doesn’t cause AIDS, what does cause AIDS?

9.1.1AIDS-1 (the original early-1980s AIDS) resulted from the “fast-lane” lifestyle of drug abuse, extreme promiscuity, and generally unhealthy behavior. The first AIDS victims were in their mid-to-late 30s, consistent with this explanation and inconsistent with a sexually transmitted disease, which affects adolescents and young adults significantly more than others.

9.1.2AIDS-2 (“HIV disease”, “HIV/AIDS”, non-African AIDS) is the mis-interpretation of “HIV” tests whereby anyone who tests “HIV-positive” is presumed to “have HIV/AIDS” — even as authoritative mainstream sources and data demonstrate that innumerable conditions, some but not all of them unhealthy, conduce to testing “HIV-positive”, and even as no “HIV” test has been officially approved for actually identifying active infection.

9.1.3African AIDS is the mis-interpretation of manifest symptoms that are entirely non-specific and moreover are associated with many diseases long endemic in Africa: prolonged fever, cough, diarrhea, bodily wasting (section 2.3.1).

9.2If HIV doesn't cause AIDS, why do ARVs successfully treat AIDS?

9.2.1They don't (section 5.1).

ARVs have not increased lifespan — except only when less-toxic combination "cocktails" replaced highly toxic AZT monotherapy. Then there was an immediate decrease in iatrogenic mortality, mortality caused by the medical treatment itself (section 5.1.6).

9.2.2ARVs are very powerful killers of biological systems, and their antibiotic or antifungal or anti- parasitic powers might overcome occult infections; but prolonged use of ARVs is likely to be fatal (sections 5.3, 5.5).

9.3Why do gay men test "HIV-positive" so frequently, if it isn't an STD?

9.3.1Certain practices common among gay men make testing "HIV-positive" likely, for example, the consequences of intestinal dysbiosis. That condition can also bring on serious illness, including the fungal infections that characterized AIDS-1 (sections 4.3.2.3, 6.1.5.3).

9.4Questions posed through ignorance of the facts about "HIV" and "AIDS".

9.4.1"Why are so many mid-life gay men getting HIV?" 492 Because everything about "HIV" and "HIV/AIDS" is most frequent in young middle age, mid-30s to mid-40s (sections 3.3.5.1, 7.1.1).

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