

## **CDC RECOMMENDS UNIVERSAL HIV TESTING: A FAITH-BASED NOT SCIENTIFIC RECOMMENDATION.**

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The U.S. government is pressing for legislation requiring mandatory HIV testing for Americans between the ages of 3 and 80. This is the biggest mistake that the U.S. could make -- the most costly mistake and the most damaging mistake for the largest amount of people possible because when you test populations of people that are considered what the "AIDS establishment" says are "low risk," you are going to get a huge number of false-positive test results, which is essentially going to ruin the lives of tens of thousands or perhaps as many as hundreds of thousands of people.

You are going to get a number of people who really are not sick in any way, shape or form, to test positive. And they won't be able to get health insurance. They may be fired from their jobs. The stigma of having AIDS causes suicide, as it did with David Acer, the dentist whom the CDC later exonerated (after his suicide), because the CDC could find no evidence after he committed suicide that the dentist's 5 "HIV-positive" patients contracted their "HIV" signatures from him. There is evidence, however, that countless others who have been given the diagnosis of an "HIV infection," in addition to Dr. Acer, have chosen to end their lives upon getting an "HIV-positive" test result.

Yet, on February 10th, 2005, three articles appeared in the New England Journal of Medicine advocating that it would be timely and cost effective to test every man, woman, and child for "HIV" at least once in their lifetime.

*"In all but the lowest-risk populations, routine, voluntary screening for HIV once every three to five years is justified on both clinical and cost-effectiveness grounds. One-time screening in the general population may also be cost-effective" [1-3].*

The authors of these articles do not define with precision who should be selectively targeted "in all but the lowest risk populations," but they now recommend testing for children, and monogamous adults, in addition to "high risk" people who are African Americans, Hispanics, alcoholics and drug addicts, pregnant women, and men who have sex with men. Some have suggested, in addition, routinely testing persons during every emergency room visit.

Other "HIV" "experts" more recently have claimed screening for AIDS would be cost-effective based on parallels with results obtained through screening for cancer" (emboldened words my emphasis):

*"In the United States, approximately 1 million persons are living with HIV infection or AIDS, and 164,000 to 312,000 of them remain unaware of their **infection**. Experts hypothesize that most of the 40,000 new **infections** that occur annually in this country arise from contact with these undiagnosed persons. Given this **likelihood**, investigators*

*have examined **the potential benefit** of routine screening, rather than testing of only **those perceived to be at increased risk**. This strategy appears to be as cost-effective as screening for colon, breast, or prostate cancer, and the availability of a rapid oral test has simplified broad scale testing" [4].*

One problem with these proposals is that "HIV" has no unique and isolatable identity or proven molecular signature as an exogenous retrovirus (a virus that comes from outside of a cell or organism) that is the cause of AIDS. "HIV" gene sequences can be detected in **non-infected** humans, chimps, and monkeys:

*"HIV-like sequences exist in normal human, chimpanzee, and rhesus monkey DNAs...Herein we describe the first report of the presence of nucleotide sequences related to HIV-1 in human, chimpanzee, and rhesus monkey DNAs from normal uninfected individuals." [5].*

Because the primate test subjects in this study were normal and healthy (no low lymphocyte counts or detectable illness), yet "HIV" sequences were detected, the molecular signature attributed to an assumed exogenous retrovirus, "HIV," may represent an inducible HERV (Human Endogenous Retroviral Sequence) molecular sequence or inducible polymorphism, which has not in itself been adequately demonstrated to be causal of immune suppression, or illness, but has been merely associated with less than 1/3 of human subjects who may be immune suppressed, according to the original studies of Robert Gallo's group that claimed a causal connection between "HIV's" molecular signature, and AIDS.

The unproven exogenous retroviral identity of so-called specific "HIV" derived proteins also can be appreciated, for instance, by considering what Nobelists Howard Temin and David Baltimore have proposed, who discovered reverse transcriptase (RT), and what Nobelist and former NIH head Harold Varmus wrote regarding reverse transcriptase, an enzyme once thought to be solely specific to retroviruses:

*"[Reverse transcriptase] is a normal protein found in the uninfected cells of **yeasts, insects and mammals**" [6].*

More recently, other investigators have claimed RT is an endogenous cellular enzyme that can assume various forms and it is important for telomere replication at the tips of normal chromosomes [7], and may have nothing to do with exogenous retroviruses. Once claimed by AIDS scientists to be a specific molecular component required for "HIV" replication, RT is now seen in market magazines concerning biotechnology stocks [8, 9], in the context of normal, non-pathological situations, despite what AIDS proponents continue to claim about the specificity of RT to exogenous retroviruses.

p24, another protein once thought to be unique to "HIV" is known to be expressed in the thymus glands of "**HIV-negative** children [10]." Other studies show that goat and cow milk that is unpasteurized induce positive "HIV" tests for proteins once thought to be derived from exogenous "retroviral HIV," and yet don't develop Goat Acquired Immune Deficiency Syndrome, or Cow Acquired Immune Deficiency Syndrome. Fifty percent of dogs in one study also exhibited "HIV" structural proteins but did not develop "AIDS" either [12].

Experiments testing the hypothesized ability of “HIV” integrase to interact with normal chromosomes revealed that the enzyme has no activity when compared side by side with histone H1 or polyamines, or the topoisomerases, and thus constituted a negative control for the minor groove-binding of the topoisomerases [13].

Although the template for the molecular signatures of “HIV” may derive from common endogenous DNA sequences whose proteins are expressed by normal uninfected yeast, insects, dogs, rhesus monkeys, chimps, and humans, neither "HIV's proposed 9,150 bp molecular sequence, or its proteins have been isolated or identified without contaminating cellular components. For instance, it has been repeatedly shown more than 30 times in “HIV” vaccine trials that antibodies against "HIV" proteins aren't evoked even when the so-called unique and diagnostic "HIV" antigens are injected directly into the bloodstream of healthy humans (according to “experts,” no molecular entity associated with "HIV" sequences, proteins, or glycoproteins such as GP120, has been shown to be immunogenic in humans, perhaps because it is a case of self being challenged by self)? The Merck "HIV" vaccine was just announced in September of 2007 as a complete and disappointing failure, not only in preventing acquisition of "HIV," but in the failure to evoke anti-"HIV" antibodies in the 741 volunteers.

According to what was believed two decades ago about Man’s immune system, it was assumed that a vaccinated individual would develop antibodies against molecules that are foreign to the human body. This would mean, in the case of an “HIV/AIDS” vaccine, that if vaccinated with components of “HIV,” the vaccinated would need to carry around a letter to prove their “HIV-positive status” was caused by a vaccine, rather than from "risky" behavior, or from being in an "at risk" group (from sex, dirty needles, exposure at the time of birth, breast-feeding, transfusions, being of African decent, being gay, being a drug addict, being pregnant, from having an autoimmune disease, or for dozens of other reasons).

But after more than as many 30, and perhaps as many as 60 "HIV" vaccine trials, letters as proof of "HIV" vaccination have not been needed. The few who have exhibited an “HIV-positive” test result after vaccination have been told their “HIV-positive” status was due to their own "risky" activities (sex). These individuals will now be regarded and treated as AIDS patients, regardless of their health status, and despite the fact they received an “HIV” vaccine.

The failure to produce an appropriate immune response (conversion from a negative to a positive "HIV" test result) or acquire protection from “HIV” or AIDS after so many "HIV" vaccine trials strongly suggests some measure of urgency or alarm is in order.

Failure to seroconvert to a positive “HIV” test result after vaccination means that the principles underlying immunology, biochemistry, genetics, epidemiology, virology, cell biology, pharmacology, neonatology, and cancer biology don’t apply to “HIV/AIDS.” Or it means that the hypothesized "HIV” causation of “AIDS,” and the imagined molecular biological causal basis of AIDS AND several other "molecular diseases" have generated catastrophic disasters that require our immediate attention.

These molecular diseases in question are those syndromes and their associated molecular signatures that have historically had some connection with cancer. This includes hepatitis B, hepatitis C, HPV, and, SV-40. Although no connection to cancer has ever been claimed, the group of diseases attributed to "prions," and their associated neurodegenerative diseases also need serious reappraisal.

Perhaps the urgency to critically examine our understanding of "HIV/AIDS" was driven home no more powerfully than this recently announced failure of the STEP "HIV" vaccine trial (Aidsmap news, Keith Alcorn, Saturday, September 22, 2007):

*"Merck HIV vaccine fails, trials halted."*

*"Trials of the most promising HIV vaccine to date have been halted following news that the vaccine did not protect against HIV infection, according to a press release issued on Friday by developer Merck. The STEP study (HVTN 502, Merck V520 Protocol 023) was a multicenter, randomized, double-blind, placebo-controlled phase II test-of-concept clinical trial. The trial enrolled 3,000 HIV-negative volunteers from diverse backgrounds between 18 and 45 years of age at high risk of HIV infection."*

*"The vaccine did not prevent infection: in volunteers who received **at least one** dose of the three-dose vaccine series, **24** cases of HIV infection were observed in the **741** volunteers who received vaccine and **21** cases of HIV infection were observed in the **762** participants in the placebo group."*

*"In the subgroup who had received **at least two** vaccinations and who were HIV negative for at least the first 12 weeks of the trial, **19** cases of HIV infection were observed in the **672** volunteers who received vaccine and **11** cases were observed in the **691** volunteers who received placebo."*

These fractions are important to remember:

***24/741** Proportion of recipients that seroconverted and who were given at least one vaccine dose- the experimentally vaccinated group.*

***21/762** Proportion of recipients that seroconverted and who were given at least one placebo vaccine dose-a placebo group.*

***19/672** Proportion of recipients that seroconverted and who were given **two** vaccine doses-the experimentally vaccinated group.*

***11/691** Proportion of recipients that seroconverted and who were given **two** vaccine doses, another placebo group*

The failure of this trial is being grieved as a huge disappointment to virtually everyone working in the field of "HIV/AIDS."

**The Challenger disaster, more and fatter cellular targets for HIV, and monkeys are too expensive.**

As mentioned, the AIDS industry blamed the few “who became infected” on the behavior of the volunteers after they had been given the vaccine, with no mention of possible false positives, or the possibility that they somehow acquired the positive result from the recombinant “HIV-component-containing” vaccine. Some experts, however, have expressed concern that somehow the vaccine itself might have caused "HIV-infection" in the 24/741 volunteers given one dose of the experimental vaccine, and in the 19/672 volunteers given two doses, which is why the trials were halted. In both studies, people who got vaccine were more likely -- not less -- to become "infected" with “HIV” with trends suggesting roughly a twofold risk after “HIV” vaccination.

Therefore, it can be safely concluded that the AIDS industry and U.S. government have spent billions to provide us with a vaccine that will increase, rather than decrease "HIV" seroprevalence.

Robert Gallo, co-discoverer of the human immunodeficiency virus (HIV), and head of the Institute for Human Virology in Baltimore, said of the trials (see **Figure 1**):



*“This is on the same level of catastrophe as the Challenger disaster” that destroyed a NASA space shuttle.”*

**Figure 1.** Challenger disaster.

The leading hypothesis offered by the AIDS industry for the vaccine’s failure and the increase in acquiring "HIV infection" among the “HIV” vaccine recipients is that:

*" People who received the vaccine had greater-than-normal activation and consequently produced **more** and **fatter** cellular targets for HIV. That then increased their chances of becoming infected should they encounter the virus in unprotected intercourse."*

Yet two facts make this claim unlikely:

*"People have been suffering immune-activating infections and getting vaccines for years, and there has never been evidence that those events increased a person's risk of*

*acquiring HIV. These vaccine trials would be odd places to first notice such a thing. Furthermore, people in the STEP study who got the vaccine did not have more activated CD4 cells than people who got placebo -- something that Merck vaccine executive Mark B. Feinberg called "kind of an interesting and unexplained observation."*

Dr. Anthony S. Fauci, head of the National Institute of Allergy and Infectious Diseases, which sponsored the trials said:

*"There is something very, very peculiar going on in the vaccine trials."*

In an interview with these and other top AIDS researchers of this "Challenger disaster-sized" vaccine failure, Ed Silverman suggested that this failure and insurmountable problems included such possibilities as (<http://www.pharmalot.com/2008/03/aids-vaccines-a-catastrophe-like-the-challenger/>):

*"The multiple surprises have reminded researchers how much they still do not know about HIV's biology. It has also focused attention on questions they never asked."*

*"For example, none of the monkey experiments with the Merck vaccine subjected animals to the kind of sexual exposure that people in the trial had -- namely, repeated encounters with low doses of HIV, with no single exposure being especially high-risk."*

*"Why not?"*

*"The researchers did not have any reason to believe the vaccine might be harmful (although they acknowledged it might not be effective), and in any case such a study would have required quite a large number of monkeys, **which are expensive to acquire and maintain for research.**"*

*"Instead, researchers vaccinated a relatively small number of monkeys with the Merck vaccine and then injected them with the **monkey equivalent of HIV** in a manner that guaranteed they would become infected. Those animals did **much better** over the long run than infected but unvaccinated ones."*

The vaccine's failure to protect recipients from acquiring "HIV" was also a big disappointment to the recipients of the anti-"HIV" vaccine. The "HIV" vaccine recipients tested positive for "HIV" slightly more frequently than the non-"HIV"-vaccinated, but the differences between the groups were not significant in any arms of the STEP trial, or in any other "HIV" vaccine trial. All of these men who now test "HIV-positive" will be regarded and treated now as AIDS patients.

However, the multiple failures of this huge, expensive, and potentially dangerous STEP trial (whose scientists and doctors couldn't afford enough monkeys to test their vaccine before trying it in humans) was predictable, not because "HIV" vaccinated or placebo vaccinated individuals became "infected" after they were vaccinated. And not because the **24/741** or the **19/672** experimental groups acquired an "HIV- positive" signal from the

components in the vaccine. Or not because somehow the experimental vaccine made volunteers more "susceptible" to acquiring "HIV infections" because they had "more and fatter cellular targets," which made them more susceptible to acquiring "HIV" infection. In all groups, whether or not they received the experimental vaccine or whether they were placebo recipients, these low numbers likely represent false positives or cross reactions (cross reactions occur when the non-specific reactivity of one molecule interact with another molecule that it isn't structurally similar to or related to in any way), or because of simple testing error.

So the question becomes, how could some 33 million people in the world be said to be "infected" and walking around with specific molecules of "HIV" in their bodies, or with molecules generated by the body's response to "HIV," while only 24/741 or 19/672 "HIV" vaccinated individuals seroconverted to "HIV's molecular signature, even after injecting these same molecules twice directly into their bodies by route of a vaccine?

This paradox suggests that perhaps the injected components of "HIV," or the antibody responses to these components have nothing to do with an "HIV" virus that is foreign to the human body.

Even from the beginning of "HIV" testing, it has been known that none of the tests can detect "HIV" virus particles directly, and that a positive antibody test may occur for 70 reasons that have nothing to do with "HIV" or "AIDS" (for a recent complete compilation and analysis of "HIV" testing artifacts see the new novel by Former Arizona Senator, Stephen Davis, [Are You Positive?](#)) The first ELISA tests showed for instance, that out of 1.2 million applicants for military service (the Burke study), there were 10,000 out of 12,000 false positives.

The "viral load tests" are based on the polymerase chain reaction (PCR) amplification of supposedly specific "HIV" gene sequences, and PCR tests are known to sometimes generate false-positive signals between 40-100% of the time, which is absurd if you consider what this really implies.

Someone with a high "viral load" should have their blood teeming with viral particles, and not be in need of any PCR amplification at all to detect this exponentially high quantity of viral gene sequences. Perhaps this is one reason why the inventor of the PCR technique, the Nobelist, Kary Mullis, once said there is no evidence that "HIV" is the cause of AIDS years ago. A patient with high "HIV" viral load should be able to walk into a physician's office, have their blood drawn, the doctor should be able to send that blood to a lab, and it should be loaded with hundreds of thousands or millions of "HIV" virus particles. But this has not been the case with "HIV." This is the reason why PCR amplification of "assumed" "HIV" viral gene sequences is measured biochemically rather than directly. Chemical amplification of "HIV" gene sequences has to be employed using PCR precisely because there are no detectable viral particles in the blood or tissues, nor have there ever been, in someone who is said to harbor the molecular signature(s) of "HIV" genomic sequences.

The plausibility of false positive readings in the STEP trial participants accounting for the few who were accused of becoming “HIV-infected” because of their behavior after vaccination is supported by a study conducted in 1992, in which a serosurvey of out of 20.2 million "HIV" tests done in Russia, only 112 were confirmed and about 20,000 were false positives (Voevodin A. *Lancet*. 339:1548, 1992).

112 “confirmed” “HIV” molecular signatures out of 20 million negative ones doesn’t constitute the kind of numbers that signal a major AIDS pandemic in Russia. The numbers could represent statistical artifact, or, in the several who seroconverted and showed a positive test result may represent the presence of some kind of auto-immune condition, like psoriasis, arthritis, or warts, or physiological stress, or a genetic polymorphism (human genetic variability).

According to former NIH director, and Nobel Laureate, Harold Varmus, retrovirus-derived DNA sequences (genes that come from viruses whose genes are made out of RNA instead of DNA), may be ancient molecular “parasites” in their associations with other organisms. They may not be recognizable as foreign molecules to the human immune system.

Thus, retroviruses or their components may not be immunogenic (capable of being seen as foreign by the human immune system), because “HIV’s” molecules are not seen as foreign or non-self.

*As molecular parasites, retroviruses, their genes, and the molecules made by their genes may simply be a part of our cells because they always have been, are, and always will be, made by our own cells.*

Alternatively, it is always stated by the AIDS establishment (those who have promoted and believe in the “HIV” equals “AIDS” hypothesis), that “HIV” is not part of self (from the immunological and molecular point of view the mainstream view says “HIV” is a virus foreign to Man and “HIV” molecules are not found in the normal, uninfected human body).

In the context of the failure of more than 60 "HIV" vaccine trials that are on the books, it may be more appropriate to say that the whole theory of "HIV=AIDS" is flawed, because there is no evidence that an exogenous "AIDS virus" has been isolated, and shown to evoke an antibody response in vaccine recipients or cause disease in either an animal model or a human being. Unless one would like to make unfounded assumptions that the 24 of the 741 volunteers that "became infected" in this last of more than 30 failed "HIV" trials actually represents an extremely low rate of seroconversion due to exposure of isolated "HIV" components to the human immune system (24/741), and that these 24 individuals are now immunized against "HIV" instead of having acquired an "HIV" infection, the similar rate of seroconversion in the control group (21/762) suggests that this cannot be the case, and it is more likely, that seroconversion in both groups represents mere testing artifacts.



In support of this seemingly radical idea, "AIDS experts" themselves have in the past announced that:

*"A sound rationale (is) needed for Phase III HIV vaccine trials" [14],*

and in 2006, Barre-Sinoussi (of the Luc Montagnier team) has "come out of the closet," so to speak on this issue at the Toronto International AIDS conference, where she said:

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

Perhaps more importantly, even after the 120 million dollar failure called AIDSVAX was announced in 2004 that prompted Dr. Gallo to state: "a sound rationale is needed for Phase III HIV vaccine trials," no re-evaluation of the basic premises of AIDS science has taken place. Instead, following that failure, Donald Francis's 120 million dollar AIDSVAX program and his company VaxGen has now been rescued with our tax dollars by the military to produce a new anthrax vaccine that also failed-but that is a different \$857 million dollar story.

Other "HIV" vaccine enthusiasts claim that although "HIV" vaccines don't work because they aren't immunogenic, it is asserted tacitly that certain vaccine adjuvants will help do the job (because the so-called proteins of "HIV" repeatedly fail to evoke humoral immunity, mucosal immunity, cellular immunity, or even T-cell activation). Vaccine adjuvants like squalene (MF-59), however, when they have been added to certain lots of anthrax (and "HIV") vaccines given to soldiers and other "volunteers" on threat of court martial if they don't roll up their shirt on command (in contrast to Walter Reed's voluntary experiment with yellow fever), have been responsible for autoimmune syndromes in most sick Gulf-War I veterans tested, as evidenced by the fact that sick veterans invariably generate antibodies to squalene in their blood [15, 16]. This type of "promising vaccine experimentation" on our young soldiers is particularly disturbing in light of the fact that squalene and other similar vaccine adjuvants have been traditionally used by scientists who study rheumatoid arthritis, lupus, or demyelinating syndromes, because experimental rodents will reliably develop experimental arthritis, macrophagic myofasciitis, multiple-sclerosis (demyelinating syndromes), and lupus-like syndromes upon exposure to squalene [17, 18, 19].

The proposal for universal "HIV" testing raises other issues about "HIV-testing" itself. In 1985, at the beginning of HIV testing among sperm donors, it was known that "68% to 89% of all repeatedly reactive ELISA (HIV antibody) tests [were] likely to represent false positive results" [20] (which is why the hypothesis was suggested regarding testing artifact to explain the 24/741 and 21/762 numbers obtained in the context of the failed Merck vaccine described above). The modern "HIV" screening tests, especially the rapid ones, are contradictory from test result to test result, they are inconsistent across national boundaries, and no consensus about their validity exists. An "HIV" positive test result obtained with an ELISA, Western Blot, or PCR, may not even mean that a person who tests positive is infected with a virus or is expressing evoked "HIV-endogenous

sequences or molecular signatures [5] (because of the cross reactivity known to exist regarding “HIV” sequences and proteins and normal endogenous cellular components that are expressed or shed under certain conditions of immunological or other types of physiological stress [10]). In this regard, a principal issue to reconcile before universal testing is implemented is that the makers of the test kits used to measure “HIV” or progression to “AIDS” are themselves aware of these issues, because they all claim their ELISA, Western Blot, and PCR-based kits can't really detect “HIV” virus in their package inserts:

*"ELISA testing alone **cannot** be used to diagnose AIDS" [21].*

*"**Do not** use this kit as the sole basis for HIV infection," [22].*

*"The amplicor HIV-1 monitor test **is not** intended to be used as a screening test for HIV, nor as a diagnostic test to confirm the presence of HIV infection" [23].*

*"The NucliSens(R) HIV-1 QT assay **is not** intended to be used as a screening test for HIV-1 nor is it to be used as a diagnostic test to confirm the presence of HIV-1 infection" [24].*

COBAS AmpliScreen HIV-1 Test ***is not** intended for use as an aid in diagnosis" [25].*

The Cambridge Biotech HIV-1 Western Blot Kit insert: *"The clinical implications of antibodies to HIV-1 in an asymptomatic person are not known" [26].*

*"The OraSure HIV-1 Western Blot Kit is not intended for use with blood, serum/plasma or urine specimens, or for screening or reinstating potential blood donors" [27].*

The Red Cross recently reported in the New England Journal of Medicine that even after repeated testing using different test kits, low-risk populations, such as blood donors (or military recruits) will typically yield 12 (PCR-positive) or 2 (ELISA positive) out of 37,000,000 samples, leaving potentially 10 out of 12 false positives, depending on which test kit you believe accurately detects "HIV's" molecular signatures [28]. While it has been pointed out that of the 2 of the 12 who initially tested positive on ELISA seroconverted in subsequent months to the molecular signature of "HIV" detected on PCR, and thus may warrant an investigation as to what the meaning of these molecular signatures represent among persons who exhibit clinical symptoms. In this regard, it could be argued that 2 or 8 out of 37,000,000 does not constitute a national health crisis, or communicable illness of the proportions of other STD's, and certainly doesn't warrant research budgets in the billions, or universal testing of "low risk" individuals.

The value of the rapid “HIV” test kits are even more problematic, and some of them have been banned from the US:

"A District Court in Seattle has granted a request from the Federal Trade Commission and issued a temporary restraining order to prevent the sale and distribution of

"defective" home HIV test kits. According to FTC, the kits' maker, Seville Marketing of British Columbia, Canada, on two Web sites had advertised the "Discreet" home HIV test kits as producing 99.4% accurate results based on three independent studies. However, CDC studied the test kits and found they were not as accurate as the company claimed on its Web site."

*"FTC will seek a permanent ban on sales and advertising of the kits in the United States and a permanent order to seize any kits that are imported. Consumers who have used the kits are advised to see a health professional for another test to determine their HIV status, according to the release"[29].*

But none of these tests have been validated against the isolation of pure "HIV" itself. They have been validated instead against other test kits that are assumed to detect "HIV."

Moreover, it has been recently proposed that viral load does not correlate with T-cell numbers, and the **rate** of progression (when an individual will exhibit symptoms of AIDS) can only be predicted in 4%-6% of HIV-positives studied (out of 2,800):

*"A nationwide team of orthodox AIDS researchers led by doctors Benigno Rodriguez and Michael Lederman of Case Western Reserve University in Cleveland are disputing the value of viral load tests—a standard used since 1996 to assess health, predict progression to disease, and grant approval to new AIDS drugs after their study of 2,800 HIV positives concluded viral load measures failed in more than 90% of cases to predict or explain immune status..." "Viral load is only able to predict progression to disease in 4% to 6% of HIV-positives studied, challenging much of the basis for current AIDS science and treatment policy" [30, 31].*

In 1992, the Lancet reported that for 66 true positives, there were 30,000 false positives. And in pregnant women,

*"there were 8,000 false positives for 6 confirmations." [32].*

In 1995, the CDC recommended offering HIV testing to all pregnant women, but according to official AIDS websites like the CDC's and on package inserts of "HIV" test kits, false positives due to pregnancy occur frequently [33]. There are some 70 factors or conditions that are known to generate false positive test results including flu vaccination [34] and hepatitis B vaccination [35], although it still isn't clear that these conclusions weren't due to vaccination cross-reactivity, or attributable to problems with the "HIV" test kits themselves. Different testing standards in different countries makes it possible that if you test "HIV" positive in the US in the morning, one can fly the same day to Canada, the UK, or Australia, where different standards are considered diagnostic, and you will be considered negative the same day and thereby retain your insurance, job, relationships, pregnancy, or life.

By 18 months after birth, in 1993, Parekh et al. reported:

*"a 60% rate of seroreversion in infants born of "HIV-positive" mothers [36, 37].*

Thus, under the new mandate to universally test infants, 60% of infants who initially test positive will serorevert by 18 months post-partum. If 60% of infants who initially test positive serorevert (change from a positive to a negative "HIV" test result) are forced to imbibe "anti-retrovirals," then 60% of infants will be needlessly exposed to toxic chemo (either in utero or post-partum).

PCR results in infant testing are not diagnostic in infants either, because the inventor of PCR has repeatedly claimed that viral load cannot be detected using PCR, because PCR can only be used to amplify the assumed nucleic acid signature of "HIV," which again, has not been validated against the isolation of "HIV" itself (Kary Mullis in numerous writings and statements that are typically ignored, is belittled, and derided by "AIDS experts").

If "HIV/AIDS" is chemotherapeutically hit hard and early as a consequence of an impassioned crusade to provide what amounts to toxic chemotherapy (see any AntiRetroviral-ARV- package insert) to millions of those who test positive (even those who live in Kenya who only have a cup of diluted gruel paste/day as food-liquid to wash down their medications-see Christiane Amanpour's July 19, 2006 documentary on CNN-[www.cnn.com/2006/WORLD/africa/07/17/amanpour.africa.btsc/index.html](http://www.cnn.com/2006/WORLD/africa/07/17/amanpour.africa.btsc/index.html)), universal testing for "HIV" "infection" would increase morbidity and death amongst those designated as "HIV/AIDS" patients, rather than decrease morbidity and death.

For example, de Martino *et al.* concluded that children born to ZDV-treated mothers (ZVD is AZT, or the AIDS drug, Azidothymidine):

*"are **more likely** to have a rapid course of HIV-1 infection compared with children born to untreated mothers, as disease progression and immunological deterioration are significantly more rapid **and the risk of death is actually increased during the first 3 years of life**" [38].*

In the journal Pediatrics, Antoni Noguera et al reported that:

*"Almost half of the children (63 of 127) who were exposed to nucleoside analogues developed benign and self-limited hyperlactatemia when symptomatic, nucleoside analogue-induced toxicity affected neurologic development " [39].*

In 1992, The Veterans Affairs Co-operative Study Group reported that AZT disproportionately harmed Blacks and Hispanics, and provided no benefit to the quelling of advancing immune suppression in Caucasians, and harmed healthier subjects (early treated) more than persons considered to exhibit clinical symptoms of AIDS [40].

The Concorde trial, which was published without endorsement by Burroughs Wellcome's Coordinating Committee who declined to endorse the final report, and which was the largest, longest, and best controlled adult AZT trial concluded:

*"The results of Concorde do not encourage the early use of zidovudine in symptom-free HIV-infected adults. They also call into question the uncritical use of CD4 cell counts as a surrogate endpoint for assessment of benefit from long-term antiretroviral therapy"* [41].

When considering "HIV" testing all infants and all subjects who visit their doctor or emergency rooms, faith-based science and medicine also dominate ideas regarding the "mutability" of the "HIV" virus, and the failure of ARV-therapy. Individuals who fail ARV therapy are told their virus has mutated and is no longer sensitive to the drugs. The impact of this hypothesis on persons living with "HIV" or "AIDS" is unfair, uninformed, and cruel. For example, Mark Harrington, a member of The Treatment Action Group (TAG) summoned *"the power of prayer"* over "HIV" mutability, and discussed *"The Chinese Menu Approach"* in a description of a meeting he attended on developments regarding anti-retrovirals that included AIDS leaders such as Marc Wainberg, Director, McGill AIDS Centre, and the 2006 Chair of The Toronto International AIDS Conference—who possesses several "HIV" drug patents such as lamivudine (3TC), and grants from GlaxoSmithKlein, Bristol-Myers Squibb and Boehringer-Ingelheim. Also present at the meeting was Emilio Emini, Tufts University's John Coffin, Roche's Noel Roberts, the CDC's Harold Jaffe, Chiron's David Chernoff, the ACTG's Robert ("Chip") Schooley and John Mellors (developer and champion of the viral load tests now known to be invalid [30]), as well as treatment activist Dawn Averitt-Doherty of Atlanta-based Woman's Information Service and Exchange (WISE):

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

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

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

*"Harrington: Take two new nucleosides and nevirapine?"*

*"Emini: Yeah. And pray."*

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

*"Sometimes the gap between how the researchers felt and how we felt became an abyss. They were excited about the endless possibilities opened up by the research advances of 1996; we were terrified about the limited treatment options facing people who had exhausted most of the current arsenal of antiretroviral therapy. What to do with those whose viral load refused to go undetectable? What to do with those who added a protease inhibitor to a failing two-drug regimen and appeared doomed to develop resistance, most of it-especially with ritonavir and indinavir-cross-resistant to all other protease inhibitors? What to do with those who jumped aboard last year's bandwagon, AZT+3TC, and now appeared likely to have developed 3TC resistance and, with it, cross-resistance to ddI, ddC and possibly 1592? **The Chinese menu approach to antiretroviral treatment suddenly looked much less appetizing, and much less nourishing**"[42].*

These same results also have been advanced in frequent warnings on MedWatch:

*"Early virologic **nonresponse** (91%) and nucleoside reverse transcriptase inhibitor (NRTI) **resistance** (50-95%) has been observed at a high rate in a Gilead Sciences-sponsored clinical study. Participants in the study were treatment-naive (ie, no previous treatment for HIV) took a once-daily, 3-drug NRTI regimen. The NRTI regimen contained didanosine enteric coated beadlets (Videx EC), lamivudine (Epivir), and tenofovir (Viread)" [43].*

*"The new information is consistent with several recent clinical studies evaluating the use of 3 NRTIs simultaneously. Suboptimal virology response has also been reported with abacavir, didanosine, and stavudine, as well as another regimen containing abacavir, didanosine, and zidovudine. Similarly, early virologic failure and high resistance rates have been reported with abacavir, lamivudine, and tenofovir (see eMedicine Recalls and Alerts 8/1/03, Nonresponse Reported in HIV Infection Treated with 3-Drug Regimen Including Lamivudine, Abacavir, and Tenofovir)"[43].*

Other warnings on FDAMedWatch support Mr. Harrington's sentiments regarding liver toxicity, and also warn about neural tube defects in fetuses from woman who test positive and who are treated with "the life saving" AIDS medicines:

*"Increased Liver Toxicity with Nevirapine (Viramune) and Higher CD4 Counts...Revised prescribing information for nevirapine (Viramune) includes a new recommendation against starting nevirapine treatment in women with CD4 cell counts above 250 cells/mL and males with CD4 counts above 400 cells/mL unless benefits clearly outweigh risks. The new recommendation is based on an increased risk of serious liver toxicity with higher CD4 cell counts prior to starting therapy with nevirapine"[44].*

*"Females and patients with higher CD4 cell counts are at increased risk of liver toxicity. Females have a three-fold higher risk of symptomatic nevirapine liver toxicity than*

males, and females with CD4 cell counts above 250 cells/mL have a 12-fold higher risk of symptomatic liver toxicity than females with CD4 cell counts below 250 (11% vs. 0.9%). Males with CD4 cell counts above 400 cells/mL have a five-fold higher risk of symptomatic liver toxicity than males with CD4 cell counts below 400 (6.3% vs. 1.2%) "[44].

*"New Drug Interaction Warning with Rifampin and Combination of Ritonavir and Saquinavir. 'Drug-induced liver toxicity with highly elevated liver enzymes (greater than 20 times the upper limit of normal) has been observed in 39% of **healthy volunteers** receiving rifampin 600 mg once daily in combination with ritonavir 100 mg/saquinavir 1000 mg twice daily (ritonavir boosted saquinavir) [45].*

*Neural Tube Defects with First Trimester Efavirenz (Sustiva) Use. "The prescribing information for efavirenz (Sustiva) has been changed to include new information. The revision result of four reports linking neural tube defects in infants born to women with first trimester exposure to efavirenz. The four cases of neural tube defects include three cases of meningomyelocele and one Dandy Walker Syndrome. Pregnancy should be avoided in women receiving efavirenz...Efavirenz is an antiretroviral drug indicated for acquired immune deficiency syndrome (AIDS, HIV-1 infection). **A registry has been established to monitor fetal outcomes born to women exposed to efavirenz.**" [45].*

Perhaps from the standpoint of inventing genetic mutation abilities or characteristics that defies all common sense, not to mention biological understanding of the invariance and stability of a genetic code, there is no bigger tragedy than what was reported this year with nevirapine. Virological failure or drug resistance are technical terms among "HIV-AIDS" proponents that have come to mean that an anti-retroviral drug doesn't work (fails to suppress virus), or that disease progression is more rapid in those that take a particular drug. In the New England Journal of Medicine, it was reported (and despite its known toxicity and withdrawal from the U.S. several years ago):

"Well over **875,000** women and infants have received a single dose of nevirapine. A single dose of nevirapine is the cornerstone of the regimen recommended by the World Health Organization (WHO) to prevent mother-to-child transmission among women without access to antiretroviral treatment and among those not meeting treatment criteria. However, nevirapine **resistance** is detected (with the use of standard genotyping techniques) in **20 to 69%** of women and **33 to 87%** of infants after exposure to a single, peripartum dose of nevirapine. Among 60 women starting antiretroviral treatment within 6 months after receiving placebo or a single dose of nevirapine, **no women in the placebo group and 41.7% in the nevirapine group had virologic failure (P<0.001)**. Women who had received a single dose of nevirapine had significantly higher rates of virologic failure on subsequent nevirapine-based antiretroviral treatment than did women who had received placebo. This apparently deleterious effect of a single dose of nevirapine was concentrated in women who initiated antiretroviral treatment within 6 months after receiving a single dose of nevirapine. We did not find that a previous single dose of nevirapine compromised the efficacy of subsequent nevirapine-based antiretroviral treatment in women who started antiretroviral treatment 6 months or more

after delivery. Among the 30 HIV-infected infants, a single dose of nevirapine (one each to mother and infant) as compared with placebo was associated with significantly higher rates of virologic failure and smaller CD4+percentage increases in response to subsequent nevirapine-based antiretroviral treatment”[46].

Football strategies and religious ideology also have been used after repeatedly failed human “HIV/AIDS” microbicide trials. Microbicides are noxious chemicals that supposedly kill "germs" like "HIV." White Western AIDS doctors go to the African continent to encourage the smearing of these toxic microbicide creams on the genitals of Africans. Although a top AIDS researcher, John Moore of Weil Medical College, claimed his multiple monkey "SIV" insemination experiments proved that his “SIV-fighting” (not “HIV-fighting”) microbicide worked because it absolved his monkeys from contracting “SIV” after he inseminated them multiple times, human microbicide trails were halted because these vile mucosal irritants, like the STEP trial vaccines, caused “more” “HIV infections” in microbicide recipients, than it did in placebos. (February 1, 2007, Tests of Drug to Block H.I.V. Infection Are Halted Over Safety: The Conrad Trial. By Lawrence K. Altman):

*"Efforts to develop a topical microbicide to prevent H.I.V. infection during sex suffered a surprising setback yesterday when researchers announced that they had stopped two full-scale trials for safety reasons."*

*"The trials, in Africa and India, involved a chemical, cellulose sulfate or Ushercell, and were the second failure of a potential microbicide in a full-scale trial in recent years. In one of the latest trials, a standard check by an independent scientific committee found an increased risk of H.I.V. infection among women who used cellulose sulfate compared with those who used a placebo gel."*

*"In 2000, a large full-scale trial showed that the only other microbicide candidate, nonoxynol-9, was unsafe when it had been expected to be effective. Subjects in that trial developed a higher incidence of H.I.V. infection, presumably through ulcers caused by chemical irritation."*

The sanctity of breast-feeding also has been violated by the champions of the “HIV=AIDS” hypothesis. It is the image in The Vatican of Michaelangelo’s Pieta-Mother Mary holding her dead child (see **Figure 2**). In fact, the practice of brow beating African women to dissuade them from breast feeding and passing onto their infants “HIV-infection” increased the death-rate in formula-fed infants some 20 times, compared to mother-infant pairs that weren’t dissuaded from breast feeding. For instance, on Monday, July 23, 2007, in Nkange, Botswana, it was reported by Craig Timberg, Washington Post Foreign Service, that in Botswana, steps to cut AIDS proves a formula for disaster:





*"Doctors noticed two troubling things about the limp, sunken-eyed children who flooded pediatric wards across Botswana during the rainy season in early 2006: They were dying from diarrhea, a malady that is rarely fatal here. And few of their mothers were breast-feeding, a practice once all but universal."*

*"After the outbreak was over and at least 532 children had*

died — **20 times** the usual toll for diarrhea — a team of U.S. investigators solved the terrible riddle."

As the U.S. government and medical establishment are considering instituting "HIV" testing of all pregnant women and infants and all who visit their doctor, or emergency rooms, religious ideology continues to direct ideas regarding the "mutability" of the "HIV" virus, and the failure of the AIDS industry to cure patients of immune suppression using ARV-therapy (therapy using ARV drugs to suppress "HIV"). For example, individuals who fail ARV therapy are told their virus has mutated and is no longer sensitive to the drugs.

Universal "HIV" screening of certain groups is nothing new, and it hasn't improved the health or reduced "infection rates" of those populations for which routine screening is already in place: military recruits [47, 48], medical students, "disease ridden foreigners" (immigrants who apply for permanent residence, and any participant in the Gay Games in Chicago, despite "some conservative groups who oppose(d) the federal government's decision to waive the ban on HIV-positive travelers to the U.S. [49], saying it threatens public health)", and, universal screening of pregnant women. The reason why none of these groups have benefited by universal testing is because of the false positive rate of the test results, especially among those "low risk" groups that will now be tested routinely at their doctor's office, or perhaps in emergency room visits.

If you test positive because you recently had a flu vaccine or are pregnant, grave psychological consequences can result. For instance, has universal “HIV” screening within mandatory medical resident training programs ever prompted a letter of apology to the family of Dr. David Acer, for his committing suicide on the basis of mistaken charges that he spread “HIV” to his patients [50], which the CDC later exonerated him of doing (after his suicide), because the CDC could "find no evidence the dentist's HIV-positive patients contracted their infections from him because their virus' DNA did not match his, and also concluded the dentist's patients did not contract the virus from one another -- in effect, that unclean dental implements did not act as conduits." Other studies that have followed exposure of health care workers have also found no transmission of AIDS [51].

Not only does transmission of AIDS not occur between 60% of positive mother-infant pairs because infants serorevert, or in health care settings such as dentist’s offices, hospitals, or sperm banks, but it doesn’t occur in serodiscordant couples. From the study called “Heterosexual Transmission of HIV in Northern California: Results from a Ten-Year Study:”

*“We followed up 175 HIV-discordant couples [one partner tests positive, one negative] over time, for a total of approximately 282 couple-years of follow up... **No transmission [of HIV] occurred among the 25% of couples who did not use their condoms consistently, nor among the 47 couples who intermittently practiced unsafe sex during the entire duration of follow-up...**” **“We observed no seroconversions after entry into the study [nobody became HIV positive]...This evidence argues for low infectivity in the absence of either needle sharing and/or other cofactors [52].”***

## GENETIC INVARIANCE

Instead of mutation, in biology the nature of life on earth suggests that genetic invariance (non-change of genetic identity) governs the characteristics of a species, a bacterial strain, or, a viral strain. The stability of the genetic code, largely because of the strong molecular material it is made out of, assures a continuance of distinctiveness of form and function in cells, organisms, and viruses.

Genetically, for “HIV’s” protein coat to change rapidly and often means that "HIV" is capable of continuously reshuffling its tiny sinister genome like a card deck, to produce proteins that are perpetually novel and unrecognizable to the immune system, but which paradoxically have remained unchanged and diagnostic on the “HIV” tests of millions of people for two decades in more than 33 million “infected” folks.

It has been said that "HIV's" genome is more complex than most retroviruses because it has more than just the typical number of gag, pol, and env genes to facilitate its supernatural ability to mutate every time it is analyzed.

However, this juxtaposition of what is known as genetic invariance (non-change) in one context (two decades of "HIV" testing) and "HIV's" imagined ability to constantly mutate

its genetic sequence in another context (in vaccine recipients, patients treated with HAART and who fail the "life-saving AIDS drugs" like nevirapine), violates what is known about the ability of the structure and chemistry of genetic material to maintain non-change over the geological time periods of hundreds of millions of years. During similar time frames, non-living things such as mountain ranges, or even continents, come and go. Therefore, it is without scientific basis to imagine that "HIV's" molecular signature has remained detectable with the same molecular probes on the more than 33 test kits in 33 million people for over a period of two decades, while at the same time, it mutates in almost each and every anti-retroviral drugged patient who dies. It is like a bad science fiction movie when we are told that "HIV" mutates in 41.7% of 875,000 black women who were told to imbibe a single dose of nevirapine, or when we are told that its genetic structure can change in the time it takes the vaccine maker to make and ship off the vaccine in a truck until it arrives in your doctor's office, during which time, the clever "HIV" "mutates."

In support of "HIV's" molecular sequence or signature being a stable phenomenon, among the human population, there has been no measured change in sequence or structure of supposedly specific and diagnostic "HIV" molecules such as p24 that are detected today, and the p24 molecules the test kits supposedly detected at the beginning of the AIDS era.

Reverse transcriptase, another supposedly imported "HIV" gene, is known for its stability (and its stable and important long history within the genomes of organisms throughout Nature), not its mutability. A person that would test positive for p24 protein in 1984, would test positive for the same p24 molecules today.

Therefore, it is unlikely that an unstable process such as mutation is the reason for "HIV's" touted ability to evade the immune system after vaccination.

Nor can mutation account for how "HIV" can evade drugs like AZT, HAART, or nevirapine by allowing "HIV" to form what has imaginatively been called "escape mutants." Chicken pox, small pox, and rabies supposedly have the same or very similar genomes and proteins today as they did centuries ago, and they cause the same collection of symptoms as they have in the past.

A person bitten by a rabid dog in Pasteur's day 150 years ago who acquired rabies would have the same symptoms as a person bitten last year in North Carolina who acquired rabies from a rabid dog. If the virus were analyzable during Pasteur's day, it would likely have had the same genes, and proteins.

We assume that clams taste the same today as they would have eight-hundred million years ago, or that blue-green algae, which are microbes, look and taste the same as they did during the pro-biotic era when life first appeared.

The distinctiveness of the leper's lesions described during in antiquity would likely exhibit the same appearance as they do today, and are associated with the same

Mycobacteria. Like gives rise to like, and if doesn't because of mutation, then it becomes something else that usually doesn't work. This is the overwhelming lesson that genetics teaches regarding mutation, and genetic invariance.

That the vaccine failures, breast feeding dissuasion disasters, and anti-retroviral induction of escape mutants, don't represent simply one carefully selected piece of "cherry picked" evidence in favor any particular viewpoint, other failures of the hypothesis that have become evident only recently, also serve to undermine the "HIV equals AIDS" hypothesis, and demonstrate how this molecular hypothesis of disease has been stretched beyond the limits of genetics or the germ theory, and now constitutes a quasi-religious series of heart-felt beliefs.

Some of these failures not only include the failure of "HIV" vaccines, but also the failure to isolate "HIV" and explain or predict the confusing molecular signatures that are detected in healthy drug-naïve persons.

The failure to consistently sequence the "HIV" genome or identify specific proteins that are **not** also found in normal, non-infected contexts.

The failure to block transmission of "HIV" or AIDS in **mother to child transmission** studies (MTCT), which show increased rates of nevirapine in 20 to 69% of women and 33 to 87% of infants after exposure to a single, peripartum dose of the black box label drug nevirapine.

The failure of ARV's (anti-retrovirals) to prevent "AIDS syndromes" while silencing "HIV's" molecular signature.

The failure to observe predictable changes in "HIV" and "AIDS" prevalence and incidence statistics, which according to epidemiologists have been manufactured from The WHO's "best guess estimates," or biased because numbers are based on STD clinics or perinatal clinics.

The "HIV=AIDS" hypothesis has also failed to explain how latency makes sense from a biochemical point of view.

It has failed to explain why there are no consistent in vitro models to detect "HIV" infection.

It has failed to explain why an "HIV/AIDS" animal model cannot be developed or found in Nature.

It can't explain why prostitutes and sex workers don't acquire "HIV's" molecular signatures or develop "AIDS" unless they are also chronic drug abusers.

It cannot account for why human transmission studies have failed to show “HIV” or “AIDS” transmission between serodiscordant couples, or among health care workers accidentally inoculated with “HIV-tainted” blood.

It cannot explain why the spouses of “HIV-positive” hemophiliacs and “HIV-negative” partners have failed to seroconvert or develop “AIDS” after numerous exposures to their “HIV” positive spouses.

It offers no explanation why on February 14th, 2008, in San Diego, California, the local county health department made quite a big press release because all sexually transmitted diseases in their local gay community have risen by an astounding 800 percent since 2003, including syphilis, gonorrhea, and Chlamydia, except for "HIV infection rates, which have miraculously dropped since 2003 in the very same gay community.

It cannot account for why there are large numbers of so-called “Long-Term Non-Progressors,” or “Elite Controllers” who never acquire any illness, although they may test positive for “HIV’s” molecular signature for more than two decades.

Why ICL-AIDS patients test negative for “HIV” but are thought to have “AIDS.”

How decreases or increases in various T-cell subsets don’t indicate and cannot predict any effect of a viral presence or infection in drug-naïve patients.

Why viral load has been aggressively monitored by doctors despite the fact that no virus has ever been observed in the blood of a so-called “HIV-positive individual harboring high “viral load” as measured by PCR (polymerase chain reaction).

And, why none of the more than 33 “HIV” test kits claim they can detect “HIV,” and continue to state on their package inserts that the significance of “HIV’s” molecular signature is not known.

## **THE MEANING OF “HIV’S” MOLECULAR SIGNATURE**

Because the components of a retrovirus that is supposed to cause immune suppression haven’t been isolated, because they can’t induce seroconversion in the vaccinated, or been shown to cause immune suppression in humans or animals, it can be stated at this point that the meaning of the molecular signature of "HIV" has not been found.

But the experimental Hepatitis B vaccines during the hepatitis B era also failed to demonstrate viremia or cell destruction: No destruction of cells or tissues was seen in the liver of chimps or mice injected with “hepatitis B” virus.

When they tried injecting chimpanzees with sera from AIDS patients or what they believed was purified “HIV,” chimps didn't get sick, nor could viremia be demonstrated in the so-called organs that the virus was supposed to attack, or the blood, where there are supposed to be millions of copies, but no photographs.

When they did studies on human sexual couples, one of which was positive and the other one was negative for “HIV’s” molecular signature -- a famous study known as the Padian study -- they found **zero** conversions out of 175 pairs of so-called “discordant couples” where one was positive and one was negative. They all had varying degrees and frequencies of sex, one assumes, and among many couples, it was not “protected” sex either. Only those lovers who showed a "positive HIV test" were considered AIDS "carriers." The fact that they didn't pass on "the virus" to their seronegative partners, proponents say, was due to good prevention counseling. So good counseling may be the cure for AIDS?

Dr. Padian herself argued that her study does nothing to belie the official model of “HIV” being sexually transmissible, or even highly transmissible. This is absurd on the face of it. There were zero seroconversions in the Padian study, among sexually active sero-discordant couples, studied over a ten-year period. Many other smaller studies have shown the same lack of seroconversion among serodiscordant couples. If human beings cannot transmit the virus sexually to one another, how could transmitting “HIV’s” molecular signature to people with a vaccine evoke either seroconversion or immunity?

There are so many different types of examples why the “HIV=AIDS” hypothesis fails to explain anything about transmission, immune suppression, or disease, or why all these vaccine trials have failed, that it cannot possibly be cherry picking of data to criticize the “HIV=AIDS” paradigm. When they launched the anti- breast-feeding programs and they warned all these African women not to breast-feed because they might pass on the AIDS virus through their breast milk, they found out -- just this year -- that the women who were dissuaded from breast-feeding their infants, had a twenty times greater rate of death among their babies than infants of mothers that breast fed, because the infants were not achieving the proper protective immunity or nutrition that goes along with normal breast-feeding in these extremely poverty-stricken places where human experiments are typically tried out first, before they are implemented in the countries whose inhabitants matter in the world.

If infants have higher infant mortality rates following the wisdom of The AIDS Establishment not to breast feed, even in regions of the world that are supposed to have high rates of “HIV,” then how could it be even considered a possibility that vaccine makers could inject some component(s) of “HIV” directly into a human vein and induce protection from immune suppression, or, in the case of the failed Merck trial mentioned before, evoke “HIV’s” molecular signature in any significant number of vaccine recipients? Most or all of the vaccinated should have at least shown seroconversion if “HIV’s” components had been isolated and are immunogenic in human beings.

These kinds of data that do not support an "HIV=AIDS" hypothesis, should be compared to other hypotheses who have claimed they found a potential and compelling cause of AIDS. For example, in 1989-1990, a series of articles published by Shyh-Ching Lo of the Armed Forces Institute of Pathology, who presented evidence that a microbe called *Mycoplasma incognitus* was found in the thymus, liver, spleen, lymph node, or brain of

22 of 34 persons who had died of AIDS. The patients who were selected for this autopsy study had all had evidence of organ failures. In another study, mycoplasma was found in seven of ten persons with AIDS. Also, a much earlier study had found *Mycoplasma incognitus* in blood lymphocytes of 12 of 23 living persons with AIDS — but in none of 22 healthy blood donors used as controls. The mycoplasma was also found in six “HIV-negative” patients with no sign of AIDS from different parts of the world, who had died in one to seven weeks of an undiagnosed infection. When four monkeys were injected with *Mycoplasma incognitus*, they all died in seven to nine months. The organism was found in the spleens of all the monkeys, and in some other organs as well. It was not found in a fifth monkey tested as a control. Electron-microscope examinations, PCR tests and immunologic tests all showed that the organism was concentrated in lesions in affected organs, and *Mycoplasma incognitus* is unusual in that it often infects and kills tissue without causing an inflammatory reaction, suggesting that it disables or evades part of the immune system. Indeed, in one of the first studies linking “LAV” (“HIV”) to AIDS, Montagnier's group also reported that mycoplasma removal agent changed the dynamics of their "LAV" expression in their Petri dishes (LAV is “HIV’s” first name), signifying that this micro-organism may also have been present in "Patient One" as well as syphilis, gonorrhea, herpes, CMV, and perhaps other pathogens.

No scientific evidence has shown that the “HIV” “retrovirus” causes the immunodeficiency illness symptoms called AIDS. We have requested the scientific paper(s) that prove that “HIV” is the causative agent. “HIV” sequences and proteins are found in a variety of non-disease-associated contexts, and “HIV” vaccines don’t evoke antibodies and are provided with dangerous adjuvants like squalene. The “HIV” screening tests are contradictory, inconsistent across national boundaries, and no consensus exists regarding their validity. ARVS induce immune suppression according to their manufacturer’s package inserts, and fears of HIV's mutability provide excuses for drug makers claims to conceal the fact that ARV's don't work. Seropositivity reverts to seronegativity in infants and in single patients and vice versa even when compared on the same test. Transmission studies show no transmission. Universal screening hasn't protected groups where universal testing is already in place, and the stigma associated with testing positive has caused many to commit suicide, prevented them from getting health insurance, caused abortions, and ruined countless lives.

Because of these considerations, the assumptions underlying universal testing are flawed. It is an idea predicated on faith rather than scientific evidence. Moreover, the numbers of "infected individuals" provided in references [1-4], by the CDC, by the WHO, or others, are fictitious.

***"Estimates on HIV called too high. New data cut rates for many nations."***

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

*"Chin recollected that the group arrived at a range of 1 million to 1.5 million people; 18 years later, the number is at about 1 million Americans. "A lot of it was guesswork, based on limited studies," Chin said. "It was the best we could do" [53].*

Regarding the imagined similarities between universal “HIV” testing and early detection of cancer with routine screening [4], unlike cancer, early screening doesn’t matter with profound immune suppressive states: the symptoms considered diagnostic for "AIDS" can’t simply be removed with a surgeon’s knife, with radiation, or with a "chemical knife" once it is detected, like a non-invasive melanoma. When considering assays in human patients which diagnose "AIDS" by quantifying the number of lymphocytes/ml, patients are not considered to have an AIDS-defining illness if they have suffered from chronic starvation, as these individuals are known to possess a helper T-cell ratio in the AIDS-defining range or even lower (< 250 cells/ml), and can present with as much as a 90% reduction in their normal T-cell number which is reversible upon nutritional supplementation and a normal diet [54, 55]. In this regard, it has been several years since the announcement in the New England Journal of Medicine that vitamin supplements can ward off progression to AIDS in the absence of HAART (Highly Active Anti-Retroviral Therapy) [56].

The recommendation handed down from CDC for universal “HIV” screening, universal screening of pregnant woman, universal screening in routine doctor office visits, and routine testing in emergency room visits are reminiscent of the hepatitis B vaccine era. Twenty years later, the evidence shows that the current hepatitis B mandate in place not only threatens our children's health [57], but also serves in the future to threaten our children's education and admission to all kinds of institutions (day care and school admission).

So don’t think about science at a time like this: either refuse or obtain a religious exemption from undergoing an "HIV" test. Faith-based exemption means that God told you not to get tested, and who can argue with that?

These are a few of the test kits that cannot detect “HIV:”

#### Licensed / Approved HIV Tests

Tradename(s) Format Sample Use Manufacturer Approval Date Coulter HIV-1 p24 Ag

Assay;

HIV-1 p24 Antigen ELISA Test System EIA Serum / Plasma Donor Screen / Prognosis & Neut Kit Coulter Corporation Miami, FL US License 1185 3/14/1996 Coulter HIV-1 p24 Ag Assay EIA Viral Culture Supernatant Prognosis (Quantitative) & Neut Kit Coulter Corp 3/14/1996 Anti-HIV-1 Oral Specimen Collection Device

Tradename(s) Format Sample Use Manufacturer Approval Date Epitope OraSure HIV-1 Oral Specimen Collection Device Oral Specimen Collection Device Oral Fluid For Use in Designated Non-Donor Screen and Non-Donor Supplemental Assays Epitope, Inc Beaverton, OR 12/23/1994 Anti-HIV-1 Testing Service



Tradename(s) Format Sample Use Manufacturer Approval Date  
A HREF="<http://www.fda.gov/cber/pma/P950002.htm>">Home Access HIV-1 Test System</A> Dried Blood Spot Collection Device Dried Blood Spot Diagnostic Home Access Health Corp Hoffman Estates, IL 7/22/1996 Hepatitis B Surface Antigen (Anti-HBs Assay)

US License 1106 2/11/1999 HIV-1 /HCV Nucleic Acid Testing  
Tradename(s) Format Sample Use Manufacturer Approval Date <A  
HREF="<http://www.fda.gov/cber/pma/p9500054.htm>">Roche Amplicor HIV-1 Monitor Test</A> PCR Plasma Prognosis / Patient Management  
HIV-1 Viral Load Assay Roche Molecular Systems, Inc  
Branchburg Township, NJ 3/2/1999 <A  
HREF="<http://www.fda.gov/cber/pma/p0100010.htm>

NucliSens HIV-1 QT</A> NASBA  
Plasma Prognosis / Patient Management  
HIV-1 Viral Load Assay bioMerieux, Inc  
Durham, NC 27712

11/19/2001 COBAS Ampliscreen HIV-1 Test PCR Plasma Donor Screen Roche  
Molecular Systems, Inc  
Pleasanton, CA 94566-0990 12/20/2002

AHREF="<http://www.fda.gov/cber/products/hivhcvgen022702.htm>">Procleix</A> HIV-1/HCV Nucleic Acid Test (TMA) Plasma Donor Screen Gen-Probe  
San Diego, CA 92121

2/8/2002 Trugene HIV-1 Genotyping Kit and Open Gene DNA Sequencing System HIV-1 Genotyping Plasma Patient Monitoring Visible Genetics, Inc  
Toronto, CA 4/24/2002

AHREF="<http://www.fda.gov/cber/products/hiv1ngi091801.htm>">UltraQual HIV-1 RT-PCR Assay</A> PCR Plasma Donor Screen National Genetics Institute  
Los Angeles, CA 92121 9/18/2001

AHREF="<http://www.fda.gov/cber/products/hepcngi091801.htm>">UltraQual HCV RT-PCR Assay</A> PCR Plasma Donor Screen National Genetics Institute  
Los Angeles, CA 92121 9/18/2001

A HREF="<http://www.fda.gov/cber/510k/k030033.htm>">ViroSeq HIV-1 Genotyping System with the 3700 Genetic Analyzer</A> HIV-1 Genotyping Plasma Patient Monitoring Celera Diagnostics  
Alameda, CA 94502 6/11/2003

A HREF="<http://www.fda.gov/cber/pma/p0000280.htm>">Versant HIV-1 RNA 3.0 (bDNA)</A> Signal amplification nucleic acid probe Plasma Patient Monitoring Bayer Corp Berkeley, CA 94702 9/11/2002

AHREF="<http://www.fda.gov/cber/products/cobaroc120302.htm>"COBAS AmpliScreen HCV Test</A> PCR Plasma Donor Screen Roche Molecular Systems, Inc Pleasanton, California 94566-0990

12/3/2002 Human Immunodeficiency Virus Type 1 (Anti-HIV-1 Assay) Tradename(s) Format Sample Use Manufacturer Approval Date HIVAB HIV-1 EIA EIA Serum / Plasma Donor Screen Abbott Laboratories Abbott Park, IL. US License 0043 3/1/1985

AHREF="<http://www.fda.gov/cber/products/hiv1gen062998.htm>">Genetic Systems rLAV EIA</A> EIA Serum / Plasma Donor Screen Bio-Rad Laboratories Blood Virus Division Redmond, WA

US License 1109 6/29/1998 Murex SUDS HIV-1 Test Rapid EIA Serum / Plasma Donor Screen Murex Diagnostics, Inc. Norcross, GA

US License 1152 5/22/1992 Vironostika HIV-1 Microelisa System EIA Serum / Plasma Donor Screen bioMerieux, Inc., Durham, NC 27712

US License 1624 12/18/1987

AHREF="<http://www.fda.gov/cber/pma/P020066.htm>">Vironostika HIV-1 Plus O Microelisa System</A> EIA Plasma / Serum / Dried Blood Spots Diagnostic bioMerieux, Inc., Durham, NC 27712

US License 1624 6/6/2003 Cambridge Biotech HIV-1 Western Blot Kit WB Serum / Plasma Donor Supplemental Calypte Biomedical Corp Berkeley, CA

US License 1207 1/3/1991 Genetic Systems HIV-1 Western Blot WB Serum / Plasma Donor Supplemental Bio-Rad Laboratories Blood Virus Division 11/13/1998 Fluorognost HIV-1 IFA IFA Serum / Plasma Donor Supplemental Waldheim Pharmazeutika GmbH Vienna, Austria

US License 1150 2/5/1992 HIVAB HIV-1 EIA EIA Dried Blood Spot Diagnostic Abbott Laboratories 4/22/1992 HIV-1 Urine EIA EIA Urine Screen Diagnostic Calypte Biomedical Corp 8/6/1996

AHREF="<http://www.fda.gov/cber/products/hiv1gen062998.htm>">Genetic Systems rLAV EIA</A> EIA Dried Blood Spot Diagnostic Bio-Rad Laboratories Blood Virus Division 6/29/1998 Vironostika HIV-1 Microelisa System EIA Dried Blood Spot Diagnostic bioMerieux, Inc., Durham, NC 27712 4/11/1990

Oral Fluid Vironostika HIV-1 Microelisa System EIA Oral Fluid Diagnostic bioMerieux, Inc., Durham, NC 27712 12/23/1994

AHREF="<http://www.fda.gov/cber/products/hiv1cam052898.htm>" Cambridge Biotech HIV-1 Western Blot Kit</A> WB Urine Diagnostic Supplemental Calypte Biomedical Corp 5/28/1998 Genetic Systems HIV-1 Western Blot WB Dried Blood Spot Diagnostic Supplemental Bio-Rad Laboratories Blood Virus Division 11/13/1998

A HREF="<http://www.fda.gov/cber/pma/P950004.htm>">OraSure HIV-1 Western Blot Kit</A> WB Oral Fluid Diagnostic Supplemental Epitope, Inc 6/3/1996 Fluorognost HIV-1 IFA IFA Dried Blood Spot Diagnostic Supplemental Waldheim Pharmazeutika GmbH 5/14/1996

A HREF="<http://www.fda.gov/cber/pma/p000023.htm>">Reveal Rapid HIV-1 Antibody Test</A> Rapid Immunoassay Serum / Plasma Diagnostic MedMira Laboratories, Inc Halifax, Nova Scotia, Canada B3S 1B3 4/16/2003

A HREF="<http://www.fda.gov/cber/pma/p0300250.htm>">Uni-Gold Recombigen HIV</A> Rapid Immunoassay Serum / Plasma / Whole Blood (venipuncture and fingerstick) Diagnostic Trinity Biotech, plc Bray Co., Wicklow, Ireland 12/23/2003 Human Immunodeficiency Virus Types 1 & 2 (Anti-HIV-1/2 Assay)

Tradename(s) Format Sample Use Manufacturer Approval Date Abbott HIVAB HIV-1/HIV-2 (rDNA) EIA EIA Serum / Plasma Donor Screen Abbott Laboratories Abbott Park, IL

US License 0043 2/14/1992 Genetic Systems HIV-1/HIV-2 Peptide EIA EIA Serum / Plasma / Cadaveric Serum Donor Screen Bio-Rad Laboratories Blood Virus Division Redmond, WA

US License 1109 12/9/2000 Genetic Systems HIV-1/HIV-2 Plus O EIA EIA Serum / Plasma Donor Screen Bio-Rad Laboratories Inc Hercules, CA

US License 1109 8/5/2003 <A HREF="<http://www.fda.gov/cber/pma/p040046.htm>">Multispot HIV-1/HIV-2 Rapid Test</A> Rapid Test Plasma / Serum Diagnostic Bio-Rad Laboratories Redmond, CA 98052 11/12/2004

AHREF="<http://www.fda.gov/cber/pma/p01004716.htm>">OraQuick ADVANCE Rapid HIV-1/2 Antibody Test</A> Rapid Immunoassay Whole Blood, Plasma, Oral Fluid Diagnostic OraSure Technologies Bethlehem, PA 18015-1360 6/22/2004

## Human Immunodeficiency Virus Type 2 (Anti-HIV-2 Assay)

Tradename(s) Format Sample Use Manufacturer Approval Date Genetic Systems HIV-2  
EIA EIA Serum / Plasma Donor Screen Bio-Rad Laboratories Blood Virus Division  
Redmond, WA. US License 1109 4/25/1990

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