The ABC's of AIDS denialism.

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Forward: The problem…AIDS denialism.

During the AIDS era, a crisis has emerged due to the insidious nature of AIDS denialism.

As subtle forms of AIDS denialism have crept into even higher levels of academia, industry, and government, some leaders of our national and international AIDS programs, have themselves inadvertently, or intentionally, become "perpetrators of death."

To quote Marc Wainberg, this summer's Chair of The Toronto International AIDS Conference-who possesses several "HIV" drug patents such as lamivudine (3TC), and grants from GlaxoSmithKlein, Bristol-Myers Squibb and Boehringer-Ingelheim):

"As far as I'm concerned, and I hope this view is adequately represented, those who attempt to dispel the notion that HIV is the cause of AIDS are perpetrators of death. And I would very much for one like to see the Constitution of the United States and similar countries have some means in place that we can charge people who are responsible for endangering public health with charges of endangerment and bring them up on trial. I think that people like Peter Duesberg belong in jail." (Quoted from the documentary, "The Other Side of AIDS" which won a special Jury Prize at the AFI Los Angeles International Film Festival-**1**).

But AIDS denialism hasn't only been advanced by individuals like Nobelist and PCR test-kit inventor Kary Mullis (PCR is used to amplify “HIV's” unique genome sequence), DNA foot-print inventor and Nobelist, Walter Gilbert, former head of the Swiss Blood Bank and European Union of Bloodbanks, Alfred Hassig, and Dr. Heinz Ludwig Sänger, Emeritus Professor of Molecular Biology and Virology. Former Director of the Department of Viroid Research, Max-Planck-Institutes for Biochemy, München. Robert Koch Award 1978, as well and many others who have asked a question about the relationship between "HIV" and "AIDS." In a letter to Süddeutsche Zeitung (Oct. 2000), Dr, Sanger wrote:

"During the past 20 years HIV-AIDS research has shown to a line of critical scientists again and again that the existence of HIV has not been proven without doubt, and that both from a aetiological (causal), and a epidemiological view, it can not be responsible for the immunodeficiency AIDS. In view of the general accepted HIV/AIDS hypothesis this appeared to me so unbelievable that I decided to investigate it myself. After three years of intensive and, above all, critical studies of the relevant original literature, as an experienced virologist and molecular biologist I came to the following surprising conclusion: Up to today there is actually no single scientifically really convincing evidence for the existence of HIV. Not even once such a retrovirus has been isolated and purified by the methods of classical virology."

What many "HIV=AIDS" believers don’t know is that AIDS denialists aren’t comprised only of these few highly respected, accomplished, and award-winning individuals. Far from AIDS denialism being constricted to a small minority, in this essay, I hope to demonstrate how AIDS denialism is widespread, and insidious.

But what is "AIDS" denialism, and who are these AIDS denialists?

Part 1a. AIDS A,B,C’s, logical constructs, and basic research:
At the beginning of the AIDS era, it was reasoned that if pathogen A ("HIV") leads to syndrome B (drop in absolute lymphocytes below 1000 cells/microliter and/or inversion of CD4/CD8-ratio of T-helper to T-suppressor lymphocytes), and syndrome B leads to condition C (opportunistic infections, Kaposi's sarcoma), then syndrome B (immune system collapse) necessarily occurs after A and precedes condition C (opportunistic infections, Kaposi's sarcoma). To assume otherwise constitutes AIDS denialism, and would invalidate the “HIV=AIDS” hypothesis.

1b. Luc Montagnier et al. are AIDS denialists; cellular activation, and PHA, a plant lectin; mycoplasma removal agent; continuous infection with no lymphocyte pathology:
Many have claimed that "HIV" is difficult, but possible to isolate, from cell cultures of activated lymphocytes, or from other cells types such as leukemia cells. AIDS denialism appeared for the first time when Luc Montagnier and his colleagues claimed in the journal *Nature*, that LAV replication ("HIV's first name-Lymphodenopathy-ASSOCIATED Virus), and its associated cytopathic effects (damage to T4 cells), only occurs when T4 cells are "activated:"

"....replication and cytopathic effect of LAV can only be observed in activated T4 cells. Indeed, LAV infection of resting T4 cells does not lead to viral replication or to expression of viral antigen on the cell surface, while stimulation by lectins or antigens of the same cells results in the production of viral particles, antigenic expression and the cytopathic effect **(2).**

In this logical construct, A (“HIV)” does not lead to B (immune suppression/collapse) to produce C (AIDS-defining illnesses), because A (“HIV) is not necessary (or present in the control non-infected cultures) to induce B (destruction of T-lymphocytes/immune collapse), because a chemical, PHA,

induces the T-cells to become activated and sick in the absence of the virus, leading to a situation in which the cell culture is coaxed artificially into shedding 80-160 nanometer membrane-coated “viral-like particles,” reverse transcriptase” (RT), and other surrogate markers thought to be specific components of the "HIV virus.” To generate, and isolate "HIV" (A) from T-cell cultures, Montagnier et al., by their denialism suggested that "A" isn't even necessary, but PHA is essential **(3-7**).

Montagnier et al., in their AIDS denialism went even so far as to suggest that "HIV" is not only not necessary, but a different pathogenic cause, mycoplasms, may cause B (immune collapse):

In a 1991 paper that was published in the journal, *Virology* (**7**), Montagnier and his colleagues not only denied the A,B,C’s of "HIV" pathogenesis by asserting that PHA was essential for T-cell activation, but they suggested in addition, that mycoplasma played some role in "HIV" pathogenesis. In postulating a role for mycoplasma, the normal sequence of cause and effect during viral replication is reversed, because maximal viral production succeeded instead of preceded, the maximum number of viable virus-producing cells, thus violating what is known about viral replication being dependent on the presence rather than an absence of cells:

" in acutely HIV infected CEM cultures in the presence of mycoplasma removal agent, cell death (apoptosis) is maximum at 6-7 days post infection, whereas maximal virus production occurred at Days 10-17."

Cell culturists know that mycoplasma infections generate confusion, because they exert cytoplathic effects on cells similar to the way the "AIDS-virus" is believed to act in humans. Cells become "weakened" by this infectious pathogen over time, but cells are not killed outright, as in lytic viral infections.

But is should be stressed here that it defies logic altogether to claim that maximum virus production is on days 10-17 while maximum cell death occurs on days 6-7. For this to occur, Montagnier et al. would have us forget what is known about viruses. The production of viruses, and there are no exceptions, requires that viruses hijack cellular machinery and cellular materials such as cellular nucleic acids, cellular proteins, and cellular lipids to make more intact virions. Thus viral replication requires cells, not a lack of cells, to replicate, and maximal production of virus should precede and not succeed maximal cell death. Viruses (V) require cells (B) to make more V. There cannot be more V after V has killed most of B, because there would be no materials with which V can make more V, after most of B is killed off. So how are we supposed to accept the AIDS denialist hypothesis of Montagnier et al., that “HIV” actually produces more “HIV” (A) when there is less B (immune system cells)? This makes no sense. Luc Montagnier et al., therefore advocated several forms of specific AIDS denialism:

Instead of:
“HIV” (A)----------Immune collapse---(B)----------AIDS-indicator----(C)
diseases
Montagnier et al. claimed:
(A plus but not minus PHA)---------- (B)----------(C)

And:
(A+Mycoplasma---------- (B)----------(C?) removal agent).

1c. Dr. Flossie Wong-Staal and Dr. Robert Gallo are AIDS denialists- Kaposi's sarcoma; T-cell activation and PHA:

Robert Gallo refused to attend this summer's Toronto International AIDS Conference because he wasn't invited as a keynote speaker. In an interview, he claimed that the conference was "a circus-like" affair devoid of basic science. Perhaps this comes as no surprise because in 1985, Flossie Wong-Stall and Robert Gallo published that:

"The association of Kaposi's sarcoma with AIDS deserves special mention. This otherwise extremely rare malignancy occurs predominantly in a restricted group, that is, the homosexuals, and can occur in the absence of any T-cell defect in the patients" (**8**).

Wong-Staal and Gallo in their statement in *Nature* quoted above, claimed that the "HIV=AIDS" chain of events does not happen such that A ("HIV") leads to B (immune collapse), which leads to C (AIDS-indicator diseases: OI's or Kaposi's). Instead, Staal and Gallo suggested that the formation of Kaposi's sarcoma (C) occurs without T-cell depletion and immune collapse (A leads to C without B). Therefore, they are AIDS denialists.

Gallo and his colleagues also reported that:

"the expression of HTLV-III ("HIV"s second name-Human T-cell Lymphotropic Virus number III) was always preceded by the initiation of interleukin-2 secretion, both of which occurred only when T-cells were immunologically activated" with PHA (**9**).

Therefore, both Gallo's on Montagnier's groups advocated a similar type of AIDS denialism, and both groups published that mitogenic stimulation and activation (of T-cells) in the absence of "HIV," can induce the same cytopathic effects as healthy, non-infected cultures that are treated with sera or cells derived from "AIDS" patients, only when mitogens such as PHA are present.

1d. DIADS are AIDS denialists: PHA stimulation leads to pathogenesis of healthy non-"HIV-infected" T-cells in 4 or more days?

The 1997 DIADS Official "HIV" Culturing Manual also exhibits evidence of AIDS denialism. Under quality control," Section VI, page 45, the DAIDS manual warned "HIV" cell culturists:

"Do not use PHA stimulated PBMC older than 3 days post stimulation" when testing them for **the absence of "HIV" from your healthy donor source** (**10**).

In non-technical language, DAIDS claimed that the way to make sure control cultures (healthy donor source) were indeed not infected with "HIV," was to quit watching the control cultures after 3 days. Perhaps DAIDS simply followed Montagnier's and Gallo's AIDS denialism, and accepted that it was PHA, and not "HIV" that could, after 3 days, induce the same effect on T-cells not incubated with "HIV" (A), as it did with infected cultures (**2-9**)? Nevertheless it is denialism, because they warn culturists to terminate control cultures after 3 days, and thus control cultures are NOT terminated at the same times as the "HIV" infected cultures.

This warning in the DAIDS "HIV" culturing manual, to "not use PHA stimulated PBMC older than 3 days post stimulation" invalidates the hypothesis that A ("HIV"), is an independent variable, and has a unique (destructive) effect on "HIV"-producing cells. When control cultures are made in a lab, the definition of "control" means that **for equal periods of time**, every molecule that is present in the

experimental (infected) cultures is exactly the same as in the uninfected, control cultures, save one variable, in this case, "HIV." Therefore this is "HIV" cell culture denialism.

1e. Nobelists, Howard Temin, and former NIH head Harold Varmus advocated AIDS denialism: It is widely appreciated amongst "HIV=AIDS proponents that reverse transcriptase (RT) is an indication of the presence of retroviruses, and particularly "HIV." However, Nobelist, Howard Temin who discovered RT, and Nobelist and former NIH head Harold Varmus, claimed that reverse transcriptase (RT) is a normal protein found in the uninfected cells of yeasts, insects and mammals (**11**). More recently, other AIDS denialists have claimed RT is important for telomere replication at the tips of normal chromosomes, and "has nothing to do with retroviruses as such." Nowadays, this denialism has led the biotech industry to perpetuate the notion that RT is not specific for retroviruses. For example, the non-specificity of RT is known in the form of market magazines concerning biotechnology stocks (**12, 13**). Claiming as Temin and Varmus did, that RT is a non-specific characteristic of A ("HIV" virus) thus constitutes a form of AIDS denialism at the cellular level, and indeed denies the mechanism of "HIV" integration into the host cell's genome.

1f. AIDS denialists are always talking about the fact that there aren't good animal models of AIDS-dogs, caprines; primates, chimp models versus SIV and others:
There are good animal models of AIDS. For example, 50% of dogs exhibit structural proteins to "HIV" but did not develop "AIDS" (**14**), so dogs constitute an animal model to study "HIV" infection in the absence of progression to AIDS. Goats and cows in other studies have been reported to test positive using the current "HIV" test kits, do not suffer from AIDS either (**15**), so goats and cows are also animal models that do not show AIDS progression (A leading to B leading to C).

Chimps are completely left unharmed by "HIV" because in the past 23 years since they were inoculated with AIDS patient's sera, not one of them has developed "AIDS." (For an amusing account of these "resistant chimps," see The New York Times story, "For Retired Chimps, a Life of Leisure," by Stolberg, 2003) which describes how it has been about 22 years since chimps were injected with both sera and "isolates" of "HIV" obtained from AIDS patients, but have yet to become ill, as they grow old in their new 27 million dollar retirement homes).

The study that some AIDS denialists constantly cite regarding the fact that chimps are models for studying AIDS and not just "HIV" infection, is the study by Novembre et al., (2001), in which they describe how chimps do die of AIDS:

"Despite the fact that most HIV-I isolates have been shown to produce non-pathogenic infections in chimpanzees, continuing efforts have been made to find or derive an isolate of HIV-1 that is more pathogenic for this speciies (3,26,33,34)."

"The development of AIDS in (chimp) C499 confirmed that pathogenic HIV infection CAN occur in experimentally infected chimpanzees (29). In addition, we recently described progressive HIV infection in other chimpanzees within the Yerkes cohort (30). Transfusion of blood from C499 to an uninfected chimpanzee, C455, resulted in a dramatic decline in CD4+ T cells in the latter animal, which suggested the presence of a novel, chimpanzee-pathogenic HIV isolate. However, because a blood transfusion was utilized, the role of other factors in CD4+ T-cell decline was unknown." {Because transfusions are immune suppressive}.

"The fact that CD4 T-cell decline was induced in a chimpanzee (in 1 chimpanzee of the 2 chimps described in this paper!) IN THE FACE OF AN APPARENTLY APATHOGENIC HIV-I INFECTION, has implications for vaccine development. In essence, pathogenic HIV-1 $_{NC}$ infection was INITIATED in (animal) C459 despite "attenuated" immunization with HIV-1 $_{LAV}$. Preexisting immunity and virus infection were unable to prevent the challenge with a pathogenic virus {in the one of the two chimpanzees with the low T-cell count}. Still, there results must be interpreted in light of the route and dose of virus administered to these chimpanzees."

"Previous work by others suggested that virus derived from C499 is pathogenic for chimpanzees (6); however, the results presented here indicate that HIV-1 $_{JC/NC}$ expresses a more chimpanzee-pathogenic phenotype than does HIV-1 JC499. ***After 3 or more years of infection, however, none of the viruses derived from C499 have induced AIDS in chimpanzees, which may allay concerns over the use of such virulent isolates in chimpanzees.*** *(A.M Prince, Letter, AIDS Res. Hum. Retroviruses 13:1259, 1997; A.M. Prince, J. Allen, L Andrus, B; Brotman, J. Eichberg, R. Fouts, J. Goodall, P. Marx, K.K Murthy, S. McGreal, and C. Noon, Letter, Science 283: 1117-1118, 1999.*)…"(**16**). Other AIDS animal model denialists also claim to have infected chimps and these chimps have gone on to develop AIDS, but the diseases they developed weren't specified (**17**).

Here we see A ("HIV") make at least one chimp during the past 23 years have a low T-cell count for awhile (after transfusion-administered "HIV" as the authors point out), with perhaps a depressed B (immune collapse) in the AIDS-defining range of 200 cells/microliter. But no C (AIDS defining illness, Kaposi's or death due to opportunistic infections).

1g. Exogenous "HIV" denialism in Minnesota:
"HIV" as a distinct virus, and, like all other biological entities in the biosphere, it has a unique genetic identity. Yet a relatively influential group of AIDS denialists in The Department of Microbiology, University of Minnesota, Minneapolis claimed that "HIV" gene sequences, can be detected in non-infected humans, chimps, and monkeys (**18**):

"Endogenous retrovirus-related sequences exist within the normal genomic DNA of all eukaryotes, and these endogenous sequences have been shown to be important to the nature and biology of related exogenous retroviruses and may also play a role in cellular functions. To date, no endogenous sequences related to human immunodeficiency virus type 1 (HIV-1) have been reported. Herein we describe the first report of the presence of nucleotide sequences related to HIV-1 in human, chimpanzee, and rhesus monkey DNAs from ***normal uninfected individuals****."*

In this scenario, A ("HIV") is not even an exogenous retrovirus coming into a host from the outside, but instead is "evoked" from normal human, chimp, and monkey DNA. Thus, because they are normal and healthy yet express "HIV" sequences, this means that A doesn't lead to B (because there is no illness-they are "healthy"), and again there can't be any C because there is no B.
Thus there is no C, no B, and A arises from within normal uninfected host genomic DNA.

1h. AIDS denialists forget about "HIV's ability to genetically mutate:
The scientific consensus says that the reason we know that "HIV" is constantly mutating and avoiding anti-retroviral therapy in patients given "the life saving ARV's (**A**nti-**R**etro**v**iral medications) is because "its molecular sequence is different from patient to patient." Thus, the virus can thereby change its genetic code and therefore its biological identity-which of course is the correct consensus reason that HAART therapy ***has failed***. Presumably, smallpox virus has the same genetic code as it did

centuries ago, because it is "the small pox virus." Measles virus also probably has the same genetic code as it did centuries ago, as does rabies virus that Pasteur worked with more than 150 years ago. But "HIV" is different. The consensus of "HIV" experts suggests that "HIV" can continuously and rapidly mutate, while "HIV" maintains its "HIV" identity, infectivity, and lethality, and does so using different genetic sequences than the one it had originally. Even in isolating the genetic sequence, "HIV" showed how mutable it is. For example, in 1990 the HIV genome was said to consist of **ten genes** (**19**). In 1996 Montagnier reported that HIV possesses **eight genes** (**20**), while Barre-Sinoussi reported HIV as having **nine genes** (**21**). So on average “HIV” has probably **9 genes**. (8+9+10=27/3=9 genes). Denialists can’t perform simple statistical averaging to come up with "HIV's" average number of genes!

Part 2a. AIDS denialists among "HIV" test kit makers- “HIV” kit manufacturers claim 100% accuracy:
It is well known amongst the "HIV/AIDS" believers that it is possible to know your own "HIV" status correctly with near 100% certainty:

From the International AIDS conference in Thailand: (**22**):

*"The true antibody status of these subjects was determined by testing of a blood sample using the standard testing method routinely used by the Anonymous Clinic for diagnostic testing**.** The Calypte blood rapid test was 100% concordant with the results of **the standard blood tests**. The Calypte oral fluid test demonstrated 99.5% sensitivity (390/392). The two false negative results were from two known positive subjects who were on anti-retroviral therapy. These patients are known to have diminished antibody levels and would not normally be seeking HIV diagnostic testing."*

It isn’t clear how anti-retrovirals can cause antibodies made by the body supposedly against “HIV” virus particles, to diminish in quantity, unless antibody-producing cells are somehow diminished in number, or are impeded somehow from producing antibodies by ARV’s. Nevertheless, some AIDS denialists have asked in response to these responsible claims by manufacturers such as Calypte:

If the makers of the standard tests say the standard tests cannot be used to detect "HIV" or "AIDS," (and they don't specify what "the standard tests" are), then how is it possible that a rapid test with near 100% accuracy based on these standard test results, can?

The answer to this question was advanced in 2004 in an article entitled, *"AIDS Home Test Kit Called Deceptive, (***23***):*

"A District Court in Seattle has granted a request from the Federal Trade Commission and issued a temporary restraining order to prevent the sale and distribution of "defective" home HIV test kits. According to FTC, the kits' maker, Seville Marketing of British Columbia, Canada, on two Web sites had advertised the "Discreet" home HIV test kits as producing 99.4% accurate results based on three independent studies. However, CDC studied the test kits and found they were not as accurate as the company claimed on its Web site."

"Three minutes after performing the test according to the package instructions, 15.4% of the results were inaccurate; after eight minutes, 29.6% of the results were inaccurate; and 59.3% of the tests produced inaccurate results after 15 minutes. The kits gave both false-positive and false-negative results, according to the release. The kits, which cost $29.95, have been available on the Web through the company's Internet sites. FTC noted in its complaint that the kits cannot be sold legally in

the United States because they are not approved by FDA as a diagnostic tool, according to the release."

"FTC will seek a permanent ban on sales and advertising of the kits in the United States and a permanent order to seize any kits that are imported. Consumers who have used the kits are advised to see a health professional for another test to determine their HIV status, according to the release."

2b. Package inserts made by denialist "HIV" test kit makers deny they can detect "HIV" in every person.

If you don't get tested for "HIV," you could die from a horrible AIDS-indicator disease in less than 10 years, according to the CDC. But some AIDS denialists have tried to undermine this simple truth, and have generated doubt about their test kit's inability to determine someone's "HIV" status, and have therefore tried to sabotage confidence in "HIV" testing. For example, certain test kit manufacturers have warnings on their package inserts, which include suggestions that imply that their test kit shouldn't be regarded as diagnostic of "HIV" disease. As a result of this intentional confusion perpetrated by these test kit makers, situations have emerged where it has become increasingly difficult to confidently obtain an accurate "HIV-positive" test diagnosis. This is especially problematic, for example, in cases where a child should be forcibly removed by the state by DFCS (Department of Family and Child Services) if a mother or family refuses "HIV" testing, or HAART for the child -a horrible situation that has "endangered countless infants and young children of criminally negligent parents" (see Moore) who have refused to test or drug their infants and children before, during, or after parturition. A few of these AIDS denialist package inserts can illustrate this sad situation:

*"ELISA testing alone **cannot** be used to diagnose AIDS." (**24**).*

*"**Do not** use this kit as the sole basis for HIV infection." (**25**).*

*"The amplicor HIV-1 monitor test **is not** intended to be used as a screening test for HIV**, nor as a diagnostic test** to confirm the presence of HIV infection." (**26**).*

These are not typo's on the package inserts! They are deliberately written to warn practitioners to be skeptical of the uncertainty of "HIV-I" testing.

Other test kit accuracy denialists have also tried to erode confidence in standard tests: For example (http://www.rethinkingaids.com/GalloRebuttal/Farber-Gallo-01.html):

"False-positive ELISA [antibody] test results can be caused by alloantibodies resulting from transfusions, transplantation, or pregnancy, autoimmune disorders, malignancies, alcoholic liver disease, or for reasons that are unclear...As the number of women being screened has increased, the proportion of false-positive and ambiguous (indeterminate) test results has increased and the positive predictive value (PPV) [a mathematical expression of the probability that a positive test is a true positive] of the standard HIV test has decreased" (**27**).

"Most patients (68 to 89%) from low risk groups (prevalence of 0.1% or less) who show reactivity on screening tests will have false-positive results…The predictive value of a positive ELISA varies from 2% to 99%…One notable association with false positive ELISA reactivity in some commercial preparations has been patients with anti-HLA-DR4 antibodies, most often multiparous [having experienced one or more births] or multiply transfused patients...the Western blot method [used to

confirm these false positive ELISA tests] lacks standardization, is cumbersome, and is subjective in interpretation of banding patterns" (**28**).

"We selected the 20 most strongly [indeterminate or atypical Western Blot] reactive samples for further evaluation…Atypical WB [Western Blot] patterns in 19 of 20 of our donors remained substantially the same over time…our data show that the presence of p24 alone in WB should not be regarded as a false positive without subsequent testing of the individual…All study donors had normal immune status…[2] donors were multiparous females [multiple children], and one other probably had received a blood transfusion…we observed a large proportion of individuals who had either lived or worked on dairy farms (6/16) and frequently drank unpasteurized cows' milk (7/16)…undefined autoimmune phenomena [such as multiple pregnancies], bovine exposure, or cross-reactivity with other human retroviruses could be possible causes for consistently reactive HIV immunologic assays" (**29**).

Therefore, one thing you could try if you continue to test positive and know that you have no risk factors, is to switch to goat's milk instead of drinking cow's milk all the time, unless of course that milk is taken from goats who test "HIV-positive" (**15**), as indicated earlier in section **1f**.

There are even "HIV" test kit accuracy denialists who are noted scientists. Busch et al., in a paper entitled, "Poor sensitivity, specificity, and reproducibility of detection of HIV-1 DNA in serum by polymerase chain reaction. (**30**), reported that:

PCR-DNA tests on 151 ELISA-negative people found that 18.5% (28 people) had positive PCRs. Furthurmore, only 25.5% of people diagnosed HIV-positive had positive PCR's.

In their conclusion section Busch et al. draw attention to how close the two numbers, 18.5% and 25.5% are:

"This study of PCR detection of HIV-DNA in serum identified a disturbingly high rate of nonspecific positivity with a widely employed gag primer pair system [gag is a protein considered to be specific to HIV]. In fact, the overall positivity was not significantly different for serum specimens from seropositive patients and seronegative control donors (25.5% vs 18.5%). ... In contrast to the high rate of false positive results observed with gag primers, env DNA [env is another protein thought to be specific to HIV] was not detected by laboratory B in any of the specimens from either seronegative or seropositive individuals. ***Absence of reactions with both primer pairs from all 59 specimens from seropositive persons meant that no serum sample could be confirmed positive for HIV-DNA, i.e. 0% sensitivity.*** *This finding is in marked contrast to the high sensitivity reported previously by Laboratory B for both gag and env primers."*

This is clear AIDS denialism because Busch et al., claim that "no serum sample could be confirmed for "HIV-DNA", which means that the test was 0% sensitive.

2c. AIDS denialism in The Red Cross- statistics regarding low incidence with PCR and protein tests.

It is well known that seroprevalence of "HIV" surrogate markers among both low or high-risk blood donors is alarmingly high, because we constantly here this from the media. For instance, "HIV" clearly appears to be exploding in the US in both "**non-risk**" (non-selectively tested) "risk," or "high risk" (selectively targeted for testing) populations (such as Blacks, Hispanics, IV drug-users or illicit drug users of any type, unsuspecting pregnant women, gay folks, or young people who had sex before

getting tested for "HIV"). But AIDS denialists at the Red Cross published statistics recently indicating that (**31**):

" among *"**non-risk**" blood donors, the current estimate of incidence out of **37,164,054** units screened, **12** were confirmed to be positive for HIV-1 RNA - or 1 in 3.1 million donations - and only **2** of which were detected by HIV-1 p24 antigen testing."*

2 or **12** out of **37,164,054** can in no way account for the near 1 million infections said to afflict Americans, so this is AIDS denialism.

What is the incidence and prevalence in "high-risk" populations? What populations are at **"high risk"**? Persons with multiple sex partners, gay folks, African and African American folks, Asian folks, just about anybody who live risky lives). A recent report published in the NEJM presented the following figures (**32**):

*"Between November 2002 and October 2003, 110,890 persons sought publicly funded, voluntary HIV counseling and testing in North Carolina. The study population consisted of 109,250 subjects for whom there were complete testing data and who were classified as being **at risk** for HIV infection."*

These "HIV"-testing denialists who published this report in April 2005, therefore claimed that even among "high-risk" populations, out of 109,250 "high-risk subjects" for which they had complete data, they could typically detect 2.2 HIV infections per 1000 person-years (95 percent confidence interval, 1.8 to 2.6), with their new testing procedure that lumps the results from different test kits together to increase the incidence of "HIV" infection by 21% over previous enzyme-based assays. This is blatant AIDS denialism because it is well known that a high proportion of these "high-risk" folks are infected with "HIV," because they are "high risk" individuals…

2d. "HIV=AIDS" apologists fight back AIDS test kit denialism:
Despite these attempts by AIDS denialist "HIV" test kit makers, scientists, and denialist epidemiologists, many courageous "HIV=AIDS" believers have fought back. For instance, because the test kits are indeed so reliable despite the denialism advanced by the test kit manufacturers, the CDC fought back by simply passing down recommendations for universal testing:

"May 5, 2006 - The CDC will recommend at least one HIV test for everyone aged 13 to 64 who visits a doctor" (**33**).

"The radical change to HIV testing guidelines will be released in June or July, says Kevin Fenton, MD, PhD, the new director of the CDC's National Center for HIV, STD, and TB Prevention. Routine HIV tests in doctors' offices and clinics will no longer require the pretest counseling now a part of all HIV testing."

"Fenton, joined by former CDC AIDS chief James Curran, MD, MPH, now dean of Emory University's Rollins School of Public Health, spoke today at a news conference marking the 25th anniversary of the AIDS pandemic."

"Most HIV is transmitted by the 25% of infected people who do not even realize they are infected," Fenton said. "We need to dramatically expand access to HIV testing by making it a routine aspect of clinical care."

This sentiment has been echoed by AIDS experts in journals such as the New England Journal of Medicine, and others, and with titles like:

Expanded Screening for HIV in the United States - An Analysis of Cost-Effectiveness (**34**).

Cost-Effectiveness of Screening for HIV in the Era of Highly Active Antiretroviral Therapy (**35**).

Routine Screening for HIV Infection - Timely and Cost-Effective (**36**).

It was recently reported that Illinois may require HIV test for all babies with mandates written into the law (**37**-Amendment to House Bill 4306, filed by Representative Mary E. Flowers, 2/2/2006):

"The health care professional shall inform the pregnant woman that, should she refuse HIV testing during pregnancy, her newborn infant will be tested for HIV."

"Consent for testing of a newborn infant shall be presumed when a health care profession or health care facility seeks to perform a test on a newborn infant whose mother's HIV status is not known, provided that the counseling under subsection (d) has taken place."

" A health care facility shall adopt a policy that provides that a report of a preliminarily HIV-positive woman and a report of a preliminarilty HIV-exposed newborn infant identified by a rapid HIV test conducted during labor and delivery or after delivery shall be made to the Department's perinatal HIV Hotline within 24 hours after birth."

"A health care facility shall adopt a policy that provides that when an HIV test performed under this Act shows that a newborn infant is preliminarily HIV-exposed, the infant's parent or guardian shall be informed of the importance of obtaining timely treatment for the infant for her HIV infection."

"The only exception would be if the mother objects on religious grounds."

Part 3a. Make sure you got AIDS-*Anthony Fauci's suggestion of ICL is AIDS denialism: AIDS with no "HIV."*

It was the notorious AIDS denialist, Dr. Anthony Fauci, along with his cohort of other AIDS denialists, who first suggested that ICL or Idiopathic CD4+ T-cell lymphocytopenia, could explain "the mysterious AIDS cases." The defining key phrase on Medline for ICL is **I**diopathic, **C**D4-Positive, (T)-**L**ymphocytopenia, " and is referred to as "ICL." The extraordinary feature of this patient group is that they test negative for HIV.

"The clinical spectrum of idiopathic CD4+ T-cell lymphocytopenia is considered diverse, and is characterized by opportunistic infections caused by one or more mycotic, bacterial, and viral infections. Less frequently parasitic infections are seen. Serologic tests for HIV-1 infection are negative when a screening and confirmatory test are used. In such patients no known cause of immunodeficiency is apparent, nor should it result from immunosuppressive therapy."

Although in all diseases, idiopathic nuances can be found and are designated as idiopathic, it really violated the HIV=AIDS A,B,C's to designate, as Anthony Fauci and others did, an idiopathic category that is characterized by a failure to identify the cause, "HIV." In the case of Fauci's ICL designation, immune suppression (B), leads to any number of "AIDS defining illnesses" (C), without A ("HIV") ever being detected, and it may not even be present at all.

This sort of AIDS denialism, that A ("HIV") isn't even required for B (immune suppression), or C (AIDS-defining illnesses), has spawned a growing body of researchers, funding directives, and literature. According to this form of AIDS denialism, you **DO NOT** have to have "HIV" to be considered an AIDS patient, but instead, you are designated an AIDS patient whether or not you show evidence of an "HIV" infection.

Perhaps this comes as no surprise because Dr. Fauci's AIDS denialism began before the AIDS era when he claimed that immune suppression is caused by doctors! Doctors cause immune suppression, Fauci claimed, if they subject their patients to multiple transfusions, transplant surgery, or corticosteroid administration, as these drugs and treatments can non-specifically induce AIDS-specific drops in T-cells with high frequency (**38, 39**). Fibrosis of the lung due to to heavy crack cocaine use also was considered a potent inducer of the AIDS-defining illness, PCP, by Fauci and others before the AIDS era. These qualifications serve to undermine the "HIV=AIDS" hypothesis, because A ("HIV"), does not generate B (immune suppression), because iatrogenically applied glucocorticoids, transfusions, blood factor concentrates in hemophiliacs, and other factors such as chronic crack cocaine use may induce a precipitous drop in B, and consequently lead to C. Thus, this is AIDS denialism in its worst form, as it denies the existence of "HIV," or the need to detect "HIV," altogether, in a patient with low (B), while suggesting that doctors, and illicit drug use, cause "AIDS-like" immune suppression.

3b. AIDS denialists Jeffrey Klausner and others, Johns Hopkins, and the New York State Department of Health claim Flu vaccines, Hepatitis B vaccines, pregnancy, warts, syphilis, mycoplasmas, and other factors confound "HIV" and AIDS diagnoses:
"HIV," like all distinct biological entities, must possess a unique molecular signature that is different from all others in nature. Some AIDS denialists, however, have challenged this "law" of molecular specificity and individuality with respect to "HIV." For instance, Christian Erickson, Todd McNiff, and Jeffrey Klausner have recently warned that influenza vaccinations generate false positive HIV results (**40**):

"A case–control study 2 of 101 blood donors (**41***) who had been vaccinated against influenza and 191 matched controls showed that recent inoculation with any brand of influenza vaccine was significantly associated with a false positive screening assay for HIV antibodies. Guidelines of both Johns Hopkins and the New York State Department of Health list influenza vaccination as a known cause of indeterminate results on Western blotting for HIV antibodies (Reasons for false-positive, false-negative, and indeterminate results in assays for the detection of antibodies against HIV.*

How can the flu vaccine cause the human body to generate proteins that are specific to The AIDS Virus (A) if the proteins or nucleic acid sequences of "HIV" are unique! "HIV" is no flu virus! This is AIDS denialism, and it serves to erode confidence in the "HIV=AIDS" paradigm. If 2 of 101 flu vaccine subjects tests false positive for "HIV," then in a population of 300 million, this would exceed by 6 fold the true rate of "HIV" infection currently thought to exist in the U.S. (currently about 1 million are said to be living with "HIV"), and it would be more difficult to convince flu vaccinees that they have acquired "HIV," as opposed to merely having developed a false-positive reaction to flu vaccines.

Hepatitis B vaccination has also been linked to positive reactions on ELISA's (**42**).

3c. Syndromes that AIDS denialists have associated with false positive "HIV" test results and non-"HIV-associated" autoimmune conditions:

AIDS denialist physicians have published scores of papers on Medline of case studies where they deny that AIDS is a specific and distinct disease syndrome. These denialists have argued, for example, that the tetanus vaccine and other vaccines may cause false "HIV" diagnoses, and persons who suffer from chronic infections are also misclassified as AIDS patients. Also, according to the CDC and other "HIV=AIDS" denialists, pregnancy itself, and non-pregnant women who have had more than 2 children, have a high frequency of testing "HIV" positive. Other denialists have claimed that alcoholic hepatitis, alpha interferon therapy, detection of antibodies with high affinity for polystyrene used in different test kits, unusual anti-carbohydrate antibodies, anti-collagen antibodies, arthritis, systemic lupus erythematosus, scleroderma, connective tissue disease, dermatomyostitis, tuberculosis, malaria, hemophilia, hepatitis, hemodialysis, high levels of circulating immune complexes and ERS rates (erythrocyte sedimentation rates), herpes simplex I and II, HLA antibodies (to Class I and II leukocyte antigens), hyperbilirubinemia, hypergammaglobulinemia, leprocy, lipemic serum, malaria, malignant neoplasms, mycobacteriaum avium, non-specific detection of free ribonucleoproteins, organ transplantation, the receipt of gamma globulin or immune globulin (as prophylaxis against infections), multiple transfusions, Q-fever with associated hepatitis, primary billiary cirrhosis, primary sclerosing cholangitis, renal failure, Stevens-Johnson syndrome, T-cell leukocyte antibodies, visceral leishmaniasis, the spurious detection of the proteins, p18, p24, p55, p12, p32, p51, p66, or gp160, gp41, gp120 antigens that may be present in fluids obtained from patients who have warts, and 36 or more other known conditions/reasons for testing false positive (**43-48**).

Other AIDS denialist have claimed that the thymus glands of "**HIV-negative**" children are known to express p24 and other so-called “HIV-specific” markers (**49**).

Furthermore, in the absence of "HIV" test results, as in most rural or 3rd world situations, some patients are considered by denialist doctors and scientists to have an AIDS-defining illness if they have suffered from chronic starvation, as these individuals are known to possess a helper T-cell ratio in the AIDS-defining range or even lower (< 250 cells/ml), and can present with as much as a 90% reduction in their normal T-cell number (**50, 51**).

Some AIDS-denialist physicians also claim that syphilis could be confused with AIDS. Here there is some room for concern because syphilis has always been known as The Great Imitator, and in fact it was present, along with gonorrhea, CMV, and Herpes, in Montagnier’s Patient One, according to Montagnier's denialist writings. Although syphilis isn’t AIDS for definitional reasons, it can cause diagnositic confusion among poorly trained physicians:

“During the great penicillin fallout” from 1945 to 1960 physicians noted a startling alteration in the appearance of the typical case of syphilis. The classic symptoms of the disease were appearing much less frequently and were apparently being “masked” or in some way disguised or perverted by the use of penicillin.”

“Ordinarily, the first sign of syphilis infection is the cancre-a sore which appears at the site of infection after incubation period of one to three months and marks the onset of the primary stage. Then the adjacent lymph glands become swollen and rubbery, a condition known as “regional lymphadenopathy.”

“Thereafter, the disease “matures” for up to six months and enters the secondary stage, characterized by a “macular” (spotty) roseola-like rash and other skin symptoms. The regional lymphadenopathy becomes generalized and affects the body’s whole lymphatic system; it is a

"valuable diagnostic finding" and one of the most characteristic aspects of syphilis; the lymph nodes are "painless," "enlarged," "rubbery," "non-tender," and "freely moveable."

"The patient will complain of rashes, fever, itching, sore throat, headache, malaise, vertigo, sweating, insomnia, nausea, prostration, weight loss, loss of hair, or aching in the bones and joints. Some have hypertension, kidney disease, swollen liver, or swollen spleen; others have a subacute meningitis with cranial nerve involvement. In this stage of syphilis is often confused with such conditions as infectious mononucleosis, iritis, neruoretinitis, lichen planus, cancer, nephritis, dementia, lymphomas, psoriasis and other skin eruptions, and even drug reaction. For this reason secondary syphilis is called the great imitator."

"The Trepanonema pallidum acts specifically against the thymus gland. The thymus-dependent parts of the lymphatic system deteriorate, and there is consequent decrease in the numbers of "T-lymphcytes. The T-helper cells are particularly affected by this: ***there is a decline in their number and the ratio with the T-suppressor cells is reversed.*** *Consequently, a long-term effect of syphilis is loss of, or decline in, the system of immunity, and lowering of the individuals capacity to defend himself against other infectious conditions."*

There are many, many other parallels too detailed to go into here regarding syphilis and AIDS. (For a comprehensive account of syphilis's similarities of epidemiology, progression throughout certain populations diagnosed with AIDS, infant-mother complexities, etc., see **52**).

Some AIDS denialists have gone so far as to claim that mycoplasm infections also induce similar symptoms as seen in AIDS patients or primates experimentally infected (**53**).

Currently, there are more than 40 previously known distinct diseases that have been reclassified as AIDS-indicator diseases: 6 AIDS-indicator cancers, 10 generalized AIDS-indicator syndromes (such as a long-lasting fever or headache), 16 opportunistic AIDS-indicator microbial and parasitic infections (such as PCP, thrush, toxoplasmosis, etc.), 5 AIDS-indicator viral infections such as Herpes, the 7 AIDS-indicator birth or perinatal syndromes such as heart defects before the HAART era (**54**) and 4 new AIDS-defining illnesses.

3d. Those who focus their study on the health effects of illicit drugs are AIDS denialists:
It is widely appreciated by the true believers in the "HIV=AIDS" hypothesis, that "HIV" (A) leads to immune collapse (B), and B leads to AIDS defining illnesses (C). But even as recently as 2003, we still find AIDS denialists suggesting that illicit drugs may induce "AIDS." For instance, some individuals, instead of advocating massive funding for clean-needle programs and safe sex or condom distribution, still claim that the immunotoxic effects of chronic intravenous drug addiction or popper use itself may lead to immune suppression meeting the surveillance definition of T-cell numbers seen in "AIDS" patients. Therefore, many addicts are not considered by these AIDS denialists to be AIDS patients, because they have advanced the notion that chronic drug abuse might induce immune suppression (**55**). Other AIDS denialists, in addition, have suggested that Ecstacy alone and combination with alcohol can induce AIDS-defining illnesses (**56, 57**).

Part 4a: So you and your doc decide you got AIDS. Whaddyagonna do about it? Pessimism and confidence among NCI denialist vaccine makers, drug makers, and the law of similars and contraries:
From classical times, medical treatments have been predicated on either a rationalist or empiricist philosophy (**58**). Rationalists, as a group, tend to regard and approach disease as a localized entity

and attack "it" directly by attempting to reduce or reverse its cause or primary symptoms. Radiation, mainstream chemotherapy, and targeted immune therapy are principal examples of a rationalist approach. Antiretroviral therapy (ARV) or HAART (Highly Active Anti Retroviral Therapy) are also examples of the rationalist approach, which employs the "law of contraries," to target a supposed exogenous and biologically unique virus in the case of "HIV," a supposed variant "of a known cancer virus," that is thought to be now responsible for 46 (47 if you now want to include amoxicillin adverse reactions, heart disease, birth defects of infants borne of women on ARV's) different syndromes that were previously known before "HIV" was announced by government proclamation as being the sole cause of "AIDS."

4b. Empiricist Law of similars:
Empiricists tend to regard and approach disease as an imbalance in the living organism, which they attempt to restore by aiding the body in re-establishing its lost balance in ways that increase "resistance," or which non-specifically alert the organism via a "danger signal." Microbial immune therapy, antiangiogenesis therapy, and hyperthermic therapy are examples of an empirical approach. AIDSVAX, the GP120-based "HIV" vaccine is also an example of an empiricist approach, as it employs "the law of similars, to provide the organism with a similar substance (and not target the hypothesized cause directly), to alert the organism to subdue the exogenous invader, which is "HIV." Also, reconstitution of the immune system through nutrition therapy would be considered a form of empiricist therapeutics for immune suppressed individuals. It should be emphasized as in **Part 3b** above, that people are not considered to have an AIDS-defining illness if they have suffered from chronic starvation, as these individuals are known to possess a helper T-cell ratio in the AIDS-defining range or even lower (< 250 cells/ml), and can present with as much as a 90% reduction in their normal T-cell number, that is reversible upon supplying the proper nutrition and nutritional supplements (**56, 57**), as Fauzi et al. have shown in a recent study using vitamin supplements in the absence of HAART (**59**).

According to the "law of similars," cells and organisms “push back” against a physical or chemical assault. Normally, the organism is in health at homeostatic balance, until illness results. Empirically, it has therefore been hypothesized, that when a similar disease-causing agent (like an active or inactivated virus, or its components) or a chemical is given to a patient that can produce the same disease symptoms in healthy people, the organism’s own natural defenses are more strenuously evoked, and the illness overcome. Vaccines, cancer immunotherapies, hyperthermic therapies, histamine (not antihistimine) therapy for asthma, are all examples of using "the law of similars" in clinical practice.

4c. Rationalist law of contraries:
"The law of contraries," that is principally touted by allopathic medicine (except of course for vaccinations which derives from the homeopathic idea of the "law of similars"), derives from the notions of Ehrich, Koch, and Virchow. Following "the law of contraries,” it is believed that one can specifically target the molecular basis of a disease-causing agent or entity, much like dyes bind to fabrics, as this idea was borne out of the German dye development era of the 1800's during Virchow's, Erhlich's, and Koch's era. Anti-retrovirals and antibiotics, glucocorticosteroids, aspirin, mastectomies, heart surgery for clogged arteries, antihistamines, are a good examples of "the law of contraries" in clinical practice. Cut out the primary syndrome-associated symptom: heart disease: clean out or remove clogged arteries; bacterial infections-kill the bacteria’ asthma-too much mucus in the airway-give whopping doses of steroids to suppress the natural immune response; cancer of the breast; chop it off.

Both approaches are "scientific", depending of course on how an experiment or trial is conducted (whether it is terminated prematurely as most, if not all of the FDA AZT and other antiretroviral trials have been for "compassionate reasons"), or if there are consistent results generated in a human patient, such as testing "HIV positive," "HIV positive," and "HIV positive." In science, a finding that repeats 2 times might be a fluke, while 3 points define a straight line, and constitute a minimum requirement to establish 'consistency,' or even 'a trend.' Rationalists also perform their medical experiments on an " average" or idealized patient harboring some "average" symptoms of "a disease," to the extent that even adverse or idiosyncratic reactions to medications such as amoxicillin are believed to fall into stereotypic responses, while empiricists perform their medical experiments in an attempt to restore the apparent imbalance manifested by person-specific, individualized symptoms that may appear different in each patient.

If a pathogen or its components have been isolated to the standards that Koch developed over 100 years ago for the first time in his "solid anthrax cultures," making a successful vaccine should be rapidly forthcoming, as HSS Secretary under Reagan, Margaret Heckler, once pointed out in a 1984 press conference with an in earnest Robert Gallo by her side. How do vaccines work? They were developed using the homeopathic idea of "the law of similars," a principle largely dismissed by allopathic medicine, but which, ironically, forms the basis of all vaccine development strategies, and provides the scientific basis for the impassioned vaccine crusades like the ones both dismissed and at the same time advocated by different groups of AIDS denialists described above. And some AIDS denialists claim that medical approaches that are based either on the "law of similars" or on "law of contraries" strategies have not cured a single AIDS patient!

4d. AIDS denialists among NCI vaccine makers:
If A is blocked by vaccine, then B will not result, nor then can C. This is the basis of the rigorous, effective and safe, "HIV/AIDS" vaccine strategy. But even here, AIDS denialism has crept in.

AIDS denialist investigators involved in the AIDS Vaccine Program, SAIC, National Cancer Institute, Frederick Cancer Research and Development Center, Maryland, also published reports stating that PHA (phytohemagglutinin) and IL2 (interleukin-2) stimulated healthy {non-infected} cells produce "viral like particles" and "HIV -specific" proteins only when stimulated with PHA and IL-2 (**60**).

In this publication, the AIDS Vaccine Program investigators claimed that A ("HIV") again isn't necessary to induce B (immune suppression) because IL2 and phytohemagglutinin stimulated healthy NON-INFECTED control cells to become ill, and produce "viral like particles," and "specific" "HIV" proteins (reverse transcriptase, p24) **only** when stimulated with PHA and IL2."

This group also claimed that microvesicles were a source of contaminating cellular proteins found in purified HIV-1 preparations, as the title of their paper, " Microvesicles are a source of contaminating cellular proteins found in purified HIV-1 preparations" suggests (**60**).

This proposed series of cellular and molecular events of course is vastly different from a scenario in which A ("HIV") leads to B (immune collapse), which leads to C (OI's or Kaposi's sarcoma). A ("HIV") is deleted from the equation altogether, because non-"HIV"-infected cultures are being discussed here, and these cultures produce virus-like particles and not ("HIV"), reverse transcriptase, p24, and other "surrogate markers" or subcomponents of what is believed to be "HIV.
"
In 1988, Jon Rappaport, an author of considerable skill who documented the early AIDS era wrote:

"While I was writing AIDS INC., I spoke with a scientist at NIH who told me that anyone, in the future, who was given a vaccine against HIV would be given a letter to carry around. The letter would say that, if at any time, this person tested positive for HIV, it wouldn't mean he was infected. It would mean he was immune. I said, "So if the person develops antibodies against HIV naturally, this is taken as a sign that he is infected, he will go on to develop full-blown AIDS, and he will probably die. But if he gets those same antibodies from a vaccine, he will be called immune. The scientist had no clear answer to this" (Jon Rappaport, personal communication).

If the AIDS Vaccine Programs ever acquire enough money and lab help that Pasteur enjoyed (at least 2 lab technicians and some stray dogs, 50 control cattle, sheep, goats, rabbits, hamsters), then potentially everyone will be vaccinated with the "HIV" vaccine, and can be given a letter to carry around to show to others they want to sleep with that they had their shots. Then everyone will test positive for "HIV," and "HIV/AIDS" stigmatization will not be possible in a world where everyone tests "HIV" positive! Then you also don't need to worry if you get a flu vaccine, or a hepatitis vaccine, that you could then test positive for "HIV" (**40, 41, 42**).

4e. Polio vaccines generate confidence for "HIV" vaccine trials:
Perhaps to achieve universal vaccine compliance for mandated vaccine programs, AIDS vaccine advocates need to offer more than glib reassurances to the public to assure them that the vaccine itself will not cause "AIDS?" Lessons learned during previous vaccine campaigns may help reassure the public. For example, from "The Virus and The Vaccine-The True Story Of A Cancer -Causing Monkey Virus-Contaminated Polio Vaccine, And the Millions Of Americans Exposed, (**61**):

"The assistant director of the NIH, Dr. James Shannon, hastily convened a 7:30 meeting of seven other NIH officials and scientist to discuss what to do, including halting all immunizations with Salk vaccine, regardless of manufacturer. Unable to reach agreement among themselves, at 3:00 AM on April 27, the group telephoned Surgeon General Scheele and asked for a decision on what to do about the polio vaccine. Sheele, awakened in the middle of the night, had no immediate answer. Later in the morning, he telegrammed Cutter Laboratories and asked the company to stop distributing vaccine. The company complied with the request immediately; within thirty minutes it had contacted all its distributors. The massive vaccination programs in schools through the Far West were abruptly halted. On the morning of April 28, the press reported the news of the withdrawal of Cutter's vaccine.

With the announcement that Cutter was withdrawing its vaccine, there ensued a nationwide panic. The AMA put out the warning to all its members to stop using Cutter vaccine, although regrettably some doctors never received word. Many states and cities announced immediate cessation of mass immunizations, even though their vaccine had come from manufacturers other than Cutter. Local health departments began to track down every single dose of Cutter vaccine, which, it was soon discovered, had traversed the entire country. Throughout May and June, cases of polio caused by Cutter's vaccine spread beyond the Far West and began to appear in every region of the country. The epicenter of the devastation was in California and the rural state of Idaho. Ninety-nine cases of polio would eventually be attributed to Cutter vaccine in California, with the incidence of polio among Cutter vaccinees exceeding the textbook definition of a wild polio epidemic by nearly threefold. In Idaho, with eighty-eight polio cases attributed to Cutter vaccine, the rate was fifteen times greater. Before it was over, the 'Cutter incident,' as it was euphemistically called in scientific circles, resulted in 260 people contracting polio and almost 200 cases of paralysis. Eleven people died. A devastating epidemic had been caused by two particularly bad batches of vaccine."

Also regarding the effectiveness of the polio vaccine, Thomas Levy, MD, FACC, also suggested that:

*“Certainly the primary purpose of a vaccine is to protect those injected from a specific disease. In fact, many vaccines have not only substantially failed in such protection, they have frequently caused the very diseases for which they were supposed to offer protection. America's own Centers for Disease Control (CDC) in Atlanta admitted in 1992 that the polio live-virus vaccine had become the main cause of polio in the United States. Specifically, the CDC asserted that, from 1973 to 1983, 87% of all (non-imported) cases of polio resulted directly from vaccine administration. Even more amazingly, it was asserted that every non-imported case of polio in the United States from 1980 to 1989 was vaccine-induced” (**62**).*

“For those who may think much of the above is some sort of statistical manipulation, consider that the overall number of reported cases of polio in the United States following the large-scale usage of Dr. Salk' skilled-virus vaccine increased substantially. Nationwide, the incidence appeared to double, with some states reporting 400% to 600% increases. And although polio has largely disappeared from the United States today, the evidence does not support the polio vaccine as being the cause of this. Not only had the polio death rate already declined by roughly 50% from 1923 to 1953 (well before the introduction of the vaccine), polio incidence was also similarly declining in Europe as well, and it continued to decline there even without the mass inoculations that were implemented in the U.S. (**63**). *The vaccine supporters nevertheless give full credit for disease eradication to a vaccine that merely 'jumped on the bandwagon" at the end of ride.”*

Things don't appear to have changed regarding the polio vaccine, especially in 3rd World countries such as Nigeria, where new vaccines and medications are always being tested so as to avoid damaging "high functioning" folks in industrialized nations. For example, in an article entitled, "Eradicating Polio," by David L. Heymann, M.D., and R. Bruce Aylward, M.D. *(NEJM* Volume 351:1275-1277 September 23, Number 13, 2004) it is claimed that another contaminated vaccine was to blame for an increase in polio there. From June 29 to July 3, 2005 Nigerian health officials in collaboration with United Nations health agencies launched an ambitious five-day Polio Plus immunization campaign of 10-million children in northern Nigeria aimed at eradicating the deadly disease from the country by the end of 2006. As recently as September 6, 2006, however, *"a reported total of 784 cases of the disease were registered in 17 states at the end of July,"* the Nigerian National Programme on Immunization said. *"In June the figures were 501 cases in 15 states, compared to 244 cases in 18 states for the same period in 2005,"* it said in a statement.

4f. **AIDS vaccine advocates also must do a better job in demonstrating the purity of AIDSVAX, to assure the public, and especially young parents, that a repeat of the SV40 scare will not happen with a new AIDS vaccine** (**61**):

"The first notice to the general public about SV40 came in July 25, 1961. Associated Press filed a story announcing the surprise cessation of Salk vaccine production by both Parke Davis and Merck. The story ran in the New York Times on page 26. Its placement in the newspaper and the fact that the Times did not assign any of the several science writers on its staff familiar with polio to cover the story suggests that DBS's (Division of Biologic Standards) effort to downplay SV40 had paid off. The article quoted directly from the DBS press release in several places; the Times subhead to the story said SV40 was 'believed harmless,' and the body of the story repeated the NIH reassurance that 'there was no evidence that small amounts [of SV40] when introduced through the vaccine produced illness in man.' The words 'cancer' and 'tumor' never appeared in the AP write-up.

The story behind the story was much more interesting. Merck had stopped shipping Purivax (its 'purified' version of the Salk vaccine) as soon as its own tests in May 1961 confirmed that the vaccine was contaminated with SV-40. Its unilateral withdrawal of vaccine from the market had not been well received by the DBS. If Merck recalled vaccine, then everyone else would have to. That would have resulted in public panic and would have run counter to the Technical Committee's May 18 directive that polio vaccination' continue to be pursued with vigor with the materials presently available.' In June, after the Girardi cancer results had come in, Hilleman (Merck's science director) had tried one more time to get all vaccine production halted. That suggestion, as we have seen, was rebuffed. Merck had already suspended production and was trying to figure out how to screen SV40 out of the vaccine when DBS tests on vaccine samples indicated that Parke-Davis supplies were also badly contaminated. Parke-Davis now also stopped vaccine manufacture. The truth was that by the time the Associated Press reported the 'news' in late July, both companies had not produced vaccine for several weeks. Parke Davis eventually resumed production, but Merck would soon decide that producing a polio vaccine that at times might be contaminated was not worth the risk. In vaccine circles, Purivax was now derisively being called 'Imprurivax,' and Ben Sweet was labeled the 'million dollar man' because that was the cost of the vaccine program that had just been killed by his discovery of SV40.

…But other than the reports in the Associated Press and the National Enquirer, there was no more news for the remainder of 1961 about SV40. Hull was in the midst of conducting his own experiments at Eli Lilly on SV40. He had found, just as Eddy and Girardi had, that the simian virus caused cancer in suckling hamsters, but his results were never published as a scientific paper. At Merck, Girardi and Sweet began a different set of SV40 experiments, but these were halted before completion. The pair had discovered that when SV40 was injected into tissue cultures of normal human cells it 'transformed' them into cancer-precursor cells. Hilleman decided, however, that this alarming development was not going to emanate from Merck. There was only so much self-inflicted damage ('hanging out dirty laundry' were Hilleman's words according to one of his subordinates) that the company could take about its SV40-contaminated polio vaccine. Instead, to Sweet's displeasure, Hilleman contacted John Enders at the Harvard Medical School and sent him some SV40 and encouraged Enders to undertake the same experiment.

Girardi had also started another experiment that was never to be completed. From throngs of monkeys that came through Merck, he had found nine non-rhesus pregnant females. After they had given birth, he injected six of their newborns with SV40, leaving three as controls. The significance of this experimental design was that monkeys are far closer to humans than hamsters. Whatever might happen to them after SV40 exposure would provide a strong signal of what the virus might do after it had been injected into people. Before Girardi could continue much farther with the live monkey experiment, word came down from higher up at Merck to quit the project.

The next big news about SV40 came in mid-April 1962. The American Association for Cancer Research, the organization that still publishes the influential scientific journal Cancer Research, was holding its annual meeting in Atlantic City, New Jersey. The association's annual weekend meetings were often the occasion for the announcement of important breaking news on the cancer front, and lay press interest in the conference was considerable. On Sunday, the last day of the scientific gathering, Girardi presented a summary of his Merck experiments hat had showed SV40 produced tumors in newborn hamsters. At the very end of his report, he announced that he and Sweet had also found SV40 transformed human cells in vitro (in tissue culture as opposed to in vivo, in a living organism). Earl Ubell, the president of the National Association of Science Writers at the time wrote up the Girardi presentation for the Chicago Sun Times:

'Polio Vaccine Virus Puzzles Scientists'

Atlantic city, N.J.--Those strange viruses found floating alive in both live and killed polio vaccines display increasingly disturbing peculiarities…

A year ago, it was reported for the first time that something in the monkey cell culture broth could cause cancer in hamsters. A few months ago, scientists at Merck & Co., identified that 'something' as SV40. Now, these same Merck researchers have found that SV40 will grow in human tissue kept alive in a test tube. They will make the cells in those tissues multiply at a greater rate.

Sunday, another report said SV40 can get into human tissue cells growing in test tubes and change the microscopic chromosomes, destroying one of the 46 (chromosomes)…

When Enders and Koprowski's studies on human cell transformation by SV40 were published in the spring and summer of 1962, it seemed as if everyone's darkest apprehensions about the polio vaccine contaminant had suddenly come to life. By the fall of 1962, as news of the most recent SV40 research spread, the anxiety that had been growing in scientific circles about the simian virus rearched its zenith. 'It was the worst thing in the world,' Hayflick recalls of the news. 'Please tell me: What else could we find worse in monkey kidney cells?' In Britain, Wellcome Laboratories decided to stop inactivated vaccine production and switch entirely to live polio vaccine production.

As in the United States, however, both the British and Canadian governments decided not to recall old stocks of Salk vaccine. Britain had a surplus of 6 million injections in 1961. In Sweden, the concern was about Sabin-type vaccine. There were plans to give monkey gamma globulin to four thousand children who had received oral vaccine in the belief that it would contain antibodies against any simian viruses, including SV40, which might have contaminated the oral doses. In the Soviet Union, site of the most extensive use of Sabin's vaccine, tests were conducted to determine the spread of SV40. Many of the technicians and scientists involved in Chumakov's massive vaccination trial proved to have been infected by the virus, and the Soviets were now fearful of SV40's possible long-term effects. Among American research and health officials, a joke with gallows-type humor began to make the rounds: The Soviets would lose the 1964 Olympics because their athletes would all have tumors thanks to SV40.

But in Bethesda, even this jibe at the cold war enemy was of little comfort. The DBS's own research was suggesting that SV40 could no longer be downplayed as a health threat to the American public. The division, to its credit, had become quite busy researching SV40 during the past year. Gerber's study confirming that the virus was not killed in Salk's vaccine had been published in the spring of 1962, and there were a dozen or so other SV40 research projects now under way. None seemed to offer reassurances that the virus was as inconsequential as Murray and Shannon had believed (or hoped) in 1961.

A young DBS researcher named Alan Rabson-future deputy director of the National Cancer Institute-found that SV40 caused ependymomas, a rare brain cancer, in a species of rats. This was the first proof that the virus could cause cancer in a mammalian species other than hamsters. Another DBS experiment led by Rabson determined that when human thyroid tissue was infected with SV40, it became cancerous. When the infected human thyroid cells were, in turn, transplanted into the brains of hamsters, the hamsters developed ependymomas. Ependymomas were also induced in hamsters by Gerber, who inoculated the animals directly with SV40. In a third Rabson experiment, SV40 was found to produce kidney cancer in hamsters. "

4g. Baruch Blumberg, D. Carlton Gadjucek, and development of molecular (recombinant vaccines):
Currently, “hepatitis B,” (and “hepatitis C” but less efficiently) is supposedly transmitted like "HIV." Also, like "HIV's" touted ability to cause 6 cancers, "hepatitis B" is thought capable of causing a type of liver cancer known as hepatocellular carcinoma, according to the CDC, the WHO, and other Public health agencies. It is also supposed to affect the same "risk groups" as "HIV." It was also first thought to be the best surrogate marker of "HIV" infection (Martin Deleney, Project Inform, Personal communication) in some of the first cohorts of U.S. and Scottish AIDS patients:

"Hepatitis B virus is found in 90% of drug addicts positive for antibody to AIDS virus" (**64**).

For his discovery of the Au blood antigen (HbsAg) in the blood of a black Australian aboriginal, Dr. Baruch Blumberg was awarded the Nobel Prize that he shared with NIH’s former Neurobiology Program director, D. Carlton Gajducek-the discoverer of the so-called “slow virus” prion diseases. The doctors were given The Nobel Prize in Physiology or Medicine in 1976 “for their discoveries concerning new mechanisms for the origin and dissemination of infectious diseases,” because the infectious agents and mechanisms of disease causation were believed not to conform to the standards of accepted pathogen isolation, the idea of distinctive genetic (nucleic acid) identity, the timing of infection to demonstrable cell pathology or morbidity, or to the classic proofs of pathogenicity worked out by Koch more than 100 years ago.

In addition, D. Carlton Gajducek believed that nucleic acids did not constitute the information molecule of the infectious agent he sought. Although his work was interrupted when he was arrested for child molestation, and he had to serve 1 year after he pleaded guilty to multiple counts of child sexual abuse, he championed the idea that "infectious proteins" were at the basis of slow, debilitating neurodegenerative disorders. These disorders, he believed, are characterized by extremely long latency periods, and destruction of the brain years or decades after infection. Kuru, CJD, scrapie, and ”Mad cow disease,” are all examples of syndromes he thought to be infectiously transmitted as proteinaceous entities now called prions. Although these concepts of slow viruses of Gajducek, and pathogens devoid of nucleic acids were vigorously challenged and rejected by many denialists in the scientific establishment during the 1980's who didn't believe that proteins could cause epidemics, because the idea ignored the established biochemical chain of events worked out for all other infectious agents, and because these syndromes appeared to be both infectious and run in families, Stanley Pruisner believed Gajducek's hypotheses to be plausible, and found that the hypothesized disease-causing PRP protein was present in both diseased and healthy hamsters (for which another Nobel Prize was awarded).

Similarly, Blumberg first proposed that "family studies" of carriers (of HbsAg) "were consistent with a genetic hypothesis of inherited polymorphism " (**65**), and an infectious agent.

How inherited traits could be infectious, or an infectious trait be inherited and run in families, stimulated a lot of controversy and dissent during the 1970's.

In 1978, experimental "hepatitis B" vaccine trials were conducted by the CDC, in New York, Los Angeles and San Francisco, and the ads for research subjects specifically asked for promiscuous homosexual men, while there is also evidence that the first "hepatitis B" vaccines were also tested on Blacks in Central Africa, and mentally retarded children. As recounted by Leonard G. Horowitz (**66**):

"Between 1974 and early 1975, 200,000 human doses of HB vaccine, representing four sub-types or strains of that virus, were administered to gay men in NYC, Blacks in Central Africa, and mentally retarded children from the Willowbrook State School on Staten Island in New York. That vaccine was prepared by initially growing the HB virus in contaminated chimpanzees and Rhesus monkeys shipped from Africa to New York by Litton Bionetics."

"Dr. Maurice Hilleman, considered the worlds leading vaccine developer, admitted during a 1986 interview (that never aired, the tape of which I recovered from the audio archives of the National Library of Medicine), that he imported the AIDS-virus into North America in contaminated monkeys destined for vaccine research and development at the Merck Pharmaceutical Company. He described how he brought the non-human primates into New York from Africa and got them off the planes. Recovered contracts show that Litton Bionetics monkey colonies, as the NCI monograph depicts, were in Southeast Uganda, and in Northwest Uganda. Litton affiliated there, at that time, with the International Agency for Research on Cancer (IARC) that conducted numerous cancer virus and vaccine studies on native populations."

"The early HB vaccines were prepared in these contaminated chimpanzees. The viruses were grown in the chimps, and then extracted along with a variety of simian virus contaminants (including SV40, SIVs, and SFRs) during the vaccine manufacturing process. The viruses were then injected into the Willowbrook children, gay men, and Black Africans. Of course, many of these people died during this part of the investigation. The survivors, who had developed (HB) antibodies, then contributed their blood. The final vaccine was prepared from this blood by separating the whole cells from the serum. It was from this (pooled) serum that four different sub-types of the 1974-75 HB vaccine were prepared and administered. The 200,000 doses were reportedly tested on these same populations..."

These types of experiences and results urged scientists to try and develop "molecular vaccines" that did not use animals such as chimps or monkey kidneys. According to Blumberg, the early investigators in the field (S. Krugman, S. Sherlock, F. Deinhardt, M. Hilleman, and many others) had by the mid-1960s defined at least two forms of the disease, inferred its viral etiology, and described in general terms the epidemiology and clinical course. However, none of the viruses had been identified. In this context, Blumberg described his collaborative work with Bayer and Werner in their Philadelphia laboratory, who identified particles with the "appearance" of a virus in the serum of individuals with the HbsAg antigen (ref. **65** PNAS, page 7123, paragraph 3-4 at the bottom of the first column) were subsequently shown to "not contain any nucleic acid" or even "core proteins," and were "neither infectious or pathogenic."

If you read Blumberg's writings, it is clear that he thought "hepatitis B" was associated with susceptibility to leukemia, and that this susceptibility ran in families as opposed to being infectious (**65**):

"i) Individuals with Au have an increased susceptibility to leukemia and this susceptibility is inherited;"

"ii) Leukemia causes Au (HbsAg);"

"iii) Au is related to "the virus" that has been postulated to be the cause of leukemia."

Blumberg also thought "children with Down syndrome have a rate of HBsAg of approximately 30% compared to other patients housed in mental institutions whose rate of HbsAg was approximately 5%." However, it makes little sense to assert that persons who suffer from Down Syndrome are more

promiscuous than other persons who are vaccine subjects in mental facilities, or that they share needles more often, or razor blades. It is also unlikely that their mothers are disproportionally infected by “hepatitis B” either. Therefore, it is “hepatitis B” denialism to claim that Down Syndrome individuals have a 30% rate of infection compared to others housed in institutions who are experimental vaccine subjects, as suggested by Dr. Blumberg. Thus, this is nothing but stigmatization against “hepatitis B” antigen expressers who happen to be mentally and physically “different,” due to a phenomenon known as chromosomal non-disjunction. It is possible that this denialism arose, perhaps in part, during the earlier failed hepatitis vaccine effort during the 1950s –1972 in which the mentally disabled children at Willowbrook School were deliberately infected with "hepatitis B" in an attempt to find a vaccine, and where participation in the study was a condition for admission to institution.

As titles of papers about Hepatitis B published in journals as prestigious as *Science*, sometimes suggest (Guidotti et al., Viral clearance without destruction of infected cells during acute HBV infection), as to why neither humans or chimps show liver pathogenicity, cellular damage, or develop anything resembling hepatitis in modern studies when they are experimentally infected with “hepatitis B,” one might cogently wonder why "hepatitis B" and "hepatitis C," like "HIV," are not considered primarily acquired autoimmune diseases, rather than infectious viral diseases, since cellular pathology in most cases is not present ("Auto Immune Deficiency Syndromes rather than Acquired Immune Deficiency Syndromes). It also should be added that the antigenicity (the presence of the “hepatitis B” antibodies among the vaccinated) does not persist beyond about 5 years (**68**), yet hepatitis infections of all kinds confer immunity and antigenicity for life in those who are unvaccinated and experience a full-blown hepatitis B syndrome that spontaneously resolves in almost all cases (**69**). All of this hepatitis B denialism has confused the innocent public and indeed some of the scientific community to the extent that entire countries are refusing the “hepatitis B” vaccine for some of their children.

The effects of hepatitis B denialism can be seen during the French mandatory hepatitis B program, which prompted France to discontinue its “hepatitis B” program several years ago, and a class action lawsuit compensated some 15, 000 families that had been devastated from hepatitis B vaccine injury. Therefore, the entire country of France has been harmed by “hepatitis B” vaccine denialist thinking.

In the U.S., it is known that the hepatitis B syndrome, when it does occur in non-vaccinated individuals, spontaneously resolves in almost 100% of those who become seropositive for the “hepatitis B antigens”, while 100 victims of the hepatitis B vaccine, experience serious, life-threatening, and life-long adverse effects for every 1 person the vaccine is claimed to protect (according to the Merck package inserts, the figure is 10.4% experience adverse reactions, with about 1% requiring emergency room admission).

Even the CDC claim that the "hepatitis B" vaccine is the vaccine that tops their agencies adverse events list of dangerous side effects, which include:

“Autism, Stevens-Jonhson Syndrome, arthritis (both transient and permanent), Gullian-Barre Syndrome, myelitis including transverse myelitis, seizure, febrile seizure, peripheral neuropathy including Bell's palsy, diabetes mellitus, pancreatitis, encephalitis, multiple sclerosis, thrombocytopenia, systemic lupus erythematosus, lupus-like syndrome, vasculitis, optic neuritis, radiculopathy, Lesser vaccine effects include vomiting, abdominal pains, vertigo, dizziness, pruritis, angioedema, uticaria, lymphadenopathy, insomnia, dysuria, hypotension, herpes zoster, migraine, severe muscle pain and weakness, hypesthesia, alopecia, petechiae, increased sedimentation rate,

tinnitus, conjunctivitis, visual disturbances, syncope, tachycardia, keratitis, irritability" (see the Merck and GallaxoSmithKline package inserts as well as the Hepatitis B adverse events on Medline and the Adverse Events Reporting System).

It is also clear denialism to assume that Black men who are Australian aborigines, or Micronesians, Vietnamese, Taiwanese, Native Americans, and patients with Down Syndrome or leukemia all share risks or risk behaviors (such as sex or shaving) to a greater extent than do caucasians. This is a highly dangerous stigmatizing of various groups. Some hepatitis B denialists have gone so far as to suggest the HPsAg antigen represent a simple and relatively rare (in the West-not so rare in Asia or Australia or Africa) blood polymorphism because the vast majority of people who test positive for HbsAg or HbeAg never become sick, develop hepatitis, or cancer of any kind. This all should be considered hepatitis B denialism, and it is clear that it served as a precedent for much of the AIDS denialism that followed during the 1980's and 1990's.

Despite Gajducek's and Blumberg's attempts to convince that infectious pathogens don't necessarily require nucleic acid templates (genes), from the perpective of AIDS denialism and AIDS denialists, it could be argued that their greatest achievement of all was to essentially re-invent the rules of pathogenicity. In so doing, both the "hepatitis B" legacy and the prion legacy opened the door for cancer researchers like Gallo to continue to postulate that "slow viruses" can cause slow diseases like cancer and AIDS, years after infection with "a cancer virus." For example, Gallo postulated that the "HIV's" cancer virus relatives, HTLV-I, and HTLV-II, which supposedly according to Gallo, were the ancestors of "HIV," cause leukemias (more B instead of less B) in places such as Japan, where atomic bombs have not been used more than twice, and in Africa where most diseases occur because blacks have "too much sex," and shoot too much drugs in their gym locker rooms-classic reasons for a region exhibiting a high endemic incidence of HBsAg, as well as of course, "HIV."

4h. "HIV" vaccine denialism advanced by Donald Francis, David Baltimore, Richard D. Klausner, Julie Louise Gerberding, Robert Gallo, Barre-Sinoussi and others have compromised the "HIV" Vaccine Program:
It was announced in Science that former head of the CDC, Donald Francis, and his company VAXGEN failed in their attempts to produce a new effective AIDSVAX, or "HIV" vaccine. How does Donald Francis know it was a failure! Has he followed every recipient of the vaccine? If not, his pessimism is a form of dangerous and extreme AIDS denialism, to claim that the vaccine was a failure!

In some "HIV" vaccine trials, in addition, it has been claimed that: "HIV" vaccines may appear to help black women more frequently than white women, but the data so far obtained are not statistically significant.

Therefore, isn't it is irresponsible AIDS denialism for Dr. Francis and the other investigators to ignore their "gut?" If those who monitor "HIV" vaccine trials feel that the vaccine helps some black women regardless of what the statistics obtained in the study concluded, then why on earth should Dr. Francis deny and the other investigators deny that AIDSVAX and other "HIV" vaccines did no good, just because there was no "statistical significance?" If this idea that the AIDVAX "HIV" vaccine trial failed is not challenged (a trial that was a true bargain at 120 million), it could deny hope to millions, merely because the numbers are not quite where they should be yet. Such pessimism will also serve to erode confidence of the public in the National Vaccine Program. In this regard, I suppose it is of no surprise to "HIV=AIDS" believers, therefore, to find none other than Gallo himself, in the pages of

Science, after the so-called failure of the 120 million dollar AIDSVAX program was announced, suggesting that:

*"A sound Rationale (is) needed for Phase III HIV vaccine trials (***70***)."*

If a virus and its associated antigens have been isolated in pure form (A), and when it or some of its components are injected in an inactive form into an antibody-generating immune competent host, an antibody against the virus or components should be produced against the virus or its components (and impurities such as cell membranes). This is the basis for, and reason why, the monoclonal (or polyclonal) antibody industry exists. This process is at the basis of vaccination and the immune response. If "HIV" (A) or some of its components (GP120) is introduced into an immunocompetent host, that subject's immune system (B) will produce antibodies that will neutralize A, so that future exposure will prevent intact virus particles, antigens or components of (A) from destroying or replicating in the immune system (B). Gallo and his colleagues throw all logic and the history of immunology to the winds when he said in this *Science* article, "A sound rationale is needed for Phase III trials." Are not the principles of antigen and antibody interactions at work for "HIV" as they are in rest of the antigenic universe? This is a more subtle form of AIDS denialism. The logical flaw? Gallo's statement arises from the AIDS denialist idea that the isolated "HIV" antigens are not "immunogenic enough." Try telling that to the millions of "HIV-positives" walking around the planet, that "HIV" isn't immunogenic!

Also, in this *Science* article, the AIDSVAX trials were criticized by Gallo and his co-authors because they were from the beginning, a colossal waste of time, money, but most of all, as Gallo warns in the last sentence of the letter to *Science*, the trials are potentially damaging for the credibility (and future funding) of the HIV=AIDS paradigm:

*"The decision about whether or not to proceed with mounting a phase III HIV-1 vaccine trial needs to take into account the likelihood of success and the consequences of failure, the value of what can realistically be learned, the human and financial costs involved. As a whole****, the scientific community must do a better job of bringing truly promising vaccine candidates to this stage of development and beyond****."* (**70**).

This negative attitude of Gallo's, certainly missed by the mainstream press who should have exposed Gallo's statement as nothing more than an extreme form of AIDS denialism, is a form of denialism that is consistent with the conclusions that AIDS denialists at the AIDS Vaccine Program, SAIC, National Cancer Institute-Frederick Cancer Research and Development Center, Maryland advanced in a published paper, which stated that PHA (phytohemagglutinin) and IL2 (interleukin-2) stimulated healthy {non-infected} cells produce "viral like particles" and HIV 'specific' proteins only when stimulated with PHA and IL-2," and therefore a specific antigen would be impossible to isolate in pure form, in order to evoke immunity, as discussed earlier. Maybe there is a conspiracy amongst these different groups of AIDS denialists?

Fortunately, following the 120 million dollar failure of AIDSVAX, the government now has given VaxGen (the company run by Donald Frances to make the "HIV" vaccine) a little more of our tax money to help them experiment with an anthrax vaccine for our young soldiers:

"2005 Newsweek reports that VaxGen, a little-known California biotechnology company, will start its first delivery of its anthrax vaccine to the government six months later than originally slated. The

company was awarded an $877.5 million contract to produce and manufacture the vaccine, which was developed by the U.S. Army Medical Research Institute of Infectious Diseases (USAMRIID),"

Despite AIDS denialism becoming entrenched in our National Vaccine Program and by Gallo and his colleagues in the pages of *Science* due to a lack of vigilance on the part of "HIV=AIDS" supportive editors (who should be reprimanded for letting this slip by), other AIDS denialists have also betrayed their AIDS denialism by advocating that we proceed with worthless "HIV" vaccines that have shown no benefits or which have not been adequately tested for safety, and which have generated no antigenicity in the vaccinated. Despite these miserable results, these denialists argue that untested "HIV" vaccines should be aggressively promoted and foisted on the general public (not only on black women). For example, in the journal *Science*, Volume 300, Number 5628, Issue of 27 Jun 2003, pp. 2036-2039, we hear an AIDS-denialist chorus, including, Richard D. Klausner, Anthony S. Fauci, Lawrence Corey, Gary J. Nabel, Helene Gayle, Seth Berkley, Barton F. Haynes, David Baltimore, Chris Collins, R. Gordon Douglas, Jose Esparza, Donald P. Francis, N. K. Ganguly, Julie Louise Gerberding, Margaret I. Johnston, Michel D. Kazatchkine, Andrew J. McMichael, Malegapuru W. Makgoba, Giuseppe Pantaleo, Peter Piot, Yiming Shao, Edmund Tramont, Harold Varmus, Judith N. Wasserheit, singing loudly and vociferously about global vaccine campaigns and strategies for controlling "HIV" and "AIDS." This is irresponsible at best and criminal at its worst. It also may even more strongly suggest that a co- conspiracy of AIDS denialism may exist, like terrorist cells, in which multiple investigators have teamed up to undermine the simple logic of A leads to B leads to C. Perhaps this is a job for Homeland Security-to root out these medical terrorists! Or at least serve as a reason to form a "HIV" Truth Commission for HIV=AIDS denialsim and AIDS denialists, as Dr. Wainberg suggested.

Even Barre-Sinoussi (one of Montagnier's original group) has "come out of the closet," so to speak, with her AIDS denialism. At the Toronto International AIDS conference, she said at the conference (**71**):

"It is not clear if therapeutic vaccines might be useful, since 15 trials to date have not demonstrated definitive evidence of improved outcomes."

This is clear AIDS denialism on the part of Barre-Sinoussi, because, sometimes it takes more than 15 times to isolate just the right antigen from a pathogen to make it evoke an antibody, not to mention, induce immunity, or prevent disease. And sometimes, it takes less than 15 times, as the experience of Pasteur, his 2 assistants, and his anthrax vaccine demonstrated. For example, on June 2, 1881, Pasteur was challenged to provide a theatrical anthrax vaccine demonstration before the Agricultural Society of Melun, at the farm of Pouilly-le-Fort. On the first try, his demonstrated showed that a vaccine could work if prepared properly, and if the experiment to show that it was prepared properly it was designed correctly, by containing what are called controls in science. Europe's most famous horse doctors, human doctors, animal breeders, senators, reporters, farmers, and scientists anxiously waited, and watched, as 24 out of 24 anthrax-inoculated sheep grazed happily next to a row of 22 out of 24 dead ones, because the 22/24 dead ones weren't vaccinated with Pasteur's anthrax vaccine. Perhaps even more interesting in the context of establishing immunity, is the story regarding the length of time and vaccine regimen needed to establish full immunity when a vaccine works.

But how can we get everybody to take their shots? Perhaps the best strategies to use are those employed during other recent vaccine campaigns. For instance, if more physicians (especially pediatricians), and pharmaceutical company workers, and vaccine scientists were to inject themselves and their loved ones on T.V., so that everybody can watch (offer their own children as

examples of the vaccine's safety in pre-scheduled demonstrations), then wouldn't it stand to reason that the medically ignorant would also line their children up in the vaccination line also to get jabbed? A good idea, perhaps, but the phenomenon of physician non-compliance to vaccination has been known since the early 1980's (From Thomas Levy, MD, FACC):

"Even among the physicians who are the biggest purveyors and promoters of vaccination, it would appear that when the needle is turned around, the inoculation mania subsides. In a study published in the Journal of the American Medical Association, 90% of obstetricians and about 70% of pediatricians refused to take the rubella vaccine. The possibility of "unforeseen vaccine reactions" seemed to have their concern ("Rubella Vaccine and Susceptible Hospital Employees: Poor Physician Participation," Journal of the American Medical Association, (February 20, 1981). Apparently, what's good for the goose is not always what's good for the gander. If these vaccines were truly all they were purported to be, these good doctors should have been pushing each other aside to be first in line to get stuck."

Other than having doctors vaccinate their children on camera on the 6:00 O'clock news, the Bush Administration may have a plan in place to insure that everybody gets their shots. For example, Bill Frist under the Bush Administration has recently taken steps to insure that medical disasters do not impede the enormous progress which the vaccinologists are making in protecting the public with "HIV" vaccines and other vaccines that may require too much time to demonstrate their efficacy and safety, especially with all of these terrorists running around stealing our anthrax from Dugway Proving Ground and putting it in Tom Brokaw's and Senator Daschl's mail before the Homeland Security Act was voted on, and perhaps from other maximum security installations that made aerosol that delivered the spores (In a way, it is a good thing that now Don Francis's company is supported through the military, by taxpayer money to make a vaccine for anthrax following the divestment following his unfortunate announcement of the failure of AIDSVAX). For example, a "Biodefense and Pandemic and Vaccine and Drug Development Act of 2005" was passed this year in order to alleviate the industrial-medical establishment from impediments such as claims for vaccine or drug damage. As a new directive, the bill amends the Public Health Service Act to enhance biodefense and pandemic preparedness activities, and for other purposes (**72**). The bill releases makers and health providers from the following impediments:

"A manufacturer, distributor, or administrator of a security countermeasure, or a qualifed pandemic and epidemic product, described subsection [b,1,A] or a health care provider shall be immune from suit or liability caused by or arising out of: the design, development, clinical testing and investigation,manufacture, labeling, distribution, sale, purchase, donation, dispensing, prescribing, administration, or use of a security countermeasure, or a qualified pandemic and epidemic product [....]"

"[I]n general, no cause of action shall exist against a person [company] described in subsection a for claims for loss of property, personal injury, or death arising out , reasonably relating to, or resulting from: the design, development, clinical testing and investigation, manufacture, labeling, distribution, sale, purchase, donation, dispensing, prescribing, administration, or use ...in defense against, or in response to, or recovery from an actual or potential public health emergency.."

What is being described here is a carte blanche freedom at last to use untested vaccines, pharma products, drugs, or "security countermeasures" carte blanche, because of this Burr-Frist-Bush-Eli Lilly-Big pharma bill. And there is nothing those AIDS denialists can do about it because it is in the interests of National Security!

Some extreme AIDS denialists who call themselves “the non-existentialists” (like others in Minnesota and elsewhere, who don’t believe “HIV” is an exogenous retrovirus-see section **1g**) have even suggested that the lack of immunogenicity with “HIV” owes to the fact that “HIV” doesn’t exist because it has not been isolated to the same standards that Koch proved that tuberculosis existed, and caused disease. This is pure denialism because it is clear that Koch did isolate tuberculosis bacillus:

"In 1890, as Professor of Hygiene in Berlin, Koch introduced a remedy for tuberculosis made from the bacillus itself. Clearly borrowed from homeopathy, Tuberculin had to be the employed in homeopathic doses, which Koch failed to do, causing thousands of deaths and virtually ending the career of the Father of German Bacteriology. (**58**).

But consider for a moment how AZT and other mildly immunotoxic nucleoside analogs induce T-cells to transiently return to normal levels in some patients (B). AIDS denialists say that these drugs (D) kill the immune system in everyone, because their molecular composition was designed to kill cancer cells that are dividing, and T-lymphocytes are dividing cells in Humans. However, this is clearly not the case, judging from reports of patients on the drugs who have “felt better,” and who demonstrate a “rebound” of their T-cell numbers, like Judge Cameron as he describes in his book, Witness to AIDS, to be discussed later. In this context, the hematological toxicity that is often touted by AIDS denialist pharmaceutical companies for being a reason not to give high dose AZT, or to stop AZT treatment. The reason: AZT at low doses may stimulate the immune system by means of the “law of similars.” If you want the immune system to increase for awhile, give it something that has been shown to be decidedly immunotoxic. This would also explain false negative antibody levels in AIDS patients on anti-retrovirals, as stated on Calypte’s announcement quoted earlier, because the drugs are eventually immunotoxic and kill antibody producing cells as well (B cells).

Also, it should be mentioned, at least as an aside, that toxic adjuvants have been used to boost the non-specific immune response in “HIV” vaccines and many others (adjuvants are compounds such as squalene known as MF59,). Adjuvants are supposed to boost the non-specific immune response stimulated by a specific pathogen-associated antigen, because the modern molecular design of the vaccines don't work as well as some of Pasteur's did, against rabies, cholera, or anthrax more than 120 years ago). For example (**73**):

A Phase I Clinical Trial to Evaluate: Part A. The Safety of MTP-PE/MF59 Adjuvant Emulsion. Part B. The Safety and Immunogenicity of Env 2-3, a Yeast Derived *Recombinant Envelope Protein of Human Immunodeficiency Virus-1, in Combination With MTP-PE/MF59.*

To evaluate the safety of a fixed antigen dose with an increasing dose of adjuvant (MTP-PE/MF59, a substance to enhance the immune response to vaccine) in volunteers. To evaluate local and systemic reactions (Part A). To determine the safety and immunogenicity of Env 2-3 in combination with MTP-PE/MF59 in volunteers (Part B). The vaccine Env 2-3 is created from one of the viral proteins that make up HIV called envelope glycoprotein gp120. A problem with many immunogens, including candidate HIV vaccines, is that they may evoke relatively weak immune responses, particularly in humans and in nonhuman primates. Thus, there is considerable interest in the development of "adjuvants" (substances that augment immune responses to vaccines). MTP-PE/MF59 is an adjuvant that appears to be particularly promising, and is selected for the studies with this HIV vaccine candidate.

However, some “HIV’ vaccine denialists claim there is evidence that adjuvants like squalene (MF-59), when they have been added to certain lots of anthrax (and perhaps "HIV") vaccines given to soldiers on threat of court martial if they don't roll up their shirt on command (in contrast to Walter Reed's voluntary experiment with yellow fever), have induced autoimmune syndromes in almost 100% of every sick Gulf-War I veteran tested, and have evoked antibodies to squalene in their blood (**76**). This type of promising vaccine experimentation on our young soldiers is particularly disturbing in light of the fact that squalene and other adjuvants have been used by scientists for many years to induce rodents to develop arthritis, macrophagic myofasciitis, mutliple-sclerosis (demyelinating syndromes), and lupus (**77, 78**).

Finally, the question remains, why aren’t orphan children and wards of the state and prisoners being subjected to more experimentation when it is a proven fact that they are perhaps the subjects most likely to be made compliant with vaccines or with drugs, as the experience of New York's Columbia’s Incarnation Children’s Center in New York showed, when g-tubes were placed into the orphans stomachs when they were not compliant (**79**)?

4i. HPV denialism regarding the ability to ward off cancer decades from now with vaccines that have only been around for a few years:
Cervical cancer has been considered a new AIDS-defining illness since 1993, at which time it was added to the list of AIDS indicator diseases, causing the rates of "HIV/AIDS-related cervical cancer" to increase notably over night. Even though some 65,000 Americans are diagnosed each year with cervical cancers, and only a small fraction of these (about .0015%) are among women that test "HIV" positive, doctors naturally assumed that "HIV-associated antibodies" + cervical abnormalities = AIDS. Cancer of the mouth was added as announced by "The New Scientist", although no comprehensive studies can be found documenting this on MEDLINE." (see Wed Feb 25, 2004. LONDON Reuters):

"Although the risk is small and it is more likely to result from heavy drinking and smoking, scientists have suggested that oral sex can cause mouth cancer (Reuters, Feb. 25, 2004).

In the case of the new HPV vaccine by Merck, and although documents prepared by the FDA suggest some women with persistent HPV infections could be at higher risk of cervical cancer after taking the vaccine, "perhaps the best strategy to make all children get “HIV” tested and take “HIV” vaccines can be borrowed from the recent marketing strategy of Merck on young girls’ parents, where the wonders of the new HPV vaccine are claimed (**80**):

"Gardasil," (cleverly named I think), *is a new vaccine against human papillomavirus, or "HPV," that was* ***100 percent effective in preventing precancerous cervical disease, but only when given to women and girls who had never engaged in sex at the time of the shots."***

Yet I suppose there are always denialists associated with any disease, even when the HPV data look this promising and have been claimed by Merck to reduce cervical cancer in women who will be 55 in the 2040's ***if given to girls who haven't yet had sex*** (**81**). For instance HPV denialists such as Dr. Schiffman have tried to slow down this amazing cure for future cancers by making bogus claims in a journal run by The College of American Pathologists:

"Dr. Schiffman heads the HPV Troup in the Division of Cancer, Epidemiology, and Genetics at NCI and is a tenured senior investigator. In mid March, Dr. Mark Schiffman, MD, MPH, called CAP TODAY's editor to voice a troubling concern: that laboratories are failing to clinically validate their HPV tests."

"What surprises me is that this {the certainty with which these tests for HPV and cervical cancer} could in any way be controversial, he says. "The issue is not so much controversial, of course, as it is loaded-with money and competitive claims, scientific complexity, and grave medical concerns."

Part 5a. AIDS denialism among ARV drug makers and the law of contraries:
As mentioned above, some AIDS denialists have even advocated living “a healthy lifestyle,” and have gone so far as to state that all "anti-retroviral" drugs come with clinical trial data and post-marketing experience claims on their package inserts that are at a minimum cause for alarm. Some of them even deny the overwhelming, absolute, completely in line across the board, proven with 100,000 published papers, the scientific consensus that A can be prevented by D (drug) from leading to B, and thereby C is circumvented. Why? Because these denialists claim the drugs themselves cause AIDS-defining symptoms! Consider this extreme form of denialism advanced by this denialist pharmaceutical company who will remain nameless, and whose package insert for AZT says:

"WARNING: RETROVIR (ZIDOVUDINE, AZT) MAY BE ASSOCIATED WITH HEMATOLOGIC TOXICITY INCLUDING GRANULOCYTOPENIA AND SEVERE ANEMIA PARTICULARLY IN PATIENTS WITH ADVANCED HIV DISEASE."

"PROLONGED USE OF RETROVIR HAS BEEN ASSOCIATED WITH SYMPTOMATIC MYOPATHY SIMILAR TO THAT PRODUCED BY HUMAN IMMUNODEFICIENCY VIRUS. RARE OCCURRENCES OF LACTIC ACIDOSIS IN THE ABSENCE OF HYPOXEMIA, AND SEVERE HEPATOMEGALY WITH STEATOSIS HAVE BEEN REPORTED WITH THE USE OF ANTIRETROVIRAL NUCLEOSIDE ANALOGUES, INCLUDING RETROVIR AND ZALCITABINE, AND ARE POTENTIALLY FATAL."

Other side effects of AZT that have been listed on the denialist AZT package inserts also include:

"Persistent headaches lasting longer than 1 month, anemia, dementia, diarrhea, muscle wasting, candidiasis, non-specific oral lesions, severe fatigue, enlarged liver and liver failure, heart failure, diabetes, unmasking of opportunistic infections including CMV retinitis, spontaneous bleeding in hemophiliacs, lymphoma, severe skin rashes, Stevens-Johnson syndrome, and other toxic reactions, back pain, body odor, chest pain, chills, edema of the lip, fever, flu syndrome, hyperalgesia, syncope, vasodilation, bleeding gums, constipation, dysphagia, edema of the tongue, eructation, flatulence, mouth ulcer, rectal hemorrhage, lymphadenopathy, arthralgia, muscle spasm, tremor, twitch, anxiety, confusion, depression, dizziness, emotional lability, loss of mental acuity, nervousness, paresthesia, somnolence, cough, dyspnea, epistaxis, hoarseness, pharyngitis, rhinitis, sinusitis, acne, changes in skin and nail pigmentation, pruritus, rash, sweat, urticaria, amblyopia, hearing loss, photophobia, taste perversion, dysuria, polyuria, urinary frequency, urinary hesitancy."

There also have been numerous mutagenesis studies conducted by AIDS denialist pharmaceutical companies regarding AZT and drugs with similar mechanisms of action to that proposed for AZT. For example, among infants of mothers given AZT "to prevent the vertical transmission of "HIV"", the peer-reviewed literature has reported physical deformities result including:

"misshapen heads, triangular faces, misplaced ears, extra fingers, albinism, cavities in the chest, webbed fingers, spontaneous abortion, and "congenital" birth defects of the heart, chromosomal damage and various cancers. "

Other denialist pharmaceutical company warnings on the package insert of AZT carcinogenesis, mutagenesis, and impairment of fertility section include:

"Zidovudine was administered orally at three dosage levels to separate groups of mice and rats (60 females and 60 males in each group). Initial single daily doses were 30, 60, and 120 mg/kg/day in mice and 80, 220, and 600 mg/kg/day in rats. The doses in mice were reduced to 20, 30, and 40 mg/kg/day after day 90 because of treatment-related anemia, whereas in rats only the high dose was reduced to 450 mg/kg/day on day 91 and then to 300 mg/kg/day on day 279."

"In mice, seven late-appearing (after 19 months) vaginal neoplasms (5 nonmetastasizing squamous cell carcinomas, one squamous cell papilloma, and one squamous polyp) occurred in animals given the highest dose. One late-appearing squamous cell papilloma occurred in the vagina of a middle dose animal. No vaginal tumors were found at the lowest dose."

"It is not known how predictive the results of rodent carcinogenicity studies may be for humans. At doses that produced tumors in mice and rats, the estimated drug exposure (as measured by AUC) was approximately 3 times (mouse) and 24 times (rat) the estimated human exposure at the recommended therapeutic dose of 100 mg every 4 hours."

" In the presence of metabolic activation, the drug was weakly mutagenic at concentrations of 1000 µg/ml and higher. In an in vitro mammalian cell transformation assay, zidovudine (AZT) was positive at concentrations of 0.5 µg/ml and higher. In an in vitro cytogenetic study performed in cultured human lymphocytes, zidovudine induced dose-related structural chromosomal abnormalities at concentrations of 3 µg/ml and higher."

"In two in vivo micronucleus studies (designed to measure chromosome breakage or mitotic spindle apparatus damage) in male mice, oral doses of zidovudine 100 to 1000 mg/kg/day administered once daily for approximately 4 weeks induced dose-related increases in micronucleated erythrocytes. Similar results were also seen after 4 or 7 days of dosing at 500 mg/kg/day in rats and mice."

Also, human chromosome breakage results are reported on the denialist AZT package inserts from human experimentation studies:

"In a study involving 11 AIDS patients, it was reported that the seven patients who were receiving Retrovir (1200 mg/day) as their only medication for 4 weeks to 7 months showed a chromosome breakage frequency of 8.29±2.65 breaks per 100 peripheral lymphocytes. This was significantly (P< 0.05) higher than the incidence of 0.5±0.29 breaks per 100 calls that was observed in the four AIDS patients who had not received Retrovir.

Some AIDS denialists have even ignorantly asserted that the DNA-chain terminator anti-virals can cause cancer! For instance, at the annual meeting of the American Association for the Advancement of Science, Dr. Vernon Walker, a research scientist at the Lovelace Respiratory Research Institute (Albuquerque, NM), presented data showing that AZT and 3TC given to pregnant women cause their

babies to have twice as many DNA mutations as infants not exposed in utero to the drugs (**83**), as suggested in the title of their paper suggests (DNA Mutations Seen in Babies of AIDS Moms):

"Walker reported that, among 68 babies not exposed to antiretroviral drugs in utero, the rate of DNA mutation (which occurs naturally in us all) was 1.3 per one million cells. Among 71 infants whose mothers took AZT, 3TC, or both during pregnancy, there were twice as many mutations: an average of 2.6 mutations per one million cells (**82**)."

"To measure potential genetic damage in another way, Walker looked at production of abnormal proteins (which are indicative of DNA damage) in exposed and unexposed infants. Among unexposed babies, about 3% had abnormal proteins produced by damaged DNA. Infants born to women who took one or both anti-HIV drugs, however, had a much higher incidence of damage: 9-14% showed evidence of mutated DNA (**82**).

"To strengthen his data even further, Walker could examine changes in the "junk genes" of the mothers and children, as is currently being done in studying radiation poisoning at the Semipalatinsk nuclear test site in Kazakhstan (the former Soviet Union), where residents were exposed to decades of radioactive fallout from testing of nuclear weapons" (**83**).

Pharmaceutical denialists don't only claim that the "life saving AIDS meds" cause mutations and cancer. The denialist K. Brinkman, et al. published in The Lancet claimed:

*"Mitochondrial toxicity induced by nucleoside-analogue reverse-transcriptase inhibitors is a key factor in the pathogenesis of antiretroviral-therapy-related lipodystrophy" (***84***):*

"nearly all side-effects that have been attributed to the use of NRTIs, such as polyneuropathy, myopathy, cardiomyopathy, pancreatitis, bone-marrow suppression, and lactic acidosis, greatly resemble the spectrum of clinical manifestations seen in inherited mitochrondrial diseases."

5b. AIDS denialism among ARV clinical trial investigators:
As recently as 2002, in *The Journal of Virology* (p. 5966-5973, Vol. 76, No. 12, June 2002), the AIDS denialists, Jérôme Estaquier et al. advanced the notion that protease inhibitors such as ***saquinavir or indinavir induced the death of healhy lymphocytes*** (**85**):

"…in treatment of peripheral blood mononuclear cells from healthy donors with a higher concentration (10 μM) of an HIV protease inhibitor, saquinavir or indinavir, induced both a loss in mitochondrial membrane potential (m) and cell death. Thus, protease inhibitors have the potential for both beneficial and detrimental effects on CD4+ T cells independent of their antiretroviral effects."

In this scenario, a drug (AZT) doesn't kill A, but kills B, which may lead to C. This is AIDS denialism.

It has been about 14 years since The Veterans Affairs Cooperative Study Group reported that, "AZT disproportionately harmed Blacks and Hispanics, and provided no benefit to the quelling of advancing immune suppression in Caucasians" (**86**). This is AIDS denialism, and it has racist overtones to boot. It also stands in sharp contrast to the AIDSVAX trial that claimed the vaccine helped Black women, but the results weren't statistically significant.

It has been about 12 years since the announcement of the Concorde study, the largest, longest, and best designed study of AZT monotherapy of its kind, reported in The Lancet that, "The results of Concorde do not encourage the early use of zidovudine in symptom-free HIV-infected adults. They also call into question the uncritical use of CD4 cell counts as a surrogate endpoint for assessment of benefit from long-term antiretroviral therapy" (**87**). Again these denialists are criticizing T cells as not being a good endpoint-denying the adage that A leads to B which leads to C. If T cells aren't the right cells to measure, then how is A causing C?

It has been about 7 years since it was published in the journal, AIDS, that children born to ZDV-treated mothers "are more likely to have a rapid course of HIV-1 infection compared with children born to untreated mothers, as disease progression and immunological deterioration are significantly more rapid and the risk of death is actually increased during the first 3 years of life" (**88**). In this scenario, fetuses develop C much more quickly, rather than less quickly, when D (AZT) is given to block A from developing B.

Moreover, these kinds of AIDS denialist statements (and there are many too many of them to list them all here) don't bode well for getting patients to be compliant-which is the reason "HIV=AIDS" believers continue to assert that all AIDS patients will eventually die, unless of course their virus mutates, and is no longer pathogenic. We can only hope that the trend continues, whereby people live longer with "the life saving AIDS cocktails." And it is not all black. New evidence suggests that people are living on average 24 years currently with AIDS, which is one year shorter than the epidemic began. For instance, in this article by Chicago Sun Reporter, Jonathan Bor (Published November 11, 2006), we find hopeful information claiming that patients are

"Living longer with HIV-Report finds patient can live average 24 years, pay $385,000."

The average patient diagnosed with HIV today can expect to live 24 years - more than triple the life span of those diagnosed with the AIDS-causing virus in the early 1990s, according to experts reporting today in a national medical journal.

But with HIV/AIDS patients living longer and using more sophisticated drug regimens, a lifetime of treatment can cost $385,000 in today's dollars, straining the federal government's ability to provide for those in need.

5c. Edmond Tramont is an AIDS denialist:

As a long time cancer researcher and cell biologist who has made various test kits and proposed new therapies for cancer, I can vouch for the fact that AIDS researchers typically do honest work. But not Dr, Edmond Tramont. For example, it was published that Dr. Tremont, who is the government's chief of AIDS research, and one of our nation's AIDS program directors, rewrote a safety report on a U.S.-funded drug study, to change its conclusions and delete negative information, and later, ordered the research resumed over the objections of his staff, in order to promote George W. Bush's $500 million dollar plan to distribute nevirapine to African women, even though its approval was withdrawn in the U.S. several years ago because of excessive toxicity. And it has only been a few months since the Institute of Medicine covered-up Tremont's changing toxicity data, according to Dr. Johnathan Fishbein, who blew the whistle, and was subsequently fired from his position as safety officer for the Nevaripine trials, that Tremont, his boss, fudged.

By Jon Solomon, Associated Press Writer
Health – AP

WASHINGTON - The government's chief of AIDS research rewrote a safety report on a U.S.-funded drug study to change its conclusions and delete negative information. Later, he ordered the research resumed over the objections of his staff, documents show.

Dr. Edmund Tramont, chief of the National Institutes of Health's AIDS Division, took responsibility for both decisions. He cited his four decades of medical experience and argued that Africans in the midst of an AIDS crisis deserved some leniency in meeting U.S. safety standards, according to interviews and documents obtained by The Associated Press.

Tramont's staff, including his top deputy, had urged more scrutiny of the Uganda research site to ensure it overcame record-keeping problems, violations of federal patient safety safeguards and other issues that forced a 15-month halt to the research into using nevirapine to prevent African babies from getting AIDS from their mothers.

AP reported Monday that NIH knew about the problems in early 2002 but did not tell the White House before President Bush (news - web sites) launched a plan that summer to spread nevirapine throughout Africa. Now, officials have new concerns the drug may cause long-term resistance in patients who received it, foreclosing future treatment options.

"I am not convinced that the site is indeed prepared to become active," Dr. Jonathan Fishbein, an expert NIH hired to improve the agency's research practices, wrote Tramont in July 2003.

Fishbein contended he should be given time to review Uganda's capabilities and safety monitoring before letting the site reopen, or NIH would risk being "toothless" in its new efforts to clean up sloppy research practices. He added that professional safety monitors hired by NIH had reservations about the site.

Tramont dismissed the safety monitors' concerns, saying he didn't believe they fully understood AIDS.

"I am convinced that this site is ready to resume given the limitations of doing research in any resource-poor, underdeveloped country," Tremont wrote July 8, 2003, in response to Fishbein.

"I want this restriction lifted ASAP because this site is now the best in Africa run by black Africans and everyone has worked so hard to get it right as evidence by the fact that their lab is now certified," he wrote.

NIH officials acknowledge Tramont rewrote the report and overruled his staff on the reopening, but said he did so because he was more experienced and had an "honest difference of opinion" with his safety experts. They noted he had no financial interest in nevirapine and that the troubled study began well before he joined NIH in 2001.

Those who raised objections "were part of a large team of which Dr. Tramont was the head, and it is important that the people involved in that team should express their opinion and there should be discussion," said Dr. H. Clifford Lane, the NIH's No. 2 infectious disease specialist and one of Tramont's bosses.

"But at the end of the day the final responsibility lies with the head of the team and it is his job to put that together the way he sees it," Lane said.

Lane said an internal NIH review concluded Tramont had not engaged in scientific misconduct. Separately, the National Academy of Sciences (news - web sites) continues to investigate whether the Uganda research was valid.

NIH believes it helped save hundreds of thousands of African babies by allowing nevirapine to be used in single doses to block the AIDS virus, Lane said. But he acknowledged the research was imperfect, and NIH now believes nevirapine should no longer be a first choice for newborn protection — if other options exist — because of the newly discovered problems about resistance.

Tramont wrote in 2003 e-mails that he reopened the clinics because he didn't want NIH "perceived as bureaucratic but rather thoughtful and reasonable" and that it was important to encourage Africans' fight against AIDS "especially when the president is about to visit them."

Bush visited the continent a few days after Tramont ordered the clinics reopened.

Tramont's actions, however, drew a blunt reply from his top deputy.

"I think we are cutting off our noses to spite our face here," AIDS Division Deputy Director Jonathan Kagan wrote. "...We should not be motivated by political gains and it's dangerous for you, of all people, to be diminishing the value of our monitors."

Tramont prevailed and the research resumed. A few days later, Tramont sent a note to his staff ordering the end of an 18-month-long debate inside NIH over whether the science from the Uganda trials was valid and safe. That debate began in early 2002 when two audits divulged widespread problems with the research.

The Uganda trial "has been reviewed, re-monitored, debated and scrutinized. To do any more would be beyond reason. It is time to put it behind us and move on," Tramont wrote in a July 13, 2003 e-mail instructing his staff that future issues about the drug be handled directly by his office.

Five months earlier, Tramont surprised one of his own medical officers who had written a report summarizing safety concerns uncovered during a second review of the Uganda trial.

Dr. Betsy Smith's report, finished in January 2003, said the Uganda trial suffered from "incomplete or inadequate safety reporting" and that records on patients were "of poor quality and below expected standards of clinical research."

She strongly urged NIH not to make sweeping conclusions about nevirapine based on the Uganda research. "Safety conclusions from this trial should be very conservative," she wrote.

Behind the scenes, Tramont asked to see Smith's report before it was submitted to medical authorities, including the Food and Drug Administration (news - web sites). "I need to see the primary data — too much riding on this report," Tramont wrote Jan. 23, 2003.

A few weeks later, the safety report was published and sent to FDA without Smith's concerns and with a new conclusion.

The study "has demonstrated the safety of single dose nevirapine for the prevention of maternal to child transmission," Tramont's version concluded. "Although discrepancies were found in the database and some unreported AEs (adverse reactions) were discovered ... these were not clinically important in determining the safety profile."

In disbelief, Tramont's staff began inquiring how Smith's report got changed. An answer came back from the top.

"I wrote it," Tramont responded.

You can't do that, Edmond! It is a form of denialism-known as denying data, or data denialism.

5d. The buzzword at the 2006 International AIDS conference in Toronto this year was "HIV-integrase inhibitors" constitute the great hope for the future:

I must confess, I have published work in which AIDS denialism has appeared. For instance, in work published in the mid-1990's, we employed an enzyme called "HIV integrase" that was used as a putative positive control for the minor groove binding activity of topoisomerase II. Despite the consistent activity on chromatin structure by positive control enzymes, "HIV-integrase" failed to show that this enzyme had any biochemical activity at all with respect to DNA minor groove binding or chromatin remodeling activity (**89**). This non-result, regarding the essential enzyme for the integration of the "HIV" genome into cellular DNA, in addition, suggested that no data was available that an exogenous "HIV-retrovirus" actually existed, let alone could be responsible for the then growing number of 29 diseases then being attributed to "AIDS." To get the result published, we needed to bury it as a negative control in a paper about topoisomerase.

5e. TAG (Treatment Action Group) are AIDS denialists: the power of prayer over "HIV" mutability, and The Chinese Menu approach:

It is widely appreciated that HAART therapy has reduced the incidence of AIDS to negligible levels in developed nations, which is why anyone fortunate enough to receive HAART medications is virtually cured. But this fact is repeatedly denied by AIDS activists such as TAG, who evoke prayer instead of anti-"HIV" drug cocktails as potentially therapeutic. For example, below is example regarding the "problem" of "HIV" resistance from The Treatment Action Group (TAG). In the dialogue that follows, it can clearly be seen how AIDS denialism infects, erodes, and finally can destroy even the most ardent "HIV=AIDS" believers, and even scientists who champion the "HIV-AIDS" paradigm:

"Activist Epistler (Harrington*) Chronicles Frightening Tales of Multiply Resistant HIV from D.C. Principles Panel* (**90**)."

"Toxic cocktail"

"The NIH panel convened late last November to develop new state-of-the-art guidelines for the treatment of HIV infection included a series of provocative (some would say alarming) presentations regarding resistance considerations in the choice of antiretroviral combination regimens. TAG's indefatigable scribe and provocateur in his own right, Mark Harrington, provided this transcript of the cross-fire which featured, among others: Merck's Emilio Emini, Tufts University's John Coffin, University of Montréal's Marc Wainberg, Roche's Noel Roberts, the CDC's Harold Jaffe, Chiron's David Chernoff, the ACTG's Robert ("Chip") Schooley and John Mellors, as well as fellow treatment activist Dawn Averitt-Doherty of Atlanta-based Woman's Information Service and Exchange (WISE)."

"Mark Wainberg presented interesting resistance data from BI 1046 (the INCAS study of AZT+ddI+nevirapine (NVP) vs. AZT+ddI vs. AZT+NVP in treatment naïve individuals with CD4 cell counts 200-600), analyzing compliance as defined by any patient who did not miss more than 28 days of any therapy. On triple drug therapy, viral load was reduced by 1.5 logs at 23 weeks. Patients non-compliant to ddI rapidly became resistant to nevirapine. At twelve months, even ***some of those*** *who were compliant developed NVP (Nevirapine) resistance, although in most patients on triple therapy (87%)* ***it was difficult to culture virus (but not impossible?-question mine)****. At twelve months, virus could not be cultured from any patient whose viral load was beneath the limit of detection (LOD). When treatment reduces viral load below LOD, virus culturable from peripheral blood mononuclear cells (PBMCs) at six months is wild-type. When treatment fails, virus culturable from PBMCs at six months is NVP resistant, but not as frequently (or as highly so) as in patients receiving only AZT and NVP."*

"Coffin: Both studies (BI 1046 and the Merck 035 study, presented earlier that day) raise the question of whether there's a rationale to include AZT anymore. It makes no difference between experienced and naïve patients. NVP and AZT didn't push the virus very hard."

"Wainberg: Combinations without AZT should be looked at-they're tantalizing."

"Emini: The combination of d4T and 3TC should be looked at."

"Coffin: We need to study the fitness of various mutants in the absence of therapy. Some mutants will have a high cost to fitness, and will be infrequent; while others may have a low cost and may be more common. There may be an evolutionary bottleneck early in disease before which such pre-existent mutants are rare, but six months into infection-or after a year-you've lost that advantage."

"Harrington: It seems to me there are two ways to avoid the development of resistance here: one is to suppress maximally with potent antiretroviral regimens. The other is to wait to begin therapy until it's necessary to prevent irreversible immunologic damage. If the only point at which to throttle the virus from an evolutionary standpoint [to limit the pool of pre-existing drug-resistant viral mutants] is in the first 6-12 months of infection, this has little relevance to most chronically-infected patients who, given the limitations of our arsenal, might be better off waiting for a clear need to emerge."

"Roche's Noel Roberts presented cross-resistance data on clinical isolates which had been presented at the Birmingham conference, suggesting that HIV that has developed resistance to any of the three licensed protease inhibitors is likely to be resistant to the other ones (licensed and unlicensed) as well, and that resistance to IDV (indinovir) (currently the most widely prescribed protease inhibitor) appeared to confer 60% cross-resistance to SQV, 80% cross-resistance to the Vertex compound (141WU94) and 100% cross-resistance to RTV and NFV! University of North Carolina's Robert Swanstrom took it a step further and looked at HIV that had become doubly protease resistant (to SQV+RTV, RTV+IDV and SQV+IDV). In his in vitro experiments, HIV that was doubly resistant to IDV+RTV was 400-fold less susceptible to SQV. And HIV with dual resistance to SQV+RTV was 60-fold less sensitive to IDV. So the implication for people failing SQV, IDV or RTV appear grim-at least from this data."

"Schooley: We need to be pretty careful and do in vivo studies of switching people from saquinavir to other protease inhibitors and vice versa."

"Roberts: That study is underway."

"Chernoff: In these trials, drug is continued post-failure, unlike in clinical practice. [This is not true; many doctors continue patients on therapy post-failure. What else can they do? There are no clinical practice guidelines out there, and many people have failed all available drugs.]"

"Roberts: Perhaps patients should change therapy as soon as viral load starts to rise."

"Mellors: It troubles me to hear a comparison of the frequency of resistance without controlling for the potency of the various regimens. The two variables are related-viral turnover and the selection process imposed by more or less potent regimens."

"Jaffe: If resistant mutations are associated with a selective disadvantage will they disappear after treatment is removed?"

"Emini: Two patients who stopped taking indinavir (one after taking low-dose, then full-dose) had a reversion to wild-type within 4-5 months post-cessation. One restarted treatment at full-dose idv, and within three weeks we isolated idv-resistant virus. This is why we say the virus is "genetically unforgiving."

"During the coffee break, I joined three activists outside to share nicotine and despair. What was the point of quitting smoking if we were still all passengers on the speeding train heading for the cliff? The Birmingham resistance data were wrenching. Our fears of multiple cross-resistance, from November 1995's 3TC and saquinavir FDA approval hearings, reared their ugly heads. Several months of post-Vancouver euphoria crumbled in a moment as it became clear that many of those who developed resistance to ritonavir and idv-as thousands clearly would-might have no protease inhibiting options ahead of them. Today's resistance news made for a toxic cocktail. As I left the auditorium I bumped into Emilio Emini."

"Harrington: So what do you do if you fail Crixivan?"

"Emini: [sighs] We don't know what to do."

"Harrington: Take two new nucleosides and nevirapine?"

"Emini: Yeah. And pray."

"No one had yet assessed the healing effects of prayer on viral load. This was what we'd come to. I rushed into the lobby of the Interior Department and ran into a colleague, who was wild with fear and disappointment."

"AC: I'm going to die."

"Harrington: This is everything we were hoping wouldn't happen."

"AC: I don't have anything to switch to. I'm going to stop everything."

"Dawn Averitt tried to calm our colleague down: Why don't you wait for you next viral load?"

"AC: I'm already back at baseline!"

"Averitt: But your CD4 count is 250, and it was down to 60 in January."

"AC: True, but my viral load is back to half a million."

"Averitt: Why don't you wait until you get your latest numbers and see what your resistance profile is?"

"AC: I'm going to go outside and have a nervous breakdown."

"We went outside. It was frigid, and fragile snowflakes swirled around in the wind. Sometimes the gap between how the researchers felt and how we felt became an abyss. They were excited about the endless possibilities opened up by the research advances of 1996; we were terrified about the limited treatment options facing people who had exhausted most of the current arsenal of antiretroviral therapy. What to do with those whose viral load refused to go undetectable? What to do with those who added a protease inhibitor to a failing two-drug regimen and appeared doomed to develop resistance, most of it-especially with ritonavir and idv-cross-resistant to all other protease inhibitors? What to do with those who jumped aboard last year's bandwagon, AZT+3TC, and now appeared likely to have developed 3TC resistance and, with it, cross-resistance to ddI, ddC and possibly 1592? ***The Chinese menu approach to antiretroviral treatment suddenly looked much less appetizing, and much less nourishing."***

"Dawn and I went upstairs where the committee was having a working lunch, discussing process. Many members questioned the existence of two committees. Why have one committee setting up principles (NIH) and one setting up practice guidelines (PHS)? Wasn't this a recipe for bureaucratic confusion-and delay? How could we disseminate principles of HIV therapy without making practice guidelines? What if the principles contradicted the data? Considering what we had just seen, doing something fast seemed imperative."

"On the other hand, many of the researchers present did not share the activist sense that we were facing a crisis that, if handled improperly, might make things worse than before. This was not the prevailing view propounded by gun-happy virologists, drug-happy pharmaceutical companies, media captivated by a surprising good-news story and many people with HIV still struggling to absorb the complex developments of 1996. Just that week, back-to-back articles in The Wall Street Journal and The New York Times Magazine, both written by HIV-infected journalists, declared that the epidemic was virtually over. We were staring into the precipice while others were still climbing the hill."

Gun-happy virologists,and drug-happy pharmaceutical companies, media captivated by a surprising good-news story indeed says this TAG writer! Has AIDS denialism, and the reasons it develops in even the most ardent “HIV=AIDS” believers, ever been more clearly obvious than in this dialogue among scientists and a TAG writer (Harrington)?

Part 6a. The practical implementation of the true A,B,C's of "HIV=AIDS" belief by David Ho, Daniel Douck, Ronald Desrosiers:

Genetics as the basis of biological invariance, and logical A,B,C, constructs aside, with time and experience, the A,B,C's of "HIV/AIDS” denialism, instead of constituting mental tools to make testable logical constructs, have evolved to represent the three cardinal rules of "HIV=AIDS" belief, or what should perhaps be described as something analogous to a catechism: **A**bstain {from sex}, **B**e

Faithful {to Your wife or Your Husband}, presuming that of course you are married before being intimate, and {use} **c**ondoms {even with your wife or husband if you don't trust them}! The AIDS A,B,C's have been advanced by hugely funded programs designed to convince both educated and uneducated folks alike, that we should all control our sexual activity as much as is humanly possible, according to doctrinal thought, or else "HIV" will get you and you will die an emaciated wreck with lesions all over your body as was the case of the lepers in Christian folklore.

Although this ABC catechism doesn't include any information about risks other than "HIV," such as shooting heroin or chronic popper use, Ecstasy, flu shots, pregnancy, or transfusions, because they are extremely dangerous, immune suppressive behaviors that evoke autoimmune diseases in many people who receive them, these reasons are generally acknowledged as unimportant, compared to acquiring "HIV."

Therefore, it is good that the "HIV"=AIDS" faithful continue to remind all of us frequently about the AIDS A,B,C's. For instance, an article advancing how the pathogenesis of "HIV" works appeared last year in *Science* Magazine with the introductory sentence reading, "It's The Gut, Stupid, by Jon Cohen (**91**), who is "an AIDS journalist" and an "HIV=AIDS" true believer, and who covered the 12th International conference on Retroviruses and Opportunistic infections. He has advocated, for instance, giving HAART to gay men prophylactically in order to 'head off' AIDS before it begins in these individuals, so the extent of his "HIV=AIDS" belief track record can be trusted. The meeting Cohen covered, as he describes, "was attended by some 3900 "HIV/AIDS researchers from 72 countries." In the *Science* article, a picture in support of Maria Wawer's work appears. It is a photograph with a Kampalan man standing in front of a billboard, which says, Condoms. Abstinence, Faithfulness, with a caption under it stating that "New data ascribe Uganda's AIDS "success" to condom use rather than the abstinence and faithfulness promoted on this Kampalla billboard (or to abstinence and monogamy, as claimed by The Bush Administration). In his synopsis of this meeting, claims by David Ho, Daniel Douck, Ronald Desrosiers, are also presented stating such phrases as "HIV" destroys the gut lymphoid tissue of "recently infected people, " and essentially "wipes clean" the lymphoid tissue lining the gut shortly after infection, and that "HIV" fibrosis might be treatable with the relatively new cancer drug Gleevec, which is supposedly an abl inhibitor designed for leukemia, but they suggest it could stop fibrosis and make AIDS a more survivable disease than cancer. There are many components of AIDS denialism here, so I will break them down one at a time.

This conclusion that "HIV" kills the lymphoid tissues of the gut in a few days to months is at variance with the CDC's long-standing contention that "HIV" has an average latency of 5-10 years before progression to AIDS (**92**). For this subtly AIDS denialist claim to be true, a colonoscopy before and after "HIV" infection from the same patient would be needed from the same section of the intestine, to show a dissolution of the lymphoid tissue over short time periods due to a "recent 'HIV' infection. Yet no such comparison is presented in the *Science* article. We are given instead two side-by-side photographs of an intestine showing patches of lymph tissue, and one that does not. A critic might ask if these are intended to represent the same patient's specific region of intestine before and after "HIV" infection, because if it is, it doesn't say that it is. For instance, one might ask, was the patient (on the right) whose colonoscopy picture lacks any lymphoid tissue at all treated with AZT or HAART? Therefore, to suggest that all of the lymphoid tissue became denuded weeks or months after infection is still AIDS denialism. I suggest, therefore, that David Ho, Daniel Douck, Ronald Desrosiers, and even Jon Cohen are advancing a subtle form of AIDS denialism: because they challenge the CDC's dictum that "HIV" takes on average 5-10 years to manifest itself in one of the AIDS-defining syndromes.

To also suggest in this article, that Gleevec might be a boon to the treatment of AIDS is also a kind of denialism, but it won't be the first time that denialists have tried using failed chemotherapies designed for cancer on AIDS patients, as is evident with the nucleoside analogs such as AZT. But denialists aren't very creative-and it is infinitely easier to dust an old drug off used for a different purpose (such as suppressing cells of the immune system), rather than coming up with a therapy that actually works for immune suppressed indivduals.

6b. Prevention and global programs-spermicides, condom crusades, and 3 million drug test subjects by 2005-Bill and Malinda Gates are being duped by denialists that have infiltrated the CDC, UNAIDS, and elsewhere:
Regarding one campaign funded by The Gates foundation, AIDS denialists claimed that spermicide doesn't actually reduce any risk of transmission but actually increased the rate of infection. This runs contrary to what is known about how safe sex practices, including condoms and spermicide, can be completely effective in quelling AIDS in backward 3rd World countries (remember the A,B,C,'s cited above-Abstanence, Being Faithful, and Condoms)? Although it is difficult to believe that AIDS denialism has even affected such organizations as the CDC and WHO, the evidence is overwhelming that this is the case, as in the following article (**93**):

"South Africa -- Researchers hoping to find a way for women to protect themselves from AIDS have said they were dismayed to find that a product they thought may prevent infection actually increased the risk.

The product, a spermicide called nonoxynol-9, did not protect prostitutes in Benin, Ivory Coast, Thailand and South Africa from infection with HIV, a team of U.N.-sponsored researchers said.

"We were dismayed to find out that the group using the N-9 gel had a higher rate of HIV infection than the group using a placebo," Dr Joseph Perriens, who heads the UNAIDS microbicide effort, told an AIDS conference Wednesday.

They tested nearly 1,000 women and found 59 of those who used the spermicide became infected with HIV, compared to 41 of those who used a dummy gel.

"We were extremely disappointed," Lut van Damme, a researcher at the Institute of Tropical Medicine in Antwerp who led the study, told a news conference.

She said researchers may be forced to suspend other trials involving the product, marketed under the trade name Advantage S by U.S.-based Columbia Laboratories Inc.

"The long-term safety of nonoxynol-9 as a family planning method may have to be re-evaluated," she said.

Activists and researchers have been clamoring for the development of a microbicide -- a gel or cream sometimes described as an "invisible condom" -- that women and men could use to protect themselves not only from HIV, but from other sexually transmitted diseases such as syphilis and gonorrhea.

"I think this may be the end of nonoxynol-9 as a potential microbicide," Van Damme said, although she said the trials did show that women -- in this case prostitutes at high risk of HIV infection -- would use a microbicide if one was available.

CDC Expresses Concern

The Centers for Disease Control and Prevention (CDC) said it was concerned by the findings because some groups advise people to use nonoxynol-9 to protect themselves from HIV if they cannot use a condom.

"I think it's pretty clear we have to tell men who have sex with men not to use it," Dr. Lynn Paxton, a microbicides expert at the CDC, said in an interview.

"I think they are most at risk and I know they are using it." She said it was less clear whether women who use nonoxynol-9 as a contraceptive -- women who are not at risk of getting HIV -- should avoid it.

"One possible reason for the findings was that the women who used the spermicide had more lesions than the women who did not," Van Damme said.

"If you use nonoxynol-9 (to protect from HIV), you are probably wasting your money. You may possibly be wasting your life," Perriens said. But, he added: "There is nothing in this trial to suggest you should stop using it as a spermicide."

UNAIDS said it was pressing for the development of other products.

"We know that there are more products to come," Perriens said. "This shouldn't be the end of the field... One of the things holding up development, increasingly, is a lack of private sector interest in this area."

The Bill and Melinda Gates Foundation said it would try to help with a $25 million grant for microbicide research."

Fortunately, the AIDS denialists at the CDC are no longer hampering work or being pessimistic about this important area of spermicide development as they have in the past. And a week or so ago, Bill and Melinda Gates said during their keynote addresses at the 16th International AIDS Conference opening ceremony in Toronto that:

"A total of 16 microbicides — a gel or cream used to block infection — are currently being evaluated. Of those, five are in major advanced studies. Drug trials into oral prevention drugs are also underway."

At the conference, Melinda Gates further encouraged researchers and politicians alike to move past the stigma of HIV/AIDS:

"Stigma is so cruel," she said. "It's also irrational. Stigma makes it easier for political leaders to stand in the way of saving lives."

The couple last week announced that their foundation would contribute $500 million over five years to fight HIV-AIDS, and met with Bill Clinton, the former U.S. president, to present their priorities for ending the epidemic.

6c. John Moore of Weil Medical College is the greatest AIDS denialist of them all-despite his "HAIL MARY Experiments," he betrayed a deep-seated AIDS denialism at the 2006 International AIDS conference:

Dr. John Moore of Weil Medical College, one of the featured speakers in this year's International Toronto AIDS Conference is an enigmatic character. In a talk he gave at the conference about his work, which involves inseminating rhesus macaques up to 5 times after smearing a spermicide cream in their vaginas to prevent "SIV," he claimed that these "HAIL MARY" experiments hold great promise and would solve the "AIDS apocalypse in Africa and elsewhere. He claimed that multiple inseminations are necessary in order to model the frequent sexual activity that goes on in these 3rd World Nations. Not being Catholic, I didn't quite understand at first what was meant by the term "HAIL MARY experiments." To rigorously prove his "SIV-fighting" spermicide worked, I gathered that HAIL-MARYING HIS monkeys and inseminating them 4-5 times represented the fact that his spermicide "absolves" the monkeys of contracting "SIV," as one would if a Catholic perhaps were "absolved of sin" after saying "HAIL MARY" numerous times as penance?

Although "SIV" has always been a better model of "HIV" than "HIV," a critic might suggest Moore try Human "HIV," perhaps with dogs, cows, goats, sheep, or non-infected monkeys, chimps, and humans that have naturally occurring "HIV" sequences (**18**). Although none of these animals acquire AIDS from human "HIV," neither do his monkeys since he is inseminating them with "SIV."

Because I learned so much at his scientific talk, I attended another talk Dr. Moore gave in a session at the Toronto Conference regarding "**AIDS and Responsible Journalism**." It was here that I noticed, however, that AIDS denialism appears to have infected even some of his thinking, despite his warnings about extreme AIDS denialists in a recent Amazon.com book review where he said that AIDS denialists are:

"scientists whose careers fizzled out; but others are zealots with extreme political views (both on the far-right and the far-left) who find AIDS denialism politically convenient; and some are deeply troubled individuals with disturbing behavior patterns who deserve pity and professional help."

Allow me to give one example illustrating Moore's denialism. In his AIDS denialism, Dr. Moore described the case of a woman in Los Angeles named Christine Maggiore, and the recent tragic death of her daughter, Eliza Jane. Dr. Moore then suggested that Ms. Maggiore and her partner, Robin Scovill, had been irresponsible and negligent parents regarding the raising of their children, and that a responsible press ought to mercilessly and unabashedly punish the parents for Ms. Maggiore's minimizing or ignoring her possible "HIV-positive" status, for her alleged subsequent infecting and killing her daughter with "HIV," and for both parents refusal to give either of their children or themselves (any more) "HIV" tests, or HAART, in the 3 years preceding the tragic death.

However, a little research into the matter would have clearly revealed the depth of this type of AIDS denialism and stigmatization (to quote Malinda Gates warning against stigmatization) that was distastefully, and I would say, angrily advanced, by Dr. Moore. But that is how AIDS denialism works

on even some of the best minds, which, as Moore himself has said, "deserve pity and professional help." Like "the virus that causes AIDS" itself, AIDS denialism can, as illustrated by TAG's pessimism I illustrated before, infect even the most faithful "HIV=AIDS" believers, which is why I say it is so insidious. For instance, Moore's ill-informed suggestion to the *AIDS and Responsible Journalism* session, that a Salem Witch Trial for Ms. Maggiore and her family be intensively pursued, was nothing less than unparalleled arrogance and a publicly-presented savage abuse of their human rights, their rights as U.S. citizens, stigmatization, and, most woefully perhaps, his tantrum bent the logic of the "HIV=AIDS" paradigm. Dr. Moore's effort to malign these parents using his scientific credentials and considerable skill and reputation to motivate the press to use its influence to pelt the Maggiore-Scovill Family with insults, threats, and other unimaginable forms of torment in the aftermath of the tragic death of the little girl, constitutes an extreme form of AIDS denialism (this was after all an AIDS and Responsible Journalism Session).

Before maligning Ms. Maggiore and Robin Scovill on stage before the entire world, a little research of Eliza Jane's hospital admission data that was published in the respected journal, Medical Veritas, and in the Coroner's report posted all over the Internet would have demonstrated to Dr. Moore instantly that Eliza Jane could not have died of AIDS. The reason I say this is because (From: Commentary on the death of Eliza Jane Scovill: *Is an amoxicillin adverse reaction the 47th AIDS-indicator disease? By* Andrew Maniotis):

Eliza Jane Scovill was a 3 1/2 year-old child who died in a hospital emergency room 36 hours after imbibing the first of 4 doses of amoxicillin. She had never been exposed to amoxicillin or any other beta-lactams before. An autopsy was performed and "no cause of death" was found by the Los Angeles County coroner's office where her case had been referred. Approximately one week after the autopsy, the coroner's office learned of her parents' unorthodox views on HIV and AIDS and the testing history of the mother (inconclusive, positive, inconclusive, positive, negative, and positive). Rather than ordering a second analysis, another medical examiner (James K. Ribe) not originally assigned to the case was "brought in to help resolve the case," and revised autopsy findings were released claiming Eliza Jane died of Pneumocystis carinii pneumonia and "HIV encephalopathy." Eliza Jane's symptoms during her crisis period, the similarities of these symptoms to amoxicillin package inserts, her vascular issues, liver issues, weight gain the last 5 months of her life according to her pediatricians, and descriptions of delayed reactions in the medical literature, do not support an "AIDS" diagnosis. The fact that she had 10,800 lymphocytes/µl at the time of her death as measured by the hospital indicates that she had more than the normal numbers of lymphocytes, casting doubt on any diagnosis of Pneumocystis carinii pneumonia, a disease indisputably associated with immune suppression.

In this scenario, if Eliza Jane had AIDS, it would mean that A ("HIV") may cause an increase in B (immune system increase), which leads to C (AIDS-indicator diseases). Despite Gallo's, Montagnier's, "HIV" test kit makers, vaccine makers, drug makers, and other AIDS denialist constructions and distortions of the correct "HIV=AIDS" hypothesis, this form of AIDS denialism is perhaps the most insidious and horrifying of all, not only because it threatens both the freedom and Human rights of those accused of being "HIV-positive," but particularly, because it distorts the "HIV= AIDS paradigm completely in the wrong direction.

In this scenario,

A ("HIV")----------10,800lymphocytes/microliter----------PCP, "HIV" encephalopathy.

To address the issue of why absolute lymphocytes versus CD4/CD8 ratios weren't measured before the coroners were made aware of Christine Maggiore's (inconsistent) "HIV-positive status," and before the coroners changed their initial “indeterminate” cause of death, and deemed Eliza Jane an "AIDS statistic," it is clear that there was no reason for anyone to assume that in Eliza Jane's case, they were dealing with an immune suppressed individual. Her acute symptoms during her 36-hour death appeared to be due to a ***hyper-immune*** reaction to a prescribed drug, and an earache. However, despite the coroner's failure to provide a CD4+/CD8+ ratio in support of the "AIDS diagnosis," **it should be emphasized that the accuracy of total lymphocyte counts in predicting death due to "AIDS-associated indicator diseases" is considered equal or even superior to measuring the CD4/CD8 ratio** (**94**). Therefore, and despite the fact that an "HIV" test or CD4/CD8 ratios were NOT obtained (by those attributing her death to AIDS after the revised autopsy report was filed some 4 months after the death), absolute lymphocyte numbers **WERE** obtained at the hospital, and according to "AIDS experts," are just as predictive of AIDS-related death in children, if not more so. In a recent study of 3917 children, it was reported that:

“For children older than 2 years, the 12-month risk of death and AIDS increased sharply at values less than 1500-2000 cells per microliter, with little trend at higher values.” (Eliza Jane's count was 10,800 cells/microliter).

“Mortality risk was substantially higher at thresholds of total lymphocyte count recommended by WHO than at corresponding thresholds of CD4-cell percentage. When the markers were compared at the threshold values at which mortality risks were about equal, total lymphocyte count was as effective as CD4-cell percentage for identifying children before death…”

In the context of lymphocyte numbers, and despite occasional and minor discord in "AIDS science meetings amongst the very smartest "HIV=AIDS" leaders about the precise molecular mechanism that explains why low lymphocyte numbers are seen in end-stage "AIDS" patients (is it really "the Gut" stupid, how quickly does "HIV" cause heart disease, or infect neuronal macrophages, kidneys, liver, etc.), "HIV=AIDS" scientists are as certain today that low, rather than high lymphocyte numbers have something to do with full-blown "AIDS," as they are about gravity being caused by those little graviton particles.

By attributing Eliza Jane's death to AIDS, Dr. Moore has in effect, "denied the cause of gravity," because if Eliza Jane had "HIV" and 10,800 lymphocytes/microliter at the time of her death, then A ("HIV") would have had to have to led to a massive stimulation or overproduction of B (immune cell numbers) (10,800 lymphocytes/microliter rather than 1000 or less), instead of a decrease in B (to a 1000 or less meeting the surveillance definition shown above), to induce C (the PC pneumonia and "HIV" encephalopathy that was missed by the first coroners but determined 4 months later by Dr. Ribe). To assume that "AIDS" is caused by too many lymphocytes, is taking "HIV=AIDS" completely in the wrong direction. AIDS is a disease showing too few lymphocytes, not too many, like cancer.

Thus in maligning Ms. Maggiore and her family before the world stage, John Moore, perhaps in a weak moment, betrayed his deep-seated AIDS denialism to the Toronto Conference, to the shame of us all.

6d. Money and pledge-making don't stop AIDS like funny, non-threatening and sex-positive programs that maintain sexual pleasure:

"HIV=AIDS" believers have learned that it is the attitude of a people and condoms, and not only spermicide, which contributes most to quelling "the global pandemic." For example, Chris Beyrer, a medical epidemiologist who directs the Center for Public Health and Human Rights at Johns Hopkins. and Voravit Suwanvanichkij, a physician in Thailand and who is on the faculty at Johns Hopkins" attribute the success in Thailand in quelling the spread of AIDS to the Thai people's condoms and attitude, and their acceptance of programs which are "non-threatening and sex-positive programs that maintain sexual pleasure," rather than "pledging" to do no sexual evil. For example:

"Twenty-five years into the H.I.V. pandemic, there remain few developing countries that have had success in controlling the virus. Thailand is one of them.

In the late 1980's, Thailand experienced the first H.I.V. epidemic in Asia, and one of the most severe. By 1991, 10.4 percent of military conscripts from northern Thailand were infected by the virus, the highest level ever reported among a general population of young men outside Africa.

It became clear early on that the commercial sex industry — illegal but popular among Thai men — was at the core of the virus's explosive spread. The Thai response was the 100 Percent Condom Campaign.

As part of the campaign, public health officials aggressively focused on bars, brothels, nightclubs and massage parlors for condom education, promotion and distribution. Sex workers were likewise offered counseling, testing and treatment. The openness of sex venues there and health officials' access to the women in them made this a relatively simple intervention.

Venues that did not agree to require condom use were shut down. Signs appeared over bar doors saying, "No condom, no sex, no refund!" And the government put resources behind the effort, distributing some 60 million free condoms a year.

A wider national effort was also under way. Condoms appeared in village shops and urban supermarkets, and frank H.I.V. education was introduced in schools, hospitals, workplaces, the military and the mass media. Thais worked hard to reduce fear and stigma and to support those living with H.I.V.

This national mobilization was classically Thai — funny, nonthreatening and sex-positive. *When we briefed the Thai surgeon general on an H.I.V. prevention program for soldiers, he said, "Please be sure the program maintains sexual pleasure, otherwise the men won't like it and won't use it."*

It worked. By 2001, fewer than 1 percent of army recruits were H.I.V. positive, infection rates had fallen among pregnant women, and several million infections had been averted.

The 100 Percent Condom Campaign proves that H.I.V. prevention efforts can succeed by focusing on at-risk populations, providing tangible services and making healthy behavior, like condom use, social norms. Cambodia, the Dominican Republic and other countries have successfully adopted the Thai model.

It's troubling then that the United States now requires all foreign and domestic recipients of H.I.V. and AIDS funding to pledge to oppose prostitution. After all, the "100 Percent Condom Campaign" and

similar efforts have been shown to decrease the spread of the epidemic through sexual intercourse; the pledge policy can make no such claim.

Quite the opposite: the policy may even limit outreach and access to sex workers, and make condom distribution more difficult. This is why Brazil rejected some $40 million in AIDS funding from the United States last year rather than take the pledge.

This is not the time for us to turn away from any approach that's proven to slow the spread of H.I.V., and yet the Bush administration lets its moral concerns trump the evidence. Even in Thailand, the government has refused to expand successful prevention services to include gay men and injecting drug users, leading to rising infection rates among these groups."

Still, we cannot ignore the lessons learned during the 100 Percent Condom Campaign. H.I.V. policy should be driven by only what's been shown to work, and prevention services have to reach those most at risk, whether or not we condone their behavior."

If the 100% condom campaign is successful and in Thailand and wherever else it is implemented, then the only problem left to figure out is how to make more people without spreading "HIV/AIDS to everybody (as in making children). Regarding population control, the AIDS denialists may not have the influence we worry about so much, given that when zero population growth is attained throughout the world, their denialism will have lost its power.

6e. Judge Cameron of South Africa is an AIDS denialist:
Tshabalala-Msimang, 64, was the Health Minister of South Africa, and spoke at the AIDS conference in Durban, SA on June 7, 1999. During her tenure, she
charted a uniquely original course in her job as the cabinet level director of medical policy for South Africa, the continent's fourth largest country. Subjected to unremitting domestic and foreign pressure of all kinds to kowtow to AIDS denialist international medical-industrial complex's demands that South Africa align itself with symptom-drug treatment allopathy and provide millions of its citizens with drugs for the treatment of HIV/AIDS, Tshabalala-Msimang instead has advocated a cautious approach that recognizes the limitations of the Western-derived pharmaceutical paradigm and the validity of natural, native healing traditions. (**95**):

Speaking at a large AIDS conference in Durban, SA on June 7, Peter Barry Chowka quoted Tshabalala-Msimang's admonishments that: "

"I hope you have come in such big numbers not just to focus on one ailment but to focus on all of them, because many other people are dying of other diseases in this country. Even though it is a conference on HIV and AIDS, you must not forget to talk about cancers, you must not forget to talk about diabetes, you must not forget to talk about other communicable diseases."

According to one news account, *"Tshabalala-Msimang also reiterated her view that anti-retroviral drugs were not the only answer to fighting HIV and that nutrition was a key component in the approach to treatment of [HIV/AIDS]."* For her efforts over the years, Tshabalala-Msimang, like LInus Pauling, has been bitterly criticized and denigrated by her many critics and there are currently demands for her to resign her government post. Instead of giving in, she has stuck to her convictions and goes forward in her work with an energy, independence, and strength unusual for a high government official anywhere.

It must be evident to most readers at this point that AIDS denialism takes on many forms. One of the most interesting forms of denialism was crystallized in Judge Edwin Cameron's book, "Witness to AIDS." One cannot help but side with the Judge on issues of Apartheid, against which he single-handedly made huge strides, as he described in "the trial of 6" case that was a landmark case in the eventual ending Apartheid. However, although Judge Cameron himself is "HIV-positive," he denies medical consensus about AIDS in Africa when he writes:

'Denying HIV/Aids is Like Denying the Holocaust.'

Sunday Times (Johannesburg) - October 6, 2002
Carmel Rickard

"ONE of South Africa's top judges has likened denying the existence of Aids to denying the Holocaust, and has taken President Thabo Mbeki to task for officially encouraging this denial."

"Speaking after being honoured with a top human rights award by the English Bar in London on Friday night, Judge Edwin Cameron of the Appeal Court said that both the denial of Aids, in its African form, and the denial of the Holocaust in which millions of Jews were killed, were based on a belief in "racial conspiracy".

"In terms of this conspiracy theory, African Aids deniers claimed that well-established facts about Aids were "a monstrous plot against Africans because they are black" and that a syndicate of white Western interests promoted antiretroviral drugs to "degrade, exploit and kill Africans".

Despite his enormous legal and human rights accomplishments for the people of South Africa, Judge Cameron's sense of epidemiology does not jive with the medical consensus presented by such journals as The New England Journal of Medicine. Therefore he is an AIDS denialist. For example: among the more sober assessments of global health crises by certain mainstream AIDS Establishment doctors and scientists, "AIDS" isn't even the collection of diseases that poses the greatest challenge. For example, a series of articles was published in the January 6, 2005 issue of the New England Journal of Medicine by Berkley et al. (**96**), that is accompanied by a short and pointed commentary in the same issue, that introduces the Berkeley et al. study, (by Kim Mulholland, and Richard Adegbola) entitled, "Bacterial Infections-A Major Cause of Death among Children in Africa:"

" For the past 25 years, since the United Nations Children's Fund (UNICEF) has been publishing estimates of mortality among children worldwide, the international medical community has been aware of the appalling burden of early deaths among African children. ***Early studies*** *indicated that, in the absence of any effective medical care, children born in a rural African village had a probability of death before the age of five years of* ***30 to 50%*** *(2.* Reference 2 given here is from Mosley WH. Primary care: rhetoric and reality. Poluli J UN Fund Popul Act 1983; 10: 41-53, which is from a period of time **before** the "AIDS era)." *From the outset, it was understood that many of these deaths result from the combined effect of poverty and malnutrition (2). Since 1990, mortality rates have fallen but remain high by global standards. Twelve African countries still report official death rates for children under the age of five of more than 20 percent. Community-based studies of death among children have been able to attribute these deaths to a number of common causes, either syndromes or specific diseases (see table I)."*

"Table I. Official Estimates of Mortality among Children under 5 years of Age According to Cause in Sub-saharan Africa and Globally in 2002.

Cause of Death	*Africa*	*Global*
Acute respiratory infection	*16*	*18*
Diarrheal disease	*14*	*15*
Malaria	*22*	*10*
Measles	*8*	*5*
HIV or AIDS	*8*	*4*
Neonatal deaths	*13*	*23*
Other causes	*19*	*25*
All causes	*4.5 million*	*10.9 million*

"Data are from the World Health Organization (WHO) and reflect the WHO African region, which excludes most North African countries, Somalia, and Sudan. Many of the deaths that were classified as due to "other causes" may actually belong among the main causes listed. A total of 54 percent of all deaths among children are believed to be associated with ***malnutrition****. HIV denotes human immunodeficiency virus, and AIDS the acquired immunodeficiency syndrome."*

"In the study, 28 percent of children admitted to the hospital with bacteremia died. Even more important, 26 percent (308 of 1184) of hospital deaths were associated with bacteremia. This finding compares with 22 percent of the deaths that were associated with malaria, suggesting that bacterial disease may be responsible for more deaths in children than malaria in this area where malaria is endemic. Did the children who died at home die from a spectrum of causes similar to that among children who died after reaching the hospital? Both malaria and bacterial illness are amenable to relatively simple therapeutic approaches, but antimalarial drugs tend to be more widely available in African communities than are antibiotics. Therefore, in a rural community, bacteremia may be even more important as a cause of death among children than it is in a hospital setting, since the management of bacteremic illness in the community is likely to be less effective than the management of malaria."

The article concludes with:

"only 18 percent of children admitted with bacteremic illness were infected with HIV, whereas severe malnutrition was present in 37 percent, suggesting that the latter is a more important cofactor."

"During the past six years, the world of international health care has been dominated by high-profile efforts to control HIV infection, malaria, and tuberculosis. Of these, malaria is seen as the most important contributor to death among children in Africa. This study (Berkeley et al) gives us cause to question whether this very narrow, disease-based approach is indeed appropriate and whether the most important causes of death among children have been appropriately targeted. Even in an area of rural Kenya with high rates of HIV infection and malaria, there appear to be more deaths of children associated with bacterial infection than with malaria, with malnutrition still the main cofactor. Global health strategies, like any other public health activities, **should be based on evidence**."

Therefore, despite Judge Cameron feeling better on his ARV meds, medical consensus at least among true “HIV=AIDS” believers who publish in the NEMJ, is that “Global health strategies, like any other public health activities, should be based on evidence.”

Conclusion:

The terms, "AIDS denialists," or AIDS denialism, are terms that identify individuals who have both inadvertently or actively created confusion (at a minimum), or who have passively stood by and allowed others to mislead the world regarding any other hypothesis than "HIV=AIDS." More egregiously, and I agree with Dr. Wainberg, AIDS denialists are individuals who have taken actions that have “perpetrated death” in subtle ways, as well as more obvious ways, and have subverted the noble ideas, and practices, of allopathic medicine's perpetual illness model that dominates our culture. It is my conclusion that the logic of The AIDS Denialists and AIDS denialism is flawed without exception, and their published statements time and again contradict “consensus" medical and scientific opinion.” Those listed above and below are not intended to be a complete list of denialists, but only serve to show that the problem is much worse than suspected by many true believers in the "HIV=AIDS" paradigm.

Fortunately, there are some checks and balances in place that oppose this denialism: most "serious AIDS researchers" ignore these attempts to subvert the "HIV=AIDS" logic. A colleague of mine who worked on the recent "HIV" vaccine trial in Thailand and elsewhere recently told me that "nobody in the AIDS research establishment really listens to what folks like Gallo, Montagnier, or other well-paid denialists say or think about the pathogenesis of "HIV/AIDS" anymore, anyway, so we just ignore them."

I hope I have sounded the alarm that will set into motion the identification, prosecution, and imprisonment of persons like Dr. Moore for his denialism, and these other "perpetrators of death," to quote Dr. Wainberg.

The solution: CDC recommendation for universal "HIV" screening of all Americans: Choose religion, not science.

There are many problems with universal “HIV” testing. As opposed to what famous doctors are saying regarding cost efficiency and similarities between screening for cancer and universal screening for “HIV/AIDS,” unlike cancer, early screening doesn’t matter with "HIV. " "HIV/AIDS" can’t simply be removed with a surgeon’s knife or "chemical knife" once it is detected, like a non-invasive melanoma. As stated by Dr. Kent Sepkowitz in the *NEMJ* (97):

“In the United States, approximately 1 million persons are living with HIV infection or AIDS, and 164,000 to 312,000 of them remain unaware of their ***infection****. Experts* ***hypothesize*** *that most of the 40,000 new* ***infections*** *that occur annually in this country arise from contact with* ***these*** *undiagnosed persons. Given this likelihood, investigators have examined the potential benefit of routine screening, rather than testing of only those* ***perceived*** *to be at increased risk. This strategy appears to be as cost-effective as screening for colon, breast, or prostate cancer, and the availability of a rapid oral test has simplified broad scale testing.”*

Even if Sepkowitz's comparison between early testing for cancer, and universal "early" testing for “HIV” made any practical sense, the number of "infected" individuals Sepkowitz's presents are meaningless. Testing "HIV" positive with different test kits, and the presence of an "HIV infection" are not the same, as assumed by words I have emboldened above in Sepkowitz's statement. First of all, no true numbers of "HIV-positive" individuals or "AIDS patients" have been determined. Since the mid-1990's, when "HIV" and "AIDS" were lumped together as a single disease entity so as to obscure results from the era of antiretroviral testing, the numbers provided by Sepkowitz, the CDC, the WHO

or others regarding "HIV" incidence or "HIV/AIDS" incidence, are fictitious. For instance, this article appeared in The Boston Globe on June 20, 2004:

"Estimates on HIV called too high. New data cut rates for many nations." By John Donnelly, Boston Globe Staff

"Statisticians traditionally have had a difficult time estimating the size of the pandemic. In 1986, Jim Chin, then a state epidemiologist in California who later developed models for the World Health Organization to calculate HIV prevalence, and several other US officials met in a West Virginia hotel room to figure out how many Americans had HIV."

"Chin recollected that the group arrived at a range of 1 million to 1.5 million people; 18 years later, the number is at about 1 million Americans. "A lot of it was guesswork, based on limited studies," Chin said. "It was the best we could do."

If "HIV/AIDS" is chemotherapeutically hit hard and early as a consequence of an impassioned crusade to provide immunotoxic chemotherapy (see any ARV package insert-**A**nti-**R**etro-**V**iral therapy) to those who test positive, universal testing for "HIV" "infection" would increase morbidity and death amongst those designated as "HIV/AIDS" patients, rather than decrease it. For example, de Martino *et al.* (**88**) concluded that children born to ZDV-treated mothers *"are more likely to have a rapid course of HIV-1 infection compared with children born to untreated mothers, as disease progression and immunological deterioration are significantly more rapid and the risk of death is actually increased during the first 3 years of life."*

Antoni Noguera *et al.*, reported (**98**) that *"almost half of the children (63 of 127) who were exposed to nucleoside analogues developed benign and self-limited hyperlactatemia when symptomatic, nucleoside analogue–induced toxicity affected neurologic development."*

By 18 months after birth, in 1993, Parekh et al. reported a 60% rate of seroreversion in infants born of *"HIV-positive" mothers* (**99, 100**). *Thus, under the new mandate, 60% of infants who initially test positive will serorevert by 18 months post-partum*." If 60% of infants who initially test positive serorevert (change from a positive to a negative "HIV" test result), are forced to imbibe "anti-retrovirals," then 60% of infants will be needlessly exposed to toxic chemo (either in utero or post-partum).

The other half might exhibit impaired neurological development, as suggested by Noguera *et al.* already mentioned above.

For adults It has been about 12 years since The Veterans Affairs Co-operative Study Group reported that, *"AZT disproportionately harmed Blacks and Hispanics, and provided **no benefit** to the quelling of advancing immune suppression in Caucasians"* (**86**).

The Concorde trial published in 1994 in *The Lancet* (**87**), which was conducted without pharmaceutical company monies, and which was the largest, longest, and best controlled adult AZT trial conducted in the 1990's and remains the most comprehensive trial of AZT to date, also concluded: *"The results of Concorde do not encourage the early use of zidovudine in symptom-free HIV-infected adults. They also call into question the uncritical use of CD4 cell counts as a surrogate endpoint for assessment of benefit from long-term antiretroviral therapy."*

For those individuals who fail ARV therapy, they are told their virus has mutated and is no longer

sensitive to the drugs. The impact of this hypothesis on persons living with "HIV" or "AIDS" is unfair, uninformed, and cruel. For example, Mark Harrington, a member of The Treatment Action Group discussed the power of prayer over "HIV" mutability, and The Chinese Menu approach while covering a meeting on developments regarding anti-retro-virals (**90**) that included AIDS leaders such as Marc Wainberg, Director, McGill AIDS Centre, and this summer's Chair of The Toronto International AIDS Conference-who possesses several "HIV" drug patents such as lamivudine (3TC), and grants from GlaxoSmithKlein, Bristol-Myers Squibb and Boehringer-Ingelheim. Also present at the meeting was Emilio Emini, Tufts University's John Coffin, Roche's Noel Roberts, the CDC's Harold Jaffe, Chiron's David Chernoff, the ACTG's Robert ("Chip") Schooley and John Mellors, as well as fellow treatment activist Dawn Averitt-Doherty of Atlanta-based Woman's Information Service and Exchange (WISE).

These same sentiments advance by the Treatment Action Group also have been advanced in frequent warnings on MedWatch:*" Early virologic **nonresponse** (91%) and nucleoside reverse transcriptase inhibitor (NRTI) **resistance** (50-95%) has been observed at a high rate in a Gilead Sciences-sponsored clinical study. Participants in the study were treatment-naive (ie, no previous treatment for HIV) took a once-daily, 3-drug NRTI regimen. The NRTI regimen contained didanosine enteric coated beadlets (Videx EC), lamivudine (Epivir), and tenofovir (Viread)."*

"The new information is consistent with several recent clinical studies evaluating the use of 3 NRTIs simultaneously. Suboptimal virology response has also been reported with abacavir, didanosine, and stavudine, as well as another regimen containing abacavir, didanosine, and zidovudine. Similarly, early virologic failure and high resistance rates have been reported with abacavir, lamivudine, and tenofovir (see eMedicine Recalls and Alerts 8/1/03, Nonresponse Reported in HIV Infection Treated with 3-Drug Regimen Including Lamivudine, Abacavir, and Tenofovir)."

Other warnings on FDAMedWatch support Mr. Harrington's sentiments regarding liver toxicity, and neural tube defects in fetuses from woman who test positive:

"*1/19/2005*
Increased Liver Toxicity with Nevirapine (Viramune) and Higher CD4 Counts."

"Revised prescribing information for nevirapine (Viramune) includes a new recommendation against starting nevirapine treatment in women with CD4 cell counts above 250 cells/mL and males with CD4 counts above 400 cells/mL unless benefits clearly outweigh risks. The new recommendation is based on an increased risk of serious liver toxicity with higher CD4 cell counts prior to starting therapy with nevirapine."

"Females and patients with higher CD4 cell counts are at increased risk of liver toxicity. Females have a three-fold higher risk of symptomatic nevirapine liver toxicity than males, and females with CD4 cell counts above 250 cells/mL have a 12-fold higher risk of symptomatic liver toxicity than females with CD4 cell counts below 250 (11% vs. 0.9%). Males with CD4 cell counts above 400 cells/mL have a five-fold higher risk of symptomatic liver toxicity than males with CD4 cell counts below 400 (6.3% vs. 1.2%)".

2/9/2005
New Drug Interaction Warning with Rifampin and Combination of Ritonavir and Saquinavir

*Drug-induced liver toxicity with highly elevated liver enzymes (greater than 20 times the upper limit of normal) has been observed in 39% of **healthy volunteers** receiving rifampin 600 mg once daily in combination with ritonavir 100 mg/saquinavir 1000 mg twice daily (ritonavir boosted saquinavir).*

"6/10/2005
Neural Tube Defects with First Trimester Efavirenz (Sustiva) Use,"

"The prescribing information for efavirenz (Sustiva) has been changed to include new information. The revision result of four reports linking neural tube defects in infants born to women with first trimester exposure to efavirenz. The four cases of neural tube defects include three cases of meningomyelocele and one Dandy Walker Syndrome. Pregnancy should be avoided in women receiving efavirenz."

Efavirenz is an antiretroviral drug indicated for acquired immune deficiency syndrome (AIDS, HIV-1 infection). A registry has been established to monitor fetal outcomes born to women exposed to efavirenz.."

Third, according to the warnings on package inserts of the commercially available test kits used in reference laboratories, there is no gold standard for identifying specific proteins or nucleic acids of a retrovirus, "HIV." And not only are T-cell numbers irrelevant for an AIDS diagnosis as indicated in the Concorde study cited above, but indeed, Robert Gallo himself even claimed that Kaposi's sarcoma could occur in the absence of any T-cell defect (**8**). *The association of Kaposi's sarcoma with AIDS deserves special mention. This otherwise extremely rare malignancy occurs predominantly in a restricted group, that is, the homosexuals, and can occur in the absence of any T-cell defect in the patients."*

It is well known, in addition, that the makers of the molecularly based test kits such as the ELISA, Western Blot, and PCR-based test kits all claim that: *"ELISA testing alone **cannot** be used to diagnose AIDS"* (**24**), *"**Do not** use this kit as the sole basis for HIV infection,"* (**25**), *"The amplicor HIV-1 monitor test **is not** intended to be used as a screening test for HIV**, nor as a diagnostic test** to confirm the presence of HIV infection"* (**26**) (emphases added).

The rapid tests are even more problematic because they were validated against the kinds of test kits listed above, and several have been recalled by the FDA, despite Sepkowitz's suggestion that " a rapid oral test has simplified broad scale testing."

Moreover, universal “HIV” screening of certain groups is nothing new, and it hasn’t improved the health or reduced "infection rates" of those populations for which routine screening is already in place: military recruits (101), medical students, "disease ridden foreigners" (immigrants who apply for permanent residence, and anybody coming to the participate in the Gay Games in Chicago, despite "some conservative groups {who} oppose(d) the federal government's decision to waive the ban on HIV-positive travelers to the U.S. (102), saying it threatens public health), and last but not least, universal screening of pregnant women. The reason why none of these groups have benefited by universal testing is because of the enormous false positive rate of the test results, especially in those groups Septkowitz and others want to test routinely-among what "experts" call, the "low risk" groups.

Despite this information, in 1995, the CDC recommended offering HIV testing to all pregnant women. According to official AIDS websites like the CDC’s, and on package inserts of "HIV" test kits, false positives due to pregnancy (**103**), flu vaccination (**40, 41**) hepatitis B vaccination (**42**) and 70 other factors always occur at high frequency in "low risk populations (One may ask, in addition, what do the

nucleic acids or proteins from these different contexts imply about the specificity of "HIV")? In addition, different testing standards in different countries completely make moot any absolutes regarding "HIV" testing. In this context, all one needs to do, for instance, if you test "HIV" positive in the US in the morning, is to fly the same day to Canada, the UK, or Australia, where different standards are considered diagnostic, and you will be considered negative the same day.

Just as in the case of pregnancy, flu or hepatitis B vaccination, or 70 other reasons to test positive like Lupus, or late stage alcoholism, universal “HIV” screening for military recruits has also generated false positives (as well as the fear and stigma associated with an "HIV/AIDS" conviction as a result of testing positive). For instance, of the 5, 340,694 individuals who applied to join one of the armed service branches of the US military between October 1985 and December 2000, 4276 applicants tested positive for HIV-1 (**104**). However, the Red Cross recently reported that even after repeated testing using different test kits, low-risk populations, such as blood donors (or military recruits) will typically yield 12 (PCR-positive) or 2 (ELISA positive) out of 37,000,000 positive samples, leaving potentially 10 out of 12 false positives, depending on which test kit you believe (**41**). These numbers, in addition don't support the propaganda and fear mongering that the government controlled media hype constantly deluges us with regarding the AIDS epidemic, nor do they support, I would argue, mandatory universal testing.

Needless to say, testing positive, even if you test positive because you recently had a flu vaccine or are pregnant, can have grave psychological consequences on some folks. Yet, universal “HIV” screening within medical resident training programs has never prompted a letter of apology to the family of Dr. David Acer, for his committing suicide on the basis of mistaken charges that he spread “HIV” to his patients [20], which the CDC later exonerated him of doing (after his suicide), because the CDC could "find no evidence the dentist's HIV-positive patients contracted their infections from him because their virus' DNA did not match his, and also concluded the dentist's patients did not contract the virus from one another -- in effect, that unclean dental implements did not act as conduits" (**105**).

Although Sepkowitz and others claim that knowing you are "HIV" positive through universal testing might be as useful as routine cancer screening, and despite the fact that "HIV" is said to constantly mutate in patients who fail ARV, or that the immunotoxic ARV's are proven to be deadly toxic in most individuals (not all), much hype, hope, and enormous amounts of money has been directed without any accountability toward the production of "HIV" vaccines. However, ever since "HIV," a variant of a known human **cancer virus**," (**emphasis mine**) was announced by media press release as being the probable cause of AIDS by Robert Gallo and Margaret Heckler in May of 1984, “HIV” vaccines haven't been shown to be immunogenic (**70**). Although Margaret Heckler promised a new vaccine in 2 years (by 1986), as Robert Gallo stood in earnist by her side, there is no reason to assume that any components of a retrovirus, “HIV,” have been isolated or identified, even according to the primitive isolation standards that Pasteur or Koch worked out more than 130 years ago. If antibodies against "HIV" aren't evoked even when "HIV's" "isolated and purified components (antigens) are injected directly into the bloodstream (no molecular entity associated with "HIV" has been shown to be immunogenic in humans, according to "the experts"), how could the test kits possibly work, and more importantly, how could the public health service continue to ruin the lives of people who test positive in light of these kinds of failures? Even Barre-Sinoussi (one of Luc Montagnier’s original group) has “come out of the closet,” so to speak on this issue. At the Toronto 2006 International AIDS conference, she said at the conference:

“It is not clear if therapeutic vaccines might be useful, since 15 trials to date have not demonstrated definitive evidence of improved outcomes.”

Even after the failure of Donald Francis's 120 million dollar AIDSVAX program (former head of the CDC), an enterprise that after its failure was announced, it was announced by Dr. Robert Gallo himself that: *"A sound Rationale (is) needed for Phase III HIV vaccine trials"* (**70**).

Moreover, it isn't clear what VaxGen is now doing with the "HIV" vaccine because the government now has given them a little more of our tax money to help VaxGen experiment with an anthrax vaccine for our young soldiers:

"2005 Newsweek reports that VaxGen, a little-known California biotechnology company, will start its first delivery of its anthrax vaccine to the government six months later than originally slated. The company was awarded an $877.5 million contract to produce and manufacture the vaccine, which was developed by the U.S. Army Medical Research Institute of Infectious Diseases (USAMRIID),"

It should at least be mentioned that the recent recommendation handed down from CDC for universal “HIV” screening is perhaps most reminiscent of the mandated theocratic sacraments put into place during the hepatitis B vaccine era. More than twenty years later, the evidence shows that the current hepatitis B mandate in place not only threatens our children's health (**105**), but also serves in the future to threaten our children's education and admission to all kinds of institutions (day care and school admission).

But isn’t "HIV" a distinct exogenous virus (comes from outside the organism), and, like all other biological entities in the biosphere, possesses a unique genetic identity that can be used to identify it, or its proteins, as "HIV-specific"? A study from the University of Minnesota doesn't support this idea: Horwitz et al., Department of Microbiology, University of Minnesota, Minneapolis, suggested that “HIV” gene sequences can be detected in **non-infected** humans, chimps, and monkeys (**18**).

*"Endogenous retrovirus-related sequences exist within the normal genomic DNA of all eukaryotes, and these endogenous sequences have been shown to be important to the nature and biology of related exogenous retroviruses and may also play a role in cellular functions…Herein we describe the first report of the presence of nucleotide sequences related to HIV-1 in human, chimpanzee, and rhesus monkey DNAs from **normal uninfected individuals**."*

In this study, “HIV, ”is not regarded as an exogenous retrovirus that enters a host from the outside, but instead is simply a molecular sequence found in normal human, chimp, and monkey DNA. Thus, because the test subjects in these groups are normal and healthy (no low lymphocyte count), yet express “HIV” sequences, this means that an exogenous retrovirus, "HIV" doesn’t lead to immune suppression (because there is no infection or illness-they are "***normal uninfected individuals***" and there can’t be any "AIDS" (or "SIDS") because there is no immune suppression (or exogenous virus) detectable.

Abundant evidence also is available regarding the non-specificity of other so-called "HIV" components, such as reverse transcriptase (RT) in non-"HIV" infected humans or other organisms. Nobelist, Howard Temin who discovered RT, and Nobelist and former NIH head Harold Varmus, claimed that reverse transcriptase is a normal protein found in the uninfected cells of **yeasts, insects and mammals** (**11,**). More recently, other investigators have claimed RT is important for telomere replication at the tips of normal chromosomes, and "has nothing to do with retroviruses." The literature describing the presence of reverse transcriptase RT, once claimed to be a specific component required for "HIV" replication (reverse

transcriptase) is known in the form of market magazines concerning biotechnology stocks (**12, 13**) to exist in normal (non-"HIV"-associated contexts. Also the thymus glands of **"HIV-negative**" children are known to express p24 and other so-called “HIV-specific” markers (**49**). In another study, 50% of dogs exhibit structural proteins to “HIV” but did not develop "AIDS" (**14**). Goats and cows in other studies have been reported to test positive using the current "HIV" test kits, and yet do not suffer from AIDS either (**15**).

Finally, serodiscordant couple studies, never have convincingly shown that "HIV" is transmissible from human to human by providing evidnence of seroconversion among serodiscordant couples. Although this conclusion was inescapable from studies conduced more than a decade ago from the study called “Heterosexual Transmission of HIV in Northern California: Results from a Ten-Year Study” (**106**):

“We followed up 175 HIV-discordant couples [one partner tests positive, one negative] over time, for a total of approximately 282 couple-years of follow up…(it was a 10 year study-emphasis mine)- No transmission [of HIV] occurred among the 25% of couples who did not use their condoms consistently, nor among the 47 couples who intermittently practiced unsafe sex during the entire duration of follow-up…” “We observed no seroconversions after entry into the study [nobody became HIV positive]…This evidence argues for low infectivity in the absence of either needle sharing and/or other cofactors.”

The public health service and government-backed media continue to terrorize us with propaganda, while even the decade-old evidence regarding transmissibility between serodiscordant couples never proved the case for "HIV's" transmissibility. Are all of these "undiagnosed diseased persons," according to Septkowitz, a real public health threat sufficient to justify or for us to tolerate mandated universal testing? Does it even matter given the current climate of fear-mongering in our culture?

The past 25 years of "the AIDS Pandemic" would indicate that you do not think about science at a time like this: think religion, and obtain a religious exemption from undergoing an "HIV" test. In this culture, and in these times, scientific evidence cannot possibly persuade like religious ideology can, and if your exemption is based on scientific evidence or logical argument, your argument for yourself or for your child can be contested by “experts.” Faith-based exemption means that God told you not to get tested, and who can argue with that?

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