

THE CASE AGAINST HIV

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Additions and corrections are welcomed,
indeed solicited, at our [comments page](#).



That HIV causes AIDS has been the officially sanctioned view for about 3 decades, believed almost universally but questioned openly by thousands of people, some of whom are expert in relevant sciences ^{1,2,3}. These dissidents point out that a comprehensive reading of the mainstream literature together with analysis of mainstream data demonstrates conclusively that HIV is neither a necessary nor a sufficient cause of AIDS. An up-to-date and comprehensive yet concise summary of the facts and the history of the HIV/AIDS blunder is provided by Donald Miller ⁹¹⁴.

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

The [Immunity Resource Foundation \(IRF\)](#) offers important archival material including many documentary films and videos; many issues of *Continuum* magazine; many [links](#) to other AIDS-Rethinking or HIV-Skeptical websites; and a [blog and newspaper](#). The 2013 award-winning film, "[Positively False – Birth of a Heresy](#)" can be rented or bought at the IRF website. Another award-winning documentary is "[House of Numbers](#)."

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

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

0. Questions to which the officially sanctioned view has no answer.
1. HIV does not cause AIDS.
2. The plain evidence about AIDS.
3. The plain evidence about HIV.
4. Failings of HIV/AIDS theory.
5. What antiretroviral drugs do.
6. Damage done by HIV/AIDS theory and practice.
7. Hindrances to making the case against HIV.
8. How could such a massive blunder come about and persist?
9. FAQs: Questions — sometimes rhetorical only — posed by adherents to HIV/AIDS theory.

Just how inconceivable most people find it, that HIV/AIDS theory could be so wrong, that official medicine and science could be so wrong in this day and age, may be illustrated by my own experience ⁵¹⁴. I had read enough — many of the books listed above — to become open to the possibility, but it took my own digging into “HIV” epidemiology to convince me ^{p.7 & chapter 1 in 5}, and that was about 10 years after I first became aware that there exist dissidents from orthodox HIV/AIDS belief. And it has taken me further years to understand that “HIV” may not even exist, and that “HIV” tests are perhaps the central issue in the whole business. My long-standing interest in [Loch Ness Monsters](#) and the like testifies that I am significantly more open to unorthodox views than are most people, so my own difficulty in recognizing the errors of HIV/AIDS theory might serve as a warning, that the task of bringing others to that understanding is an extraordinarily difficult one.

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

0. QUESTIONS TO WHICH THE OFFICIALLY SANCTIONED VIEW HAS NO ANSWER

0.1 Why is there no gold-standard test for HIV infection? ¹²⁷

0.1.1 [Because authentic pure HIV virions have never been isolated from supposedly infected individuals nor have they ever been successfully synthesized (cloned) — see [section 3.1.3](#)]

- 0.2 How does HIV supposedly destroy the immune system? (see sections [1.3.3](#), [4.4.4](#))
- 0.3 Why do people of African ancestry test "HIV-positive" more than all others, whether in Africa or America or Europe? chapters 5-7 & p. 106 in [5](#)
- 0.4 Why were AIDS and HIV first identified in America and Europe when HIV is supposed to have first infected human beings in Africa? (see [section 4.6](#))

1. HIV DOES NOT CAUSE AIDS

- 1.1 It was never established in the first place, nor later proved, that HIV causes AIDS.

1.1.1 Kary Mullis has described his *unsuccessful* quest — including asking the discoverer of HIV — for citations to the scientific articles that prove HIV to be the cause of AIDS ²³.

1.1.2 The "fact sheets" issued by the National Institutes of Health are not scientific articles, and their claims of proof have been refuted in full detail ^{24,25}. Those refutations have been ignored or misrepresented but never effectively challenged.

1.1.3 The issue is complicated by progressive re-definitions of AIDS, see [section 2](#).

1.1.4 Luc Montagnier, credited with the discovery of HIV, reported that AIDS seemed to be caused by a mycoplasma and not by HIV ^{26,27,28,29,30,31}.

1.1.5 By 1993 so many cases of "HIV-negative" "AIDS" had been reported ^{32,33,34,35} that the condition was pronounced a new disease, "idiopathic CD4 T-cell lymphopenia" (ICL) ^{36,37,38,39,40,41,42,43} (also "HIV-negative adult-onset immunodeficiency" ⁴⁴): immune deficiency of unknown cause with low CD4 counts; but this is precisely the same as the original definition of AIDS.

1.1.6 "HIV-positive" individuals do not necessarily ever progress to AIDS in absence of any treatment ⁴⁵.

1.1.6.1 Co-factors in addition to HIV required to bring on AIDS have been postulated on a number of occasions: mycoplasma ^{26,27,28,29,30,31}; HTLVs page 248 in [257](#); cell surface protein CD26 ^{871,872}; the protein fusin ⁸⁷³.

1.1.7 Specific Italian data illustrate that HIV does not cause AIDS ^{46,47,48}.

- 1.2 HIV and AIDS are not even correlated.

1.2.1 The seminal papers claimed to have found the putative retrovirus in only "18 of 21 patients with pre-AIDS ... [and] 26 of 72 adult and juvenile patients with AIDS" ⁴⁹. This did not even establish that HIV is correlated with AIDS ⁵⁰, let alone causes it. The principal author, Robert Gallo, may have committed scientific misconduct as well ^{7,51,648}.

1.2.1.1 Most of those who refer to the discovery of HIV credit Montagnier, not Gallo ⁵².

1.2.2 Kaposi's sarcoma (KS) was one of the three originally iconic AIDS diseases, yet HIV-negative cases of KS had been noted at the very beginning ⁵³ and turned out to be quite common ⁵⁴.

1.2.2.1 KS is now ascribed not to HIV but to something else ⁶⁴, perhaps KSHV (Kaposi's sarcoma herpes virus) or HHV-8 (human herpes virus 8) ^{55,56,57,58}.

1.2.2.2 AIDS-1 (section 2.1) KS was probably caused by the widespread use of nitrite "poppers" by many gay men ^{59,60,61,62,63,64}. Although described as a cancer (sarcoma), it may actually be non-malignant damage to blood vessels.

1.2.3 HIV and AIDS are not correlated with respect to geography ^{chapter 9 in 5,80}.

1.2.4 HIV and AIDS are not correlated with respect to race ^{chapter 9 in 5}.

1.2.5 HIV and AIDS are not correlated with respect to the sexes ^{chapter 9 in 5}.

1.3 HIV does not even cause illness, let alone death ^{66,45}.

1.3.1 The mortality of "HIV-positive" individuals and of "People with AIDS" (PWAs) is independent of age whereas mortality increases very significantly with age in every (other) illness ^{67,68,69,70,71}.

1.3.2 About 50% of people testing "HIV-positive" never experience illness associated with "HIV" ^{72,73,74}.

1.3.3 It remains mysterious, in what way or by what mechanism HIV could cause illness of any kind; a number of mechanisms have been bruited, none has been demonstrated or accepted as satisfactory ⁷⁵.

1.3.3.1 "HIV" is found in only a tiny proportion (<1%) of the T-cells that it supposedly kills, so the decrease in CD4 counts supposedly characteristic of AIDS or "HIV disease" is ascribed to an unspecified "bystander mechanism" ^{833,866,867,868}.

1.3.3.2 Duesberg long ago argued that no retrovirus could act as claimed for HIV ⁷⁶.

2. THE PLAIN EVIDENCE ABOUT AIDS

Which AIDS?

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

2.1 The first definition of AIDS, therefore AIDS-1: A supposedly unprecedented syndrome characterized by immune deficiency (specifically, low CD4 counts) of unknown cause presumed responsible for the presence of manifest opportunistic infections, chiefly Kaposi's sarcoma, *Pneumocystis carinii* pneumonia (PCP), or candidiasis (fungal: thrush, yeast infection) ^{77,78}.

2.1.1 Designating AIDS-1 as a new medical phenomenon was an error because

2.1.1.1 None of the “AIDS-1” diseases was previously unknown. They occur in HIV-negative individuals for a wide range of reasons ⁷⁹.

2.1.1.2 A great many conditions and infections induce immune deficiency, even specifically the low counts of CD4 cells purported to be characteristic of AIDS — non-specific conditions like oxidative stress ^{80,15} (see also sections [3.2.2](#), [4.3.2.4](#), [5.3.3.1](#), [5.3.3.11](#), [7.3.3.4](#)) or such specific diseases as tuberculosis ^{82,83}.

2.1.1.3 The initial diagnosis ¹⁰³ was by a young physician early in his career who also had access to the relatively new technique of counting CD4 cells ⁸⁴. However, we now know that CD4 counts are not a valid measure of good or bad health ⁸⁹⁷.

2.1.1.4 In particular, “recreational” drugs ^{85,86,87,88,89,90} including nitrites (“poppers”) ^{91,92} cause the same conditions as are said to be characteristic of AIDS, including loss of CD4 cells ⁹³, and drug addicts display the same manifest symptoms as were ascribed to AIDS-1 ¹³.

2.1.1.5 The first AIDS-1 patients were indeed typically users of “recreational” drugs ^{p. 191 ff. in [16](#)}, pursuing a “fast-lane” lifestyle ^{p. 79 ff. in [17,99,100](#), p. 292 ff. in [894,895,896](#)} conducive to ill health. They were on average in their mid-to-late thirties with histories of many bouts of syphilis, gonorrhea, and other infections ^{95,96,97,98}.

2.1.1.6 The Centers for Disease Control & Prevention used a unique, bizarre, misleading statistical classification scheme that obfuscated the fact that drug abuse was the primary common feature among victims of AIDS ^{chapter 1 in [16](#)}.

2.1.1.7 “AIDS” was a new *social* phenomenon, irrational exuberance by a proportion of gay men following “liberation”, expressed in an impossibly unhealthy lifestyle ^{pp. 119-20 in [5,99,100,101,102](#)}. It had first been designated more correctly as GRID: Gay-Related Immune Deficiency; though since it was only a small proportion of gay men who practiced the “fast-lane” lifestyle, most correct would have been FLLRID.

2.1.2 The first AIDS-1 patients had not been in sexual contact with one another ¹⁰³. AIDS-1 came to be regarded as infectious only after the mistaken conclusion that HIV causes AIDS.

2.2 Following the mistaken identification of “HIV” as cause of AIDS-1, an increasing number of diseases have come to be labeled “AIDS” just because in their presence an “HIV” test is fairly often positive. That defines AIDS-2: “HIV-positive” by definition, as in the now-common usage “HIV/AIDS”, which masks the fact that AIDS-1 was not HIV-caused. Recently the term “HIV disease” has become common.

By subliminal definition creep, “HIV disease” has come to include dozens of ailments, many of which are not opportunistic infections and all of which are previously known conditions, for example tuberculosis, weight loss or wasting, dementia ¹⁰⁴.

2.2.1 1985 definition (AIDS-2a): “HIV-positive” and additional opportunistic infections beyond KS, PCP, or candidiasis ¹⁰⁵.

2.2.2 1986 definition (AIDS-2b): “HIV-positive” and low CD4 counts and opportunistic infections ¹⁰⁵.

2.2.3 1987 definition (AIDS-2c): “HIV-positive” “[r]egardless of the presence of other causes of immunodeficiency” [emphasis in original] and in presence of more than a dozen diseases ¹⁰⁶.

2.2.4 1993 definition (AIDS-2d): Re-definition increased number of “AIDS” cases in that year by 75% ¹⁰⁷.

2.3 AIDS in Africa (henceforth AIDS-Africa) is neither AIDS-1 nor AIDS-2 ¹⁰⁸.

2.3.1 Although AIDS-2 had been defined as caused by HIV, the lack of HIV-testing facilities in Africa led to defining AIDS via the Bangui definition ¹⁰⁹: chronic or persistent weight loss, diarrhea, fever — entirely non-specific symptoms consistent with any number of endemic African diseases.

2.3.1.1 Africans dying from “AIDS” are succumbing to diseases that have ravaged Africans for centuries ^{108,110}.

2.3.1.2 Since the criterion for AIDS diagnosis in Africa is independent of “HIV”, one cannot know how many African “AIDS” patients are HIV-negative ³².

2.3.1.3 Malnutrition is widespread in Africa and is a known cause of lack of resistance to infection. It can be responsible for any infection incurred within 1 month of the end of food deprivation ⁸⁷⁰.

3. THE PLAIN EVIDENCE ABOUT HIV

3.1 “HIV tests” have never been shown to detect “HIV”, namely an exogenous retrovirus ^{111,112,113,114,115,116}. Therefore the term HIV denotes only whatever it is that produces a positive HIV test, and this should be indicated by always writing “HIV” or F(HIV) ^{chapter 9 in 5} or something similar.

3.1.1 That a retrovirus could be found in AIDS patients had been inferred from the presence of reverse transcriptase ^{117,p. 1259 in 118}, an enzyme used by retroviruses to infiltrate the DNA genomes of the cells they invade. But reverse transcriptase turned out to be present in all mammalian cells and is not a valid marker for the presence of “HIV” ¹¹⁹ or any other retrovirus.

3.1.2 The mistaken claim to have found a retrovirus in AIDS patients became a claim, announced at a press conference ¹²⁰, that it was the probable ^{121,122,123} cause of AIDS, discovered by Robert Gallo. The articles later published by Gallo ^{49,124,125,126} did not establish that claim (see [section 1.2.1](#)).

3.1.3 “HIV” tests have never been validated against a gold standard ^{127,910}, namely, authentic pure virions (virus particles).

3.1.3.1 Actual virions of “HIV” have never been isolated from an AIDS-1 patient nor from an “HIV-positive” individual ^{50,111,128,129,130,131}.

3.1.3.2 "Isolation of HIV" in the mainstream HIV/AIDS literature does not carry the usual meaning of isolation, namely, separating out and purifying; instead, the so-called "isolation" of HIV involves a complex culturing technique without subsequent purification; it amounts to a self-fulfilling prophecy ¹³².

3.1.3.3 The only published electron micrographs of "isolated" "HIV" show a motley mixture of particles and debris that may not even include any retrovirus particles pp. 127-9 in ^{119,129,133}.

3.1.3.4 A reward of \$100,000 for an electron micrograph of isolated pure HIV virions was offered in 2002 and has never been claimed ¹³⁴.

3.1.3.5 Montagnier has acknowledged that his laboratory never isolated pure HIV ^{135,136,137}.

3.1.3.6 Gallo acknowledged that his laboratory had not isolated HIV; he even claimed that copious production of HIV in culture was superior to isolation and purification and that it had made purification unnecessary pp. 1257-8 in ¹¹⁸.

3.1.3.7 Synthetic "HIV", a "molecular clone", contained only between 1 in 10,000 and 1 in 10 million actually infective virions and they were unstable, self-destructing quickly ¹³⁸.

3.1.3.8 Various sources make available "HIV-1 isolates". *These should not be confused with authentic pure HIV particles (virions), which have never been prepared.* The National Institutes of Health list ⁹⁰¹ an "International panel of 60 HIV-1 isolates". Penn Center for AIDS Research lists 11 "Prototype HIV-1 Strains" ⁹⁰² and 66 "Primary HIV-1 isolates" ⁹⁰³ as well as 9 "HIV-1 mutant viruses" ⁹⁰⁴. This variety already suggests that there is really no such thing as an "HIV virus". These so-called "HIV-1 isolates" are mixtures of a variety of different particles (vesicles) and different substances misinterpreted as "rapidly evolving quasispecies [of HIV]" ⁹⁰⁵ or "a complex mixture, or swarm, of mutant virus variants" ⁹⁰⁶.

3.1.4 "Validation" of "HIV" tests is a self-fulfilling tautology ^{139,140,141}.

3.1.5 The instructions in test kits acknowledge that the tests are not approved for detecting infection ^{142,143}.

3.1.6 The first "HIV" test — "ELISA" (enzyme-linked immunosorbent assay) — detects antibodies ^{144,145} that are *presumed* to characterize "HIV" proteins, but these and later tests react "positive" to many kinds of antibodies, other proteins, or bits of RNA or DNA. "HIV" tests are not specific, see [section 3.2](#).

3.1.6.1 That the tests detect active virus infections came to be believed without the benefit of evidence ¹⁴⁶.

3.1.6.2 That belief, that detection of antibodies demonstrates presence of active virus, is an unprecedented and unwarranted inference: antibodies indicate earlier exposure, not infection, and in absence of manifest symptoms of illness antibodies are regarded — except only with HIV — as a priori evidence of established immunity to the respective infection.

3.1.7 Measurement by PCR of so-called “viral load” (the purported amount of HIV particles in “HIV-positive” individuals) has been criticized as inherently invalid by the inventor of PCR, Nobelist Kary Mullis ¹⁴⁷.

3.1.7.1 “Viral load” measurements may not be specific to the presumed “HIV” genome ¹⁴⁸.

3.1.7.2 “Viral load” measurements yield appreciable numbers of false negatives ¹⁴⁹.

3.1.7.3 “Viral load” measurements yield appreciable numbers of false positives ^{149,150}.

3.1.7.4 “Viral load” measurements suffer from poor reproducibility ^{149,151,152}.

3.1.7.5 “Viral load” is not a marker for risk of death or progression to disease ^{153,154,155}.

3.1.7.6 “Viral load” does not measure amount of virus, since virus could not be cultured from some people with significant “viral loads” ^{156,157}.

3.1.7.7 “Viral” genes can be found in “HIV-negative” individuals ^{158,159,160,161}.

3.1.8 There are no valid “confirmatory” tests. Although Western Blot is routinely referred to in that way, its criteria have never been standardized or validated ^{127,162,163,164} and it is itself also liable to false positives ¹⁶⁵.

3.1.9 The initial “HIV” test was based on blood drawn from gay men who were manifestly ill “with AIDS”. No surprise, then, that a wide range of illnesses or degrees of ill health conduce to testing “HIV-positive”: for example, TB patients and drug addicts are as likely to test “HIV-positive” as are gay men, who were the very first purported “risk” group for “AIDS” ¹⁶⁶.

3.2 False-positive “HIV” tests are common ^{165,167,168,169,170,171,172,173}. For consequent misinterpretations and their consequences, see sections 4.3 & 6.1 respectively.

3.2.1 Rates of false-positive “HIV” test-results depend on the prevalence of positive-testing substances in the tested population. At the prevalence of “HIV-positive” (<1%) typical in populations outside southern Africa, the rate of false positives is likely to be quite high ¹²⁷.

3.2.2 Dozens of physiological conditions — normal, in disease, or owing to medical treatment — conduce to false-positive “HIV” tests ^{110,145,175,176,177,178,179} — possibly because “HIV-positive” correlates with oxidative stress ^{180,181,182,183,184,185,186} (more about oxidative stress in sections 2.1.1.2, 4.3.2.4, 4.3.2.8, 5.3.3.1, 5.3.3.11, 7.3.3.4).

- 3.2.2.1 Auto-Immune Diseases and antibodies to many stimuli
 187,188,189,190,191,192,193,194,195,196,197,198,199,200,201, anti-carbohydrate antibodies 178,202,203, anti-collagen 204, anti- lymphocyte 204,205, anti-phospholipid ("sticky blood") 80,206, HLA antibodies 178,179,187,188,189,197,207,208,209,210, mother's antibodies transferred to babies 211, normally occurring antibodies 203,212,213, antibodies to components of test kits 196,214, lupus 215,216.
- 3.2.2.2 Illnesses that are not infectious: Cancers (cervical cancer 217,218); cardiovascular, atherosclerosis 219,220, chronic obstructive pulmonary disease (COPD) 221, cutaneous T-cell lymphoma 232, cystic fibrosis 222,231, diabetes 197, hemophilia 187,188,913, kidney failure and dialysis treatment 178,179,187,188,205,216,223,224,225,226,227,228, leprosy 229,230, multiple myeloma 187,189,210, multiple sclerosis 231,232, periodontal disease 233, rheumatoid arthritis 238, genital inflammation 919,920.
- 3.2.2.3 Infections and toxins: Aflatoxin 234, cytomegalovirus infection 235, Epstein-Barr virus 236,237, flu (and flu vaccination) 178,189,238,239,240,241,242,243,244,245,250, hepatitis 179,187,188,210,225,246,247,248, herpes 249,250,251,252,253,254,255,256,258, HTLV p. 248 in 257, malaria 258,259,260,261,262,263,264,265,274,266, Mycobacterium avium 230, paramyxovirus 199, schistosoma 267, syphilis 179,187,188,197,268,269,287,320, Trichomonas vaginalis parasites 270,271, Trypanosoma parasites (Chagas disease) 272,273,274, tuberculosis 230,258,275,276, visceral leishmaniasis 277,278.
- 3.2.2.4 Medical procedures: Blood transfusion 178,188,189,209,24,238,279, globulins, in sick people or given as prophylaxis 110,178,189,262,280,281,282,283,284,285,286,287, hormonal contraception 288,289,290, organ transplants 178,179,205,238,291,292,293.
- 3.2.2.5 Natural conditions, not unhealthy: Pregnancy Fig. 22 p. 83 in 5,178,189,210,238,294,295,296,297,298,299,300,301,302,303,304,305,874, receptive anal sex 111.
- 3.2.2.6 Normal components of human cells: HIV-like genetic sequences occur in HIV-negative human genomes 306,307,308 and can generate immune responses to "HIV" proteins 309,310,311, supposedly "HIV" proteins occur normally in many human cells 178,179,172,313,111,315, normal human extravillous trophoblast cells express "HIV-1" antigens 316.
- 3.2.2.7 "Recreational" drugs: 231 Alcohol 317, cocaine 317, crack cocaine 317,318, crystal meth 319, methamphetamine 320.

3.2.2.8 Vaccinations: Experimental HIV vaccines ³²¹; flu ³²² (also see above under infections); globulins (also see above under medical procedures); hepatitis B vaccination ^{189,323,324}; rabies ¹⁹⁰; rubella ³²⁵; tetanus ^{326,327,328}.

3.2.2.9 Fever is very non-specific. "HIV-positive" is often associated with fever ⁸⁷⁴.

3.2.3 False positives are especially common in emergency rooms since the probability of a positive "HIV" test increases with degree of ill-health ^{Fig. 22, p. 83 in 5, and associated text}.

3.2.3.1 In Cincinnati with a population "HIV-positive" rate of 1.7 (per 100,000), the emergency-room rate was 7.8 ³²⁹.

3.2.3.2 Only 9 of 26 "HIV-positive" test results in an emergency room were positive on a later test ³²⁹.

3.3 HIV – rather "HIV-positive" – has never been shown to be infectious or transmissible.

3.3.1 Prospective studies to detect sexual transmission of "HIV" seropositivity have not observed transmission ^{330,331}.

3.3.1.1 In Africa, more than two thirds of couples are serodiscordant: one is "HIV-positive", the other is not ^{page 118 in 875}.

3.3.2 The often-cited rates of transmission are calculated by making unprovable assumptions, including about when individuals became "HIV-positive" ³³⁰.

3.3.3 The Centers for Disease Control & Prevention report the probability of transmitting HIV from female to male by vaginal intercourse as 4 in 10,000; from male to female, 8 per 10,000; by receptive anal intercourse, 138 in 10,000; by insertive anal intercourse, 11 in 10,000. Those numbers are far too low to bring about any sort of epidemic; (see [section 3.3.12](#)). With genuinely sexually transmitted diseases – gonorrhea, syphilis, herpes – the probability of transmission is hundreds of times greater ⁹¹⁸.

3.3.4 Mother-to-child transmission has not been shown to occur.

3.3.4.1 Definitely transferred are substances that produce positive "HIV" tests, in particular "HIV" antibodies. Those dissipate within a year and "HIV-positive" babies then revert to "HIV"-negative without medication ^{Fig. 2 and Tables 25-27 in 5,332}.

3.3.4.2 "[T]here is no proof that HIV, even if it is assumed to be present in pregnant women, is perinatally transmitted to their offspring" ³³³.

3.3.4.3 The presently available data do not prove that HIV can be transmitted by breastfeeding ³³³. Babies breast-fed exclusively by "HIV-positive" mothers become "HIV-positive" less frequently than those not fed solely from the breast ^{334,335,336}. The research about mortality and "HIV"

transmission associated with breast-feeding has brought inconsistent and confusing results ^{337,338}.

3.3.4.4 A large percentage of "HIV-positive" babies had "HIV"-negative mothers ^{339,340}.

3.3.5 "HIV" varies in regular fashion and independently with age, sex, race, and geography, unlike the stochastic patterns seen in infectious diseases ^{5,341,342} — see also [section 3.4](#) below.

3.3.5.1 The median age-range for testing "HIV-positive" is 35-45 ^{Fig. 2, p. 26 in 5}, comparable to the median age-range for diagnoses of AIDS and for deaths from AIDS ^{343,344,345,346,347}. These have remained unchanged throughout the AIDS era and are the same in almost every tested group.

3.3.6 The Office of Medical and Scientific Justice has successfully defended dozens of "HIV-positive" people (52nd case in June 2013) charged with endangering others by exposing them to possible transmission of "HIV": OMSJ forces the prosecution to acknowledge — at least implicitly by altering charges or dropping prosecutions — that positive "HIV" tests do not prove infection ³⁴⁸.

3.3.7 Innumerable attempts to create a vaccine against "HIV" infection have all failed ^{349,350,351,352,353} during the nearly 3 decades since Robert Gallo in 1984 envisaged a vaccine being ready within a couple of years ^{354,355,356}, despite continuing pronouncements of optimism and announcements of promising "breakthroughs" ³⁵⁷.

3.3.8 Drug addicts supposedly become "HIV-positive" through re-use of infected needles, yet use of fresh new needles increases rather than decreases the incidence of "HIV-positive" tests ^{358,359,912}.

3.3.8.1 Successfully rehabilitated drug addicts can revert from "HIV-positive" to "HIV"-negative ³⁶⁰.

3.3.8.2 There was little difference in risk behaviors between HIV-negative and HIV-positive drug-injecting gay men ³⁶¹.

3.3.8.3 Drug use and venereal disease but not sexual behavior were risk factors for being "HIV-positive" among gay men ³⁶².

3.3.8.4 That the drugs are responsible for high rates of "HIV-positive" among drug abusers, and not infection via pre-used needles, is demonstrated by the very small probability of transmitting "HIV" via needles: 63 in 10,000 by sharing needles when injecting drugs, 23 per 10,000 by needle-stick in the skin ⁹¹⁸.

3.3.9 Medical personnel are extraordinarily unlikely to be infected by "HIV" or "AIDS" whereas they run appreciable risk with hepatitis, for example ⁸⁸. An "HIV-positive" surgeon performed many open-heart surgeries without any patient becoming "HIV-positive" ³⁶⁴. "There is no recorded case of transmission of HIV from an infected health care worker to a patient in the UK [as of November 2006]" ³⁶⁵.

3.3.10 Condoms do not decrease the incidence of "HIV-positive" ^{366,367,368}.

- 3.3.11 HIV and AIDS are almost unknown in the porn industry ^{369,370,371} even though chlamydia and gonorrhea infection and re-infection are common ³⁷².
- 3.3.12 The claimed rate of "HIV-positive" in sub-Saharan Africa can only be explained by postulating an impossible rate of promiscuity: 20-40% of adults having 10 or more sexual partners at any one time and changing them frequently ^{pp. 63-5 in 373}.
- 3.3.13 Thus there are no demonstrated epidemics of heterosexually transmitted "HIV" ³⁷⁴.
- 3.3.14 Racial disparities in prevalence of "HIV-positive" do not correlate with respective sexual behavior ^{375,376} and thereby seem inexplicable on HIV/AIDS theory.
- 3.3.15 The incidence of "HIV" does not parallel the incidence of known STDs (chlamydia, gonorrhea, syphilis) ^{pp. 35 & 109 in 5,377,378,893}.
- 3.3.16 Married women are more at risk for becoming "HIV-positive" than are prostitutes or widows, incongruous for any sexually transmitted disease ^{379,380}.
- 3.3.17 That pregnancy is a risk factor for testing "HIV-positive" (section 3.2.2.5) is incongruous for any sexually transmitted disease.
- 3.3.18 Prostitutes do not become "HIV-positive" unless they are drug addicts ^{12,pp. 41-2 in 20,381,382,465}.
- 3.3.19 Drug addicts tend to test "HIV-positive" to different degrees from different drugs ³⁶⁰.

3.4 "HIV" tests are racially biased.

- 3.4.1 In any group, black people (people of relatively recent sub-Saharan ancestry) test "HIV-positive" about 7 times (males) or 20 times (females) more often than Caucasians. Asians test "HIV-positive" about 2/3 as often as Caucasians. Native Americans and Mexicans test "HIV-positive" perhaps 10-20% more frequently than Caucasians ^{chapters 5 & 6 & passim in 5,383,384,385}.
- 3.4.1.1 The supposedly "HIV" protein p24 generates a stronger response in black people than in others ³⁸⁶.
- 3.4.1.2 Higher levels of "HIV-1 RNA" were found in Malawians than in Swiss or USA men ³⁸⁷.
- 3.4.1.3 Africans and Caucasians differ genetically with respect to the human T-cell antigen receptor ³⁸⁸.

4. FAILINGS OF HIV/AIDS THEORY

HIV/AIDS theory has persistently led to wrong predictions and to inadequate or totally missing, and not infrequently absurd, explanations. After three decades, basic issues remain unresolved about isolation and identification of "HIV", about epidemiology, and about anti-retroviral drugs ⁹¹¹.

4.1 Predictions have invariably been wrong.

4.1.1 "Generalized" epidemics leading to "HIV-positive" population levels of more than 1% have never eventuated outside populations of African ancestry, namely sub-Saharan Africa and the Caribbean ³⁸⁹.

4.1.2 Even in sub-Saharan Africa, "HIV-positive" levels are "explained" by postulating an impossible level of promiscuity ^{pp. 63-5 in 373} (see also sections 3.3.12 & 6.1.4).

4.1.3 Predicted Philippines epidemic did not happen ³⁹⁰.

4.1.4 Forewarned epidemic in porn industry ³⁹¹ never eventuated despite lack of condom use.

4.1.5 Predicted Asian epidemics never eventuated ³⁹².

4.1.5.1 In 1995, Peter Godwin, head of the Regional HIV Project, United Nations Development Program: "by the year 1997 the annual number of new HIV infections in Asia will exceed those in Africa, and its share of worldwide cumulative infections will increase to nearly 25% by the year 2000" ⁸⁷⁶ but by 2007, Asia had only 5 out of a global 33 million "HIV-positives" while sub-Saharan Africa had 19 million ⁸⁷⁵.

4.1.6 Predicted decimation of populations did not occur in Africa. Instead, there has been robust population growth ¹¹⁰: "Recent [2007] reports from Uganda, Kenya and Burkina Faso show . . . concern over rapid population growth" ³⁹³.

4.1.7 Vaccines were predicted within a couple of years of 1985 and have never been achieved ³⁵⁷.

4.1.8 "Breakthroughs" in preventing or treating infection are announced — and then never live up to their promise ^{394,395,396,397,398,399,400,401,402,403,404,405,406,407,408,409,410,411,412,413,414,415,416,417,418,419}.

4.1.8.1 Trojan Horse inhibitors ^{877,878,879}.

4.1.8.2 Killing "HIV" by shaking it with tuned laser ⁸⁸⁰.

4.2 Public statements emphasize how much is known about HIV/AIDS, yet researchers do not understand many practical as well as theoretical aspects.

4.2.1 "We probably know more about how HIV produces its pathology than about the pathological mechanism of virtually any other microbe" ⁴²⁰.

4.2.2 "[I]dentification of immune correlates of protection from HIV infection is still lacking" ⁴²¹. In other words, no clue (by 2013!) about how to make a vaccine.

4.2.3 "35 top British and US scientists . . . predicted this week [29 April 2008] that a vaccine would be at least 10 years and maybe even 20 years away" ⁴²² (see also sections 3.2.2.8, 3.3.7, 4.1.7).

4.2.4 The recommended treatments are revised several times a year (section 5.4), including when to begin treatment ⁴²¹.

4.2.5 Characteristics of the purported “acute viral syndrome” postulated to accompany initial infection — sometimes — are speculative: “diagnosis of acute HIV-1 infection remains problematic” ⁴²³.

4.2.5.1 Seeking manifest signs accompanying infection by “HIV”, a correlation has *sometimes* (e.g. in 20% of cases ⁴²⁴) been suggested with transient “flu-like” or mononucleosis-like ^{425,426} symptoms that are entirely non-specific ⁴²⁷: fevers, sweats, malaise, lethargy, anorexia, nausea, myalgia, arthralgia, headaches, sore throat, diarrhoea, generalised lymphadenopathy, rash ⁴²⁸ (sometimes “macular erythematous truncal eruption”), thrombocytopenia. Since those symptoms as well as “HIV-positive” can result from a large number of different conditions, fleeting as well as chronic, the phenomenon of “acute viral syndrome” cannot be regarded as established.

4.2.5.2 Such symptoms could only be potentially connected to “HIV” or “AIDS” by some sort of prior assumption, which makes the purported correlation a self-fulfilling presumption. Why were such symptoms not only noticed but also suspected of being associated with “HIV” rather than with flu, mononucleosis, or the many other possibilities? So “[d]iagnosis of primary HIV infection remains a relatively infrequent occurrence [in 2008]” ⁴²⁹, and generalizations currently accepted may well be mistaken.

4.2.5.3 It is *assumed* that such symptoms indicate high levels of viremia ⁴³⁰ — but since “HIV” tests are generally not carried out concurrently with the “acute viral syndrome” ⁴³¹, this is mere presumption.

4.2.5.4 The *postulate* of “acute viral syndrome” with HIV/AIDS was made already in the early 1980s ⁴³² and has subsisted by inertia without serious reconsideration.

4.2.5.5 “Clinical signs and symptoms of acute human immunodeficiency virus (HIV) infection in infants are not well characterized” ⁴³³.

4.2.6 How “HIV” could damage the immune system remains a mystery ^{434,435,436,437,864,881}.

4.2.7 When and how HIV appeared in humans remains controversial ⁴³⁸.

4.3 Treatment of “HIV-positive” individuals and HIV/AIDS research are misguided through misinterpretation of positive “HIV” tests.

4.3.1 Genetic, race-correlated tendencies to test “HIV-positive” are misinterpreted.

4.3.1.3 Race-correlated genes are postulated to drive mutation of HIV ⁴³⁹.

4.3.2 Conditions that conduce to positive “HIV” tests are misinterpreted as susceptibility to “HIV” infection; see the list of false-positive possibilities, [section 3.2](#).

4.3.2.1 The unhealthy "fast-lane" lifestyle (drug abuse, alcohol abuse, promiscuity with frequent infections and courses of antibiotics) conduces to testing "HIV-positive".

4.3.2.2 Drug addicts who test "HIV-positive" are presumed to have been infected with "HIV".

4.3.2.3 Damage to gut bacteria and mucosa (intestinal dysbiosis) is attributed to "HIV" ^{437,440,441} whereas strong evidence indicates the opposite, that testing "HIV-positive" is a result of damage to the gut (see sections [6.1.5.3](#), [9.3.1](#)). Probiotics increase CD4 counts ⁴⁴².

4.3.2.4 "AIDS" may reflect oxidative stress rather than a viral infection ⁸⁰ (see also sections [2.1.1.2](#), [3.2.2](#), [4.3.2.8](#), [5.3.3.1](#), [5.3.3.11](#), [7.3.3.4](#)) but "HIV" is held responsible for causing oxidative stress ⁴⁵⁴.

4.3.2.5 In several Central Asian countries, inexplicable cases of "HIV-positive" are ascribed to infection in some unknown manner by needles supposedly infected from some unknown source instead of to birth stress and other conditions that can produce positive "HIV" tests ^{443,444}.

4.3.2.6 Probiotic treatment against bacterial vaginosis is misinterpreted as acting against "HIV" ^{445,446}.

4.3.2.7 Hemophiliacs who test "HIV-positive" are assumed to have been infected by blood transfusion or blood-clotting factor ⁴⁴⁷, Appendix A in 10, passim in [20,913](#).

4.3.2.8 Psychiatric problems are attributed to "HIV" ^{448,449} instead of realizing that stress, including psychological stress, can induce testing "HIV-positive" Fig. 22 & p. 80 ff. in [5](#) (re oxidative stress, see sections [2.1.1.2](#), [3.2.2](#), [4.3.2.4](#), [5.3.3.1](#), [5.3.3.11](#), [7.3.3.4](#))

4.3.2.9 Intracranial aneurisms are attributed to "HIV" ^{450,451}.

4.3.2.10 Cardiovascular disease ⁸⁸².

4.3.4 Iatrogenic ailments caused by ARVs are legion ([section 5.3](#)), but they are often misattributed as "HIV-associated":

4.3.4.1 Lipodystrophy, which is caused by protease inhibitors in particular ⁴⁵².

4.3.4.2 "HIV-associated" arthritis, said to include reactive arthritis, psoriatic arthritis, osteomyelitis, polymyositis, vasculitis, infected joints and fibromyalgia ⁴⁵³.

4.3.4.3 Age-related conditions (cancer, dementia, heart disease) ⁴⁵⁴.

4.3.4.4 “HIV-associated” mania ^{455,456,457}.

4.3.4.5 Heart attacks ^{458,459}.

4.3.4.6 Neuropathy ^{460,461,462}.

4.3.4.7 Kidney disease ⁴⁶³.

4.3.4.8 Bone disease, osteopenia, osteoporosis ⁸⁸³.

4.3.5 Three decades of efforts to find a vaccine against “HIV” have failed (sections [3.3.7](#), [4.1.7](#), [4.1.8](#), [4.2.2](#), [4.2.3](#)) even though quite a number of people with natural immunity against “HIV” have been identified and studied ^{464,465,466,467,468,469,470,471,472,473,474,475,476}.

4.3.6 Decades of efforts to find a microbicide have also failed ^{477,478,479,480}.

4.3.6.1 “The trial did not demonstrate that Carraguard is effective in preventing male-to-female HIV transmission” ⁴⁸¹.

4.4 A number of basic aspects of HIV/AIDS theory are known to be wrong.

4.4.1 The so-called “latent period” between infection and illness, an essential component of the original labeling of HIV as a lentivirus (slow virus), doesn’t exist ^{482,483}.

4.4.2 KS was the iconic AIDS disease, recognized by the purple blotches on the skin and affecting 25-40% of AIDS patients in the early 1980s. But since the early 1990s ⁴⁸⁴ and thereafter only about 5% of AIDS cases have manifested KS. Furthermore, Kaposi’s sarcoma is now said to be caused primarily ^{pp. 125-9 in 5,485,486,487} by HHV-8 (human herpes virus 8) or KSHV (Kaposi’s sarcoma herpes virus) — and “HIV-associated” KS may not even be a cancer ⁴⁸⁸.

4.4.3 Cervical cancer had been declared to be an AIDS disease ⁴⁸⁹, i.e. caused by “HIV”, but now it is said to be caused by HPV, human papilloma virus ⁴⁹⁰.

4.4.3.1 It is a mystery, why cervical cancer was ever declared an AIDS disease, given that its incidence had been *declining* steadily throughout the AIDS era ^{490,491}.

4.4.4 HIV is supposed to kill CD4 cells, but there is no correlation between CD4 levels and the purported amount of “HIV” (“viral load”) or even the patient’s clinical condition ^{154,493,494,495,496}.

4.4.4.1 There is no correlation between CD4 counts and state of health ⁸⁹⁷.

4.4.5 “HIV-positive” is not permanent; people sometimes spontaneously become “HIV-negative”, a phenomenon known as seroreversion ^{497,498,499,500,501,502}.

4.4.6 Low T-cell counts are a predictor for becoming “HIV-positive”, they are not a consequence of “HIV” ^{503,504}.

4.4.7 The theoretical basis for Highly Active AntiRetroviral Treatment, HAART, was that there was very rapid turnover of T-cells ^{505,506}. That model has been shown to be wrong ^{507,508,509,510}.

4.5 HIV/AIDS statistics are unreliable ^{511,512}.

4.5.1 UNAIDS ⁵¹³ inflates estimates in order to dramatize the situation ³⁷³.

4.5.2 For more than a decade, official data for "HIV" and "AIDS" have come from computer models and not actual counts ^{pp. 114 & 135-6 & 203-10 & 221-5 in 5,515,516}.

4.5.3 The computer models have needed perpetual correction ^{517,518}; for example, estimates of new infections were *reduced by 40%* in 2007, and totals reduced from 40 million to 33 million ⁵¹⁹.

4.5.4 Estimates of deaths by the Division of HIV/AIDS of the Centers for Disease Control and Prevention (CDC) differ from the counts of death certificates by the CDC's own Center for Health Statistics ^{520,521,522}.

4.5.5 Peer-reviewed, published, and widely publicized assertions about AIDS deaths in South Africa ^{523,524,525} are based on computer models whose estimates are more than on order of magnitude greater than the published data from South Africa Statistics ⁷⁴.

4.5.6 The World Health Organization claimed 85,000 "HIV-positive" Pakistanis when only 3200 were actually known from tests ⁵²⁷.

4.5.7 HIV/AIDS numbers asserted for Liberia during the 2000s varied between 1.5% and 8.2% ⁵²⁸.

4.5.8 Circumcision is reported as both decreasing the risk of becoming "HIV-positive" and as not decreasing the risk ^{529,530,531,532,533,534, 535,536,537,538,539,540,541,542,543,544}.

4.5.8.1 Circumcision increased the rate of "HIV-positive" among virgins ⁵⁴⁵.

4.5.9 Absurd numbers are promulgated (sections [4.7.16](#), [4.7.18](#)).

4.5.9.1 Zimbabwe claimed reduction in "HIV-positive" rate from 34% to 18.1% between 2002 and 2005-6 — implying that 15.9% of the population had died in five years if there were no new "HIV-positive" cases, or else the population had grown at 3% per year with no new infections ^{546,547}. Or the rate was said to have dropped from 22.1% to 20.1% in just two months ⁵⁴⁸.

4.5.9.2 Similarly absurd claims have come from Uganda ^{304,549}.

4.6 The origin and spread of HIV have found no satisfactory explanation.

4.6.1 AIDS was first named and recognized as characteristically affecting gay men in a few large cities in the United States, but HIV is held to have infected humans for the first time in West Africa at least a decade earlier and perhaps several decades earlier ^{14,550}.

4.6.1.1 In 1985, "HIV" in Southern Africa was found only in gay men who had been in the USA or in contact with Americans ^{551,552}.

4.6.1.2 PCP was the chief opportunistic infection characterizing the original AIDS-1. In AIDS-Africa it apparently affected only young children ^{553,554}.

4.7 Self-contradictions and absurdities of HIV/AIDS theory and practice.

4.7.1 That pregnancy (section 3.2.2.5, 3.3.17, 6.1.1.4) is a risk factor for acquiring this sexually transmitted disease.

4.7.2 HIV/AIDS activists insist that no stigma should be attached to those who become "HIV-positive" even as HIV/AIDS theory asserts that "HIV" is contracted through behavior that is appropriately frowned upon: careless promiscuity or drug abuse and injecting drugs with dirty needles.

4.7.3 HIV/AIDS activists urge that drug abusers be given new needles so that they can "safely" inject heroin and other "recreational" drugs. In every circumstance except HIV/AIDS, use of illegal injected drugs is regarded as criminal behavior ^{555,556}, and it is recognized that drug addicts harm their families as well as themselves. Moreover, clean needles are associated with greater incidence of "HIV-positive" (section 3.3.8), owing to the ill-health brought about by the drugs.

4.7.4 "HIV" is supposed to spread by different mechanisms in different parts of the world ^{557,558,559}.

4.7.5 Those who are most susceptible to becoming "HIV-positive" nevertheless live longer ⁵⁶⁰.

4.7.6 Poverty is supposed to conduce to "HIV-positive" by increasing risk factors, but in Africa it is wealth that conduces to being "HIV-positive" ^{561, page 89 in 875}.

4.7.7 An "HIV-positive" man who did not infect his wife despite intercourse with her must have nevertheless infected his child by biting her finger ⁵⁶².

4.7.8 Babies infected by dirty needles are supposed to have transmitted "HIV" to their mothers by biting their nipples ⁵⁶³.

4.7.9 Breast-feeding by "HIV-positive" mothers is said to risk transmitting HIV to the babies, yet *exclusive breast-feeding brings the lowest risk* that babies will become "HIV-positive" ³³⁴ (section 3.3.4.3).

4.7.10 Tuberculosis (TB) patients test positive as often as do gay men and drug addicts ^{Fig. 22 p. 83 in 5,564} so, irrationally, TB is sometimes said to be an AIDS disease rather than just TB.

4.7.11 Cervical cancer was said to be an "AIDS disease", i.e. caused by "HIV", in 1993 ⁴⁸⁹. Yet nowadays it is said to be caused by human papillomavirus (HPV), again on the basis of a mere correlation.

4.7.12 Increased obesity is attributed to desire to show that one is not "HIV-positive" ⁵⁶⁵.

4.7.13 When malnourished Africans test "HIV-positive", their ill-health is attributed to "HIV" rather than lack of food ^{110,566}.

- 4.7.14 "Washing the penis minutes after sex increased the risk of acquiring H.I.V. in uncircumcised men. The sooner the washing, the greater the risk of becoming infected" ⁵⁶⁷.
- 4.7.15 When ARVs appeared to work against "HIV" but patients nevertheless became more ill, this was ascribed to the newly invented "immune restoration syndrome": recovery or re-activation of the immune system supposedly caused inflammation and illness ^{568,312}.
- 4.7.16 Official numbers just don't compute ⁵⁶⁹. Estimates have perhaps one in four ⁵⁷⁰ of "HIV-positive" Americans unaware of their status — up to 75% of gay men ⁵⁷¹, even 93% of young gay black men ⁵⁷² (and about a third of "HIV-positive" people in Britain ^{573,574}). Now, about 1 million Americans have been "HIV-positive" throughout 3 decades pp. 1-2 in ⁵. By 2 decades ago, therefore, assuming the 10-year "latent period" (which doesn't actually exist ^{482,483}), at least 250,000 "HIV-positive" people should have been coming down with AIDS and dying within a year or two, being replaced by the ~55,000 new annual infections ⁵⁷⁵ to somehow keep the total number of infected at about 1 million. But reported HIV/AIDS deaths rose to a peak of 42,000 in 1994 and then declined steadily to <16,000 ⁵⁷⁶.
- 4.7.17 Measles virus slows progression of HIV infection ^{577,578,579,580,581}.
- 4.7.18 "HIV" tests are sometimes said to be 100% sensitive and 100% specific ⁵⁸².
- 4.7.19 Sleeplessness and not taking ARVs are correlated [big surprise] ⁵⁸³.

5. WHAT ANTIRETROVIRAL DRUGS DO ^{584,585,586,587,588}

The criterion for effectiveness of ARVs is action in reducing "HIV-positive" or "viral load" or increasing CD4 counts, judged initially by in vitro experiments. But this does not necessarily correlate with clinical improvement of the patient ¹⁵⁴. This is a real-life illustration of the old saw that an operation may be judged by the experts to have been successful even if the patient died. Suppression of "viral load" does not always restore the immune system ⁹¹⁷; level of "viral load" does not correlate with level of CD4 cells and neither correlates with clinical condition of the "patient" ¹⁵⁴.

- 5.1 There is no evidence that ARVs prolong life ^{68,589,590} or improve the quality of life ^{591,592,593,594,595,596,597}.

- 5.1.1 Despite FDA warnings, manufacturers advertise ARVs misleadingly as though they allow a completely healthy life ^{598,599,600}.

- 5.1.1.1 Some people become manifestly more ill as soon as they start taking ARVs. This happens so often that it has been given a name, "immune restoration syndrome" ³¹².

- 5.1.2 "Virological response after starting HAART improved over calendar years, but such improvement has not translated into a decrease in mortality" ⁶⁰¹.

- 5.1.2.1 Mortality of 25-year-old "HIV-positive" people responding successfully to HAART was 5.3 and 10.4 times greater than in the general population, for men and women respectively ⁶⁰².

- 5.1.3 No life-prolonging benefit is claimed for AZT in a review that attempts to calculate the supposed benefits of ARVs ⁶⁰³.

5.1.4 Deaths from “AIDS” continued to increase after the introduction of AZT treatment. The proportion of AIDS patients surviving for even one year was not increased by AZT plus prophylaxis against PCP ⁶⁰⁴.

5.1.5 AZT actually killed about 150,000 “HIV-positive” people between the mid-1980s and the mid- 1990s ⁶⁸.

5.1.5.1 Side effects unpleasant enough to report were experienced by 50-75% of *healthy* medical personnel treated for possible exposure to HIV, and the side effects were severe enough that 24-36% discontinued the therapy ⁶⁰⁵.

5.1.6 When AZT was replaced by “cocktails” [Highly Active AntiRetroviral Treatment (HAART) or Combination AntiRetroviral Therapy (CART)] the death rate of “AIDS” patients almost instantly declined solely because the new treatment was less toxic ^{68,604}.

5.2 The very concept of ARVs was misguided.

5.2.1 Bacterial and parasitic infections can be successfully treated with antibiotics because those can kill bacteria and parasites without killing the human patient: the physiology of the invading agents is sufficiently different from that of the patient. By contrast, viruses use the host’s biochemical machinery, so preventing virus replication means disabling some of the body’s essential mechanisms.

5.2.2 Nevertheless, social hysteria over the putatively fatal, sexually transmitted “HIV” led to a trial- and-error search for virus-killers.

5.2.3 The initial clinical trial of AZT ^{606,607} — interpreted as showing that AZT extended *by a few months* the lives of AIDS-1 patients who were at death’s door — was badly flawed ^{608,609}, as was ⁶¹⁰ the later, much larger “Concorde” trial ⁶¹¹.

5.2.4 AZT (Retrovir), renamed zidovudine (ZDV), is a nucleoside reverse transcriptase inhibitor (NRTI). Nowadays it is acknowledged that these drugs are not effective “HIV”-killers: “Single-NRTI therapy *does not demonstrate potent and sustained antiviral activity and should not be used* (All). For prevention of mother-to-child transmission (PMTCT), zidovudine (ZDV) monotherapy is not recommended but might be considered in certain unusual circumstances” [*emphasis added*] ⁶¹².

5.2.4.1 Yet AZT monotherapy for PMTCT had been introduced in 1994 and later, in the HAART era and until at least 2007, “[d]uring pregnancy, HIV-1-infected women in industrialized nations . . . commonly receive[d] highly active antiretroviral therapy . . . that generally consist[ed] of three or more drugs, including two . . . NRTIs . . . most frequently. . . AZT and lamivudine [3TC]” ⁶¹³.

5.2.5 Mainstream data should have made it obvious long ago that AZT therapy is too carcinogenic ⁶¹⁴ (section 5.3.3.4) as well as toxic (in particular to mitochondria, sections 5.2.6, 5.3.3.1, 7.1.3.1) to use in humans and moreover could not defeat “HIV” ⁶¹⁵ (sections 5.1, 5.2.4).

5.2.6 Nevertheless, NRTIs including AZT/ZDV remain a component of most combination therapies, despite lack of effectiveness and considerable toxicity: “ZDV can cause bone marrow suppression, myopathy, lipoatrophy, and rarely lactic acidosis with hepatic steatosis” ⁶¹⁶; “Bone marrow suppression, manifested by macrocytic anemia and/or neutropenia, is seen in some patients. ZDV also is associated with GI [gastrointestinal] toxicity, fatigue, and possibly mitochondrial toxicity ^{613,617}, including lactic acidosis/hepatic steatosis and lipoatrophy” ⁶¹⁸. The manufacturer’s own pamphlet included a dozen pages detailing adverse reactions ⁶¹⁹.

5.2.7 Combination antiretroviral treatments are less obviously and speedily toxic than monotherapy because the dosages of each of the toxic substances are smaller and some of the components are somewhat less toxic than AZT.

5.3 Toxic side-effects of ARVs are legion ^{620,621,622,623,624}.

5.3.1 "[A] growing proportion of patients receiving long-term antiretroviral therapy are experiencing treatment failure, drug toxicities, side effects, and drug resistance. . . . an increased incidence of malignancies, cardiovascular and metabolic complications, and premature aging associated with long-term HIV disease or antiretroviral therapy." ⁶²⁵

"Mortality of HIV+ hospital patients owing to non-AIDS events (non-AIDS infections, cancers, cardiovascular and liver diseases) was higher among patients receiving antiretroviral treatment." ⁹²¹

5.3.1.1 Toxicity of stavudine increased with dose and over time ⁶²⁶.

5.3.1.2 In December 2011, activists asked the Gates Foundation to cancel a clinical trial comparing stavudine to tenofovir because the former is so toxic ⁶²⁷.

5.3.1.3 Risk of non-AIDS-related mortality may exceed risk of AIDS-related mortality among individuals enrolling into care with CD4+ counts greater than 200 cells/mm3 ⁹¹⁵.

5.3.1.4 Liver fibrosis caused by some ARVs ⁹¹⁶.

5.3.2 The side-effects are so intolerable that patients' non-adherence to treatment is a perpetual theme in the literature ^{628,629,630,631,632,633,634}.

5.3.2.1 NIH Treatment Guidelines are replete with references to non-adherence ⁶³⁵, e.g. "Adverse effects have been reported with use of all antiretroviral (ARV) drugs; they are among the most common reasons for switching or discontinuing therapy and for medication nonadherence" ⁶³⁶.

5.3.2.2 "Not surprisingly, nonadherence to prescribed medications is common in teens" ⁶³⁷.

5.3.3 Specific side-effects impinge on every part of the body.

5.3.3.1 Aging prematurely ^{454,638,639}, damage to mitochondria ^{613,617,640,641,642,643,644,645,646,647,649,650,651,690} could be a reason for this and for muscle deterioration ⁶⁵⁵ and oxidative stress ⁶⁵² (re oxidative stress, see also sections [2.1.1.2](#), [3.2.2](#), [4.3.2.4](#), [4.3.2.8](#), [5.3.3.1](#), [7.3.3.4](#)).

5.3.3.2 Allergic reactions including rash and skin death ^{653,654,655};

5.3.3.3 Bleeding, spontaneous, with all protease inhibitors ⁶⁵⁵.

5.3.3.4 Cancer ^{613,656,657,658,659,660,661,662,663,664}.

5.3.3.5 Central nervous system effects ^{665,666} including psychosis ^{655,667}: neuromuscular weakness, somnolence, insomnia, abnormal dreams, dizziness, impaired concentration, depression, suicidal ideation, depression ⁶⁵⁵.

5.3.3.6 Functional and physiological disturbances: headaches ⁶⁰⁷; insomnia ⁶⁰⁷;

5.3.3.7 Gallstones, apparently inevitable with protease inhibitors: "Median time to onset is 42 months (range 1–90 months)" ⁶⁵⁵.

5.3.3.8 Gastrointestinal: vomiting, nausea, diarrhea ^{607,655,668,669}.

5.3.3.9 Metabolic syndrome ^{670,678} and metabolic dysfunctions ⁶⁷¹: diabetes, insulin resistance ^{655,672,673,674,675,676,677,678,679,680}, dyslipidemia (dysfunctional blood lipids) ^{655,672,674,675,676,677,678,680,681,682,683,684,685}; lactic acidosis ⁶⁵⁵; lipodystrophy ^{655,672,674,675,676,677,678,680,683,684,686,687,688,689,690,691,692,693,694,695}.

5.3.3.10 Organ deterioration and failure: anemia and bone-marrow suppression ^{607,655}; heart disease including heart attacks ^{655,673,678,696,697,698,699,700,701,702,703,704,705,706,869}; kidney disease, kidney stones ^{655,707,708,709,710}; liver damage ^{655,711,712,713,714,715,716}; neutropenia ⁷¹⁷; pancreatitis ⁷¹⁸; stroke ⁷¹⁹.

5.3.3.11 Osteoporosis ^{655,720,721,885}.

5.3.3.12 Oxidative stress ⁷²² (see also sections 2.1.1.2, 3.2.2, 4.3.2.4, 4.3.2.8, 5.3.3.1, 7.3.3.4).

5.3.3.13 Peripheral neuropathy ^{460,461,462,655}.

5.3.3.14 T-cell killing ^{607,723,922}.

5.3.3.15 Vitamin D deficiency ⁸⁸⁴.

5.4 The official Treatment Guidelines ⁷²⁴ are perpetually revised, and once-recommended treatments become not recommended or to be avoided ^{725,726,727,728,729}. Innumerable changes can be identified in successive versions of the Guidelines.

5.4.1 Bear in mind that these revisions are based on knowledge gained through already observed severe damage in a significant number of cases (sections 5.1.5, 5.2.5, 5.3).

5.5 Some physicians have successfully treated AIDS patients without resort to ARVs ^{730,731,732}, though they sometimes resort to *very short* courses of ARVs, which are potent antimicrobials, to eliminate possibly occult bacterial infections.

5.5.1 Juliane Sacher has had better success treating AIDS patients than other German physicians who use standard anti-"HIV" treatment ^{733,734,735}.

5.5.2 Claus Köhnlein has successfully treated AIDS patients without the anti-“HIV” approach ⁷³⁶.

5.5.3 A decrease in opportunistic infections in “HIV-positive” individuals may not be due to killing “HIV” but to direct suppression of fungal infections ^{737,738}.

5.5.4 “Lazarus Effect”: Anecdotal reports describe “AIDS” patients on the point of death who recover immediately upon receiving antiretroviral drugs. But any antiretroviral action could only produce a very slow, lengthy effect. The Lazarus Effect demonstrates that antiretroviral drugs are very efficient killers of all cells, bacterial and mammalian, including the lymphocytes that produce inflammation ^{898,899}.

6. DAMAGE DONE BY HIV/AIDS THEORY AND PRACTICE

6.1 To individuals, through misinterpretation of positive “HIV” tests.

6.1.1 Everyone who is ill for any reason is likely to be subjected to an “HIV” test and damaged (sections [6.1.2](#) and [6.1.3](#)).

6.1.1.1 The greatest human tragedy of HIV/AIDS theory is that “HIV-positive” individuals *who become ill for any reason at all* — and sometimes who are not ill at all but tested “positive” because of a life-insurance examination or something similar — are classed as “having HIV/AIDS”.

6.1.1.2 So long as HIV/AIDS theory remains in force, there is a crying need for authoritative information for people who are told they “have HIV/AIDS”, many of them knowing with certainty that they could not have become infected in any of the ways that HIV/AIDS theory says they must have been.

6.1.1.3 There is a crying need for doctors to learn how to deal with laboratory results claiming “HIV-positive”: that none of the tests are approved for actually identifying infection; that there are any number of false positives; that there are no valid confirmatory tests; and that they should use every diagnostic tool available to determine whether there is any reason at all to think the person might actually have an illness.

6.1.1.4 There is a crying need for doctors to learn that a very common reason for an “HIV-positive” result is pregnancy ([section 3.2.2.5](#)).

6.1.1.5 There is a crying need for doctors to learn that there are genetic, race-correlated factors that conduce to testing “HIV-positive” and that the tests are thereby severely racially biased ^{pp.}
100-2 & 171 in [5](#).

6.1.2 Everyone who tests “HIV-positive” is thereby at risk of psychological and social harm.

6.1.2.1 Individuals are not properly informed about the high probability of false-positive “HIV” tests, particularly with low-risk individuals
[739](#).

6.1.2.2 Promiscuity is inferred with no further ado, and relationships are broken

⁷⁴⁰.

6.1.2.3 "HIV-positive" individuals who engage in sex may be sent to prison for allegedly endangering their partners ⁷⁴¹.

6.1.2.4 "HIV-positive" individuals have been sent to prison even for spitting on someone ^{742,743,744}.

6.1.2.5 "Veteran who was WRONGLY treated as HIV positive for nine years sues hospital after being 'emotionally and mentally destroyed'" ⁷⁴⁵.

6.1.2.6 Boxer Tommy Morrison lost his career because of inconsistent "HIV" test-results ⁷⁴⁶.

6.1.2.7 "HIV-positive" Asian women have been driven from their marital homes ⁷⁴⁷.

6.1.2.8 "HIV-positive" women in Chile have been forcibly sterilized ⁷⁴⁸.

6.1.3 Everyone who tests "HIV-positive" is at risk of bodily harm from toxic (section 5.3) ARVs and from other experimental treatments.

6.1.3.1 ARVs have been tested on foster children ^{749,750} and orphans ^{751,752,753,754} without proper safeguards.

6.1.3.2 Chemotherapy to kill the immune system to avoid rejection of transplanted baboon bone-marrow cells because baboons couldn't be infected with "HIV" ⁸⁸⁶. The first attempt involved "an unidentified 56-year-old man who was dying of AIDS...The experiment was not a success. The baboon cells failed to grow, and **the man died two months later. But Dr. Ricordi said his team had been encouraged because the man did not suffer any adverse reactions from the transplant**" [emphasis added] ^{887,889}.

6.1.4 Black people are at particular risk because they test "HIV-positive" much more often than others; black women seem to be particularly at risk — see 3.4.1

6.1.4.1 African ancestry is misinterpreted as *behavioral* risk of infection even though blacks test "HIV-positive" more often than others *irrespective of behavior* ^{755,756,757,758,759,760,761}.

6.1.4.2 Extraordinarily promiscuous "concurrency" is postulated to explain the uniquely high sub-Saharan prevalence of "HIV-positive" ^{373,762,763,764} even though actually observed sexual behavior does not support the postulate of high levels of concurrency ^{p. 78 in 5,375}.

6.1.4.3 Black people are presumed to be not only more promiscuous but also more likely to inject illegal drugs ⁷⁶⁵.

6.1.4.4 "HIV-positive" black men are immediately assumed to be on "the down low" ^{766,767} — behavior that may be far less common than is now widely presumed ^{768,769}.

6.1.5 Gay men are at particular risk because something about the lifestyle seems to conduce to testing "HIV-positive".

6.1.5.1 Probably only those gay men who practice the "fast-line" lifestyle, but data are lacking to reach firm conclusions.

6.1.5.2 Extraordinary promiscuity is inferred from dubious data: "exactly the same strain of HIV can be shown to have infected all five of these people. . . . [and] transmission probably occurred from a single person to these various partners *within just a few hours*" [emphasis added] ⁷⁷⁰.

6.1.5.3 Intestinal dysbiosis theory ^{735,771} suggests that deliberately responsible behavior like anal douching may actually conduce to becoming "HIV-positive" and even ill.

6.1.5.4 Some "HIV-positive" gay men (as well as some women ⁹⁰⁷) occasionally suffer AIDS-like illness including low CD4-T-cell counts after having been healthy for as long as a couple of decades. Given that "HIV" does not cause immunodeficiency or AIDS, the circumstances of these people are mysterious in a way that is comparable ⁹⁰⁸ with those diagnosed as having "idiopathic CD4-T-cell lymphopenia" (section 1.1.5). Similar treatment might then be appropriate, namely, treating any manifest illnesses directly, preventing opportunistic infections, and strengthening immune systems, for instance with interleukin, interferon, or hematopoietic stem cell transplantation ⁹⁰⁹.

6.2 To social institutions

6.2.1 When finally it becomes universally recognized that HIV/AIDS theory is wrong, trust in the institutions of medicine and science will take a very severe blow.

6.2.2 In the meantime, individual institutions may be sued for damages when positive "HIV" tests were mistakenly taken as proof of permanent "HIV-positive" status ^{745,772}.

6.2.3 Law enforcement gets egg on its face when prosecutions fail because they cannot prove the transmissibility of "HIV" ^{348,773}.

6.3 To society as a whole: Huge sums of money have been and continue to be wasted on anti-"HIV" and anti-"AIDS" activities.

6.3.1 The United Nations HIV/AIDS program ⁷⁷⁴ and National Institutes of Health ^{775,776} spend disproportionate amounts on "HIV/AIDS" compared to other health concerns.

- In Africa, billions of dollars are spent on ARVs and associated activities when far smaller amounts could
- 6.3.2 improve health and save lives immediately ^{110,777,778,779}, for example by providing:
- a. means for water purification;
 - b. minimal amounts of decent food ⁷⁷⁷;
 - c. treated anti-mosquito nets to prevent malaria;
 - d. \$35 oxygen valves for hospitals ⁷⁷⁷.

6.3.3 Billions of dollars continue to be spent on attempts to find an anti-“HIV” vaccine despite 3 decades of evidence that it cannot be done (sections 3.3.7, 4.1.7, 4.1.8, 4.2.2, 4.2.3, 4.3.5).

6.3.4 Well-intentioned “education” programs reinforce the hegemony of HIV/AIDS theory.

6.3.4.1 The Bill and Melinda Gates Foundation actually paid for entertainment programs to present the mainstream viewpoint about HIV/AIDS ⁷⁸⁰.

6.4 Hegemony of HIV/AIDS theory and practices means that some central questions cannot be answered.

6.4.1 When “HIV-positive” individuals become ill, all too often the real cause of illness is not looked for.

6.4.2 When “HIV-positive” individuals using antiretroviral drugs die, no autopsy inquires into whether death may have been owing to the drugs ^{888,889}.

7. HINDRANCES TO MAKING THE CASE AGAINST HIV

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

7.1 Misinformation is ingrained in the public sphere, in the conventional wisdom, about the discovery of “HIV” and the histories of HIV and of AIDS ⁷⁸¹.

7.1.1 That AIDS-1 first appeared among “young, previously healthy, gay men”. In reality they were not particularly young (average age mid- to late 30s) and far from healthy ⁹⁵, characterized primarily by heavy drug abuse and a “fast-lane” lifestyle rather than by being gay ¹⁶.

7.1.1.1 In the earliest days of the “AIDS” era, the Centers for Disease Control, in a quest for increased funding, instituted a PR campaign asserting that everyone is at risk for HIV, even as they knew that AIDS was restricted to specific “risk groups” ⁹⁰⁰.

7.1.2 “HIV” tests are taken as showing infection, and “confirmatory” tests (typically Western Blot) are taken as validating that. In reality, neither presumption is correct, there are no valid tests for infection (sections 3.1, 3.2) and so-called “confirmatory” Western Blot itself is liable to false-positives ¹⁶⁵.

7.1.3 Antiretroviral therapy is *not* “life-saving”, as it’s often described ⁵⁸⁹ (section 5.1). The false claim is sustained in part by attributing toxic side-effects of ARVs to “HIV” rather than to the drugs ^{782,783,784,785,786,787} (section 4.3.4).

7.1.3.1 Premature aging is attributed to ARVs keeping people alive longer and supposedly suffering long-term damage from "HIV", when actually ARVs are known to damage mitochondria (sections 5.2.5, 5.2.6, 5.3.3.1), and damage to mitochondria happens to be a direct cause of aging ^{788,789,790,791,792,793}.

7.1.4 References in fiction and on television ^{794,795,796,797,798,799} reinforce the hegemony of HIV/AIDS theory.

7.1.4.1 That "HIV" is *readily* spread by sexual intercourse ^{800,801}.

7.1.4.2 That one could be infected by "HIV"-tainted blood splashed into one's eye ⁸⁰².

7.1.4.3 That HIV can be transmitted by saliva on a baseball ⁸⁰³.

7.1.4.4 That AZT is a powerful ARV ⁸⁰⁴.

7.1.4.5 However, Daniel Easterman correctly noted in 1990 ⁸⁰⁵ that some individuals could overcome AIDS by making lifestyle changes, possibly reflecting the experience of Michael Callen ¹⁰¹.

7.1.4.6 That an HIV-infected needle on a chair seat can be used to assassinate someone, death following in 5 months ⁸⁶².

7.1.4.7 That smoking crack cocaine avoids worrying "about needles and AIDS" ⁸⁶³.

7.1.4.8 That getting a tattoo risks getting AIDS from an infected needle ⁸⁶⁵.

7.1.4.9 That many hemophiliacs were infected by tainted blood products. "Two thirds of our hemophiliacs have received infected blood" ⁸⁹⁰.

7.2 Fresh misinformation about "HIV" and AIDS continually enters and pervades the public sphere ⁸⁰⁶.

7.2.1 "News" items incessantly reinforce mistaken views by reiterating "HIV/AIDS"; "HIV, the virus that causes AIDS"; "life-saving" ARVs; etc.

7.2.1.1 The media typically broadcast "breaking news" about science and medicine but fail to revisit the topic when the original claim turns out to need modification or complete withdrawal, which is the usual circumstance with the latest from the research front ⁸⁰⁷ — for example, 30 years of promises and promising breakthroughs toward an "HIV" vaccine without any genuine, perceptible progress (sections 3.3.7, 4.1.7, 4.1.8, 4.2.2, 4.2.3, 4.3.5).

7.2.1.2 Governmental and non-governmental agencies continually urge the media to campaign for awareness of HIV/AIDS theory

7.2.1.3 The mistaken belief that “HIV” is transmitted sexually (see [section 3.3](#) for disproof) is incessantly repeated, for example that prostitutes contract and spread “HIV” ^{891,892}.

7.2.2 It takes longer to demonstrate the errors in a claim than to make the mistaken assertion.

7.2.2.1 The flaws in any new mainstream claim about “HIV” and “AIDS” can only be explained once it is recognized that HIV/AIDS theory is wrong.

7.2.2.2 For example, “antiretroviral drugs can forestall long-term health risks of the disease and cut the risk of transmission by as much as 96 percent” ⁸⁰⁹.

To debunk that sentence requires presenting the copious but circumstantial proof that “HIV” entails no “long-term health risks”, as well as surveying the copious data on toxicity of ARVs, not to speak of demonstrating the faulty statistics underlying that “96%”: since the claimed transmissibility is already so low ([section 3.3.3](#)), the reported “96%” cut could only be observed in a clinical trial of immense proportions and duration. Everything based on “HIV” tests is likely to be wrong and should not be accepted at face value, but to make the case with any specific claim requires debunking the whole basis and edifice of HIV/AIDS theory.

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

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

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

7.3.1.1 This is typical for people in opposition to mainstream views. Internal disagreements and organizational schisms are common among such “single-issue” groups whose members are not also bound together for other strong overarching and self-interested reasons ^{810,811}.

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

7.3.2.1 HIV has never been proven to cause AIDS.

7.3.2.2 HIV has never been proven to exist ⁸¹².

7.3.2.3 HIV does not exist ⁸¹².

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

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

7.3.3.1 AIDS-1 was a multifactorial syndrome caused by a combination of insults ²⁰.

7.3.3.2 More specifically, AIDS-1 resulted from the “fast-lane” lifestyle common among a proportion of gay men during the early years of gay liberation: promiscuous consumption of “recreational” drugs ¹⁶, promiscuous sex, frequent infections by gonorrhea, syphilis, etc., indiscriminate consumption of antibiotics even as prophylactics ¹⁰⁰, generally unhealthy behavior.

Such behavior damages the intestinal microflora, the immune system's first line of defense, specifically against the fungal infections that were common in AIDS-1. Such damage brings illness as well as positive “HIV” tests ^{813,814,815}, and explains some of AIDS-2 as well as AIDS-1.

7.3.3.3 AIDS-1 was caused specifically by drugs, including ARVs ^{736,816}. So is a proportion of AIDS-2.

7.3.3.4 AIDS-1 was and is, and a proportion of AIDS-2 & AIDS-Africa are, a syndrome associated with oxidative stress ⁸⁰, which can result from a wide range of physical (and even mental) insults (see also sections 2.1.1.2, 3.2.2, 4.3.2.4, 4.3.2.8, 5.3.3.1, 5.3.3.11).

7.4 HIV/AIDS theorists and advocates, and therefore the media and the public, lump together indiscriminately everyone who does not accept the mainstream view *in toto*, so they do not distinguish between “AIDS Rethinkers” or “HIV Skeptics” who just deny that “HIV” causes “AIDS” by contrast with charlatans and conspiracy theorists ^{817,818}, for example:

7.4.1 Peddlers of fake remedies ⁸¹⁹.

7.4.2 Claims that HIV was man-made ^{820,821}.

7.4.2.1 Deliberately or accidentally in research on biological warfare ^{822,823,824}.

7.4.2.2 To damage certain social groups ^{825,826,827} — “to depopulate vulnerable target groups, including blacks and other minorities, homosexuals, and perceived ‘decadent’ sexually active individuals” ⁸²⁸, or that condoms sent to Africa were spiked with “HIV” ⁸²⁹.

7.4.3 Claims that HIV originated in unrelated cancer ⁸³⁰ or vaccine research or practice ^{831,832}.

7.5 The mainstream refuses to engage the evidence or to debate substantively with dissenters.

7.5.1 Dissenters are ignored, not answered, boycotted, black-listed, maligned.

7.5.1.1 Not answered: Duesberg's seminal article ⁸³³ never answered ^{p. 233 in 5; p. 147 in 6; p. 198 in 10; p. 139 ff. in 13}; Kary Mullis, request for published proof that HIV causes AIDS ^{pp. 171-4 in 23}; Gary Null, asking Robert Gallo to cite publications proving HIV causes AIDS ^{p. 39 in 834}

7.5.1.2 Excluded from professional meetings: Peter Duesberg ^{p. 147 in 13}

7.5.1.3 Hindered or excluded from professional publications: Peter Duesberg ^{pp. 229-30 in 5; pp. 147-52 in 13}; Gordon Stewart ^{pp. 100-31 in 13; pp. 230-1 in 5}

7.5.1.4 Not permitted to reply to published criticism: Peter Duesberg ^{p. 229 in 5; chapter 3 in 834}

7.5.1.5 Research no longer funded: Peter Duesberg ^{p. 229 in 5}

7.5.1.6 Misrepresented: Various HIV/AIDS skeptics ^{p. 234 in 5}

7.5.1.7 Scheduled public events canceled: Showing of *House of Numbers* to be followed by debate ⁸³⁵

7.5.1.8 Disinvited at the last moment: Peter Duesberg & Celia Farber, from appearing at Congressional hearing ⁸³⁶

7.5.1.9 Personally maligned: Various people, as "flat-earthers" ^{pp. 212 & 233-4 in 5}

7.5.1.10 Journalists warned against covering dissenting views ^{837,838,839}

7.5.2 Where mainstream and dissenters do publicly address the same points, they do not engage with one another.

7.5.2.1 Dissenters were accused of complicity in deaths in South Africa on the basis of computer-modeled estimates of deaths ^{523,524,525} that are contrary to the official South Africa Statistics data ⁷⁴.

7.5.2.2 The progressively modified NIH "fact sheet" ⁸⁴⁰ (most recent revision 14 January 2010) fails to address the specific criticism ^{25,841} made of its arguments.

7.6 The mainstream tries to discredit dissenters via *ad hominem* polemics ⁸³⁹, not by substantive argument ^{pp. 212 & 233-4 in 5; pp. 49 & 80 in 834}.

7.6.1 Because the dissenters have never themselves done HIV/AIDS research.

7.6.1.1 This is a non sequitur.

Informed individuals are perfectly capable of critiquing the work of others. Peer review of manuscripts and grant proposals is often done by supposedly informed individuals who have not themselves worked on exactly the same topic. Indeed, the advantage of freedom from

conflicts of interest makes it desirable that critiques come from other than insiders, be they colleagues or competitors.

7.6.1.2 Many supporters of the mainstream view and critics of the dissenters — indeed some of the most prominent and vociferous HIV/AIDS proponents — have themselves done no HIV/AIDS research and may not even have any scientific credentials at all ^{842,843,844}; Jeanne Bergman ⁸⁴⁵ (lawyer) ^{843,844}; Nathan Geffen ^{846,847} (activist) ^{848,849}; Seth Kalichman ⁸⁵⁰ (social psychologist) ⁸⁵¹; Nicoli Nattrass ^{523,524,852} (social scientist, economist) ^{853,854,855}. As to the many physicians among public proponents of HIV/AIDS theory, it should be remembered that physicians, doctors, MDs, are not scientists, were not trained to do or to understand research, have no preparation for doing scientific research ^{856,857}.

7.6.1.3 The mainstream refers queries to official sources like the NIH “Evidence” ⁸⁴⁰, but such in-house writings for public consumption are not scientific publications, they are public-relations pieces; they have never been peer-reviewed and are often written by PR personnel, not by scientists. Many official reports are not only not scientific writings, they may be demonstrably incompetent ^{Chapter 8 in 834}.

7.6.2 Dissenters are labeled denialists ^{839,850}

7.6.2.1 The deliberate analogy with Holocaust deniers is emotionally fraught and is used because the mainstream cannot answer the dissidents’ substantive points ⁸⁵⁸.

7.6.2.2 They’re “flat-earthers” p. 297 in ²⁵⁷.

7.7 The media do not cover dissenting views.

7.7.1 They fail even to discuss, let alone expose, the improper tactics of those who malign dissenters.

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

8.1 The general context of medical science permits this sort of blunder ^{Chapters 11-13 in 5; 834}.

8.1.1 Theories once accepted are then not perpetually questioned.

8.1.1.1 Observations that contradict the accepted view are ignored for as long as possible ^{65,94,859,860,861}.

8.1.1.2 Boat-rockers are not appreciated. There is no career role in science for inveterate questioners of accepted practices; if possible there is even less room in medical practice for transgressing established practice.

8.1.1.3 Peer review is almost universal as a purported safeguard of quality. In reality, it serves to enshrine whatever the mainstream consensus happens to be ^{81,526}. "Peer review ... is simply a way to collect opinions from experts in the field. Peer review tells us about the acceptability, not the credibility, of a new finding" ³⁶³.

8.1.2 There is no organized coordination of specialized research areas.

8.1.2.1 Virologists don't concern themselves with epidemiology. Clinicians simply accept what the virologists and the drug designers tell them. If data in one specialty are relevant to another specialty, that may not be realized quickly or efficiently. Specialists feel unqualified to critique the specialties of others.

8.1.2.2 So much is published that researchers find it difficult to keep up with what everyone is doing even within their own very narrow specialty.

8.2 This particular blunder came about via specific identifiable steps ^{Chapters 14 & 15 in 5}.

8.2.1 Mis-classification of characteristics of AIDS patients: they were primarily drug addicts rather than gay men ^{Chapter 1 & p. 191 ff. in 16}.

8.2.2 Mistaking a social phenomenon for a medical one (section 2.1.1).

8.2.3 Accepting inadequate evidence for the presence and activity of a retrovirus (sections 1-3).

8.2.4 Once Gallo, with the imprimatur of the Department of Health and Human Services, had been credited with discovery of the probable cause of AIDS, researchers framed their subsequent grant requests and consequent research on the virus hypothesis.

The overwhelming majority of funding of biological research comes from the National Institutes of Health, which is an agency within the Department of Health and Human Services.

8.2.5 Alternatives to the retrovirus hypothesis ceased to be discussed by mainstream researchers.

8.2.6 Minority views and those of outside observers were peremptorily dismissed.

8.2.7 The media did not attend in neutral fashion to dissenting views.

8.3 How science and medicine are communicated to the general public entrenches such blunders ^{314, Chapter 7 in 834} (see also sections 7.1, 7.2, 7.4, 7.7).

8.3.1 "a politics dominated by experts and mass persuaders" ¹⁷⁴.

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

9.1 If HIV doesn't cause AIDS, what does cause AIDS?

9.1.1 AIDS-1 (the original early-1980s AIDS) resulted from the "fast-lane" lifestyle of drug abuse, extreme promiscuity, and generally unhealthy behavior. The first AIDS victims were in their mid-to-late 30s, consistent with this explanation and inconsistent with a sexually transmitted disease, which affects adolescents and young adults significantly more than others.

9.1.2 AIDS-2 ("HIV disease", "HIV/AIDS", non-African AIDS) is the mis-interpretation of "HIV" tests whereby anyone who tests "HIV-positive" is presumed to "have HIV/AIDS" — even as authoritative mainstream sources and data demonstrate that innumerable conditions, some but not all of them unhealthy, conduce to testing "HIV-positive", and even as no "HIV" test has been officially approved for actually identifying active infection.

9.1.3 African AIDS is the mis-interpretation of manifest symptoms that are entirely non-specific and moreover are associated with many diseases long endemic in Africa: prolonged fever, cough, diarrhea, bodily wasting ([section 2.3.1](#)).

9.2 If HIV doesn't cause AIDS, why do ARVs successfully treat AIDS?

9.2.1 They don't ([section 5.1](#)).

ARVs have not increased lifespan — except only when less-toxic combination "cocktails" replaced highly toxic AZT monotherapy. Then there was an immediate decrease in iatrogenic mortality, mortality caused by the medical treatment itself ([section 5.1.6](#)).

9.2.2 ARVs are very powerful killers of biological systems, and their antibiotic or antifungal or anti-parasitic powers might overcome occult infections; but prolonged use of ARVs is likely to be fatal ([sections 5.3, 5.5](#)).

9.3 Why do gay men test "HIV-positive" so frequently, if it isn't an STD?

9.3.1 Certain practices common among gay men make testing "HIV-positive" likely, for example, the consequences of intestinal dysbiosis. That condition can also bring on serious illness, including the fungal infections that characterized AIDS-1 ([sections 4.3.2.3, 6.1.5.3](#)).

9.4 Questions posed through ignorance of the facts about "HIV" and "AIDS".

9.4.1 "Why are so many mid-life gay men getting HIV?" ⁴⁹² Because *everything* about "HIV" and "HIV/AIDS" is most frequent in young middle age, mid-30s to mid-40s ([sections 3.3.5.1, 7.1.1](#)).

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