

# THE CASE AGAINST HIV

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

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

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

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

1. HIV does not cause AIDS.
2. The plain evidence about AIDS.
3. The plain evidence about HIV.
4. Failings of HIV/AIDS theory.
5. What antiretroviral drugs do.
6. Damage done by HIV/AIDS theory and practice.
7. Hindrances to making the case against HIV.
8. How could such a massive blunder come about and persist?
9. FAQs: Questions — sometimes rhetorical only — posed by adherents to HIV/AIDS theory.

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

## 1. HIV DOES NOT CAUSE AIDS

- 1.1 It was never established in the first place, nor later proved, that HIV causes AIDS.
  - 1.1.1 Kary Mullis has described his *unsuccessful* quest — including asking the discoverer of HIV — for citations to the scientific articles that prove HIV to be the cause of AIDS <sup>23</sup>.
  - 1.1.2 The “fact sheets” issued by the National Institutes of Health are not scientific articles, and their claims of proof have been refuted in full detail <sup>24,25</sup>. Those refutations have been ignored or misrepresented but never effectively challenged.
  - 1.1.3 The issue is complicated by progressive re-definitions of AIDS, see [section 2](#).
  - 1.1.4 Luc Montagnier, credited with the discovery of HIV, reported that AIDS seemed to be caused by a mycoplasma and not by HIV <sup>26,27,28,29,30,31</sup>.
  - 1.1.5 By 1993 so many cases of “HIV-negative” “AIDS” had been reported <sup>32,33,34,35</sup> that the condition was pronounced a new disease, “idiopathic CD4 T-cell lymphopenia” (ICL) <sup>36,37,38,39,40,41,42,43</sup> (also “HIV-negative adult-onset immunodeficiency” <sup>44</sup>): immune deficiency of unknown cause with low CD4 counts; but this is precisely the same as the original definition of AIDS.
  - 1.1.6 “HIV-positive” individuals do not necessarily ever progress to AIDS in absence of any treatment <sup>45</sup>.
  - 1.1.7 Specific Italian data illustrate that HIV does not cause AIDS <sup>46,47,48</sup>.
- 1.2 HIV and AIDS are not even correlated.
  - 1.2.1 The seminal papers claimed to have found the putative retrovirus in only “18 of 21 patients with pre-AIDS ... [and] 26 of 72 adult and juvenile patients with AIDS” <sup>49</sup>. This did not even establish that HIV is correlated with AIDS <sup>50</sup>, let alone causes it. The principal author, Robert Gallo, may have committed scientific misconduct as well <sup>7</sup>.
  - 1.2.2 Kaposi’s sarcoma (KS) was one of the three originally iconic AIDS diseases, yet HIV-*negative* cases of KS had been noted at the very beginning <sup>51</sup> and turned out to be quite common <sup>52</sup>.
    - 1.2.2.1 KS is now ascribed not to HIV but to KSHV (Kaposi’s sarcoma herpes virus) or HHV-8 (human herpes virus 8) <sup>53,54,55,56</sup>.
    - 1.2.2.2 AIDS-1 KS was probably caused by the widespread use of nitrite “poppers” by many gay men <sup>57,58,59,60,61</sup>. Although described as a cancer (sarcoma), it may actually be non-malignant damage to blood vessels.
  - 1.2.3 HIV and AIDS are not correlated with respect to geography <sup>62,77</sup>.
  - 1.2.4 HIV and AIDS are not correlated with respect to race <sup>62</sup>.
  - 1.2.5 HIV and AIDS are not correlated with respect to the sexes <sup>62</sup>.
- 1.3 HIV does not even cause illness, let alone death <sup>63</sup>.
  - 1.3.1 The mortality of “HIV-positive” individuals and of “People with AIDS” (PWAs) is independent of age whereas mortality increases very significantly with age in every (other) illness <sup>64,65,66,67,68</sup>.
  - 1.3.2 About 50% of people testing “HIV-positive” never experience illness associated with “HIV” <sup>69,70,71</sup>.
  - 1.3.3 It remains mysterious, in what way or by what mechanism HIV could cause illness of any kind; a number of mechanisms have been bruited, none has been demonstrated or accepted as satisfactory <sup>72</sup>.
    - 1.3.3.1 “HIV” is found in only a tiny proportion (<1%) of the T-cells that it supposedly kills, so the decrease in CD4 counts supposedly characteristic of AIDS or “HIV disease” is ascribed to an unspecified “bystander mechanism”.
  - 1.3.4 Duesberg long ago argued that no retrovirus could act as claimed for HIV <sup>73</sup>.

## 2. THE PLAIN EVIDENCE ABOUT AIDS

### Which AIDS?

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

- 2.1 The first definition of AIDS, therefore AIDS-1: A supposedly unprecedented syndrome characterized by immune deficiency (specifically, low CD4 counts) of unknown cause presumed responsible for the presence of manifest opportunistic infections, chiefly Kaposi's sarcoma, *Pneumocystis carinii* pneumonia (PCP), or candidiasis (fungal: thrush, yeast infection) <sup>74,75</sup>.
- 2.1.1 Designating AIDS-1 as a new medical phenomenon was an error because
  - 2.1.1.1 None of the "AIDS-1" diseases was previously unknown. They occur in HIV-negative individuals for a wide range of reasons <sup>76</sup>.
  - 2.1.1.2 A great many conditions and infections induce immune deficiency, even specifically the low counts of CD4 cells purported to be characteristic of AIDS — non-specific conditions like oxidative stress <sup>77,78</sup> (see also sections 3.2.2, 4.3.2.4, 5.3.3.1, 5.3.3.11, 7.3.3.4) or such specific diseases as tuberculosis <sup>79,80</sup>.
  - 2.1.1.3 The initial diagnosis <sup>100</sup> was by a young physician early in his career who also had access to the relatively new technique of counting CD4 cells <sup>81</sup>.
  - 2.1.1.4 In particular, "recreational" drugs <sup>82,83,84,85,86,87</sup> including nitrites ("poppers") <sup>88,89</sup> cause the same conditions as are said to be characteristic of AIDS, including loss of CD4 cells <sup>90</sup>, and drug addicts display the same manifest symptoms as were ascribed to AIDS-1 <sup>91</sup>.
  - 2.1.1.5 The first AIDS-1 patients were indeed typically users of "recreational" drugs <sup>p. 191 ff. in 16</sup>, pursuing a "fast-lane" lifestyle <sup>96, 97</sup> conducive to ill health. They were on average in their mid-to-late thirties with histories of many bouts of syphilis, gonorrhea, and other infections <sup>92,93,94,95</sup>.
  - 2.1.1.6 The Centers for Disease Control & Prevention used a unique, bizarre, misleading statistical classification scheme that obfuscated the fact that drug abuse was the primary common feature among victims of AIDS <sup>chapter 1 in 16</sup>.
  - 2.1.1.7 "AIDS" was a new *social* phenomenon, irrational exuberance by a proportion of gay men following "liberation", expressed in an impossibly unhealthy lifestyle <sup>pp. 119-20 in 62,96,97,98,99</sup>. It had first been designated more correctly as GRID: Gay-Related Immune Deficiency; though since it was only a small proportion of gay men who practiced the "fast-lane" lifestyle, most correct would have been FLLRID.
- 2.1.2 The first AIDS-1 patients had not been in sexual contact with one another <sup>100</sup>. AIDS-1 came to be regarded as infectious only after the mistaken conclusion that HIV causes AIDS.
- 2.2 Following the mistaken identification of "HIV" as cause of AIDS-1, an increasing number of diseases have come to be labeled "AIDS" just because in their presence an "HIV" test is fairly often positive. That defines AIDS-2: "HIV-positive" by definition, as in the now-common usage "HIV/AIDS", which masks the fact that AIDS-1 was not HIV-caused. Recently the term "HIV disease" has become common.

By subliminal definition creep, "HIV disease" has come to include dozens of ailments, many of which are not opportunistic infections and all of which are previously known conditions, for example tuberculosis, weight loss or wasting, dementia <sup>101</sup>.

  - 2.2.1 1985 definition (AIDS-2a): "HIV-positive" and additional opportunistic infections beyond KS, PCP, or candidiasis <sup>102</sup>.
  - 2.2.2 1986 definition (AIDS-2b): "HIV-positive" and low CD4 counts and opportunistic infections <sup>102</sup>.

- 2.2.3 1987 definition (AIDS-2c): “HIV-positive” “[r]egardless of the presence of other causes of immunodeficiency” [emphasis in original] and in presence of more than a dozen diseases <sup>103</sup>.
- 2.2.4 1993 definition (AIDS-2d): Re-definition increased number of “AIDS” cases in that year by 75% <sup>104</sup>.
- 2.3 AIDS in Africa (henceforth AIDS-Africa) is neither AIDS-1 nor AIDS-2 <sup>105</sup>.
  - 2.3.1 Although AIDS-2 had been defined as caused by HIV, the lack of HIV-testing facilities in Africa led to defining AIDS via the Bangui definition <sup>106</sup>: chronic or persistent weight loss, diarrhea, fever — entirely non-specific symptoms consistent with any number of endemic African diseases.
    - 2.3.1.1 Africans dying from “AIDS” are succumbing to diseases that have ravaged Africans for centuries <sup>105, 107</sup>.

### 3. THE PLAIN EVIDENCE ABOUT HIV

- 3.1 “HIV tests” have never been shown to detect “HIV”, namely an exogenous retrovirus<sup>108, 109, 110, 111, 112, 113</sup>. Therefore the term HIV denotes only whatever it is that produces a positive HIV test, and this should be indicated by always writing “HIV” or F(HIV)<sup>62</sup> or something similar.
- 3.1.1 That a retrovirus could be found in AIDS patients had been inferred from the presence of reverse transcriptase<sup>114, p. 1259 in 115</sup>, an enzyme used by retroviruses to infiltrate the DNA genomes of the cells they invade. But reverse transcriptase turned out to be present in all mammalian cells and is not a valid marker for the presence of “HIV”<sup>116</sup> or any other retrovirus.
- 3.1.2 The mistaken claim to have found a retrovirus in AIDS patients became a claim, announced at a press conference<sup>117</sup>, that it was the *probable*<sup>118, 119, 120</sup> cause of AIDS, discovered by Robert Gallo. The articles later published by Gallo<sup>49, 121, 122, 123</sup> did not establish that claim (see [section 1.2.1](#)).
- 3.1.3 “HIV” tests have never been validated against a gold standard<sup>124</sup>, namely, authentic pure virions (virus particles).
- 3.1.3.1 Actual virions of “HIV” have never been isolated from an AIDS-1 patient nor from an “HIV-positive” individual<sup>50, 108, 125, 126, 127, 128</sup>.
- 3.1.3.2 “Isolation of HIV” in the mainstream HIV/AIDS literature does not carry the usual meaning of isolation, namely, separating out and purifying; instead, the so-called “isolation” of HIV involves a complex culturing technique without subsequent purification; it amounts to a self-fulfilling prophecy<sup>129</sup>.
- 3.1.3.3 The only published electron micrographs of “isolated” “HIV” show a motley mixture of particles and debris that may not even include any retrovirus particles<sup>pp. 127-9 in 116, 126, 130</sup>.
- 3.1.3.4 A reward of \$100,000 for an electron micrograph of isolated pure HIV virions was offered in 2002 and has never been claimed<sup>131</sup>.
- 3.1.3.5 Montagnier has acknowledged that his laboratory never isolated pure HIV<sup>132, 133, 134</sup>.
- 3.1.3.6 Gallo acknowledged that his laboratory had not isolated HIV; he even claimed that copious production of HIV in culture was superior to isolation and purification and that it had made purification unnecessary<sup>pp. 1257-8 in 115</sup>.
- 3.1.3.7 Synthetic “HIV”, a “molecular clone”, contained only between 1 in 10,000 and 1 in 10 million actually infective virions and they were unstable, self-destructing quickly<sup>135</sup>.
- 3.1.4 “Validation” of “HIV” tests is a self-fulfilling tautology<sup>136, 137, 138</sup>.
- 3.1.5 The instructions in test kits acknowledge that the tests are not approved for detecting infection<sup>139, 140</sup>.
- 3.1.6 The first “HIV” test — “ELISA”( enzyme-linked immunosorbent assay) — detects antibodies<sup>141, 142</sup> that are *presumed* to characterize “HIV” proteins, but these and later tests react “positive” to many kinds of antibodies, other proteins, or bits of RNA or DNA. “HIV” tests are not specific, see [section 3.2](#).
- 3.1.6.1 That the tests detect active virus infections came to be believed without the benefit of evidence<sup>143</sup>.
- 3.1.6.2 That belief, that detection of antibodies demonstrates presence of active virus, is an unprecedented and unwarranted inference: antibodies indicate earlier *exposure*, not infection, and in absence of manifest symptoms of illness antibodies are regarded — except only with HIV — as *a priori* evidence of *established immunity* to the respective infection.
- 3.1.7 Measurement by PCR of so-called “viral load” (the purported amount of HIV particles in “HIV-positive” individuals) has been criticized as inherently invalid by the inventor of PCR, Nobelist Kary Mullis<sup>144</sup>.

- 3.1.7.1 “Viral load” measurements may not be specific to the presumed “HIV” genome <sup>145</sup>
- 3.1.7.2 “Viral load” measurements yield appreciable numbers of false negatives <sup>146</sup>
- 3.1.7.3 “Viral load” measurements yield appreciable numbers of false positives <sup>146, 147</sup>
- 3.1.7.4 “Viral load” measurements suffer from poor reproducibility <sup>146, 148, 149</sup>
- 3.1.7.5 “Viral load” is not a marker for risk of death or progression to disease <sup>150, 151, 152</sup>
- 3.1.7.6 “Viral load” does not measure amount of virus, since virus could not be cultured from some people with significant “viral loads” <sup>153, 154</sup>
- 3.1.7.7 “Viral” genes can be found in “HIV-negative” individuals <sup>155, 156, 157, 158</sup>
- 3.1.8 There are no valid “confirmatory” tests. Although Western Blot is routinely referred to in that way, its criteria have never been standardized or validated <sup>124, 159, 160, 161</sup> and it is itself also liable to false positives <sup>162</sup>
- 3.1.9 The initial “HIV” test was based on blood drawn from gay men who were manifestly ill “with AIDS”. No surprise, then, that a wide range of illnesses or degrees of ill health conduce to testing “HIV-positive”: for example, TB patients and drug addicts are as likely to test “HIV-positive” as are gay men, who were the very first purported “risk” group for “AIDS” <sup>163</sup>
- 3.2 False-positive “HIV” tests are common <sup>162, 164, 165, 166, 167, 168, 169, 170</sup>. For consequent misinterpretations and their consequences, see sections 4.3 & 6.1 respectively.
- 3.2.1 Rates of false positive “HIV” test-results depend on the prevalence of positive-testing substances in the tested population. At the prevalence of “HIV-positive” (<1%) typical in populations outside southern Africa, the rate of false positives is likely to be quite high <sup>124</sup>
- 3.2.2 Dozens of physiological conditions — normal, in disease, or owing to medical treatment — conduce to false-positive “HIV” tests <sup>107, 171, 172, 173, 174, 175, 176</sup> — possibly because “HIV-positive” correlates with oxidative stress <sup>177, 178, 179, 180, 181, 182, 183</sup> (more about oxidative stress in sections 2.1.1.2, 4.3.2.4, 4.3.2.8, 5.3.3.1, 5.3.3.11, 7.3.3.4).
- 3.2.2.1 **Auto-Immune Diseases and antibodies to many stimuli** <sup>184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198</sup>; anti-carbohydrate antibodies <sup>175, 199, 200</sup>; anti-collagen <sup>201</sup>; anti-lymphocyte <sup>201, 202</sup>; anti-phospholipid (“sticky blood”) <sup>77, 203</sup>; HLA antibodies <sup>175, 176, 184, 185, 186, 194, 204, 205, 206, 207</sup>; mother’s antibodies transferred to babies <sup>208</sup>; normally occurring antibodies <sup>200, 209, 210</sup>; antibodies to components of test kits <sup>193, 211</sup>; lupus <sup>212, 213</sup>
- 3.2.2.2 **Illnesses that are not infectious:**  
 Cancers (cervical cancer <sup>214, 215</sup>; cardiovascular, atherosclerosis <sup>216, 217</sup>; chronic obstructive pulmonary disease (COPD) <sup>218</sup>; cutaneous T-cell lymphoma <sup>229</sup>; cystic fibrosis <sup>219, 228</sup>; diabetes <sup>194</sup>; hemophilia <sup>184, 185</sup>; kidney failure and dialysis treatment <sup>175, 176, 184, 185, 202, 213, 220, 221, 222, 223, 224, 225</sup>; leprosy <sup>226, 227</sup>; multiple myeloma <sup>184, 186, 207</sup>; multiple sclerosis <sup>228, 229</sup>; periodontal disease <sup>230</sup>; rheumatoid arthritis <sup>235</sup>
- 3.2.2.3 **Infections and toxins:**  
 Aflatoxin <sup>231</sup>; cytomegalovirus infection <sup>232</sup>; Epstein-Barr virus <sup>233, 234</sup>; flu (and flu vaccination) <sup>175, 186, 235, 236, 237, 238, 239, 240, 241, 242, 247</sup>; hepatitis <sup>176, 184, 185, 207, 222, 243, 244, 245</sup>; herpes <sup>246, 247, 248, 249, 250, 251, 252, 253, 255</sup>; HTLV *p. 248 in 254*; malaria <sup>255, 256, 257, 258, 259, 260, 261, 269</sup>; Mycobacterium avium <sup>227</sup>; paramyxovirus <sup>196</sup>; schistosoma <sup>262</sup>; syphilis <sup>176, 184, 185, 194, 263, 264, 280, 313</sup>; Trichomonas vaginalis parasites <sup>265, 266</sup>; Trypanosoma parasites (Chagas disease) <sup>267, 268, 269</sup>; tuberculosis <sup>227, 255</sup>; visceral leishmaniasis <sup>270, 271</sup>
- 3.2.2.4 **Medical procedures:**  
 Blood transfusion <sup>175, 185, 186, 206, 221, 235, 272</sup>; globulins, in sick people or given as

- prophylaxis <sup>107, 175, 186, 259, 273, 274, 275, 276, 277, 278, 279, 280</sup>; hormonal contraception <sup>281, 282, 283</sup>; organ transplants <sup>175, 176, 202, 235, 284, 285, 286</sup>.
- 3.2.2.5 Natural conditions, not unhealthy:**  
Pregnancy <sup>Fig. 22 p. 83 in 5, 175, 186, 207, 235, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298</sup>;  
receptive anal sex <sup>108</sup>.
- 3.2.2.6 Normal components of human cells:** HIV-like genetic sequences occur in HIV-negative human genomes <sup>299, 300, 301</sup> and can generate immune responses to “HIV” proteins <sup>302, 303, 304</sup>; supposedly “HIV” proteins occur normally in many human cells <sup>175, 176, 305, 306, 307, 308</sup>; normal human extravillous trophoblast cells express “HIV-1” antigens <sup>309</sup>.
- 3.2.2.7 “Recreational” drugs:** <sup>228</sup>  
Alcohol <sup>310</sup>; cocaine <sup>310</sup>; crack cocaine <sup>310, 311</sup>; crystal meth <sup>312</sup>; methamphetamine <sup>313</sup>.
- 3.2.2.8 Vaccinations:**  
Experimental HIV vaccines <sup>314</sup>; flu <sup>315</sup> (also see above under **infections**); globulins (also see above under **medical procedures**); hepatitis B vaccination <sup>186, 316, 317</sup>; rabies <sup>187</sup>; rubella <sup>318</sup>; tetanus <sup>319, 320, 321</sup>.
- 3.2.3 False positives are especially common in emergency rooms since the probability of a positive “HIV” test increases with degree of ill-health <sup>Fig. 22, p. 83 in 5, and associated text</sup>.
- 3.2.3.1 In Cincinnati with a population “HIV-positive” rate of 1.7 (per 100,000), the emergency-room rate was 7.8 <sup>322</sup>.
- 3.2.3.2 Only 9 of 26 “HIV-positive” test results in an emergency room were positive on a later test <sup>322</sup>.
- 3.3 HIV — rather “HIV-positive” — has never been shown to be infectious or transmissible.
- 3.3.1 Prospective studies to detect sexual transmission of “HIV” seropositivity have not observed transmission <sup>323, 324</sup>.
- 3.3.2 The often-cited rates of transmission are calculated by making unprovable assumptions, including about when individuals became “HIV-positive”.
- 3.3.3 Those often-cited rates of transmission are ~1 per 1000 acts of unprotected intercourse for male-to-female transmission and an order of magnitude less for female-to-male transmission <sup>323</sup>, *hundreds of times less than with STDs* — gonorrhea, syphilis, herpes.
- 3.3.4 Mother-to-child transmission has not been shown to occur.
- 3.3.4.1 Definitely transferred are substances that produce positive “HIV” tests, in particular “HIV” antibodies. Those dissipate within a year and “HIV-positive” babies then revert to “HIV”-negative without medication <sup>Fig. 2 and Tables 25-27 in 5, 325</sup>.
- 3.3.4.2 “[T]here is no proof that HIV, even if it is assumed to be present in pregnant women, is perinatally transmitted to their offspring” <sup>326</sup>.
- 3.3.4.3 The presently available data do not prove that HIV can be transmitted by breastfeeding <sup>326</sup>. Babies breast-fed exclusively by “HIV-positive” mothers become “HIV-positive” less frequently than those not fed solely from the breast <sup>327, 328, 329</sup>. The research about mortality and “HIV” transmission associated with breast-feeding has brought inconsistent and confusing results <sup>330, 331</sup>.
- 3.3.4.4 A large percentage of “HIV-positive” babies had “HIV”-negative mothers <sup>332, 333</sup>.
- 3.3.5 “HIV” varies in regular fashion and independently with age, sex, race, and geography, unlike the stochastic patterns seen in infectious diseases <sup>5, 334, 335</sup> — see also “HIV” tests are racially biased, **section 3.4** below.
- 3.3.5.1 The median age-range for testing “HIV-positive” is 35-45 <sup>Fig. 2, p. 26 in 5</sup>, comparable to the median age-range for diagnoses of AIDS and for deaths from AIDS <sup>336, 337, 338, 339, 340</sup>. These have remained unchanged throughout the AIDS era and are the same in almost every tested group.

- 3.3.6 The Office of Medical and Scientific Justice has successfully defended dozens of “HIV-positive” people (52<sup>nd</sup> case in June 2013) charged with endangering others by exposing them to possible transmission of “HIV”: OMSJ forces the prosecution to acknowledge — at least implicitly by altering charges or dropping prosecutions — that positive “HIV” tests do not prove infection <sup>341</sup>.
- 3.3.7 Innumerable attempts to create a vaccine against “HIV” infection have all failed <sup>342, 343, 344, 345, 346</sup> during the nearly 3 decades since Robert Gallo in 1984 envisaged a vaccine being ready within a couple of years <sup>347, 348, 349</sup>, despite continuing pronouncements of optimism and announcements of promising “breakthroughs” <sup>350</sup>.
- 3.3.8 Drug addicts supposedly become “HIV-positive” through re-use of infected needles, yet use of fresh new needles *increases* rather than decreases the incidence of “HIV-positive” tests <sup>351, 352</sup>.
- 3.3.8.1 Successfully rehabilitated drug addicts can revert from “HIV-positive” to “HIV”-negative <sup>353</sup>.
- 3.3.8.2 There was little difference in risk behaviors between HIV-negative and HIV-positive drug-injecting gay men <sup>354</sup>.
- 3.3.8.3 Drug use and venereal disease but not sexual behavior were risk factors for being “HIV-positive” among gay men <sup>355</sup>.
- 3.3.9 Medical personnel are extraordinarily unlikely to be infected by “HIV” or “AIDS” whereas they run appreciable risk with hepatitis, for example <sup>356</sup>. An “HIV-positive” surgeon performed many open-heart surgeries without any patient becoming “HIV-positive” <sup>357</sup>. “There is no recorded care of transmission of HIV from an infected health care worker to a patient in the UK [as of November 2006]” <sup>358</sup>.
- 3.3.10 Condoms do not decrease the incidence of “HIV-positive” <sup>359, 360, 361</sup>.
- 3.3.11 HIV and AIDS are almost unknown in the porn industry <sup>362, 363, 364</sup> even though chlamydia and gonorrhea infection and re-infection are common <sup>365</sup>.
- 3.3.12 The claimed rate of “HIV-positive” in sub-Saharan Africa can only be explained by postulating an impossible rate of promiscuity: 20-40% of adults having 10 or more sexual partners at any one time and changing them frequently *pp. 63-5 in 366*.
- 3.3.13 Thus there are no demonstrated epidemics of heterosexually transmitted “HIV” <sup>367</sup>.
- 3.3.14 Racial disparities in prevalence of “HIV-positive” do not correlate with respective sexual behavior <sup>368, 369</sup> and thereby seem inexplicable on HIV/AIDS theory.
- 3.3.15 The incidence of “HIV” does not parallel the incidence of known STDs (chlamydia, gonorrhea, syphilis) *pp. 35 & 109 in 5, 370, 371*.
- 3.3.16 Married women are more at risk for becoming “HIV-positive” than are prostitutes or widows, incongruous for any sexually transmitted disease <sup>372, 373</sup>.
- 3.3.17 That pregnancy is a risk factor for testing “HIV-positive” (*section 3.2.2.5*) is incongruous for any sexually transmitted disease.
- 3.3.18 Prostitutes do not become “HIV-positive” unless they are drug addicts <sup>12, pp. 41-2 in 20, 374, 375</sup>.
- 3.3.19 Drug addicts tend to test “HIV-positive” to different degrees from different drugs <sup>353</sup>.
- 3.4 “HIV” tests are racially biased.
- 3.4.1 In any group, black people (people of relatively recent sub-Saharan ancestry) test “HIV-positive” about 7 times (males) or 20 times (females) more often than Caucasians. Asians test “HIV-positive” about 2/3 as often as Caucasians. Native Americans and Mexicans test “HIV-positive” perhaps 10-20% more frequently than Caucasians *chapters 5 & 6 & passim in 5, 376, 377, 378*.
- 3.4.1.1 The supposedly “HIV” protein p24 generates a stronger response in black people than in others <sup>379</sup>.
- 3.4.1.2 Higher levels of “HIV-1 RNA” were found in Malawians than in Swiss or USA men <sup>380</sup>.

3.4.1.3 Africans and Caucasians differ genetically with respect to the human T-cell antigen receptor<sup>381</sup>.

#### 4. FAILINGS OF HIV/AIDS THEORY

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

##### 4.1 Predictions have invariably been wrong.

- 4.1.1 “Generalized” epidemics leading to “HIV-positive” population levels of more than 1% have never eventuated outside populations of African ancestry, namely sub-Saharan Africa and the Caribbean <sup>382</sup>.
  - 4.1.2 Even in sub-Saharan Africa, “HIV-positive” levels are “explained” by postulating an impossible level of promiscuity <sup>pp. 63-5 in 366</sup> (see also sections 3.3.12 & 6.1.4).
  - 4.1.3 Predicted Philippines epidemic did not happen <sup>383</sup>.
  - 4.1.4 Forewarned epidemic in porn industry <sup>384</sup> never eventuated despite lack of condom use.
  - 4.1.5 Predicted Asian epidemics never eventuated <sup>385</sup>.
  - 4.1.6 Predicted decimation of populations did not occur in Africa. Instead, there has been robust population growth <sup>107</sup>: “Recent [2007] reports from Uganda, Kenya and Burkina Faso show . . . concern over rapid population growth” <sup>386</sup>.
  - 4.1.7 Vaccines were predicted within a couple of years of 1985 and have never been achieved <sup>350</sup>.
  - 4.1.8 “Breakthroughs” in preventing or treating infection are announced — and then never live up to their promise <sup>387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412</sup>.
- ##### 4.2 Public statements emphasize how much is known about HIV/AIDS, yet researchers do not understand many practical as well as theoretical aspects.
- 4.2.1 “We probably know more about how HIV produces its pathology than about the pathological mechanism of virtually any other microbe” <sup>413</sup>.
  - 4.2.2 “[I]dentification of immune correlates of protection from HIV infection is still lacking” <sup>414</sup>. In other words, no clue (by 2013!) about how to make a vaccine.
  - 4.2.3 “35 top British and US scientists . . . predicted this week [29 April 2008] that a vaccine would be at least 10 years and maybe even 20 years away” <sup>415</sup> (see also sections 3.2.2.8, 3.3.7, 4.1.7).
  - 4.2.4 The recommended treatments are revised several times a year (section 5.4), including when to begin treatment <sup>414</sup>.
  - 4.2.5 Characteristics of the purported “acute viral syndrome” postulated to accompany initial infection — sometimes — are speculative: “diagnosis of acute HIV-1 infection remains problematic” <sup>416</sup>.
    - 4.2.5.1 Seeking manifest signs accompanying infection by “HIV”, a correlation has *sometimes* (e.g. in 20% of cases <sup>417</sup>) been suggested with transient “flu-like” or mononucleosis-like <sup>418, 419</sup> symptoms that are entirely non-specific <sup>420</sup>: fevers, sweats, malaise, lethargy, anorexia, nausea, myalgia, arthralgia, headaches, sore throat, diarrhoea, generalised lymphadenopathy, rash <sup>421</sup> (sometimes “macular erythematous truncal eruption”), thrombocytopenia. Since those symptoms as well as “HIV-positive” can result from a large number of different conditions, fleeting as well as chronic, the phenomenon of “acute viral syndrome” cannot be regarded as established.
    - 4.2.5.2 Such symptoms could only be potentially connected to “HIV” or “AIDS” by some sort of prior assumption, which makes the purported correlation a self-fulfilling presumption. Why were such symptoms not only noticed but also suspected of being associated with “HIV” rather than with flu, mononucleosis, or the many other possibilities? So “[d]iagnosis of primary HIV infection remains a relatively infrequent occurrence [in 2008]” <sup>422</sup>, and generalizations currently accepted may well be mistaken.

- 4.2.5.3 It is *assumed* that such symptoms indicate high levels of viremia <sup>423</sup> — but since “HIV” tests are generally not carried out concurrently with the “acute viral syndrome” <sup>424</sup>, this is mere presumption.
- 4.2.5.4 The *postulate* of “acute viral syndrome” with HIV/AIDS was made already in the early 1980s <sup>425</sup> and has subsisted by inertia without serious reconsideration.
- 4.2.5.5 “Clinical signs and symptoms of acute human immunodeficiency virus (HIV) infection in infants are not well characterized” <sup>426</sup>.
- 4.2.6 How “HIV” could damage the immune system remains a mystery <sup>427,428,429,430</sup>.
- 4.2.7 When and how HIV appeared in humans remains controversial <sup>431</sup>.
- 4.3 Treatment of “HIV-positive” individuals and HIV/AIDS research are misguided through misinterpretation of positive “HIV” tests.
  - 4.3.1 Genetic, race-correlated tendencies to test “HIV-positive” are misinterpreted.
    - 4.3.1.3 Race-correlated genes are postulated to drive mutation of HIV <sup>432</sup>.
  - 4.3.2 Conditions that conduce to positive “HIV” tests are misinterpreted as susceptibility to “HIV” infection; see the list of false-positive possibilities, [section 3.2](#).
    - 4.3.2.1 The unhealthy “fast-lane” lifestyle (drug abuse, alcohol abuse, promiscuity with frequent infections and courses of antibiotics) conduces to testing “HIV-positive”.
    - 4.3.2.2 Drug addicts who test “HIV-positive” are presumed to have been infected with “HIV”.
    - 4.3.2.3 Damage to gut bacteria and mucosa (intestinal dysbiosis) is attributed to “HIV” <sup>430,433,434</sup> whereas strong evidence indicates the opposite, that testing “HIV-positive” is a result of damage to the gut (see [sections 6.1.5.3, 9.3.2](#)). Probiotics increase CD4 counts <sup>435</sup>.
    - 4.3.2.4 “AIDS” may reflect oxidative stress rather than a viral infection <sup>77</sup> (see also [sections 2.1.1.2, 3.2.2, 4.3.2.8, 5.3.3.1, 5.3.3.11, 7.3.3.4](#)) but “HIV” is held responsible for causing oxidative stress <sup>447</sup>.
    - 4.3.2.5 In several Central Asian countries, inexplicable cases of “HIV-positive” are ascribed to infection in some unknown manner by needles supposedly infected from some unknown source instead of to birth stress and other conditions that can produce positive “HIV” tests <sup>436, 437</sup>.
    - 4.3.2.6 Probiotic treatment against bacterial vaginosis is misinterpreted as acting against “HIV” <sup>438, 439</sup>.
    - 4.3.2.7 Hemophiliacs who test “HIV-positive” are assumed to have been infected by blood transfusion or blood-clotting factor <sup>440, Appendix A in 10, passim in 20</sup>.
    - 4.3.2.8 Psychiatric problems are attributed to “HIV” <sup>441,442</sup> instead of realizing that stress, including psychological stress, can induce testing “HIV-positive” <sup>Fig. 22 & p. 80 ff. in 5</sup> (re oxidative stress, see [sections 2.1.1.2, 3.2.2, 4.3.2.4, 5.3.3.1, 5.3.3.11, 7.3.3.4](#))
    - 4.3.2.9 Intracranial aneurisms are attributed to “HIV” <sup>443,444</sup>.
  - 4.3.4 Iatrogenic ailments caused by ARVs are legion ([section 5.3](#)), but they are often misattributed as “HIV-associated”:
    - 4.3.4.1 Lipodystrophy, which is caused by protease inhibitors in particular <sup>445</sup>.
    - 4.3.4.2 “HIV-associated” arthritis, said to include reactive arthritis, psoriatic arthritis, osteomyelitis, polymyositis, vasculitis, infected joints and fibromyalgia <sup>446</sup>.
    - 4.3.4.3 Age-related conditions (cancer, dementia, heart disease) <sup>447</sup>.
    - 4.3.4.4 “HIV-associated” mania <sup>448, 449, 450</sup>.
    - 4.3.4.5 Heart attacks <sup>451, 452</sup>.
    - 4.3.4.6 Neuropathy <sup>453, 454, 455</sup>.
    - 4.3.4.7 Kidney disease <sup>456</sup>.
  - 4.3.5 Three decades of efforts to find a vaccine against “HIV” have failed ([sections 3.3.7, 4.1.7, 4.1.8, 4.2.2, 4.2.3](#)) even though quite a number of people with natural immunity against “HIV” have been identified and studied <sup>457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469</sup>.

- 4.3.6 Decades of efforts to find a microbicide have also failed <sup>470, 471, 472, 473</sup>.
- 4.3.6.1 “The trial did not demonstrate that Carraguard is effective in preventing male-to-female HIV transmission” <sup>474</sup>.
- 4.4 A number of basic aspects of HIV/AIDS theory are known to be wrong.
- 4.4.1 The so-called “latent period” between infection and illness, an essential component of the original labeling of HIV as a lentivirus (slow virus), doesn’t exist <sup>475, 476</sup>.
- 4.4.2 KS was the iconic AIDS disease, recognized by the purple blotches on the skin and affecting 25-40% of AIDS patients in the early 1980s. But since the early 1990s <sup>477</sup> and thereafter only about 5% of AIDS cases have manifested KS. Furthermore, Kaposi’s sarcoma is now said to be caused primarily <sup>pp. 125-9 in 5, 478, 479, 480</sup> by HHV-8 (human herpes virus 8) or KSHV (Kaposi’s sarcoma herpes virus) — and “HIV-associated” KS may not even be a cancer <sup>481</sup>.
- 4.4.3 Cervical cancer had been declared to be an AIDS disease <sup>482</sup>, i.e. caused by “HIV”, but now it is said to be caused by HPV, human papilloma virus <sup>483</sup>.
- 4.4.3.1 It is a mystery, why cervical cancer was ever declared an AIDS disease, given that its incidence had been *declining* steadily throughout the AIDS era <sup>483, 484</sup>.
- 4.4.4 HIV is supposed to kill CD4 cells, but there is no correlation between CD4 levels and the purported amount of “HIV” (“viral load”) or even patient’ clinical condition <sup>485, 486, 487, 488, 489</sup>.
- 4.4.5 “HIV-positive” is not permanent; people sometimes spontaneously become “HIV-negative”, a phenomenon known as seroreversion <sup>490, 491, 492, 493, 494, 495</sup>.
- 4.4.6 Low T-cell counts are a predictor for becoming “HIV-positive”, they are not a consequence of “HIV” <sup>496, 497</sup>.
- 4.4.7 The theoretical basis for Highly Active AntiRetroviral Treatment, HAART, was that there was very rapid turnover of T-cells <sup>498, 499</sup>. That model has been shown to be wrong <sup>500, 501, 502, 503</sup>.
- 4.5 HIV/AIDS statistics are unreliable <sup>504, 505</sup>.
- 4.5.1 UNAIDS <sup>506</sup> inflates estimates in order to dramatize the situation <sup>507</sup>.
- 4.5.2 For more than a decade, official data for “HIV” and “AIDS” have come from computer models and not actual counts <sup>pp. 114 & 135-6 & 203-10 & 221-5 in 5, 508, 509</sup>.
- 4.5.3 The computer models have needed perpetual correction <sup>510, 511</sup>; for example, estimates of new infections were *reduced by 40%* in 2007, and totals reduced from 40 million to 33 million <sup>512</sup>.
- 4.5.4 Estimates of deaths by the Division of HIV/AIDS of the Centers for Disease Control and Prevention (CDC) differ from the counts of death certificates by the CDC’s own Center for Health Statistics <sup>513, 514, 515</sup>.
- 4.5.5 Peer-reviewed, published, and widely publicized assertions about AIDS deaths in South Africa <sup>516, 517, 518</sup> are based on computer models whose estimates are more than an order of magnitude greater than the published data from South Africa Statistics <sup>519</sup>.
- 4.5.6 The World Health Organization claimed 85,000 “HIV-positive” Pakistanis when only 3200 were actually known from tests <sup>520</sup>.
- 4.5.7 HIV/AIDS numbers asserted for Liberia during the 2000s varied between 1.5% and 8.2% <sup>521</sup>.
- 4.5.8 Circumcision is reported as both decreasing the risk of becoming “HIV-positive” and as *not* decreasing the risk <sup>522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537</sup>.
- 4.5.8.1 Circumcision increased the rate of “HIV-positive” among virgins <sup>538</sup>.
- 4.5.9 Absurd numbers are promulgated (*sections 4.7.14, 4.7.16*).
- 4.5.9.1 Zimbabwe claimed reduction in “HIV-positive” rate from 34% to 18.1% between 2002 and 2005-6 — implying that 15.9% of the population had died in five years if there were no new “HIV-positive” cases, or else the population had grown at 3% per year with no new infections <sup>539, 540</sup>. Or the rate was said to have dropped from 22.1% to 20.1% in just two months <sup>541</sup>.

- 4.5.9.2 Similarly absurd claims have come from Uganda <sup>297, 542</sup>.
- 4.6 The origin and spread of HIV have found no satisfactory explanation.
- 4.6.1 AIDS was first named and recognized as characteristically affecting gay men in a few large cities in the United States, but HIV is held to have infected humans for the first time in West Africa at least a decade earlier and perhaps several decades earlier <sup>14, 543</sup>.
- 4.6.1.1 In 1985, “HIV” in Southern Africa was found only in gay men who had been in the USA or in contact with Americans <sup>544, 545</sup>.
- 4.6.1.2 PCP was the chief opportunistic infection characterizing the original AIDS-1. In AIDS-Africa it apparently affected only young children <sup>546, 547</sup>.
- 4.7 Self-contradictions and absurdities of HIV/AIDS theory and practice.
- 4.7.1 That pregnancy (section 3.2.2.5, 3.3.16, 6.1.1.4) is a risk factor for acquiring this sexually transmitted disease.
- 4.7.2 HIV/AIDS activists insist that no stigma should be attached to those who become “HIV-positive” even as HIV/AIDS theory asserts that “HIV” is contracted through behavior that is appropriately frowned upon: careless promiscuity or drug abuse and injecting drugs with dirty needles.
- 4.7.3 HIV/AIDS activists urge that drug abusers be given new needles so that they can “safely” inject heroin and other “recreational” drugs. In every circumstance except HIV/AIDS, use of illegal injected drugs is regarded as criminal behavior <sup>548, 549</sup>, and it is recognized that drug addicts harm their families as well as themselves. Moreover, clean needles are associated with greater incidence of “HIV-positive” (section 3.3.8), owing to the ill-health brought about by the drugs.
- 4.7.4 “HIV” is supposed to spread by different mechanisms in different parts of the world <sup>550, 551, 552</sup>.
- 4.7.5 Those who are most susceptible to becoming “HIV-positive” nevertheless live longer <sup>553</sup>.
- 4.7.6 Poverty is supposed to conduce to “HIV-positive” by increasing risk factors, but in Africa it is wealth that conduces to being “HIV-positive” <sup>554</sup>.
- 4.7.5 An “HIV-positive” man who did not infect his wife despite intercourse with her must have nevertheless infected his child by biting her finger <sup>555</sup>.
- 4.7.6 Babies infected by dirty needles are supposed to have transmitted “HIV” to their mothers by biting their nipples <sup>556</sup>.
- 4.7.7 Breast-feeding by “HIV-positive” mothers is said to risk transmitting HIV to the babies, yet *exclusive breast-feeding brings the lowest risk* that babies will become “HIV-positive” <sup>327</sup> (section 3.3.4.3).
- 4.7.8 Tuberculosis (TB) patients test positive as often as do gay men and drug addicts <sup>Fig. 22 p. 83 in 5, 557</sup> so, irrationally, TB is sometimes said to be an AIDS disease rather than just TB.
- 4.7.9 Cervical cancer was said to be an “AIDS disease”, i.e. caused by “HIV”, in 1993 <sup>482</sup>. Yet nowadays it is said to be caused by human papillomavirus (HPV), again on the basis of a mere correlation.
- 4.7.10 Increased obesity is attributed to desire to show that one is not “HIV-positive” <sup>558</sup>.
- 4.7.11 When malnourished Africans test “HIV-positive”, their ill-health is attributed to “HIV” rather than lack of food <sup>107, 559</sup>.
- 4.7.12 “Washing the penis minutes after sex increased the risk of acquiring H.I.V. in uncircumcised men. The sooner the washing, the greater the risk of becoming infected” <sup>560</sup>.
- 4.7.13 When ARVs appeared to work against “HIV” but patients nevertheless became more ill, this was ascribed to the newly invented “immune restoration syndrome”: recovery or re-activation of the immune system supposedly caused inflammation and illness <sup>561</sup>.
- 4.7.14 Official numbers just don’t compute <sup>562</sup>. Estimates have perhaps one in four <sup>563</sup> of “HIV-positive” Americans unaware of their status — up to 75% of gay men <sup>564</sup>, even 93% of young

gay black men <sup>565</sup> (and about a third of “HIV-positive” people in Britain <sup>566, 567</sup>). Now, about 1 million Americans have been “HIV-positive” throughout 3 decades <sup>pp. 1-2 in 5</sup>. By 2 decades ago, therefore, assuming the 10-year “latent period” (which doesn’t actually exist <sup>475, 476</sup>), at least 250,000 “HIV-positive” people should have been coming down with AIDS and dying within a year or two, being replaced by the ~55,000 new annual infections <sup>568</sup> to somehow keep the total number of infected at about 1 million. But reported HIV/AIDS deaths rose to a peak of 42,000 in 1994 and then declined steadily to <16,000 <sup>569</sup>.

- 4.7.15 Measles virus slows progression of HIV infection <sup>570, 571, 572, 573, 574</sup>.
- 4.7.16 “HIV” tests are sometimes said to be 100% sensitive and 100% specific <sup>575</sup>.
- 4.7.17 Sleeplessness and not taking ARVs are correlated [big surprise] <sup>576</sup>.

## 5. WHAT ANTIRETROVIRAL DRUGS DO <sup>577,578,579,580,581</sup>

The criterion for effectiveness of ARVs is action in reducing “HIV-positive” or “viral load” or increasing CD4 counts, judged initially by *in vitro* experiments. But this does not necessarily correlate with clinical improvement of the patient <sup>151</sup>. This is a real-life illustration of the old saw that an operation may be judged by the experts to have been successful even if the patient died.

- 5.1 There is no evidence that ARVs prolong life <sup>65, 582, 583</sup> or improve the quality of life <sup>584, 585, 586, 587, 588, 589, 590</sup>.
  - 5.1.1 Despite FDA warnings, manufacturers advertise ARVs misleadingly as though they allow a completely healthy life <sup>591, 592, 593</sup>.
  - 5.1.2 “Virological response after starting HAART improved over calendar years, but such improvement has not translated into a decrease in mortality” <sup>594</sup>.
    - 5.1.2.1 Mortality of 25-year-old “HIV-positive” people *responding successfully to HAART* was 5.3 and 10.4 times greater than in the general population, for men and women respectively <sup>595</sup>.
  - 5.1.3 No life-prolonging benefit is claimed for AZT in a review that attempts to calculate the supposed benefits of ARVs <sup>596</sup>.
  - 5.1.4 Deaths from “AIDS” continued to increase after the introduction of AZT treatment. The proportion of AIDS patients surviving for even one year was not increased by AZT plus prophylaxis against PCP <sup>597</sup>.
  - 5.1.5 AZT actually killed about 150,000 “HIV-positive” people between the mid-1980s and the mid-1990s <sup>65</sup>.
    - 5.1.5.1 Side effects unpleasant enough to report were experienced by 50-75% of *healthy* medical personnel treated for possible exposure to HIV, and the side effects were severe enough that 24-36% discontinued the therapy <sup>598</sup>.
  - 5.1.6 When AZT was replaced by “cocktails” [Highly Active AntiRetroviral Treatment (HAART) or Combination AntiRetroviral Therapy (CART)] the death rate of “AIDS” patients almost instantly declined solely because the new treatment was less toxic <sup>65, 597</sup>.
- 5.2 The very concept of ARVs was misguided.
  - 5.2.1 Bacterial and parasitic infections can be successfully treated with antibiotics because those can kill bacteria and parasites without killing the human patient: the physiology of the invading agents is sufficiently different from that of the patient. By contrast, viruses use the host’s biochemical machinery, so preventing virus replication means disabling some of the body’s essential mechanisms.
  - 5.2.2 Nevertheless, social hysteria over the putatively fatal, sexually transmitted “HIV” led to a trial-and-error search for virus-killers.
  - 5.2.3 The initial clinical trial of AZT <sup>599, 600</sup> — interpreted as showing that AZT extended *by a few months* the lives of AIDS-1 patients who were at death’s door — was badly flawed <sup>601, 602</sup>, as was <sup>603</sup> the later, much larger “Concorde” trial <sup>604</sup>.
  - 5.2.4 AZT (Retrovir), renamed zidovudine (ZDV), is a nucleoside reverse transcriptase inhibitor (NRTI). Nowadays it is acknowledged that these drugs are not effective “HIV”-killers: “Single-NRTI therapy *does not demonstrate potent and sustained antiviral activity and should not be used* (AII). For prevention of mother-to-child transmission (PMTCT), zidovudine (ZDV) monotherapy is not recommended but might be considered in certain unusual circumstances . . . .” [*emphasis added*] <sup>605</sup>.
    - 5.2.4.1 Yet AZT monotherapy for PMTCT had been introduced in 1994 and later, in the HAART era and until at least 2007, “[d]uring pregnancy, HIV-1-infected women in industrialized nations . . . commonly receive[d] highly active antiretroviral therapy . . . that generally consist[ed] of three or more drugs, including two . . . NRTIs . . . most frequently. . . AZT and lamivudine [3TC]” <sup>606</sup>.

- 5.2.5 Mainstream data should have made it obvious long ago that AZT therapy is too carcinogenic<sup>607</sup> (section 5.3.3.4) as well as toxic (in particular to mitochondria, sections 5.2.6, 5.3.3.1, 7.1.3.1) to use in humans and moreover could not defeat “HIV”<sup>608</sup> (sections 5.1, 5.2.4).
- 5.2.6 Nevertheless, NRTIs including AZT/ZDV remain a component of most combination therapies, despite lack of effectiveness and considerable toxicity: “ZDV can cause bone marrow suppression, myopathy, lipoatrophy, and rarely lactic acidosis with hepatic steatosis”<sup>609</sup>; “Bone marrow suppression, manifested by macrocytic anemia and/or neutropenia, is seen in some patients. ZDV also is associated with GI [gastrointestinal] toxicity, fatigue, and possibly mitochondrial toxicity<sup>606, 610</sup>, including lactic acidosis/hepatic steatosis and lipoatrophy”<sup>611</sup>. The manufacturer’s own pamphlet included a dozen pages detailing adverse reactions<sup>612</sup>.
- 5.2.7 Combination antiretroviral treatments are less obviously and speedily toxic than monotherapy because the dosages of each of the toxic substances are smaller and some of the components are somewhat less toxic than AZT.
- 5.3 Toxic side-effects of ARVs are legion<sup>613, 614, 615, 616, 617</sup>.
- 5.3.1 “[A] growing proportion of patients receiving long-term antiretroviral therapy are experiencing treatment failure, drug toxicities, side effects, and drug resistance. . . . an increased incidence of malignancies, cardiovascular and metabolic complications, and premature aging associated with long-term HIV disease or antiretroviral therapy”<sup>618</sup>.
- 5.3.1.1 Toxicity of stavudine increased with dose and over time<sup>619</sup>.
- 5.3.1.2 In December 2011, activists asked the Gates Foundation to cancel a clinical trial comparing stavudine to tenofovir because the former is so toxic<sup>620</sup>.
- 5.3.2 The side-effects are so intolerable that patients’ non-adherence to treatment is a perpetual theme in the literature<sup>621, 622, 623, 624, 625, 626, 627</sup>.
- 5.3.2.1 NIH Treatment Guidelines are replete with references to non-adherence<sup>628</sup>, e.g. “Adverse effects have been reported with use of all antiretroviral (ARV) drugs; they are among the most common reasons for switching or discontinuing therapy and for medication nonadherence”<sup>629</sup>.
- 5.3.2.2 “Not surprisingly, nonadherence to prescribed medications is common in teens”<sup>630</sup>.
- 5.3.3 Specific side-effects impinge on every part of the body.
- 5.3.3.1 Aging prematurely<sup>447, 631, 632</sup>; damage to mitochondria<sup>606, 610, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 683</sup> could be a reason for this and for muscle deterioration<sup>648</sup> and oxidative stress<sup>645</sup> (re oxidative stress, see also sections 2.1.1.2, 3.2.2, 4.3.2.4, 4.3.2.8, 5.3.3.1, 7.3.3.4).
- 5.3.3.2 Allergic reactions including rash and skin death<sup>646, 647, 648</sup>;
- 5.3.3.3 Bleeding, spontaneous, with all protease inhibitors<sup>648</sup>.
- 5.3.3.4 Cancer<sup>606, 649, 650, 651, 652, 653, 654, 655, 656, 657</sup>
- 5.3.3.5 Central nervous system effects<sup>658, 659</sup> including psychosis<sup>648, 660</sup>: neuromuscular weakness, somnolence, insomnia, abnormal dreams, dizziness, impaired concentration, depression, suicidal ideation, depression<sup>648</sup>.
- 5.3.3.6 Functional and physiological disturbances: headaches<sup>600</sup>; insomnia<sup>600</sup>;
- 5.3.3.6 Gallstones, apparently inevitable with protease inhibitors: “Median time to onset is 42 months (range 1–90 months)”<sup>648</sup>.
- 5.3.3.7 Gastrointestinal: vomiting, nausea, diarrhea<sup>600, 648, 661, 662</sup>.
- 5.3.3.8 Metabolic syndrome<sup>663, 671</sup> and metabolic dysfunctions<sup>664</sup>: diabetes, insulin resistance<sup>648, 665, 666, 667, 668, 669, 670, 671, 672, 673</sup>; dyslipidemia (dysfunctional blood lipids)<sup>648, 665, 667, 668, 669, 670, 671, 673, 674, 675, 676, 677, 678</sup>; lactic acidosis<sup>648</sup>; lipodystrophy<sup>648, 665, 667, 668, 669, 670, 671, 673, 676, 677, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688</sup>

- 5.3.3.9 Organ deterioration and failure: anemia and bone-marrow suppression <sup>600, 648</sup>; heart disease including heart attacks <sup>648, 666, 671, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699</sup>; kidney disease, kidney stones <sup>648, 700, 701, 702, 703</sup>; liver damage <sup>648, 704, 705, 706, 707, 708, 709</sup>; neutropenia <sup>710</sup>; pancreatitis <sup>711</sup>; stroke <sup>712</sup>.
- 5.3.3.10 Osteoporosis <sup>648, 713, 714</sup>.
- 5.3.3.11 Oxidative stress <sup>715</sup> (see also sections 2.1.1.2, 3.2.2, 4.3.2.4, 4.3.2.8, 5.3.3.1, 7.3.3.4).
- 5.3.3.13 Peripheral neuropathy <sup>453, 454, 455, 648</sup>.
- 5.3.3.14 T-cell killing <sup>600, 716</sup>.
- 5.4 The official Treatment Guidelines <sup>717</sup> are perpetually revised, and once-recommended treatments become not recommended or to be avoided <sup>718, 719, 720, 721, 722</sup>. Innumerable changes can be identified in successive versions of the Guidelines.
  - 5.4.1 Bear in mind that these revisions are based on knowledge gained through already observed severe damage in a significant number of cases (sections 5.1.5, 5.2.5, 5.3).
- 5.5 Some physicians have successfully treated AIDS patients without resort to ARVs <sup>723, 724, 725</sup>, though they sometimes resort to *very short* courses of ARVs, which are potent antimicrobials, to eliminate possibly occult bacterial infections.
  - 5.5.1 Juliane Sacher has had better success treating AIDS patients than other German physicians who use standard anti-“HIV” treatment <sup>726, 727, 728</sup>.
  - 5.5.2 Claus Köhnlein has successfully treated AIDS patients without the anti-“HIV” approach <sup>729</sup>.
  - 5.5.3 A decrease in opportunistic infections in “HIV-positive” individuals may not be due to killing “HIV” but to direct suppression of fungal infections <sup>730, 731</sup>.

## 6. DAMAGE DONE BY HIV/AIDS THEORY AND PRACTICE

- 6.1 **To individuals**, through misinterpretation of positive “HIV” tests.
- 6.1.1 Everyone who is ill for any reason is likely to be subjected to an “HIV” test and damaged (sections 6.1.2 and 6.1.3).
- 6.1.1.1 The greatest human tragedy of HIV/AIDS theory is that “HIV-positive” individuals *who become ill for any reason at all* — and sometimes who are not ill at all but tested “positive” because of a life-insurance examination or something similar — are classed as “having HIV/AIDS”.
- 6.1.1.2 So long as HIV/AIDS theory remains in force, there is a crying need for authoritative information for people who are told they “have HIV/AIDS”, many of them knowing with certainty that they could not have become infected in any of the ways that HIV/AIDS theory says they must have been.
- 6.1.1.3 There is a crying need for doctors to learn how to deal with laboratory results claiming “HIV-positive”: that none of the tests are approved for actually identifying infection; that there are any number of false positives; that there are no valid confirmatory tests; and that they should use every diagnostic tool available to determine whether there is any reason at all to think the person might actually have an illness.
- 6.1.1.4 There is a crying need for doctors to learn that a very common reason for an “HIV-positive” result is pregnancy (section 3.2.2.5).
- 6.1.1.5 There is a crying need for doctors to learn that there are genetic, race-correlated factors that conduce to testing “HIV-positive” and that the tests are thereby severely racially biased *pp. 100-2 & 171 in 5*.
- 6.1.2 Everyone who tests “HIV-positive” is thereby at risk of psychological and social harm.
- 6.1.2.1 Individuals are not properly informed about the high probability of false-positive “HIV” tests, particularly with low-risk individuals <sup>732</sup>.
- 6.1.2.2 Promiscuity is inferred with no further ado, and relationships are broken <sup>733</sup>.
- 6.1.2.3 “HIV-positive” individuals who engage in sex may be sent to prison for allegedly endangering their partners <sup>734</sup>.
- 6.1.2.4 “HIV-positive” individuals have been sent to prison even for spitting on someone <sup>735,736,737</sup>.
- 6.1.2.5 “Veteran who was **WRONGLY** treated as HIV positive for nine years sues hospital after being ‘emotionally and mentally destroyed’” <sup>738</sup>.
- 6.1.2.6 Boxer Tommy Morrison lost his career because of inconsistent “HIV” test-results <sup>739</sup>.
- 6.1.2.7 “HIV-positive” Asian women have been driven from their marital homes <sup>740</sup>.
- 6.1.2.8 “HIV-positive” women in Chile have been forcibly sterilized <sup>741</sup>.
- 6.1.3 Everyone who tests “HIV-positive” is at risk of bodily harm from toxic (section 5.3) ARVs.
- 6.1.3.1 ARVs have been tested on foster children <sup>742,743</sup> and orphans <sup>744,745,746,747</sup> without proper safeguards.
- 6.1.4 Black people are at particular risk because they test “HIV-positive” much more often than others; black women seem to be particularly at risk — see 3.4.1
- 6.1.4.1 African ancestry is misinterpreted as *behavioral* risk of infection even though blacks test “HIV-positive” more often than others *irrespective of behavior* <sup>748, 749, 750, 751, 752, 753, 754</sup>.
- 6.1.4.2 Extraordinarily promiscuous “concurrency” is postulated to explain the uniquely high sub-Saharan prevalence of “HIV-positive” <sup>366, 755, 756, 757</sup> even though actually observed sexual behavior does not support the postulate of high levels of concurrency *p. 78 in 5, 368*.
- 6.1.4.3 Black people are presumed to be not only more promiscuous but also more likely to inject illegal drugs <sup>758</sup>.
- 6.1.4.4 “HIV-positive” black men are immediately assumed to be on “the down low” <sup>759, 760</sup> — behavior that may be far less common than is now widely presumed <sup>761, 762</sup>.

- 6.1.5 Gay men are at particular risk because something about the lifestyle seems to conduce to testing “HIV-positive”.
  - 6.1.5.1 Probably only those gay men who practice the “fast-line” lifestyle, but data are lacking to reach firm conclusions.
  - 6.1.5.2 Extraordinary promiscuity is inferred from dubious data: “exactly the same strain of HIV can be shown to have infected all five of these people. . . . [and] transmission probably occurred from a single person to these various partners *within just a few hours*” [*emphasis added*] <sup>763</sup>.
  - 6.1.5.3 Intestinal dysbiosis theory <sup>728, 764</sup> suggests that deliberately responsible behavior like anal douching may actually conduce to becoming “HIV-positive” and even ill.
- 6.2 **To social institutions**
  - 6.2.1 When finally it becomes universally recognized that HIV/AIDS theory is wrong, trust in the institutions of medicine and science will take a very severe blow.
  - 6.2.2 In the meantime, individual institutions may be sued for damages when positive “HIV” tests were mistakenly taken as proof of permanent “HIV-positive” status <sup>738, 765</sup>.
  - 6.2.3 Law enforcement gets egg on its face when prosecutions fail because they cannot prove the transmissibility of “HIV” <sup>341, 766</sup>.
- 6.3 **To society as a whole:** Huge sums of money have been and continue to be wasted on anti-“HIV” and anti-“AIDS” activities.
  - 6.3.1 The United Nations HIV/AIDS program <sup>767</sup> and National Institutes of Health <sup>768, 769</sup> spend disproportionate amounts on “HIV/AIDS” compared to other health concerns.
  - 6.3.2 In Africa, billions of dollars are spent on ARVs and associated activities when far smaller amounts could improve health and save lives immediately <sup>107, 770, 771, 772</sup>, for example by providing
    - a. means for water purification;
    - b. minimal amounts of decent food <sup>770</sup>;
    - c. treated anti-mosquito nets to prevent malaria;
    - d. \$35 oxygen valves for hospitals <sup>770</sup>.
  - 6.3.3 Billions of dollars continue to be spent on attempts to find an anti-“HIV” vaccine despite 3 decades of evidence that it cannot be done (sections 3.3.7, 4.1.7, 4.1.8, 4.2.2, 4.2.3, 4.3.5).
  - 6.3.4 Well-intentioned “education” programs reinforce the hegemony of HIV/AIDS theory.
    - 6.3.4.1 The Bill and Melinda Gates Foundation actually paid for entertainment programs to present the mainstream viewpoint about HIV/AIDS <sup>773</sup>.

## 7. HINDRANCES TO MAKING THE CASE AGAINST HIV

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

- 7.1 Misinformation is ingrained in the public sphere, in the conventional wisdom, about the discovery of “HIV” and the histories of HIV and of AIDS.
  - 7.1.1 That AIDS-1 first appeared among “young, previously healthy, gay men”.  
In reality they were not particularly young (average age mid- to late 30s) and far from healthy <sup>92</sup>, characterized primarily by heavy drug abuse and a “fast-lane” lifestyle rather than by being gay <sup>16</sup>.
  - 7.1.2 “HIV” tests are taken as showing infection, and “confirmatory” tests (typically Western Blot) are taken as validating that.  
In reality, neither presumption is correct, there are no valid tests for infection (sections 3.1, 3.2) and so-called “confirmatory” Western Blot itself is liable to false-positives <sup>162</sup>.
  - 7.1.3 Antiretroviral therapy is *not* “life-saving”, as it’s often described <sup>582</sup> (section 5.1). The false claim is sustained in part by attributing toxic side-effects of ARVs to “HIV” rather than to the drugs <sup>774, 775, 776, 777, 778, 779</sup> (section 4.3.4).
    - 7.1.3.1 Premature aging is attributed to ARVs keeping people alive longer and supposedly suffering long-term damage from “HIV”, when actually ARVs are known to damage mitochondria (sections 5.2.5, 5.2.6, 5.3.3.1), and damage to mitochondria happens to be a direct cause of aging <sup>780, 781, 782, 783, 784, 785</sup>.
  - 7.1.4 References in fiction and on television <sup>786, 787, 788, 789, 790, 791</sup> reinforce the hegemony of HIV/AIDS theory.
    - 7.1.4.1 That “HIV” is *readily* spread by sexual intercourse <sup>792, 793</sup>.
    - 7.1.4.2 That one could be infected by “HIV”-tainted blood splashed into one’s eye <sup>794</sup>.
    - 7.1.4.3 That HIV can be transmitted by saliva on a baseball <sup>795</sup>.
    - 7.1.4.4 That AZT is a powerful ARV <sup>796</sup>.
    - 7.1.4.5 However, Daniel Easterman correctly noted in 1990 <sup>797</sup> that some individuals could overcome AIDS by making lifestyle changes, possibly reflecting the experience of Michael Callen <sup>98</sup>.
- 7.2 Fresh misinformation about “HIV” and AIDS continually enters and pervades the public sphere <sup>798</sup>.
  - 7.2.1 “News” items incessantly reinforce mistaken views by reiterating “HIV/AIDS”; “HIV, the virus that causes AIDS”; “life-saving” ARVs; etc.
    - 7.2.1.1 The media typically broadcast “breaking news” about science and medicine but fail to revisit the topic when the original claim turns out to need modification or complete withdrawal, which is the usual circumstance with the latest from the research front <sup>799</sup> — for example, 30 years of promises and promising breakthroughs toward an “HIV” vaccine without any genuine, perceptible progress (sections 3.3.7, 4.1.7, 4.1.8, 4.2.2, 4.2.3, 4.3.5).
    - 7.2.1.2 Governmental and non-governmental agencies continually urge the media to campaign for awareness of HIV/AIDS theory <sup>800</sup>.
  - 7.2.2 It takes longer to demonstrate the errors in a claim than to make the mistaken assertion.
    - 7.2.2.1 The flaws in any new mainstream claim about “HIV” and “AIDS” can only be explained once it is recognized that HIV/AIDS theory is wrong.
    - 7.2.2.2 For example, “antiretroviral drugs can forestall long-term health risks of the disease and cut the risk of transmission by as much as 96 percent” <sup>801</sup>.  
To debunk that sentence requires presenting the copious but circumstantial proof that “HIV” entails no “long-term health risks”, as well as surveying the copious data on toxicity of ARVs, not to speak of demonstrating the faulty statistics underlying that “96%”: since the claimed transmissibility is already so low (section 3.3.3), the reported “96%” cut could

only be observed in a clinical trial of immense proportions and duration.

Everything based on “HIV” tests is likely to be wrong and should not be accepted at face value, but to make the case with any specific claim requires debunking the whole basis and edifice of HIV/AIDS theory.

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

In addition, it is notoriously difficult to prove a negative case, and the case against HIV is in some sense a negative case.

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

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

- 7.3.1.1 This is typical for people in opposition to mainstream views. Internal disagreements and organizational schisms are common among such “single-issue” groups whose members are not also bound together for other strong overarching and self-interested reasons <sup>802, 803</sup>.

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

- 7.3.2.1 HIV has never been proven to cause AIDS.

- 7.3.2.2 HIV has never been proven to exist <sup>804</sup>.

- 7.3.2.3 HIV does not exist <sup>804</sup>.

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

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

- 7.3.3.1 AIDS-1 was a multifactorial syndrome caused by a combination of insults <sup>20</sup>.

- 7.3.3.2 More specifically, AIDS-1 resulted from the “fast-lane” lifestyle common among a proportion of gay men during the early years of gay liberation: promiscuous consumption of “recreational” drugs <sup>16</sup>, promiscuous sex, frequent infections by gonorrhea, syphilis, etc., indiscriminate consumption of antibiotics even as prophylactics <sup>97</sup>, generally unhealthy behavior.

Such behavior damages the intestinal microflora, the immune system’s first line of defense, specifically against the fungal infections that were common in AIDS-1. Such damage brings illness as well as positive “HIV” tests <sup>805, 806, 807</sup>, and explains some of AIDS-2 as well as AIDS-1.

- 7.3.3.3 AIDS-1 was caused specifically by drugs, including ARVs <sup>729, 808</sup>. So is a proportion of AIDS-2.

- 7.3.3.4 AIDS-1 was and is, and a proportion of AIDS-2 & AIDS-Africa are, a syndrome associated with oxidative stress <sup>77</sup>, which can result from a wide range of physical (and even mental) insults (see also sections 2.1.1.2, 3.2.2, 4.3.2.4, 4.3.2.8, 5.3.3.1, 5.3.3.11).END-START

- 7.4 HIV/AIDS theorists and advocates, and therefore the media and the public, lump together indiscriminately everyone who does not accept the mainstream view *in toto*, so they do not distinguish between “AIDS Rethinkers” or “HIV Skeptics” who just deny that “HIV” causes “AIDS” by contrast with charlatans and conspiracy theorists <sup>809, 810</sup>, for example:

- 7.4.1 Peddlers of fake remedies <sup>811</sup>.

- 7.4.2 Claims that HIV was man-made <sup>812, 813</sup>.

- 7.4.2.1 Deliberately or accidentally in research on biological warfare <sup>814, 815, 816</sup>.

- 7.4.2.2 To damage certain social groups <sup>817, 818, 819</sup> — “to depopulate vulnerable target groups, including blacks and other minorities, homosexuals, and perceived ‘decadent’ sexually active individuals” <sup>820</sup>, or that condoms sent to Africa were spiked with “HIV” <sup>821</sup>.

- 7.4.3 Claims that HIV originated in unrelated cancer<sup>822</sup> or vaccine research or practice<sup>823, 824</sup>.
- 7.5 The mainstream refuses to engage the evidence or to debate substantively with dissenters.
- 7.5.1 Dissenters are ignored, not answered, boycotted, black-listed, maligned.
- 7.5.1.1 **Not answered:**  
 Duesberg's seminal article<sup>825</sup> never answered<sup>p. 233 in 5; p. 147 in 6; p. 198 in 10; p. 139 ff. in 13</sup>  
 Kary Mullis, request for published proof that HIV causes AIDS<sup>pp. 171-4 in 23</sup>  
 Gary Null, asking Robert Gallo to cite publications proving HIV causes AIDS<sup>p. 39 in 826</sup>
- 7.5.1.2 **Excluded from professional meetings:** Peter Duesberg<sup>p. 147 in 13</sup>
- 7.5.1.3 **Hindered or excluded from professional publications:**  
 Peter Duesberg<sup>pp. 229-30 in 5; pp. 147-52 in 13</sup>  
 Gordon Stewart<sup>pp. 100-31 in 13; pp. 230-1 in 5</sup>
- 7.5.1.4 **Not permitted to reply to published criticism:**  
 Peter Duesberg<sup>p. 229 in 5; chapter 3 in 826</sup>
- 7.5.1.5 **Research no longer funded:**  
 Peter Duesberg<sup>p. 229 in 5</sup>
- 7.5.1.6 **Misrepresented:**  
 Various HIV/AIDS skeptics<sup>p. 234 in 5</sup>
- 7.5.1.7 **Scheduled public events canceled:**  
 Showing of *House of Numbers* to be followed by debate<sup>827</sup>
- 7.5.1.8 **Disinvited at the last moment:**  
 Peter Duesberg & Celia Farber, from appearing at Congressional hearing<sup>828</sup>
- 7.5.1.9 **Personally maligned:**  
 Various people, as "flat-earthers"<sup>pp. 212 & 233-4 in 5</sup>
- 7.5.1.10 **Journalists warned against covering dissenting views**<sup>829, 830, 831</sup>
- 7.5.2 Where mainstream and dissenters do publicly address the same points, they do not engage with one another.
- 7.5.2.1 Dissenters were accused of complicity in deaths in South Africa on the basis of computer-modeled estimates of deaths<sup>516, 517, 518</sup> that are contrary to the official South Africa Statistics data<sup>519</sup>.
- 7.5.2.2 The progressively modified NIH "fact sheet"<sup>832</sup> (most recent revision 14 January 2010) fails to address the specific criticism<sup>25, 833</sup> made of its arguments.
- 7.6 The mainstream tries to discredit dissenters via *ad hominem* polemics<sup>831</sup>, not by substantive argument<sup>pp. 212 & 233-4 in 5; pp. 49 & 80 in 826</sup>.
- 7.6.1 Because the dissenters have never themselves done HIV/AIDS research.
- 7.6.1.1 This is a *non sequitur*.  
 Informed individuals are perfectly capable of critiquing the work of others. Peer review of manuscripts and grant proposals is often done by supposedly informed individuals who have not themselves worked on exactly the same topic. Indeed, the advantage of freedom from conflicts of interest makes it desirable that critiques come from other than insiders, be they colleagues or competitors.
- 7.6.1.2 Many supporters of the mainstream view and critics of the dissenters — indeed some of the most prominent and vociferous HIV/AIDS proponents — have themselves done no HIV/AIDS research and may not even have any scientific credentials at all<sup>834, 835, 836</sup>:  
 Jeanne Bergman<sup>837</sup> (lawyer)<sup>835, 836</sup>; Nathan Geffen<sup>838, 839</sup> (activist)<sup>840, 841</sup>; Seth Kalichman<sup>842</sup> (social psychologist)<sup>843</sup>; Nicoli Nattrass<sup>516, 517, 844</sup> (social scientist, economist)<sup>845, 846, 847</sup>.
- As to the many physicians among public proponents of HIV/AIDS theory, it should be remembered that physicians, doctors, MDs, are not scientists, were not trained to do or to understand research, have no preparation for doing scientific research<sup>848, 849</sup>.

- 7.6.1.3 The mainstream refers queries to official sources like the NIH “Evidence”<sup>832</sup>, but such in-house writings for public consumption are not scientific publications, they are public-relations pieces; they have never been peer-reviewed and are often written by PR personnel, not by scientists. Many official reports are not only not scientific writings, they may be demonstrably incompetent *Chapter 8 in 826*.
- 7.6.2 Dissenters are labeled denialists<sup>831, 842</sup>
  - 7.6.2.1 The deliberate analogy with Holocaust deniers is emotionally fraught and is used because the mainstream cannot answer the dissidents’ substantive points<sup>850</sup>.
  - 7.6.2.2 They’re “flat-earthers” *p. 297 in 254*.
- 7.7 The media do not cover dissenting views.
  - 7.7.1 They fail even to discuss, let alone expose, the improper tactics of those who malign dissenters.

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

- 8.1 The general context of medical science permits this sort of blunder *Chapters 11-13 in 5, 826,*
- 8.1.1 Theories once accepted are then not perpetually questioned.
- 8.1.1.1 Observations that contradict the accepted view are ignored for as long as possible *851, 852, 853, 854, 855*
- 8.1.1.2 Boat-rockers are not appreciated. There is no career role in science for inveterate questioners of accepted practices; if possible there is even less room in medical practice for transgressing established practice .
- 8.1.2 There is no organized coordination of specialized research areas.
- 8.1.2.1 Virologists don't concern themselves with epidemiology. Clinicians simply accept what the virologists and the drug designers tell them. If data in one specialty are relevant to another specialty, that may not be realized quickly or efficiently. Specialists feel unqualified to critique the specialties of others.
- 8.1.2.2 So much is published that researchers find it difficult to keep up with what everyone is doing even within their own very narrow specialty.
- 8.2 This particular blunder came about via specific identifiable steps *Chapters 14 & 15 in 5*
- 8.2.1 Mis-classification of characteristics of AIDS patients: they were primarily drug addicts rather than gay men *Chapter 1 & p. 191 ff. in 16*
- 8.2.2 Mistaking a social phenomenon for a medical one (*section 2.1.1.1*).
- 8.2.3 Accepting inadequate evidence for the presence and activity of a retrovirus (*sections 1 - 3*).
- 8.2.4 Once Gallo, with the imprimatur of the Department of Health and Human Services, had been credited with discovery of the probable cause of AIDS, researchers framed their subsequent grant requests and consequent research on the virus hypothesis.
- The overwhelming majority of funding of biological research comes from the National Institutes of Health, which is an agency within the Department of Health and Human Services.
- 8.2.5 Alternatives to the retrovirus hypotheses ceased to be discussed by mainstream researchers.
- 8.2.6 Minority views and those of outside observers were peremptorily dismissed.
- 8.2.7 The media did not attend in neutral fashion to dissenting views.

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

- 9.1 If HIV doesn't cause AIDS, what does cause AIDS?
- 9.1.1 AIDS-1 (the original early-1980s AIDS) resulted from the “fast-lane” lifestyle of drug abuse, extreme promiscuity, and generally unhealthy behavior. The first AIDS victims were in their mid-to-late 30s, consistent with this explanation and inconsistent with a sexually transmitted disease, which affects adolescents and young adults significantly more than others.
- 9.1.2 AIDS-2 (“HIV disease”, “HIV/AIDS”, non-African AIDS) is the mis-interpretation of “HIV” tests whereby anyone who tests “HIV-positive” is presumed to “have HIV/AIDS” — even as authoritative mainstream sources and data demonstrate that innumerable conditions, some but not all of them unhealthy, conduce to testing “HIV-positive”, and even as no “HIV” test has been officially approved for actually identifying active infection.
- 9.1.3 African AIDS is the mis-interpretation of manifest symptoms that are entirely non-specific and moreover are associated with many diseases long endemic in Africa: prolonged fever, cough, diarrhea, bodily wasting (*section 2.3.1*).
- 9.2 If HIV doesn't cause AIDS, why do ARVs successfully treat AIDS?
- 9.2.1 They don't (*section 5.1*).  
ARVs have not increased lifespan — except only once, when less-toxic HAART replaced highly toxic AZT monotherapy. Then there was an immediate drop in mortality, but only the mortality caused by the medical treatment (*section 5.1.6*).
- 9.2.2 ARVs are very powerful killers of biological systems, and their antibiotic or antifungal or anti-parasitic powers might overcome occult infections; but prolonged use of ARVs is likely to be fatal (*section 5.3*).
- 9.3 Why do gay men test “HIV-positive” so frequently, if it isn't an STD?
- 9.3.1 Certain practices common among gay men make testing “HIV-positive” likely, for example, the consequences of intestinal dysbiosis. That condition can also bring on serious illness, including the fungal infections that characterized AIDS-1 (*sections 4.3.2.3, 6.1.5.3*).
- 9.4 Questions posed through ignorance of the facts about “HIV” and “AIDS”.
- 9.4.1 “Why are so many mid-life gay men getting HIV?”<sup>856</sup>  
Because *everything* about “HIV” and “HIV/AIDS” is most frequent in young middle age, mid-30s to mid-40s (*sections 3.3.5.1, 7.1.1*).

- 1 The doubters; <http://aras.ab.ca/rethinkers.php>
- 2 The Perth Group, <http://www.theperthgroup.com>
- 3 The Group for the Scientific Reappraisal of the HIV-AIDS Hypothesis;  
<http://www.virusmyth.com/aids/group.htm>
- 4 Ian Young, *The AIDS Dissidents: An Annotated Bibliography* (Scarecrow, 1993).
- 5 Henry H. Bauer, *The Origin, Persistence and Failings of HIV/AIDS Theory* (McFarland, 2007).
- 6 Harvey Bialy, *Oncogenes, Aneuploidy and AIDS: A Scientific Life & Times of Peter H. Duesberg*  
(Institute of Biotechnology, Autonomous Antional University of Mexico, 2004; ISBN 1-55643-531-2).
- 7 John Crewdson, *Science Fictions: A Scientific Mystery, a Massive Cover-Up, and the Dark Legacy of Robert Gallo*, Little, Brown (2002).
- 8 Rebecca Culshaw, *Science Sold Out: Does HIV Really Cause AIDS?* ( North Atlantic Books, 2007);  
French translation by Pol Dubart, *La théorie VIH du SIDA, incohérence Scientifique* (Résurgence).
- 9 Etienne de Harven & Jean-Claude Rousez, *Ten Lies about AIDS* (Trafford, 2008).
- 10 Peter H. Duesberg, *Inventing the AIDS Virus* (Regnery, 1996); French translation by Pol Dubart,  
*L'invention du virus du sida* (Résurgence).
- 11 Celia Farber, *Serious Adverse Events: An Uncensored History of AIDS* (Melville House, 2006).
- 12 Christian Fiala, *Lieben wir gefährlich? Ein Arzt auf der Suche nach den Fakten und Hintergründen von AIDS* (Deuticke, 1997) [Do we love dangerously? A doctor in ssearch of the facts and background of AIDS].
- 13 Neville Hodgkinson, *Aids: The Afilure of Contemporary Science: How a Virus That Never Was Deceived the World* (Fourth Estate, 1996).
- 14 F. I. D. Konotey-Ahulu, *What is AIDS?* (Tetteh-A'Domeno CO., 1989; ISBN 0-9515442-3-3).
- 15 Heinrich Kremer, *Die stille Revolution der Krebs — und AIDS — Medizin* (Wolfratshausen, 2001);  
English translation by Jamie McIntosh, *The Silent Revlolution in Cnacer and AIDS Medicine* (Xlibris, 2008; ISBN 978-1-4363-5084-6, ISBN 978-1-4363-5083-9).
- 16 John Lauritsen, *The AIDS War: Propagnada, Profiteering and Genocide from the Medical-Industrial Complex* (ASKLEPIOS, 1993; ISBN 0-943742-08-0).
- 17 John Lauritsen & Ian Young, *The AIDS Cult: Essays on the Gay Health Crisis* (ASKLEPIOS, 1997; ISBN 0-934742-10-2).
- 18 Michael Leitner, *Mythos HIV: Eine kritische Analyse der AIDS-Hysterie* (Verlag videel OHG [Niebüll], 2000) [Mythical HIV: A Criticial Analysis of AIDS Hysteria].
- 19 Christine Maggiore, *What If Everything You Thought You Knew about AIDS Was Wrong?* (American Foundation for AIDS Alternatives, 2007, 4<sup>th</sup> rev. ed.; ISBN 0-9674153-2 [first ed. 1996]).
- 20 Robert S. Root-Bernstein, *Rethinking ADS: The Tragic Cost of Premature Consensus* (Free Press/Macmillan, 1993).
- 21 Joan Shenton, *Positively Fales: Exposing the Myths around HIV and AIDS* (I. B. Tauris, 1998).
- 22 <http://archive.org/post/243665/wayback-machine-comes-to-life-in-new-home>
- 23 Kary Mullis, *Dancing Naked in the Mind Field*, Vintage (Randoom House) 2000, pp. 171-4.
- 24 Perth Group, “NIH / Antibodies” (contributed to Internet debate preceding Presidential AIDS Advisory Panel meeting, Johannesburg, July 2000);  
<http://www.theperthgroup.com/OTHER/nihantibodiesshort.html>, accessed 23 August 2013.
- 25 Robert Johnston, Matthew Irwin, & David Crowe “NIAID/NIH “Evidence” — Rebuttal”;  
<http://www.healtoronto.com/nih>
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- 33 A. G. Bird, “Non-HIV AIDS: nature and strategies for its management”, *Journal of Antimicrobial Therapy*, 37 (suppl. B, 1996) 171-83.
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