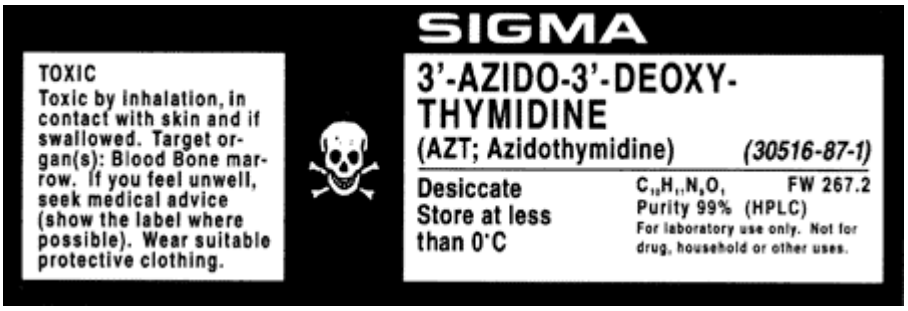
LAZARUS EFFECT OR AIDS BY PRESCRIPTION?

Dedicated to providing lifesaving drugs to Africans with aids, through a partnership between the Global Fund and companies such as Apple, Armani, and Gap, (Product) Red could be a revolution in consumer-driven philanthropy. First introduced in 1987, anti-retroviral drugs—ARVs for short—block H.I.V.'s assault on the body's immune system. As the drugs have improved, becoming less toxic and easier to take, they have largely turned aids in the Western world from a death sentence into a manageable disease (see: Vanity Fair - The Lazarus Effect, July 2007). Really – lifesaving but toxic drugs? Which drugs are the improved drugs that have become less toxic? What comes across clearly is that consumer-driven philanthropy does not provide "lifesaving drugs" but toxic drugs. The truth is summed up within their own words and the question is..."How Toxic?"

The fact about AZT (RETROVIR or ZIDOVUDINE) is that "It was often difficult to distinguish adverse events possibly associated with zidovudine [AZT] administration from the underlying signs of HIV disease" - Physician's Desk Reference, 1994. THE ACTUAL COPY OF AN AZT LABEL Gives the Following Warning;-

Physician's Desk Reference, 1994



THIS IS AN ACTUAL COPY OF AN AZT LABEL

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

PROLONGED USE OF RETROVIR [=AZT] 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 (SEE WARNINGS)." from Glaxo Welcome AZT product information.

It is "the most toxic drug that has ever been licensed for long term consumption in the free world. ... AZT is a prescription drug and according to the manufacturer itself it causes symptoms that are indistinguishable from AIDS. It has the following effects in the human body:-

> "Excruciating headaches; severe nausea; muscular pain; wasting of the muscles; damage to kidneys and nerves; excruciating pains in the legs; encephalitis; severe anemia requiring transfusions to stay alive; lymphoma (cancer); cancer in 49% of cases, versus 2% incidence in non AZT group; liver damage; nail dyschromia (fingernails turn black); insomnia; impotence; dementia; mania; ataxia (failure of muscular coordination); seizures; alopecia (hair falls out). It is a fairly well established fact that AZT was designed to kill the bone marrow. It causes neutropenia or leukopenia (loss of white blood cells) or bone marrow aplasia. Bone marrow toxicity. White blood cells are the basis of the immune system. T cells, granulocytes, those are all parts of the immune system. You kill those with AZT and the immune system is gone."
>
> ***- Harvey Bialy***
> *Research Editor Bio/Technology Science Journal*

The doctors measure the aids virus's progress in attacking the immune system by testing each patient's level of CD4 immune cells. Patients with a count of more than 500 are released without further treatment. Those whose CD4 levels are between 500 and 350 are **told to come back for more tests in three months**. Those who score between 350 and 0 are **eligible** for ARVs (Liam says: June 24th, 2007 at 7:09 pm). The fact is that most drugs that are used as "medicine" are immunotoxic or immunosuppressive and many drugs actually result in lowering the white blood cell counts. Tragically AZT and the toxic retrovirals can lower the white blood cell count to the level that you actually qualify for treatment by the very same drugs that produced the medical predicament! It is such an awesome phenomenon of modern medical science that it deserves a special term – let's call it the **LAZARUS PARADOX**.

"The major side effect of AZT is bone marrow suppression which causes a decrease in the number of red and white blood cells" (see:HIV/AIDS, MayoClinic.com, June 25, 2007).

"Mothers who received the long AZT treatment had a higher rate of stillbirth (8% vs. 4%), severe anemia (7% vs 4%), infection or other HIV events (20% vs 17%), events related to pregnancy or delivery (24% vs 17%) than mothers who received the short course, although fewer died (3% vs 8%)" (Lallemant M et al, A trial of shortened zidovudine regimens to prevent mother-to-child transmission of human immunodeficiency virus type 1, NEJM. 2000 Oct 5;343(14):982-91).

"Infants with early positive HIV-1 cultures demonstrated a notable decrement in neurodevelopmental functioning within the first 30 months of life. They achieved motor developmental scores that were increasingly and significantly discrepant [worse] both from the average and from scores achieved by late HIV-1-positive children over the course of the study period" (Smith R et al. Timing of perinatal human immunodeficiency

virus type 1 infection and rate of neurodevelopment, Pediatr Infect Dis J. 2000;19:862-71).

The UK's Committee on Safety of Medicines has issued a warning to doctors about the risk of AZT leading to mitochondrial dysfunction in infants (Perinatal AZT: New warning on potential risk to infants, www.aidsmap.com, 1999 Jul 21). Mitochondrial dysfunction leads to a decline in ATP output followed by fatigue and muscle wasting. The mDNA depletion is due to the robbing of the hydrogen atoms from the DNA molecule by hydroxyl radicals generated by AZT while the incorporation of AZT into the DNA molecules cause mitochondrial dysfunction. "The data show that AZT crosses the human placenta and becomes rapidly incorporated into DNA of placental tissue in a dose-dependent fashion, suggesting that even short exposures to this drug might induce fetal genotoxicity and might also inhibit maternal-fetal viral transmission" (Olivero OA et al. 3'-azido-3'-deoxythymidine (AZT) transplacental perfusion kinetics and DNA incorporation in normal human placentas perfused with AZT, Mutat Res Fundam Mol Mech Mutagen. 1999 Jul 16;428(1-2):41-7). Yet it is prescribed as a medicine to pregnant mothers and infants!

AZT is a poison that is cytotoxic. Originally developed for chemotherapy, it was never approved for use in humans because of its toxicity. It kills healthy cells by terminating the DNA synthesis in cells. Its mDNA depletion activity explains muscular fatigue and its role in causing mitochondrial dysfunction leads to muscular atrophy later in long term use. AZT is confirmed to be carcinogenic in mice. In humans, AZT increases the risk of lymphomas by 50 times. AZT decreases white blood cells by killing young CD4 lymphocytes. It causes anemia, vomiting, lactic acidosis, fatigue, muscle wasting and lymphocytopenia and it stimulates leukemia – all the classic symptoms of AIDS!

Stop to think for a moment. When AZT was declared “toxic by inhalation” and if you had forced someone to inhale it, the law would declare that act as a crime, wouldn’t it?

It is a paradox advocated by modern medical science, in the field of pharmacy that recommends AZT as the “pharmaceutically prescribed” drug. And once it becomes the “pharmaceutically prescribed drug,” the health authorities and doctors administer it without question even though in the same breath these doctors and authorities advocate evidence-based medicine. The layman with the gift of commonsense logic will tell you that you cannot give toxic drugs that produce the symptoms of AIDS to AIDS patients and evidence-based medicine will tell you the same but perhaps with the extra warning that such drugs must avoided by AIDS patients. However, in consumer-driven philanthropy such toxic drugs are lifesaving….exactly what the AIDS posse says.

Our health science teacher in secondary school told us that when foreign substances or toxic substances or pathogens entered the body, its immune function responds by increasing the number of white blood cells or increasing the number of T4 cells. Research has proven that toxic substances have been observed to stimulate the release of T cells from the bone marrow and prolonged administration of toxic drugs will eventually be exhausting the supply and causing immune cell depletion and anemia or interfere with

cell division in the bone marrow. The initial rise in CD4 counts seen in the case of administration of toxic AIDS drugs is interpreted as improved immune function! The bullshitting just won't stop. And there are other side effects of toxic drugs.
Liam says "I am introduced to a woman **who developed lipodystrophy from taking her first trio of ARVs**. A distortion of the body-fat distribution in the arms, legs, breasts, face, and buttocks, **lipodystrophy is a common complication of stavudine**, one of the medications that was in her first-line cocktail. When that was replaced with abacavir, the woman returned to normal. Still, she complains that the drugs are so strong **she can't stand them without eating well**, but since she isn't working, **she can't afford food** (Liam says, June 24th, 2007 at 7:09 pm).

Stavudine must be further researched and studied to determine if it depletes or interferes with Alpha-lipoic acid – the master antioxidant within the natural antioxidant network system of the body as a sudden depletion of this antioxidant tends to promote the conversion of protein into fats and that may be the cause of the distortion of fats in her body.

One startling and noteworthy observation about such toxic medication is that they deplete the natural antioxidants in the body just like it happens in chronic malnutrition or by continuous use or exposure to chemical stressors. The additional action of such toxic drugs is that they generate large amounts of free radicals and promote the formation of secondary free radicals that oxidatively damage cell membranes, deplete mDNA and interfere with the cytochrome system and the Krebs cycle leading to a decline in ATP production and lowering of cell output. When such detrimental biochemical activity occurs in any biological system that is low in natural antioxidants, it will certainly lead to the development of disease conditions including AIDS when this biochemical activity affects and impairs the immune system. Consider the tragic irony of the woman who developed **lipodystrophy after she was given AVRs.**

Evidence-based medicine demands that all drugs given or pharmaceutically prescribed to AIDS patients be tested to determine their profile with regard to their antioxidant depletion activity in vitro and in the mammalian system.

A panel of leading AIDS specialists has developed recommendations for the use of anti-retroviral (AVR) medications in people with HIV – a virus that has not been seen in electron microscopy even though it is supposed to be an enveloped virus but there is no evidence of its "budding process" – a virus that is supposed to virulently attack the cells of the immune system and disable it but is being cultured in an immortal line of T4 cells since 1984! According to their current guidelines, treatment should focus on achieving the maximum suppression of the symptoms for as long as possible! This aggressive approach is known as highly active antiretroviral therapy (HAART). "The goal of the AIDS treatment is to find the strongest possible regimen that is also simple and has fewest side effects" and there is also emphasis on the quality of life! (see:HIV/AIDS, MayoClinic.com, June 25, 2007). Now how do you aggressively administer toxic drugs with the strongest possible regimen that reduce your red and white blood cell counts and cause side effects to achieve suppression of the symptoms for as long as possible and yet

focus on quality of life? Only modern medical logic can possibly twist the facts to provide an answer for you, but only in the case of AIDS. So they are trying to move on to protease inhibiting drugs.

Protease inhibitors (PIs) interrupt HIV replication at a later stage in its life cycle by interfering with an enzyme known as HIV protease. This causes HIV particles in your body to become structurally disorganized and noninfectious. Among these drugs are saquinavir (Invirase), ritonavir (Norvir), indinavir (Crixivan), nelfinavir (Viracept), amprenavir (Agenerase), lopinavir, atazanavir (Reyataz) and tipranavir (Aptivus). Darunavir (Prezista), a protease inhibitor approved in 2006, is intended for people who haven't responded to treatment with other drugs. Darunavir is used in conjunction with ritonavir and other anti-HIV medications (ref:HIV/AIDS, MayoClinic.com, June 25, 2007). Please note two important facts in this literature as follows:-

1. **"HIV particles** in your body to become structurally disorganized and non-infectious." I have clearly stated one form of AIDS may be a latency disease of the Epstein-Barr virus.

   "This is primarily because many AIDS patients do not have the virus, pointing clearly to oxidative stress in malnourished people as the actual cause factor of AIDS and even when the reactivated EBV is involved, in certain groups of people, in the destruction of parts of the immune system, it occurs in conditions of oxidative stress and more startling is the fact that when **EBV viral parts 'hide**' in cells of the immune system, they are reactivated by hydrogen peroxide which is a by-product of oxidative stress. So, however you look at the AIDS condition, oxidative stress is a critical factor. Logically, therefore nutritional intervention is the key and should form the basic thrust in responding to the AIDS problem (see:THE EPSTEIN-BARR VIRUS IN AIDS, Health Supreme, Sept 05, 2006)) .

2. The "protease inhibitor approved in 2006, is intended for people who haven't responded to treatment with other drugs." The truth is that these drugs are meant for interfering with a viral replication process and do not have any effect on viral parts or viral particles and as Gallo says, only 40% of people have the HIV virus going by his simple fractionation method which does not meet the gold standard of virology. And that conclusively means that most people do not have a virus that targets the cells of the immune system and disables it but we do have a recommended medicine that causes bone marrow suppression that causes the red and white blood cells to decline or other drugs that lower the white blood cell count. So, the disease can be established and its progress accelerated by the drugs used on AIDS patients.

   It therefore becomes even more interesting, in fact madly exciting to note the correctly printed disclaimer on AIDS test kits which says that the tests cannot be used to diagnose and treat AIDS – but that is how hospitals diagnose the AIDS condition! All of these are components of a strange paradox in medical science

that is strenuously defended by the AIDS posse as AIDS has lead to the growth of a multibillion dollar industry that is simply too lucrative to give up.

The most common side effects of protease inhibitors (PIs) include nausea, diarrhea and other digestive tract problems. PIs can also cause a significant number of side effects when they interact with certain other medications you may be taking. That's because all PIs, to one degree or another, affect an enzyme system in your liver that is responsible for metabolizing a large number of drugs. Newer side effects have also appeared with the continuing and widespread use of protease inhibitors. These include elevated triglyceride levels and problems with sugar metabolism that may sometimes progress to diabetes (see: HIV/AIDS, MayoClinic.com, June 25, 2007). Diabetes is a glucose metabolic disorder associated with secondary radicals called the peroxynitrite radical. Diabetics have been shown to have relatively more free radicals in the body and consequently the diabetic population has a higher risk to cancers, arthritis and cardiovascular disease. This clearly proves that when the enzyme that is responsible for metabolizing drugs in the liver is inhibited, those drugs are not broken down but continue to circulate in the bloodstream or tend to accumulate in the liver. Circulating drugs generate free radicals throughout the body leading to problems in glucose metabolism.

There may also be abnormalities in the way fat is metabolized and deposited in your body. Some people lose much of their total body fat; others gain excess fat on the back between their shoulders (buffalo hump) or in the stomach (protease paunch) (ref: HIV/AIDS, MayoClinic.com, June 25, 2007). Quite obviously, the increase in blood triglyceride levels with the administration of PIs indicate that they block the conversion of fats into glucose just like some biguanides and the PIs may also be inhibiting the formation of alpha-lipoic acid in the body and like some statins inhibit the formation of CoQ10 in the body.

The authorities have approved another class of drugs called Nonnucleoside reverse transcriptase inhibitors (NNRTIs). Three NNRTIs are approved for clinical use: nevirapine (Viramune), delavirdine (Rescriptor) and efavirenz(Sustiva). These drugs are said to bind directly to the enzyme reverse transcriptase but they all produce a major side effect – a rash. This means these drugs are destroying the lipid part of the cell membranes through oxidative stress. In addition, people taking efavirenz may have side effects such as abnormal dreams, sleeplessness, dizziness and difficulty concentrating – an indication of lipid peroxidation in the brain cells and impairing the MT protein system in brain cells.

In a study of 1,160 patients on at least three HIV drugs, Swiss researchers found that more than two-thirds suffered symptoms such as vomiting, diarrhea or sleep disturbance, or showed problems in lab results, such as potentially serious abnormalities in blood cells, proteins or cholesterol. A "significant proportion" of these side effects were serious or severe, according to Dr. Jacques Fellay, of the University Hospital of Lausanne, and his colleagues. Of the lab abnormalities, 16% were serious or severe, the researchers report. A few patients had been hospitalized for conditions such as kidney dysfunction and severe fatigue that were "probably or definitely" due to their HIV treatment (Adverse Effects From HIV Drugs Found To Be Common, Reuters 19 Oct. 2001). All of these

conditions could have been due to the patients' HIV therapy, the investigators report in the October 20th issue of The Lancet.
Nevirapine is acknowledged by Boeringer Ingelheim, its German manufacturer, to be capable of causing severe liver damage and life-threatening skin reactions soon after patients start taking regular doses. This month a new warning about its dangers was issued by US health officials. Deaths have been reported from several countries. On 19 January, the US Food and Drug Administration (FDA) warned that cases of liver damage were more common with nevirapine, especially in women, than with other anti-HIV drugs (see:Neville Hodgkinson, Fresh cause for concern over the side-effects of nevirapine, January 2005, Health Supreme;The Trouble with Nevirapine, January, 2005, Anthony Brink, Alberta Reappraising AIDS Society).

Toxic drug administration has acquired a momemtum in the last two decades and there is a haloed dogma in using them (see:CAN I HAVE MY CHEMO SUPPLEMENT PLEASE!, Beldeu Singh, March 2006).

The continued and widespread use of drugs in treating people has become a public health issue and the aggressive use of toxic drugs that lead to disabling and immunosuppressive effects that can cause fatigue and symptoms of AIDS is distressing and any consumer-driven philanthropy of such drugs to the poorest of people on earth simply hurts human dignity as it disturbs the inner moral chord. These people need nutrition not drugs that are so strong that they can only weaken their chronically malnourished bodies.

The fact is – there are alternatives to AVR and AZT (see:Alternatives to AZT in Aids Patients, Health Supreme, May 07, 2007). Palamara et al, investigated the effect of glutathione on the replication of human immunodeficiency virus (HIV) in chronically infected macrophages, a known reservoir of the virus in the body [AIDS Res Hum Retroviruses 1996 Nov 1;12(16):1537-41] Exogenous GSH strongly suppresses the production of p24gag protein as well as the virus infectivity. This is related to a dramatic decrease in both budding and release of virus particles from chronically infected cells (either macrophages or lymphocytes) This study suggests that GSH (glutathione) can interfere with late stages of virus replication and the suppression of virus replication by GSH is related to the selective inhibition of envelope glycoproteins. These results suggest a potential role of GSH taken in combination with other appropriate phytochemicals. But there is an even more interesting study.

Herzenberg et al conducted in vitro studies that showed that low GSH levels both promote HIV expression and impair T cell function and they suggested a link between GSH depletion and HIV disease progression (Glutathione deficiency is associated with impaired survival in HIV disease, Proc Natl Acad Sci U S A. 1997 Mar 4;94(5):1967-72). Their clinical studies directly demonstrate that low GSH levels predict poor survival in otherwise indistinguishable HIV-infected subjects while, specifically, that GSH deficiency in CD4 T cells from such subjects is associated with markedly decreased survival 2-3 years after baseline data collection. This finding "establishes GSH deficiency as a key determinant of survival in AIDS patients and the unnecessary or excessive use of acetaminophen, alcohol, or other drugs known to deplete GSH should be avoided by

HIV-infected individuals". And quite naturally, minerals that work with glutathione and enhance its antioxidant enzyme activity are equally important.

Sprietsma J.E. showed that the way in which the right amount of cysteine, glutathione (GSH), and copper and zinc ions made available in the right place at the right time and in the right form can prevent an unchecked multiplication of (AIDS) viruses in a more passive or active way forms the basis for the AIDS zinc-deficiency hypothesis (A-Z hypothesis) presented in this article [Med Hypotheses. 1999 Jun;52(6):529-38. Review] Comment in: Med Hypotheses. 2000 Nov;55(5):456-7. Zinc and copper ions that remain available in sufficient amounts via cysteine/GSH are effective natural inhibitors/combaters of (AIDS) viruses and thereby prevent the development of chronic virus diseases that can lead to AIDS, autoimmune diseases, (food) allergies and/or cancer. These ions are important for the efficient functioning of the glutathione-catalase antioxidant system that converts hydroxyl radicals into water and oxygen and also convert hydrogen peroxide into water and oxygen. Their biochemical activity that converts toxic radicals and chemicals into useful intracellular water and oxygen are key to healthy function of the cells and for the promotion of antioxidant-driven biochemical pathways in the body. Deficiencies of these antioxidant enzymes and ions result in free radical induced pathways that lead to the development of disease states and aid the progression of disease conditions.

Interestingly, most toxic medication and D-form chemicals tend to deplete the natural antioxidants in the body particularly glutathione and natural vitamin C. And such depletion impairs and disables or otherwise destroys the immune function but the experts and AIDS specialists insist on aggressive toxic interventions for as long as possible! And at the end of this period, the patients' immune system is virtually gone and ready for opportunistic infections. That is the meaning of "as long as possible".

The AIDS specialists want to aggressively administer toxic drugs into the AIDS patient "as long as possible" which means until the opportunistic infections become established in the body and then comes the regime of antibiotics. By this time the natural vitamin C levels in the lungs are critically depleted and the lung's vitamin C-dependent antioxidant defense mechanism is disabled. So, in most cases AIDS patients, at the terminal end tend to suffer and die from opportunistic infections of the lungs that may be associated with candidiasis or systemic fungal disease. The antibiotic regimes kill both the pathogenic bacteria along with the symbiotic (good) bacteria that are a healthy part of the gut microflora that keep the candida in check. When the symbiotic bacteria are killed off, the candida begin to multiply in the body to produce candidiasis. The AIDS patients may succumb to the aflatoxins produced by the candida.

Candida aflatoxins can cause a general sense of weakness with or without chronic fatigue, muscle weakness, sleep disorders, anxiety, digestive complaints, vaginal yeast infection, skin disorders such as rashes, itching, headache, chemical sensitivities, depression, muscle and joint pain and genito-urinary problems and these symptoms are frequently misdiagnosed and require investigation to determine the underlying causal link with candida aflatoxins. At a glance, it may appear as AIDS. It is common knowledge in

many societies that coconut oil prevents systemic fungal disease and cures Athlete's foot. Now this knowledge is found in modern science and scientific journals.

The AIDS scientists claim that "HIV infects and kills CD4+ T lymphocytes. They clearly assert that primary HIV infection is associated with a burst of HIV viremia and often a concomitant abrupt decline of CD4+ T cells in the peripheral blood (Cooper et al., 1985; Daar et al., 1991; Tindall and Cooper, 1991; Clark et al., 1991; Pantaleo et al., 1993a, 1994). The decrease in circulating CD4+ T cells during primary infection is probably due both to HIV-mediated cell killing and to re-trafficking of cells to the lymphoid tissues and other organs (Fauci, 1993a). And while they stick to the viral pathogenic cause that must produce the same disease in all infected persons, they also state that "HIV disease, however, is not uniformly expressed in all individuals" (see: Course Of HIV Infection, The Relationship Between the Human Immunodeficiency Virus and the Acquired Immunodeficiency Syndrome, Sept 1995). The HIV postulate for AIDS also claims that, once the virus infects CD4+ T cells, the virus' genetic material is permanently integrated into the cell's chromosomes, establishing permanent latency within infected cells. Please note that they are not sure about the disease – whether the HIV actually targets the T4 cells and destroys them followed by burst of HIV viremia which means the HIV acts virulently and the progression ought to be fast (like days and weeks instead of 10 – 12 years) or if their fictitious virus is breeding a latency disease by incorporating its genetic material in the host cell DNA. If the former is correct, why are the AVRs not effective in treating the viral infection? If the later is true, which it is not, how can it be treated by toxic medication?

How about consumer-driven philanthropy that is dedicated to giving toxic drugs to a large number of false positives? "In 1990, of 20.2 million HIV tests done in Russia only 112 were confirmed and about 20,000 were false positives, 1991 saw some 30,000 false positives out of 29.4 million tests, with only 66 confirmations...in 1991 alone some 8000 false-positive results were reported in pregnant women, with only 6 confirmations [presumably with the Western Blot test]" (Voevodin A. HIV screening in Russia, Lancet. 1992;339:1548). We are a testing culture. Furthermore, any increase in the false positive rate could turn a screening program into a social catastrophe (see: Screening For HIV: Can We afford The False Positive Rate? The New England Journal of Medicine, Vol. 317 No.4, July 23, 1987). Strangely hospitals are using test kits to diagnose AIDS that correctly carry a disclaimer they cannot be used to diagnose and treat AIDS and are not getting sued.

If the virus existed, there would have been developed a virus specific diagnostic test, not one that tests only for proteins associated with oxidative stress and a vaccine would already have been produced. Since they are only testing for proteins, there are false positives and each of those tests kits come with a disclaimer. Hence people recovering from Malaria or Flu can also test positive! I would like to repeat what I have written long ago – there will never be an AIDS vaccine simply because there is no HIV virus and because it is a disease associated with chronic malnutrition and oxidative stress that depletes the natural antioxidants in the body.

Gallo's testimony in the Court Of Appeal in South Australia is highly illuminating. He claimed to have "isolated the HIV" and said that it was the "probable cause of AIDS". The evidence on p1294 tends to show that HIV was isolated from only 40% of patients but the finding of positive antibody was in 88% of the patients! That shows that there are people who test positive without an "infection". What about the remaining 12%? The evidence on p1300 proves that for adults AIDS with Kaposi's sarcoma was only 30.2% while for adult AIDS with opportunistic infections was only 47.6%. So, between 52.4% and 69.8% of people with Kaposi's sarcoma and opportunistic infections are not linked to AIDS, and HIV could be isolated as a supernatant in only 40% of AIDS patients, yet Gallo insists that HIV causes AIDS. It drills a hole in the concept of viral pathogenicity but the AIDS posse is ignoring this piece of truth. It would hurt business.

Well if you could be blind or choose to ignore the confounding probability of a line of T cells established from a leukemia patient that could be infected with virus from the cells of AIDS patients and go on producing virus indefinitely when the retrovirus was killing the cells it infected, especially targeting cells of the immune system, like the T cells, you can ignore whatever that hurts the business and go on towards consumer-driven philanthropy that ensure people, even the false positives get their toxic doses instead of nutrition and a wide range of antioxidants.

And it becomes possible to propagate the HIV cause of AIDS even with contradictions. Montagnier has actually stated that "it would be a tribute to their (dissidents like us) courage and honor to abandon the HIV cause of AIDS in the face of overwhelming evidence (Virus, New York, WW Norton & Company Inc, 1999). Ok fine. Let's abandon the questioning of that dogma but let's look at their science. At least that should be allowed. It is still science, isn't it? In that book, Montagnier states that in AIDS patients, oxidative stress is massive and it occurs at an early stage. The cause of the oxidative stress is HIV! In an interview in 1995, Montagnier said that for the progression of AIDS, oxidative stress is a key factor. The contradiction here is that we should expect massive oxidative stress only at a later stage, after a large number of HIV replications have occurred, certainly not in the initial stages. Hello, people, if oxidative stress is the key factor for the progression of AIDS, then why prescribe toxic medication that generates a detrimental amount of oxidative stress? The answer ironically is – to aid the progression of AIDS. Oh blind me.

So, that means any consumer-driven philanthropy dedicated to provide toxic medication to poor people has only one scientific aim – aid the progression of AIDS.

Medical science, as it presents itself today, is largely a treatment science where disease conditions are to be treated with drugs while health science, which is about restoring health through biomolecules that promote and restore cellular function, has largely been abandoned. This chronic deviation is slowly and progressively repositioning toxic drugs and chemicals as clinically useful and later on as harmless or even beneficial for people who have not yet developed any symptoms. As a strategy, toxic drugs appear to be moving in that cycle and AZT is a good example that has dogmatic support (see: Beldeu Singh, Can I Have My Chemo Supplement Please? & see: A WORLD TURNED UPSIDE DOWN :

HEALTH SUPPLEMENTS MUST BE REGISTERED AS PHARMACEUTICALS WHILE TOXIC CHEMICALS BECOME HEALTH SUPPLEMENTS).

Now there is an advertisement in a peer review journal that touts that AZT is well tolerated in children, improving cognitive function, growth and well being! It is already sounding like a health supplement. We have created AIDS by Prescription. Where are we heading?

There is an obvious case to distinguish four types of AIDS: one that is caused by free radicals generated by pollutants; another caused by lifestyle toxic chemicals such as in alcoholics, drug abusers and the gay population; the third being correctly labeled as "prescription AIDS" as it is caused by prescribed medications; and in any of these cases where there is HIV virus infection, the virus gains entry into the cell through the cell wall that has suffered free radical damage. In all of these cases, only when the immune and endocrine systems are severely degenerate or destroyed will the opportunistic infections set in to manifest the full blown AIDS (AIDS, Non-HIV AIDS, and 'Prescription AIDS', October 7, 2004, independent-media TV, Beldeu Singh, April 12 2004, Health Supreme - HIV-Aids: A Tragic Error). But there is no evidence of HIV and the closest to a viral related cause is possibly viral parts of the EBV virus which means we have AIDS by oxidative stress and AIDS by prescription of toxic medication.

The adverse effects of alcohol and other drugs on the immune system have been documented since the beginning of last century. There is a growing body of human and animal evidence of the immunotoxicity of tobacco smoke, alcohol, marijuana, cocaine, heroine, alkyl nitrites, metamphetamines, qualones and other street drugs. These facts form some of the scientific bases for the "drug-AIDS hypothesis". We developed a very large number of prescription drugs and most of the allopathic pharmacopeia is toxic. These drugs generate free radicals in the body some of which cause mitochondrial depletion or have immunotoxic properties.

Slowly, but surely, evidence is beginning to emerge that some senior officials within the UN may perhaps be beginning to get the message about the relationship between poor nutrition, depressed immunity, and AIDS (see;Nutrition and Immunity - The hungry can't eat Aids messages, Sepp Hasslberger, www.newmediaexplorer.org/sepp, September 5, 2006).

Taken alongside the recent 3-page World Health Assembly resolution calling on Member States to ensure that special attention be given to integrating nutrition into all HIV/AIDS policies, this is undoubtedly good news.

Yes it's about time that the UN policies on AIDS pursue a proper and biochemically logical response and practices that promote integration of nutrition into a comprehensive response to HIV/AIDS.

This is primarily because many AIDS patients do not have the virus, pointing clearly to oxidative stress in malnourished people as the actual cause factor of AIDS and even when the reactivated EBV is involved, in certain groups of people, in the destruction of parts of

the immune system, it occurs in conditions of oxidative stress and more startling is the fact that when EBV viral parts 'hide' in cells of the immune system, they are reactivated by hydrogen peroxide which is a by-product of oxidative stress. So, however you look at the AIDS condition, oxidative stress is a critical factor. Logically, therefore nutritional intervention is the key and should form the basic thrust in responding to the AIDS problem.

Resolution WHA57.14 which urged Member States, inter alia, to pursue policies and practices that promote integration of nutrition into a comprehensive response to HIV/AIDS is therefore considered urgent.

The recommendations of WHO's technical consultation on nutrition and HIV/AIDS in Africa (Durban, South Africa, 10-13 April 2005), which were based on the main findings of a detailed review of the latest scientific evidence on the macronutrient and micronutrient needs of HIV-infected people, including pregnant and lactating women and patients on antiretroviral therapy, make more sense now than before these recommendations were drafted.

Natural antioxidant oils are important for AIDS patients and of critical importance to AIDS patients who took toxic medication. These must be a blend of essential fatty acids (EFAs) with coconut oil and sesame seed oil. EFAs help to reduce oxidative stress in the cell membranes and promote the repair of cell membranes. Integrity of cell membranes is important in regulating vital cell activity including regulating transport of molecules across membranes. EFAs promote such activity at the cellular level their conversion to eicosanoids and improve sleep patterns and concentration, improve skin condition and they also have an anti-inflammatory effect. Coconout water and coconut oil has been shown to have anti-viral and anti-bacterial and anti-fungal properties after its triglyceride is broken down in the liver into monoglycerides and Africa has plenty of this “tree of life”. Sesame seed oil helps elevate CoQ10 levels in the body. Increasing selenium intake from food sources such as brazil nuts and intake of milk thistle helps increase blood glutathione levels (See:Selenium and it's Relationship in Cancers and AIDS, January 05, 2005, Beldeu Singh). So, the UN Resolution to integrate nutrition into the diet of AIDS patients is important but in most cases a proper nutritional intervention has been shown to improve the health and vitality of AIDS patients. Philanthropy must first focus on this area.

You cannot restore a patient to health by working against his/her immune system and by working against his/her natural antioxidant defense mechanism. But that is exactly what toxic drugs do and it is a health science issue in any consumer-driven philanthropy.