BACK

STATEMENT OF THE PERTH GROUP'S VIEWS ON "HIV"/AIDS

November 2011

Since:

1. Many "HIV"/AIDS experts claim the members of the Perth Group are dangerous pseudo-scientists and AIDS denialists.

2. Some dissidents including the president and other members of the Rethinking AIDS group claim we are no different from the "HIV"/AIDS experts

we thought it necessary to make a short statement explaining our views.

According to some members of RA:

1. We agree with the AIDS experts that AIDS exists.

   True, we do. It is an undeniable fact that at the beginning of the 1980s a new phenomenon, very high frequencies of PCP, KS and a few other rare diseases appeared in a minority of young, homosexual men living principally in New York City, Los Angeles, Amsterdam and Sydney. Some of these men also had low T4 cell counts which immunologists claim play a key role in immune competence. By definition the above diseases, in the presence of low T4 cells (immune deficiency), became known as AIDS. Following claims of the discovery of "HIV" and its causative role in AIDS, many other, not so rare diseases such as tuberculosis, most of them unrelated to those occurring in homosexual men, were added to the list of AIDS indicator diseases. That is, "HIV" became the cause of a panoply of diseases including those already endemic in developing countries.

   One can argue about:

   (a) the profiles of diseases that characterise the different risk groups;[1-4]

   (b) the role of T4 cells (immune deficiency) in the development of the clinical syndrome;[2, 5-7]

   (c) the existence and role of "HIV" in the development of AIDS[2, 5-17]

   but one cannot argue against the "HIV" theory of AIDS on the basis of the clinical syndrome. For example, it has been argued the HIV theory of AIDS is wrong because by definition TB + HIV = AIDS while TB – HIV =TB. Naming TB + HIV as AIDS will be wrong if and only if one has prior evidence that either HIV does not exist or if it does, it is not one of the causes of TB. The notion that AIDS in

homosexual men can be dismissed because of problematic definition(s) belies the fact that a totally new phenomenon arose in such men in the late 1970s and, at least in developed countries, homosexual men still bear the brunt of a new and deadly syndrome for which there must be an explanation. The clinical syndrome exists no matter what one calls it.

2. We agree with the AIDS experts that sexual practices play a role in AIDS.

   True, we do. The evidence in the scientific literature proves beyond all reasonable doubt that sexual intercourse is a highly significant factor leading to the development of a positive antibody test and AIDS in both men and women. However, analysis of the data also shows that (a) the risk factor for the acquisition of a positive antibody test and AIDS in both men and women is passive anal intercourse; (b) it is not the act *per se* (sexual orientation) but the very high frequency of this practice, especially when associated with gastrointestinal trauma and drug use, that underlies this risk. (Nitrites, cocaine, heroin).

3. Unlike members of RA we do not consider the antibody tests are meaningless.

   True, we do not think the tests are meaningless. Our view, that the presently available data do not prove the existence of a retrovirus "HIV", is well known. If "HIV" has not been proven to exist there can be no "HIV" antibodies. However, the scientific literature contains abundant evidence of a relationship between a positive antibody test, whatever its genesis, and the risk of current or future diseases. This is not surprising. From the very first papers on antibody testing[18, 19] it is obvious the test was designed to determine the relationship between a positive test and AIDS, not a positive test and HIV. Over the years the criteria for a positive HIV antibody test have been adjusted to fit the profiles of AIDS patients in the developed countries. The "tuning" of HIV antibody tests is discussed in our Mother-To-Child Monograph,[20] pages 1-7 and was addressed by Professor Elizabeth Dax during her testimony at the 2006 Parenzee hearing.[21] In developing countries this matter is much more complicated. For example, the majority of "HIV-free" individuals infected with the leprosy mycobacterium, as well as their healthy contacts, have Western blot antibody profiles which would be deemed HIV positive in most places in the world. Significantly tuberculosis, the main AIDS indicator disease in developing countries, is caused by a mycobacterium which shares many antigenic features with the leprosy bacterium.[22]

   While in our view the scientific literature does not support the existence of retroviral (HIV) antibodies, there is ample evidence that the antibodies reacting with the antigens in the "HIV" test kits may be antibodies associated with (a) the generalised, non-specific polyclonal activation typical of HIV positive and AIDS patients; (b) infectious agents such as bacteria and fungi, including mycobacteria, *E. coli* and *Candida albicans*;[16, 23, 24] (c) auto-antibodies synthesised *de novo* or;

(d) immunoglobulins rendered self-reacting by alteration in cellular redox.[25] Unfortunately, because individuals being tested are very unlikely to be aware of the problematic nature of "HIV isolation" or the list of "non-HIV" mechanisms that may underlie a positive antibody test, they will believe that being "HIV" positive can signify nothing but infection with a deadly virus. One can only speculate on the psychological and physical consequences of such a belief.

4. We do not condemn the use of "antiretroviral" drugs (ARVs) in the treatment of AIDS.

   True, and there are a number of reasons for this:

   (a) We have not studied the scientific literature.

   (b) Since in our view "HIV" has not been proven to exist there can be no antiretroviral drugs. However, this does not mean such drugs cannot or should not be used to treat AIDS. They may induce effects by means other than "anti-HIV". For example, if the French scientist Jean Umber is correct, protease inhibitors are reducing agents and thus may act as anti-oxidants. There is also evidence that both reverse transcriptase inhibitors and protease inhibitors have multiple pharmacological actions including "Apoptosis Enhancers, Antibacterials, Antifungals, Antimalarials, AntiSARS and Anti-Influenza Agents" and "antitumor".[26] It is simplistic to dismiss ARVs on the basis of their toxicities. All drugs are toxic to greater or lesser degrees and the decision to use a particular drug is based on the clinician's assessment of its benefit/toxicity ratio. Although we are not familiar with the literature we know HIV experts claim ARVs are efficacious and recommend their use. There are even dissident physicians who think there are situations that warrant their use. It is also a fact that most of the ARV treatments have been trialled in gay men and the same experts who recommend their use in this group have published data showing their efficacy is problematic in those countries with the greatest AIDS burden. As May *et al* state in 2006 in *Lancet*:

      > "The discrepancy between the clear improvement we recorded for virological response and the apparently worsening rates of clinical progression might be related to the change in the demographic characteristics of study participants, with an increasing number of patients from areas with a high incidence of tuberculosis. For example, in the Swiss HIV Cohort Study there was a steady increase in the number of patients from sub-Saharan Africa. These patients were younger, more likely to be female, and more likely to have been infected heterosexually than other study participants. Also, they had lower CD4 cell counts at presentation, and the most frequent AIDS-defining event was tuberculosis. Similar trends have been seen in other European countries and in North America".[27]

It is also important to stress that ARVs, no matter how beneficial, do not prove the HIV theory of AIDS.

We would like to remind those who think we are dangerous pseudo-scientists that:

1. Our public health policies accord with and in fact go beyond those of the HIV experts. Hence it is not possible we are dangerous.

   We advocate:

   a. safe sexual practices apply to passive anal intercourse with both HIV positive and HIV negative partners.

   b. clean needles but the best option is no drugs and hence no need for needles.

   c. testing all blood and blood products.

2. There are two old fashioned ways to prove we are pseudo-scientists:

   a. With great difficulty we have managed to publish papers in scientific journals. Such individuals, whoever they may be, should write to the editors of such journals submitting their evidence.

   b. Any scientist who understands the cellular oxidation theory of AIDS will have no trouble designing experiments to prove our theory wrong. Montagnier seems to understand because he has long been an apologist[12] for our theory, at least in Africa.[28] The expertise required to perform such experiments falls well within the abilities of the HIV experts with access to a reasonably sized laboratory. In terms of AIDS funding the cost of such experiments would be trivial.

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