WITH THE STROKE OF A PEN, PRESIDENT OBAMA COULD STOP THE MEDICAL MADNESS, THE CONSPIRACY OF "HIV" TESTING, NEEDLESS AIDS DEATHS, AND SAVE HUNDREDS OF BILLIONS FOR THE IMPENDING DEPRESSION.

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With the removal and resignation of Mark Dybul, the architect and executioner of George Bush's PEPFAR initiative, I would like to offer my willingness to take up the task of his position in the new Obama administration, and describe how I would organize this effort toward a more effective program of humanitarian aide.

It should be stated from the start that I would organize the program on the basis of suggestions promoted by organizations like Doctors Without Borders, rather than continue to direct it as it has been for years according to pharmaceutical interests and questionable science. It also should be declared from the outset of this proposal that I clearly recognize, having been a critic of the AIDS establishment since its inception, that I consider the efforts of many, if not most of the promoters of AIDS, including Mr. Dybul, to have acted out of genuine concern for the people of the world, regardless of how misguided and destructive these policies prooved, and despite the assumptions of their efforts being based upon faith instead of solid scientific evidence.

One may begin this task of overhauling World AIDS initiatives by asking President Obama's new science advisors if they intend to maintain the violation of human rights that is caused by "HIV" molecular testing of so-called "low-risk" and "high-risk" individuals. "HIV" test kits cross-react non-specifically with other factors and known disease syndromes.

Among "HIV" test subjects, with respect to the accuracy of diagnosis, complete disclosure to human test subjects about the facts that:

1. There are at least 70 known false positive "HIV" cross-reactions;

2. To obtain an unequivocally positive "HIV" test result each of the following potential cross reactivities should be eliminated through differential diagnosis as possible cause of a false-positive result on the ELISA's, WB's, or PCR-based tests, before a positive "HIV" conviction is made by an attending physician: The spurious detection of p18, p24, p55, p12, p32, p51, p66 and gp160, gp41, gp120 antigens that may be present in fluids obtained from patients who are pregnant, or from patients who suffer from other acute viral infections, or who have had recent flu or hepatitis B vaccinations.

For example, Josephson et al. (1) reported the results of a Western Blot study that analyzed the supposed "HIV" capsid protein, p24, in indeterminate patients, in which they claimed:

"Despite the fact the the majority of p24-and p24/25-indeterminate specimens exhibited specific antibody reactiviy with HIV core antigen, there was no evidence linking this reactivity to HIV infection. On the contrary, based on available data and limited patient information, we predict that HIV infection was not the cause in most cases…"

"A possible explanation for the specific p24 antibody reactivity in our patient population is that it represents cross-reactivity with another human retrovirus."

In other words, these authors have claimed that although all of the samples tested were initially reactive, they "feel" that in actuality none of the patients were really carrying "HIV," because 12 were from **"low-risk groups"** (perhaps they weren't black, or openly admitting that they had just experienced a 20 year addiction to heroin, or were in fact pregnant, or had warts, or had a recent flu, hepatitis B, or tetanus vaccine, or had one of several dozen autoimmune diseases like arthritis that also generates “HIV-like sequences”). The explanation these AIDS researchers provided, in addition, is really quite imaginative as well-that perhaps these people were all infected with some **other** retrovirus to account for their indeterminate reactions (HTLV-5 is even suggested). So if you test indeterminate for "HIV" as all these 21 samples did, then perhaps you harbor "a different retrovirus," one perhaps in time, will be non-specifically linked to 99 previously known and described diseases, instead of the mundane 48 that "HIV" is said to cause currently?

These authors forgot to mention that it should also be determined that alcoholic hepatitis, exposure to alpha interferon therapy, antibodies of healthy patients with high affinity for polystyrene used in different test kits, anti-carbohydrate antibodies, anti-collagen antibodies, arthritis,systemic lupus erythematosus, scleroderma, connective tissue disease, dermatomyostitis, tuberculosis, some strains of malaria, hemophilia, hepatitis, hemodialysis, high levels of circulating immune complexes, herpes simplex I and II, HLA antibodies (to Class I and II leukocyte antigens), hyperbilirubinemia, hypergammaglobulinemia, leprocy,

lipemic serum, malaria, the presence of some malignant neoplasms, mycobacteriaum avium, non-specific detection of free ribonucleoproteins, organtransplantation, other retroviruses, the receipt of gamma globulin or immune globulin (as prophylaxis against infections), multiple transfusions, pregnancy especially in multiparous women, Q-fever with associated hepatitis, primary billiary cirrhosis, primary sclerosing cholangitis, renal failure, rheumatoid arthritis, Stevens-Johnson syndrome, recent tetanus, flu, or hepatitis B vaccination, T-cell leukocyte antibodies, chronic drug addiction, or visceral leishmaniasis are all known to be responsible for a false cross-reactive HIV test, as all of these (and about 40 other) factors have been shown to generate false positives (2).

AIDS diagnosis is different in different places.

To further emphasize the deadly absurdity and unnecessary expense of the current situation and policies, if someone "HIV-positive" is diagnosed with AIDS in the U.S., all he/she has to do is go to Canada for another opinion, and voila (!), nineteen out of twenty times he/she will no longer be an AIDS patient, and thus not be prescribed the toxic drugs that actually bring mortality by their "side effects" such as liver or pancreatic failure, neurological damage, lymphoma, mitochondria destruction, and heart attacks, all typically requiring millions of dollars for further palliative treatments.

One must also take into account, the colossal waste of money and lives that continues to occur because of the misguided and illogical surveillance definitions are followed, because the standards for making an "HIV," "ARC," or "AIDS" diagnosis vary, and are different depending upon the country or region of a country where people are tested.

For example, following the years during which AIDS diagnoses were made presumptively without molecular testing, now, if a WB is performed on an African in most countries in Africa, the presence of any two of the 9 proteins detectable on a Western Blot (WB) including GAG (p24, p40, p55), POL (p32, p53, p68), or ENV (p 41, p120, p160) is diagnostic of a positive diagnosis, whereas in Australia, one or more ENV-associated proteins plus one or more of either POL or GAG is diagnostic of a positive diagnosis.

In The United Kingdom, any one or more of the ENV proteins, plus p31 (p32), plus p24 is diagnostic of a positive diagnosis, whereas, in the US, all 4 ENV proteins, plus p31, and p24 must be present, according to the CDC. The US FDA, and Red Cross have different standards as well (with respect to how many bands must be present on the WB (Biotechnology, June, 1993,11:696-711).

In 2001, the CDC's MMWR, Guidelines for Laboratory Test Result Reporting of Human Immunodeficiency Virus Type 1 Ribonucleic Acid Determination, the

recommendations from a CDC Working Group as of November 16, 2001 (50(RR20);1-12) reported that:

"Results obtained with available test methods are variable, and laboratories present these results in different ways, indicating that guidelines to promote standard practice in reporting of test results are warranted."

"No test reporting standardization exists; specifically, standard units of measurement of test method have not been established. Laboratory viral load test reports should be accurate and adequate for patient treatment and public health monitoring of the HIV and acquired immunodeficiency syndrome (AIDS) epidemic. To assure test reporting comparability among laboratories, standard methods are needed; moreover, standardized results are needed for early detection of infection, early access to patient care, and early detection of treatment failure."

In January 1, 2000, the CDC HIV-infection surveillance case definition was expanded to include viral load test results despite the fact that:

"In certain cases, laboratory slips indicated that HIV had been detected at a value below the test's lower limit (e.g., HIV detected was <400 copies/mL), or the laboratory slip provided an actual number of copies outside of the stated reportable range."

The National Institutes of Health and Henry J. Kaiser Foundation, US Department of Health and Human Services, National Institutes of Health, 2001 have claimed the following (available at <http://www.hivatis.org>. Accessed July 20, 2001):

..."Until a common standard is available to use for normalizing values obtained with different assay methods, choosing one assay method is advisible when HIV RNA levels are monitored to guide therapeutic decision-making. The goal to develop a common standard for normalizing values obtained with different test kits has recently been reported."

*"**Available tests are not licensed for diagnosing HIV infection**, but the viral load test results are used for reporting HIV infection to local and state health departments."*

This was the state of affairs at the beginning of our new century. Things have become much worse since then.

In May 2000, President Clinton declared AIDS to be a national security threat, followed by President Bush and Congress spending huge funds for America, Africa, and elsewhere. In October 2008 $48 billion was given for Africa alone, to be spread over the next five years. Being directly under

the purview of his executive office, and commandeering almost 1% of the entire Federal budget, even without investigating or continuing to ignore the fraud perpetrated and lives ruined by “HIV-testing” as discussed above, it is imperative President Obama order a complete review of both the incredulously higher U.S. death rate compared to all other Western nations, and to ascertain the truth of genuine African AIDS belatedly acknowledged by many authorities to be grossly overestimated. United States annual “AIDS deaths” have been near 16,000 for many years, providing fodder for ceaseless news accounts. What is keep quiet however, censored may be more accurate, is the U.S. death rate is twenty-five times European Union (EU) country citizens, after Third World immigrant data is discounted. Other countries such as Canada right next door, Australia, and New Zealand, match the EU success, all with AIDS deaths having sunk to double digits, basically to background levels before the term AIDS was coined 24 years ago. The self-perpetuating U.S. death toll springs from an errant definition of AIDS employed solely in the U.S. that initiates toxic drug therapies, that in turn brings iatrogenic AIDS mortality, with U.S. health generals inexplicitly failing to learn from these resounding “successes.” Having demonstrated their commitment to their undeviating tragic course, it is up to the President to relieve the captain and officers of the leviathan U.S. AIDS, without a moment's delay.

Moreover, the preventable U.S. death toll, compared to success elsewhere, should be succinctly and logically explained to the public, politicians, and medical professionals. Equally important, there are many scientists with world-class credentials able to enlighten President Obama, and President Obama's administration must allow them to be heard and not filtered through layers of handlers, or the chiefs of NIH unwilling to review the truth amply shown all around the world.

In 1993, U.S health authorities expanded AIDS diagnoses to include a category of people having but two laboratory conditions: a low white blood cell count (low WBC) and a test showing HIV antibodies of a high concentration. Thus these two test results, graded and judged on an arbitrary scale, despite a person having excellent clinical health and with no symptoms of disease whatsoever, stamp one in the U.S. to have "AIDS." Then, despite beginning in fine health, the nightmare of toxic drug therapies is initiated, with scared witless new patients conjuring up ludicrous dim memories of perhaps a brief sexual fling, blood transfusion, or bloody injury often decades ago. By year 2000, this singular low WBC rogue category of AIDS (the last year this data was available) cited by New York City Department of Health data was 90% of their AIDS cases, and rising.

Since other Western countries attribute a low WBC count as only an AIDS-indicator “illness,” and despite having similar “HIV-positive” rates,

other Western countries have but a tiny fraction of the U.S. AIDS diagnoses. Thus, few are given the toxic treatment drugs designed to raise the WBC count and suppress “viral load.” Perhaps the physicians of these countries realize that low WBC and CD4+ T lymphocyte counts (CD4 counts) are associated with a variety of conditions, including many viral infections, bacterial infections, parasitic infections, sepsis, tuberculosis, coccidioidomycosis, burns, trauma, intravenous injections of foreign proteins, malnutrition, over-exercising, pregnancy, coricosteroid use, normal daily variation, psychological stress, and social isolation? There are also a number of people (about 3-5% of non-"HIV-positives) who are completely healthy and who have low CD4 counts for no apparent reason.

However, in the U.S., even if and when WBC counts are optimistically raised, patients' clinical results and mortality have been the opposite. The results have been consistent annual U.S. AIDS cases of 39,000, with the high death toll already noted, clearly tied to the taking of the treatment drugs. These deaths are usually blamed as “HIV-caused” even though scientists after 25 years on their medical Manhattan Project have never been able to elucidate how HIV actually kills cells, and have never been able to provide an electron microscope photo from the tissues or blood of an “HIV-positive” or “AIDS patient,” of such cellular murder. As for the real facts, minimal deaths in all other countries resoundingly implicate the U.S. AIDS definition and consequent treatment drugs: Germany with a population of 83 million had 73 "AIDS deaths" in 2006 and but 373 new "AIDS cases;" other 2006 examples include Sweden with 9 million having but 10 "deaths" and 59 new "AIDS cases," Canada with 33 million people had but 34 "deaths" and 255 new "AIDS cases," and so on (Sources: EUROHIV; HIV/AIDS surveillance in Europe: end-year report 2006; Surveillance Report to Dec. 31, 2006, Public Health Agency of Canada).

In 2006, the December Senate approved Burr's bioterrorism bill-a bill just in time for Christmas to establish the Biomedical Advanced Research and Development Authority, commonly referred to as BARDA, which passed by unanimous consent. The bill describes how forced vaccines, quarantines, criminalization of “HIV” and other molecular diseases should be signed into law as the 'debate' regarding Bush's war in Iraq continued. Also in 2006, the massive recalls of “HIV-test kits” continued during the last decade. For example, the FDA recalled Vironostika HIV-1 test kit lots: 259606, 121566,1008926, 259606, 121567, 1008926, 259606,121568, 1008926, 259605, 259717,160342, 1011220, 259605, 259717,160339, 1011021, and said:

"These HIV-1 finished kit lots in the field have been reported to contain EnzAbody reagent that appears noticeably cloudy and/or flocculent, instead of clear and non-turbid as expected 30 minutes after reconstitution. Use of cloudy EnzAbody could possibly increase your risk of inaccurate HIV test results in patients and therefore should be avoided."

A more of less complete list of similar recalls would take volumes of tables to present here, but are available upon request of the reader.

Suffice it to say, those accused by these kits of being "HIV" positive are rarely informed about "HIV" testing accuracy as they prepare themselves for eventual death or perpetual toxic drugging, amounting to approximately $350,000/patient over the course of their "treatment" according to recent reports. For instance, in 2006, Dr. Bruce R. Schackman, chief of health policy at Weill Cornell Medical College in New York and lead author of a paper appearing in Medical Care in 2006, a journal published by the American Public Health Association claimed that *"...patients can live average 24 years, if they pay $385,000.*"

But there are legions of "HIV-positive" individuals who have escaped the State's reporting systems as well, who have never taken or who refused to take "HIV" tests or anti-retrovirals, and who also have lived for 24 years since the beginning of the AIDS era. The self-reported reasons for their disease-free and drug-free survival has been amply documented on documentaries that have won awards such as Special Jury Prize at the AFI Los Angeles International Film Festival (e.g. "The Other Side of AIDS").

In 2006, a nationwide team of AIDS researchers led by doctors Benigno Rodriguez and Michael Lederman of Case Western Reserve University in Cleveland disputed the value of viral load tests-a standard used since 1996 to predict when progression to AIDS would occur in drug-naïve individuals, and to grant approval to new AIDS drugs, after their study of 2,800 HIV positives concluded that viral load measures failed in more than 90% of cases to predict or explain immune status (3):

"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."

And a major groundbreaking study affirms being "HIV-positive," by itself, is anything but a death sentence: Denmark's Dr. Nicolia Lohse, with seven co-investigators, published Jan. 16, 2007 in the Annals of Internal Medicine the status of every "HIV-positive" Denmark resident through the years 1995-2005. The study compared those "HIV-positive" to otherwise normal Danes, and tallied mortality of any cause, including drug overdose, accident, alcoholism, AIDS, etc. The study concluded that the life expectancy of Danes judged "HIV-positive" at age 25, taking the milder anti-viral drugs started in 2000, could expect another 39 years of life to age 64, compared to otherwise normal Dane life expectancy of 76.

What is even more striking in Lohse's charts is that 25% of those "HIV-positive" in the years' 2000-2005 cohort refused anti-viral drugs, yet had even lower mortality rates compared to the anti-"HIV" drug takers, the "HIV-positive" women refusing

drug treatments in particular approaching a normal life span. Importantly, Lohse also states those "HIV-positvies" typically had high health risks such as smoking, alcohol and other drug addiction, so it should hardly be surprising those “HIV-positive” would have a shorter life span than fellow Danes (who have less alcohol-related accidents, drug overdoses, or lung cancer/heart mortality).

Lohse's Denmark study, as do countless others, demolishes the entrenched belief that having "HIV" antibodies demands anti-viral treatments. In fact the opposite is true, as his study clearly documented the extraordinarily high mortality of those taking the earlier anti-virals like AZT. Again, these results emphatically contradict the belief that "HIV-positives” progress to deadly disease, unless anti-viral/retroviral drugs are taken.

In view of the Denmark study being published in January, 2007, in a major journal of wide readership and undoubtedly delivered to thousands of scientists' offices including the CDC and the National Institute of Allergies and Infectious Disease (NIAID), and also considering the low AIDS mortality enumerated for years in Europe's annual surveillance reports (available at the click of a mouse), the ignorance and continuance of Big Pharma-directed polices of the Global and U.S. health generals are appalling and unforgivable. As to the American press, their self-censoring of Europe's success (and Canada, Australia, and so on), and nonstop promoting of HIV hysteria, speaks for itself.

President Obama and Congressional leaders must demand of NIAID Director Dr. Anthony Fauci, having vainly sent him over $50 Billion dollars to understand "HIV," why he has not read Lohse’s study, or not learned from the other countries’ such as Germany's remarkable success over AIDS mortality.

The utter failure of NIAID cannot be tolerated a day longer. For 20 years under Fauci, NIAID has directed hundreds of chemotherapeutic anti-HIV trials strictly limited to a first set of anti-viral/retroviral chemicals tested against a second set of toxic chemicals, without ever permitting a single true non-toxic placebo given to human subjects since the 1987 Fischl AZT trail, that was terminated prematurely, became unblinded, had its records blacked out before submission to Freedom of Information Act Requests, and whose patients in the AZT treated arm were given transfusions to stay alive until all of them were placed on "the life saving medication" and eventually all died 3 years into the trail. (See John Lauritsen's books, 'The AIDS War; Propaganda, profiteering and genocide from the medical-industrial complex' (1993); and 'Poison by Prescription; The AZT Story' (1990); 'The AIDS Cult' (1997), and his essays entitled, 'AZT on Trial' (1987),'AZT and Cancer' (1989),'The AIDS War' (1991), 'HIV Voodoo From Burroughs-Wellcome' (1991),'FDA Has Second Thoughts on AZT' (1991),'FDA Documents Show Fraud in AZT Trials' (1992),'Looking Back on Berlin' (1993),'Recovery from "AIDS"' (1993),'The Death of Rudolf Nureyev' (1993), and 'The Poppers-Kaposi's Sarcoma Connection' (1994). Also see investigative journalist, Celia Ingrid Farber's damning essay, entitled, 'Sins of Omission; The AZT scandal' (1989).

The "Concorde" trial, a collaborative effort between researchers in the United Kingdom and in France, and the U.S. Veterans Administration's Study 298, both compared early and delayed AZT treatment, but the Concorde study researched asymptomatic patients at all CD4 levels, while the VA study included only symptomatic patients with CD4 levels of 200 to 500.

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 [JD Hamilton et. al. and the Veterans Affairs Cooperative Study Group. 'A controlled trial of early versus late treatment with zidovudine in symptomatic human immunodifficiency virus infection.' New England Journal of Medicine, 326: 437-434, 1992], and in 1994, the Concorde study, which was up until then the longest, largest, and most carefully controlled AZT trail reported:

"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" [Seligmann et al., Concorde: MRC/ANRS randomised double-blind controlled trial of immediate and deferred zidovudine in symptom-free HIV infection. Concorde Coordinating Committee. Lancet, Apr 9;343(8902):871-81, 1994].

The same kind of results obtained during these massive human drugging experiments was further emphasized after the first decade of HAART therapy where it was reported that:

Methods: We analyzed data from 22,217 treatment-naïve HIV-1-infected adults who had started HAART and were followed in one of 12 cohort studies. The probablility of reaching 500 or less HIV-1 RNA copies per mL by 6 months, and the change in CD4 cell counts, were analyzed for patients starting HAART in 1995-96, 1997, 1998, 1999, 2000, 2001, and 2002-03. The primary endpoints were the hazard ratios for AIDS and for death from all causes in the first year of HAART, which were estimated using Cox regression.

Interpretation: Virological response after starting HAART improved over calander years, but such improvement has ***not*** *translated into a decrease in mortality.* [The Antiretroviral Therapy (ART) cohort Collaboration-www.thelancet.com Vol 368, 451-58, August 5, 2006].

This comes as no surprise. Dr. Fauci's AIDS promotionalism began even before the AIDS era when he claimed that immune suppression is caused by doctors!

(The term AIDS promotionalism or Promoters of AIDS is being used here to indicate pharmaceutically myopic doctors like Fauci, who continue to advance

the “HIV”=AIDS=Death paradigm against all the evidence which is obtainable in the mainstream scientific literature such as The Lancet, and the New England Journal of Medicine). Doctors cause immune suppression, Fauci claimed, if they subject their patients to multiple transfusions, transplant surgery, or corticosteroid administration, as these drugs and treatments can non-specifically induce AIDS-specific drops in T-cells with high frequency (4, 5). Fibrosis of the lung due to to heavy crack cocaine use also was considered a potent inducer of the AIDS-defining illness, PCP, by Fauci and others before the AIDS era. The expense to the American taxpayer of this iatrogenic carnage cannot even be calculated, but it would amount to a staggering amount of money that could by itself restore the American economy.

Lohse's study, The Concorde and Veterans Affairs studies, and many others in the peer-reviewed literature that have published similar results, have drawn back this forbidden-placebo curtain with spectacular life expectancy revelations. Denmark's study, buttressed by countries' successes already enumerated, demands an American about face, to employ the scientific method not permitted for two decades. A thorough review by President Obama is also relevant to in the most fundamental fiscal way, as spending on AIDS now comprises almost 1 percent of the entire federal budget, and at this point constitutes a complete waste of taxpayer monies, and worse.

As for Africa, news stories have leaked out from WHO officials admitting AIDS numbers had been greatly exaggerated beginning in the 1980's, and even most medical "experts" in the U.S. never have realized that most all African AIDS cases came from the "Bangui Definition," created in 1985 by WHO and CDC officials meeting in the Central African Republic capital city of Bangui 23 years ago.

This Bangui definition stated an African AIDS case was anybody having the three health conditions of a fever, weight loss, and diarrhea over the period of 30 days (or a cough instead of fever), requiring no medical tests whatsoever that would, if taken, typically be diagnosed as malaria, tuberculosis or scores of other identifiable, treatable diseases.

Instead, virtually all African disease mortality was wrongly piled together as "AIDS" and still is.

Until recently, in Africa, and due to a lack of medical infrastructure in many areas, persistent war in other regions, and the ravages of that continue because of Apartheid in South Africa, positive "HIV-AIDS" diagnoses have been made traditionally without the use of serological testing altogether, if the treating physician felt that a particular case of persistent diarrhea or persistent coughing or tuberculosis exhibited by their patients appeared to be an AIDS case. In addition, many of the cases of "AIDS" in Africa that the WHO uses for their dire estimates of 40 million infected were extrapolated from maternity clinics or non-

validated rapid tests were used, and in many cases only where only women are tested, and projected onto the rest of the population, who weren't pregnant (pregnancy itself is a known reason for false positives, according to the CDC). Therefore, the AIDS-defining illnesses may be different among Africans than among non-Africans, may differ among African males and females, and are different among those tested by the Red Cross, from those tested by the CDC. These differences in testing standards make it possible to test positive in the United States in the morning, and by flying to Canada and getting tested, one can test negative in the afternoon.

For twenty years, news stories, politicians, and drug companies exploited fear, promoting massive African AIDS cases that, in fact, never did exist, with "AIDS" cases bearing no relationship to immune deficiency caused by a virus. It is vital to further note that most of the $9.8 billion a year of U.S. tax dollars presently going to Africa (noted above) via PEPFAR (President's Emergency Plan For AIDS Relief) is earmarked for the exact anti-viral drugs that have been causing the mortality of Americans the last 15 years, year after year, and with no solution in sight staying the present course.

But these facts have not deterred PEPFAR-in fact they have provided it's justification. Instead of critical examination of evidence, policies based on biblical rather than scientific evidence have been advanced. Noted and celebrated researchers such as Robert Bailey of the University of Illinois are given lavish praise for now promoting such ideas that all African males should be circumcised to prevent the spread of the dreaded "virus," "HIV." It is beyond belief and human reason that these pogroms based on these bizarre interpretations of reality continue to claim that Egyptian and Hebrew biblical practices such as circumcision has won out over pharmaceutical technologies, vaccines, microbicide campaigns, and breast feeding dissuasion campaigns designed to diminish Mother-To-Child Transmission of "HIV" (each of which have been halted by various oversight and human protection committees recently due to their tendency to **increase** rather than **decrease** "HIV" incidence in these various African test populations). But a new AIDS ambassador might well ask if it is true if biblical approaches such as circumcision really reduces "HIV" incidence of African men in STD clinics typically presenting with multiple STD's simply because AZT, HAART, microbicides, vaccines, breast feeding dissuasion campaigns, nevirapine, and condom crusades simply haven't and don't work, and bizarrely, have each increased the level of morbidity in African "lab rats" before they were halted.

If you read Pasteur and believe in the “germ theory,” the failure to seroconvert to a positive “HIV” test result after 63 failed "HIV" vaccination trials which include even booster series (two or more vaccinations given sequentially) 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," whose science the AIDS era was based upon, have generated catastrophic disasters that require our immediate attention so that we can revise these vehemently defended deadly, and expensive Public Health policies that continue to ruin the lives of millions.

It is not accidental, that all of these "molecular diseases" that are in question are those syndromes, and their molecular markers, that have had some connection with cancer, and which have been blamed on such processes as supernatural abilities to mutate, “oncogenes,” “retroviruses,” the enzyme reverse transcriptase, and the concept of “slow viruses.”

Proof of the logic of this statement in the context of "HIV/AIDS" is simply realized by considering the contradiction regarding how some 33 million people in the world that are 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 after vaccination in the recent STEP trials? Those few who have produced antibodies to “HIV” after vaccination, or even after two vaccinations as in the recently aborted “HIV” STEP trials demonstrated, and in the 62 prior "HIV" vaccine trials, couldn’t even show appropriate T-cell responses in most cases as evidence that something foreign had been injected into their bodies. The control group not given “HIV” molecules had less “seroconversion” in response to their control injection, while the “HIV-component” vaccinated showed slightly more “HIV-positive” signals, but the differences between the two groups weren’t significant. But to erect a smoke screen to cover this massive blunder, it was a result interpreted and fed to the press by the promoters of AIDS as evidence that the “HIV-vaccinated” went out for some reason and had more “risky” behaviors than the control vaccinated group, which is why the trial was aborted, or that they had more susceptibility to the worthless adenoviral vector used as a carrier.

It should be emphasized that this Step Trail result is why one of the AIDS Czars, Anthony Fauci, cancelled the so-called upcoming PAVE “HIV” vaccine trial, until the scientific basis for the “HIV/AIDS” paradigm is re-examined. The failure of another large millions of dollar AIDSVAX vaccine trail a few years ago, also forced Robert Gallo to publish in the form of damage control letters in the world famous *Science* magazine, that a sound rationale for future vaccine trials is needed before trials should continue, and before the public’s faith in vaccines and AIDS paradigm is undermined by repeated vaccine trial failures. Dr. Gallo even compared the failure of the STEP trial to 'The Challenger disaster.'

Considering the failure of no less than the 62 previous “HIV” vaccine trials that are on the record (and which can be provided upon request to the reader), and the “Challenger-sized” disaster claimed for the recently aborted STEP trial that was discontinued because it increased, rather than decreased the rate of acquiring an “HIV-positive” test results among the vaccinated, isn't it about time

that we heed Dr. Fauci's and Dr. Gallo's suggestions to re-examine the entire basis of "HIV/AIDS" "science?" Or should we continue to reward failure after failure, as was horrifically demonstrated a few years ago when the promoters of AIDS asked for, and received a $870 million dollar taxpayer-provided gift (Donald Francis's VAXGEN) to dump their taxpayer supported "HIV" AIDSVAX vaccine program, and then manufacture an even more problematic, ineffective, and dangerous anthrax vaccine in the name of National Security? Although many of the 63 recorded "HIV" vaccine trials were smaller than these colossal disasters and wasting of our tax dollars just mentioned, they do add up, and then often usher in even more non-bid contracts totaling in the billions for continued failure.

The available evidence suggests that the simplest explanation for the vaccination failures and other failures of the "HIV=AIDS=Death paradigm is that the injected components of "HIV," and the antibody responses to these components, have nothing to do with a virus that is foreign to the human body, or infectious, or which should be aggressively treated with toxic drugs. This evidence also suggests that there are clearly identifiable reasons to explain why one of the leading causes of AIDS death today in the United States of America are iatrogenic (doctor-induced) deaths, and that the leading cause of death among "AIDS patients" has come to be liver failure, heart attacks, gastroenteritis, anemias, kidney failure, infectious diseases that form bacterial biofilms, and other non-AIDS-defining syndromes.

The one positive thing about current "HIV" and "AIDS" policy that should provide optimism, even for skeptics, and especially for persons who have been victimized by selective testing bias (Blacks, Hispanics, pregnant women, people who are gay, Haitians, Africans, Indians, Asians, etc), in many cases, a negative diagnosis can be only an airplane ride away if a positive diagnosis is made in one country.

What are the probable causes of "HIV" and the slippery slope of institutionalized racism and homophobia.

It is easy to find fault with Public Health policies, but can the iatragenic and pharmaceutical carnage that is currently occurring in the name of "HIV/AIDS" be replaced by a more rational science, and effective public policy? As with any science based on an assumption, it is that assumption, and typically the origin of that assumption, that is baseless. For example, a likely explanation of the origin of "HIV" comes not from notions of monkey or ape-to human transmission of a virus due to Africans smearing monkey blood on their loins for sexual orgies as published in The Lancet and other top journals at the beginning of the AIDS era (6), nor was "HIV" likely transmitted to African children or their parents by playing with or by eating dead monkeys or chimps as "bush-meat" because their parents couldn't find or afford toys or food (7), or by Africans in Cameroon building cities 125 years ago and having "close associations with chimps as was published this last October 2008 in Nature and news-flashed around the world. As recently as

this last year, for instance, and in no less a journal than Nature we find that, unfortunately, Western racism continues:

“2008, October. News Flash: “HIV/AIDS Originated 125 Years Ago, Spread from Chimps to Humans…”

“TUCSON, Arizona, October 2, 2008 (ENS) - New research indicates that the most pervasive global strain of HIV began spreading among humans as early as 1884, suggesting that growing urbanization in colonial Africa through the early 1900s set the stage for the current HIV/AIDS pandemic. More than 25 million people have died of AIDS since 1981, and at least 30 million people are living with the disease today.”

“The estimated period of origin, much earlier than the previous estimate of 1930, coincides with the establishment and rise of urban centers in west-central Africa where the pandemic HIV strain, HIV-1 group M, emerged.”

“The growth of cities and associated high-risk behaviors may have been the key change that allowed the virus to flourish, scientists believe.”

“The research, led by Michael Worobey, an assistant professor of ecology and evolutionary biology at the University of Arizona in Tucson, was co-sponsored by the National Institute of Allergy and Infectious Diseases, part of the National Institutes of Health, and the David and Lucile Packard Foundation. The findings are published in the current issue of the journal Nature."

“Research shows that the HIV virus spread from chimps to humans in southeastern Cameroon. *Worobey said the resulting HIV epidemic among humans correlates to the growth of urban centers near this area, principally the present-day city of Kinshasa in the Democratic Republic of the Congo, which began as a colonial center for Belgium.”*

What research? From flawed and highly suspect comparisons of chimp and human "HIV" sequences? Although out of political correctness this 2008 racist Nature-published interpretation of "HIV" spreading from chimps to humans in the vicinity of Cameroon isn't as clearly spelled out as it was when Robert Gallo and Max Essex claimed that their first human and mistaken “cancer retrovirus,” "HTLV-1," was spread during the "slave trade," and which according to them also was associated with black people and monkeys during the transcontinental forced slavery and transport of Africans and monkeys more than a Century ago, it is far more likely, and because of modern molecular evidence, that “HIV” originated not from Africans, African Americans, Haitians, African-non-human primate “associations,” or from anyone else harboring a lot of melanocytes or who lives close to non-human primates ("HTLV-1 was the so-called first human

cancer retrovirus upon whose isolation and epidemiological techniques and assumptions the "HTLV-III/"HIV" paradigm was based). Nor did “HIV” emerge from a Special Virus Program or U.S. government conspiracy for population control or for germ warfare. "HIV" did not crawl out from a monkey or chimp kidney culture used during the manufacture the hepatitis B vaccine or other vaccines, and certainly it didn’t occur during these “close associations” between Africans and non-human primates that Gallo and Essex like to imagine for each “slow-virus” these “slow virologists” like to invent.

Recent studies in gene research and molecular biology suggests that the so-called specific markers of “HIV” are produced by our own non-specific endogenous DNA sequences called retroelements or "retroids."

A retroid is a special kind of mobile gene sequence that has been associated with diseases such as multiple sclerosis, and with normal biological functions involving the placenta (8). It is known that these retroid sequences make cellular proteins that are expressed by normal uninfected (healthy) yeast, insects, and a variety of mammals (9), 50% of healthy dogs (10), "uninfected" rhesus monkeys, chimps, and humans (11).

Retroelements are now known to be important sequences for telomere replication at the tips of normal and cancer cell chromosomes (12). Once claimed by AIDS scientists to be a specific molecular component required for "HIV" replication, retroids and specifically reverse transcriptases (RT) are now seen frequently in market magazines concerning biotechnology stocks (13, 14) **in the context of normal, non-pathological situations,** despite what AIDS promoters like Gallo, Essex, Fauci, Wainberg, the CDC, and others continue to claim about the specificity of RT used as a surrogate marker for detecting exogenous retroviruses.

p24, another protein once thought to be the unique capsid protein that supposedly makes up the proteinaceous shell of “HIV,” is now known to be expressed in the thymus glands of "HIV-negative" children (15). An "HIV" positive result can also occur simply when some infants are exposed to the proteins in cow's or goat's milk (16). Two-percent of people will test positive transiently after the flu vaccine (17), or hepatitis B vaccine (18), and as mentioned before, normal pregnant women are known to frequently test false positive (19), as do individuals who test under conditions of physiological or extreme emotional stress caused by disease, drugs, oxidation, malnutrition, a fatal diagnosis, and because of dozens of other factors or reasons (20), but paradoxically, not after specific "HIV" sequences or proteins are directly injected into "HIV-negative" "HIV-vaccine recipients after 63 failed “HIV” vaccine trials.

That these endogenous human genetic elements exist but yet are ill-defined has been shown again and again to be likely from studies on presumptively named "HERV's" (Human Endogenous Retro-Viruses) such as the "Phoenix

viruses" (presumptively named because nobody has shown that endogenous infectious "retroviruses" exist). "HERV's" (viral-like particles that look like "HIV" virus particles are supposed to look) can be produced by infecting (transfecting in Petri dishes) cells with certain sequences of DNA or RNA (21), which then are replicated and packaged by the cells into virus-like "enveloped" particles that look identical to "HIV." Modern analyses of the human genome database (which presumably wasn't derived from anyone infected with "HIV") have revealed more than 120, 000 full-length retroids containing (once thought to be) specific viral reverse transcriptase transcripts (22).

Although the promoters of "HIV=AIDS" are always saying the "HIV virus's" reverse transcriptase sequence and other parts of it's genome are mutating every time a patient dies while on “life saving” anti-retroviral drugs that supposedly target this and other "HIV-specific" gene sequence products, genomic analyses show that these retroid reverse transcriptase elements are among the most stable transcripts that make up these retroids. In other words, amongst gene sequence analysts, some of whom are developing this hypothesis instead of trying to pin the origin of "HIV" on black people's association with monkeys or apes in Cameroon, or elsewhere, it is the sequence stability rather than the instability or mutability of the reverse transcriptase sequence itself that make these 120,000 retro-element sequences possible to classify as distinct DNA sequences (22), while at the same time, the AIDS Establishment points to the mutability of these same sequences as the reason why they have failed to find a stable target in "the AIDS virus," or why they believe that virtually all cancer associated viruses ultimately derive from Africans, or black peoples (West Nile was "isolated" from a healthy Ugandan woman who had a cold, Hepatitis B was isolated from a black Australian Aboriginal gentleman, the 6 "HIV-associated cancers, ultimately came from non-human primates, etc).

This World health disaster called the AIDS era, and agony on a personal level, continues every day, brought by anti-retroviral drugs and mindless vaccine trials that should be instantly stopped or minimized. U.S. AIDS cases and deaths continue to be needlessly created by the 1993 AIDS definition which in a single day in 1993 caused a 204 percent increase in AIDS cases reported since the implementation of the new federal AIDS surveillance definition (AIDS Alert (06/93) Vol. 8, No. 6, P. 81). This "Challenger-sized disaster" continues with the current useless tests, with Congress and top health officials conducting business as usual, and blind to victory over AIDS throughout Europe, Australia, and even right next door in Canada, all who reject the U.S. model of AIDS. The new President Barack Obama must demand complete reassessment of this monumental medical fiasco, and stop the mindless massacre, racism, and homophobia.

For starters, any new Global AIDS coordinator working for the Obama adminstration should immediately demand a reappraisal of:

a.The failure to evoke seroconversion, in most cases T-cell activation, or protection after sixty-three multi-million dollar vaccine failures all raise issue with the “HIV=AIDS” hypothesis;

b.The failure to really isolate “HIV,” from all other objects in the Universe, or to explain what its confusing presence in healthy drug-naïve persons means;

c.The failure to appreciate, that the association of a molecular marker with any disease state, does not prove, disprove, or even suggest causality;

d.The failure of the 2008 Nobel committee to appreciate, in the case of awarding the recent Nobel Prize to Luc Montagnier and Barre-Sinoussi, that according to their 1983 paper, their Patient One’s “viral” isolate,” was derived from a fellow with swollen lymph nodes, a history of syphilis and syphilis treatment the year before, a history of gonorrhea, a history of cytomegalovirus infection, a history of herpes I and II infection, a history of Epstein-Barr virus infection, and God knows what else;

e. The failure of the December 2008 Nobel committee to appreciate that, in their granting of either the first or second half of their Nobel Prize award to Montagnier, Barre-Sinoussi, and Zur Hausen, that although “HIV” has been mistakenly associated with six different cancers, that “HIV” never could be linked to one of the first two “AIDS-defining illnesses” (Kaposi’s sarcoma), that “HPV” has never been shown to transform cells in a scientifically acceptable experiment, and that the reason why “HPV” (human papilloma viruses) molecular sequences are sometimes associated with cervical cancers is because these are all simply endogenous molecular sequences, not Human immunodifficiency or papilloma viruses. In this context, HPV virus particles, to date have not been shown to induce cervical cells or any other kind of cells to become cancerous no more than "HIV" has even been shown to transform any human cells. Also in this context, the Nobel committee should be held accountable about the fact that many of us in the scientific community know that it is simply mindless greed and conflicting interests that has appeared to motivate this last December’s Nobel Committee NOT to acknowledge and heed the widely publicized warnings on all of the "HIV" package inserts that claim their kits cannot detect "HIV," and ignore such agencies as The “College of American Pathologists (CAP),” and also senior investigators at the National Cancer Institute, and the company Digene who make and interpret “HPV” molecular tests, that neither "HIV" sequences or “HPV-sequences” have been validated against the clinical occurrence of AIDS or clinical cervical cancer (several of the Nobel committee had direct ties to AstraZeneca and other biopharmaceutical companies and “HIV” vaccine trails). In this context, the Nobel committee also failed to appreciate the shameful carnage currently being perpetrated by the so-called first cancer vaccine GARDASIL (made by the same company Merck, who 20 years ago claimed that

their hepatitis B vaccine was the first “anti-cancer” vaccine, before France filed a class action suit to stop the hepatitis B vaccine mandate for its young citizens, because it harmed so many);

f. The failure to sequence the “HIV” genome as a consistent pattern or sequence, or to identify specific proteins that are not also found in normal, “non-infected” contexts;

g.The failure to inform the public (and most scientists) that reverse transcriptase is not specific to viruses, nor are the gag, pol, env, p24, and other so-called “HIV-specific” genes and their products, which all can be detected in normal, “non-infected” contexts, and which are published on Medline;

h.The failure to block transmission of “HIV” or AIDS in mother to child transmission studies (MTCT) as shown by the Cochran Meta-analysis and other peer-reviewed reports, which almost without exception showed increased “HIV mutation rates” after black box label drugs such as nevirapine were discontinued in the U.S. because of their toxicitiy, and then ashamedly were administered to more than eight hundred seventy five thousand African mother-infant pairs by Max Essex of Harvard, and others.

i. The failure to acknowledge, appreciate, or investigate that safety officers of the NIH, such as Dr. Fishbein, who monitored the nevirapine trials as a safety officer, were fired, while those individuals such as Edmond Tremont who directed the nevaripine trial(s) were not even reprimanded after he had changed the data in safety reports that Dr. Fishbein and others had uncovered, in order to push forward George Bush’s and Mark Dybul’s PEPFAR pogrom and their abstinence-biblical-practice-enriched eugenics pogram on Africans;

j. The failure to understand why ARV’s (anti-retrovirals) in some individuals, can prevent "AIDS syndromes," because of their toxicity to normal immune cells can not only can block these cells from expressing “HIV-specific” molecules as a normal response to a physiological or pharmaceutical stress on lymphocyes, or as evidence of a rare genetic polymorphism, and the failure to appreciate that as shown in the Fischl, Veterans Affairs, Concorde, and first decade of HAART, that these drugs are so toxic, that they can in some individuals suppress both fungal and bacterial growth, but cannot prevent theoretical virus proliferation, because if the “HIV” paradigm is correct, these genomes of “HIV” are rapidly integrated into the DNA of the “infected,” and will never be sensitive to drugs designed against their “molecules.”

k. The failure of microbicides, condom campaigns, and circumcision, to reduce "HIV-transmission" that have more often than not, increased the rate of detecting “HIV’s” molecular markers, instead of decreasing them among African human “lab rats;”

l.The failure to appreciate the disaster and infant mortality caused by breast feeding dissuasion campaigns, designed to decrease infant mortality from “HIV-infection,” but which increased infant mortality 20 times in formula fed infants, compared to mother-infant pairs that didn’t listen to their doctors, and who weren’t dissuaded from breast feeding, and the failure to appreciate the corresponding terrorism that has been waged against new mothers to promote formula dumping on 3rd World nations;

m.The failure to acknowledge how projected and WHO-manufactured “HIV” and “AIDS” prevalence and incidence rates have not materialized, and how they have been recently dismissed by world AIDS leaders such as Kevin de Cock as signaling the end of the “heterosexual AIDS era” (except of course among people of African dissent or homosexuals who have been selectively biased during “HIV” testing campaigns, or selectively targeted during “HIV-preventative” microbicide or circumcision campaigns, or manufactured from “best guess estimates” based on STD clinics or perinatal clinics);

n. The failure to explain how “HIV’s” long “slow-virus-like” latency makes sense from any biochemical point of view;

o.The failure to support the progress of Doctors Without Borders, who recently showed how the cheap food supplement plumpynut, when given to the children of Niger, the poorest nation in Africa, has reversed the infant mortality rate, and without antibiotics or drugs, or without significant funding, as was revealed on 60 minutes;

p. The failure to develop a consistent in vitro model to detect “HIV” infection;

q. The failure to develop any “HIV” animal model, while “HIV” exposed chimps now rest in their 27 million dollar retirement homes because they never developed AIDS after injection with AIDS patient sera or “HIV;”

r. The failure of the biomedical establishment to offer and provide support to pursue and fund at least 17 other hypotheses that have explained or have even reversed in some cases, the development of acute Acquired Immune Deficiency Syndrome;

s. The failure to pursue and fund inexpensive treatment regimens such as those developed in the German drug-abuse clinics by Heinrich Kremer, Juliane Sacher, or in African in Niger, by Doctors Without Borders who fed starving children plumpynet, and by many others who have shown they can reverse immunosuppression non-toxically, and with a minimum, or in most cases, with a complete lack of HAART;

t. The failure to appreciate why prostitutes and sex workers don’t acquire

“HIV’s” molecular markers, or develop “AIDS,” unless they are also chronic immunosuppressive illicit or pharmaceutical drug users or abusers;

u. The failure to account for why Human “HIV” transmission studies have not shown “HIV” or “AIDS” transmission between serodiscordant couples, or among health care workers inoculated with “HIV-tainted” blood, or why the spouses of “HIV-positive” hemophiliacs and “HIV-negative” partners have failed to seroconvert or develop AIDS after numerous unprotected and repeated exposures to their “HIV” positive spouses;

v. The failure to address the phenomenon announced as recently as February 14th, 2008, in San Diego, California, when the local county health department made quite a big deal out of the fact that all sexually transmitted diseases in their local gay community have risen by an astounding 800 percent since 2003, including syphilis, gonorrhea, and chlamydia, while “HIV” infection rates have dropped since 2003 in the very same gay community;

w. The failure to explain how there can be 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, or how it is possible that ICL-AIDS patients to test negative for “HIV” but who are thought to have “AIDS;”

x. The failure to account for how T-cell numbers or “viral load” don’t indicate any effect of a viral presence or infection, or explain why viral load continues to be aggressively monitored 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);

y.The failure of the AIDS establishment or Nobel committee to acknowledge the significance of the recent Semmelweis “clean hands” award to Peter Duesberg for initially alerting the scientific community as to the impossibility of the “HIV=AIDS” hypothesis, and to appreciate the significance of the co-presentation of that award to investigative journalist, Celia Farber, for her initial expose regarding the iatrogenocide committed against gay men during the high-dose AZT era;

z. And finally, the failure of “The AIDS Establishment” or “AID$ incorporated,” to address in any invited public forum, or in the media, why none of their more than 33 “HIV” test kits first initially patented and launched by Robert Gallo and Abbott Laboratories claim they can’t detect “HIV,” and continue to state on their package inserts, that the significance of “HIV’s” molecular signature is not known.

These are the true ABC's of AIDS denialism, all of which point to the glaring absurdity that A ("HIV)" leads to B (immune suppression), which leads to C (AIDS).

It isn't all bad news.

It is true that there have been some successes, and these should be intensively reappraised and investigated as well. For instance, Donald Rumsfeld's former biotech company, Giliad Biosciences, makes the AIDS cocktail drug atripola, which is now making obscene amounts of money in a plethora of AIDS pogroms (as well as Giliad's Tamiflu, purchased by the American taxpayer, to fight the global and non-existent "bird flu pandemic").

It is also a cheerful news that George Bush, and his Global AIDS coordinator, Mark Dybul's PEPFAR pogrom was funded by a propagandized and hoodwinked Congress, and will now move forward to dump these and other rank poisons on millions of Africans, and other nations like India, China, and others. We also have much to be optimistic about because drugs like nevirapine were withdrawn from use in the U.S. a few years ago because of its rank liver-destructive toxicity, especially in women, and is now continuously being dumped on Africans and other of the World's most vulnerable.

Another piece of good news is that Kevin de Cock who is a World AIDS leader, announced recently that "heterosexual AIDS is over," except of course, and according to the WHO and to him, among large segments of Africa, and the African American community perhaps, who remain problematic not because of some difference compared to whites in their heterosexual behavior, but simply because they are black. Such institutionalized racism, cultural phobia, and targeted selective testing biases have come to define the current "AIDS pandemic."

As presented above, it is a hopeful idea that with a simple pen stroke, Mr. Obama could save billions of dollars to bail out our failing petrochemical economy that refuses to support the development of renewable energy, while it is being developed in civilized continents like South America and Europe. Such a pen stroke also could at the same time save many of our white 13 year-olds (like Ryan White who died of a liver bleed, and whose misfortune because he was a hemophiliac was exploited with the help of the moralistic Jesse Helms to advance the Ryan White Act during the Reagan administration). With the stroke of a pen, President Obama could even save the occasional "low risk" always faithful to her husband" soccer mom, boy-scout-leader dad, or world-class boxers like Tommy Morrison who tested "HIV" positive years ago but who now tests negative and whose career was ruined), or Arthur Ashe, or Kimberly Bergalis, or the Glasers, and countless others, from the devastation that will inevitably occur because of the universal testing now proposed by the CDC, the American Society of Pediatrics, the AMA, and other physician organizations to test everybody over the age of 13, everyone who enters an emergency room, the entire African American population of New York City, and of course, every infant born in a hospital. A pen stroke could save thousands of "low risk

persons," who will at low frequency, be convicted of being "HIV-positive" because they had a recent flu or hepatitis B vaccine.

In conclusion, these facts are added to the political-economic inevitabilities of The Church of Modern Medicine's Dark-Ages view of Mankind, the formula for disaster becomes especially toxic. This view isn't that Man is now viewed and treated as if he is inherently sinful, but instead, Man is viewed as inherently physically sick, and in need of medicine, doctors, and medical care from the moment of birth to death.

In the case of "HIV/AIDS," it all becomes heartbreaking and life-ending. It isn't just restless leg syndrome, mind you, or the suggestion that our children who are wildly obese begin their statin regimens, or prozac if they are aggressive or moody. And it isn't that the CDC wants all infants and children to get 20 vaccines or ban our children from entering schools, or charge their parents $500.00 dollars/day until they vaccinate, as what happened to mostly Black parents in New Jersey recently. You will be convicted of murder if you don't tell folks "your status."

For "HIV-positives," no less than scarlet letters, or tattoos, have been suggested. These people are not human. They are dehumanized, and this is a difficult thing for people like us (and probably you) to understand At a minimum, it should be stated clearly that after knowing many of these brave souls during the past 25 years, words are lacking for sure to properly convey the extent of their dehumanization due to the stigma of AIDS.

Let it be expressed this way: "HIV-positives" have no basis for believing they deserve human rights or that they are actually human beings. They can't travel or enter the U.S. without great hardship. Their doctors won't even touch their breast cancer biopsies, and will run out of the examining room (as in the Audrey Serrano case and many others). As the German philosopher Nietzsche once described it, these folks are "undermenchen, " that really have no business living amongst "ubermenchen" (underman versus overman), and they should be identified, and then "weeded out."

The pure and proud institutionalized racisim and homophobia that emerges from such a belief system is no different than what the Nazi's achieved: "infected" or "defective people" eventually should be sterilized or weeded out of the gene pool completely through various eugenics pogroms.

They shouldn't be allowed to reproduce or pass on their "infections" or defects. These individuals will eventually include, the mentally and emotionally "different," as well as homosexuals, criminals, Africans, Hispanics, Jews, Muslims, Zorastrians, Amish, "HIV-positives," perhaps pianists someday, and other groups that may be deemed "high risk."

Even when there is no illness, but simply a molecular signature or marker detected by the medical establishment, these people should not be allowed to reproduce or pass their "infection" to others without facing criminal charges and incarceration. The people themselves have no worth, as you see them come into your examination office. It's easy to convince them of this logic, and continuously reinforce it, when mandated by The State. Have they been "compliant" you ask? Do they “know their status?” Do you know your status?

Meanwhile, even while experiencing perfect health but now carrying the State Government-reportable "HIV-infection," the patient begins the long struggle with paralyzing feelings of isolation and violence against them, that they feel is directed at them. Anger, pain, and great paranoia are commonly described. They have a high suicide rate as they internalize these feelings, because who would wish to live under these circumstances?

If it is a child of a parent who "is infected" (despite a 60% sero-**reversion** rate after 9-18 months after birth), the parents can be held for criminal negligence unless they submit to having the children drugged to death, or to the extent that neurological demise develops or drug-induced diseases, as in the case of the more than 300 orphans drugged through g-tubes with 7 black box label drugs at New York’s Incarnation Children’s Center (ICC), and elsewhere (Chicago's Northwestern Hospital), or, when many of them are taken away from the natural parents or legal guardians to be made compliant with the drug regimens, after which only about 80 deaths were eventually admitted in one trial (at ICC).

Mothers and infants who are “HIV-positive” are dissuaded from bonding during the time of birth, and parents are brow beaten and threatened by The State in many cases to force their infant to imbibe black-box-label drugs through forced administration or through surgically-implanted g-tubes with drugs that have been shown to be able to induce brain abnormalities, liver failure, stunted growth, and death. To do otherwise is, irresponsible.

What a difference it would make for our society and world under the Obama administration to direct public health policy not predicated upon failed and dangerous Pharma-doctor-prescribed and junk-science-based pogroms like those of the past that were predicated on fears, racism, homophobia, sexism, faith-based recommendations, or worse, as it was the case with DES:

National Academy. Dr. Bern had exposed the dangers of DES (diethylstilboestrol)- a widely used synthetic oestrogen (Modified from DES action of Australia http://www.desaction.org.au/aboutdes.htm):

“Synthesised in 1938, laboratory studies showed animals administered DES developed mammary cancer, with high rates of fetal death, sterility and cancer in the offspring. Despite this, DES was approved for use in humans in 1940. Initially used to treat late pregnancy complications, by the mid 1940s the use

was widened to include the prevention of miscarriage, i.e. for prophylactic use by women who had a history of miscarriage. However by 1949 DES was seen as making "a normal gestation more normal". By the early 1950s DES was being prescribed and marketed as a general pregnancy "tonic", mixed with vitamins and recommended for all pregnant women to ensure healthier pregnancies with "bigger and stronger" babies. A 1953 study showed, to the surprise of the researchers, that the DES-treated group experienced higher rates of miscarriage, premature labour and neonatal death than the control group, and the 1953 Dieckmann study was ignored. DES was already entrenched as standard obstetric clinical practice. Also by this stage DES was being aggressively promoted by the drug companies for use in all pregnancies. In 1971 it was discovered that DES caused clear cell cancer of the vagina/cervix in DES daughters. DES was thus proven to be carcinogenic in humans. Regardless of these findings, it was continued to be used as a treatment for acne, to dry up breast milk, as a contraceptive like a morning after pill, as hormone replacement therapy during menopause, as a treatment for "tall girls" to stunt their adult height, and to fatten up livestock to increase profits."

"In 1981 landmark publication, 'Developmental Effects of DES in Pregnancy' was edited by Arthur L Herbst and Howard A. Bern, which brought together leading experimental researchers and expert clinicians on DES. In an experiment on mice, Herbst and Bern showed that in later life, the immune system of DES exposed mice was suddenly compromised. Preliminary studies of DES daughters in the early 1980s indicated that DES exposure is linked with immune system problems, including a higher incidence of autoimmune disease, such as asthma, arthritis, diabetes, systemic lupus and thyroid dysfunction."

What a difference it would make, instead, to predicate these global policies upon science, honest empirical assessments of truly promising programs as advocated by Doctors Without Borders, as opposed to the pharma-directed and iatrogenic perversions of science that have and are still occurring among The Church of Modern Medicine). One example of such a promising program should suffice, and also, should guide the future Global AIDS Coordinator, whomever this person will be now that Dybul has been "relieved." Here are a few segments from a story that recently appeared on 60 minutes:

DOCTORS WITHOUT BORDERS NEEDS MONEY FOR PLUMPYNUT: SAY CHILDREN NEED FOOD, NOT DRUGS:
Oct. 21, 2007. Doctors Without Borders Briefing Paper: Food Is Not Enough: African children need food, not drugs (See the video free at: http://www.cbsnews.com/stories/2007/10/19/60minutes/main3386661.shtml).

Plumpynut is cheap, nutritious and needs no refrigeration. It is saving starving children in the developing world and could save more … ***if there were more of it.***

*You've probably never heard a good news story about malnutrition, but you're about to. Every year, malnutrition kills **five million** children -- that's **one child every six seconds**. But now, the Nobel Prize-winning relief group "Doctors Without Borders" says it finally has something that can save millions of these children.*

It's cheap, easy to make and even easier to use. What is this miraculous cure? As CNN's Anderson Cooper reports, it's a ready-to-eat, vitamin-enriched concoction called "Plumpynut," an unusual name for a food that may just be the most important advance ever to cure and prevent malnutrition.

"It's a revolution in nutritional affairs," says Dr. Milton Tectonidis, the chief nutritionist for Doctors Without Borders.

*"Now we have something. It is like an essential medicine. In three weeks, we can cure a kid that is looked like they're **half dead**. We can cure them **just like an antibiotic**. It's just, boom! It's a spectacular response," Dr. Tectonidis says.*

"It's the equivalent of penicillin, you're saying?" Cooper asks.

"For these kids, for sure," the doctor says.

No kids need it more than a group of children 60 Minutes saw in Niger, a desperately poor country in West Africa, where child malnutrition is so widespread that most mothers have watched at least one of their children die.

Why are so many kids dying? Because they can't get the milk, vitamins and minerals their young bodies need. Mothers in these villages can't produce enough milk themselves and can't afford to buy it. Even if they could, they can't store it -- there's no electricity, so no refrigeration. Powdered milk is useless because most villagers don't have clean water. Plumpynut was designed to overcome all these obstacles.

Plumpynut is a remarkably simple concoction: it is basically made of peanut butter, powdered milk, powdered sugar, and enriched with vitamins and minerals. It tastes like a peanut butter paste. It is very sweet, and because of that kids cannot get enough of it.

The formula was developed by a nutritionist. It doesn't need refrigeration, water, or cooking; mothers simply squeeze out the paste. Many children can even feed themselves. Each serving is the equivalent of a glass of milk and a multivitamin.

*Niger has become Plumpynut's proving ground. A daily dose costs about **$1**; small factories mix it here and in three other African countries. Tectonidis says other companies could make similar products wherever children need them.*

"There's many countries in Africa now saying, 'We want a factory. We want a factory.' Well let's give it to them," he says. "We just have to focus on these areas. We don't have to feed the whole world. We have to go for the jugular. Where are they dying? Where are they ***wasted****? That's where we have to intervene. If you feed them well until they're two or three years old* ***it's won****. They're healthy, they can get a healthy life.* ***If you miss that window, it's finished."***

Normally a children's hospital 60 Minutes visited would have more patients than beds. But now, thanks to Plumpynut, ***it has empty beds****. Dr. Susan Shepherd, a pediatrician from Butte, Mont., runs Doctors Without Borders in Niger.*

She says children that would have been hospitalized in the past can now be treated at home. "The reason we can do that is because we can give children Plumpynut here in the ambulatory center, and they take a week's ration home. Moms ***treat*** *their children at home and come back every week for a weight check," Dr. Shepherd explains.*

CBS) If Plumpynut is the answer, how come kids are still dying?

"The answer is getting to kids earlier," Shepherd says. "Once children are as sick as she is, Plumpynut is not gonna save her."

Rashida was buried in a nearby cemetery. The grave digger, Salifu Ibrahim, told 60 Minutes he used to dig graves for about ***seven children a day****, but now, on most days, he digs* ***only one****.*

Asked why he thinks fewer children are dying, Ibrahim says, "It is God's will."

God's will and Plumpynut.

Two years ago this region had the highest malnutrition rate in Niger. But now, after widespread use of the Plumpynut, it has the lowest. Dr. Shepherd told Cooper they'll be able to treat more than ***120,000*** *kids this year, up from just* ***10,000*** *children three years ago.*

It's hard to imagine a less industrialized country than Niger. On a list of 177 developing countries, the United Nations ranked Niger dead last -- least developed. More than 70 percent of the people don't know how to ***read****. Most work in the fields and earn less than a dollar a day. Nomadic goat herders still roam this land -- their children and their kids travel by camel. Goats seem to be the main garbage disposal, but clearly the goats are falling behind. You can still spot a skinny guard dog, but we were told all the cats have been cooked.*

In the countryside, where 85 percent of people live, girls start marrying as young

*as **11** years old. By the age of **15** most are wed, and by **16** most have already become mothers. The average woman here will give birth at least **eight times** in her lifetime. But largely because of malnutrition, one in five of their children will die before they reach the age of five. Of those who survive, **half** will have stunted growth and never reach full adult height.*

But now, with Plumpynut, more children are surviving and thriving.

*Doctors Without Borders is asking for more of this type of food. Their success in Niger proves, they say, that fortified ready-to-eat products, like Plumpynut, save children's lives. Dr. Tectonidis says **if the United States and the European Union were willing to spend part of their food aid on this**, more companies will start making it.*

*"Even by taking a miniscule proportion of the global food aid budget, they will have a huge impact, huge impact!" Tectonidis says. "**We're not even asking for billions**. It will solve so much of the underlying useless death. So we gotta do that now."*

"It's useless death," Cooper remarks.

"Wasted life. Just totally wasted life for nothing. Because they don't have this product, little a bit of peanut butter with vitamins," Tectonidis says. "What a waste."

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Andrew Maniotis, PhD., and David M. Burd, Medical Technology Consultant, January 2, 2009.

ADDENDUM: CANADA CONQUERS PEDIATRIC AIDS - CAN THE U.S. LEARN FROM ITS NEIGHBOR?

by David M. Burd, Alexandria, VA; Andrew Maniotis, PhD, Chicago, Il. Jan.6, 2009

Canada has achieved victory over pediatric AIDS, going unreported by the mainstream press and unheeded by the U.S. medical establishment. Over the last seven reporting years ending 2007, neighboring Canada tallied but a single AIDS death of infants and children under 15.

Comparably, for the last available seven-year period ending 2006, The U.S. death total was 258 for those under age 15. After adjustment for Canada's smaller population, U.S. pediatric AIDS deaths were 29 times per capita greater.

Also during their last seven-year time frames, Canada had but 24 new pediatric AIDS diagnoses, the U.S. had 1,023. Adjusting for Canada'spopulation, the U.S. pediatric AIDS cases were higher by a factor of five.

Since both countries use the same antiretroviral drug treatments for pregnant mothers (universally employed in both countries) to prevent a fetus from acquiring "HIV" markers during its gestation, since both also have the identical regimen of doses of extremely powerful antiretroviral failed cancer drug zidovudine (commonly known as AZT) for the child's first six weeks, there is clearly something dramatically different how infants born to "HIV-positive" mothers are medically treated by the two medical systems, starting at the six week juncture of the infants' lives.

The answer to Canada's success seems to be their very cautious drug therapy approach. It begins with their per capita AIDS cases being a small fraction of the U.S. because they have rejected the U.S. category of low CD4 counts as an AIDS condition. Then, after six weeks, their infants are carefully monitored, and receive the prophylaxis drugs trimethprim-sulfamethoxazole (aka TMP-SMX, commonly called by its trade names Bactrim or Septrin) for pneumonia prevention and stopped after ten weeks. With but three infants per year since 2005 determined to have AIDS conditions, the Canadian Paediatric Society states physicians should consider (clearly leaving it up to the physicians themselves) putting these infants on a combination of antiretrovirals including AZT. Whether they do or don't is not in the province of the author.

However, the spectacular success for the last seven years, with zero deaths ***reported*** the last three years, speaks volumes about the successful Canadian approach.

As to the U.S., several distinct drug dosing therapies differing from Canada merit

discussion as to the vast pediatric mortality disparity.

First, U.S. babies are also given the same anti-pneumonia Bactrim doses, but may be started as early as four weeks (compared to six weeks in Canada) and continued for "indeterminate" HIV negative" infants (the majority of babies) for a full year, though stopped at 18 weeks if the infant's various "HIV" tests come up negative (the minority of babies as it is known that more than 60% will serorevert-see reference in first article).

Compared to Canada stopping Bactrim at ten weeks, and with an abundance of medical literature citing this drug combination as causing life-threatening side effects for the majority of immunocompromised adults (and also for otherwise healthy adults at a significant frequency), the full-year of this powerful sulfur-based Bactrim dosing could be a crucial factor causing the U.S. infant deaths. Bactrim is the exact opposite of a trivial drug though it is considered the "drug of choice" for such as adult urinary tract infections. Its chemical action is to stop the metabolizism of folic acid in suspected disease bacteria, and is claimed to not interfere significantly with the crucial need for to properly metabolize human folic acid, an absolutely vital process for cellular division and DNA synthesis.

However, with the long-acknowledged possible side effects for adults when prescribed for only a few weeks, it is stunning it be given nonstop for a year to U.S. "HIV-indeterminate" infants, at their most crucial time of life. One has to only give a cursory search on the Web to verify the dangers of trimethoprim-sulfamethoxazole (TMP-SMX).

A second significant difference is antiretroviral dosing. With U.S. criteria such as CD4 white blood cell counts at arbitrary thresholds determining an infant to be an AIDS case (not used by Canada), U.S. NIH guidelines (prior to July 31, 2008) have strongly recommended the AZT already used for the first six weeks to be continued at even stronger doses, and with the addition of one of two other antiretroviral drugs called lamivudine or emtricidabine. Tellingly, AZT and lamivudine, along with a large dose of protease inhibitor, were completely dropped for adults in August, 2006, when the new Donald Rumsfeld-associated triple drug Atripla was declared the drug combination. The result? Innumerable deaths due not to "AIDS" diseases, but from the treatment drugs themselves causing organ failure of every type.

The NIH pediatric protocols prescribe AZT pediatric dose strengths corresponding to 1,800 milligrams a day if given to a normal weight adult of 160 pounds, a dose adults rarely are known to have survived (note: for those familiar with antiretroviral drugs, the daily 1,800 milligrams is not a typographical error).

The new July 31, 2008 NIH revised Guidelines actually cite the same AZT doses as the 1998 recommendations but reclassify AZT from the most preferred to one of the four equally preferred options. These treatments originated from the

Working Group on Antiviral and Medical Management of HIV-infected Children published in the journal Pediatrics, Oct., 1998, featuring AZT as the recommended drug. Doctors in the U.S. for decades have followed these protocols, all springing from the 1987 FDA official blessing of AZT.

Yet, all the pediatric antiretroviral drugs are fundamentally incompatible with cell reproduction, and even questionable as a last resort. With the complete success shown by Canada and their very cautious drug treatments, it begs belief that U.S. practitioners remain loyal to their NIH protocols. Clearly, to change over to Canada's example would be a tacit admission of the deadly mistake U.S. practitioners have followed for over 20 years.

But this admission must be done. Until so, the iatrogenic AIDS deaths of American children will inexcusably and inevitably continue.

All of this would be fine and for the good of course, if indeed “HIV” were an exogenous retrovirus, instead of simply an endogenous signature of oxidative stress and 70 other known non-“HIV-associated non-specific markers, as is shown by the admissions within the DIADS (Division of AIDS) culturing manual which states that all of us have “HIV’s” capsid protein:

Those of us (including our infants) with more than 30pg/ml of p24 protein detected on the DIADS tests should be convicted of having “HIV/AIDS” and drugged to death, while those with less than 30pg/ml on 2 separate tests can go out have sex, donate blood and have a merry old time.

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DEAR SENATOR OBAMA-THE CDC RECOMMENDS UNIVERSAL HIV TESTING WHICH IS A FAITH-BASED AND NOT A SCIENTIFIC RECOMMENDATION.

Dear Mr. Obama,

You are a wonderful Senator and I will vote for you again. But you should be aware that Representative Mary Flowers' promotion of the CDC and IDPH recommendation for universal "HIV" screening of all Illinois citizens and indeed all Americans is a faith-based recommendation, and not a scientific one. Due to your recent media-projected "HIV" testing, you could be in grave if not mortal danger. I'd hate to see your life ruined, and the potential good you will do for Illinois and the nation thwarted, because of medical and scientific ignorance, and because of institutionalized racism regarding "HIV" among many of my peers in the scientific/medical establishment.

I'm aware that your wife, as well, has pioneered outreach programs at the University of Chicago. These are the programs that are most needed, not for "HIV" testing, or drugging, but for high blood pressure, diabetes, and other programs. I hope that she knows about the testing issue as I have tried to convey here to you.

Sincerely,

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The U.S. medical establishment and public health agencies are currently 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 promoters of AIDS say 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. All who test "HIV-positive" in a "low risk" population are false positives, **by definition.** It is my contention that all who test "HIV-positive," or whose T-cells are deemed "too low" are selectively biased by these tests, **by definition.**

Why? 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. “HIV” terrorizes familes that are split apart by The State, children are placed into foster care, and people are forcibly drugged. As you will see, I am not understating these facts.

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 or underlined words are my emphasis and are highlighted to point out baseless or non-scientifically validated assumptions):

*“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 <u>uninfected</u>** 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 once 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.” 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, allo-immunized mice, 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 60 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 molecules derived from 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:

"In a major setback, one of the leading experimental AIDS vaccines not only failed to prevent test subjects from becoming infected with HIV, but it didn't offer any indication it might delay the onset of full-blown AIDS, which had been a key hope."

"24 of 741 volunteers who got the vaccine in one segment of the experiment later became infected with HIV, the virus that causes AIDS. In a comparison group of volunteers who got dummy shots, 21 of 762 participants also became infected."

"The ultimate fear among researchers is that the whole theory underlying the Merck vaccine might be flawed, which, if true, could doom an entire class of experimental vaccines."

As mentioned before, 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 60 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 like Anthony Fauci have just cancelled the new PAVE vaccine trial, and Robert Gallo wrote in the pages of Science several years ago that:

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

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). It is now established that some of these vaccine adjuvants have been responsible for autoimmune syndromes in most of the sick Gulf-War I veterans tested, as evidenced by the fact that sick veterans invariably generate antibodies to vaccine adjuvant, 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, mutliple-sclerosis (demyelinating syndromes), and lupus-like syndromes upon intravenous 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**]. This and many other similar false-testing trials all support the hypothesis was suggested above regarding testing artifact to explain the 24/741 and 21/762 numbers obtained in the context of the failed Merck STEP vaccine trial mentioned 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 markers [**5**]. Cross reactivity has also again and again been shown to exist regarding “HIV” sequences and proteins, and normal endogenous cellular components 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-I 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 markers 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 ot trillions, or universal testing of "low

risk" individuals, or anybody else.

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**].

None of these tests have been validated against the isolation of pure "HIV" itself. They have been validated instead against other test kits that were 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. Many countries such as England do not use a confirmatory WESTERN BLOT.

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**].

Seroreversion means, that the infants may test positive at birth, but that 60% of them will generate a negative test if tested at 12 or 18 months. Thus, under the new mandate to universally test infants, 60% of infants who initially test positive will serorevert by 18 months post-partum, and 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, post-partum, or through surgically inserted gastric feeding tubes placed there by doctors to force compliance of these deadly medications).

PCR results in infant testing are not diagnostic in infants either, because the inventor of PCR, the Nobel Laureate Kary Mullis, 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" and the promoters of AIDS).

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), 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 currently dominate ideas and therapies that address the imagined "mutability" of the "HIV" virus, and the failure of ARV-therapy is always based on mutation, rather than toxicity caused by the drugs. 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 indirovine-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 indinovir-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 imagining genetic mutation abilities or inventing viral characteristics that defy all evidence and all common sense, 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**].

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, it hasn't occurred in health care settings such as dentist's offices, hospitals, or sperm banks, or between serodiscordant couples, such as hemophiliacs. It hasn't even been scientifically shown to be transmitted between persons who have frequent unprotected sex. 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…" "<u>We observed no seroconversions</u> 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]."**

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 thy 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 or philosophical exemption from undergoing an "HIV" test. Faith-based exemption means that God told you not to get tested, and who can argue with that?

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