CONTINUUM

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changing the way we think about aids

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CONTINUUM

ending aids

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CONTINUUM *magazine*
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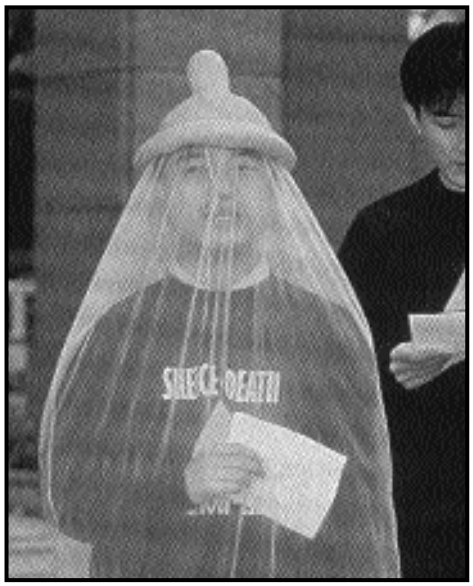
features



Is there a cover-up? (see pp. 46-49 etc.)

regulars

health • pass • it • on

Orthodoxy Opens Doors

Alternative medicine

Complementary/alternative medicine (CAM) continues to triumph in terms of public support. Some 50% of Australians and 65% of Germans use some form of CAM according to studies in *The Lancet* (Vol 347, p 569). The budget for the U.S. Office of Alternative Medicine (OAM) is now some US$20 million a year. The OAM supports 11 research centres in the US. This autumn, the *Journal of American Medical Association* and *Archives of Internal Medicine* will produce issues with CAM themes. *New Scientist* 18 April 98

Mind-Body-Link

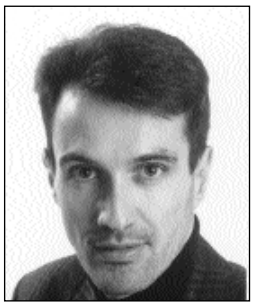
Emotions affect health in conjunction with the neuroendocrine and immune systems say new results reported at the Psycho Neuro-Immunlogy Research Society meeting (Bristol, UK, April 1-4). TB is one disease reactivated by stress. L. Hoffmann and A Sullivan (Royal Victoria Hospital, McGill University, Montreal, Canada) presented data that a patient's psychological profile (FIT score), based on family relationships, interpersonal skills and attitude to surgery can help predict survival rate after bone-marrow transplants. *The Lancet* 18 April 98

PI's Heart attack

Severe coronary artery disease may be a complication of PI therapy in some 'HIV+' patients, according to a Minnesota-based team. Dr. Keith Henry of Regions Hospital in St. Paul and colleagues describe two such cases. The first was admitted for angina: four weeks prior to admission, the patient began a 'combo' regimen that included ritonavir, saquinavir, lamivudine and stavudine. The second patient also presented with angina. Before she began treatment with indinavir her cholesterol was 4.28 mmol/L, which doubled after 5 months of treatment. The patient had also developed a fat pad in the cervical area. Dr Henry reported the case of a 35 year-old man: "He had been on the protease inhibitor Inidinavir for several months when he developed severe accumulation of fat in the arteries and also a blockage of an artery in the heart…Clinicians need to be aware of the potential for accelerated atherosclerosis in patients treated with PIs". *The Lancet* 2nd May 98

For the first time since World AIDS Conferences began in 1985 in Atlanta, USA, critics of the hiv-aids-hypothesis have been given an official forum, in Geneva at the 12th international meeting. The request to address the key-question of the lack of isolation of hiv, posed by the team of Australian scientists lead by Eleni Papadopulos-Eleopulos and confirmed by others, was formally placed before the organisers of the 12th World AIDS Conference last January by the International Forum for Accessible Science (IFAS), the umbrella organisation representing some of the leading voices critical of the 'hiv' hypothesis of AIDS. Supporting organisations included Meditel (UK), Reappraising AIDS (USA), HEAL United (USA), GaIA Trust (UK/Switzerland) and Continuum.

Michael Baumgartner, Secretary General of IFAS says it was a long and bumpy journey to finally get invited to supplement the tight orthodox programme. After a long letter and fax exchange between the conference office and IFAS in Bern, Switzerland, the historic breathrough came as a letter confirming the forum as an Official Satellite Meeting entitled "HIV-Testing: Open Questions Regarding Specificity", for the evening of the opening day of the conference. The meeting was given free of charge and is announced in the programme along with all other meetings. There has never before been agreement to let critics be heard at these mainly pharmaceutically sponsored events. This "gift" was issued after both organisations co-sponsoring the conference and representing individuals living with a positive hiv-test result, Global Network of People Living with HIV/AIDS (GNP) and the International Community of Women (ICW), supported the request.



IFAS's Michael Baumgartner

Chairman of the Conference Executive Committe Dr. Bernhard Hirschel personally addmitted in a phone converation with Baumgartner that he sees the importance of clarification of the isolation/testing issues.

Despite alleged heavy pressure by other conference co-sponsors UNAIDS and the International AIDS Society (IAS) to prevent the invitation, committed support in particular by Director of GNP, Shaun Mellors, ensured the issues raised by IFAS will be officially addressed. Could this be the long awaited breakthrough in aids?

For more information see p. 6.

'hiv'p24 common in liver diseases

Startling new findings reported in the May 30th issue of *The Lancet* show a protein said to be the most specific marker for hiv, the suggested virus expected to cause aids, is detected in 35% of patients with primary biliary cirrhosis, a disease of the liver of unknown aetiology, possibly related to copper toxicity. Reactions to the 'hiv protein' were also found in 50% of people with chronic viral hepatitis.

Dr. Andrew L. Mason of the Alton Ochsner Medical Foundation in New Orleans, Louisiana, and a multicentre team, conducted tests for reactions to p24 in blood from 77 patients with primary biliary cirrhosis, and 126 patients with chronic liver disease, 48 with systemic lupus erythematosus and 25 healthy volunteers.

Besides the cirrhosis and hepatitis patients, the study found 29% of those with lupus and 39% with either sclerosing cholangitis or biliary artesia also showed immunological reactivity to the 'hiv *gag* gene' protein. Even 4% of patients with alcohol-related liver disease and healthy controls were p24 positive.

Since 1984 'the discoverer of hiv', Prof. Luc Montagnier, has claimed p24 is the most specific protein for the suggested retrovirus. It is included as a test substance in almost all 'hiv-test' kits.

The number of biliary cirrhosis patients reactive with p24 is similar to the finding of R.W. Coombs *et al* in 1991 of an "absence of anti-p24 antibody in 75% of AIDS subjects".

It is unclear why one group of people are said to be specifically hiv-infected upon detection of p24, and another not. The study's authors suggest an explanation for their findings may be in an autoimmune aetiology to bilioary cirrhosis, where "antibodies may coincidentally cross-react with shared antigenic determinants" i.e. antibodies not in the first place made against p24 may nonetheless react with p24.

The claim that p24 formed part of the structure of a new retrovirus hiv, and p24's inclusion in 'hiv-test' kits, was based on the same immunological reactions.

Some 90% of people with biliary cirrhosis also have antibodies reactive with mitochondria.

Photo : Clair Walton

Journalists, activists and well-wishers joined Joan Shenton (centre) at the launch of her book 'Positively False - Exposing the Myths around HIV and AIDS' at London's famous Groucho Club, Soho on April 30th (see p. 27)

Latest hiv/aids figures show decline continues

Figures recently published by the U.S. Centers for Disease Control for the year ending 1997 show U.S. hiv/AIDS diagnoses declined from 68,808 in 1996 to 60,634 in 1997. 'Heterosexual contact cases' declined from 9,526 in 1996 to 8,112 in 1997. In 1996 they were 14% of all cases; in 1997, 13%. Female adult diagnoses declined from 13,767 to 13,105. Pediatric diagnoses declined from 671 to 473, of which all but 63 were from racial/ethnic minorities. Teenage cases fell from 401 to 379. 'Heterosexual transmission' teenage cases fell from 19 to 14 for boys, 90 to 78 for girls.

Commented Philip Johnson, Professor of Law, University of California at Berkeley, 'We are not surprised that responsible newspapers refused to print such scurrilous data, which threaten the very survival of scientists who have families to feed, and loans to pay off. Everyone is at risk, and the pandemic is increasing geometrically at an astonishing rate. Women and minorities are disproportionately affected, and Olympic Decathlon competitors are the fastest growing afflicted group. Unless my research grant is at least quadrupled, planet-wide disaster is inevitable."

Dissidents Address 54th Session of Commission on Human Rights

In April the Swiss-based International Forum for Accessible Science (IFAS) joined with one of the longest-standing UN-accredited human rights organisations, International Educational Development (IED)-Humanitarian Law Project, to address human rights violations in Africa based on fraudulent hiv science, at the UN Human Rights Commission. IED delivered the statement, co-sponsored by Continuum and the GaIA Trust, concerning aggressive administration of toxic drugs, especially AZT, to the most vulnerable group of people in Africa, newborn children, on the presumption that they are infected by 'hiv'. While there is little evidence provided to back up alledged hiv infections in such infants, there is plenty of evidence calling into question the safety and benefits of AZT, and pointing out its dangers especially to unborns and babies. The presentation was well received and an increasing number of delegates from African countries share the concerns raised by IED and IFAS, already alerted through previous UN presentations by People's International Health Project and Continuum.

Docs to Tell the Truth?

U.K. doctors will be struck off if they fail to tell patients the truth about their treatment, the General Medical Council announced on 19 May. Doctors are not legally obliged to tell patients all the details of their treatments, but the council decided that they must do so to improve public confidence in the profession. A U.K. Court of Appeal ruled last year that doctors were under no legal obligation to tell the truth and therefore could not be sued for concealing the failures that led to a child's death. "Patients have a right to expect that doctors will explain things to them fully and honestly, especially in the unlikely event that something goes wrong in their treatment," said Sir Donald Irvine, President of GMC.
***The Times* 20 May 98**

Retinoids cure KS?

At the 2nd International AIDS Malignancy Meeting (Bethesda, MD, USA, April 6-8) researchers reported oral and liposomal retinoids seem to be effective in AIDS patients with refractory KS. Bruce Dezube reported 38% of patients given up to 100 mg/m2 daily of an oral-cis retinoic acid, LGD 1057, had a partial response. At 16 weeks there was one complete responder, 36% of patients were stable. Toxicity was a problem: 25% of patients reported grade 3-4 headache, 13% had elevated triglycerides. 15 patients withdrew from the trial in which 66 patients were enrolled.
***The Lancet* April 18 98**

Pinching slams dual PIs

Immunologist Prof. Tony Pinching, of St. Bartholomew's Hospital London warns against the use of dual 'combo' therapy saying: "I wouldn't consider dual protease therapy as standard therapy on the present evidence." The ongoing study of PI Combination in Europe (SPICE) is one of the few trials currently looking at dual PI therapy. Involving 157 patients, the first results are due to be published at the Geneva World AIDS Conference. Prof. Pinching concluded: "At this stage the SPICE results are not compelling and I am concerned that treatment decisions are being made on the basis of trends in early research."
***The Pink Paper* 22 May 98**

Prescriptions kill

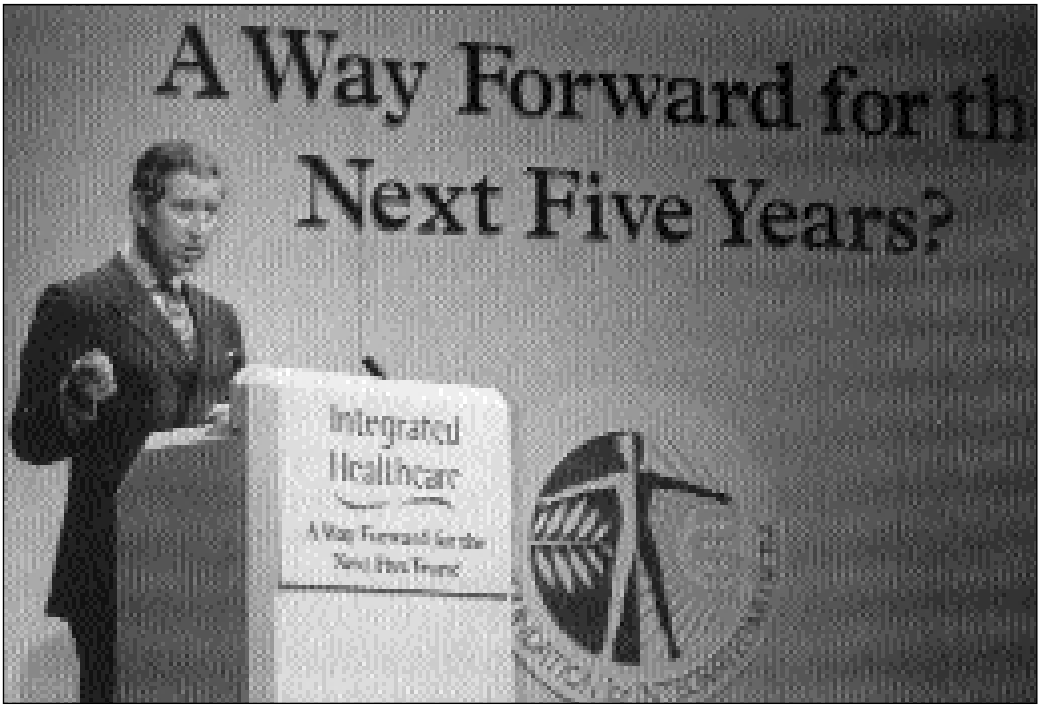
Bad reactions to prescription and over-the-counter medicines kill more than 100,000 Americans and seriously injure an additional 2.1 million every year, researchers esitmate. Such reactions, which do not include prescripton errors or drug abuse, rank sixth among US causes of death. Dr. Bruce H. Pomeranz, principal investigator, University of Toronto warned: "What we are arguing is that there should be increased awareness also of side effects, which until now have not been too well understood." Pomeranz *et al* analyzed 39 studies of hospital patients from 1966 to 1996. Serious injury was defined as being hospitalized, having to extend a hospital stay or suffering permanent disability. The most surprising result was the large amount of deaths, the authors said.
***San Francisco Examiner* 14 April 98**

Nazi Doctor Wanted

The Danish Government has been asked to help establish the fate of Nazi doctor Carl Vaernet, who fled to Argentina after the war. Vaernet was a pro-Nazi Danish citizen who served in the SS, conducting medical experiments on gay concentration camp prisoners at Buchenwald and Neuengamme. Unlike other Nazi doctors, he was never put on trial at Nuremberg, and was allowed to flee to Argentina after the war. Vaernet's role in the medical abuse of gay prisoners is documented in the archives at the International Tracing Service at Arolsen.
***Metropolis* 30 April 98**

PIs just target proteins

Of the available PI's, ritonavir is the most potent inhibitor of liver cytochrome enzymes with the highest risk of incurring drug interactions, according to research by Dr. Lisa L. von Moltke *et al*, of Tufts University. She studied the effects of ritonavir, indinavir, nelfinavir, and saquinavir PI's on P450-3A activity. The effects were strongest for ritonavir and indinavir. The team urges clinicians to consider "…route of metabolism as well as interference with or enhancement of rates of metabolism…" for each drug they administer. "There is obvious potential for kinetic variability that may have a major impact on efficacy and toxicity."
***Journal Clinical Pharmacology*, Vol. 38, 1998**



Prince Charles backs call to end "double standards"

Britain's Prince Charles, as President of the Foundation for Integrated Medicine, opened a conference in London in June by backing calls for eliminating double standards in evaluation of orthodox and alternative or complementary treatments. Said the prince, "We need to commit ourselves to a rigorous but open minded evaluation of practice in all aspects of health care and to find ways of translating ideas into action in the most effective manner."
Dr. Ian Chalmers, Director of the UK Cochrane Centre and a noted proponent of systematic reviews, told delegates, "Critics of complementary medicine often seem to operate a double standard, being far more assiduous in their attempts to outlaw unevaluated complementary medical practices than unevaluated orthodox practices." It is thought that more than 60% of orthodox treatments have not been scientifically proven. Said Chalmers, "These double standards might be acceptable if orthodox medicine was based solely on practices which had been shown to do more good than harm, and if the mechanisms through which their beneficial elements had their effects were understood, but neither of these conditions applies."
Prince Charles urged national funding and educational bodies to consider what they could contribute to increase research and awareness in the field. Commented Secretary of State for Health Frank Dobson, "I believe that what works is what counts and what counts is what works," noting that it was only "right and proper" that rigorous standards of efficacy and safety should be applied across the board.

Wellcome genome

The Wellcome Trust plans to significantly raise its investment in the Human Genome Project by providing an aditional £110 million to the project over a period of seven years. The investment will raise the Trust's contribution to the project to £250 million with the result that it will fund one-third of the sequencing of the human genome. Wellcome is also to review the scope of commercial patents that are based exclusively on DNA sequencing and is prepared to challenge certain patents.

ACT UP SF move to new space

ACT UP San Francisco recently moved into its new community workspace at 3391, 17th Street, Castro District, San Francisco, CA 94114. The official opening was 30th May. In the new space ACT UP provide dissident literature, an HIV rejectionist resource library, a community posting board, and access to DNCB and medical marijuana. ACT UP SF continue to refuse any funding from government or pharmaceutical industry sources relying instead on community support. Says David Pasquarelli, "The space allows us the opportunity to attract a large crowd of clients and slowly re-orient their thinking about the HIV lie and the plethora of poisons being pushed on people with AIDS. It has been quite a fabulous transformation for the organisation." ACT UP SF have joined the international *Refuse and Resist HIV-Testing* campaign initiated by Continuum, which includes other organisations worldwide, and plan to protest at a San Francisco testing clinic to focus media attention on the issue.

New theory of mechanism of AIDS

Medical Hypotheses (Jan. 1998, Vol 50, No.1 pp67-80) featured an interesting, highly plausible theory by K. Shallenberger. The author begins by stating that the single ('HIV') infectious pathogen model of AIDS just does not fit the bill, and points out that nearly twenty years into the epidemic, many scientists realise this. The others are still vainly trying to work out a feasible mechanism of how 'HIV' causes AIDS. Shallenberger has developed a theory of AIDS based on the immune system itself, rather than a single invasive virus. He does not question the existence of 'HIV', but argues that AIDS is a multifactorial condition based on a reversal of the traditional roles of the two principal arms of the immune system, cell mediated immunity (CMI) and antibody mediated immunity (AMI).

Shallenberger calls his model for AIDS aetiology Selective Compartmental Dominance (SCD). This posits that whereas the infectious agent theory of AIDS is based on a supposed, but by no means complete, correlation between 'HIV' antibodies and cellular depletion, his own theory is based on a three phase development of disease based on the initial failure of CMI and the increasing dominance of AMI. His explanation for this is extremely complex, but it seems to explain many of the anomalies of the 'HIV'/AIDS model.

Briefly, Shallenberger proposes that usually, infectious organisms are dealt with by a primary cellular immune response, which clears the body via mechanisms such as phagocytosis, the killing of virus-infected cells by killer cells etc. AIDS is the result of many and repeated chronic infections which put an intolerable strain on the CMI, allowing the secondary, antibody response to become dominant. This asymptomatic 1st phase of AIDS precedes the failure of the cellular arm of the immune system. The 2nd phase is characterised by hyperproduction of antibodies by the humoral arm, which may ultimately be destructive of helpful cells in a vicious circle involving destructive autoimmune antibodies. This phase produces high levels of antibodies against numerous organisms, including 'HIV', in people who appear to be totally well. Bloodwork, on the other hand, amongst asymptomatic gays, drug addicts and haemophiliacs, frequently shows a high incidence of cellular abnormalities, even in the absence of 'HIV' antibodies, in ostensibly healthy subjects. This suggests that AIDS is a disease event entirely separate from 'HIV', and found principally in people most subject to repeated antigenic exposure e.g. sexually hyperactive gays with multiple STD's, viral, bacterial and parasitic infections: drug addicts exposed to various hepatitis and other pathogens via dirty syringes and contaminated street drugs: haemophiliacs exposed to commercially-made clotting factor consisting of 99% alloantigenic impurities.

2nd phase AIDS in Shallenberger's model is characterised by gradual decline in T-Cell numbers which can take years, and the third or final phase is the irreversible collapse of both the CMI and AMI arms of the immune system. Prior to this, Shallenberger believes phases 1 and 2 may be reversible, and suggests controversially that ozone treatment should be tested in large scale trials. However, this will get no support from at least the pharmaceutical companies because ozone is cheap and plentiful.

This well researched, peer-reviewed paper is very feasible as far as it goes. Socio-cultural developments allow and even encourage the emergence of previously unsuspected disease mechanisms albeit the mechanisms per se are not new. The relaxation of sexual taboos combined with increased foreign travel and regular use and abuse of both recreational and medical drugs have combined to increase disease incidence, particularly noticeable in a previously complacent, increasingly healthy developed world. Shallenberger's paper may be best read with this in mind - there are no new mechanisms, merely a better understanding of the old ones.

There are some surprising omissions e.g. no mention is made of the supposed AIDS epidemics in Africa and the Far East, and how they relate to his theory. Unhappily, he makes no mention of the concept of vaccination: in a healthy person, with functional CMI, a vaccine is deemed to have worked if the recipient makes an antibody response. Shallenberger's paper seems to suggest that vaccines would not produce antibodies except in subjects with a previously compromised cell mediated immunity.

The main reason this paper should be read is that the author is part of the growing number of scientists who are questioning previously held suppositions about the immune system, like Polly Matzinger and others. Several scientists have observed that a more thorough understanding of the mechanics of the immune system will help solve the riddle of AIDS.

A Third fail on 'combos'

The first International Workshop on Salvage Therapy for 'hiv' Infection expressed concern that between 30 and 50 per cent of patients prescribed 'combo' therapy experienced failure of the treatment within one year of initiation. Recklessly opined Dr. Robert Schooley of the University of Colorado,"Antiviral therapy should be changed early in order to prevent immunological damage and cross-resistance to other agents."
***The Pink Paper* 1 May 98**

Glaxo Greed

Glaxo-Wellcome plan to charge treatment centres £7 per day for accessing the unproven 'AIDS' drug abacavir drug on an experimental basis. Says ATP's Simon Collins: "There is serious doubt about the effectiveness of this drug… Normally pharmaceutical companies provide such drugs for free in return for regular safety reports. Glaxo is not considering a controlled study to assess the effiacy of abacavir in treatment strategies for antiretrovirally experienced patients." Six people experienced life-threatening reactions when re-starting abacavir.
***The Pink Paper* 8 May 98**

PI's control KS?

Dr. Celeste Lebbe of Hospital Saint-Louis in Paris and a multi-centre team reported in the May 7 issue of *AIDS* that 'anti-HIV' protease inhibitor treatment appears to be effective against Kaposi's sarcoma. The researchers - who examined nine patients with progressive KS and one patient with stable KS, on 'combo' therapy regimens - observed a complete regression of the blood vessel neoplasm in six of the patients, with two partial responses. PIs may be effective in the reduction of KS.
***HEAL Magazine* No.12 29 May 98**

9 Thai 'hiv' Pros Murdered

U.S. National Public Radio May 23rd interviewed a social reformer trying to end female sexual slavery in Thailand who reported girls who test 'HIV+' are being murdered by pimps, citing a recent case of 9 girls found dead in an apartment, murdered by cyanide injections because they tested 'HIV+'. Pimps say the 'AIDS-epidemic' in Thailand is scaring off the customers.

NEED TO KNOW?

CONFERENCES

GENEVA, Switzerland - World AIDS Conference, 28th June - 3rd July.

Sunday 28th - of great interest: Official Satellite Meeting, **HIV-Testing: Open Questions Regarding Specificity**. Organised by IFAS. Major dissident representatives. Venue - Session Hall III, Palexpo Centre. Time 20.00-22.00
For Conference information call Secretariat on Switzerland + 41 22 737 3344

GENEVA - **Alternative Symposia**. Supplementary events from 28th June to 3rd July, organised by Aktion positiv Schweiz (ApS) Switzerland, Continuum UK, Gay International Association (GaIA Trust) UK/Switzerland, Meditel UK, HEAL USA, COBRA Spain, and International Forum for Accessible Science. At the Swissair Guesthouse, Chemin de la Violette 11, Geneva.

Sunday 28th June: **Long Term Survivor Day** (ApS)
11.00 Press Conference, launching Long Term Survivor Study followed by Long Term Thriver Party

Monday 29th : **Viral Isolation/Testing** (Continuum)
15.00-17.00

Tuesday 30th : **Sexuality, Epidemiology and HIV/AIDS** (GaIA) 15.00-17.00

Wednesday 1st July : **HIV/AIDS and the Media** (Meditel) 15.00-17.00

Thursday 2nd : **AIDS-causation, AIDS-prevention. A Different View** (COBRA) 15.00-17.00

Friday 3rd : **Summary** chaired by HEAL 15.00-17.00

For more information call Switzerland + 41 31 332 9373

PUBLISHING

The Canadian and U.S. distributors for the new book *Positively False, Exposing the Myths Around HIV/AIDS* by Joan Shenton are St Martin's Press, 175 Fifth Avenue, New York, NY 10010

The video *AIDS - A Second Opinion* can be obtained on Canadaian/USA NTSC VHS format from Gary Null & Associates, PO Box 918, Planetarium Station, New York, NY 10024. Tel. 212- 431 3990

WEBSITES

- German translation of Eleopulos interview with Christine Johnson from *Continuum* vol 5 No 1 at
http://privat.schlund.de/mleitner/papadop

- Continuum website in development at
http://www.virusmyth.com/aids/data2/continuum.htm

- Perth group of HIV/AIDS scientists at
http://www.virusmyth.com/aids/perthgroup

- Reappraising AIDS website at
http://www.virusmyth.com

- Noam Chomsky Continuum interview at
http://www.homeusers.prestel.co.uk/littleton/ai_aids.htm

- Death Camp website at
http://www.angelfire.com/ar/dthcamp

CONTINUUM
Meeting

Questions
Discussions
Experiences

Thursday 16th July,
6:00 - 8:00pm
at Continuum, 172 Foundling Court, Brunswick Centre (door 3) Marchmont St London WC1N 1QE
(near Russell Square tube station)
Please call to indicate attendance on
0171 - 713 7071

correspondence

Exposing Montagnier

Thank you for exposing once and for all that charlatan Luc Montagnier who albeit unintentionally deconstructs his insane "belief" that what he has "seen" and "encountered" is a "retrovirus" - "HIV"! Montagnier's replies in Djamel Tahi's interview (*Continuum*, Vol.5, No.2) are full of contradictions and inconsistencies. As Eleni Eleopulos (too politely) asks in her critique of the Montagnier/Tahi interview: "If 'HIV' exists, and it is 'clear' to Montagnier that he has 'seen it' and 'encountered it', where is his proof?" So where is his "proof?" Why has Montagnier got away with his fraudulent HIV invention for so long and what are we going to do about bringing this criminal to justice? Surely if there were any justice, Montagnier would be tried by a French Court on charges of fraud and collaborating in genocide. His HIV mistake has led to global human rights violations, as well as the deaths caused by the 'anti-retroviral' drugs. Montagnier's somewhat inverted 'confession' is almost near enough in getting him to sign his own death-warrant. As he will obviously not do this we must demand he be put on trial for gross crimes against humanity. It is truly appalling that the international media and journals like *Nature* and *Science* seem to be turning a blind eye to such an outright criminal as Montagnier. We need to orchestrate an international campaign to get Montagnier brought to justice. Maybe *Continuum* could instigate this enquiry?
André de Silver,
Paris.

Luc Montagnier *is killing himself*, notably by his statements like the one he did in Djamel Tahi's interview according to which he believes in HIV because he encountered it. *Errare humanum est, sed perseverare diabolicum*. Some of Luc Montagnier's fellow-researchers at Pasteur Institute will soon openly start fighting him. The French government will also be obliged to investigate Montagnier's 'research' procedures. We could launch the first lawsuit against him, for scientific fraud. 'Patients' accused of being 'HIV+' or who lost their loved ones to the fake 'virus' may first want to kill him. Then they probably will look for financial compensations, because Montagnier became a millionaire through his HIV/AIDS fraud. Former French officials whose (political) lives have been broken by Montagnier's ungrounded accusations, may also want to retaliate.
Henri-Claude Saint-Fleur,
Psy. Clin. D.E.S.S,
Truth International,
Miami, USA.

I appreciate every issue of *Continuum* and work with it - send some articles to friends and use the contents as argument in petitions, letters to institutions and authorities.
The contradiction between Montagnier's admission "We did not purify" and the claim in Montagnier's *et al's* 1983 *Science* paper to have done so! I do not know French laws, but I could imagine that this is a cheat, a punishable cheat.
Hans Bernd Ashauer-Jerzimbeck,

correspondence

Smallpox and polio

I am writing to draw attention to a misquote attributed to me by Michael Verney-Elliott on page 6 of the latest issue of *Continuum*. He says, correctly, that I discussed with him confusion in diagnosis between smallpox and chickenpox during the WHO eradication campaign in the 1970's but he adds, incorrectly, that "Official figures for chickenpox disappeared during the campaign but reappeared with a bang after smallpox was declared eradicated in 1980". There were, as far as I know, no official figures for chickenpox. It is possible that more cases were detected but if he heard this, it was not from me. I am very firmly on record in 1972 in Chapter 9 of my book on Trends in Epidemiology in supporting the need for a radical programme for eradication of smallpox from endemic areas which includes, of course, differentiation of chickenpox in case detection, contact-tracing and other steps besides vaccination.

The comparison with polio is also unreal. The polio epidemic in Europe and Africa began in the late forties and spread in the 1950's. It was subsiding before either he Salk or Sabin vaccines were used but did not recur and there is little doubt that this was attributed to the vaccines, especially Sabin. There is very little similarity between paralytic poliomyelitis and viral encephalitis and, in any case, the only viral infection which mimics polio is Coxsackie which was not differentiated until the late fifties. The statement that the vaccines:"Frequently caused polio" is quite wrong. Salk ('killed') vaccine caused polio in one unfortunate incident in a batch which was live but never again. The Sabin (live) vaccine can cause vaccine-related polio very rarely (estimate < 1/million doses). There was a "National panic" in the USA about polio because it had appeared as a disaster disease in children but the implication that this was exploited commercially at that time is unjustifiable. The development, safety and

widespread use of Sabine vaccine was a memorable achievement, as was the seemingly final eradication of smallpox from endemic areas in SE Asia and Africa.

As Michael says, there are good reasons for expressing doubts about the search and need for a vaccine against AIDS, and there are grounds for criticising some other aspects of vaccine policies. But these errors or misunderstandings of the situation between 1950 and 1980 and of the copious literature on smallpox and the two polio vaccines are unfortunate because they will be interpreted as accusations that all three were ineffective, unsafe and promoted for commercial reasons. Michael whom I know well is a conscientious medical journalist and it is unlike him to make such serious mistakes. It is important that, in such matters, *Continuum* maintains its standard of accuracy and objectivity. It is especially important that eradication programmes which include vaccinations against polio in Eastern Europe, Asia and Africa are not jeopardised by false alarms.

On the positive side, I would like to congratulate you on the inclusion and quality in the same issue of *Continuum* of the interviews with Val Turner and Eleni Eleopulos, and with Luc Montagnier.

Prof. GT Stewart.
Bristol

Michael Verney-Elliott replies:

I wish to apologise for misrepresenting Prof.Gordon Stewart in my article "AIDS Vaccines - The Cruel Delusion". I stated that it was he who told me about the disappearance of the official figures for chickenpox during the anti-smallpox campaign carried out in India. I discussed the anti-smallpox campaign with the Professor some ten years ago, as well as with several other vaccine experts, and I am afraid I did not keep careful notes of my conversation with Professor Stewart. Whoever told me of the missing chickenpox figures, it was not Professor Stewart, and I am currently rummaging through my notes to try to find the correct source for this information. A

corrigendum will be published in due course. Meanwhile, I apologise for any distress or irritation my sloppiness may have caused to Professor Stewart.

More importantly, the Professor was concerned about my statement that polio vaccines "frequently caused polio!". However, the offending remark was based on several sources.

1.The Washington Post, 16.9.1976 quoted testimony by Prof. Jonas Salk, creator of the killed virus polio vaccine, who stated that the live-virus vaccine (devised by Sabin) was "the principle if not sole cause of all reported polio cases in the United States since 1961."

2. In a report published by the Centres For Disease Control in 1992, 87% of polio cases reported in the US between 1973 and 1983 (excluding imported cases) were caused by the polio vaccine. (CDC, "Clinical Infectious Diseases", Feb, 1992: pp568-579) The same report further states that between 1980-1989, 100% of polio cases (excluding imported cases) were caused by the vaccine. Moreover, of the five US subjects who contracted polio whilst abroad, three had received polio vaccination against the disease.

Professor Stewart has had a long and distinguished international career in public health and epidemiology, so I naturally defer to his opinion that the polio vaccines have prevented a repetition of the large-scale epidemics of polio which he witnessed at first hand, but I nevertheless have the gravest doubts about the benefits of vaccination in general.

Don't stop!

Your issues may be coming out less often, but the quality has not decreased. Your winter 1997/8 issue was superb. It amazes me that *Continuum* can cover such a wide range of issues, especially such technical topics as methods for proving the existence of retroviruses. Not only that, but reading these articles is fascinating.

Just don't stop!

David Crowe
Calgary, Canada

Awareness in India

We thank you very much for sending back issues of Continuum and the book entitled 'AIDS The Failure of Contemporary Science' written by Neville Hodgkinson. We will be highly obliged if you can send us 'AIDS: A Second Opinion' as it will be used for telling the truth to the people at large in India.

Due to General Elections, the Government of India is not able to arrange yet a Scientific Meeting on 'AIDS' despite our persistent demand. In the meanwhile, we have asked Director General, I.C.M.R., New Delhi to provide data confirming the relationship between HIV=AIDS=DEATH and we have asked them to stop 'AIDS' awareness programme launched in the country. We are enclosing herewith a copy of our letter addressed to D.G., I.C.M.R. for your information.

Dr. Shantilal Kothari,
Academy of Nutrition Improvement,
India.

Animal Tests

The magazine is always such a good blend of highly detailed science and more easily assimilable 'human' stories. Good, too, to see virtually no pro-vivisection propaganda these days! Whatever is found in a lab animal is medically meaningless for the extra-laboratory human (different species) situation - so pointless to use always inconclusive vivisection 'data'...

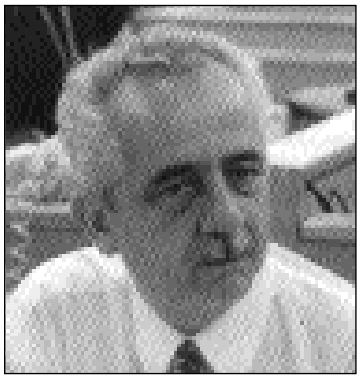
The article by Rev.Dr. Michael Ellner on *'Collective Stupidity'* (last issue) particularly spoke to me as a 'vivisection dissident', since no matter how often you tell medics that up to 95% of the time vivisection delivers the wrong answers on adverse drug reactions - they still say, "Ah, what about 5% of the time when the answer is right"! Madness - made possible by the mass conditioning from 'education' and the media.

All the best to you at Continuum.

Dr. Tony Page,
London

AIDS is neither an infectious disease nor is sexually transmitted

by Roberto A. Giraldo, MD.



Roberto Giraldo is a Specialist in Internal Medicine from the University of Antioquia, Colombia. He graduated with distinction from the University of London after obtaining a MSc in Clinical Tropical Medicine. For 30 years he has been dedicated to clinical, academic and research activities in infectious diseases in Colombia, USA and Europe. He currently works in the Clinical Immunology section of the Department of Microbiology, University Hospital, New York City. He has been an independent researcher into AIDS for the past 15 years.

There are many scientific facts which show that the so-called human immunodeficiency virus ('HIV') does not fulfil the epidemiological and biological requirements, nor the common sense requirements, to be the cause of the human immunodeficiency syndrome (AIDS). [9-14, 26, 31-33, 36, 37, 44, 52, 59]

'HIV' is neither necessary nor sufficient to cause AIDS, and antibody positivity does not always precede the development of the syndrome.[11,32] This is demonstrated by thousands of AIDS cases that are 'HIV' negative and a host of people that are absolutely healthy and have never developed AIDS, even though they are diagnosed HIV positive. [2,13,20,31,32,49] HIV is not a pathogenic agent, and for this reason it cannot explain the immunological alterations, nor the pathogenesis, nor the natural history, nor the different clinical forms within the groups of people that develop AIDS. [9,13,14,29,30,32,41,42,59] What is called HIV has never been isolated as an independent, free viral entity.[60] There are facts that question the existence of HIV as a real virus. [44]

Since it has never been proven that 'HIV is the cause of AIDS', investigators who enthusiastically defend HIV as the cause of the syndrome have proposed a vast variety of agents as helpers or "co-factors" of HIV in the genesis of AIDS.[21,48] However, these "co-factors" are by themselves causal agents of immunodeficiency and may generate AIDS with or without the diagnosis of 'HIV'.[12-14,32,59] I prefer to call the "co-factors" immunological stressor agents.[34]

The new real circumstance that surrounds all the groups of people that develop AIDS with the greatest frequency is the exaggerated exposure in the last decades to a variety of stressor agents against the immune system, that can have a chemical, physical, biological, mental or nutritional origin.[12,28,29]

Coincidentally AIDS appears in various and distant groups of people in the second half of the twentieth century, at the time when the immune system of human beings is already saturated and has seriously deteriorated, due to involuntary exposure (and many times voluntary) to immunological stressors.[28,32] The capabilities and functions of the immune system are neither infallible nor infinite. They have limits. The increment of stressors in the human ecosystem is putting in serious danger the preservation of our own species.[28,34] AIDS is an alarm sounding.

The distribution of these stressors varies within the groups of people that develop the syndrome and this fact is the explanation for the different clinical forms of AIDS that occur in these groups.[30,32] The immunological stressor agents create immunotoxic or immunogenic effects, or both, which generate a state of oxidative stress on immunocompetent cells and metabolic reactions of the immune system.[29,56,57] Stressor agents also generate oxidative stress on other body systems.[29,34] Progressive and continuous deterioration of the immune system causes a deficit of the defence, surveillance and homeostasis immunological functions, with the subsequent development of infections, neoplasias, and metabolic alterations.[29,30] The severe weakening of the immune system and of the entire body eventually causes death.[30] By contrast, all the definitions for AIDS created by the Centres for Disease Control and Prevention (CDC) are subjective, arbitrary, and include other less severe immunodeficiencies that are not AIDS at all.[6,7]

This conception of toxic pathogenesis and of the natural history of AIDS allows new forms of treatment and prevention that have positive repercussions on individual and community health.[13,30]

Drug treatments like AZT, the protease inhibitors and other similar antiretrovirals, must be eliminated from the treatment and prevention of AIDS, because they are immunotoxic agents and rather than producing wellness, they can generate AIDS.[15,32,33,46,47]

The prevention, control, and eradication of AIDS are easily possible and they depend on avoiding exposures to immunological stressors.[12,13,30,32] The current programmes for preventing AIDS, based mostly on what is called "safe sex", with generalised and indiscriminate distribution of condoms, rather than achieving any benefit promote the risks of promiscuity, a potentially toxic lifestyle that helps undermine the immune system. [32,34,62] In the same way, the programmes of providing free "clean syringes" ("without HIV") to drug addicts stimulate addiction to drugs and indirectly promote the traffic of drugs.[13,32] All the psychoactive drugs that are introduced to the body are potent immunotoxic agents.[12,34]

This toxic hypothesis of AIDS solves the problems that the infectious hypothesis [HIV/AIDS] has not yet solved, not to mention the millions of dollars invested in research, prevention, and patient care within the infectious conception of the syndrome.[9-12,32,33]

The so-called 'AIDS test' is neither sensible nor specific for detecting past or present infection with an HIV.[39,41,42,49,58]

v i e w

Without reason it is used for diagnosis, or to decide the medications to treat or prevent this syndrome.[2,38,41,42,49,58]

'HIV antibody' positivity may act as a marker for immmunodeficiency, but is not generative of AIDS.[13,16,56,57] HIV on the contrary could be an effect of the pathogenesis of this syndrome.[29,31] There is scientific evidence that suggests that stressors of the cells of all species can work as inductor agents of viruses and virus-like particles.[5,8,25,31,32,43,51,54,61,68]

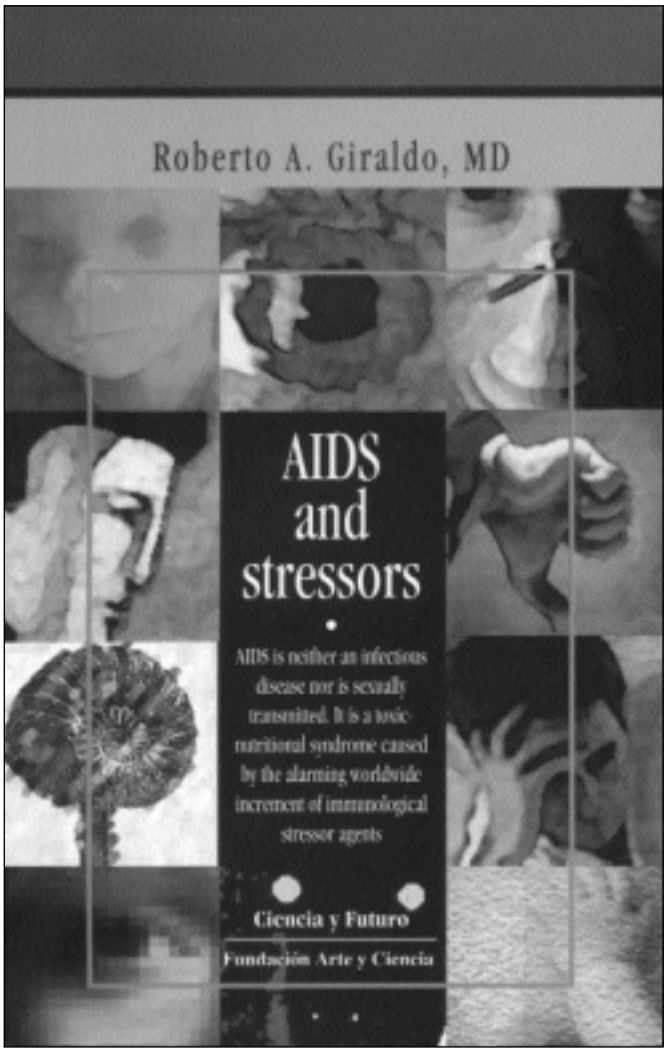
The error over the etiology of AIDS was committed in part due to microbiologic prejudice in the mind of researchers, health professionals, journalists, and the public at large.[31] This prejudice comes from the exaggeration of the germ theory of disease promulgated by Pasteur and Koch, which brought many benefits to the medical field at the time. Unfortunately, today they continue to think as at the end of the last century - that all is infectious, that all is contagious, and that it should be a microbe that causes everything. The world was prepared by a century of panic over microbes to mistake the etiology of AIDS. It was not possible to avoid it.

Another contribution to the error about the cause of AIDS is the failure in research methodology to fulfil epidemiological requirements.[1,3,4,17-19,23,24,35,40,45,50,53,55,63-67,69-75] None of the postulates on which the infectious hypothesis of AIDS is based fulfil the requirements of the research method.[2,9-14,27-34,56-59] None of the bases of the HIV-AIDS hypothesis has been demonstrated at an objective level.[2,9-14,27-34,56-59] They are theoretical assumptions, created by the minds of those who generate and defend that hypothesis.[22,38,48] Practically the entire world has become accustomed to believe all that we are told by the so-called men of science. Currently, the critical and questioning capabilities of 'the people' are null. They do not ask for the necessary proofs for the affirmations that can look objective.[31] The worst epidemic that the contemporary world suffers is an epidemic of crises in the scientific method.[27] It is more extensive than the AIDS epidemic. There will be more consequences unless we take a pathway paved with an authentic objective research methodology.

The scientific community has been wrong many times in this century, by considering as infectious diseases that are not - pellagra, scurvy and beriberi.[14,31] The error currently made with AIDS has a larger magnitude due to the catastrophic repercussions on thousands of people that suffer from this toxic syndrome.[32,33] Guilt for the error made with AIDS falls on a few researchers and health institutions of the United States government. The majority of people in the world simply believed the so-called men of science.

Analysis, understanding and solution of the error will force international medical authorities to rediscuss their tactics and strategies in the health care of people. This will lead to questions, investigations and solutions to the unfair forms by which men socially relate amongst themselves in modern society, which in the end are the reason for the existence of AIDS.

Let us go back to Hippocratic medicine. Let us divulge and stimulate the discussion about the cause of AIDS.



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For references 26 - 75 see page 51

AIDS - OH WHAT A PHONEY WAR

by Michael Verney-Elliott

Photo : Joan Shenton

"We fought in nineteen-seventeen
And drove the tyrant from the scene.
We're in a bigger, better war
For your patriotic pastime.
We don't know what we're fighting for
But we didn't know the last time.
So load the cannon, draw the blade,
Come on, and join the Death Brigade."

George and Ira Gershwin.

These are the opening words of one of George Gershwin's most rousing songs - "Strike Up The Band". They were invariably omitted as being too bitter, too cynical. I can't get them out of my head as I write about the war against AIDS

I was nearly two years old when the first 'Phoney War' began. The term 'phoney war' was coined by historians to describe the six month lull, between the declaration of war by the British government against Nazi Germany on September 3 1939, and the start of the real fighting. During that period, the British busily dug defences, stripped out iron railings to make munitions, filled sandbags, distributed gasmasks, dispatched the first infant evacuees to safer areas, and generally got ready for the serious business of repelling the invading hordes. The Americans stood on the sidelines, apparently justifying their nickname of 'Doughboys' - kneaded at the beginning of World War 1, but not rising until halfway through. Still, it wasn't a fight most Americans understood, as Ira Gershwin's lyric shows, and a sizable portion of the US population were of German origin, with understandably torn loyalties.

Forty-odd years later, the world was stampeded, this time largely by America, into another phoney war, this time against 'HIV', "the probable cause of AIDS". A principal difference between the two wars is that the first 'phoney war' was the overture to one of the bloodiest conflicts the world has seen, culminating in the revelation in 1944 of the horrors of the concentration camps and the obscenities of Hiroshima and Nagasaki in 1945 before final victory. The AIDS war, by contrast, is still, some 14 years later, a phoney war, a looking glass war directed against a non-existent enemy retrovirus, 'HIV'. It has already cost tens of billions of dollars, and shows no sign of being won. AIDS stands for Acquired (as opposed to congenital) Immunodeficiency (as judged by failure to combat normally harmless pathogens) Syndrome (a collection of diseases with a linking factor), and affects different groups of people for group specific reasons.

Who contrived this phoney AIDS war? By 1981, the US Centres for Disease Control (CDC) had not had a major epidemic to deal with since its inception following the polio epidemic in the late 40's, and by the late 70's, their track record stank. After the 1976 twin debacles of the wrongly predicted swine flu epidemic which left hundreds paralysed after the use of an inappropriate vaccine, and legionnaires' disease, which was blamed on an ubiquitous bacterium found in soil and air conditioning units, for political reasons the CDC needed a genuine epidemic fast - by the late 70's, there was talk of closing down the inefficient facility. Meanwhile, the National Institutes of Health (NIH) were under pressure to find the cause of an apparently new aggregation of previously barely noticed illnesses proving fatal amongst gay men and drug addicts. The National Cancer Institute, a tentacle of

Robert Gallo

the NIH, also needed a boost to its flagging reputation. Very expensive labs had been set up as part of Nixon's War on Cancer, but with the exception of claims by Dr. Robert Gallo to have found a viral cause of leukaemia, (subsequently completely debunked by Prof. Peter Duesberg), the National Cancer Institute was deemed by the early 80's to have lost the war against cancer, and there was talk of closing, or at least mothballing some of those labs. In an uneasy alliance, the CDC and NIH, joined forces to combat a proposed AIDS 'epidemic', initially called GRID (Gay Related Immune Deficiency). Can anyone seriously believe that the largely homophobic staff at both agencies really cared that some gay men or drug addicts were dying of a rare pneumonia, and a form of blood vessel cancer usually associated with elderly men - the two original AIDS-defining diseases? The NIH's interest in sick gays and drug addicts secured funding, keeping the labs working.

The first casualty in any war is truth, closely followed by common sense and rationality. The CDC-led propaganda machine was not helped by the fact that the two principal risk groups, gay men and drug addicts, were marginalised by society, and nobody cared very much what happened to them. The 'risk groups' were rather like the Czechs whom Hitler invaded at the start of his quest for lebensraum - the rest of Europe didn't care much, and Czechoslovakia was thought of as merely a small far away country, about which people knew little, and cared even less. How do you whip up enthusiasm and funding for a war which seemed to most middle-Americans to be fought solely on behalf of faggots and junkies, whose illness was perceived by many to be self-inflicted?

The first task was to make the public aware of AIDS as a general threat to the population at large. When haemophiliacs started to show signs of immune suppression, as well as recipients of blood transfusions, the CDC stressed that here were cases of the mysterious plague outside the original risk groups; some people may remember the clumsy description by Princess Anne of the 'innocent victims of AIDS'. The impression was fostered that gay men and drug addicts had donated their blood and plasma to hospitals and the manufacturers of haemophiliac clotting factors, and infected innocent bystanders. No-one mentioned that the blood products were made from commercially acquired plasma, including imports from countries like Haiti, Senegal, Brazil, Belize and Zaire, as well as from drug addicts in America. I couldn't find any evidence that gays were in the habit of selling their blood or plasma, but the propaganda machine made no mention of that. The CDC played on popular fears and terror, and soon the world was convinced we were in for a deadly plague which would wipe out millions by the end of the century.

Gallo and his colleagues claimed a transmissible agent, probably a virus, was involved, and started to rummage in the 'retroviral' ragbag established in 1970 when Temin and his team revealed the phenomenon of reverse transcription. Virologists in other countries were also fashionably hunting for a viral cause of the new immune suppression syndrome, and very soon laboratories in France, Britain, America, Sweden, and Germany claimed to have come up with variants of the indirect markers that would come to be known as 'HIV' in co-cultures of cells from the tissues of patients, mostly gay men suffering from lymphadenopathy and irregularities in their T-cell subsets.

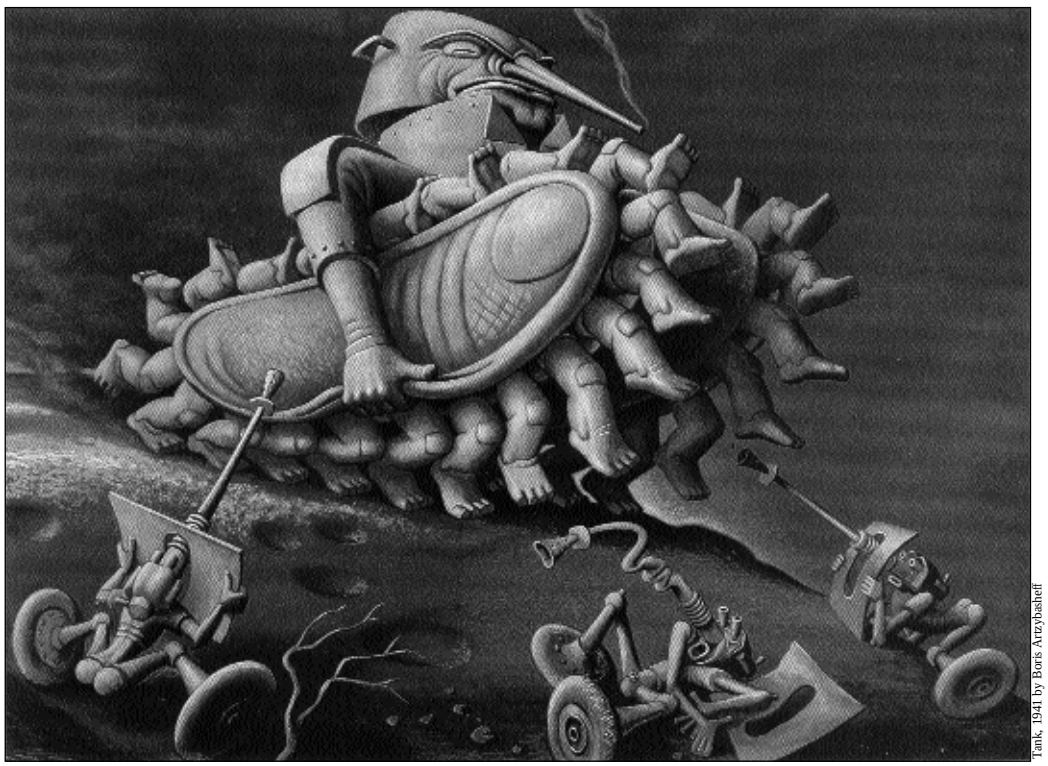
The Oxford English Dictionary defines the word 'epiphenomenon' thus: "Secondary symptom, mere concomitant of something else not regarded as its cause or result" - a perfect description of 'HIV', as the last fourteen years have shown. That claims of detection of variants of 'HIV' should be made almost simultaneously in several labs world-wide seemed like confirmation that scientists were on the right track. However, this was not the first time that different experts came to the same wrong conclusion, as the history of diseases like beri beri, pellagra and smon shows. I try to put myself in their place, given a first class ticket to ride the AIDS War gravy train. If I were the first to realise that train was steaming in the wrong direction, would I have had the guts to pull the communication cord? When Margaret Heckler's announcement in 1984 that the 'probable' cause of AIDS had been found was welcomed unquestioningly by an anxious world, the enemy had been identified, and war could be declared. No-one asked why human retroviruses had waited for thousands of years until some seven years after Temin's discovery of reverse transcription to start to cause diseases.

After an assay to detect alleged 'HIV antibodies' was patented, the CDC and NIH cast their net wider, and started to test blood samples in the Third World, Africa, South America etc. and sure enough they struck gold. The non-specific tests reacted in some members of all these populations, and AIDS went global. The discovery that 'HIV antibody positivity' was distributed world-wide finally guaranteed enormous funding for a global anti-'HIV' war. The World Health Organisation joined the fray, and by the late 80's, was predicting 20 million people infected with 'HIV' by the year 2000, and 6 million AIDS cases. AIDS was being touted as an even bigger threat to the world than the Black Death which had wiped out a third of Europe's population in the middle ages. By comparison with AIDS, we were assured, the Black Death would seem a minor blip in health history.

From the outset, not everyone was happy about the proposal of an HIV=AIDS=death scenario. Dr. Joe Sonnabend had been treating immune suppressed gay men in New York for a plethora of STD's all through the 70's, and he was convinced that AIDS was the result of an antigenic overload. The same patients who had continually come back to him for antibiotic and other treatments for a whole raft of herpes, hepatitis, syphilis and other STD's then were among those who first came down with AIDS-defining conditions in the early 80's. They had ignored his warnings that they were permanently undermining their health. The complacent belief in the efficacy and low-to-no risk of antibiotics had led most gay men to regard STD's and their treatment as a mere recreational

hazard. Today, however, we are continually being told that antibiotics are losing the fight against such diseases as tuberculosis, and even in the 70's there was a known strain of gonorrhoea allegedly brought back from Vietnam, and known as Saigon Rose, which was highly resistant to treatment. Sonnabend founded a journal called AIDS Research, to publish original research into feasible causes of AIDS that could not find publication in orthodox scientific journals. The magazine was soon taken out of his hands, re-funded by Burroughs Wellcome, and retitled AIDS Research and Human Retroviruses. Such is the neurosis of the propaganda machine during a war that even one small enquiring journal had to be silenced, and converted to yet another cog in the disinformation machine. One of the most powerful weapons in any war is censorship.

One of the the first scientists to stick his head above the parapet and state his disbelief in what was by then officially called HIV as the cause of AIDS was Dr. Peter Duesberg, the world's foremost retrovirologist. He was commissioned to write a paper for *Cancer Research* about the role of human retroviruses in disease, the expectation and the reality, and in an elegant work published on March 1 1987, he demolished not only the Gallo theory that HTLV1 was the cause of Adult T-Cell Leukaemia, but stated in the last third of the paper that from the available evidence 'HIV' could not be the cause of AIDS. His paper was a bombshell, and swiftly earned him the condemnation of the fat cats in the AIDS War - he was treated as a fifth columnist or saboteur because he had dared to break ranks and tell the truth as he saw it. The subsequent list of such 'saboteurs' reads like an Honour Roll - Kary Mullis, Nobel prizewinner for the invention of polymerase chain reaction; Prof. Walter Gilbert, Nobel prizewinner for his work on bacteriophages; Prof. Harry Rubin, winner of the prestigious Lasker Award for his work in virology; Prof. Serge Lange, the greatest mathematician in the USA; and Britain's Prof. Gordon Stewart, who has repeatedly been refused publication of letters to leading medical journals, despite the fact that his predictions of the numbers of AIDS cases have been consistently and uncannily accurate. All these prominent scientists and doctors, and numerous others, expressed their unease about the premature consensus which labelled 'HIV' the sole cause of 'AIDS'.



Tank, 1941 by Boris Arzybasheff

The fact is that once the 'HIV'-AIDS war machine was rolling, no-one on board wanted to dismantle it and lose not only credibility but all the money and prestige that being an AIDS 'expert' generate. For example, *The Boston Globe* reported as recently as April 18 1998:

"Two scientists who have fought bitterly over discovery rights to the virus that causes AIDS will share a $ 100,000 prize for their joint achievements. Dr. Robert Gallo of the University of Maryland and Dr. Luc Montagnier of the Pasteur Institute in Paris and Queens College in New York are scheduled to share a podium at Boston's Four Seasons hotel on April 30 to accept the 10th annual Warren Alpert Foundation Award."

The booty may console Gallo for the fact that even now, the US Government is thinking seriously whether or not to extend funding to his posh new institute in Baltimore, due to end officially on June 30th. (*Nature Medicine*, p.541, May 1998).

For some time, evidence has been growing that there are efforts afoot to 'downsize' or even call off the AIDS War. By the end of the 80's, the propaganda department at the CDC were having to duck and dive to maintain the AIDS panic. Even by finagling the estimated 'HIV' positivity figures, which see-sawed up and down from 1 million constant for several years, to a low of 600,000, and adding new diseases into the syndrome, the US AIDS cases failed to live up to their inflated predictions. Still it dawned on no-one that if the estimated, or even real, numbers of 'HIV'-positives never reflect the actual numbers of AIDS cases, they had the wrong presumed bug in their gunsights. AIDS was the first recorded example of a virgin-soil epidemic in which the numbers of people supposed to be infected by an exponentially spreading pathogen were remaining stable or even diminishing.

I remember being puzzled when Margaret Thatcher cut off £350,000 funding for the projected Medical Research Council HIV positivity survey planned for 1993. This was designed to try to estimate the number of 'HIV' infectees in Britain. Had she been told by one of those secret, black and midnight Think Tanks who advise governments, that there was no heterosexual AIDS epidemic, and that the money would be wasted? Many people had been pointing out since the late '80's that the threatened heterosexual epidemic had not materialised, and that all the government advisers had been totally wrong about projected AIDS figures. They were roundly denounced as homophobes, out of touch with reality. As it transpired, the AIDS War free loaders, speculators, profiteers, spivs, hangers on and camp followers in 1993 needn't have worried. Wellcome came to the rescue with a sack of gold to fund the study - when you make anti-'HIV' drugs, you need punters, so they paid for the MRC to find them. There weren't many.

By the mid 90's, it seemed most people were beginning to treat the AIDS War rather like one of those desultory, incomprehensible little civil wars rumbling on in the Balkans or the former satellite states of the dead USSR - self-absorbed and self-inflicted, hardly worth a glance as you turn the pages of the newspaper to find the footie results. The WHO, realising that AIDS had passed its panic-by date in Europe, but still trumpeting a worst-case scenario for AIDS in the 3rd World, nevertheless gave the boot to 750 workers in the Global AIDS Programme in April 1995. After all, if AIDS cases in the West are falling, even in the absence of a cure or a vaccine, then AIDS cannot be an infectious epidemic at all.

What I interpret as the winding down of the AIDS war, much akin to America's slinking out of Vietnam, is reflected in an article in *The National Journal*, May 9, 1998, Pg. 1062; Vol. 30, No. 19. Entitled *The AIDS Initiative*, One Year Later, by Garance Franke Ruta, it is worth quoting at length:

"Last May 18, in a commencement speech at Morgan State University, President Clinton declared the development of an AIDS vaccine a national priority, saying, "I am prepared to do all I can do to make it happen." He called for the development of a vaccine within a decade, likening the endeavour to the race to land on the moon. One year later, the National Institutes of Health (NIH) has yet to name a director to set up the new Vaccine Research Center Clinton announced. The search process had to be reopened after everyone in the first crop of candidates was deemed inadequate or withdrew from consideration. And that's not the only important vacancy at NIH: The Office of AIDS Research (OAR) has not had a permanent director since November, when the former head, William E. Paul, decided to return to his immunology lab. And the directorship of the vaccine and prevention research program at the National Institute of Allergy and Infectious Diseases (NIAID) has been empty ever since Patricia Fast left last November to join Aviron, a California-based biotech firm. The Administration has been slow to fill positions throughout the government, and this is just another example of that," said Jeff Jacobs, director of government affairs at AIDS Action, a Washington-based advocacy group. "If the Administration has an intent to have this vaccine on line, they need to move as quickly as possible to make sure the director of the vaccine center is on line at the NIH."

This smacks of rats, sinking ships, and dodging the poisoned chalice. To head the department which doesn't come up with a vaccine against 'HIV' won't look good on anyone's CV.

The growing dissatisfaction amongst gay men in particular with the way in which AIDS funding is administered by AIDS charities has become even more marked since this article by Erin McCormick appeared last year in the *San Francisco Examiner* (26.4.97). British AIDS charities should take note:

"Michael Petrelis wants to know what happened to the $1.5 billion the United States spent on AIDS last year. The 39-year-old AIDS patient, and a growing number of activists like him, have been willing to bang on locked boardroom doors, rifle through file cabinets and generally raise hell to make sure money raised for AIDS goes to fight the deadly disease and not to overhead expenses and high salaries for charity executives. Now they are taking their crusade public with an Internet Web site that will allow donors and people with AIDS to follow the money that goes to the dozens of charity relief efforts around the country. "There's a new phenomenon of people with AIDS living longer, which means we're asking more questions about services," said Petrelis, who said since he started prodding organisations for financial information he has been banned from receiving full services at three Bay Area AIDS charities. "We're now questioning where the money goes from the AIDS Walk, the AIDS Redound the AIDS Dance-a-thon because we would like to have services like hot meals and housing," he said. The Accountability Project Web site(www.accountability project.com), which reveals IRS tax filings and other financial information about major U.S. AIDS charities and other nonprofit (organisations), makes it possible for Internet surfers to get instant information about how they spend their money. The project, an offshoot of the in-your-face AIDS activist group, ACT UP Golden Gate, is also pushing for laws to require open board meetings, democratic management and greater financial scrutiny for the nation's rapidly growing nonprofit sector."

A more recent piece posted on the *Rethinking AIDS* website (16.4.98) from Tom Hudson concerns the huge funding for Gay Men's' Health Crisis, the original AIDS self-help group in New York.

"I just received in yesterday's mail a reply from the New York State Department of Charities. I had requested a copy of the financial status of the Gay Men's Health Crisis of West 20th street here in New York. For the last fiscal year available - ending June 30, 1996 the GMHC had received $28.3 million dollars in contributions, including $5.2 million in government grants. GMHC spent that year $5.1 million in FUNDRAISING expenses, which is $21.4% of their budget. They have a full time public relations and media research staff. My dear friends, what could we do with $28.3 million a year? Think of it. I also have before me an article in a local newspaper written by several people including former GMHC employees who say that the place is a joke. If they hand out a leaflet they call it patient counselling on their reports. Case after case of clients asking for the help promised in the leaflets and posters are turned away and phone calls are not answered whilst within the organisation they live like royalty. GMHC owns two office buildings and occupies three others as well. They have a huge staff of hundreds. Can you just imagine what could be done with this huge amount of money for truly honest and health producing information? Gary Null once said that it sure pays to sell out your integrity. Shocking as his statement was, it is proven over and over again. Now the GMHC leaders are weeping that the CDC is reporting large decreases in AIDS deaths. They are lamenting the news. I won't say why, but could it be because their funding is based upon AIDS deaths?"

What I interpret as the winding down of the AIDS war is akin to America's slinking out of Vietnam

Nearer home, a letter to *Pink Paper* from Pete Forest (May 15,1998) commented on the 3 directors of the Terrence Higgins Trust (THT) on £43,000 a year and the secret salary of the Chief Executive Nick Partridge. On May 19, a very concerned Susie Parsons, Chief Executive of the London Lighthouse, was interviewed on BBC TV news about the threat to close the 'flagship hospice' She was obviously deeply distressed and who wouldn't be at the thought of losing her Director's salary reported to be £60,000. That's a lot of moolah for dispensing tea and sympathy. If nothing else, the AIDS war has certainly inflated the price of altruism. For as long as diamond studded vivandieres like Liz Taylor, Elton John and the late Princess Diana could guarantee that the donations rolled in, the AIDS charities were awash with money and could fulfil their function as the AIDS War's deluxe equivalent of the Women's Voluntary Service (WVS) but when the phoney war finally peters out, once the party's over, who'll take care of these overpaid caterers? All the hands-on work with PWAs is done by dedicated, unpaid volunteers or low paid workers, so we need feel no sympathy for the executive greedies. Partridge worked hard for the Troops Out of Ireland movement before cashing in at the THT, so perhaps he'll be quite philosophical about being demobbed.

The world is getting ready for the biennial AIDS conference in Geneva, where the nostrum floggers will be out in force, glossy brochures at the ready. I wonder if they will spare a thought for the ultimate fate of the 1500 chimpanzees, bred specifically for AIDS research, and now regarded as surplus to requirement, but costing the US Government $7.3 million a year to house and feed. All those people currently earning unjustifiably fat salaries on the backs of PWA's would do well to monitor just what happens to

their primate cousins. Perhaps they could get jobs looking after the chimps in the sanctuaries proposed by Newt Gingrich to the US House of Representatives on May 5th.

It would be nice to think the real war against the AIDS phenomena could begin once the phoney war against 'HIV' has been exposed for the grotesque con trick it is, but I'm not hopeful: Phil Johnson of *Rethinking AIDS* posted an article from the *San Francisco Weekly* (May 13 1998) by Tara Shioya dealing with the wave of 'Circuit Parties' sweeping the gay scene in the USA. She describes the parties on a circuit which takes in Palm Springs, Fire Island, Miami, Atlanta, New Orleans and Montreal, where up to 7000 gorgeous young men party non stop for three days :

"During a circuit party weekend, the dancing usually begins around 9 p.m. and goes until 3 a.m., followed by various after-parties that run till midmorning. Most Circuit-goers will rely on drugs - poppers (a gold-coloured liquid sold legally as "liquid incense," which causes a high when the fumes are inhaled); crystal methamphetamine, popularly known as crystal, "Tina," or "Crissy"; and to a lesser extent, cocaine - to stay awake for the parties. Then there's an alphabet soup of other illegal drugs that heighten the emotions and senses. Ecstasy ("X"), or MDMA, is at the heart of the scene because of its relaxing and, some say, aphro-disiac effects; it's usually taken in combination with one or more other drugs. Ketamine ("Special K" or just "K") is an anaesthetic veterinarians use on cats and "subhuman primates"; partygoers usually dry or bake it into crystal form, and then crush it into a fine white powder that's inhaled in "bumps" from a small glass vial with a rounded plastic cap, called a "bullet." Users feel happy and relaxed - unless they overdose and fall into a "K-hole," a temporary trance-like state. GHB ("G"), Gamma hydroxybutyric acid, a liquid anaesthetic with effects similar to Special K, is taken orally: While some users report a better high from G, its effects are unpredictable. (Health food stores once sold GHB as a growth hormone supplement, but the FDA took it off the market.) Too much G can induce any number of effects, including violent vomiting or a "G-coma," which lasts hours. Combined with alcohol, the drug can be lethal."

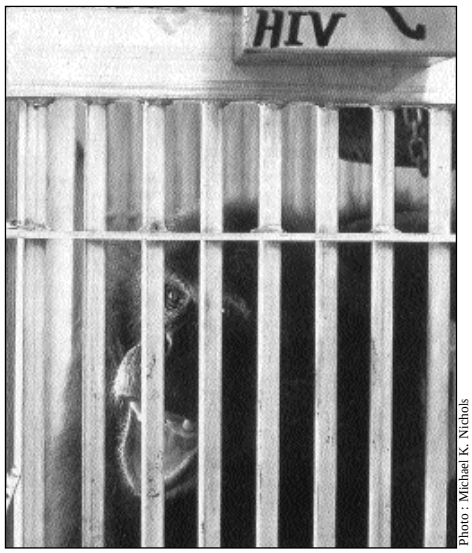


Photo : Michael K. Nichols

"Spare a thought for the ultimate fate of the 1500 chimpanzees, bred specifically for AIDS research, and now regarded as surplus to requirement."

This list of drugs is highly reminiscent of that described by Larry Kramer in his novel *Faggots* in the late 70's, just before the appearance of the first gay AIDS cases, as well as the list given by John Lauritsen in the Meditel/Channel 4 documentary *The AIDS Catch* in 1990. The different combinations of these drugs, accompanied by repeated infections with - is it? - eight different herpes viruses, who knows how many hepatitises, and bacterial STD's, plus the mass of antibiotics used to treat them, are going to make a lot, if not all, the sad young men very sick. When Michael Callen described the identical lifestyle he led in the late 70's, before subsequently developing various AIDS-defining illnesses, he was honest enough to admit that this was the cause of his illness. As he said to me, the wonder was that he had the strength to crawl to Joe Sonnabend's surgery for treatment. Shioya's article mentions the reservations of "AIDS experts" who ".... fear the prevalence of drug use on the Circuit - particularly, crystal - leads to dangerous sexual practices that will increase the spread of HIV." Wearing a condom as thick as a wellington boot will not save anyone who repeatedly turns their body into a toxic battlefield or sticks a loaded gun to his head and pulls the trigger? Could it be that the CDC and NIH now know they can never win the War against AIDS by fighting 'HIV' and are preparing to make gays the scapegoats for their failure?

Real victory over the illnesses grouped as AIDS can only begin when gay men can be honest and admit that in our case, AIDS is a hedonistic holocaust brought on by our own excesses, and stop passing the buck to a harmless irrelevant epiphenomenon called 'HIV'. They can either get real or get dead. The choice is theirs. The fight for gay liberation was surely about more than an inalienable right to drug-fuck each other to death. Lest I be misunderstood, the war against AIDS-defining illnesses is a just war, a must war, and worthy the winning; but the phoney war against 'HIV' is a wicked waste of time, blood, hope and treasure.

Pharma-management mantra

Novartis is the Swiss-based pharmaceutical company that makes the protease inhibitor 'anti-hiv' drug Indinavir. For an insight into corporate morale building, **Greenpeace** Zurich has disseminated the words of the official English-language Novartis company song.

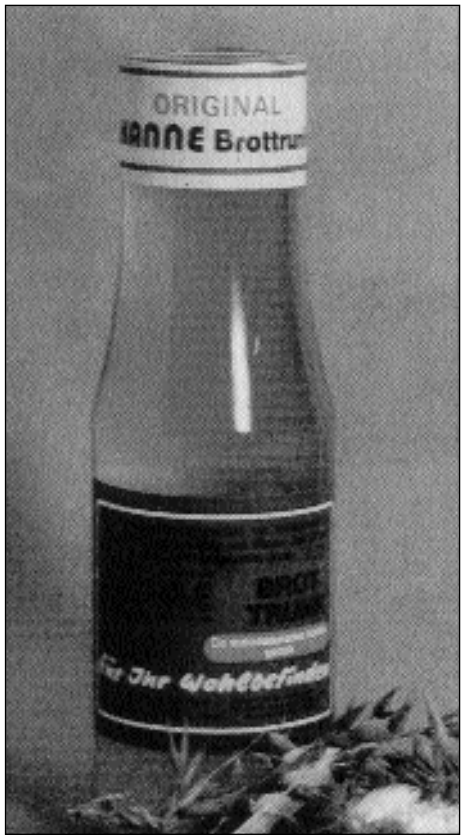
The Novartis Hymn
New days off in the distance suddenly seem to be here.
New worlds under the surface magically seem to appear.
New challenges on the horizon.
We are the new pioneers.
New skills promise to take us beyond frontiers.
Unlock your hearts. Open your eyes. Uncover your ears.
Come hear the song of alliance.
Come see Novartis unite.

Come hear the call of tomorrow.
Come watch the future flight.
Come sing in the spirit of science.
Come hear the song of alliance.
Come see Novartis unite.

New days, new worlds, one dream in the spirit of science, one song in the science of life.
News kills.
In matters pharmaceutical we're gunning for the best.
We may be number two but we'll meet the test - be impressed.
Baby food, Health food, Medical Nutrition -
We make a mean Ovaltine to beat the competition.
At crops we're the tops, and that's the way it is -
Everybody stops when they hear Agribiz.
We're big and we're fast and we're only getting started!
So feel the best and beat the best - we're Novartis.

New days, new worlds, new needs, new hopes, new skills, new challenges.
Come hear the song of alliance.
Come see Novartis unite.
One dream in the spirit of science,
One song in the science of life.

A Drink for all Seasons?



For years people in Germany have been able to purchase Kanne Bread Drink not only as an aid to the promotion of good health but also to assist in the recovery process after illness. Seven million bottles of this product are sold each year. Kanne drink has been available in Britain since 1996 (see box).Dirk J. Petersen, Doctor of Chinese Medicine, presents the product as follows:

"In recent decades medicine has made incredible progress in the field of technology. Operating techniques and methods of diagnosis have reached an amazing level, but great successes have also been achieved in the field of infectious diseases, through the controlling of smallpox, cholera, typhoid, polio and other scourges of humanity.

Nevertheless there are many illnesses and health problems which obviously cannot be successfully treated by the methods of modern medicine. There are too many patients who are treated by conventional scientific methods and who, however, retain their symptoms. Not everything can be treated with cortisone, antibiotics or chemical drugs - this is all too clearly demonstrated by the large number of patients who do not get better.

Since I particularly wanted to help those patients, I have taken an interest in alternative methods of treatment alongside conventional medicine. And so, after studying in Germany I went to Taiwan, to study traditional Chinese medicine there. Later, on extended trips to many countries, I attempted to become acquainted with the interesting treatments of primitive peoples. As a result I was then often able to help patients in my practice in Germany with, for example, a Chinese treatment, if Western medicine failed, or with a South American one, if the didn't work.

In many cases it was necessary to recommend a special form of nutrition for patients, to prepare for or to guarantee the success of the treatment. In doing this it is surprising to learn that patients only alter their eating habits very unwillingly - even in instances where they have had symptoms for years.

It was therefore a blessing for many of my patients that I met Wilhelm Kanne, Master Baker, in 1983 . He is a fascinating personality and radiates vitality. What impressed me most, however, was the enthusiasm with which he introduced me to two new health-foods which he had developed. I resolved to try these out with the help of my patients.

The effect on their health of these foods was often spectacular and, if previously I always had to remind my patients very firmly about keeping to their diet, then my attitude changed, if they promised me that they would use the two products of Wilhelm Kanne, Master Baker. In these cases I could expect to see an improvement, even if their diet was rather neglected.

Both healthfoods have supported my treatment in many cases. It was frequently even enough to introduce these two healthfoods, without further treatment, in order to cure patients of symptoms which have been present for a long time.

I have also recommended these products to all normal healthy people, however, as they help them to maintain their health for a long time. The products concerned are a drink and a grain powder.

At the same time I am delighted to be able to announce that I was able to persuade Wilhelm Kanne to put on the market, in Britain and Ireland, his products which so many are using, because they are convinced of their effectiveness. He offers you a great opportunity as regards your health.

You can read, amongst other things, about the trial which the Russian Health Minister initiated in 1993. He has children, who had been affected by radiation, treated with the KANNE products. The results were so spectacular, that now a large-scale trial with 1000 patients is beginning in Chernobyl!"

Kanne products are not medicines but healthy nourishment based on grains fermented in lactic acid and rich in trace elements and minerals whose positive effect of people's health was more or less discovered by chance.

The product has been found to aid recovery in people suffering from a wide range of illnesses and skin disorders, including: lack of vitality and energy; circulatory disturbances in small blood vessels; hypertension; many forms of skin disease; diabetes; many forms of gastro-intestinal illness; hypercholesteremia; rheumatic and arthritic illnesses; digestive problems and dysentery; low levels of potassium, calcium and magnesium; osteoporosis; wounds, injuries and insect bites.

A booklet is available containing testimonials and scientific documentation recording the successes experienced in using "Kanne Bread drink" (see box below).

Some recipes for nutritional drinks similar to Kanne drink can be found in wholefood literature. Often very good, their low-cost home production requires a commitment to regularly culturing the drink.

For an information booklet about Kanne Bread Drink send 4 x 1st class stamps to the address below.
The drink is available by cash and carry and mail order and sold at £2.49/bottle.

Human Nature

13 Malvern Road

London NW6 5PS

Please make cheques payable to: Mr Nari Sadurham and send to the address above, OR for credit card orders call 0171 328 5452. Door to door 4-day delivery (mainland) costs: 6 bottles - £8.50; 12 bottles - £10.50; 18 bottles - £12.50; 24 bottles - £14.10 (£5 surcharge for Scotland).

ST. JAMES'S PALACE
LONDON SW1 1BS

Seeds of disaster

HRH the Prince of Wales, who farms organically, says the genetic modification of crops is taking mankind into realms that belong to God, and God alone

I have always believed that agriculture should proceed in harmony with nature, recognising that there are natural limits to our ambitions. That is why, some 12 years ago, I decided to farm organically - without artificial pesticides or fertilisers. From my own experience I am clear that the organic system can be economically viable, that it provides a wide range of environmental and social benefits, and, most important, that it enables consumers to make a choice about the food they eat.

But at a time when sales of organic food are soaring, a development in intensive agriculture is actually removing a fundamental choice about the food we eat, and raising crucial questions about the future of our food and of our environment which are still to be answered. Genetically modified(GM) crops are presented as an essentially straightforward development that will increase yields through techniques which are merely an extension of traditional methods of plant breeding. I am afraid I cannot accept this.

The fundamental difference between traditional and genetically modified plant breeding is that, in the latter, genetic material from one species of plant, bacteria, virus, animal or fish is literally inserted into another species, with which they could never naturally breed. The use of these techniques raises, it seems to me, crucial ethical and practical consideration.

I happen to believe that this kind of genetic modification takes mankind into realms that belong to God, and to God alone. Apart from certain highly beneficial and specific medical applications, do we have the right to experiment with, and commercialise, the building blocks of life? We live in an age of rights - it seems to me that it is time our Creator had some rights, too.

We simply do not know the long-term consequences for human health and the wider environment of releasing plants bred in this way. We are assured that these new plants are vigorously tested and regulated, but the evaluation procedure seems to presume that unless a GM crop can be shown to be unsafe, there is no reason to stop its use. The lesson of BSE and other entirely manmade disasters in the cause of "cheap food' is surely that it is the unforeseen consequences which present the greatest cause for concern.

We are told that GM crops will require less use of agro-chemicals. Even if this is true, it is certainly not the whole story. What it fails to take into account is the total ecological and social impact of the farming system. For example, most of the GM plants marketed so far contain genes from bacteria which make them

resistant to a broad-spectrum weedkiller available from the same manufacturer. When the crop is sprayed with this weedkiller, every other plant in the field is killed. The result is an essentially sterile field, providing neither food nor habitat for wildlife. these GM crop plants are capable of interbreeding with their wild relatives, creating new weeds with built-in resistance to the weedkiller, and of contaminating other crops. Modified genes from a crop of GM rape were found to have spread into a conventional crop grown more than a mile away. The result is that both conventional and organic crops are under threat, and the threat is one way.

GM crop plants are also being developed to produce their own pesticide. This is predicted to cause the rapid appearance of resistant insects. Worse still, such pesticide-producing plants have already been shown to kill some beneficial predator insects as well as pests. To give just two examples, inserting a gene from a snowdrop into a potato made the potato resistant to greenfly, but also killed the ladybirds feeding on the greenfly. And lacewings, a natural predator of the corn borer and food for farmland birds, died when fed on pest insects raised on GM maize.

Despite the vast acreages which are likely to be involved, there is no official requirement to monitor genetically modified commercial crops to see exactly what is happening. Think of the agricultural disasters of the past which have stemmed from over-reliance on a single variety of a crop, yet this is what genetic modification will encourage. It is entirely possible that within 10 years virtually all of the world's production of staple crops, such as soya, maize, wheat and rice, will be from a few GM varieties, unless consumer pressure dictates otherwise.

English Nature and other official bodies have sounded warnings about the potentially damaging consequences for the environment of introducing GM crops on a wide scale. They have called for a moratorium on the use of at least one of these crops.

Once the genetic material has been released into the environment it cannot be recalled. The likelihood of a major problem may, as some people suggest, be slight, but if something does go badly wrong we will be faced with the problem of clearing up a kind of pollution which is self-perpetuating. I am not convinced that anyone has the first idea of how this could be done, or indeed who would have to pay.

We are also told that GM techniques will help to "feed the world". This is a fundamental concern to all of us. But will the companies controlling these techniques ever be able to achieve what they would regard as a sufficient return from selling their products to the world's poorest people? Nor do I believe that the basic problem is always so simple. Where the problem is lack of food, rather than lack of money to buy food, there may be better ways of achieving the same ends. Recent research has shown, for example, that yields from some traditional farming systems can be doubled, and even trebled, through techniques that conserve natural resources while making the best use of labour and management skills.

Do we need to use GM techniques at all? Technology has brought massive benefits to mankind, but there is a danger, especially in areas as sensitive as food, health and the long-term future of our environment, in putting all our efforts into establishing what is technically possible without first stopping to ask whether this is something we should be doing. I believe we should stop and ask that question, through a wide public debate of the issues of principle which cannot be addressed effectively;y through science and regulation alone.. Is it not better to examine first what we actually want from agriculture in terms of food supply and security, rural employment, environment protection and landscape, before we go on to look at the part genetic modification might, perhaps, play in achieving those aims?

Obviously, we all have to make up our own minds about these important issues. I personally have no wish to eat anything produced by genetic modification, nor do I knowingly offer this sort of produce to my family or guests. There is increasing evidence that a great many people feel the same way. But if this is becoming a widely-held view, we cannot put our principles into practice until there is effective segregation of genetically modified products, backed by a comprehensive labelling scheme based on progress through the food chain.

Arguments that this is either impossible or irrelevant are simply not credible. When consumers can make an informed choice about whether or not they eat products containing genetically modified ingredients they will be able to send a direct and unmistakable message about their preferences. I hope that manufacturers, retailers and regulators will be ready to take on the responsibility to ensure that this can happen.

Gene Technology - Illusion and Reality

Education is necessary before choices can be made.

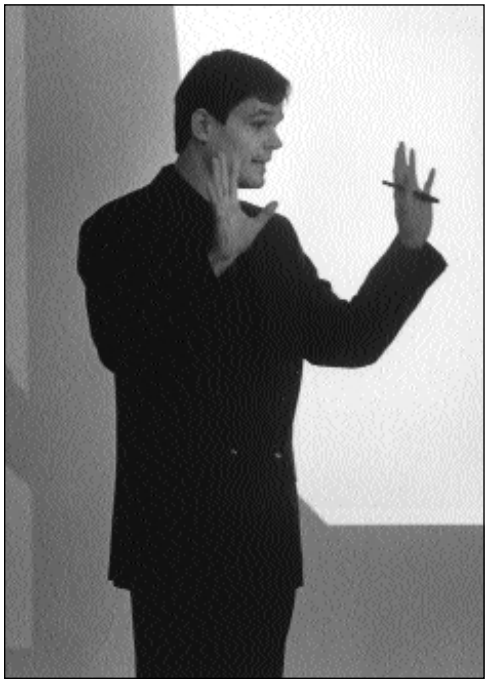


Photo : Rainer M. Hotz

Dr Stefan Lanka is a virologist and geneticist, well known for his revolutionary scientific work and his commitment to human rights. In his lectures and seminar-workshops he explains his view that gene manipulation/technology in the "Network of Life" should be prohibited, once it is understood how flimsy and capricious the evidence for such activities is. He explains in a clear manner what the underlying principles are, so that no-one should have difficulty understanding the headline-grabbing developments of the past 30 years. The listener will be able to judge for him/herself what the concealed motives behind the concepts of 'genetic engineering' are. He/she will also be able to assess the often irreversible damage and dangers to the cells, the body and the environment.

Dr Lanka is spokesman for ***regimed*** (Study Group for Investigative Medicine and Journalism), an international network of distinguished and experienced scientists, doctors and journalists, who value their integrity. Lanka argues with regard to the most modern developments, and sets out to convinve the scientific layman as well as doctors, specialists and above all, the duped scientist, of the inherent dangers of gene technology, by clearly stating the true facts rather than wishful thinking. This often involves bringing to the fore inconvenient data that zealous propagandists prefer to keep under wraps.

Regimed has already discovered
• how and why gene technology causes massive damage in medicine - insulin
• how antibiotics undermine the basis of life by damaging human DNA which is passed on to our offspring
• how immunology is entrapped in irrelevant side-issues and what the "immune system" really is
• how cellular repair mechanisms especially those to do with DNA, were deliberately misconstrued as cancer viruses, and subsequently as its diametric opposite, HIV
• why up till now it has been possible to misrepresent long known about manifestations of long-term poisons as an apparently new disease called 'AIDS'
• what all this has to do with cancer, and especially what cancer is in biological terms

The lectures and seminars describe what the future has in store, and provide scope for discussion as to what can be done to protect oneself, how to stop new disasters and what might be done to reverse existing damage.

Please contact Dr Lanka via
• ***raum&zeit*** - Akademie Ehlers-Verlag GmbH, Mühlweg 2c, 82054 Sauerlach, Germany. Tel (0)8104 663518 Fax 663515
• **Continuum**, London
• **C.O.B.R.A.**, c/Cartagena 230, Piso 5 Puerto 1, 08013 Barcelona, Spain. Tel (0)3 450 1300 Fax 456 4825

Photo : Image Bank

Swiss campaigners against the release into the environment of genetically modifed organisms

A gentle herbal antioxidant

Padma 28 can help restore bio-chemical balance

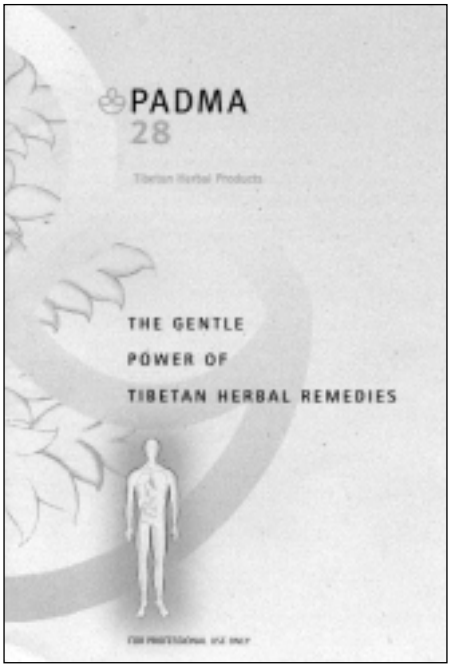
edited by Huw Christie

A Tibetan herbal antioxidant supplement, Padma 28, originally formulated 2,000 years ago, is generating increasing interest in the West. Based on a combination of 22 natural herbs, this preparation was one of several recipes which travelled through Russia to eastern Europe in the 18th century with Tibetan Buddhist philosophers and doctors, finally arriving in Switzerland in the 1960s.

Tibetan medicine is unique in its philosophy and practice and can trace an unbroken Buddhist tradition of more than 2,500 years. These teachings relate illness not only to physiological factors but also to mental and emotional and environmental influences - a truly holistic approach to healthcare.

The Ancient Tibetans believed that:
- a healthy person maintains a state of equilibrium
- like a gently swinging pendulum, the body constantly gravitates back to the central point
- the central point is the domain of health and well-being

Tibetan medical philosophy was based on restoring and maintaining this centre of balance by normalising extreme states in the body. Medical practitioners throughout the western world have acknowledged the efficacy of Tibetan medicines in treating a range of illnesses and complaints.



The leading U.K. orthodox medical journal *The Lancet* November 12 1994 reported, "One of the complex plant formulations examined was Padma (literally lotus) 28 (*Lancet* 1994, 343:847), a Tibetan herbal formulation preserved by Mr Karl Lutz (*Lancet* Apr 2, P 847). Its 22 different raw, dried plant ingredients are dense with heparinoids and flavonoids, and the formulation is proving to be a powerful mixed-plant antioxidant source. Dietary flavonoids, highly concentrated in common foods such as black tea, onions and apples, are inversely associated with coronary heart disease mortality rates, said Dr M.G. L. Hertog ...The balance of antioxidants has been reported to be important in modulating immunological activities (*Chem-Biol* 1994; 91: 147-58). [Prof. Alfred Hassig's] suggestion for prophylaxis of AIDS by reducing stress (infectious, toxic and psychological) and adding a spectrum of antioxidant food supplements was similar to that proposed at the NIH Fogarty Conference on Oxidative Stress in HIV/AIDS last November in Bethesda, USA."

In contemporary, result-orientated societies, the immune system is often pushed to extreme levels of performance. However, this should otherwise occur only in extreme situations e.g. at a time of acute infection. Nobody can work properly or efficiently under constant tension for a prolonged period. Persistent cases of unrelenting pressure will eventually immobilise our immune system. Effective treatment of chronic illnesses ideally involves a spectrum of natural substances delivered in a steady, gentle manner, a principle which is embodied in Tibetan remedies. This form of treatment is the only way the body can truly regain its balanced state of health. It is the potent mixture of carefully balanced natural ingredients that is vital - therein lies the strength of Tibetan medicine.

Plants can help

Medical reports on advances in the treatment of chronic disorders often mention the word antioxidants. Antioxidants are substances the body needs in order to protect itself against adverse biochemical reactions arising from harmful environmental influences. We may have come to believe that antioxidants are derived only from vitamins and minerals but this ignores the enormous range of phyto-chemicals in plant mixtures that have powerful antioxidant effects.[1]

Modification of harmful biochemical reactions is vital in preventing ill heath and this is a major function of the body's immune system.

Meticulous and diligent efforts by researchers across the globe have led to the discovery of a previously untold variety of plant substances that can favourably influence various immune functions. All parts of our immune system have to interact well in order to guarantee an effective defence against disease.

Padma 28 Potentilla Formula is a natural product. Each tablet consists of 20 dried and ground but otherwise untreated medicinal herbs: Saussuria 40mg, Icelandic Moss 40mg, Margosa 35mg, Myrobalan 30mg, Red Sandalwood 30mg, Cardamon 30mg, Allspice 25mg, Bengal Quince 20mg, Potentilla golden herb 15mg, Licorice 15mg, Ribwort 15mg, Columbine 15mg, Knot grass 15mg, Cloves 12mg, Gingerlily 10mg, Heartleaved Sida 10mg, Valerian 10mg, Wild Lettuce 6mg, Marigold 5mg, and natural Camphor 4mg and Calcium sulphate 20mg, plus Sorbitol 73mg and Cilicum dioxide 12mg. Thanks to the wide variety of herbs used, Padma contains ingredients beneficial to the whole spectrum of our body's defence mechanisms. As only small amounts of each individual plant are used, the supportive and healing inputs provided have a gentle effect.

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Remarks on methods for retroviral isolation

Dr Etienne de Harven

is *emeritus* Professor of Pathology, University of Toronto. He worked in electron microscopy (EM) primarily on the ultrastructure of retroviruses throughout his professional career of 25 years at the Sloan Kettering Institute in New York and 13 years at the University of Toronto. In 1956 he was the first to report on the EM of the Friend virus in murine (mouse) leukemia, and in 1960, to coin the word "budding" to describe steps of virus assembly on cell surfaces. He will deliver a speech at the 12th World Aids Conference in Geneva (June 28-July 3) at the session "HIV-testing: Open Questions about Specificity".

The most impressive developments of molecular genetics over the past 20 years do not make Robert Koch's postulates obsolete. The first of these postulates indicates that to be considered as pathogenic, a microorganism should be isolated in every single case of the disease. Still, according to E. Papadopulos *et al*[1] and S. Lanka,[2] isolation of hiv from fresh plasma of aids patients has never been achieved under any circumstances. Moreover, and most surprisingly, the "efficiency" of current antiviral therapeutic protocols (AZT, tri-therapy) is being measured by determining "viral load" in the plasma of treated patients. "Viral load" implies viremia, i.e. the presence of circulating viral particles in the peripheral blood. The virus incriminated being allegedly a retrovirus, this would have been the time to remember that the morphology of such viruses in several animal experimental tumors and leukemias had been extensively characterised by transmission electron microscopy (EM) over the past 40 years, the viral particles having a characteristic ultrastructure and a diameter ranging between 100 and 120µm. Some of them had been studied by methods of high resolution transmission electron microscopy.[3] In the 1960s, transmission electron microscopy was by far the best available method to identify viruses within or around diseased cells. Consequently, many cancer research centres all around the world, started to compete for the best equipment and training in EM, aiming at the demonstration in human malignancies of viruses similar to those which had just been recognized as significantly associated with tumors and leukemias of several laboratory animals. This approach to cancer research appeared highly justified when Lwoff, Horne and Tournier proposed to classify all viruses primarily on the basis of their morphologjcal features demonstrated by electron microscopy.[4] Identification of viruses by EM in leukemic animal tissues became unambiguous when steps in virus assembly, i.e. the 'budding' of complete virions from the surface of the infected cells, were described.[5] In spite of considerable efforts, the search for similar, typical viruses in human malignancies remained entirely negative. Pleomorphic membranous microvesicles, approaching viral size, and frequently described in the literature on human malignancies as "virus-like particles" were without any pathogenic significance. As stated in 1965, typical RNA tumor viruses have never been observed in association with human neoplasia.[6]

Concentrations of retroviruses from murine and avian leukemic tissue homogenates were reproducibly achieved, permitting titration of infectivity into receptive laboratory animals. This was not, however, an easy approach to the problem of virus purification, large amounts of microvesicles and cell debris being usually present. As far as virus purification was concerned, it soon became evident that when viremia is present, blood plasma was far better than tissue homogenates for efficient virus isolation and purification.

In the case of RNA tumor viruses, now called retroviruses, the demonstration of viremia in the blood plasma of experimental leukemic animals (chickens and mice) was published more than 35 years ago. A most efficient purification method including ultrafiltration and ultracentrifugation of a 1/1 dilution of plasma in heparinized Ringer's solution, allowed me to demonstrate packed retroviruses by transmission electron microscopy[7] in thin sections of pellets obtained by high speed centrifugation of the purified virus, quite clearly establishing that the amount of contaminating cell debris was remarkably small, a conclusion which could never have been reached by using the negative staining EM method. Using this simple ultrafiltration procedure, virions were never exposed to hypertonic shock. However, sedimentation in sucrose density gradients, at the density of 1.16 gm/ml, soon became the most popular method for retrovirus purification.[8] Interestingly, it was very well known by electron microscopists in the 1960s, that sharp bands sedimenting at the density of 1.16 frequently contained large amounts of microvesicles and cell debris of non-viral nature. These debris just happened to sediment in sucrose gradients at a density very similar to that of retroviruses, clearly indicating that finding a "sharp band" at the density of 1.16 gm/ml was of little significance and was certainly far from any demonstration of retroviruses isolation. But

this conclusion was based on EM findings, and around 1970 the faith in retroviral oncology was assuming quasi-religious proportions! If EM cannot demonstrate viruses in the 1.16 bands, let us forget about EM and rely on other "markers"!

When around 1980, R. Gallo and his followers attempted to demonstrate that certain retroviruses can be suspected of representing human pathogens, to the best of my bibliographical recollection, electron microscopy was never used to demonstrate directly viremia in the studied patients. Why? Most probably, EM results were negative and swiftly ignored! But over-enthusiastic retrovirologists continued to rely on the identification of so-called "viral markers", attempting to salvage their hypothesis.

When retrovirus particles are legion, the study of molecular markers can be useful, and provide an approach to quantification probably better than direct particle counting under the EM (which I always found very difficult). But when, using EM, retrovirus particles are absent, relying exclusively on 'markers' is a methodological nonsense. 'Markers' of what?

Nevertheless, for the past ten years, hiv research and clinical therapeutic trials have been primarily based on the study of several hiv "markers".

First the antibody. Elisa, then Western Blot tests were hastily developed (at sizable financial profit eagerly split between the Pasteur Institute and the US). "Seropositivity" became synonymous with the disease itself, plunging an entire generation into behavioural panic, and exposing hundreds of thousands of people to "preventive" antiviral AZT therapy which actually hastened the appearance of severe or lethal immunodeficiency syndrome. Appropriate controls were apparently never carried out, or were never published. Still, back in 1993 it became clear that the so-called hiv antibody tests badly lacked specificity,[9] cross-reactivity being observed with patients suffering from a long list of pathological conditions including malaria, leprosy, auto-immune diseases and many more.

Secondly, 'viral proteins'. Several proteins have been identified as 'hiv markers', most frequently because they were identified in a variety of 1.16 bands. The case of the p24 "viral" antigen is a significant example and its lack of viral specificity has been well documented.[10]

Third, reverse transcription. If reverse transcriptase activity were a unique feature of retroviruses, it could have been an interesting molecular marker. Unfortunately, it has been shown that reverse transcriptase is found in the uninfected cells of yeasts, insects and mammals[11] and "has nothing to do with retroviruses as such" as well referenced in a recent report from S. Lanka. Moreover, K. Mullis himself does not support the use - to amplify and quantify the "hiv genome" - which is being made of the PCR methodology he developed, which is the current method of "measuring the viral load" in aids patients.

More disturbing is the fact that some 'markers' are searched for in the 1.16 gradient sedimenting material which is the density where intact virions are expected to be found, but not their molecular fragments. If lysed retrovirus particles released molecular markers, the 1.16 samples should at least initially allow investigators to demonstrate virus particles by EM. They don't. However, after 15 years of most intensive hiv research, two independent groups finally decided to explore by electron microscopy the ultrastructural features of the material sedimenting at the 1.16 density. Working on "hiv-1 infected T-cell" cultures supernatants, both groups found that it contains primarily cellular debris and cell membrane vesicles which could definitely not be identified with hiv particles and rare "virus-like" particles.[12, 13] Still, this is the type of sample in which "viral markers" are currently identified and used to measure the effects of anti-viral drugs in current clinical trials.

In conclusion, and after extensive reviewing of the current aids research literature, the following statement appears inescapable: neither electron microscopy nor molecular markers have so far permitted a scientifically sound demonstration of retrovirus isolation directly from aids patients. This conclusion fully confirms the recent reports published in *Continuum* by E. Papadopulos and by S. Lanka.

Harvey Bialy, editor of the journal *Bio/Technology* has stated that[14] "A powerful hypothesis has to explain and predict. What kind of scientist continues to support a hypothesis that fails to explain and fails to predict?". The hiv/aids hypothesis fails to explain the considerable drop of T4 circulating lymphocytes in aids patients. It predicted a dramatic aids epidemic which was never observed (unless we accept the CDC's most surprising redefinition of aids as including some 31 "aids defining illnesses"!).

Obviously, the hiv/aids hypothesis has to be scientifically reappraised.[15] And, most urgently, the funding for aids research should no longer be restricted to laboratories working on an hypothesis which has never been proven.

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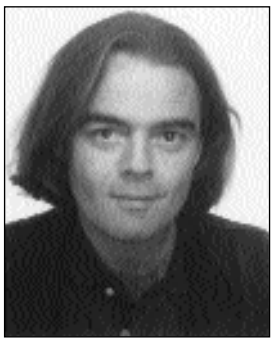
"Neither the virus nor the tests for AIDS : all are lies"- demonstrators against 'HIV' in St Jaume Square, Barcelona

Beyond 'Self Help' : Developing a social movement to defeat a medica



by Kevin Corbett, BA(Hons), HDFA, MSc, RGN

The Centro Orientativo De Bio Regeneracion Aplicada (COBRA), the Barcelona based AIDS/Cancer dissident group, organised a conference in March this year: it was an "International Reunion To Understand That The Official Version of 'AIDS' Is Unfounded And To Study How To Dismantle The 'Entity' Called 'AIDS' ". This educationally focused conference showed how the European AIDS dissident groups may foster the growth of a broad social movement to counter the biomedical construction of 'AIDS/HIV', building upon individuals' experiences of the scientific fallacies in 'AIDS/HIV' testing and antiretroviral and antibiotic treatments.

This conference set out to heighten participants' awareness of the methodological debates surrounding the biomedical construction of 'HIV/AIDS'. The participants included many individuals medically diagnosed with 'HIV antibodies' as well as people rejecting 'HIV antibody' testing and members of the nursing, medical and other health related professions. Participating groups were represented from all over Europe including Austria, Germany, Holland, United Kingdom, Ireland, France, Switzerland, the many regions of Spain, as well as from further afield, like Brazil. In addition to the Barcelona based hosting organization, COBRA, several other Spanish anti AIDS organizations were significant in their presence (Table 1). A hallmark of the international AIDS conference scene (like the upcoming AIDS Congress in Geneva) is multinational corporate patronage. This was not forthcoming for this particular conference, as its organizing participants (Table 1) have successfully, over the last ten years and more, contested the commercial vested interests and the so called scientific basis behind the proposed retroviral causation of AIDS. This placed the Barcelona conference both morally and ethically above the usual 'junket' style of AIDS conference, which are typically awash with funding from the AIDS pharmaceutical industry.

The core of the Barcelona conference consisted of a focused scientific course for its international participants. In many ways, this was the 'doppleganger' of the AIDS orthodoxy: a course to deconstruct the 'AIDS/HIV orthodoxy', and so critically different from the introductory 'starter AIDS/HIV courses' which those 'HIV antibody' diagnosed are offered by the gamut of drug company sponsored 'self help' groups in Britain. The course aimed to deconstruct the existence of 'HIV' and the validity of antibody testing. It also aimed to describe how the official or 'orthodox' medical treatments for AIDS are toxic and to further describe the range of efficient and non aggressive therapies available for helping people experiencing a variety of illnesses.

The conference began with a public inauguration covered by reporters from the Spanish national and Catalan media. There

followed nine full days of heated discussion and intellectual debate on a multitudinous variety of topics. Within each topic area, led by a panoply of immunologists, virologists and nutritionists, the scientific evidence contesting the orthodox view of 'AIDS/HIV'(the 'HIV/AIDS hypothesis') was described and the epistemology of retrovirology critically examined. Many of the multilingual presenters also acted as translators into German, English and Spanish thus enabling considerable accuracy in translation for what was very detailed content. Included was coverage of scientific methodology, epidemiology, virology, immunology, and non orthodox treatment issues. A variety of presentation formats, from workshops and small group/lecture format to video presentations and discussion groups, made the detailed content much more accessible for those without experience of the methodology of the natural and medical sciences. Participants included the epidemiologist Professor Gordon Stewart of Glasgow University, the virologist Dr Stefan Lanka of REGIMED, Germany and immunologist Professor Alfred Hassig of the Berne Nutrition Group, Switzerland. Hosting video workshops were Joan Shenton of Meditel, London and Djamel Tahi from France. Joan has just published a new book which shatters the myths of 'AIDS/HIV'and Dhamel showed his video 'AIDS' (Djamel recently interviewed Luc Montagnier, the discoverer of 'HIV', published in *Continuum*, where Montagnier revealed he did not truly isolate a 'retrovirus' called 'HIV'). The program of the Barcelona conference is shown in Table 2.

A congenial atmosphere was maintained with evening time song, dance and dramatic entertainment performed by Spanish and Catalan artists. Together with the glorious local tapas and vinho tinto, these rejuvenating experiences inspired and renewed the focus of participants for the next day's full program.

al orthodoxy and dismantle 'aids'

'Anti-HIV' drugs displayed in St. Jaume Square, Barcelona

Well dispersed within the daily sessions were personal presentations in the form of testimonies from both women and men medically diagnosed as having 'HIV antibodies'. These individuals were 'diagnosed' over 13 years previously. Most were medically advised at that time to begin prescribed courses of antiretroviral therapy, AZT, and more recently AZT in combination with a variety of protease and other 'anti HIV' drugs, as well as prophylactic antibiotic therapy, like Septrin. What no participant, nor especially any self respecting 'health professional', could afford to ignore in this two week long conference were the frightening details embodied in such testimonies.

In every case, these personal testimonies from individual participants told of an overwhelming rejection of the 'label of HIV antibody positive' as part of their rejection of the orthodox biomedical construction of AIDS and all that entails. These individuals had intuitively understood at the time of their 'HIV antibody positive diagnosis' that the orthodox medical construction of the 'HIV/AIDS hypothesis' was erroneous, rejecting the notion of infection with a 'retrovirus'. Many reported that if they had accepted the label of 'HIV antibody positive' they would have embarked upon a (short) life time of testing/screening, abortions and toxic experimental drug treatments. They had understood that this overly 'medicalized' future was being offered to them and their loved ones by the medical establishment, and on this basis they all had, individually, rejected it. In retrospect, given the prospective good health of every one of these individuals and their partners and children, all had experienced the 'AIDS/HIV' industry as a reality of 'entrapment' and coercion, led by AIDS health and social care 'professionals'. This was experienced as starting with 'HIV antibody testing' and then potentially progressing to a lifelong 'patient' occupation of regular clinic based screening, testing and the taking of prescription experimental drugs, for both themselves and perhaps all of their loved ones.

These empowering testimonies acted as a counterpoint to the narrative of deconstruction of the so called 'basic science' of 'AIDS/HIV', the major theme of this conference. Such individual testimonies of empowerment aptly demonstrated how personal strength can overcome the almost overwhelmingly powerful and all pervasive imperative to test/screen, medicate and thus label 'HIV antibody positive'. For many of these quite ordinary Spanish men and women (and on behalf of their children), to decide against this powerful orthodoxy must have been a profound act of self determination in the face of what the whole world appears to believe is 'fact'. All the women decided against such 'advice' and went to full term with uneventful deliveries and now thirteen years later have healthy adolescent children. The advice had been given solely on the basis of a positive ELISA or Western blot 'HIV antibody test', even though the women reported being in extremely good health during the mid late 1980s when 'HIV antibody tested' . Several of these women reflected upon such 'testing ordeals', often experienced at the hands of overly zealous male and female obstetricians, who seemed from their testimonies as less motivated by ethical and moral practice than by their desire to boost the local hospital's 'HIV antibody cohorts', receive extra monies from the Spanish government for 'AIDS' cases and more likelihood of being published by the medical press. One woman recalled how such an erstwhile male obstetrician gleefully conceded herself as his 'first HIV positive pregnancy', whom he wanted to publish as a 'case

A.V.E.S. (Association of Victors over the 'AIDS' label)
Barcelona

REGIMED, Germany
(Research Group For Investigation In Medicine and Journalism)

E.C.O.S. (Complementary Studies Oriented Towards 'AIDS')
Madrid

G.E.A.S. ('AIDS' Alternative Studies Group)
Valencia

T.A.P.S. (Current Topics in Promotion of Health)
Brazil
CONTINUUM journal
United Kingdom

MEDITEL
United Kingdom

I.F.A.S. (International Forum for Accessible Science)
Switzerland

G.E.T.S. (Study Group For 'AIDS' Treatments)
Switzerland

Andromeda
Italy

Carta
Italy

Table 1: Organising and Collaborating bodies for the International Conference in Barcelona 6th-15th March, 1998.

FRIDAY 6TH
International Press Conference & Public Inauguration
Welcome Dinner.

SATURDAY 7TH
Study Session: "Understanding chronic illness via Evolutionary biology" by Dr H. Kremer
Group presentation: Continuum, London UK
Study Session: "Learn immunology in order to understand that 'AIDS' is an autoimmune problem" by Dr. A. Hassig, Switzerland.
Video workshop: Joan Shenton viewing and discussing MEDITEL Channel
documentaries, London, UK. Exclusive presentation of Ms. Shenton's book "Positively False".
Cultural/Fun event: KIT Pop/Folk group.

SUNDAY 8TH
Study Session: "Epidemiology proves there is no epidemic of 'AIDS' " by Prof. G. Stewart, Glasgow University, UK.
Study Session: "The conceptual errors in the pseudoscience of AIDS" by Dr H. Kremer, Germany.
Group presentation: International Forum For Accessible Science, Switzerland (IFACS) by Michael Baumgartner.
Cultural/Fun event: De tapas por las tascas de Correos.

MONDAY 9TH
Group Presentation: "Lieben Wir gefarlich ? ("Do we love dangerously ?)" Led by Dr C. Fiala, Austria.
Group discussion: "Is there an 'AIDS' epidemic or is it a deliberate statistical artefact ?" Led by Prof. G. Stewart, Glasgow University, UK.
Cultural/Fun event: Dancing.

TUESDAY 10th
Demonstration with placards St. Jaume Square, Barcelona. Handing in of official, poisonous medicines to the Generalitat and the Town Council.
Group discussion: "Are the 'AIDS' tests valid, or should they be abolished ? Is 'AIDS' a (contagious) disease which needs treatment, or is it a construct which should be dismantled ?" Led by Dr.'s Hassig and Kremer.
Cultural/Fun event: DESSEUS Duo (guitar and saxophone) play works by Jacques Ibert, Manuel De Falla and Astor Piazolla.
WEDNESDAY 11th
Personal testimony: Testimony of a haemophiliac who step by step discovered the falsehoods of 'AIDS'.
Group discussion: Does 'HIV' exist or is it a consciously designed technical mirage ? Led by Dr. S. Lanka, Germany.
Cultural/Fun event: Surpise THURSDAY 12th

THURSDAY 12th
Personal testimony: Story of a five year legal battle which has resulted in a Court of Appeal of la Plata recognising that it has not been demonstrated that 'HIV' causes 'AIDS'
Group discussion: Are there non aggressive treatments suitable for people labelled as 'HIV seropositive' or 'AIDS' cases ? Led by Dr. C. SSali, Uganda.
Cultural/Fun event: "Molestador Automatic" and "Alternaiu X" present the satirical work "Paranoia Congresista".

FRIDAY 13th
Presentation: Dr. Enric COSTA presents the 2nd edition of his book "SIDA: Juicio a un virus inicente" ("AIDS: An innocent virus on trial").
Group presentation: Discussion group with members of AVES, a number of defeaters of 'AIDS' give their views.
Cultural/Fun event: Rosa Zaragoza sings Songs of the Mediterranean.

SATURDAY 14th
Study session: "The official treatments, both allegedly antiviral ones and the allegedly preventive ones, are poisonous" by Dr. H. Kremer.
Study session: "There are effective, non aggressive treatments for the energy deficiencies and the immuno deficiencies and for the 29 'AIDS' diseases" by Dr. C. Ssali, Uganda.
Video presentation: Dhamel Tahi, Director Paris, viewing and discussing his documentary 'AIDS'.
Cultural/Fun event: Immaculada Balsells at the guitar plays themes by F. Tarrega, F. Sor, M. Llobert, H. Villalobos and S enz de la Maza.

SUNDAY 15th
Study Session: "Virology shows there is no proof at all of the existence of 'HIV' " by Dr S. Lanka, Germany.
Study Session: "Beyond 'AIDS' " by Dr S. Lanka, Germany.
Closing dinner.

TABLE 2: Conference Programme

"Participants handed in poisonous antiretroviral and antibiotic 'medicines' publicly to Barcelona's Generalitat and Ajuntament."

study', before strongly advising her to have an abortion due to 'HIV infection'. This woman did not take his 'advice' and now her son is a fit and healthy 13 year old attending school. Within the testimonies of the many gay and straight men, a similar resolve and empowerment was very evident: a rejection of the biomedical certainty of 'HIV infection' premised on positive ELISA and Western blot 'HIV antibody tests'. They reported a by now familiar and disconcerting interaction with health professionals in the 'AIDS/HIV' testing and treatment services, an interaction infused with prejudice against gay men and drug users and premised on socially constructed notions of being 'at risk' and 'viral' contagion.

These testimonies, set against the scientific deconstruction of the 'HIV/AIDS hypothesis', could easily be confused with those of a 'self help' group. For example, 'traditional' self help groups are often posited as being concerned with mutual aid as a significant alternative to formal health care systems with which their relationship is usually marginal[1]. In this respect, groups like COBRA in Spain and Continuum in Britain are similar to traditional self help groups as they foster mutual aid, propose alternatives to the mainstream health system and have a marginal relationship to the mainstream. Yet, the AIDS dissident experience is unlike any 'traditional' self help grouping. Of crucial difference is the very nature of the 'AIDS dissident' experience. In the Barcelona conference (as in COBRA, Continuum, IFAS and other groupings) there is a public, scientific and group refutation of the biomedical construction of 'AIDS/HIV'. For example, in Barcelona this refutation was 'scientific', given the nature of the information disseminated and awareness raising; it was public', as there was an open demonstration in Barcelona's St. Jaume Square on the 5th day of the conference, where participants handed in poisonous antiretroviral and antibiotic 'medicines' publicly to Barcelona's Generalitat and Ajuntament (Regional and Town Councils). Like many of those reading *Continuum* or joining COBRA, this particular scientific group refutation of the biomedical construction of 'AIDS/HIV' informs the essential ethos of such groupings. For example, the Barcelona conference developed a manifesto ('Barcelona Manifesto') to dismantle 'AIDS' by the year 2000. The overarching discourse throughout the Barcelona conference was of collaboration, perceived of as instrumental for successfully refuting the biomedical construction of the 'HIV/AIDS hypothesis', in both its 'causation' ('dissidents as to the cause of AIDS') and its 'treatment' ('dissidents as to its treatments'). This was a call for a strategic orientation amongst all those critical of the 'HIV/AIDS hypothesis'.

Yet, if this were a 'traditional' 'self help' grouping, for example, like those for people diagnosed with diabetes, there would not typically be calls for the deconstruction of the biomedical 'problem' which had mobilized its foundation. 'Traditional' self help groups can have a too narrow focus on "..those who share the problem for which the group was founded, having no awareness of belonging to a broader category of self help groups"[2]. As the dissident Barcelona AIDS conference (and COBRA, Continuum, IFAS and others) did not reflect such limitations, it went beyond self help, even though mutual aid ('self help') is well fostered through such activity as people are linked together and become more informed about various critiques of what is, after all, a very contested and "impure" science[3]. The Barcelona conference together with Continuum, IFAS and many others, are defining a broader category of a social movement4 , that is, a social movement against the 'HIV/AIDS hypothesis'. Health professionals have been encouraged to take a stand in support of such social movements, and "bear witness" and "tell the truth"[5]. Like those in Barcelona, recounting personal testimonies of 'taking a stand' - 'telling the truth' from one's own experience and 'non expert' knowledge of antibody testing and antiretroviral drugs - one trusts that 'health professionals' involved in 'AIDS/HIV' will take a stand and do it soon.

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The second international gathering hosted by COBRA in Barcelona will be 19 - 28th March 1999.

COBRA's new address is : CARTEGENA 230, 08013 Barcelona, Spain. Tel + 34 93 450 1300 Fax 456 4825

HEAL Conference in Toronto

by Clair Walton

Representatives of Continuum were invited to Canada to attend the HEAL (Health Education AIDS Liaison) Conference in Toronto on 11th and 12th April. It proved to be an excellent opportunity for many people to meet, some for the first time. The extensive preparation together with the warmth and hospitality of our Canadian hosts at HEAL Toronto, in particular Carl Strygg and Rob Johnson, ensured the conference ran smoothly and certainly contributed to its success. The ground floor of the beautiful home of John Scythes was donated to the conference for the Easter weekend. It proved a most congeniel environment for the serious discussion that materialised as the conference unfolded.

Rafael Ramos, Michael Baumgartner, also wearing his other hats of President of GaIA and Secretary General of IFAS, and myself attended as the Continuum delegation. Various chapters were able to attend with delegates representating HEAL Toronto, New York, LA, Denver, Seattle, Detroit, Atlanta and New England. Dr Michael Ellner, President of HEAL, began with a history of HEAL. He spoke of the growth of the chapters and how he had been happy to give permission for the HEAL name and logo to be used. In the past this had been without restrictions. Whilst pleased with the growth, he was opposed to group thinking where, as he warned, there is a danger of no thinking. He expressed his admiration of Continuum which he saw on its birth as a rising sun in the darkness. There followed a welcome from Carl Strygg and voting on the discussions to take place.

photo : Clair Walton

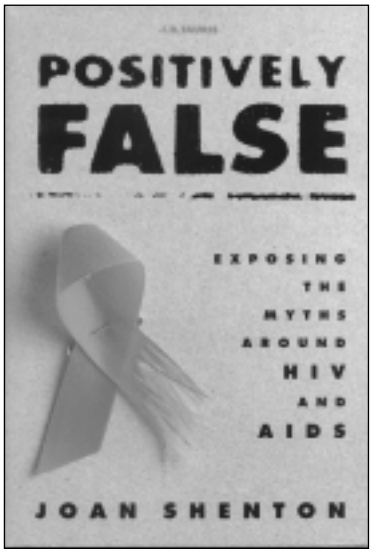
Delegates representing HEAL Toronto, New York, LA, Denver, Seattle, Detroit, Atlanta, and New England, and Continuum

Improving Internal Communication, Self-Definition, and Supporting Local and World Dissident Groups/Activities were amongst the topics discussed. The formal conference was chaired throughout by David Grierak who ensured the tight schedule allowed opportunity for all delegates to participate and, when necessary, to a time limit. Affection for Continuum was expressed frequently throughout the weekend and discussion took place on how HEAL could help to ensure distribution of *Continuum* magazine.

On Saturday night many of us attended a public lecture by Christine Maggiore of HEAL LA at the George Ignatieff Theatre. Christine's forthright, witty and moving account of her journey from her first positive test result proved a powerful testimony judging by the reception she received. Christine's story is fascinating. It took us through her desire to unravel the mystic that masks the scientific arguments; to understand them herself and represent them to the uninitiated in an accessible language. Her courage and determination, in the face of hostility that many of us are familiar with, was clear to those present. Christine's strength of character coupled with a healthy dose of humour is an inspiration to many, in particular as we witnessed her most recent defiance of orthodox opinion in the form of her beautiful bouncing baby.

After the conference there was an opportunity to experience one of the many public aids education sessions Toronto offers. The subject, viral load. The venue, the twenty sixth floor of the city's Metro Hall with its backdrop of the night city. Certainly it lifted the spirits to turn and view the night lit skyscapers when the endless graphs and charts became too much. Indeed, the stultifying air-conditioned environment probably accounted for the dull performances which almost numbed the audience into submission. The format was familiar, certainly to London audiences, but with multinational corporate backing that would hardly be surprising - a representative from the 'hiv' testing unit, a 'hiv' doctor, a professional from an aids organisation plus a positive individual. The main thrust of the session seemed to be to sell viral load as another surrogate marker so that drug treatment could be given at an earlier stage, even when - it was admitted - the patient felt perfectly well.

Fond memories reverberate from our visit to Toronto, both of our Canadian hosts and HEAL friends. There is appreciation for the professional manner in which the HEAL chapters conducted their business and settled their differences. Furthermore, there is admiration of how an organisation, diverse and disparate as HEAL, can capture itself, recognise its assets and motivate forward with a determination for the future. I look forward to the official resumé of the conference in due course.



Positively False -
Exposing the myths around HIV and AIDS
by Joan Shenton

I.B. Tauris U.K.
St Martin's Press U.S./Canada
277 pages
ISBN 1-86064-333-7

by Celia Farber

Celia Farber lives in New York and is a writer and journalist who has covered the AIDS debate over the last decade. She is famous for her column in *Spin* magazine, *AIDS - Words from the front*.

There are two books in this book: one that unravels, thread by thread, the scientific assumptions, assertions and delusions of the "AIDS establishment" and one that tells a story of human beings, journalists, (in the truest sense of the word) on an Orwellian odyssey into a time in history that can only be described as the End of Reason.

Joan Shenton, sometimes referred as the "den-mother" of the dissidents, inhabits a creative space between journalist, researcher, and human rights campaigner, and it is because she so brazenly broke the rules of upwardly mobile mainstream journalism that she has such a compelling story to tell, and so many arrows in her back. Hers is a narrative voice that is all but extinct in our culture: it is the voice of a journalist who reports out of a sense of alarm, with an eye on humanity, rather than "the story" as an end in itself.

Reading the passages that detail Shenton and Meditel's (the independent documentary film company she founded) trial in front of the BCC (Broadcasting Complaints Commission) over whether they had "unfairly treated the subject of AIDS" and been "unfair to (Glaxo) Wellcome", read like cut-outs from the book George Orwell never finished. One feels what must have been the stark terror of Shenton, as the frothing righteous dogs of the AIDS establishment close in on not just her journalism, but more chillingly, her *moral judgment*. And most infuriatingly, Meditel is never permitted to quantify or demonstrate their scientific argument. With names like 'Derek Ogg' and 'Duncan Campbell', the enemies of free speech and open scientific debate are so flatfootedly repugnant, one desires to reach through the book and personally throttle them. Instead it is Shenton who gets throttled, time and again, by the besser-wissers of the AIDS-throne, and their wrath only worsens as time progresses through the book, and their cherished assumptions are proved abjectly wrong.

As a first generation American dissident, I was struck by a quality in the U.K. AIDS debate that we thankfully lack here. It is a quality of European formality, of "complaints commissions", and "hearings", and characters like "Lady Anglesey" who Shenton aptly described as being "one of the 'great and the good' ". My incredulity hit an all-time high (and I thought I'd heard everything) when the laughable dissident hater and pharmaceutical loyalist Duncan Campbell starts showing the "panel" *his own* video in which he'd re-interviewed some of Meditel's interviewees, collecting what sounded like minor disgruntlements over how their views had been portrayed. How can somebody be "mis-represented" when they are speaking on camera? The true distortion is the way in which dissident journalists are attacked, no matter what lengths they (we) go to be fair and thorough. What Campbell and his ilk are actually demanding is that journalism cease in the face of AIDS, this 'terrible pandemic'. When they call Shenton "murderous", it is a fascinating manifestation of projection. Rarely have I read such a vivid portrayal of the true dynamic of organised hysteria that exists between the AIDS and scientific establishment, the pharmaceutical industry, the media, the dissident media, and the so-called activists as in this fascinating and terrifying chapter titled 'Fall Out'.

Those of us who've been immersed in dissidentia for years are familiar with the arguments against HIV, AZT, the HIV test, and the putative virus itself. Shenton documents the flaws, anomalies, and mysteries with great tenacity and detail. But it is when she tells us stories that Shenton truly comes alive: The man in the Dominican Republic whose wife drinks bleach and dies an agonising death because she believes he has 'AIDS' and who after her death, tests negative. The heart-breaking story of Arthur Rhodes, hospital painter, married with a 19-year old son, who pricked his finger after catching a box of used hypodermic needles he'd knocked off a window ledge. Frantic with worry about 'the AIDS virus', he kills himself with carbon monoxide poisoning. Shenton has a profound understanding of the scope of the tragedy, and it is illuminated, suddenly and heart-stoppingly, when she allows us to walk with her - through Sub-Saharan Africa, and Berkeley, and London where we meet the real people and hear the real voices that spell out the horror of the modern AIDS machine. Shenton depicts a world darkened by censorship, and when her good-guy characters appear fire-fly like - in the form of doctors, nurses, scientists, and ordinary citizens - one feels a temporary relief...until they vanish again, engulfed by the darkness.

Shenton writes with what I would call classic British elegance and restraint, but the narrative is livened up each time she injects a bit of her personality and wit. "All I could see," complains the African Professor Kassi Manlan whom Shenton bumps into at the AIDS conference in Berlin, "was white women rolling condoms on to big black penises. It is *très dégoutant*." Having had the pleasure of Ms. Shenton's company over the years, I've always regretted that her humour and personality could never be conveyed through the medium of film. I wish she had let it transfuse this book even more, but what is here is delightful. Describing the hostility of the 1993 Berlin AIDS Conference, she writes, "all we could do every morning was set our faces into a concrete mould and wade through the sea of scowling faces."

And that is precisely what Shenton, with her 'boys', (Verney-Elliott, Gildemeister, Adams) in tow has succeeded in - maintaining composure under unimaginable and bizarre journalistic duress. She documents the attacks, but not self-pityingly; in the end it is her rabid opponents who wind up pinned like moths to a scientific exhibit of strange human behaviour. Shenton never for one moment relinquishes the pointing stick.

WAKE THE LAW!

Photo : Joan Shenton

by Huw Christie

Damaging, non-specific hiv™ testing at the hands of the medical industry must soon prompt large financial compensation for 'the diagnosed'. It's time to sue!

Changes to the system of public access to justice in Britain dating back to 1995 open further the door for people to sue in court for substantial compensation if tested positive on tests for hiv™, the suggested virus expected to cause aids, (hereinafter referred to as 'hiv').

British law introduced the option of Conditional Fees for solicitors' work. When a solicitor enters into a Conditional Fee Agreement with a client, in the unlikely event that a case is not won, no fee is paid by the client - 'no-win no-fee'. The client may be liable to pay the opponent's court costs, and insurance is sold by several insurance companies to meet this, which can be taken out once a Conditional Fee Agreement is signed with a solicitor.

Conditional Fee Agreements, which are considered risky business by many solicitors, can currently be used in Britain for cases relating to personal injury, and for cases taken to the European Court of Human Rights. Either of these is already an appropriate area to seek compensation for an invalid 'hiv-positive' diagnosis[1]. There are well-advanced plans to extend the new fee system to other areas of the law in the near future.

A legal case for compensation against (i) a Health Authority and/or (ii) a testkit manufacturer and/or (iii) the British Department of Health would probably take account of the following:

As medical devices no 'hiv-testkit' has had to be licensed for use in Britain, as a medicine has to be. They still are not.

Since 1992 it has been thoroughly on the record in major scientific literature that there is no known specificity and accuracy for so-called hiv-antibody tests, (or "viral load" tests).[2,3]

In 1992 all Britain excepting Scotland ceased using one type of antibody testkit - the Western blot - which is the preferred type in most of the rest of the world due to what is considered its superior specifcity.[4]

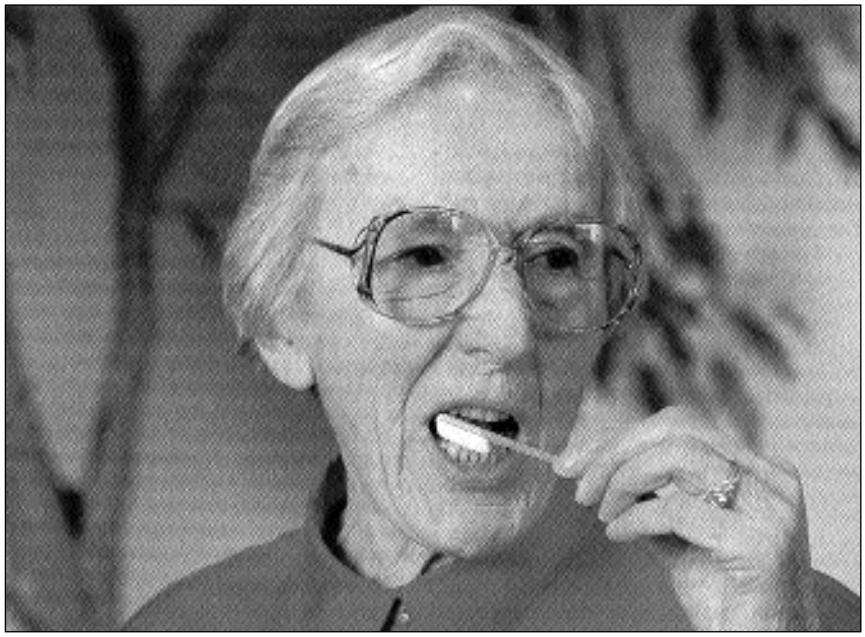
Different countries use significantly different types of 'hiv'/antibody tests, the results of which frequently conflict, and even when the same test is used in different countries, there are seriously differing criteria between countries for how the result should look in order to be positive. On the internationally preferred Western blot design of testkit, a person can be positive in Africa and negative in Australia or Scotland. The Head of the Virus Reference Laboratory of the British Public Health Laboratory Service, Dr Philip Mortimer, wrote in 1992, "It may be impossible to relate an antibody response specifically to HIV-1 infection."[5]

The only way to prove the specificity of an 'hiv testkit' - i.e. how frequently it tells the truth about 'hiv infection' - is to run a check of a positive result in a person against isolating some actual human immunodeficiency virus from the person, and to do it in thousands of people, many of them from the 'risk groups' where such antibodies are most frequently found in high levels. If the antibody test is positive when, and only when, isolation is positive, the test is 100% specific. The more times the antibody test is positive when isola-

tion is not, the less specific the test is.

These checks have never been performed in Britain or indeed successfully anywhere. When the defining work designing 'hiv' antibody tests was done by Robert Gallo and his colleagues in the US in 1984, using principles and assumptions that have *not* changed, they achieved a match between positive-for-'hiv-antibodies' and positive-for-'hiv-isolation' of only about one third. Substandard criteria for isolation were used that would not be acceptable today. In other words, nearly two thirds of people testing antibody-positive were virus-isolation-negative under conditions that maximised claims of isolation.

The more than sixty conditions - some of them aids-defining - already known in scientific literature to induce antibodies that can turn 'hiv-antibody' tests positive include: *PCP*, *candida*, *MAI*, *TB*, hepatitis B and C, flu vaccines, *Herpes simplex I* and *II*, and autoimmune diseases. There are many more.[6,7]



"ORAL SAMPLE COLLECTOR from Epitope, which can be used for gathering specimens for HIV screening, is placed between the gum and cheek. The sample of saliva and blood components is then sent by the health provider [*sic*] to a laboratory for testing." *Scientific American*, July 1994

To date it has been impossible effectively to validate 'hiv' tests - antibody *or* PCR *or* antigen - because actual isolation of an hiv by the standards of virology has never been achieved, and it may never be. In March 1997, two independent teams, one at the Robert Koch Institute, Berlin[8], and the other at the Aids Vaccine Programme in Maryland, USA[9], published hitherto missing electron microscope pictures of their state-of-the-art attempts to purify and so isolate 'hiv'. The leading Berlin pictures were instead captioned 'purified microvesicles', because these mini-cell particles - that look a bit like viruses - were all that could be collected where 'hiv' should have been.

The trauma of a positive antibody test result for 'hiv', the suggested virus expected to cause AIDS, is for the individual often the beginning of a gruelling and dangerous process of toxic prophylaxis, experimental 'anti-hiv' medication, biological and emotional stress and psychological decline. Suicide is a known response too. If treatment is needed for an illness, it is most often interpreted in light of the patient being 'hiv-positive', with assumptions about AIDS clouding the approach and placing the patient at greatly increased risk. Anybody given a positive 'hiv-antibody' test result has been medically abused in a highly vulnerable situation. Professional pre- and post-test counselling promotes belief in a high reliability for these tests, and a patient is told to accept the results as secure, particularly if he or she has elicited two positive results. But of course reproducibility is most definitely not specificity - the two results could both be positive (reproduced) due to the same non-'hiv' cause.

Solicitors are as likely as anyone not to have understood the inevitability and dimensions of such lawsuits; one leading solicitor who is already aware of some of the issues remains skeptical, responding that a client would have a case only if he or she had tested negative after testing positive i.e. their first result was a 'mistake'. However, legal perceptions may begin to clarify soon, when for the first time ever at a World Aids Conference (12th International, Geneva, June 28 - July 3), there will be an official public scientific meeting on fundamental problems with 'hiv-tests', entitled 'Hiv Testing: Open Questions Regarding Specificity'. This critical and historic conference session takes place on the opening day of the conference.

These unlicensed tests with no biological gold-standard and no consistent criteria for interpretation have been inflicted on individuals and populations despite clear evidence of their inadequacy and danger, and at immense profit to test makers, and drug makers. Recent compensation cases against tobacco sellers and mining interests over undeclared health risks have resulted in very large pay-outs to those abused.

Experimenting with unvalidated 'hiv-tests' should be immediately terminated, and appropriate compensation awarded to those misled, abused, damaged - and/or to the families/partners of those who have died during this scenario. Research into therapies and medical protocols for genuine illnesses, immune suppression and health risks should be funded without delay.

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Uganda on my mind

Photo : Eddie Sekabembe

"The Ugandan public is convinced an individual's blood is checked to find the 'virus' in the body - 'moving up and down' - the insect or the bug as they term it in local dialects."

by Winfred Mwebe

Last month I was in Uganda for 4 weeks. I was very happy to see my family after ten years without seeing them. I had fun and felt the warmth of a big family. But after a few days of good food and warm welcome I had to face reality.

I saw how people have lost hope, how people neglect their own lives. Everyone has 'AIDS' in Uganda. The poor say: "What can we do?...the virus is killing us!" The poor are not expected to live; the rich are expected to live as they are thought to be sent to America and Europe to remove their blood every other month. On the other hand, while the poor widows have no hope, the rich ones get on with their lives and find new partners as soon as their husbands or partners die. These rich widows are not dying and everyone knows that rich widows do not die. It has reached the extent of identifying 'AIDS' with certain parts of the country. Once certain places are mentioned, then people say that such an area is an 'AIDS' zone, and in most cases these places are slums.

What I saw in Uganda with my own eyes was a loss of hope. People roam the streets looking for something to do but nothing is there for them. I saw people on the streets looking very hungry and unable even to afford to drink at least two glasses of water a day. Malnutrition is rampant and this is not taken seriously as the few who understand how it can be fatal, are protecting themselves well and do not care much. Those who care are powerless to make a change and are never listened to when they try.

By the time I left the UK, the government here was complainingg of the overuse and dangers of antibiotics. Well, if anyone wants to know what antibiotic overuse is about, then Uganda is the best place for this. Every corner shop has antibiotics and most of the shopkeepers do not even know the brand names of the medicines they are selling. They just sell them as 'double colour' because the capsules normally have two colours. They are very cheap and by Ugandans most of them are thought to be fake. Antibiotic overuse in Uganda has been going on for a long time and it gets worse and worse, year after year. To my surprise antibiotics are causing more harm than good as anyone can get them freely on self-diagnosis. The inability of Ugandans to afford private doctors or hospitals has caused them to resort to desperate measures, especially medication. As there is no free or even cheap medication, people have no choice but to use a cocktail of capsules hoping to get better without considering the dangers or side-effects these antibiotics can bring to the health and immune system.

After prolonged use of antibiotics, people develop persistent coughs, malaria and several other tropical illnesses that have been known for centuries. The difference is that now on the eve of the millennium, these illnesses are called 'HIV'-related!

In Uganda 'HIV' and 'AIDS' interpretation is very different from how it is known here in the West. Ugandans kept asking me, "Are white people also dying as we are?" My response of course was "NO!" People could not believe me because they have no idea that they are being classed as a 'high risk group'; neither do they know that malnutrition kills more people than so-called 'AIDS', nor do they have any knowledge on how stress-related illnesses are increasing because of rural-urban migration. Those who leave their villages for the city soon find that there is nothing to do or even eat. Ugandans take material things more importantly than their health and lives.

The big 'AIDS' industry in Uganda is busy telling the world how Ugandans are dying of 'AIDS' and money continues to be pumped into condom industries, raising 'HIV/AIDS' awareness programmes etc. However, no-one puts money into advising people on healthy eating/nutrition or hygiene - without forgetting poverty. We all know poverty kills. What about advising Ugandans of the dangers of antibiotics, or getting rid of them on the open market? Fake doctors in Uganda do business like fish and chips sellers because being a doctor has proved very commercially rewarding in the era of 'AIDS'. If you are not rich in Uganda, you are destined to die. There is no medication in hospitals and one wonders what has happened to our hospitals, our National Health Education and the state dispensaries. I feel sick because every time I hear about only one thing: 'AIDS' - yet we all know that there are more dangerous diseases in tropical countries such as Uganda. Only if those diseases can be properly treated would they evidently reduce the number of reported 'AIDS' cases.

We should not disguise the failure of Uganda's Health Education, the lack of medications in hospitals, and above all corruption within the Health Ministry that wants to insist on 'AIDS' programmes because they are commercially beneficial especially from the Western World's perspective. It is pathetic! My hope is that once these problems are looked into, many lives can be saved, so the 'Pearl of Africa' as Churchill once named this beautiful country, can flourish.

In a country like Uganda, 'AIDS' is not a genuine issue. What is more important is who has power. Genuine doctors are fighting each other instead of fighting to save lives. Take the example of

Ugandan Professor Ssali in Kampala who has an interest in 'HIV/AIDS' and a specialist clinic. Instead of being helped by the government, he is being threatened by the Ugandan Medical Board not to 'interfere'. Is this really working for the interest of Ugandan people, or for political interests. 'AIDS' becomes not a health debate but rather a political and financial one.

No-one is going to solve Uganda's medical blunders better than Ugandans themselves. Instead of making money from the 'AIDS' industry, people's lives should come first. Pharmaceutical companies, like Glaxo-Wellcome, are interested only in making money from the Ugandan government and some concerned organisations like WHO, Red Cross, etc.

Condom 'awareness' is considered a priority in Uganda. The condoms can even be distributed by companies freely in communities. Nowadays in Uganda people talk about condoms as some sort of fashion for the 90s. The hypocrisy is that no-one can get even free chroloquine tablets once they are down with malaria. Malaria kills in hours or days but 'AIDS' can take even '30 years' to kill. In a country like Uganda, where 80% of the population lives under the poverty line without the basic necessities of life, expect to be save by a condom? These people do not have food to eat - what quality of life would a condom add? The Health Authorities talk about condoms to impress the public. How come sex in Uganda is taboo while in the Western World sex is fun and people still enjoy it as 'normally' as they have always done? The West has judged that only the Sub-Saharan, the Gay community, IV drug users, haemophiliacs and those who have just visited Africa are the high-risk groups.

To my surprise most Ugandans are not aware of these risk group classifications of 'HIV/AIDS' strategy induced by the Western politics of policy makers. Ugandans still think that anyone can 'catch it' as shown in misleading advertisements against the 'killer virus'. The way the 'HIV' test works is not explained to people. The public is convinced an individual's blood is checked to find the 'virus' in the body - 'moving up and down' (the insect or the bug as they term it in local dialects). They have no clue that the 'HIV' test is an antibody test, and non-specific.

To my knowledge antibodies are usually a sign of health and functioning defence in the body. Antibodies show that the body can respond to infections. What makes 'HIV' antibodies different from other antibodies? Well, no one seems to know the answer to this. I was stunned to hear a Ugandan doctor explain to a patient that the test for antibodies is done only in African countries. He continued to explain that in the West, Europe and America, where technology is highly advanced, there are machines that see the 'virus' itself 'doing the job'. At this point I interfered saying it was not true and antibody testing is used also in the West although this so-called 'virus' has never been purified and isolated .

The 'AIDS' acronym - Acquired Immune Deficiency Syndrome - can be describe many things like malnutrition, malaria, stress, TB, post-war related illness. The issue however remains in 'high-risk' categories that are 'destined' to die of 'AIDS' by all means whether by 'acquiring it' or being defined as having it. Research carried out in 1994 by King College Hospital here in London found that losing a spouse undermines the immune system and leaves a person prone to illnesses. But, in Sub-Saharan Africa, this cannot be the case and cannot be looked into because it is always politically correct to blame those who cannot defend themselves. In the Ugandan context losing a partner can be so cruel, and no-one can escape the stigma, unless of course you are rich and by finding a new partner can reduce the stress imposed on you by the community in general.

The most worrying question every Ugandan person asks is about people dying in couples. They cannot possibly relate it to stress so it is assumed to be 'AIDS'. The next is that the children die too. This time it is not because of 'AIDS' but because of loneliness and the inability to cope alone with the pressures of life without guidance. All these people wait for their turns, and so they start dying early. People die mentally first, then their physical health also detoriates. Fear, isolation, loneliness, and above all lack of survival income leads to death. The usual conclusion is 'death by AIDS' - certainly no-one in these conditions dies with a healthy looking body.

Antibiotic overuse in Uganda has been going on for a long time and it gets worse and worse, year after year.

Ugandans living in the UK who are aware of the nasty side effects and the toxicity of the 'AIDS' drugs that are still on trial here, do not use them themselves - they get them from their doctors and send them to Uganda for commercial interests. It is very sad to see that such a practice going on. How can one know of something so bad for them and then go on to make money out of it - especially when it can be fatal? While I was in Uganda so many people came to me asking for new 'wonder drugs' stating that in Europe and America there is 'a cure' already. I tried to explain that there is no such thing as a cure for 'AIDS'. I told them that the combination therapies have been on trial for ages and that Ugandans are still used as guinea pigs. The only people who are doing well with the 'HIV' diagnosis are those who have decided to take control of their lives and not to listen to the myth that HIV=AIDS=DEATH. They get normal treatment for any symptoms they get, look after themselves sensibly, eat a balanced diet, opt for alternative treatment if need be and in most cases go back to the natural healing process that will not damage their bodies. These people have left their immune systems to return to normal with a positive mind.

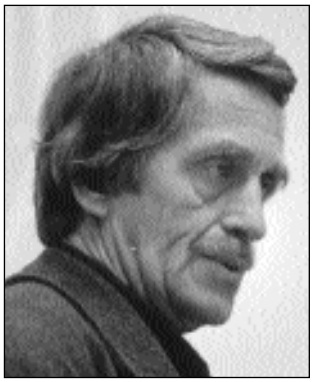
While some 'HIV/AIDS' wards are scaling down in the UK the same type of centres are opening up in Uganda - and are becoming a booming business exploiting rich upper class families. Instead of using a new hospital for humane purposes, the hospital is being built 'apparently to offer subsidised prices' for 'AIDS' treatment. No one needs to be a professor of medicine to realise that there is more to the marketing of 'AIDS' than just the hypothesis itself. Well, ladies and gentlemen, get up and join in the fight! Do not let capitalists extend their money-making schemes at the cost of human life.

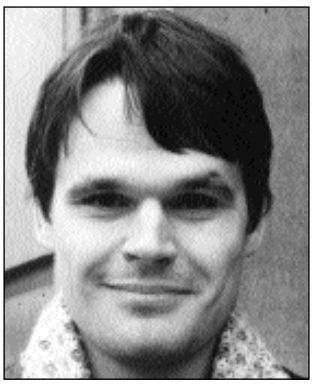
15 years of

The continuous failure in the prevention and treatment of AIDS is rooted in the misinterpretation of an inflammatory autoimmune process as a lethal, viral ver

by

Prof. A. Hässig MD H. Kremer MD S. Lanka PhD





Summary

The question of the specificity of the anti-HIV antibody test has to be revaluated as it was shown that the viral enrichment obtained from co-cultivations of patients' lymphocytes with fetal cord blood by Barré-Sinoussi *et al*. and leukemia cells by Gallo *et al*., exclusively consisted proteins of the cell types used in the cell culture. This precludes a clear separation of presumed retroviral from cellular proteins or extracellular matrix proteins. In this context it was shown that the anti-HIV antibody test detects autoimmune antibodies directed against cyto-skeletal proteins e.g. the liver cells. Strongly augmented anti-actin autoantibodies is considered close to pathognomonic for chronically active hepatitis. The original assumption that 'reverse transcription' from RNA to DNA is evidence for the existence of retroviruses, was wrong. In fact, 'reverse transcription' is a vital mechanism for the maintenance of the genome. The decrease in numbers of circulating CD4 lymphocytes can be explained by a stress-induced hyper-cortisolism. Up to date, direct HIV-mediated destruction of CD4 lymphocytes could not be proved. The same is true for measuring of the 'viral load'. Shortcomings of the applied method to quantify the 'viral load' do not permit definitive conclusions. Possibly, it may be taken as an expression of a stress-induced weakening of the cellular immune reactions, in the course of which the nucleoside fragments resulting from the current cell turnover are inadequately eliminated. Furthermore, the treatment of patients with nucleoside analogues has a toxic effect on both the genome of the cell-nucleus and the mitochondria. The latter, therefore, may produce insufficient amounts of ATP, causing organ failure and, eventually, death. The synthetic protease inhibitors used these days are associated with serious side-effects. Therefore, it seems worthwhile, in these patients, to bring back the catabolic situation due to whole body inflamation to homeostasis by administering anabolic phytopolyphenolic compounds.

AIDS is the abbrevation for acquired immunodeficiency syndrome. AIDS, as a term for an illness, originated in the search by the American Centers of Disease Control for sick homosexual men, also suffering from Kaposi's Sarcoma (KS) and/or Pneumocystis Carinii Pneumonia (PCP). In 1983 Barré-Sinoussi *et al*. reported on a T-lymphotropic retrovirus which they allegedly isolated from an enlarged lymphnode of a homosexual patient.[1] In 1984 Gallo *et al*. reported the alleged isolation of an identical retrovirus from CD4-lymph cells from homosexual patients, clinically diagnosed as suffering from AIDS.[2] Barré-Sinoussi *et al*. cultivated these patients' lymph cells in question with fetal cord blood and Gallo *et al.* co-cultivated theirs with leukemia cells. Initially, these laboratory methods must raise doubts as to whether the isolation of a new human retrovirus is evident just by data. Gallo *et al*. stated that their allegedly isolated retrovirus caused the destruction of CD4 lymphocytes in those patients, whose heterogenic illness was taken as an after-effect of the CD4-cell destruction and so subsumed as AIDS. Besides, Gallo *et al*. announced that in due time a vaccine would be available for the formation of antibodies against the discovered virus.[2] Today, fifteen years later, the question still remains open, whether HI retroviruses actually do exist or whether the postulated retroviral 'HIV'-antigens as well as the postulated 'HIV' reverse transcription are a matter of human protein molecules derived from cells in co-cultured cell cultures used by both Barré-Sinoussi *et al*. and Gallo *et al*. The most extensive investigations in this regard are owed to Eleni Papadopulos-Eleopulos and her group in Perth, Australia. In 1993 they published a review concluding that there is no evidence for the existence of HI viruses.[3] In 1994 Lanka concluded that all 'retroviruses', including 'HIV', are biologically nonexistent and their phenomenology is based on laboratory artefacts.[4-6]

These fundamental counter-statements to the current HIV-

AIDS

e

nereal disease

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AIDS-theory have been strongly supported in the last few years. Upon investigations in order to develop a vaccine against 'HIV' it became apparent, that the enrichment of presumed HIV-1 preparations, considered as pure, consist of proteins of the cell types used in the cell cultures, which resist a clean separation into presumed retroviral and cellular proteins, i.e. extracellular matrix proteins. Above all, these cell proteins, also occur in the inside of extracellular particles, which have been misread as it seems as so-called HI virions by the retrovirologists.[8-10] These findings were to be expected as Gallo *et al*., when developing the 'AIDS test', did not investigate the presence of cells' own proteins in the protein mixture, released during the co-cultivation of patients' lymphocytes and leukemia cells. Upon developing the ELISA and Western Blot tests it should have been imperative to consider proteins released from stimulated leukemia cells, not being mixed with patients' lymphocytes, and to differentiate these from the ones, released only after addition of patients' lympocytes.

In view of this it seems to be mandatory to re-evaluate the question of the specificity of the anti-HIV-antibody test.

What is the laboratory finding "anti-HIV-positive" based on?

In a series of preceding reports we have discussed this question in detail [11-14]. We came to the conclusion: the laboratory finding "anti-HIV- positive" is primarly the expression of an autoimmune activation of the immune system linked to a persistant catabolic state of metabolism. In view of the fact that the diseases grouped under the term AIDS are limited to risk groups such as homosexuals, drug addicts and recipients of blood products contaminated with parenterally transmitted hepatitis inductors, the question is raised, whether the anti-HIV test determines autoantibodies directed against cell envelope structures with a specificity to the body's own proteins of the host cells. It has been known for over twenty years that chronically active hepatitis (currently hepatitis B, hepatitis C and autoimmune hepatitis without evident antiviral antibodies) react by the formation of autoimmune antibodies directed against cyto-skeletal proteins of the liver cells. Thus, the raised anti-actin-autoantibodies are pathognomonic for chronically active hepatitides[15]. Johnson *et al*., in 1965, were the first to report on anti-actin-autoantibodies[16]. They described autoantibodies directed against smooth muscle cells and showed that this had to be considered as characteristic indication of "lupoid hepatitis". In 1973 Gabbiani *et al*. demonstrated that autoantibodies directed against smooth muscle cells react with actin-containing microfilaments[17]. Further investigations indicate that autoantibodies with anti-actin specificity are to be classified within the big group of autoantibodies against filamentous proteins of smooth muscle fibres. 3 - 18% of healthy individuals present low titer autoantibodies against cyto-skeletal proteins[18]. High titer anti-actin autoantibodies, on the other hand, are only found in patients suffering from chronically active hepatitis and/or biliary cirrhosis.[19] In 1994 Bermas *et al*. showed that both sera from patients with lupus erythematosus and from mice suffering from the same illness react with glycoprotein 120 and peptides of the postulated HIV-1 envelope.[20] They further proved that control sera of healthy individuals and patients with other autoimmune diseases contain small amounts of the same autoantibodies. Last but not least, they showed that autoantibodies reacting with glycoprotein 120 do not possess antinuclear specificity. They refrained from investigating a specificity against cytoskeletal proteins of these autoantibodies.

Evidence is given that the HIV test does not indicate antibody

formation against the postulated retroviruses as, during the last decade in Germany, not a single seroconversion has been observed in inprisoned drug addicts. All sero-positive drug addicts acquired their anti HIV 'positivity' before their imprisonment. In opposition to this, seroconversion by hepatitis B inductors was recorded in intravenous drug addicts[21-23]. The same was also observed in haemophiliacs, i.e. despite continuous substitution with hepatitis-contaminated blood products approximately a third of these individuals never become anti-HIV positive. This is characteristic for the individual response to autoimmune reactions against cyto-skeletal proteins in the host cells, in which Girard and Senecal observed a polyreactivity[24]. The individual autoimmune reactivity either appears at first contact or fails to appear even at multiple contacts.

We conclude that a positive anti-HIV test does not indicate an antibody formation against "retroviral HIV antigens". Low titer "anti HIV" antibodies are common even in healthy individuals. High titer antibodies are pathognomonic in chronically active hepatitis. The anti HIV test does not answer the question whether anti HIV antibodies occur or not; the test differentiates between "plenty = positive" and "few = negative".

Rethinking as to "Reverse Transcription"

The error, taking proteins resulting from 'HIV' isolation for retroviral proteins, dates back to 1970. The paradigm, that DNA codes information and programs relating to all physiological and phenomenological aspects of all organisms, resulted in the postulation of the irreversibility of the genetic flow of information for the synthesis of proteins - from DNA via messenger substance (RNA) to proteins. This was the crucial genetic dogma[25]. Despite the proven reversibility in 1970, that from RNA DNA can re-emerge, this fact was postulated as an exception that proves the rule by stating the existence of retroviruses, qualified for this reversibililty, which, at this time, were only considered as tumor viruses.[26,27] With the discovery of this enzymatic activity in all living cells it soon became clear that the evidence of the function of "reverse transcription" from DNA into RNA was not a proof for the existence of retroviruses, because the genome of all eukaryotic cells is clearly marked by this activity[28,29]. Retrospectively, it seems rather astonishing that in 1983 Montagnier and in 1984 Gallo still postulated a new retrovirus despite the fact that a new viral entity had never been isolated or described, according to the standard regulations in virology. As a matter of fact, the enzyme Reverse Transcriptase from 'HIV' has never been isolated or described, but only inferred from functions to its existence, when new formation from DNA into RNA was proven by laboratory techniques.
Since 1985 it has been known that the 'Reverse Transcription' plays a decisive role in the maintenance of the structure of the genome, by repairing chromosome fractures and, especially, by limiting the loss of chromosomal end components, the telomeres occuring at cell replication[30-33]. The respective enzymes for this kind of reverse transcription, the telomerases dispose of a type-specific RNA matrix for the formation of the repeating telomer units. Somatic human cells, that do not belong to the reproductive path, cannot adapt to the shrinking of their telomeres when replicating and so cease the replication at a certain degree of depletion.

Up to date, the influence of nucleoside analogues on the action of telomeres at replication has obviously not been investigated: We could trace only two publications, in 1996, which describe an in vitro investigation of nucleoside analogues inhibiting the telomerase activity. In our view, the knowledge, already gained in 1980, on the vital physiological function of 'reverse transcription' should have lead to a rethinking as to the establishing of nucleoside analogues as pharmacological inhibitors that time on the physiological function of the 'Reverse Transcription', it should have been rejected.[34-35]

What is the decrease of CD4-lymphocytes in AIDS based on?

The decrease of the circulating CD4-lymphocytes in the blood stream during progressive immune deficiency in AIDS has generally been explained by the progressive destruction caused by Hl viruses[36]. Four years ago Carbonari *et al*. showed in an *in vitro* investigation that the apoptosis of the lymphocytes in AIDS patients is mainly related to CD8 - T-cells and CD19 B-cells[37]. Finkel *et al*. then pointed out that apoptosis concerns mainly 'bystander' cells and spares supposedly infected cells from so-called HIV- and SIV-lymphnodes[38]. These reports remind us of Fauci's classical publications of the 70's in which he and his working group clearly demonstrated that, in persisting hypercortisolism, an increasing number of CD4-cells leave the blood stream and can thus activate B-cells in the marrow.[39-44] The migrated CD4-cells return to the blood stream upon dropping to normal values of the cortisol level.
At the beginning of 1995 Wei and Ho *et al*. published a report in which they declared, that the extremely fast multiplication of Hl-1 viruses produces a raised turnover of CD4-lymphocytes.[45-46] Towards the end of 1996 Wolthers *et al*. showed that the telomere length of CD4-lymphocytes in anti-HIV positive individuals remains normal, whereas the one of CD8-cells decreases.[47]
During the latest international congress of leading HIV scientists the long-term criticism of the HIV/AIDS theory has been confirmed: despite intense and precise investigations there was no proof of a pathophysiological mechanism explaining the different reaction of CD4- and CD8- lymphocytes to the postutated retrovirus HIV.[48] It was literally stated: "The riddle of CD4 cell loss remains unresolved." Paul Johnson of the Harvard Medical School in Boston voiced in a disillusioned way the helplessness of the conventional AIDS scientists: "We are still very confused about the mechanism that leads to CD4 depletion; but at least now we are confused at a higher level of understanding. In other words, Faucil's pioneering work, based in the seventies, on experimental traumatology fell into oblivion. Calvano clearly documented in a review published in 1986 that the selective depletion of CD4-lymphocytes is induced by neuroendocrine mechanisms in traumatic conditions such as injuries and burns, whereas its proportions depend on the degree of hypercortisolism[49]. It remains enigmatic why Fauci, after having joined the AIDS research, never again mentioned his own reports.

What does the "viral load" measure?

Immediately, after the publication of Wei's and Ho's reports in January 1995[45,46] in which they put forward the hypothesis that Hl viruses multiply at raving speed destroying a similar number of CD4 helper cells, quantitative tests based on the genetic multiplication method PCR were introduced and so a large number of 'HIV' in the blood stream was postulated It has been well known among 'HIV' scientists that the so-called viral load, i.e. the measurement of the 'viral load' - "is no evidence of the entire virus genome or intact viruses".[50] The "viral load" measures short components of the messenger substance RNA, attributed to the Hl viruses. Because the virus genome per se never could be described it is impossible to designate these RNA fragments as viral. Going through the records of the presumed characterization of 'HIV' it can be inferred that all components - proteins and genetic substance - attributed to HIV, are of pure cellular

origin.[3-7] Therefore, the results of the 'viral load' can only have an indirect significance, such as the measurement of an increase or decrease of cellular RNA, as it can be observed as increasing in catabolic conditions of cell disintegration and decreasing in anabolic conditions. However, these results cannot be considered as clinically relevant as, besides the technical inadequacy, control investigations with both non-positive defined healthy and ill individuals have never been published.
The polymerase chain reaction (PCR) is a technique for a manifold multiplication of short DNA fragments, developed by Nobel prize winner for chemistry, Kary Mullis. Upon measuring the 'viral load' the RNA fragments in the blood stream first have to be converted into DNA and then multiplied as such. The single, developing technical steps of this method are prone to failure. The slightest impurity, drugs, such as heparin and other substances interfere with a reproducible functioning of the PCR method, especially with quantification.[53] Kary Mullis, the inventor of this method does not miss any occasion to critizise the application of his technology in the context of AIDS.[52] Furthermore, it is concealed that it does not make sense, either practically or theoretically, to initially multiply manifold fragments of genetic structure and then to postulate their manifold presence. In case they were actually present in the blood samples it would cause no problem to prove their existence by simple, quick and cheap standard methods[51] and, if de facto, viruses did exist in the blood stream, scientists certainly would have been successful in making them visible. Hence, up to date, no scientist claims this achievement, a fact which has been confirmed under coercive evidence by the German Health Ministry in 1996. After the report of a produced "positivity" in the "viral load" during a vaccination test with proteins[54] of a previously "negative" defined test person it is now frankly admitted that repeated wrong-positive results in the viral load are quite a well known phenomenon.[55]

Impairment of energy formation in mitochondria by nucleoside analogues such as AZT (Azidothymidine, Zidovudine)

AIDS patients quite often demonstrate a weakening of their skeletal muscles. Up to 1990 this was considered a HI-virus-caused impairment of muscles. In 1990 Dalakas *et al*. demonstrated that this kind of muscle disease is due to an administration of AZT, weakening the mitochondria within muscle cells. With the excessive release of free radicals the mitochodria are affected in their function of forming ATP as key substance in metabolic energy.[56] Hayakawa *et al*., in 1991, demonstrated important changes in the mitochondrial DNA (mtDNA) in the liver of mice after the administration of AZT. The final sentence of this paper reads: "However, for AIDS patients it is urgently necessary to develop a remedy substituting this toxic substance AZT".[57] These results were confirmed by histochemical methods in the same year by Chariot and Gherardi.[58]
The toxicity of nucleoside analogues in the treatment of viral diseases was thoroughly dealt with in the following years and, it was proven that the toxic effect causes multiorganic impairments in heart muscle, brain and kidney, as well as in liver and pancreas.[59] Further, it was shown that successor drugs of AZT such as ddI and ddC cause the same mitochondrial impairment.[60] Since 1991 it would have been mandatory that not only the pharmaceutical industry but also the registration authorities seriously consider these impairments caused by long-term administration of nucleoside analogues and provide proof of the incoherence of AIDS patients' death with this drug treatment; in general this obligation has been avoided and now they face upcoming connected liability questions.

HIV-proteases inhibitors: A new therapeutic principle in the prevention and treatment of AIDS

According to the HIV-model long precursor molecules of proteins along the multiplication process, have to be cut at certain interfaces in order to create functional 'HIV' proteins upon which, ultimately, new HI viruses form Synthetically produced short protein molecules, reproduced after the interface to be cut from the precursor protein but which cannot be cut should, according to the model again, inhibit the natural activity of the HIV protease and thus prevent the formation of new HI viruses. As a matter of fact the 'HIV' protease has not been isolated, but has been reconstructed by genetic engineering upon which it was observed that this enzyme is very similar to the human digestive enzyme, pepsin of the class of the asparate proteases. The problem of the model is that the one and the very same 'HIV' protease would have to be cut at completely different interfaces in order to forrn functional proteins and, ultimately, 'HIV'. Practically, this is not conceivable and has been explained as: "enzymes do not have a high sequence specificity" although it has been postulated that: "a therapeutically applicable inhibitor has to be specific, and should not inhibit human enzymes of this class of substance."[61] Considering these explanations of the head of the chemical department of the scientific laboratories at Bayer's, it becomes obvious that, theoretically, it is not possible to exactly target the postulated HIV protease. Further, it is impossible not to interfere in the cellular processes of integration and disintegration of a variety of proteins. The inhibition of the active protease in AIDS *per se* makes sense. However the pharmacological administration of high doses of distinct aromatic substances is a non-physiological measure, connected with serious side-effects which excludes their pharmacological use.
Indeed, up to date, the pharmacological 'HIV' protease inhibitors prove to be connected with side-effects, which demand the absolute necessity of their replacements by phyto-therapeutic mixtures. Apart from side-effects such as kidney stones, damage of the liver, an increase of diabetic impairment of metabolism, CMV retinitis and haemolytic anaemias these protease inhibitors, after a short-term administration, also demonstrate a loss of effect on the inflammatory process which was misinterpreted as a result of an acquired resistance by HIV as well as an incompatibility with many drugs, especially with the ones of the group of Cytochrom-P450-inhibitors and inductors.[62]

Nutritional possibilities in the prevention and treatment of AIDS

Looking at the formula of structure of the synthetic protease inhibitors, it becomes obvious that these are artificially produced aromatic compounds. As we have suggested lately, polyphenols as well as tannins and flavonoids are phyto-protective substances against harmful external influences. As aromatic substances, they cannot be synthesized by the animal organism. The nutritional supply of a variety of phyto-polyphenols to the animal organism has the function of operating as a redox buffer and rebalancing oxidative stress conditions with their catabolic alteration of metabolism to the anabolic state of equilibrium.[63]

Flavonoids and tannins are effective with respect to:
1. Inhibition of lipid peroxidation
2. Scavenging of oxygen radicals
3. Binding and inactivation of pro-oxidative transition metals such as Fe and Cu

4. Binding of proteins including attenuation of their enzymatic activity (protease inhibitors)

Upon these reductive activities flavonoids and tannins are oxidized themselves; a well known example is the reduction of vitamin E by vitamin C or coenzyme Q. These mechanisms are at the beginning of a cascade of recycling. This example demonstrates, that the multitude of almost 5000 different flavonoids and tannins is used to overcome the oxidative state of the ex-antioxidative molecules at the end of the cascade of recycling, by transferring it to a variety of native molecules.
The stress-induced state of catabolic metabolism in AIDS is in the center of the pathogenesis. The correction of the connected whole body inflammations, caused by oxygen radicals and protease activation, is a compelling preventive and therapeutic action which urgently demands the use of phyto-therapeutic polyphenol compounds.

Possibilities and limits of treatment of hepatitis in anti-HIV positive individuals

A symptomlessness and the stress-induced activation of liver inflammation in healthy individuals are characteristic of parenterally transmitted inoculation hepatitis (hepatitis B and C). The classic example for this occurrence is posttransfusional hepatitis caused by blood and blood products of clinically healthy blood donors. At the occasion of a study, made in the early fifties at the blood transfusion service of the Swiss Red Cross on recipients of lyophilized pools of mixed plasma of 50 - 70 healthy blood donors, it was observed that this caused serious, sometime even lethal hepatitis in many ill recipients.[64-66] It is emphasized that in a contaminated organism with parenterally transmitted hepatitis inductors (now called hepatitis B and C), the aim of treatment has to be reduced to just reach a normal state of health. The administration of virucide, cytotoxic drugs is not able to eliminate these inductors from the organism. Proceeding from this knowledge, in Poland, for two decades, BRZOSKO *et al*. have been collecting data with the Tibetan prescription of phyto-therapeutic formula, PADMA 28[67]. They showed that this phenol-rich plant compound is able not only to reduce the serum level of hepatitis B antigens in hepatitis B patients but also to augment the serum level of hepatitis B antibodies. At the same time an amelioration was observed in these patients regarding their clinical condition and the biochemical and histological results from their hepatitis. Based on these pioneer results, today, in patients suffering from chronically active hepatitis, the substitution with phyto-polyphenolic mixtures has priority over other treatments.

How does the nucleoside analogues treatment of AIDS patients influence their course of disease?

After having examined 8 reports on 'HIV' positive long-term non-progressors who stayed clinically symptomless for over 10 years, we realized, that, without exception, they had not been treated with nucleoside analogues.[68-75] We consider this as a confirmation of our above-mentioned caution as to the prophylactic and therapeutic administration of these cell toxics, originally developed for treating cancer, in the autoimmune course of disease in AIDS.

Nutritional supply of polyphenolic mixtures as basic treatment of anti-HIV positive individuals and AIDS-patients

As initially showed, a positive anti-HIV test is an indication of an augmented formation of autoantibodies against cytoskeletal proteins, i.e. actin. This condition is pathognomonic for chronically active hepatitis.
AIDS, as serious immuno-deficiency-syndrome is the expression of a persistant hypercatabolic state of metabolism along with a stress-induced whole body inflammation. A successful treatment of such conditions consists of the nutritional supply of a sufficient quantitiy of antioxidative and antiproteolytic phyto-phenolic mixtures, consisting of flavonoids and tannins. As neither the animal nor the human body are able to synthesize aromatic compounds they are fully dependent on a sufficient supply of anabolic effective phyto-polyphenolic mixtures, in order to adjust catabolic states of metabolism. These mixtures are present in drugs made of teas and spices. Padma 28 proved to be the most effective one. Additionally, it is recommended to balance other possible states of deficiency of vital nutritional components such as polyanions and essential fatty acids.
Completing this review we came across the publication by PADIAN *et al*. which remarkably emphasizes the insignificance of heterosexuals transmitting 'HIV'. In this study, extended to 10 years, the authors say: "male-to-female transmission was approximately eight times more efficient, than female to male transmission and male-to-female per contact infectivity was estimated to be 0.0009". Obviously, AIDS is not a viral venereal disease, but an inflammatory autoimmune process[76].

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Where have we gor

by Dr Valendar F. Turner

The real purpose of scientific method is to make sure Nature hasn't misled you into thinking something you don't actually know. There's not a mechanic or a scientist alive who hasn't suffered from that one so much that he's not instinctively on guard. That's the main reason why so much scientific and mechanical information sounds so dull and so cautious. If you get careless or go romanticising scientific information, giving it a flourish here and there, Nature will soon make a complete fool out of you. It does it often enough anyway even when you don't give it opportunities. One must be extremely careful and rigidly logical when dealing with Nature: one logical slip and an entire scientific edifice comes tumbling down. One false deduction about the machine and you can get hung up indefinitely.

Robert Pirsig. *Zen and the Art of Motorcycle Maintenance*

Over the seventeen years since the beginning of the AIDS era our small group in Perth, Western Australia have researched and written considerable amounts detailing why currently it is not possible to accept the HIV theory of AIDS.[1-16] Indeed, the cruelest irony of the AIDS era is that, right from the very beginning, armed with a few, simple biological facts, it was possible to foresee that cell cultures derived from AIDS patients and those at risk would evince the very phenomena erroneously inferred as proving the existence of a unique, exogenously acquired retrovirus. The problem that has developed from these data, that is, the HIV theory of AIDS, stems from the fact that these phenomena, while characteristic of retroviruses, are not specific to retroviruses. The truth of this statement is obvious from an appreciation of basic science and was astonishingly confirmed quite recently by none other than the discoverer of HIV, Professor Luc Montagnier from the Pasteur Institute.[17] Interestingly, in Djamel Tahi's monumental interview, Professor Montagnier gives on one hand while taking with the other. Having conceded the non specificity of reverse transcription, viral-like particles and protein/antibody reactions for retroviruses, he then claims that "it was the assemblage of such properties [in cell cultures] which made me say it was a retrovirus". This is analogous to claiming that since your newborn baby has red hair, fair skin and a beguiling smile, she must be a girl. Or more precisely, that a febrile, asthenic, lifetime heavy smoker coughing up blood must have lung cancer when he might just as well have tuberculosis or a pulmonary abscess. In fact, well before the time of Montagnier's discovery of what has been called HIV, it was well known that the collective phenomena ascribed as retrovirus could even arise spontaneously in normal tissue cultures derived from healthy animals, and that certain stimuli and culture conditions considerably accelerate this process. Significantly, these are the same factors that operate in AIDS patients and are obligatory accompaniments for HIV to "appear" in cultures regardless of their origin from the tissues of AIDS patients. In fact, according to the distinguished retrovirologist George Todaro, if a researcher had sufficient time and ingenuity he could make retroviruses appear in any uninfected cell culture.[18] These retroviruses, that have no parents and materialise from nowhere, are indistinguishable from exogenous retroviruses and owe their existence to latent, DNA genomes in animal cells being handed down to offspring via the germ (sex) cells of parents. They are not introduced into the cells by the action of an external particle. When such endogenous DNA is copied

ne wrong?

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Photo : David Smith, Perth

into RNA and the RNA translated into proteins, ultimately leading to the assembly and release of particles (known in virological jargon as viral expression), the particles are called endogenous retrovirus. *No data ever obtained in the aids era exclude the "assemblage of such properties" known as HIV, if a retrovirus, from being endogenous.* Well before the AIDS era, to explain endogenous retroviruses, retrovirologists claimed that pathogenic processes including diseases may cause retroviruses and not *vice versa*. *No data in the aids era preclude a similar genesis for all the phenomena adduced as HIV including HIV DNA*. Despite the fact that the cell theory of biology transcends all species, as recently as 1994 neither Gallo nor Fauci accepted that what readily took place in animal cells could occur in normal or sick human cells and manifest as human endogenous retroviroviruses.[19] Nowadays it is known that endogenous retroviral genomes constitute at least 1% of the human genome and are present "in all of us" in an amount of DNA 3000 times the size of the HIV genome.[20] It was from a prolonged, intense study of retroviruses, combined with our hypothesis that the common link amongst those with AIDS or at risk is cellular oxidation (this prediction is now well established by numerous papers), that we came to our theory which explains both AIDS *and* 'HIV' (although at the beginning it was politically impossible to argue outright there was no proof for the existence of HIV. Even to accept the existence of HIV but to question a pathogenic role provoked the ire of editors and reviewers and posed more than enough difficulties publishing). The fact is, that at very best, Montagnier's assertion translates to circumstantial evidence for the existence of a unique retrovirus in AIDS patients and as such his ultimate conclusion warrants the strongest rejection. This is especially so given the existence of the method, blessed with the *imprimatur* of the Pasteur institute,[21,22] which leads to unambiguous and direct proof for the existence of a retrovirus. This was well established at least a decade before the discovery of HIV and why it was never used for proving the existence of HIV is one of the many great AIDS mysteries. Perhaps this enigmatic omission will one day serve as a memorial to the rapidity with which the clever age forsook reason under the alluring, imperious cloak of late twentieth century technology.

It is all too easy, and all too human, to get carried away with a host of non-scientific speculation as to why the HIV theory of AIDS is seriously adrift. Thus we have the Russians, the CIA, Africans eating dead monkeys, nepotism at the Centers for Disease Control, the AIDS industry, the seductiveness of the germ theory of disease, self seeking, self aggrandising government and non-government individuals and organisations and profit motives for avaricious biotechnology and pharmaceutical companies, perhaps incorporated into a flavour of the month conspiracy theory. Some of these make exciting reading but in my experience, given the choice of a conspiracy theory or human foibles, it is a far better bet to opt for the latter every time. To hypothesise that one day in the early 1980s a group of scientists colluded with diverse others to deliberately mislead the rest of the world strains belief. There is no need to invoke these kind of agencies in order to point a stolid finger at the problems with the HIV theory. There are abundant scientific reasons why HIV cannot presently be accepted as the cause of AIDS. And in my view, and as is the purpose of this article, the central problem, that is, HIV itself, can be relatively easily explained. To paraphrase Cassius, the fault, lies not in our stars but in our scientist selves. Given the truth of the arguments below, if and when HIV is finally discredited, it will not be for HIV that the bell tolls. It will be for science and those science is meant to serve.

There are several scientific issues we could consider and for the previous readers of *Continuum* most of these ideas are not new. However, it may unmuddy the waters for us all to collect and arrange these into more manageable chunks. The seminal argument is this: For an HIV theory of AIDS we must begin by proving we have HIV. This involves the following steps:

1. Since HIV is purportedly a retrovirus we need to know
   (a) what is a virus;
   (b) what properties distinguish retroviruses from viruses in general.
2. From our knowledge of (1) we must devise a method of proving the existence of a retrovirus in AIDS patients that is congruent with the properties of such a family of viruses.
3. An examination of the published evidence in order to ascertain whether (2) has been achieved for HIV.

What is a virus? The answer is intuitive from common experience. A person in a crowded train is suffering a cold. He or she coughs several times and within hours the former, fellow passengers develop the same symptoms. A child develops hepatitis and a few weeks later his brother and sister complain of anorexia, nausea and soon their skin is also yellow. In turn, these individuals cause others to develop identical symptoms so on. According to the germ theory of disease, the process occurring is that a particle, having a separate existence from the person with the disease, is transferred to another person, invades the cells forming the lining of the upper respiratory passages or liver cells and, in the process of multiplying inside and at the expense of these cells, causes the illnesses. Thus we affirm a virus as a microscopic object (a particle), transmitted from one individual to another and which is able to multiply only at the behest of living cells. The latter property differentiates viruses from bacteria which may multiply on an inanimate source of materials and energy. Not surprisingly, since viruses are obligatory intracellular parasites, they are much smaller than cells or bacteria and do not crowd their limited space with the food and machinery necessary to generate the energy to turn chemicals into copies of themselves. In practice virus particles are a stretch of nucleic acid (DNA or RNA) "instructions" for making proteins (the stretch is called the viral genome), packaged inside a protein core which in turn is surrounded by an envelope containing yet more proteins protecting the viral genome from the rigors of extracellular life. However, the viral envelope is not just packaging. Its chemical nature determines its interactional proclivities and thus for example, to what kinds of cells the particle is capable of attaching and entering, that is, which particular cells the virus can infect. A last but vitally important point is that from an electron microscope (EM) picture it is impossible to claim that a particle is a virus, even if it looks like one. From our definition, being a virus is entirely contingent upon demonstrating that the particles of interest possess the ability to make more of the same particles. This is in fact what is meant by the term infectious and to demonstrate this property experiments are required. All the electron microscope can tell the experimenter is that particles are viral-like (and that the preparation of such particles is pure or impure).

A vitally important point is that from an electron microscope (EM) picture it is impossible to claim that a particle is a virus, even if it looks like one.

What properties make up retroviruses? For the technically minded, these are taxonomical, physical and biochemical. The family *retroviridae* is divided in three subfamilies, *oncovirinae* , *lentivirinae* and *spumavirinae* .[23] *Oncovirinae* are in turn divided into genus type -A, -B, -C and -D particles. These subdivisions are based on EM descriptive properties (morphology), principally a restricted range of diameters, that is, 100-120nM and containing "condensed inner bodies (cores)" and surfaces "studded with projections (spikes, knobs)".[24] According to accepted wisdom, HIV is now classified as a lentiviris but this was not always the case. Past descriptions of the particles found in cultures of tissues from AIDS patients but nonetheless all claimed to be the HIV particle include type -A, -C and -D as well as the current appellation.[13] (This is analogous to describing a new species of mammal first as human, then a gorilla and finally an orang-utan). The principal physical property is a density of 1.16 gm/ml which forms the basis for the method of their purification, that is, separation from everything else that is not retroviral particles. Biochemically, retroviruses are packaged with an RNA (not a DNA) genome and a small number of proteins, one of which is an enzyme which copies RNA into DNA (reverse transcription). Having listed these properties, it is important not to make the common mistake that what is different about retroviruses is unique to retroviruses. Especially their ability to reverse transcribe. Reverse transcription is carried out by hepatitis B virus and indeed by all cells including bacteria.[25] Significantly, particles with the morphology of retroviruses, even those containing a reverse transcribing enzyme, are not proof that a particle is a retrovirus. Gallo himself confirmed this in his writings as far back as 1976.[26] What is said to be "special" about retroviruses is that they insert a DNA copy of their RNA genome into the cellular DNA as a prelude to their reproduction. It is this act, and not the means, that is regarded as the most important distinguishing feature of retroviruses.

What method of proving the existence of a virus is congruent with its definition? This is quite easy to conceptualise although its realisation may prove difficult, tedious and relatively expensive in practice. This unfortunate reality may tempt scientists to adopt shortcuts (see below) and the dangers implicit in the failure to utilise a scientifically authentic method is perhaps no better illustrated than in the caveat issued by JW Beard[27] in 1957 (ironically when the technological craze was electron microscopy coupled with the inconsistent use of pure materials). Beard warned that "identification, characterisation, and analysis [of viruses] are subject to well-known disciplines established by intensive investigations, and the possibilities have by no means been exhausted. Strangely enough, it is in this field that the most frequent shortcomings are seen. These are related at times to evasion ofdisciplines or to their application to unsuitable materials. As was foreseen, much of the interest in the more tedious aspects of particle isolation and analysis has been diverted by the simpler and undoubtedly informative processes of electron microscopy. While much can be learned quickly with the instrument, *it is nevertheless clear that the results obtained with it can never replace, and all too often may obscure, the need for the critical fundamental analyses that are dependent on access to homogenous materials*" (italics mine).

The steps to prove the existence of a retrovirus flow logically from an appreciation of their nature:

1. Culture the cells that are considered infected by the retrovirus particle.
2. Purify putative retroviral-like particles by application of a method that is capable of extracting them from everything else that is not retroviral-like particles (banding in sucrose density gradients).
3. Proof obtained by use of electron microscopy that (a) there are such particles. (It is frankly misleading to proceed as if there are particles when in fact there are none). (b) the particles are pure; (c) the morphology of such particles is consistent with this family of viruses.

The procedure to judge the morphology and purity of particles is to focus one's eye on one particle, decide it has the appropriate size, shape and other distinguishing characteristics, then satisfy oneself that each particle surrounding the first particle is identical, and then repeat this process for

all particles. Retroviral particles need to have a dense core, a diameter of 100-120 nM, to be almost spherical and to have their surface studded with knobs approximately 10nM in length.

4. Disrupt a preparation of pure particles and analyse the constituents (RNA and proteins). The latter must include an enzyme able to catalyse the synthesis of DNA from a piece of RNA.

5. Take a preparation of pure particles and prove that such particles, when introduced into fresh, uninfected cells, produce exactly the same particles, that is, the particles are infectious. This necessitates repeating steps (1) to (4). Thus proving the existence of a retrovirus involves isolating the particles twice. (And although it may seem trite to need even mention the fact, viral proteins and RNA are those and only those proteins and RNA that appear following disruption of purified viral particles).

Indeed, (1) to (5), with the addition of experiments involving control cultures of cells obtained from sick, non-AIDS affected individuals with AIDS-like diseases, are the challenge underlying the *Continuum* prize. (This £1000 reward is for a scientific paper proving that HIV exists and is still on offer). For those scientists who fail to use suitable controls (and that is the vast majority of HIV experts), "Nature will soon make a complete fool out of you" if the "assemblage of such properties" is also observed under circumstances where there are no retroviruses. Here it is not necessary to go into details since the views of the Perth group have been published in the scientific literature since 1988. Suffice it to repeat categorically that to date no HIV/AIDS researcher has published such evidence for HIV. Indeed, the interview with Professor Montagnier revealed that (a) despite a "Roman effort", he was unable to find any viral-like particles in his "purified" specimens. (Whatever the other "assemblage of such properties", no particles, no virus but these are the very specimens from which all HIV/AIDS researchers and biotechnology companies obtain "HIV" proteins and RNA by the ton for use in diagnosis and treatment); (b) despite not having any evidence for the existence of retroviral-like particles in his 1.16 gm/ml sucrose density gradient this material was used in other experiments to pronounce certain proteins in this culture "soup" as the "viral" proteins; (c) in his opinion neither did Gallo purify his HIV. Thus, according to the disparity between the definition of a virus and the evidence provided by Montagnier in 1983 and Gallo in 1984 (and everyone else since), there is no scientific proof for the existence of HIV. This leaves us with the uncomfortable question as to why, despite this lack of evidence, does nearly the rest of the world appear to believe otherwise and boldly act on the consequences of this belief?

Photo : Pasteur Institute

Luc Montagnier
"It is firmly entrenched in the public record that both in May 1983 and July 1997 Montagnier had no evidence of viral-like particles in his 'purified' specimens."

Perhaps the first thing necessary to discuss is the notion of "the rest of the world". Given the population of Earth, only a tiny proportion of the "rest of the world" consists of physicians. However, physicians as an example, are far more likely than most to possess knowledge and understanding of the laboratory experiments that are said to support the existence of HIV and the HIV theory of AIDS. But in practice and of necessity, physicians, even specialist physicians, need to accept in good faith the vast majority of claims that form the basis of their practice. Medical training including postgraduate and continuing education consists of so much data that it is impossible to treat every statement as a scientific investigation. For example, as far as HIV/AIDS is concerned, the average, busy, practising doctor accepts that HIV has been isolated and that a positive HIV antibody test signifies HIV infection. However, the same doctor has little or no idea that seropositivity is defined by use of a discriminatory test called the Western blot, how a Western blot is manufactured, constructed and read, and that Western blots positive under the interpretive rules of one country or institution are not positive under the rules of another. The position with the properties of retroviruses or the rules of isolation is far worse. In my experience even HIV/AIDS experts are not aware that reverse transcription is non-specific for retroviruses, for example, that normal lymphocytes, grown under the influence of the same chemicals obligatory to produce "HIV" from co-cultures of tissues from AIDS patients[28,29], as well as normal spermatazoa,[30] reverse transcribe RNA including the same synthetic RNA used to "prove" the existence of HIV reverse transcriptase. Or that retroviral particles are purified taking advantage of their density by banding at 1.16 gm/ml in sucrose density gradient solutions. In my view, the clinician is excused for failing to appreciate the implications such knowledge poses against the HIV theory of AIDS. But not the experts. Thus, the oft heard statement that "99.99% of the world's scientists can't be wrong that HIV exists and is the cause of AIDS" needs to be reworked. The reality is that nearly all the world's scientists, along with the remainder of humanity including virtually all the remaining non-scientists including physicians, accept the HIV theory of AIDS because they are wedded to the word of a relatively tiny number of specialists whose positions assert their claim on the basis of being experts. In the religion of science, these few are sacrosanct. This view is not meant to trivialise in a political sense the power of experts or the effect of that power magnified by public opinion. After all, for aeons 99.99% of the world's authority figures asserted to an accepting populace that the sun circled the earth and flying machines an impossibility. Indeed, there is little doubt that the experts feel their views *are* scientifically justified. But, and here is the rub, according to the rules of proof determined by the properties of retroviruses, no expert can claim there are experiments which prove the existence of HIV *according to the schema detailed above*. There are no such experiments. Notwithstanding, even though it is firmly entrenched in the public record that both in May 1983 and July 1997 Montagnier had no evidence of viral-like particles in his "purified" specimens, the status quo staunchly remains. This represents the most pernicious kind of folly because, although there are no scientific impediments to a debate, the experts, the institutions and the journals steadfastly refuse to engage. One is led to wonder how far our civilisation has progressed since the murder of Giordano Bruno and the trial of Galileo? And who is paying the ultimate price?

The 1983 Montagnier paper[31] and the four, 1984 Gallo papers,[32-35] all published in *Science*, the journal founded by the philanthropy of Alexander Graham Bell, purportedly prove the existence of HIV and that HIV causes AIDS. Unfortunately, to the chagrin of "the rest of the world", these papers contain a plethora of unfamiliar data and detail none of which make for light reading. Nonetheless, it is possible to take a few steps back from the data presented in these

crucial publications and begin to understand why their conclusions are so unreservedly unwarranted. (It is also important to note that these papers remain the very best published on the existence of HIV. None more modern is even remotely nearer the mark and to this day these are the papers cited as proof of HIV and causation). What soon becomes obvious, and as Montagnier has recently affirmed is, that in place of the logic and rigor demanded by the steps discussed above, a series of nonspecific phenomena has been accepted as proof for the existence of HIV. From papers he published in the 1970s we know Gallo at least realised that particles and reverse transcription are not sufficient to prove the existence of retrovirus. In other words Gallo realised the need to demonstrate replication to prove that particles bearing the expected morphological and biochemical properties of retroviruses are not exanimate and are in fact retroviruses. For example, in 1976 he wrote, "Release of virus-like particles morphologically and biochemically resembling type-C virus but apparently lacking the ability to replicate have been frequently observed from leukaemic tissue".[26] Whether he appreciated it or not, this concession by Gallo is in fact no more than an acknowledgment of the "particle problem", the same problem that exercised the minds and pens of researchers such as JW Beard two decades earlier. The "particle problem" is that cell cultures have the propensity to produce a myriad of particles of many morphologies and thus strict rules must apply to make sense of this menagerie, that is, which if any particles are viruses and which are not. Beard's own words[27], again no more than common sense, preempt by two decades the Pasteur rules for the isolation of retroviruses. "...the scheme of approach, as well illustrated by that devised and rigorously tested in investigations of viral agents, is relatively simple. This consists in (1) isolation of the particles of interest; (2) recovery (purification) of the particles in a given preparation that are homogeneous with respect to particle kind; (3) identification of the particles, and (4) analysis and characterisation of the particles for the physical, chemical, or biological properties desired". To confirm retrovirus-like particles as a retrovirus the quintessential biological property required is proof of their ability to replicate. However, given there are no published data that retroviral-like particles have been isolated, analysed, reintroduced into fresh culture and subsequently reanalysed, we must conclude that HIV researchers regard other data as proof of replication. What are these data?

For HIV/AIDS researchers the crux of their proof is the fact that some antibodies in AIDS patients react with some proteins that exist in the chemically stimulated cultures of lymphocytes derived from the same patients. (So what, we may wonder and even if significant, where is there evidence of a nexus between reverse transcription and antibody/antigen reactions in a test-tube, and the scant particles seen only in unpurified material?) If we adopt the premise that there do exist unique, exogenously acquired retroviral particles, HIV, which causes thirty different diseases (AIDS), certainly we would expect proteins from unpurified cultures or from a 1.16 gm/ml sucrose density gradient (the latter regarded by all experts as the "purified virus") from such individuals to interact with antibodies in the sera of AIDS patients. This is because such particles will be expected to replicate in humans (as well as in their cell cultures), and induce antibodies *in vivo* because they are foreign. However, in the HIV expert scheme, "proof of replication" relies not only on assuming the existence of such antibodies but also on the specificity of protein/antibody reactions, that is, given the existence of an agent HIV, this agent and this agent alone is capable of stimulating the clones of B lymphocytes that produce particular antibodies which are the only antibodies capable of reacting with particular culture proteins which are constituents of HIV. Apart from adopting the very premise they are setting out to prove, the mistake made by all HIV researchers is the overvalued idea that antibody/antigen reactions a priori are specific. (The argument is also circular since antibodies are used to "prove" which proteins in the cultures are "HIV" and then these proteins are used to "prove" the antibodies are "HIV"). Antibody/antigen reactions do not possess such specificity properties, a fact well publicised and discussed in most immunology text books and by many research scientists such as Stratis Avrameaus from the Pasteur Institute. Antibody molecules, even monoclonal antibodies, may not interact only with the inducing antigen but also with other antigens, that is, antibodies "cross-react".[36-42] Indeed, there are instances where "cross-reactive antigen binds with *higher affinity* than the homologous antigen itself...The most obvious fact about cross-reactions of monoclonal antibodies is that they are characteristic of all molecules and cannot be removed by absorption without removing all reactivity...Even antigens that differ for most of their structure can share one determinant, and a monoclonal antibody recognizing this site would then give a 100% cross-reaction. An example is the reaction of autoantibodies in lupus with both DNA and cardiolipin" (italics mine). However, "It should be emphasised that sharing a "determinant" *does not mean that the antigens contain identical chemical structures*, but rather that they bear a chemical resemblance that may not be well understood, for example, a distribution of surface charges"[43] (italics mine). Since polyclonal [mixtures of] antibodies are no more than a miscellany of monoclonal [single] antibodies these facts apply equally, if not more so, to polyclonal antibodies. Thus HIV/AIDS experts, in ignoring the "particle problem", have come hard up against the "antibody problem" and, in apparent ignorance of this fundamental problem, have fallen foul of Nature and been misled into thinking something that is not actually known. However, the bitter consequence of this logical slip is the contrivance of a retrovirus and a retrovirus theory of AIDS. Indeed, given (a) the experimental methods employed by HIV/AIDS researchers; (b) that retroviral-like particles are virtually ubiquitous in biological material; (c) that reverse transcription is likewise a commonplace and trivial cellular function; (d) the many and varied pathological processes associated with antibodies each with propensities to cross-react with an array of antigens; a jocose sceptic might logically argue that sets of the "assemblage of such properties" await future generations of robustly funded virologists and the discovery of a host of new retroviruses as causative agents of perhaps all diseases.

To prove HIV isolation, both Montagnier and Gallo and their colleagues also employed sera from rabbits which they claimed contained "specific reagents"

This also leads to yet another great AIDS mystery. To prove HIV isolation, both Montagnier and Gallo and their

colleagues also employed sera from rabbits which they claimed contained "specific reagents".[44] However, rabbits do not develop HIV infection or AIDS and if such specific antibodies were to exist they could only be produced by immunisation of rabbits with *pure HIV* or, as the first Gallo group paper reported, "from rabbits infected repeatedly with disrupted HTLV III [HIV]". If rabbits were immunised with pure virus, why should it be necessary to produce specific reagents to define the isolation of virus that had already been isolated? That an antibody/antigen reaction cannot be used to prove the existence of a new virus is accepted by Donald Francis, a researcher who with Gallo, played a significant role in developing the theory that AIDS is caused by a retrovirus.[45] In 1983, Francis, then the chief collaborator of the AIDS Laboratory Activities, US Center for Disease Control (CDC) and former chief of the WHO smallpox program, speculated on a viral cause for AIDS: "One must rely on more elaborate detection methods through which, by some specific tool, one can "see" a virus. Some specific substances, such as antibody or nucleic acids, will identify viruses even if the cells remain alive. The problem here is that such methods can be developed only if we know what we are looking for. That is, if we are looking for a known virus we can vaccinate a guinea pig, for example, with *pure virus*... Obviously, though, if we don't know what virus we are searching for and we are thus unable to raise antibodies in guinea pigs, it is difficult to use these methods...we would be looking for something that might or might not be there using techniques that might or might not work"[46] (italics mine).


Antivirals fail to [illegible] all T-Cells

Conference hears over a third fail on combos

Glaxo warning follows abacavir disasters

Pinching: 'Decisions being made on basis of early research'

Doc claims dual combo therapies not beneficial

Significantly, at the time when gay men were first developing the diseases which now constitute the clinical AID syndrome, scientists should have well and truly been aware of the humiliating *caveat* consequent upon the sudden, 1980 "disappearance" of the world's "first human retrovirus", Gallo's HL23V.[15] Even though the laboratory evidence for the existence of HL23V surpasses that of HIV, HL23V fell ignominiously from its proud place because "its" antibodies were found to be antibodies that form in response to a large range of non-viral, non-infectious agents which are common in human populations. In the view of the scientists who made this critical discovery, these antibodies follow "exposure to many natural substances possessing widely cross-reacting antigens and are not a result of widespread infection of man with replication-competent oncoviruses [retroviruses]".[47] The intriguing part of this murky episode of virology is that although Gallo conceded the nonspecificity of the antibody reactions for the purposes of defining certain culture proteins as "HL23V" proteins (exactly the same method is used to define the "HIV proteins and thus "HIV"), the common belief remains that HL23V was a contaminant mixture of monkey retroviruses. Reading to learn the history of this episode one cannot help be impressed by Gallo"s detailed account as to how difficult (if not impossible) it would have been for such contamination to occur in his laboratory. However, from the point of view of retrovirology, contamination is a far more propitious explanation because it at least is congruent with the existence of a retrovirus (or retroviruses) albeit nonhuman, rather than no retrovirus(es). Given the latter, the use of antibody/culture protein reactivity to "prove" the existence of retroviruses would long have been seen to have much to do with sophistry and nothing whatsoever to do with science. This follows because, in the case of HL23V, antibody reactivity would have predicated the presence of a virus which does not exist. This episode, more than anything else, illustrates just how fragile is the notion of HIV. When dispassionate scientists and others realise what is actually the basis for the characterisation of proteins deemed to be HIV, and accept the already abundant evidence that, like antibodies to HL23V, "HIV"antibodies arise where there is no HIV, HIV will likewise fall. (It is worth adding that as far as AIDS is concerned, it is sufficient to argue that HIV has not been shown to exist. There is no need to postulate that no retroviruses exist. To present such data and argument, while of scientific interest would represent a gargantuan effort both diversionary and irrelevant to the current problem).

In summary, what can be said is this: In their attempts to prove the existence of HIV, HIV/AIDS researchers have made two fundamental mistakes. They have ignored the particle problem and have either ignored or misunderstood the antibody problem. Rather, in seeking their goal, the few scientists involved have adopted the premises that (i) a retrovirus does exist; (ii) it is present in AIDS patients; (iii) it induces specific antibodies *in vivo*; (iv) it can be successfully cultured *in vitro* from tissues derived from AIDS patients; (v) the antibodies interact specifically with particular proteins in such cultures. Although these postulates may ultimately prove correct, since none can be verified without recourse to the virus ("virological *habeas corpus*"), they cannot be used as a platform from which to interpret experimental data as proof of the existence of HIV. In virology as in life, one cannot put the cart before the horse. The reality is this: when it is pared down to the essentials, what masquerades as proof of the existence of HIV is sets of antibody/antigen reactions between two sets of unknowns (culture proteins and antibodies). And for those unlucky enough to possess the cells or antibodies capable of producing similar reactions, the enormous weight of the HIV theory of AIDS becomes their lifelong yoke. This, the HIV theory of AIDS, is *par excellence* an example of Robert Pirsig's warning, *"One false deduction about the machine and you can get hung up indefinitely"*. However, from the scientific point of view, it is still possible that experiments, properly constituted (with controls) as enumerated by JW Beard and the Pasteur Institute, could be performed to prove there is a bona fide, so called HIV. This would represent an admission of the pressing need to start out all over again but even if successful, would not overcome the other multitudinous

difficulties accepting that such an HIV is the cause of AIDS. Thus, in the absence of scientific evidence that it even exists, thorough investigations of alternative hypotheses should be urgently pursued, especially those that offer hope of control or even cure for the many affected.

The final matter to consider is how long humanity must endure the scientific misdemeanors of the HIV/AIDS experts. Or to be unreservedly blunt, since gay men with AIDS far out number all others, when will gay men wake up? Consider for a moment the strange but true story of the current "technological craze", the use of AZT and protease inhibitor (PI) "cocktails" to treat both AIDS patients and healthy seropositive individuals. Both classes of drugs are stated to prevent viral replication, that is, they are claimed to interfere in the cycle of newly hatched HIV particles infecting fresh T4 cells and generating more HIV particles to infect more cells and so on. According to HIV "science", AZT does this "on the way in", PIs "on the way out". Thus AZT prevents HIV copying its RNA into the nuclear, DNA proviral form while PIs produce defective, incompetent HIV. Either way, no "new" HIVs arise capable of perpetuating the replication cycle. According to David Ho, "virus producing" infected T4 cells die after only a few days. Thus, after a short time (weeks) on these drugs, T4 cells already infected should die (thus eliminating their contribution to the viral DNA equation), and no new cells should become infected (no new viral DNA can enter the equation). Thus the level of viral DNA, (referred to as the "viral burden", not to be confused with "viral load" which is RNA measured in plasma) should decrease. However, neither class of drugs has any effect on viral burden. [48-50] The levels are unmoved by administration of these drugs. The failure to decrease viral burden means the drugs cannot work in the manner stated and/or that "HIV DNA" (and thus HIV) has nothing to do with the beneficial effects (if any) of these agents. If the latter then what does HIV have to do with causing AIDS? And to pour salt into the wounds, any increase in T4 cells observed in individuals taking AZT is claimed to be caused by decreased HIV despite the fact that AZT raises the number of T4 cells (sometimes dramatically) in humans who take it following a needlestick injury but who never seroconvert.[51,52] Notwithstanding, various HIV/AIDS experts are now proclaiming that PIs, like AZT from the earlier days, are doomed to failure. Researchers at the University of California at San Francisco, who first reported a failure rate of more than 50%, say the "honeymoon" is over. A recent paper in the journal *AIDS* reported that three PIs failed in 30-64% of patients. Given all the hope (and hype) made over these drugs at various times, perhaps there may at last be a catalyst to a denouement. The more one reads, and the more one studies the vast HIV/AIDS literature, the more it becomes apparent that the data are far better explained without recourse to an HIV. I reiterate our group's earlier position: HIV is the greatest single obstacle to overcoming the problem of AIDS[14]. In the sixties Bob Dylan put it all in a song: "How many deaths will it take till he knows that too many people have died?". Reprehensibly, the answer is still the song.

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The doctors' dilemma

HIV Adverse Drug Reactions Reporting Scheme

An extension to the Yellow Card Scheme

excerpted from
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The Medicines Control Agency (MCA) UK and Committee on Safety of Medicines (CSM) in collaboration with the Medical Research Council HIV Clinical Trials Centre (MRC) launched the HIV Adverse Drug Reactions Reporting Scheme in November 1997.

Reasons for launching the scheme
Over the last few years, various new drugs have become available for the treatment of individuals with HIV1. Several of the new drugs were authorised on the basis of clinical trials studying small numbers of patients which were designed to show changes in surrogate markers of disease (CD4 lymphocyte count and HIV RNA viral load).1 Therefore, at the time of authorisation, only limited data were available on their safety.

Recent safety issues
Since these drugs were marketed, spontaneous reporting has identified a number of important adverse reactions to anti-HIV drugs including:
• diabetes mellitus with protease inhibitors; saquinavir (Invirase), ritonavir (Norvir), indinavir (Crixivan)2, and nelfinavir (Viracept).
• haemolysis with indinavir.3
• severe fatty change of the liver and lactic acidosis with all the available nucleoside analogues; zidovudine (Retrovir), didanosine (Videx), zalcitabine (Hivid), stavudine (Zerit) and lamivudine (Epivir).
• lipodystrophy/redistribution of body fat with combinations of anti-HIV drugs which include protease inhibitors.

How the scheme works
The scheme is an extension to the Yellow Card Scheme, and invites reports of severe or serious suspected adverse drug reactions from specialist health professionals working with people with HIV. Reporting forms specific for the scheme are available from HIV Adverse Drug Reactions Reporting Scheme, Freepost, London SW8 5BR. Others should continue to report suspected adverse reactions to these drugs on Yellow Cards. Reports are handled in strict confidence and will be analysed jointly by the MCA, CSM and MRC. Information from the scheme will be fed back to reporters through this bulletin [*CPP*] and a newsletter called HIV Adverse Drug Reactions Reporting Scheme News.

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2. MCA/CSM *Current Problems in Pharmacovigilance* 1997; 23:10
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COUNTERCULTURE

The HIV™ Haute Couture Habitus

by Alex Russell MA(Thames)

Photo : Tony Thompsett

"The new, sought for its own sake, a kind of laboratory product, petrified into a conceptual scheme, becomes in its sudden apparition a compulsive return of the old, not unlike that in traumatic neuroses…Faithlessness and lack of identity, pathic subservience to situations, are induced by the stimulus of newness, which as mere stimulus, no longer stimulates…The occultist draws the ultimate conclusion from the fetish-character of commodities: menacingly objectified labour assails him on all sides from demonically grimacing objects."

ARMANI™, GAULTIER™, GUCCI™, HIV™ are just some of the over-hyped designer labels that fags are 'into'. HIV™ is a 'must have' haute couture accessory sought after by aspiring gay men who see 'HIV+ status' as just that: a status symbol, a form of economic, cultural and symbolic capital. The 'HIV' High Life offers many perks, pleasures, publications and products from the 'HIV' Culture Industry Shopping Malls.

The fetish-object 'HIV' is a paradigm example of what Karl Marx formulates as 'commodity fetishism'. In a society in which the products of human Labour acquire the form of commodities, the crucial relations between people take on the form of relations between things, between commodities - instead of immediate relations between people, we have social relations between things. It is precisely this thing 'HIV' that stands in for human relationality. 'HIV' becomes the ventriloquist's dummy through which the human subject mimics, believes, acts. Those that are ideologically interpellated as 'HIV+' become object-ified: relating to others as a 'thing', as the commodity fetish object 'HIV'. That is: 'they' no longer 'believe' but the 'things' themselves 'believe' for them. The point of Marx's analysis is that the things (commodities like 'HIV') themselves stand-in the place of the human subject: it is as if all beliefs are embodied in the "social relations between things". Their 'beliefs' are embodied in 'HIV' Ideology which 'speaks' them. Why do many gay men 'wear' their custom-tailored 'HIV+ status' as a haute couture accessory? Because as a form of 'drag', the designer-label 'HIV' masks the 'real-conditions' of the 'material-body'. The body's 'hidden history' (multiple-STD's, psycho-immuogenic illness and drug-use) that form the 'AIDS-body' are 'erased' (stifled facts) and 'clothed' by the haute couture garment - 'HIV'. What is absurdly and wrongly termed 'HIV dementia' is an example of this clothing, masking. Pseudo 'HIV dementia' covers-up, 'clothes', veils, what is really contributing to dementia in PWA's: long-term heavy recreational drug use, nutritional deficiencies, AZT (mono or with combo) and bone-pointing death-programming. The AIDS Memorial Quilt is like visceral VERSACE™ veneer veiling the venomous poison that drips from the fangs of the cunning 'HIV Combo' Corporate corpse collectors.

It is the 'HIV Habitus' which constitutes the (re)production of the 'HIV' Commodity Culture through mass media, welfare services, pharmaceutical industries, political lobby groups and lifestyles filtered via the 'diagnosed' consumers. Habitus may be understood as a social space, a structure that organises, reproduces/disseminates cultural practices within a classified group of people. Sociologist Pierre Bourdieu explains: "The habitus is not only a structuring structure, which organises practices and the perception of practices, but also a structured structure: the principle of division into logical classes which organises the perception of the social world is itself the product of internalisation of the division into social classes. The habitus generates representations and practices which are always more adjusted than they seem to be to the objective conditions of which they are the product". The 'HIV' Culture Industry is largely marketed by petit-bourgeois empire-builders. The petite-bourgeoisie are found in the occupations involving presentation and representation (sales, marketing, advertising, fashion) as well as jobs in medical, charity and social assistance and in cultural production (media, journalism). One only has to scan the field of the 'HIV' Culture Industry (charity directors, journalists) to see that it is dominated by these dross petit bourgeois bureaucrats. Known as 'need merchants', sellers of 'HIV' related symbolic goods and services see themselves as models and as guarantors of the value of their products who 'sell so well' because they 'believe' in what they sell. Their 'HIV Habitus Ideology' (an internalised programme of predetermined and formulated judgements) is materialised in their 'HIV' manifestos which reek of reactionary conservatism and intellectual stagnation. The petit-bourgeois mentality of 'narrowness', 'bigotry', 'petty-mindedness' is the mind-set of the 'HIV' con-merchants whose stock-in-trade is to sell 'HIV' as a 'household name' to 'reach a wide audience'(something that 'affects us all'): thus packaging 'HIV' as a 'family concern'. They are the vendors who deceive the customer (only insofar as they deceive themselves) - but in the 'belief' that the product 'HIV' is 'sincerely' sold. Theodor Adorno sums this up: "The ungenuineness of the genuine stems from its need to claim, in a society dominated by exchange, to be what it stands for yet is never able to be". Just like the logo 'HIV'.

According to Bourdieu the whole dynamics of consumption is primarily based on the strategies of distinction - of those representing 'good' or 'legitimate' taste. Buying 'HIV+ status' is seen as a chic 'status symbol' of the new petit-

bourgeois fag life-style. Taste or consumer desire is the result of struggles between different class groups. The designer label HIV™ is something 'they' mimetically 'wear' with smug snide 'pride' ; many introducing themselves with the vulgar inanity: 'Hello, I'm HIV'! (How many people do you know who introduce themselves with: 'Hello, I'm HHV-8', 'Hello, I'm Ebola virus', 'Hello, I'm KS'?) 'HIV' is predominantly marketed and sold to gay consumers. *The New York Times* (5 July,'96) reported: "It is almost impossible to pick up a gay magazine these days without seeing four page ads for Invirase...". Many gay men buy into 'HIV' because they see in this object of desire a reflection of themselves, as elective affinities, 'feeling at home' with 'HIV'. Taste is what brings together things and people that 'go together'. Many 'diagnosed' fags see 'their HIV' as 'made for them'. Taste is a match-maker: 'HIV' is often perceived as an alter ego or idealised-partner. 'GAY'™identity is synonymous with 'HIV'™ identity: they are 'made for each other', a 'well-matched couple'. 'HIV' has become an object of narcissism and cultural capital for many fags. Like the possession of luxury goods, 'HIV' becomes the object of value that reflects-consolidates the owners' (diagnosed) cultural status and symbolic power: one's 'HIV' status becomes a register for one's cultural (and even economic) value. When asked "What does HIV status mean to you?" - these were some of the replies: "With HIV, you become somebody - you get noticed", "It's the done thing to be", "As the élite-set, you become part of a community and meet interesting people", "HIV is my security blanket - it keeps me warm, snug and cosy" and "I was nothing untill I was HIV": at The Landmark,'98.

Shaw™ is now available under five brand labels: Porn Star, Pro Star, Pop Star, Poet Star, Poz Star

Porn star, poof, prostitute, pop-singer, poet and self-propagandist Aiden Shaw™ has made his narcissistic self-love find its 'mirroring' in his object of desire, 'HIV': "And so I got HIV, just as I'd wanted. I laughed when I was told. It was such a relief. Every thing fell into place. The future was clear; there was no need to worry about a career or old age. My marginalisation and self-image was distilled, purified. An HIV community materialised where the mythical gay one never had....so I hitched a ride with HIV." - *POZ*, November,'97. Aiden Shaw™ went shopping for a customised brand-label and bought 'HIV'. Thus the brand-labels Aiden Shaw™and 'HIV'™ are 'made for each other'. With Shaw™ and HIV™ it was 'love at first sight' - or love at first testing site. He said regarding one of his porn films in *Attitude*, February,1998: "In this video they were paying for my name on the box. I was a label". Shaw™ is now available under five brand labels: Porn Star, Pro Star, Pop Star, Poet Star, Poz Star. Shaw™ stated he will only 'perform' in porn films with other 'positives' setting up a sort of pernicious positive-porn apartheid. Shaw™ is reduced to the realm of reification and standardisation: no longer 'a self' he takes his place as an over-priced, over-determined commodity object on a display rack waiting to be noticed, paid for, consumed and shitted-out. His identity lies in non-identity. Shaw™ and HIV™ have become objects of symbolic overdetermination. Many fags want 'to be noticed' as both 'GAY' ™ and 'HIV'™ which is like having a double noble-title. They become their own advertising agents and billboards for their consumer identities. It is not surprising that 'GAY' identity 'goes hand in hand' with 'HIV' identity: as consumer identities they both operate through the 'world of appearances'. 'GAY' identity like 'HIV' identity is essentially role playing 'make believe' since both 'perform' at the level of mimetic representation. The petit-bourgeois credo: 'His Home is His Castle' becomes: 'His HIV status is His Lifestyle'. 'GAY' (Subject-ivity) and 'HIV' (Object-ivity) are assemblages, collages, constructs, necessary illusions. Primarily no one is anything: everyone is nothing. Cultural analyst Mark Cousins on identity: "There is no such original thing such as identity: (where identity is considered to be the identity of one thing with itself).The psychoanalytical proposition is that the identity of a thing is first of all is a secondary thing; it is not what defines the essence or the pure interior of a subject: it is a secondary characteristic which is built upon the activity of identification. And the mechanism of identification is one that shows us that identity is something in which the thing is never identical to itself but is in fact always different from itself.." (lecture: 17th November, '95, London).

Thus, identity is a constructed and secondary characteristic - the primary characteristic is the act of identification. People identify with 'HIV' by treating it as a 'mirror'; just like a fag who goes into a VERSACE™ store and picks up a garment and says : "Do you think that's Me!" (identifying himself with the item). This is the mechanism of identification. So fags identify with the object 'HIV' as if it had always already come from 'within' them; not as an 'exogenous infection' but as an endogenous projection. Behind this idealised-image of 'HIV' will always be the possibility of it breaking down (especially in the context of the Eleopulos exquisite deconstruction of 'HIV') As we are made up of internalised objects (like 'HIV') then such objects will be projections of subjects, of us. This is why many fags become hurt, defensive and angry (responding with abject horror) when you tell them that 'HIV' does not exist: - since this implies that they do not exist. Their identity is found in non-identity. There is no clear distinction, demarcation between the subject and object: human subjects are arrangements of internalised objects. Thus objects become projections of subjects: the 'HIV'object thus becomes fused with the 'GAY' subject. The status of the subject itself (the subject of the signifier 'HIV') is that of a 'virtual image': it exists only as a virtual point that is never present in 'reality' but in some virtual void of science fiction. As 'HIV' is an error, a mistake, an abstraction, then the subject that 'identifies' with 'HIV' is thus identifying with an error, a mistake: hence the subject's identity is always already null and void. The subject that seeks 'reflection' in 'HIV' becomes the smashed mirror of misrecognition. Abject 'HIV' is the 'black spot', a 'black hole', that cannot reflect.

Cultural theorist, Slavoj Zizek pinpoints the fact that people know that objects such as 'HIV' are necessary illusions but still hold on to them: "We have established a new way to read the Marxian formula 'they do not know it,

but they are doing it': the illusion is not on the side of knowledge, it is already on the side of realty itself, of what people are doing. What they do not know is that their social reality itself, their activity, is guided by an illusion, by a fetishistic inversion. What they overlook, what they misrecognise, is not the reality but the illusion which is structuring their reality, their real social activity. They know very well how things really are, but still they are doing it as if they did not know". They know very well that 'HIV' does not exist, but still they are believing as if they did not know. The subjugated 'HIV' subject is the slave-object of science fiction. Joining in the 'collective belief' of 'HIV' consumer fetishism constitutes, reproduces and legitimates the illusion of 'HIV' Cultural Identity. Bourdieu explains: "Culture is a stake which, like all social stakes, simultaneously presupposes and demands that one take part in the game and be taken in by it; and interest in culture, without which there is no race, no competition, is produced by the very race and competition which it produces. The value of culture, the supreme fetish, is generated in the initial investment implied by the mere fact of entering the game, joining in the collective belief in the value of the game which makes the game and endlessly remakes the competition for the stakes". Fags join "in the collective belief in the value of the game" of virtual 'HIV'testing thus endlessly promoting the value of the 'HIV' culture industry which is geared to mimetic regression and to the insidious manipulation of repressed impulses to copy and regurgitate 'HIV' life-style tracts. From science journals to the gay press tripe 'HIV' related science fiction is sold to a largely regressive and uncritical consumership.

Selling and Buying 'HIV' is an industry all of its own where the pharmaceutical industry and the culture industry have marketed a highly profitable and desirable product. Dr. Milo Gibaldi wrote in his essay *'The Commerce of HIV Disease'*: "From the outset it was a business...Today, the U.S. Patent and Trademark Office has awarded more than 1,500 patents related to HIV and AIDS. Sales of diagnostic and monitoring kits in 1995 were $186 million, and analysts project a 50 percent increase by the year 2000...Cumulative worldwide sales of AZT to date: $2.5 billion..." One reason that 'HIV' testing has become in vogue and pushed is precisely because the 'HIV' Services are facing Titanic cut backs; notably in London the Terence Higgins Trust, The London Lighthouse have hit the iceberg while the HIV Project has sunk. Recently Crusaid, London ran the ichor (blood like flowing) 'Try this HIV test?' campaign adverts (at an obscene cost of £260,000) in *The Pink Paper,Boyz, Axiom, Attitude, Gay Times* and *Thud.* The fag press are greedy enough to take 'HIV' blood-money advertising revenue without having the integrity to inform their readers as to the non-specificity of these pastiche 'HIV antibody' tests. The fag press endlessly-ape the vacuous 'HIV' waffle offal because it is 'easy listening' and 'tailor made' for their retard readers. The kindergarten-babble of 'HIV' journalism is on the same level as a syrupy Eurovision Song Contest ditty: easy to hum along to. The metaphor of muzac aptly mimics the intellectually barren discourse of 'HIV science': 'facile effects', 'banal', 'dross', 'undemanding', 'superficial', 'frivolous', 'repetitious', 'mundane', 'bilge', 'trite', 'light'. In contrast Dr David Roscoe (Biology, University College London) found the *Continuum* supplement 'The Isolation of HIV: Has It Really Been Achieved? The Case Against' by Eleopulos *et al* - "too heavy and difficult to understand" - when one of his students, Rajah Hassain, gave him the paper as a reference for a project proposal (taking on the question of 'HIV' isolation.) Mr Hassain was advised to drop the idea as it would be "too difficult" for him to understand.

Intellectually lazy fag journalists find it easier to 'go along' with the insipid 'HIV' world-view with their ethos of 'keep it simple' and 'keep it short' by giving fag-fodder tripe entrails on 'HIV Reader's Digest' (while ignoring the complexities of iatrogenic and psychogenic illness). The international fag press and the fag journalistic field is permanently subject to trial by market, whether directly, through advertisers, or indirectly through audience ratings. Moreover, as *The Pink Paper*, *Boyz*, *Positive Nation*, *Positive Times* and *Axiom* are distributed free they largely depend on 'HIV Industry' advertising revenue to keep in business. Recent 'HIV' propaganda adverts in London's fag press featured designer-bodied, designer-dressed, affluent 'bourgeois' fags shopping at a high-class supermarket, trolley adorned with expensive consumer goods. Here 'HIV+' is marketed as a sign of cultural capital and upward mobility. Many fags were no-bodies until they were marketed as 'HIV+': they became heavily State-subsidized celebrities over night. Buying 'HIV' class-status opens doors to lucrative careers. 'HIV Officialization' can be seen as the process whereby the group (or those who dominate it) teaches itself and masks from itself its own truth, binds itself by a public profession which sanctions and imposes what it utters, tacitly defining the limits of the thinkable and so contributing to the maintenance of the 'HIV' social order from which it derives its power. Hence the gay culture industry has become subsumed by the 'HIV'Culture Industry; the latter informing the former on cultural practices and life-styles. Pharmaceutical multinationals have a powerful symbolic and economic control over gay culture by selling the whole louche 'HIV' show to gullible gay shoppers. Hard-sell advert slogans such as Bristol-Myers Squibb's Orwellian newspeak 'HIV POSITIVE THINKING' and Crusaid's sacramental 'Try this HIV Test?' set the obscene and facile 'HIV' Life style agenda. Fags get 'into testing' because they see it 'as the done thing' and want to 'keep up with fashion': it is seen as the 'proper thing to do'. Buying 'into HIV' means shopping for a multiple range of pharmaceutical products and social services from the 'shop till you drop' over-priced 'HIV' shopping malls.

'NEW, liquid SPORANOX® gets THRUSH out of your mouth' : "These laughing Jaws with gleaming white teeth remind one of a hideous hyena with diffuse diarrhoea."

'HIV' is intrinsically 'bought' by gay petit-bourgeois consumers: along with their mock 'HIV+' status and mock 'antiretroviral' drugs, they are 'into' mock-luxury furniture from Ikea and build mock-'Olympian' bodies to display on mock luxury holidays at Mockynos. Fags buy 'HIV' because, as a product, they see it as 'value for money', as 'cheap and long-lasting', as well as 'trendy', 'fashionable', 'up-market' and 'fun-loving'.

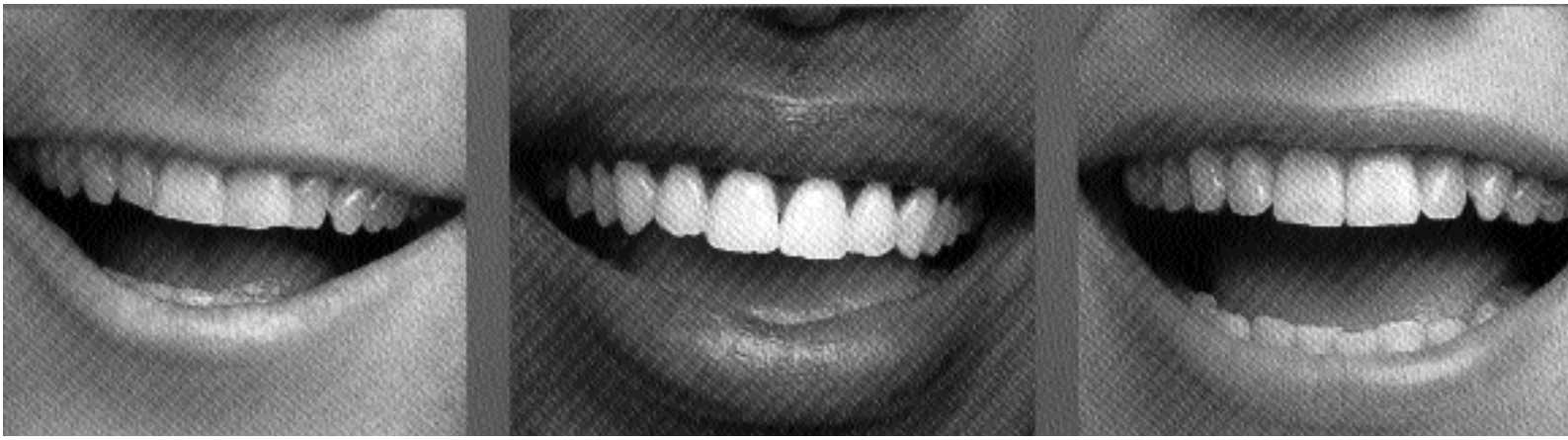
The petit-bourgoise 'HIV' life-style is epitomised by the abhorrent yuppie magazine *POZ* which hard sells the poison-by-mouth 'HIV' Pharmaceutical Industry. The pernicious Procrustean *POZ* is 'retroviral' soft-porn, hard-selling mock 'retroviral' drugs to mock 'HIV+' consumers. In *POZ*, April, '98, of the 88 pages 38 are adverts for pharmaceuticals or the 'AIDS' service-industry! In *POZ*, September, '97 there are 44 photos of laughing hyena faces: why are we being presented with such superficial sickly smiles? In the same issue is a sinister advert for SPORANOX® sporting six snap shots of smiling mouths with the sound bite: "Liquid SPORANOX® gets THRUSH out of your mouth..." These laughing Jaws with gleaming white teeth remind one of a hideous hyena with diffuse diarrhoea. In this case the 'liquid' gives oral-anal satisfaction! This 'Oral Solution'suggests an 'anal-delight' sublimated message through oral-anal-liquid-diarrhoea-vile-bile gratification!

The putrefying *POZ* construction of an 'HIV Community' is profoundly petit-bourgeois: a suburban-utopia of pharmaceutical consumers hermetically-sealed in a smug space of vacant 'HIV' virtuality. *POZ* cannot transcend the limits of its vacuous 'HIV' ventriloquism. As Marx said: "the petit bourgeois cannot transcend the limits of his mind". Thus 'diagnosed HIV believers' world-view, body-view is conditioned by the symbolic power invested in the 'HIV' consumer life-style; they 'feel at home' with 'their HIV'. Bourdieu states: "Symbolic power works partly through the control of other people's bodies and belief that is given by the collectively recognised capacity to act in various ways on deep-rooted linguistic and muscular patterns of behaviour, ether by neutralising them or by reactivating them to function mimetically..."

swimmer diving with the slogan: 'Dive into a new way of treating HIV'. *POZ* epitomises all that is sordid, insipid, obscene, meretricious and disingenuous about *nouveau riche* 'HIV'consumer culture. The hysterical hyena laughter that shrieks from *POZ's* puke pulp pages masks the screaming skulls that have died from 'antiretroviral' drug poisoning.

The Red Ribbon™ symbolises all that is cheap, phoney, vulgar and visceral about the 'HIV' Culture Industry. Camille Paglia condemns the vapid-putrid schmaltz-tackyness of the Red Ribbon™: "When are people going to stop wearing those red ribbons? I hate this sanctimony about AIDS. I've never worn a red ribbon, ever. When is this gonna stop? It's obscene. You can be perfectly sympathetic to AIDS without this self-advertisement. This has gotta stop. Gay men created fashion, and now these red ribbons are ruining the lines, ruining the look...So I say, for the sake of gay men everywhere, please stop wearing these things" (*POZ*, No.5, Dec./'94 Jan.'95). The maudlin-kitsch Red Ribbon™ epitomizes the petit-bourgeois 'HIV' mentality *par excellence*. Red Ribbon International with MBNA Int. offer you the Red Ribbon Visa Card: "Every time you use it you raise funds and AIDS awareness...If you earn £20,000 or more a year, you may prefer the extra privileges of the Red Ribbon Visa Gold Card, which include a higher credit limit". The cloying sentiment of 'AIDS awareness' marries cultural capital to economic capital giving the consumer a sense of smug self-satisfaction by 'investing' in a 'worthy cause'.

Sean O'Brian Strub (*POZ*), Graham McKerrow (*Positive Nation*), Neil Beasley (*Positive Times*), Paul Disney (*Axiom*) do not have the intellectual acumen and political courage to inform their readers that 'HIV' does not exist. Their 'HIV' careerism is more profitable than the truth. They know there's big bucks in 'HIV'. Their insidious, naive, and trivial 'belief in HIV' blinds them to the structuring power of the 'HIV' ideological fantasy that interpellates them. These snide, supine, servile editors just 'keep in fashion' and 'go along with' the global 'HIV' fraud because it is 'the done thing'. Only by refusing and resisting 'HIV' testing can we end this panic-buying-death programming. Don't Take the 'Test'. Don't Buy into the 'HIV Lie'. Burn the AIDS Memorial Quilt. Remove your Red Ribbons. No One is 'HIV+'. Why not say: 'I don't shop their for I am not'? Or in the words of Frantz Fanon: "Let us go forward brothers...we must leave our dreams and abandon our old beliefs...It is necessary to grow a new skin, to develop new thoughts, to set afoot a new man".



In *POZ*, March, 1998, the advert for PROCRIT® sports middle-class trend-setters partying with the slogan: "To most people, there's nothing special going on here. To someone with HIV-related fatigue, this is a good day". Actually, it's a good day because there is no such thing as 'HIV-related fatigue'. Here, PROCRIT® becomes a product of cultural value and symbolic power promoting the 'HIV High-Life'. In *POZ*, adverts of sporting imagery are used to sell the 'HIV Olympian Body': Merck's CRIXIVAN advert states: 'In the battle against HIV, there's a change in outlook', we see a mountain climber gripping to a rock face followed by an image of him at the summit having 'made it to the top'. An advert for FORTOVASE™ has an image of a woman javelin throwing while Immunocal™ has a women

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TRICKED AGAIN!

Political visions and latex law suits in New York

photo : Bud Weiss

by Rev. Dr. Michael Ellner

Michael Ellner is President of HEAL in New York City. He has received many homours including the first Internatonal Association of Counsellors and Therapists' Mind/Body/Spirit Award.

Several weeks ago, I attended the 1st International HEAL (Health Education AIDS Liaison) conference hosted by the Toronto chapter of HEAL. HEAL Toronto was the perfect host and I came away from the conference feeling more upbeat and optimistic that we can stop the murder than I have felt in the last ten years! I feel certain that the conference will have a positive impact on the future of HEAL and the downfall of hiv/aids. But something that happened there combined with a more recent event have, taken together, convinced me of the real possibility of at least two more horrifying phenomena underlying the aids juggernaut.

In a nutshell, the HEAL Network agreed to participate in both the International "refuse and resist hiv testing" movement initiated by Continuum, and actively to assist in the long-term survival study along with Continuum, Aktion positive Schweiz, and the Gay International Association (GaIA trust). HEAL will be developing a set up assistance program for new HEAL chapters which will operate out of HEAL, L.A. We plan to take action in Atlanta, home of the CDC. HEAL Atlanta will coordinate and host this special event which is being planned for October '98, so please contact them for more information. The HEAL Network also agreed to promote subscriptions to Continuum's excellent and life-saving journal.The HEAL network is also looking for ways to support Michael U. Baumgartner's crucial work with the International Forum for Accessible Science in Geneva.

As often happens, some of the most exciting and important exchanges occur outside of the conference or lecture itself. And so it was for me both in Toronto and back in NYC. And this brings me to the first part of the horror.

During one of the breaks at the Toronto conference Marty Frior (Founder/Director HEAL Denver) remarked that he was finding it very difficult to get gay men to even consider that they had been 'tricked again'. He made a strong case that for anal receptive partners ninoxynol 9 could account for many of the health problems these gay men were/are having. He felt condoms lubricated with immunocides was a clear and present danger to gay men. I agree.

Which reminds me that about six years ago, I was talking to Jeremy Selvey (PAI) and he made a forceful case that for anal receptive gay men the immunosuppressive chemicals found in the anal lubricants gay men were using, could very well account for many of the health problems these men were/are having. Whoa!

And what about the dangers of latex condoms themselves? After all, many dentists are developing life threatening immune disorders due to poisoning from latex gloves. Are insertive partners wearing latex condoms at any less risk than dentists wearing latex gloves? And what about the increased risks to receptives?

What is really mind blowing is that at present there is no proof that latex condoms are even able to prevent sexually transmitted diseases!* HEAL often asks people to consider if we need condoms for 'hiv' or if we need the hiv myth to promote condom use.

And now the second and even more horrifying horror. On 13th May '98 Dr. Stefan Lanka gave an electrifying presentation on "AIDS in the perspective of Evolutionary Biology" sponsored by HEAL (NYC). HEAL has received more favorable feedback on this lecture than for any other speaker we have presented in the last 15 years. Most often people comment on how easy Lanka made it for them to understand the many complex and confusing issues being discussed. If you are planning an educational event, HEAL (NYC) highly recommends Dr. Lanka.

I used to think (but now I know) that a handful of government scientists and health officials knowingly sacrificed the public's life and liberty in the pursuit of abstinence.** I believed that behavior modification and population control were driving forces in the 'hiv' fraud. I still do! But I now also believe that it is even more sinister than that.

As a result of discussions in Toronto, previous discussions in New York and now Dr. Lanka's presentation, I'm becoming convinced that the 'aids' hoax is also about creating an ongoing pool of experimental human animals while concealing the serious threat to our health caused by 'scientific medicine'.

Some background is needed in order for you to understand how I came to these conclusions. Several years ago, Dr. M.

Dennis Paul (Founder/Director HEAL New England) told me that he feared that the government was intentionally organizing people with AIDS-related conditions into a ready made pool for experimental research in organ transplants. Just consider recent baboon and bone marrow research. It's as if the AIDS industires are making monkeys out of anyone who believes HIV=AIDS.

And at the end of Dr. Lanka's fact based presentation, he shared his opinion that gay men were perfect candidates for experimental subjects in the development of antibiotics. Gay men are unlikely to reproduce and so protect against the genetic damage that comes with antibiotics and the problems that would arise in offspring.

In many of our private conversations Lanka educated me about the antibiotic crisis which was being acknowledged in the seventies within the medical establishment. We also discussed the dangers of vaccines.

I now feel very strongly that the aidstory is just the U.S. governments' way of hiding the monster that they created in over forty years of reckless and irresponsible antibiotic and vaccine use both in the day to day practice of medicine and the processing of our foods. I fear that the people who test 'at-risk positive' (alleged 'hiv positive') are being organized into experimental human animals under the cloak of aids.

I believe the biggest risk anal receptives face is the risk of testing 'at-risk positive' on the alleged hiv tests. The people who use (used) lots of drugs, alcohol and/or latex condoms, with or without toxic lubes are the most likely to be at greatest risk for developing 'aids' indicator diseases. Of course as with any toxic overload the danger lies in the doses of toxins. The bigger the toxic load, the more toxic the shock!

Even if an hiv did cause an aids, promoting condom use for people not in the social health risk groups makes no sense. The cold hard fact is there would be little risk of cross-over infections outside the well known social health risk groups because (1) there is almost no sexual contact with people outside of the social health risk groups and (2) the claimed transmission (ie so-called sero-conversion) usually requires 1,000 so-called exposures. The sexual terrorism serves a masking function.

But what even makes less sense is the conventional wisdom that people who test 'positive' having sex with other people who have also tested 'positive' must wear condoms. I remind you this is in the absence of any scientific evidence that latex condoms are even able to prevent sexually transmitted diseases* . Never-mind the lack of evidence that aids is communicable in the first place.

By distracting the public with threats of aids, the aids bureaucracy was not only able to fund an industry, but they were able to create an on-going pool of people likely to test positive on their non-specific "at-risk behavior antibody tests" (people in the social health risk groups) who were ripe for exploitation.

Sometimes playing it 'safe' is the most dangerous thing a person can do.

Note: This essay was inspired in part by the collective work of Alex Russell, the Perth Group and Dr's Schmidt, Hassig, Kremer and Lanka.

* Sexual Health - Condoms on trial, 5/7/98 *Daily News*, p. 63

**Wall Street Journal* 5/1/96 pg 1 & 6 A, Health Hazard - AIDS Fight Is Skewed By Federal Campaign Exaggerating Risks, by Amanda Bennett and Anita Sharpe.

*** According to risk assessment expert Peter Plumley, F.S.A., *Heal Bulletin* - Spring 1995, Condomania - Con Sense or Nonsense?

THE MICROBE

The Microbe is so very small
You cannot make him out at all,
But many sanguine people hope
To see him through a microscope.
His jointed tongue that lies beneath
A hundred curious rows of teeth;
His seven tufted tails with lots
Of lovely pink and purple spots,
On each of which a pattern stands,
Composed of forty separate bands;
His eyebrows of a tender green;
All these have never yet been seen -
But Scientists, who ought to know,
Assure us that they must be so...
Oh! let us never, never doubt
What nobody is sure about!

Hilaire Belloc, from *More Beasts for Worse Children*, 1897

Thanks to John Lauritsen

Oxidative Stress and Antioxidants - A N

by Leanne Reid

Leanne Reid is completing the Nutrition Consultants Diploma Course at the Institute for Optimum Nutrition, London, and works at Biolab Medical Unit, London, assessing patients' nutritional status using various methods. She is a Registered General Nurse, and worked at Guy's Hospital London and the GU Clinic of Newham General Hospital before going on to qualify in Aromatherapy, and Therapeutic Massage.

Antioxidants play a vital role in immune system health and as a consequence in total wellbeing. Deficiencies of antioxidants can leave the body overwhelmed by the effects of free radicals, making a person vulnerable to a variety of diseases. There are a number of nutritional factors that can be implemented to boost antioxidant levels and strengthen health and the immune system.

With the participation of Continuum, I have been conducting a four month study looking at antioxidant levels in six antibody positive individuals (each antibody tested at different times and some positive for different antibody-antigen reactions) and trying to boost their levels by diet and supplementation. I have measured the levels of pre- and post-study antioxidants - red cell fragility (vitamin E), red cell glutathione and red cell glutathione peroxidase (selenium). As of this date pre-testing for five of the six participants has been carried out. It is hoped that by modifying diet and using supplements, the participants will improve their antioxidant levels and health.

Oxidative stress occurs when the quantity of free radicals the body has to cope with exceeds the availability of antioxidants. Free radicals are molecules with an unpaired electron in the outer orbit which makes them very reactive and unstable. They take electrons from other molecules. The process is a chain reaction. Our body naturally produces free radicals as part of everyday reactions, e.g. our white blood cells produce them when they attack foreign bodies, bacteria, viruses, other infections etc. We receive free radicals also from the environment - air pollution, cigarette smoke, chemicals in our drinking water, nitrites, food additives, radiation, toxic chemicals, dry cleaning fluids etc.

Free radicals are thought to be major contributors to poor health and disease. They attack the lipid membranes of our cell walls and the DNA within the nucleus of each cell, turning the lipid rancid (lipid peroxidation). This causes the cell to malfunction as the cell wall is either hardened so that nutrients cannot get into the cell, or it is punctured so that the cell collapses as the cell fluid drains out. It is thought that free radicals' contributions to undermining health and the immune system are linked with inflammation and triggering mutations which can lead to cancer and are associated with many of the degenerative diseases found today.

Fortunately our bodies have evolved to produce antioxidant enzymes which scavenge free radicals and so render them harmless. A balance between these enzyme systems, antioxidant nutrients received from the diet and supplements, and free radicals is essential for maintaining health (see table 1)

GLUTATHIONE

Glutathione (GSH) is a tripeptide - a peptide is made of at least two amino acids - and accounts for over 90% of the intracellular non-protein thiols (thiols = sulphur containing compounds) - where it functions as an antioxidant and in the activation of T cells. It is especially important in the intracellular removal of the free radical hydrogen peroxide (H_20_2) because it provides a substrate for glutathione peroxidase, the major H_20_2 removing enzyme in humans.

GSH, the main intracellular defence against oxidative stress, has been reported to be markedly decreased in plasma, lung epithelial-lining fluid and T lymphocytes in antibody-positive individuals. Of the six individuals in the study five have so far been tested and four out of five have low glutathione levels (see figure 1a).

GSH is present in foods only in very small amounts. It is synthesised in the body from other peptides - cysteine (a sulphur containing amino acid), glycine and glutamine. Cysteine and overall protein intake is very important for the synthesis of GSH. They are rate limiting factors for making intracellular GSH[1]. Effective cysteine supplementation directly leads to an increase in intracellular GSH. However, there is also frequently a cysteine deficiency in antibody positive individuals, whilst glutamate is elevated[2]. Glutamate competes with cysteine for its uptake into cells. Cysteine can be synthesised from methionine (another sulphur containing amino acid) using vitamin B6 as a co-factor, but it is important that there has been found to be up to a 50% lowering of B6 levels in antibody positive persons[3].

In the four month study, the participants are taking Amino-Plex which is a blend of sulphur containing amino acids. It contains cysteine and methionine for boosting GSH levels. They are also taking Cellguard Forte, which contains some antioxidant nutrients as well as vitamin B6 and reduced glutathione, another source of GSH. Foods which can help to boost GSH levels are eggs, onions and garlic and all sulphur containing amino acids.

VITAMIN C

Vitamin C is relatively non-toxic (mild diarrhoea can be

Nutritional Perspective

Figure 1a – Red cell glutathione

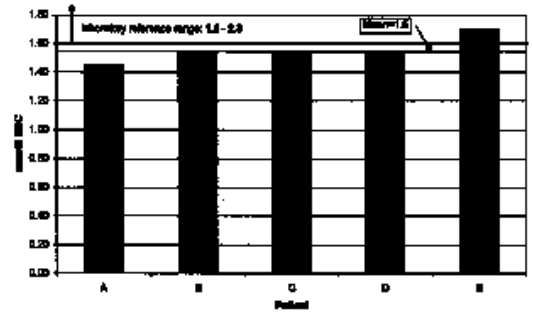


Figure 1b – Red cell glutathione peroxidase

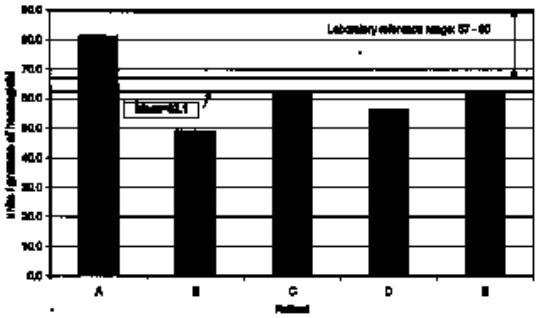
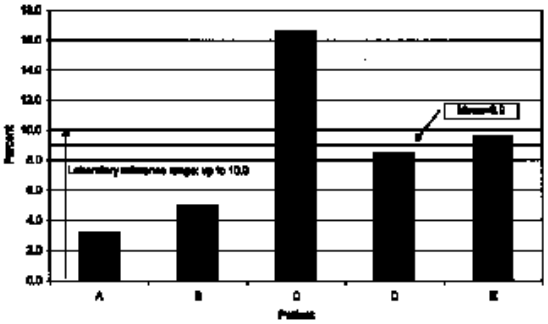


Figure 1c - Red cell fragility



expected if taken in excess; there is current research into some other aspects) and is one of the most protective substances we have. It has anti-tumour, anti-viral and anti-bacterial properties; it supports immune function and increases the strength and integrity of collagen, the tissue which literally holds us together. It offers protection against many toxic substances which produce free radical activity, as well as enhancing the antioxidant potential of other substances such as vitamin B5 and cysteine. Its antioxidant function is strongest when combined with cysteine. It functions as an antioxidant by protecting body components from free radicals and keeps the mineral portions of certain enzymes in their proper reduced electronic state.[4] Vitamin C is an essential antioxidant under conditions of glutathione or cysteine deficiency. It can help to replenish GSH levels as well as potentiate the effectiveness of N-acetyl-Cysteine (a cysteine precursor which is converted to GSH in the liver). The study participants are taking a combined dose of Buffered Vitamin C 800mg daily. Foods rich in vitamin C are green leafy vegetables, berries, tomatoes, cauliflower, potatoes, sweet potatoes and citrus fruits.

VITAMIN E

This vitamin is the best natural nutrient protector against fat peroxidation and so is a defender of the integrity of all cell membranes, which have a large lipid content. Cytokines are powerful immune system modulators. A disturbance in the production of certain cytokines brought about by infections or otherwise can have profound effects on the immune system. Vitamin E appears to have direct modulating abilities on cytokine production. Though they may be ethically controversial, several *in vivo* studies of mice have shown high dose vitamin E normalised cytokine production and reversed several micronutrient deficiencies (vitamins A, E, Zinc and Copper).[5-6] Vitamin E and selenium work synergistically. Vitamin E is thought to help offset GSH deficiency[7].

The study participants are taking 15Omg Vitamin E daily. Food sources of vitamin E are soya beans, nuts and seeds, broccoli, Brussels sprouts, leafy greens, wheat germ, whole grain cereals and eggs.

Vitamin E levels (red cell fragility) have been tested pre-study in five out of six participants. Three out of five participants have borderline levels or deficiencies of this vitamin. (see figure 1c)

SELENIUM

This trace element is often considered an antioxidant because it is required for the activation of the enzyme glutathione peroxidase (GP). Sappey C *et al*[8] suggest that selenium supplementation can effectively increase GP activity in T lymphocytes. The selenium supplemented cells exhibited an important protection against the cytotoxic and reactivating effects of hydrogen peroxide. Jariwalla[9] states that in selenium deficiency the activity of natural killer cells is significantly reduced.

The study participants are taking 250mcg selenium daily. Food rich sources are nuts and seeds, seafood, tuna, tomatoes, onions and broccoli. Five out of six participants have had a pre-study GSH-Px (functional test for selenium). Four out of five have a low selenium level. (see figure 1b)

VITAMIN A AND ß-CAROTENE

Vitamin A and its precursor ß-carotene are essential for the proper functioning of the immune system. The ability of vitamin A to act as an antioxidant is strongest in the linings of tissues where it acts to protect the mucous membranes of the lung, intestinal tract and bladder, as well as the skin. ß-carotene not only turns into vitamin A in the body but is itself a quencher of singlet (a form of free radical) oxygen, which it deactivates without damage to itself. Therefore it is important to get adequate amounts of both in the diet. Vitamin A deficiency is associated with increased frequency and worsened severity of infections. The study participants are taking 800mcg Vitamin A and 22mg ß-carotene. Good food sources are fish, liver, carrots, green and yellow vegetables, eggs and yellow fruits.

GENERAL NUTRITIONAL RECOMMENDATIONS

I would like to use this opportunity to emphasise the importance of looking at each person's nutritional status individually. The most appropriate dietary supplementation

recommendations are those that are based on an individual's unique requirements, not solely on his or her disease symptom or antibody diagnosis. This is the basis of nutritional therapies and anything that I suggest should be considered only when an individual's requirements have been assessed.

1) Anyone should endeavour to optimise his or her nutrient intake by eating organic foods since most non-organic crops are grown in soil supporting much more growth than it has natural nutrients for. And if this is not possible then all fruits and vegetables should be washed in a dilute vinegar solution, cider vinegar being preferable, at least to remove external toxins from the food. Aim for three meals a day, with snacks in between. If personal diet permits eat 3-4 pieces of fruit per day, plus one meal consisting of a large salad plus protein. Vegetable protein is preferable, but lean meat and fish are of benefit. Vegetables should be lightly steamed or steam-fried for the shortest possible time. Raw and lightly cooked vegetables provide high levels of antioxidants. Vegetable protein is a good source of protein without the saturated fat found in meat. Fruit also contains high levels of antioxidants. Green leafy vegetables and seaweeds are a good source of vitamins and minerals.

2) Whey Protein Concentrate (WPC) dramatically elevates glutathione levels and improves both humoral and cellular immunity in vivo. In a small pilot study with antibody positive men, there was a dramatic rise in the levels of GSH and most participants reached ideal bodyweight[10]. WPC can be added to fruit or vegetable juices, stews, soups, etc. Use 1-2 scoops daily.

3) Intake of anti-nutrients should be minimised. These include phytates from wheat and bran, sugar, tea, coffee, alcohol, cigarettes and recreational drugs. These substances either prevent absorption, or deplete the body of valuable nutrients.

4) Heavy metal toxicity should be investigated and treated. An overload of toxic metals (mercury, cadmium, aluminium, lead and fluoride) can cause serious weakening of the immune system and use up valuable antioxidant nutrients.

5) Any subsidiary health problems should be dealt with e.g. Gut fermentation, food intolerances, parasites, a/hypochlorhydria (deficiency or absence of digestive hydrochloric acid), insufficient pancreatic enzymes, poor blood sugar balance, increased intestinal permeability, malabsorption, nutrient deficiencies etc.

6) Supplementation should be designed for each individual based on their specific needs. Here are some suggested doses for some of the important nutrients:

• Vitamin C: to bowel tolerance, increasing when required. (1- 10 g+ daily)
•Vitamin E: 400 - 8OOi.u. Start off at a lower dose and slowly increase •Vitamin A: 5000-10000 i.u. daily, increasing when required (not if pregnant)
•ß-carotene: 15-60mg three times daily with meals. Best given in divided doses, either reducing the dose after three months or discontinuing the dose for a short period
•Selenium: 100 - 300mcg daily
•Vitamin B Complex: 50-200mg twice a day
•Zinc: 30-60mg daily
•N-Acetyl-cysteine: 500-600mg in 2-3 doses per day. (It is thought that levels beyond this are probably counterproductive.)
• Copper: 1-2mg daily
• Manganese. 2.5-5mcg daily

7) Other supplemental considerations:

• Magnesium
• Bifidobacteria/Lactobacilli
• Essential Fatty Acids
• HCL (Hydrochloric Acid): half to I cap. with meals
• Digestive enzymes: 1-2 caps. with meals
• B12 Injections (available from G.P.) important if experiencing gastrointestinal or neurological symptoms.

From the research literature it is apparent that antioxidant nutrients and enzymes are an effective way to boost health and the immune system. The more common antioxidant nutrients have been proven beneficial and should therefore be included in a diet and supplementation programme. Less studied antioxidants should not be discounted because of the lack of available research. These could be cautiously tried and any effects monitored.

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What could a nutritional therapist do for you?

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Nutritional therapists are complementary medicine practitioners who combat illness with the use of special diets and a wide variety of nutritional products to assist specific metabolic functions.

In prison, hiv-paranoia simmers

Nigel Edwards is a prizewinning journalist who has worked in BBC News and World Service, and has been Acting Editor of The Pink Paper, Britain's national gay and lesbian newspaper. He was jailed in January 1997 for serious sexual offences against a 13-year-old-boy. He has consistently denied the allegations and claims he is a victim of a miscarriage of justice. At his trial, no corroborating evidence for the charge by the then 16 y.o. youth was presented. He is preparing an appeal for later this year. His address is KD1492 Edwards, HMP Stafford, 54 Gaol Rd, Stafford ST16 3AW, UK.

by Nigel Edwards

Paranoia is one of the most common illnesses in prison. Most inmates will suffer some form of it to a greater or lesser degree. Perhaps paranoia should not be understood as a medical pathology but rather a form of dealing with 'reality' in an 'unreal' context like prison. Prisons are fertile ground for irrational fears. It is easy to lose a sense of proportion. The worst scenario is often the first scenario. In a place where authoritative information runs scarce, rumour rules. The gullible are led by the ignorant, and the ignorant are driven by their ill informed prejudices. Drop into this already simmering cauldron the spectre of a deadly 'virus'. British prisons, guided by the Home Office and the Department of Health, walk a careful tightrope over 'HIV' and AIDS. It goes without saying they accept and promote the orthodox line: that AIDS is caused by a 'virus'. No prison staff would think to question that line, let alone promote any alternative viewpoint. The prison service is a disciplined service. It blindly obeys the instructions of its civil service masters and does not think for itself. Those instructions require the Prison Service to make inmates duly aware, in orthodox terms, of the 'dangers' of 'HIV', but at the same time to play down those dangers so as not to let the cauldron boil over. So it is commonplace to see posters up around prisons emphasising that 'HIV' is not easily passed on. The Prisoners' Information Book, covering all aspects of prison life, says: "You cannot catch HIV by normal daily contact with someone who has it - from shaking hands, brushing past, using the same toilets, plates or cutlery or even from being spat at or bitten by someone who has HIV...The only way it can be passed on is when blood or semen from someone with HIV gets into the blood stream of someone else." That advice neatly reveals some of the irrational fears prisons have experienced in the years since the spectre of 'HIV' was dropped into the cauldron.

But the Prison Service appears to have been highly successful in promoting this strategy because in practice today most inmates seem remarkably unconcerned about 'HIV' - that is, until they are actually confronted by a prisoner with an 'HIV' diagnosis. "It's then that people hit panic station," says Richard Hardin, currently an in mate HMP Stafford. It was Hardin who saw for himself exactly how inmates at his previous prison reacted to the arrival of a prisoner who was totally open about his 'HIV' status (see panel: Andy's story). Hardin was so shocked at the way Andy was treated that he went out of him way to befriend him and to show others he had no fear of 'HIV', even though he did believe in the 'virus' theory. "I managed to break down a lot of barriers," he said. Andy was a nice a guy as you could ever meet. At first I got a lot of stick for talking to him, but gradually I began to him people over and attitudes began to change." It was Hardin who saw how staff at that same prison reacted on one occasion when an inmate with an 'HIV' diagnosis tried to commit suicide (see panel: Richard's Story).

But in practice, attitudes to 'HIV' awareness are now highly relaxed. Most prisons include the showing of a video about 'HIV' and AIDS on their induction itinerary for new prisons. But the

Richard's Story

In 1996 Richard Hardin was an inmate at a small prison in the Midlands where he had a job as a wing cleaner. From time to time, depressed inmates would "cut up", either in a serious attempt at suicide or more often a bid for attention. Usually, the officers would ask the wing cleaners to clear up the mess and they would be offered a half-ounce of tobacco in return for carrying out the unpleasant task.

One night, Richard was woven up by a commotion in the cell directly opposite. By squinting through the gap round his steel door he was able to see what was going on. The inmate opposite was on a self-harm watch, which meant that the night officers had to look in on his cell every 15 minutes. They had found him lying unconscious on the floor with his wrists cut. While one officer opened up the cell to go in, the other, in line with procedure, rushed to the landing office to grab the inmate's file. Moments later, the officer with the file shouted: "Don't touch him. For God's sake don't touch him!" He came running back with the file and told his colleague the inmate was 'HIV+'. Despite this, they managed to bring the inmate round, and took him off to hospital. When Richard offered to clean up the cell the next day he was told that on no account was anyone to touch the blood. The cell was left untouched for two days on the advise of a doctor. Then a prison medical orderly arrived earing a white protective suit, a face mask, a cap and green Wellington boots. He bagged up and burnt all the bedding and clothing and took all morning to give the cell the most meticulous cleaning out.

Andy's story

Andy was a young heroin addict who worked as a rent boy in a midlands town. He also had a boyfriend who died in his arms with an AIDS diagnosis. Andy himself was diagnosed as having. 'HIV'. In 1996, now in his mid-20's, Andy was sent to a small prison in the Midlands. There he was proudly open about his sexuality and his 'HIV' status. The other prisoners treated him like a leper while prison staff tried to strike what they thought was a sensitive balance between their fears and his needs. He slept on his own in a special hospital cell, but was allowed to mix with the others for association periods and education. They did not want to mix with him and many were openly hostile to him, although none would actually touch him. They complained about him using the telephones. Staff would allow Andy to use the telephone at times when the others had been locked up and would not know. He was always meticulous in wiping down the instrument afterwards. They complained about him using the showers, so staff made him use the showers in the medical centre. He repeated requests to be 'two-ed up' with another inmate for company (like everyone else) but was refused. Inmates made a big fuss about his clothes. So each week, at kit change, the clothes Andy had worn were placed in a special green bag and sent off to be burnt so they never reentered the system. He was not allowed to eat off the same food trays as everyone else. Even when he was promoted to enhanced privileges for good behaviour, which meant his door could be unlocked during association, no-one would go to visit him. The prison said it could not afford to give him medication he wanted. So Andy wrote off to a special trust fund, and the prison was sent a cheque to cover the cost.

(continued over page)

video is in fact rarely shown. Inmates arriving at prisons like Gloucester, Shrewsbury, or Stafford, for example, say they have never seen it. Most prisoners, asked what they know about 'HIV' and AIDS, will come out with a fairly accurate summary of the orthodox line. At the same time, they will state it is something they personally do not need to be concerned about. Most will happily admit to indulging in what the orthodox claim is "risk behaviour": unprotected or "bare-back" sex, and/or sharing needles.

The conventional line on 'HIV' is reinforced in a variety of ways, including, in the Midlands prisons at least, annual calendars with pictures and texts promoting 'safer-sex', advice on drug injecting, compassionate attitudes to 'HIV' and AIDS, and information about World AIDS Day and helplines.

Despite this, the Prison Service's attitude to the issuing of condoms remains fudged. In response to the Liverpool solicitor Elkan Abrahamson last year it wrote: "Sex between prisoners is not condoned by the Prison Service - but it is recognised that in reality it occurs. Current policy on the issuing of condoms to prison inmates gives to medical officers the freedom to prescribe condoms if in their clinical judgment there is a known risk of HIV infection. That policy is widely circulated in the form of a 'Dear Doctor' letter, issued in August 1995."

Abrahamson, who specialises in representing the rights of prisoners, is currently gathering information on how the policy works in practice, with view to getting a Judicial Review.

Every inmate arriving at a prison will be seen by a doctor and asked some basic questions about their health. This will usually include a question about their 'HIV' status. But there is no question to disclose it. Edward Copeland, a 21-year-old inmate at HMP Stafford, speaks for many prisoners when he says he believes all inmates should undergo an 'HIV' test when they arrive and when they leave. He says that a newly-arrived inmate, discovering he was 'HIV+', would then be able to ensure he did not "pass it on." A departing inmate, discovering he had 'sero-converted' during his time inside, could sue the prison service.

Drug use by inmates continues to be an increasing problem for prisons, and despite the introduction of mandatory drug tests, all the evidence points to the Prison Service losing the battle. Luke Stokes, a 25-year-old inmate at Stafford, has a history of heavy drug use, including heroin, speed, LSD and cannabis. He has frequently shared needles and has never used a condom, right up to the time he came into prison three-and-a-half years ago. But Stokes is currently attending a Stafford Prison drug awareness course designed to put him off going back onto drugs. It included three two-hour sessions on 'HIV/AIDS' which, he says, has effectively frightened him: "Every time I get a cold now I will be wondering if I have caught HIV," he said. He claims the information, which included watching a video, was so effective in scaring him that he will never inject drugs again, or fail to use a condom. "I want to learn more about it so that I can pass the warnings onto my kids," he added. The course provided a questionnaire. Two examples: "Among what group of people is HIV spreading most quickly in Britain? Heterosexuals," and "If you are already HIV positive, is there any health risk in being exposed to the virus again through an unsafe practice with someone else with the virus? Yes, repeated exposure can increase the speed and likelihood of developing AIDS."

(continued)

Throughout all this, Andy remained stoic, understanding and accepting. Then Andy suggested to the prison staff that he should give a talk to other inmates about 'HIV' and AIDS, illustrated with one of the standard orthodox videos. The governor approved the idea and Andy enthusiastically began to prepare his presentation. But just before he could bring it off, Andy was suddenly moved to another prison.

The annual calender supplied to inmates at Stafford carries more (mis)information: "Today HIV, which causes AIDS, is present in virtually every country in the world and continues to spread faster than international efforts to stop it. Every day an estimated 7,500 people become infected." But the calender also includes some surprisingly optimistic advise. After stating that some people with 'HIV' could live 20 years or more, it promotes "positive thinking" and says: "the link between the mind and the body is very powerful". It recommends relaxation, meditation and visualisation, and says diet, sleep, exercise, drug and alcohol-use and smoking are known to affect everyone's health, "especially if someone has a virus like HIV".

Anecdotal evidence suggests the Prison Service is successfully managing to educate inmates in orthodox views about 'HIV/AIDS' without at the same time alarming them. But an inmate coming out as 'HIV+' still runs the gauntlet of ill-informed prejudice. A Stafford inmate, made to share a cell for one night with an openly gay prisoner, was frightened he might have caught 'HIV' by just sleeping in the cell. There are still pockets of extreme ignorance, even of the orthodox position. The early scares have left their mark.

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Lust for Life...

My leap of faith

by Sylvie Cousseau

"No!" said my doctor, "it's impossible!"
In June 1987 I was 22 years old and had just returned from Mexico. I had gone there in order to stop four years of chronic heroin abuse and now I was diagnosed HIV+. After such a struggle to stop drugs and live again I felt I was being condemned to death in the long or short term.
The doctor explained to me that I must have regular examinations to assess the level of my T-cells which are attacked by the virus. I was told that when the T-cell count was at a certain level, which at the time was 400, then I could expect the onset of AIDS. The question that occurred to me was that if the T-cell count could fall, could it not also rise? "No!" said my doctor, "it's impossible!" At that time my T-cell count was 580 so I was advised by my doctor to take AZT, but I refused because the idea of taking this sort of toxic experimental treatment was quite unacceptable. I was tired and in shock but from the very start I hung on to the fact that I was alive and there was something I very much wanted to do before I died. One of my dreams had been to go to the Himalayas and I decided to make that dream come true.

A trek in Nepal demolishes my doctor's "impossible"

During the winter I worked on an Alpine ski resort to save the money for my trip. By April 1988 I was in Kathmandu with a group of friends for three weeks, walking in the mountains of the roof of the world. I forgot the turmoil of the world below and all those tiny viruses. I was completely absorbed by that wonderful country and the smiles of the Nepalese people.
When I returned to France I rechecked my T-cells. My count was 1220! I was jubilant, arguing with my doctor that a small trek had done the impossible. He was unable to find a satisfactory explanation.
A friend told me of a Homeopathic doctor who also used colon hydrotherapy and acupuncture. Through him I found another approach to health where the viruses are not considered to be so important as strengthening the body's own resources.
In spite of my raised T-cell count my health remained fragile as I had repeated ear, nose and throat infections and a bout of shingles. I went into hospital for treatment to reduce the pressure in my ears, confident with orthodox medicine and feeling that I was being well cared for. At the same time I changed my diet to one based on organic food and I also had homeopathic treatment, oligo-elements and vitamins.

AZT for hepatitis!

In the summer of 1990 I was feeling extremely tired. My doctor again advised treatment by AZT. My fatigue, he explained, was the result of the virus. I did not understand this because my T-cell count had not changed at all. I had an inspired thought and demanded a check-up for hepatitis. The analysis showed that I had hepatitis B, which had nothing to do with AIDS. My way of dealing with this condition was to stop drinking alcohol, be careful with my diet and to drink clay mixed with pscillium husks.

At seven months pregnant I was told to abort.

In 1991 I went to India again. This time for six months and I followed a curative diet of exotic fruit and coconut. At the end of the summer I found that I was pregnant but I felt well and decided to have my child. Once again I had to face the fear of others, including my own family, and the pressure from doctors to take AZT as prevention. In the seventh month of pregnancy my gynaecologist advised an abortion but I told everyone I had faith and that no one could make me change my mind in spite of the fact that my T-cells had begun to diminish. Today I am convinced that these same T-cells in HIV negative mothers would diminish during pregnancy too - if anybody could be bothered to check this.

My baby born HIV+ becomes HIV- without treatment

Arthur was born on the 10th June 1992 and he was HIV+. Thanks to my paediatrician I learned that 80% of HIV+ babies seroconvert and retest negative between 12 and 18 months of age. In spite of the pressure I refused all treatment and all tests for my baby before the age of one. I was very tired after giving birth. My best friend had just died of pleurisy. I had lost a lot of weight and was very thin. My T-cell count was 246, but I wanted to live for my son and to continue with the steps I had begun to take towards recovering my health, despite my doubts and fear.
In June 1993 Arthur was one year old. I took him to the hospital to have the test although I was fearful of the trauma I knew he would experience when the blood sample was taken. One week later the paediatrician came to my home in person to tell me the good news. We embraced, we laughed and I cried with joy. My son was HIV negative!

T-cell count artificially raised by cortisone

Some time later I had pneumonia. I had taken homeopathic treatment and antibiotics, but finally at the end of twelve days I had to go into hospital where I had more treatment with antibiotics and with cortisone taken intravenously. My T-cells went up to 580, but my doctor told me it was a "false result" - it was raised by the cortisone. Isn't that exactly what happens with treatments such as AZT and protease

inhibitors? Once more my doctor tried to persuade me to have anti-viral therapy and preventive medication, saying that if I contracted pneumonia once more then I would be clinically diagnosed as having AIDS.
I spent the summer of 1994 in the mountains with my mother who looked after my son. I gradually put on weight and gained hope, despite having candida for which I took antibiotics. By the autumn I was better despite a T-cell count of less than 200, which is supposed to indicate the onset of very serious illness.
My partner, my son and I left for India that autumn for five months. Five months of Hell during which I succumbed to the temptation of heroin again.

"Schizophrenic" crisis - consequence of heroin?
I returned to France in a pitiful state, weighing only 42kgs. This time I was in a schizophrenic state, which was considered to be "AIDS related". I was placed in a psychiatric hospital for twelve days. My only thought was that the stress of eight years living with an HIV+ diagnosis was made worse by heroin toxicity and its severe consequences contributed directly to the crisis and my own mental confusion.

I pray to all the saints and all the gods.
By chance two books came to my rescue: "Pensez et Guérissez" (The healing power of thought) by Kurt Tepperwein and the "Bardo - Thodol" of the Tibetans. I returned to my homeopath brandishing my two books. We had a long conversation on life, death, reincarnation and on the power of thought and meditation on health. The national prayer group of Maguy Lebrun, which I attended in my town, had a holistic library with books on health, sprouting grains, techniques for natural detoxification and one notable one, "SIDA Espoir" (AIDS Hope) by Dr. Christian Tal Schaller.

I decide to make a "leap of faith"
At the end of December 1995 I left my partner with whom I no longer agreed and went to live with my parents, begging my mother to look after Arthur and to have confidence in me and in God without showing her fear. I weighed 42kg, coughing day and night, spitting blood, and I had candida both internally and externally. I felt I would die, but first I would try all that was in my power to try and pull myself through. I fasted, underwent colon hydrotherapy and used Amaroli. This consists of drinking your own urine. At the beginning the situation seemed to get worse as I had dysentery and lost another 4kg, so I stopped weighing myself, telling myself that I must have faith and let go of my fear. I spent many days in bed with dysentery and fever, then, with the support of my mother, I slowly began to eat raw food, sprouted seeds, algae, fruits and thin vegetable broth. For two months I followed a very strict organic diet and drank a glass of urine each morning. Little by little my health improved. I slowly gained weight and as I became better I began some sessions of acupuncture, osteopathy and went to my prayer group twice a month. I continued to have long talks with my homeopath who was my greatest moral support. My cough disappeared at the end of two and a half months, but the candida took much longer to clear up.

On meeting my new partner I threw my last fears in the bin
In April 1996 I came across the work of Mark Griffiths and our subsequent meeting transformed my life. What a relief it was to meet people who are there and approachable and to no longer be alone facing the trauma and fear of AIDS. Thanks to him I have been able to throw my last fears in the bin and to realise that I had struggled for ten years against a virus that does not exist! For ten years I had been in a state of permanent stress and at war with myself. Today, thank heaven, I have discovered a marvellous life. AIDS has allowed me to connect with my deepest instincts and the word "faith" has now taken on its true dimension. My experience has proved to me that science without conscience helps to drive those diagnosed HIV+ to death.
I now live in the South West of France with the two men I love - Mark and my son, Arthur. From here the first French HIV health journal has sprung forth...

I wish you all good natural immunity, peace, joy and love.

Joan Shenton
of Meditel Productions

GALLO'S GOBBLEDYGOOK

The last time I saw Gallo in the flesh was at the Berlin World AIDS Conference in 1993 where he had appeared with three bodyguards, flashing smiles at the press like a Hollywood film star. He had come to announce yet a another string of bogus "advances" in AIDS research. This time it was the "theoretical possibility of using triple helix oligonucleotides antisense". A bemused and disgruntled press listened to his *pot-pourri* of virological mystification-speak, peppered with "might","may", "could" and "theoretically" and found nothing to write home about. Then, having settled into his new job at the Institute of Human Virology, he announced two further 'breakthroughs': something called HIV-SFs (HIV suppressive factors, or chemokines) that appeared to be able to halt replication of HIV by locking it out of cells. And a new treatment for KS (Kaposi's sarcoma) using proteins linked to a hormone found in the urine of pregnant women.
What news do we have on these? Not much, just another string of wishful phrases and appeals for more money. Listen to the reply Gallo gave David Gold in *Poz* magazine last month: On chemokines he said, "Every month we know more about how the virus pokes its head through the doorway of the cell, but so far we are still scratching the surface. ...So could we use this (chemokines) therapeutically? I would like to. How fast are we making progress? Not as fast as I'd like... We'll do primate studies - but we need money for that".
On his KS treatment with HCG (human chorionic gonadotropin) research he claimed 50% partial regression of KS lesions and "a documented viral reduction .. but I'm very disappointed that we don't know exactly which molecule in HCG is responsible for this activity." (*Poz*, April 1998, p 64).
But there is a new tone emerging in Gallo's statements to the press. In a piece by Andrew Quinn (Reuters, 19 May 1998) Gallo says that the 12th World AIDS Conference in Geneva at the end of this month is in for some grim news: no breakthroughs in the hunt for a vaccine and major setbacks with the protease inhibitor (PI) triple therapy cocktail. PIs, he said, were presenting problems with toxicity and the difficulty in ensuring that patients comply with the complicated schedule of pills per day. Gallo criticises the elation that surrounded the success of PI cocktails. He says that the 1996 Vancouver World AIDS Conference overstated the case. "It was a mistake to make such noise when the therapy breakthroughs came through," he said. "That period of Vancouver was too much and too cocky. It was not time for champagne." Yet another "breakthrough" bites the dust. Interestingly Gallo is beginning to hedge his bets all round.
He is using phrases like the need for "biologic" and "economical therapies" which would be best tried out without protease inhibitors alongside (as current medical ethics dictate).
Sounds mighty like what AIDS dissidents have been advocating for over a decade. Could it be that Gallo is beginning to guard against all those extravagant claims of the past because he is at last (albeit secretly) aware that his virus-AIDs hypothesis has finally gone bankrupt?
Gallo has survived three federal investigations into his conduct at the National Institutes of Health, as well as the enmity of many disaffected former colleagues and lab employees. But the voice of his critics is getting louder. One recent disagreement involving the Aaron Diamond AIDS Research Centre, headed by David Ho, led to this chilling statement to *Poz* magazine from one of Ho's researcher's, John Moore: "[Gallo] is grossly overrated as a scientist. If you are dumb enough to believe Gallo's personal propaganda, that's your problem. ...And if you think he had much to do with chemokine work, you are a fool." (*Poz*, April 1998, p 75).

Back Issues

Copies are available for all back issues of the magazine. Where we have no stock of original copies, articles reproduced from these issues are available individually. The index below details the contents of recent issues (available as complete magazines). A list of contents of earlier issues is available on request. To order please use the form overleaf.

Recent back issues

Vol 5, No 2 winter 1997/8 60 pp

Focus: Dr Valendar Turner interviewed by Huw Christie - Do antibody tests prove HIV infection?
Features: Looking from inside: Healthcare of orphans in Tanzania by Philippe Krynen
London's timid Africans: Winfred Mwebe says the community needs to get a life
Pioneer deplores "HIV": Retrovirologist Etienne de Harven attacks "HIV" isolation
A Brief History of Retroviruses: Eleni Eleopulos gives a historical overview
Did Luc Montagnier discover HIV?: The French scientist interviewed by Djamel Tahi
Between the Lines: Eleni Eleopulos et al analyse Montagnier's interview answers
Long-term Survival Study: Clair Walton explains the progress
Protective Stupidity: Hysteria and Mass Hypnosis in AIDS explored by Michael Ellner
We're all what we eat: Seven nutritional-health texts reviewed by Martin Walker
Co-enzyme Q10, antioxidant energy: Rohit Mehta explains
PLUS: News, HIV Watch, Lust for Life etc

Vol 5, No 1 autumn 1997 44pp

Focus: Christine Johnson interviews leading AIDS analyst biophysicist Eleni Papadopulos-Eleopulos
Healthy Options: Michael ellner on how to choose a doctor in the age of AIDS
Virus Challenge: Karl Krafeld says scientists always knew HIV was an invention
Hospital Watch: Nursing AIDS patients can be an ethical challenge says Kevin Corbett
CounterCulture: Witchboys: Confession, Possession, Obsession by Alex Russell
Nutrition: Linda Lazarides on the importance of the liver and detoxing
Feature: A Seller's Market. Part 2 of Martin Walker's history of the AIDS-defining drug
Dissenting View: Whose hysteria?
Plus: News, HIV Watch, Lust for Life, etc

Vol 4, No 6 June/July 1997 40pp

FOCUS: Antibiotics:
Geoffrey Cannon looks at the magic bullet concept
Micro-ecology: Heinrich Kremer asks some evolutionary questions
Antibiotic alternatives: discussed by Leon Chaitow
Interview: Immunologist Prof. Alfred Hässig on politics, risks and therapies
Immune Suppression in Hypercatabolic Diseases, by Alfred Hässig
Conference Report on the Chemotherapy of AIDS, by David Rasnick
Nutrition: The vital role of minerals
FEATURE: HIV, AZT, big science and clinical failure: Martin Walker on the history of an AIDS-defining drug
Escpaping the AIDSzone: a new column
Dissenting View: the provocative work of Elaine Showalter

Vol 4, No 5 February/March 1997 40pp + 24pp Supp

FOCUS: Protease inhibitors (PIs):
PIs in Provincetown: John Lauritsen wonders how hope can exact such a price
From Hype to Hesitation: Recent research has led to serious caution
SUPPLEMENT: Peter Duesberg and David Rasnick's The Drugs-AIDS Hypothesis
Conference report: Alternative therapies in France
Interview: Holistic doctor Leon Chaitow, on wide-ranging health
Counterculture: part 2 of Ian Young's The AIDS Cult and its Seroconverts
Virus isolation:
– Near enough is good enough? Peter Duesberg defends existence of HIV
– Why no whole virus? Eleopulos et al. argue Duesberg's claims are unsubstantiated.
– No viral identification - Stefan Lanka says human rights are the issue
Nutrition: Vitamins, how and why
Review: The AIDS Cult, editors Lauritsen and Young
Dissenting View: Innocence is no defence - Nigel Edward's story from prison
Workshops for Change: Michael Baumgartner on the process of personal growth after diagnosis
PLUS: News, HIV Watch, Lust for Life etc

Why CONTINUUM?

CONTINUUM, the CONTINUUM magazine, the other projects of the organisation and its international network were born out of the necessity for integrity, justice and healing around the death prognosis promoted throughout the AIDS-era.

The orthodox view on AIDS holds that it is caused by a retrovirus known as hiv that is transmitted through the exchange of body fluids. Once infected, a person will remain well for a time, though infectious to others, before going on to develop AIDS and dying. There is still no 'cure', just drug therapies said to slow the progress of the disease, and T-cell and 'viral load' counts to measure health.

Fourteen years after the proposal of an hiv as the "probable cause of AIDS", toxic medication is still marketed and huge sums of money are spent on research with little verifiable hope for the future. Powerful pharmaceutical corporations have grown ever larger, capable in some ways of superceding the 'richest' nations on Earth. These corporations have substantial financial interests in controlling disease management, diagnostic tests and so-called terminal illnesses.

Naive patients - mostly homosexuals, drug ab/users, black people, US Latinos, haemophiliacs, babies and the destitute - have become guinea pigs condemned to die young after being labelled with hiv. In contrast, the images and voices of the resistance of many analysts - including scientists, Nobel Laureates, medical doctors, researchers and health activists - worldwide have been disregarded by the mass media for questioning the hiv/AIDS-hypothesis.

CONTINUUM magazine began as a newsletter encouraging those effected to become responsible and to participate consciously in their own healing process. An important function of the work is to generate and disseminate alternative information on AIDS and immunity, establishing networks with those dedicated to the analysis of scientific research and holistic models of health.

Assumptions run so deep among the medical establishment that only the unproved viral hypothesis has been promoted or funded in AIDS. Immunological investigations have confirmed more than 60 conditions can trigger a positive 'hiv-antibody' test result. There is no scientific documentation proving the existence of hiv as a unique, exogenous retrovirus, much less one capable of precipitating some 29 diseases and death.

Among CONTINUUM readers are a good number of long-term diagnosed individuals not taking anti-retroviral drugs. Many are doing well after more than 13 years of being labelled with hiv. We work towards enabling alternative and immune enhancing studies that will help enable people maintain or regain their health.

CONTINUUM magazine is a unique forum for those in the scientific and health communities challenging the AIDS orthodoxy.

CONTINUUM a voluntary organisation dedicated to providing information we believe necessary for the fuller understanding of hiv/AIDS, immunity and health. We aim to encourage those whose lives have in some way been touched by the hiv-hypothesis to seek scientific proofs that an hiv has been isolated and exists, and that it causes AIDS.

Our workers are unpaid and the organisation relies on subscriptions and donations to maintain its work. Your support in any way is greatly appreciated.