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A brief Answer to Questions raised by South Africa's President Thabo Mbeki at the Conference of Specialists on HIV/AIDS Issues in Pretoria on 6-7 May 2000

Questions:

1. What evidence is there for the assumption that HIV is the cause of AIDS, and what consequences would result for the emergence of symptoms and their diagnoses?

This question contains the related questions:

a) What is the cause of immundeficiencies that lead to AIDS and ultimately to death?
b) What are the most efficient options to react to these causes?
c) Why is HIV/AIDS transmitted heterosexually in black Africa (south of the Sahara), while it is supposedly transmitted homosexually in the industrialized countries?

2. What role can treatment play in developing countries?

   The following related issues should be considered:
   What possibilities of treatment are suitable for developing countries?
   - For AIDS patients?
   - For HIV-positive patients?
   - For prevention of mother-child transmission?
   - In preventing HIV infections through work-related injuries?
   - In preventing HIV infections after rape?

3. Therapeutic prevention of HIV/AIDS?

"Discussion should always consider the social and economic context, especially poverty and other frequently occurring diseases as well as the limited infrastructure in developing countries. (C. Köhnlein and C. Fiala: Report on the 1st meeting at the invitation of South African President Mbeki; C. Fiala: AIDS in Africa, the way forward (Koehnlein-Kiel@t-online.de / christianfiala@aon.at).

Answers:

Furchgott and Ignarro secured evidence for the first time in 1987 (Nobel Prize, 1998) that cell systems of the human organism are controlled by nitric oxide gas. During the following years it was demonstrated that immune cells eliminate microbial disease pathogens within cells by producing nitric oxide (NO) gas. It was found that there are two types of immune cells: those that produce NO gas and its derivates and those that produce no NO gas but stimulate formation of antibodies to inhibit microbial disease pathogens outside the body cells. These revolutionary findings have resulted in revising many disease theories held as correct up to the present. Immunological disease phenomena that had previously been interpreted as causal results of "HIV", based on prevailing immune-system theories, can now be explained based on the pioneering new research data without contradiction or assumption of a

“HIV” infection. These new findings fully justified the critical questions of President Mbeki on HIV/AIDS and have far-reaching consequence for medicine, society, politics, and economics.

There must be a balance between NO gas-producing immune cells and those that do not produce NO gas. This balance in cellular and so-called humoral antibody immunity can be disturbed by non-infectious as well as infectious factors, as either can lead to an acquired cellular immunodeficiency (AIDS). Over-stimulation of the immune cell’s NO gas production that that is either too strong or lasts too long leads to inhibition of NO gas production in the immune cells and increased activation of antibody-producing cells in its place. The result can be an uninhibited rise in intracellular microbes such as fungi, parasites, mycobacteria, and viruses (opportunistic disease pathogens) within the body cells that would normally be eliminated without symptoms by cytotoxic NO gases. This clinical disease diagnosis is defined as AIDS.

Oxygen respiration of certain cell systems can be blocked by simultaneous over-stimulation of NO gas production and counter-regulation of certain cell biology. These cells can switch to energy production independent of oxygen, and this can lead to tumor formation. This process was already known in 1924 (the Warburg phenomenon). Yet it can only be explained by the NO research findings. Nerve and muscle cells can also suffer degenerative damage by disturbing oxygen respiration for the same reason. AIDS in the defined sense is a rare form of disease in Western countries with an annual incidence amounting to 0.001 – 0.002% of the entire population.

The large group of AIDS patients in a numerical sense affects a minority of anally receptive homosexuals. The causes of NO over-stimulation in this risk group are: inhalation of organic nitrogen gases (poppers) as sexual means of doping, abuse of antibiotic chemicals that become metabolized into NO and nitrosamines; acceptance of foreign protein as the result of unprotected anal intercourse that can lead to NO over-stimulation analogous to NO over-stimulation by microbial antigen protein and antigen toxins in case of multi-infectiousness if cell detoxification is interrupted.

Intravenous drug addicts are the second-largest risk group, and their cellular immune balance is disturbed by drug intoxication itself, by frequent microbial infections resulting from contamination of used needles, toxic additives to the drug substances, low and lack of nutrition related to bodily consumption resulting from drug-dependent lifestyles. Those potentially affected in this risk group amount to about 5% of the total population of intravenous drug users. In relatively rare cases the children of drug-dependent mothers are affected as a result of the mothers’ chronic intoxication. The cell respiration disturbance related to it in immune and non-immune cells causes these newborns to suffer maturity damage in cell immunity.
Hemophiliacs are a further risk group that has injected commercially obtained but highly contaminated coagulating protein that results in surviving NO over-stimulation (as animal experiments have shown).

Multi-transfusion receivers with a serious basic disease are another small risk group in numerical terms. On average they have received 35 storage units of foreign blood.

A 10-year clinical study in Canada involving several thousand patients already published in 1986 that more than 30% of surgical patients indicated immune anomalies that are viewed today as disturbances in NO gas-producing immune cells and as a preponderance of non-NO gas-producing immune cells.

Already during the 1960s it became known that organ-transplant patients developed entirely identical diseases after treatment with immunotoxic drugs. These appeared from the late 1970s among homosexual patients. They were classified as AIDS from 1982 on. The same AIDS-indicator diseases, inhibition of NO gas production in immune cells, and predominately mature non-NO gas-producing immune cells as well as opportunistic infections (AIDS) developed in the same form among patients with blood-cell cancer treated with pharmaceutical substances from the substance class to which the AIDS medicine AZT and related substances belong. Immune cells responded to entirely different types of triggers with NO gas production as well and in cases of over-stimulation with inhibition of NO gas production. These can be toxic and pharmatoxic substances, malnutrition or lack of nutrition, foreign protein intake, infections, inflammations, lack of hormone regulation, emotional stress, and many others.

Chronic infectious and inflammatory processes, malnutrition or lack of nutrition, as well as contaminated drinking water play the most vital role in developing countries. The reasons for this lie in general living conditions for which Western countries bear a historically shared responsibility.

Under the conditions given, a much higher exposition for microbial disease pathogens exists in developing countries for embryos in the mother's womb, newborns, children, women, and men than in developed industrialized countries. Microbes outside the body cells are inhibited or eliminated by antibodies and other endogenous mechanisms as well as a variety of cells in the immune-cell network. If they manage to get inside the body cells, according to new findings, they can only be inhibited effectively or eliminated by a functioning NO gas resistance. This applies especially for fungi, parasites, mycobacteria, and a number of viruses.

Chronic infections develop if cytotoxic NO gas no longer suffices. This means a constant irritation of the NO gas stimulation. The cells must be protected from potential damage and accelerated death by endogenous gas production. Sulfurous protein, vitamins, and enzymes (antioxidants) fulfill these tasks. These must be accepted or synthesized from nutritional components. The antioxidants are called this because they constantly have to neutralize nitrogen oxide (NO) and its derivatives as well as reactive oxygen species (ROS). If the antioxidants are exhausted, because nutritional intake of antioxidants and/or components to synthesize antioxidants is lacking or one-sided and/or chronic infections and inflammatory processes cause too high use of antioxidants, NO gas production and formation of reactive oxygen molecules can no longer be neutralized sufficiently. Increased cell deterioration and/or cell-biology counter-reactions occurs in immune cells and non-immune cells that lead to secondary inhibition of NO gas production. Under this conditions opportunistic infections can occur as a result.

This vicious circle of a high exposition for chronic infections and inflammations, anti-oxidative undernourishment and malnutrition, as well as disposition for opportunistic infections is well known as nutritional AIDS in developing countries. (W.R. Beisel, 1992; J Nutr. 122:591-596; W.R. Beisel, 1996; J Nutr. 126: 2,611-2,615).

The primary causes of this form of AIDS in developing countries, regardless of gender, concern unborn babies in their mothers' wombs, newborns, children, women, and men. These primary causes usually differ basically from the primary causes of most AIDS-indicator diseases in the risk groups of Western countries.

AIDS in Africa is no more a result of transmitting a so-called AIDS pathogen sexually in Africa than it is in Western countries. There is no such AIDS pathogen. Nor would it be either sufficient or necessary to understand the disease processes. The assumption of such an AIDS pathogen stems from a not too distant time when one had not yet understood the fundamental processes in immune cells and non-immune cells. Even in AIDS cases where primarily infectious processes are a co-deciding cause for failure of NO gas resistance in the immune cells, sexually transmitted infections play no exclusive role. The sexual channel is only one of the possible means of access for infections. Most chronic infections are not transmitted sexually (for example, lung tuberculosis, miliar tuberculosis, malaria, worm infections, and numerous other tropical infections. This also applies for secondary opportunistic pathogens, mainly fungi, parasites, mycobacteria, and cytomegaloviruses, as well as other herpes viruses. The most common AIDS indicator disease, PC lung infection, demonstrates this point. It is triggered by an airborne fungus pathogen.

The scientific reduction of thought to homosexual or heterosexual transmission of a so-called AIDS pathogen has veiled the actual causes of developing opportunistic infections. All are caused by inhibiting NO gas production in immune cells and non-immune cells as well as by blockading the oxygen respiration of certain cells. HIV/AIDS medicine has not been able to explain to date why the identical diseases of pharmacotoxic AIDS and nutritional AIDS develop entirely independent of any "HIV" pathogen, while — despite analogous excessive toxic, pharmatoxic, infectious, and nutritive immune stressors or massive administration of immunotoxic foreign protein in other human cases — the AIDS-indicator diseases only develop if a so-called AIDS pathogen has been transmitted sexually or via the bloodstream.

Numerous experimental and clinical studies have established that the antioxidant and sulfurous detoxifying protein in the immune cells are sharply reduced, and that the immune cells which predominate, produce no more NO gas, but that antibody production is increased among "HIV-positives" at the earliest possible moment of "HIV" seroconversion, when the "HIV test" shows a positive result. This fact proves that the immune cells of these patients cannot be disturbed by a so-called AIDS pathogen, such as that claimed by HIV/AIDS theory, but that the immune cells have inhibited NO gas production due to a shortage or total lack of antioxidant detoxifier molecules. The not NO gas producing TH2-immune cells are moving mainly outside the bloodstream, where they can take over the stimulation of B-lymphcells for antibody production.

However, the reduced number of immune cells is only measured in flowing blood as a alleged proof for destruction by “HIV” viruses. This AIDS definition even applies in the USA if no clinical symptoms are at hand but only the number of T4 immune cells in the blood stream has fallen below a certain level and the “HIV” test shows a positive reaction. This obscure diagnostic procedure (AIDS without the clinical syndrome or “AID” without “S”) has raised the officially recorded count of “AIDS cases” in the USA since 1 January 1993 by more than 100%. This AIDS definition has not been accepted in Europe, and the AIDS case numbers are dropping accordingly.

Just as questionable as these definitions is the diagnosis of AIDS diseases in Africa. The Bangui AIDS definition of 1985, which is in use today with variations, enables AIDS diagnosis by appearance based on unspecified symptoms such as coughing, fever, diarrhea, etc., if they last longer than one month. Such symptoms are frequent in developing countries in case of chronic inflammatory and infectious processes. These cases, recorded as AIDS without diagnostic standards, are reported to the World Health Organization in Geneva. Based on the summary judgment of the assumed “spread dynamics of HIV in Africa”, the HIV/AIDS cases are projected, and the data gained is offered to the world press as the current status of the “HIV/AIDS pandemic “ in Africa. Given this completely obscure HIV/AIDS data, the international mass media paint this picture of the “dying continent of Africa” without referring to the slipshod method of data gathering. These practices have led to the manipulated world opinion that 90% of all HIV/AIDS infections occur in Africa.

Thus in the USA, Europe, and Africa there are differing factual bases treated in public opinion as HIV/AIDS. To this extent, in view of “the limited infrastructure in developing countries”, it only makes sense to raise questions according to the cause, therapy, and prevention of AIDS if the real biomedical core of the problem is cleanly separated from manipulation of HIV/AIDS medicine and their profiteers by propaganda.

As to the question about the “consequences resulting from the emergence of symptoms and their diagnoses”, knowledge of the real background facts in Africa means that the actual causes of patients’ diseases are diagnosed incorrectly or not at all. It also means that patients and their family members are placed in mortal fear, excluded, and submitted to hopelessness. There is no proof to support the ”HIV causes AIDS” disease theory, but there is an overwhelming abundance of evidence against it. Nobody has actually isolated the “HIV”, and the existence of such a virus was concluded by unspecified molecular markers after manipulation of immune cells from the blood of homosexual AIDS patients. These immune cells were stimulated with highly oxidized substances that, as one knows today, trigger reactive NO gas production. Since the cells were greatly decreased by detoxifying molecules containing sulfur, a portion of the cells perishes. This phenomenon then interpreted as destruction by the hypothetical HIV. Another portion of the cells reacted with cell-biology counter-regulations. These include formation of regenerative protein and export of oxidized stress protein from the cells. Both molecular markers were seen as exclusive proof of the presence of “HIV”, although the same molecular markers could be provoked in numerous other cells under the same laboratory conditions.

All cell experiments that have supposedly detected isolation of the “HIV” are based on evidence of such unspecific markers after stimulation with such highly oxidizing substances in cell cultures. Nobody has been able to demonstrate cell-free HIV in the blood serum of “HIV”-positives or AIDS patients without such biochemical manipulations, although they should multiply a billion-fold according to the HIV/AIDS theory prevailing since 1995. According to the findings of NO research, HIV researchers have confused cause and effect. This knowledge is supported by the fact that the discoverer of the patented “HIV” test of 1984, Dr. Gallo, manipulated cell cultures of AIDS patients with hydrocortisone. The hormone hydrocortisone blocks cell splitting including reproduction of viruses potentially existing that can only reproduce with host cells in synchronized manner. Hydrocortisone also inhibits NO gas production but promotes formation of regenerative protein.

Two of Dr. Gallo’s external colleagues, who had worked with him on cell experiments, published in 1987 that the “HIV” sought in AIDS patients’ immune cells based on molecular markers (regenerative protein, export of stress protein from the cells in the form of so-called virus-like cell particles) had been demonstrated especially well after adding hydrocortisone to the cell culture. These data referred to experiments in Dr. Gallo’s laboratory during 1984 when setting up the “HIV” test. Yet Dr. Gallo, who had deliberately kept a secret of this hydrocortisone effect in his publications, had to admit the fact after a reproach at the 1998 press conference of the international World AIDS Congress in Geneva.

Dr. Gallo he has been unable to explain to this day why the splitting of host cells is blocked after adding hydrocortisone (as any physician from clinical application knows about hydrocortisone) but the “HIV” reproduced especially well with hydrocortisone present. NO research provides this explanation: unspecific molecular markers, allegedly proof of “HIV” existence, are nothing else than regenerative protein and cellular waste exported from oxidative cells under stress from cells in so-called virus-like cell particles as the byproduct of cell-biology counter-regulation. Thus these markers have nothing to do with “HIV”.

Dr. Gallo misinterpreted the protein released after oxidizing stimulation from the immune cells of AIDS patients that were cultivated jointly with human leukemia cells. He identified it as “HIV” protein. Using this human cell protein, Dr. Gallo equipped the test substrate for his patented “anti-HIV” antibody test. This test substrate, which had been adjusted to especially high antibody amounts, reacted with antibodies in blood serum of people whose immune cells form a particularly high level of antibodies. This is true above all for people whose immune cells no longer produce NO resistance gas but increasingly stimulate synthesis of antibodies instead. A “HIV”-positive test result means nothing else than that the test person has particularly high amounts of antibodies in the blood, and these react accordingly with foreign human test protein. Since there are no antibodies in human blood that react only with protein against which they were originally formed, the “HIV” test demonstrably reacts to many different antibodies. In Africa, antibodies in the blood serum of test subjects reacts positively in the HIV test, though the antibodies formed originally against antigen protein from tuberculosis, malaria, and PCP fungi pathogens as well as many other pathogens.

Hence there are no “HIV” infections either by sexual transmission or via the bloodstream. So-called mother-child transmissions are transmissions of maternal antibodies to the child and/or toxic damage to the child’s immature immune-cell formation in the mother’s womb and/or immune-cell anomalies after birth by toxic medication treatment. They can also be the result of the mother having a chronic infection that was transmitted to the child.

So-called professionally caused “HIV” transmissions or transmission by rape are anecdotal reports. There is no validated proof case of this in all the HIV/AIDS literature. These horror stories are based on the pseudo-logic of the HIV/AIDS theory and serve as alleged confirmation of the “HIV” infection for the general public. Consequently there is also no treatment or prevention against the putatively real “HIV” as the alleged cause of AIDS.

Yet there are effective prevention and treatment possibilities for pre-AIDS and AIDS. Besides compensating for undernourishment and malnutrition as well as the treatment sought for infectious and noninfectious causes of disease and avoidance of specific risks, a suitably dosed antioxidant compensatory therapy is indicated. This calls for proteins containing sulfur and other additives as well as amino acids (glutathione, cysteine, homocysteine, arginine, etc.), vitamins, minerals, trace elements, plant polyphenols, natural protease inhibitors such as polyanions based on sea algae and cartilage preparations, prostaglandin modulators made of fish oils (omega-3 fatty acid) or, in difficult cases, selective cyclooxygenase-2 inhibitors, if necessary difluoromethylornithine as a polyamine inhibitor, and gamma globulin (Hässig et al., 1998, medical hypothesis 51: 59-63) in case of opportunistic infections. Non-toxic therapeutics recognizes many possibilities of balancing a disturbance of cellular immunobalance without blocking cellular respiration by AZT and related substances. Within recent years orthodox HIV/AIDS medicine too has begun to rediscover the possibilities of consistent antioxidant protection and liver protection for patients with acquired cellular immunodeficiencies. In this sphere, developing countries have an abundance of potential options by using sea products as food supplements, building up a license-free plantation economy for phytotherapeutics, and recollection of ethnomedical experience.

An incredible waste of resources has occurred in Western countries since 1984 in connection with the largest capital investment in medical history based on the objectively false disease theory “HIV causes AIDS”. Poor countries can hardly afford the luxury of crippling the will of their people to survive through irrational sex and death fantasies instead of investing their meager resources in improving general living conditions. This also includes comprehensive continuing education of medical staff to the state of medical knowledge in 2000 instead of 1984. The history of Western medicine has demonstrated that the prevalence of chronic inflammatory and infectious processes could be reduced drastically and continuously up until the middle of the previous century prior to introduction of chemotherapeutics, antibiotics, and mass immunization (L.A. Sagan: *The Health of Nations: True Causes of Sickness and Well-being.* Basic Books, New York, 1987). Meanwhile, fundamental findings of Western medical research into NO, cell symbiosis, and other areas have gained significance in other important spheres of preventive and therapeutic medicine outside official HIV/AIDS medicine.

Sooner or later these findings will also prevail in the broadest sense in AIDS prevention and therapy. Scientists, physicians, and others involved (particularly in the news media) have benefited 16 years from the massive capital flow to research and combat “HIV”/AIDS. They have been outraged by the South African government’s critical questions about the cause, treatment and prevention of AIDS, reacting out of ignorance or unwillingness to learn.

However, discriminating against physicians and scientists as AIDS dissidents, who have only drawn rational conclusions from validated medical-research findings based on the best available knowledge, their consciences, and their sense of duty, is an unacceptable violation of general human rights — especially for the patients involved. What would happen if the South African government would maintain the “HIV causes AIDS” disease theory that has become scientifically obsolete in the meantime and approve recommended mass poisoning with AZT and related toxic pharmaceuticals? It would actually trigger the catastrophe suggested to the Africans by interested physicians, mass media, politicians, and drug concerns as well as the large army of profiteers as the stream of capital flows to exploit the self-staged archaic fear of a plague. After having overcome the racist mania of Apartheid, it must become the historic mission of the South African government to resist the HIV plague mania and to develop its own African way to improve general living standards and standards for prevention and therapy.

Such “HIV”-positives have survived in Western countries by resisting mass fear hysteria, recognizing risks of disease, and using a broad range of natural food-supplement resources and antioxidant medicine. Meanwhile, the “HIV”-positives who trusted the highly toxic so-called antiviral pharmaceutical substances and chemo-therapeutics have fallen victims to HIV/AIDS medicine. According to official government statistics published by the German public-health authorities in 1985, for example, each German with “HIV” must have been infected until 1995 and died of AIDS until 2000. These figures, projected by the semi-logarithmic Weibull statistical method, have never been corrected. Instead, the country’s mass media have bought these and many other absurd claims as medical facts.

The same health-care authorities officially stated that 0.0015% of the population was newly registered as “HIV”/AIDS cases in 1999, and that it still concerned people from the same risk groups. The same leading news media failed to report on this result “of the fatal sex epidemic transmittable to anybody”. Instead it promptly reported at the World AIDS Congress on 9 July 2000 in South Africa that “Almost half of all young women there are HIV-positive at age 20, and 58% of them are by age 25. Among men, the infection rate reached its apex at age 32, since 45% had the fatal virus in the blood” (*Der Spiegel*, 3 July 2000). A similar numbers game — the same horror stories about epidemic, sex, and sensation spread in the USA and Europe during the past two decades — projected at the moment to South Africa, the country that should serve as a strategic beachhead for the pharmaceutical firms in all other developing countries.
The director of the Epidemiological Institute of Johannesburg, Dr. Williams, is quoted as the only verifiable source of the assertion on the alleged epidemic nature of

HIV/AIDS in South Africa: “The sudden increase in tuberculosis cases among gold miners turned the attention of epidemiologist Williams to Carletonville. Within 10 years the number of tuberculosis patients had almost quadrupled; TB frequency was 100 times greater than in Western industrial nations. The researcher knew: lung disease often comes as the result of a HIV infection. Tests confirmed his suspicion. Every third miner was already infected with HIV, as were 37% of all adult women”. (*Der Spiegel*, “Fluch der Jungen“, 3 July 2000).

What Europe’s largest news magazine with the advertising slogan ”*Spiegel* readers know more“ failed to tell its readers was that orthodox HIV/AIDS researchers at America’s Harvard University had established in a comprehensive 1994 study that “results with the anti-HIV antibody test ELISA and WB should be interpreted with caution in case of serial tests with people who came in contact with tuberculosis pathogens or other mycobacterial species. ELISA and WB cannot be viewed as sufficient for a HIV diagnosis in AIDS endemic areas in Africa where the prevalence of mycobacterial disease is very high. There is a very high rate of false-positive ELISA and WB results in HIV tests" (Kashala *et al*., 1994, in *J Infect. Dis*. 169: 296-304).

Like many other leading media, *Der Spiegel*, has been informed several times in writing of the untenable nature of the HIV/AIDS claim in Africa based on enclosures from scientific publications. But it has not changed its deliberately false coverage. Already in 1985 the ELISA test had admittedly only been accepted as a “HIV” diagnostic test by Western countries due to “the 90% false-positive HIV results”. According to Western testing guidelines, a second positive ELISA test result must be confirmed by a positive test result in the so-called WB test. In Africa, as a rule, only the ELISA test is carried out, if any, on cost grounds, and indeed using two test antigen proteins. Such HIV-positive test results do not count as confirmed positive results in Western countries.

Since 1992 the WB confirmation test has not been allowed as a “HIV” confirmation test any more in Great Britain, since this is considered too unreliable. There are no binding international standards for “HIV” tests. However, the biomedical truth is that any “HIV” test is false-positive, and none of these tests can show antibody bond against “HIV”, since nobody has provided proof that the test substrate of the “HIV” test contains “HIV” protein.

On the other hand, any informed person knows the specific causes for tuberculosis and other infections among itinerant workers under African gold-mine labor conditions and living conditions in the residential camps of these workers. To understand these diseases, as recent medical research has sufficiently explained, there needs to be no “HIV” infection or HIV-positive test results among people in Africa who have come into contact with the endemic tuberculosis pathogen. Does the South African government really want to deliver the South African people over to the obscure practitioners of international epidemic speculators and “brutality typical of concerns in the pharmaceutical sector” (*Der Spiegel*, 26 June 2000). The years of experience in Western countries has taught that preventive and therapeutic recommendations were not understood and could not have been implemented to target groups properly

during recent decades without basic communication of medical research's changing knowledge.

Medicine and health-care policy are always part of tacit system know-how that must be counterchecked by transparency. However, during the past two decades counterchecking by institutionalized medicine and medical opinion leaders speaking in trade journals has failed in the case of HIV/AIDS medicine, since the self-styled "HIV-retrovirus" researchers have been originators of the epidemic hysteria and at same time chief experts deciding on release of immense amounts of research money as well as publishers on HIV/AIDS in the specialized media (Lang*: Challenges*, Springer, New York, 1998, pp. 361-741).

The South African government will have to find a more than rhetorical response to the extremely dangerous challenge of the World AIDS Congress in its own country that is known to have been sponsored by the international pharmaceutical concerns. Most of the unscrupulous mixture of deliberate medical perjury, distortion of scholarly based counter-analyses, malicious personal discrimination and discrediting of a sovereign government's members may hardly be able to climb higher in the service of the "brutality typical of the sector" of economic interests.

"Briefly before the13th World AIDS Conference that took place in the harbor city of Durban 9-14 July", reported *Der Spiegel*, "Chief of State Thambo Mbeki also caused annoyance and confusion. He sought to speak to scientists who championed the long refuted thesis that AIDS is not the result of an HIV infection but the consequence of drug and alcohol abuse, poverty, and underdevelopment. As the Boers' racist regime was forced to abdicate in 1994, the country still had a chance to stem the epidemic. Yet the national AIDS plan broke down due to an authority free-for-all, mistrust for white experts, and a lack of political will to lead. In his five-year term in office, the country's first black president, the globally respected Mandela dedicated less public time to the South African AIDS topic than he did to a PR meeting with the Spice Girls, Naomi Campbell, and Michael Jackson. Prominent black leaders had indeed already warned in 1990 that AIDS could "ruin the fulfillment of our dreams", indeed a health-card paper written by the then still exiled African National Congress (ANC) had conceded that almost 60,000 freedom fighters could be infected, yet none of the returnees were tested. And only once, at the end of 1998, did Mandela make AIDS the topic of a detailed speech — at an economic forum in Switzerland. Every fifth new South African mother was already HIV-positive at the time. Meanwhile 22.4% of all newborns countrywide are infected. The epidemic rate among women under 30 even lies at almost 26%. Nonetheless, in no year since the ANC's takeover of power has the national AIDS budget even been fully spent. At the same time the health minister refuses AZT "on cost grounds", though it would reduce the probability of HIV transmission to the newborn by half" (*The Spiegel*, 3 July 2000).

Even though thoroughly informed, the editorial board of *Der Spiegel* — one priding itself on having the most serious journalistic reputation — suppresses the following important fact in its coverage: Highly toxic AZT blocks maturation of antibody-producing immune cells in bone marrow (G.J. Rosenthal and M. Kowolenko, *Immunotoxicological Manifestations of AIDS Therapeutics*; J.H. Dean *et al., eds.*

Immunotoxicology and Immunopharmacology. Second Edition, Raven Press, New York, 1994, pp. 249-365).

The newborn will be protected against extracellular disease pathogens during the first months of life by antibodies transmitted from the mother. Newborn antibodies measured by the "HIV" test are therefore antibodies of the mother. About 12% of newborns with "HIV"-positive mothers in Western countries react positively in these tests. In the sense of HIV/AIDS theory, this finding means that 88% of newborns should have accepted no antibodies in the mother's womb via the common circulatory system, although the mother's "HIV" should have increased a billion times a day and the mother's antibodies may have had to survive for years against the "HIV" in the blood serum. On the other hand, 12% of newborns should have accepted the mother's "HIV" antibodies and react positively to the "HIV" test. This assumption means an insoluble contradiction in the sense of HIV/AIDS theory, since any newborn accepts antibodies from the mother and logically — according to HIV/AIDS theory — must also accept the "HIV" allegedly multiplying a billion-fold in the blood serum of the "HIV"-positive mother. In this logical difficulty, one treats all "HIV"-positive pregnant mothers with AZT, although one knows that pregnant mothers in Africa even in the sense of HIV/AIDS theory could show a "very high rate" of false-positive results in ELISA and WB HIV tests (Kashala *et al*., 1994). If the newborn is negative in the "HIV" test after birth, one claims that the "HIV" infection has been prevented through AZT. On the other hand, if the newborn is positive in the "HIV" test, the newborn will continue to be treated with AZT.

Nobody really knows with which antibodies the mother and newborn have reacted positively to the test. Since the sensitivity threshold of the "HIV" test is adjusted to a certain amount of antibodies, the so-called "positive HIV" test means only that the mother and newborn indicate a sufficiently high amount of antibodies to react positively to the "HIV" test's protein. A "negative HIV" test for a newborn of a "HIV"-positive mother says merely that the newborn has not accepted enough antibodies from the mother or has already formed them itself to register a so-called positive result in the "HIV" test. Yet the "HIV" could still have been transmitted from the mother to the newborn if one assumes that the "HIV" exists in the mother's bloodstream (demonstrated by the "HIV" test) with which all possible antibodies can react. Since AZT, due to its biochemical properties, suppresses immune cells producing newly maturing antibodies among pregnant women treated with AZT the probability increases that the newborn accepts fewer antibodies than would be required for a positive result in the "HIV" test. The claim that "use of AZT reduces the probability of HIV transmission to the newborn by half" (*Der Spiegel*, 3 July 2000) is based on this effect.

In reality, neither a "HIV"-positive nor -negative result for the newborn would express something about transmission of the "HIV" after a "HIV-positive" pregnant woman has been treated with AZT, even if one assumes that she were actually infected by the "HIV". Even in this (fictitious) case, the "HIV" test result would provide only information that more or less of the mother's antibodies were transmitted to the child without being able to know if it concerned antibodies against (fictitious) "HIV" or an antibody against other antigens.

However, the biological truth is that AZT, due to its biochemical properties, could not inhibit “HIV”, since the substance is not integrated in any DNA or any provirus DNA of a “HIV”. Rather it blocks the cell respiration of immune and non-immune cells and causes secondary DNA damage to these cells. Thus the logical consequence would be that HIV would not be inhibited if prescribed to all pregnant women in South Africa with so-called positive HIV tests (allegedly 22.4% of all pregnant women) as a prophylaxis against transmission of the “HIV” to the newborn. AZT does not do what it allegedly should but demonstrably does what the substance should supposedly prevent, namely promote acquired immunodeficiency. AZT has caused newborns serious birth defects and other maturity disturbances. (J. Kumar *et al*., *Acquir. Immundef. Syndr*. 7, 1994: pp. 1,035-1,039; Moye *et al*., 1996, *Journal Pedriatics,* 128: pp. 58-67)

Administration of AZT is strictly contraindicated for all “HIV”-positives and AIDS patients, pregnant women, newborns, children, women, and men including those patients diagnosed as “HIV-positives” without a “positive HIV” test finding according to the Bangui definition of AIDS cases. “A critical analysis of presently available data claiming that AZT has anti-HIV effects shows that there is neither theoretical nor experimental evidence confirming that AZT alone or in combination with other substances has any such effect” (Papadopulos-Eleopulos, 1998, *Curr. Med. Research and Opinion* 15, Suppl. 1: pp. 1-45).

The real active mechanism of AZT is clearly known. AZT inhibits certain enzymes in cell respiration of immune and non-immune cells. The result is development of opportunistic infections (AIDS), certain tumors, and degeneration of muscle and nerve cells. Even the manufacturer warns: “Retrovir (Zidovudine = AZT) can be associated with serious toxic damage to blood-building cells including white blood cells and serious anemia. Degeneration of muscle cells has been associated with long-term medication of AZT” (Glaxo Wellcome: Retrovir (Zidovudine) In: *Physicians’ Desk Reference*. Medical Economic Co., Monvale, 1998, pp. 1,167-1,175).

The fact that AZT also inhibits enzymes in microbes has been misinterpreted as inhibiting “HIV” replication. Since opportunistic pathogens can adapt better to the inhibiting effect than the cell systems of patients whose immune systems have already been weakened, AZT medication will favor uninhibited development of opportunistic pathogens (AIDS) sooner or later. Due to their similar action, AZT and over-stimulation of NO gas have identical effects: accelerated cell deterioration and/or cell-biology counter-regulations. However, fixation on “HIV” infection veils this causal relationship. The AZT manufacturer admits that “similar pathological changes such as those produced by HIV illness have been associated with long-term medication of AZT” (Glaxo Wellcome, 1998). However, symptoms of “HIV” illness (anomalies of cellular immunity, positive “HIV” test, and opportunistic infections) can be explained free of contradiction by NO research findings and without assuming the existence of “HIV”. The test findings of Dr. Brian Williams ignore the fact that this causal relationship can be demonstrated as follows:

- "The ELISA and WB test results should be interpreted with caution when conducting serial tests of persons who have come in contact with mycobacterium tuberculosis or other mycobacterial species."

- "The ELISA and WB HIV test cannot be sufficient for HIV diagnosis in AIDS-endemic areas of Central Africa where the prevalence of mycobacterial diseases is very high" (Kashala *et al*., 1994*, J. Infect. Dis*. 169: 296-304).

The lack of a well-informed medical base has had disastrous effects for South Africa and other developing countries. The World Health Organization (WHO) based much of its prognosis on so-called positive HIV test findings by the director of the Epidemiological Institute in Johannesburg, Dr. Williams, working with cases of tuberculosis infections in Carletonville and other areas in South Africa.

"'Every other South African youth will die of AIDS', a WHO study predicted," reported *Der Spiegel*. "Every hour another 70 South Africans are infected with the fatal virus. And nowhere, believes epidemiologist Brian Williams, 55, is the situation as bad as in the mining city of Carletonville. Because gold mining offers the ideal breeding grounds for a virus transmitted by sexual acts. Some 70,000 lonesome men live in the barracks of the mining companies around the small town and its black townships. This is the result of a job-creation policy introduced during Apartheid times. Gold lies several thousand meters below ground in Carletonville. Not much more than a gram is gain from every ton of boulders extracted. If the mining is to pay, itinerant workers must be shipped to the mining sites. To this day they only see their families every two to three months. The rest of the year they live crammed together, 14 men to every 45 square meters" (*Der Spiegel*, 3 July 2000).

Every experienced industrial physician knows that the working and living conditions described are ideal breeding grounds for tuberculosis and other microbial infections in view of the low medical standards in African countries.

"The sudden increase in tuberculosis cases among gold miners made epidemiologist Williams aware of Carletonville," *Der Spiegel* reported further. "Within 10 years the number of tuberculosis patients almost quadrupled. TB incidence was 100 times greater than in Western industrialized countries. The researcher knew that lung disease often comes after a HIV infection. Tests confirmed his suspicion: HIV had already infected every third miner. Another 37% of all adult women were also infected. Completely unprepared, the researcher concluded the extent to which the epidemic had infected Khutsong's young people. Among girls the HIV infection rate rose with a leap at age 15; at age 20 almost half of all young women were HIV-positive; at age 25 some 58% had been infected. Among men the epidemic rate reached its apex at age 32, since 45% had the fatal virus in their blood" *(Der Spiegel*, 3 July 2000).

These claims on the alleged epidemic rates in South Africa have been diagnosed with so-called ELISA HIV diagnostic tests that even in orthodox HIV/AIDS medicine have recorded 90% false-positives from the outset. Moreover, the test result depends on the blood's viscosity, and this is higher in tropical countries than in Western countries. Testing preparation and testing technique in African countries do

not qualify as meaningful in Western HIV/AIDS medical circles, so that people who test “HIV-positive” in Africa regularly show “HIV-negative” test results in repeat tests in Western countries. Despite this, these “HIV-positive” test results are bought by the WHO, Western HIV/AIDS physicians, and the international news media as biological facts in order to exert political and economic pressure on developing countries.

Yet from the viewpoint of scientifically based medicine with a minimum claim to seriousness, it is crucial to know for reasons of interpretation what these antibody reaction tests in case of serial tests in Africa could tell us — if anything at all. That is:

- if “HIV” tests react positively to antibodies in the blood stream of test subjects that should only have been formed against “HIV” after sexual transmission of “HIV” to people with a healthy immune system.

- or if the test subjects in “HIV” tests react positively to antibodies that have formed in their bloodstream after primarily latent or manifest infection with mycobacteria (M tuberculosis, M leprosy, M avium, intracellular),.fungal microbes (pneumocystis carinii, candida, cryptococcus, coccidioides, histoplasma, etc.) or other microbes entirely without a hypothetical infection with “HIV”.

The answer to these crucial diagnostic questions can be demonstrated by comparisons with assertions of HIV/AIDS theory and the data from NO research as well as findings actually validated scientifically (see illustration at the end of this paper).

The research data show clearly that “HIV” tests react positively to antibodies formed against mycobacteria and fungus microbes. The assertion of HIV/AIDS medicine that “positive HIV” test results in Africa should be given equal diagnostic weight with a fatal “HIV” infection is not scientifically viable. The assertion of Dr. Williams that development of tuberculosis among Africans is the result of a “HIV” infection is without medical foundation. The biological truth is rather that a mycobacterial tuberculosis infection leads to antibody formation that could react positively to test protein in the “HIV” test. The mycobacterial infection precedes a positive result in the “HIV” test and not *vice versa*. If a positive result in the “HIV” test actually indicates a still active mycobacterial or fungal infection or another infection cannot be decided on the basis of a “HIV” test. Specific diagnostic processes must be used for such a statement. The antibody reaction in the “HIV” test could involve existing antibodies stemming from an earlier infection, for the test fails to show which infection it has identified. To this extent, use of a “HIV” test is senseless, misleading, and highly unethical.

Scientific and deliberately false assertions on lethal “HIV” infections in South Africa make perfidious use of pseudo-evidence of “positive HIV” tests to allot political guilt to the South African government and to spread irrational death fears out of vested political and economic interest.

“Half of the young people will die of the epidemic because the state has failed to act…” warned *Der Spiegel*. “And the major death toll has just begun… A

catastrophe of unimaginable extent looms in countries such as Zimbabwe, Zambia, Botswana, and South Africa. The land at the Cape was the last to register the pandemic. At first the disease seemed to affect white homosexuals above all. That was in the late 1980s as the Boers still ruled. They regarded the epidemic as divine punishment for sexual perversion. Health-care policy measures were not taken. Then the radical change occurred. A civil war raged in the country's most populated state, Kwazulu-Natal. Right-wing white militants threatened a coup as the blacks celebrated the release of their hero, Nelson Mandela, after 27 years of imprisonment. The virus was forgotten. Ten years later it has inflicted more than one tenth of the population. And almost all victims are black. Yet the political leadership still reacts helplessly to the epidemic. Indeed a health-care paper written by the African National Congress (ANC) had conceded while still in exile that nearly 60,000 freedom fighters could be infected. Yet none of the returnees were tested" (*Der Spiegel*, 3 July 2000).

Thus it aroused the impression that 60,000 freedom fighters potentially infected with the lethal "HIV" had dragged the "HIV" epidemic into the country upon their return, and the ANC government had looked on idly at "the death of half of the young people". Yet the same news magazine had already declared Africa the "dying continent" in 1991 (*Der Spiegel*, 17 June 1991). Since then, according to data from the United Nations, the population in Africa has increased by more than 100 million people. If the South African government, under pressure from the international epidemic speculators, were to adopt the medically and scientifically untenable HIV/AIDS theory as national doctrine and approve the mass poisoning with AZT and other toxic AIDS medicines, this would in fact be "criminal betrayal of responsibility to one's own people" (Mbeki: Letter to world leaders on AIDS in Africa, 3 April 2000).

The World AIDS Congress hops from continent to continent every two years, invading another country like a plague of locusts. The horror story of the homosexual scene as the breeding grounds of the "death virus", transmittable to anybody through sex, has lost its impact among the Western public. For example, according to the official 1999 medical statistics from Germany, a total of about 800 "HIV" people stigmatized by "HIV" died of AIDS. All of these victims were treated pharmatoxically. Given the non-event nature of the mass epidemic predicted for years and effective counterintelligence independent of the Western mass media, some 11,000 stars and their supporting cast staged the HIV/AIDS traveling circus during the millennium year. The doctors, scientists, health-care officials, media reporters, and epidemic activists had been lured to South Africa with sponsoring funds from the drugs firms. There they would tell the gruesome epidemic saga of the 60,000 demilitarized bush warriors who had returned to their country untested for the death germ they were prepared to sow among every other youth. In return, shareholders wanted to see the turnover of pharmatoxic products increased with "the brutality typical of the sector" (*Der Spiegel*, 26 June 2000).

The turnover figures in developing countries would pay off in view of stagnating sales in Western countries, even at the dumping prices offers from the World Health Organization and the Western pharmaceutical firms. Millions of poisoned corpses should pay the price for the grotesque epidemic. The opening strategy should focus on treatment of "HIV"-positive pregnant women with so-called antiviral AIDS medicines that inhibit maturing of antibody-producing bone-marrow cells and in this

way fake inhibition of “HIV” in newborn babies. South Africa, *quo vadis*? Will the freedom fighters of the ANC stop the virus hunt? Or will epidemic Apartheid replace racial Apartheid?

“Not long ago in our own country,” President Mbeki wrote to world leaders concerning AIDS, “people were killed, tortured, imprisoned, and inhibited from being quoted in private and in public, because the established authority believed that their views were dangerous and discredited. We are now being asked to do precisely the same thing that the racist apartheid tyrany we opposed did, because it is said, there exist ascientific view that is supported by the majority, against which dissent is prohibited." (Mbeki: Letter to world leaders on AIDS in Africa, 3 April 2000).

Yet today the issue is no longer scientific dissent. It is hard medical facts suppressed by vested interests. This specifically concerns the “clean torture” of millions of defenseless people who have been placed in deathly fear and should be treated with demonstrably toxic pharmaceutical substances. These form the diagnostic basis of antibody reaction tests that demonstrably indicate anything else than an infection with a fatal “HIV”. And it specifically concerns medical and social standards in developing countries to improve the state of knowledge in the year 2000 in order to hinder the actual causes of AIDS (in the most narrow and broadest senses) preventively and therapeutically. This task of the century will also demand use of all powers and resources in an intelligent manner and without the obsession of HIV/AIDS medicine, which simplifies and compounds the problem facing us in a terrifying fashion.

The speech of President Mbeki at the opening of the 13th World AIDS Congress in Durban on 9 July 2000 was the right signal for all independent scientists if the practice of future health-care policy is not to be determined by organized disinformation but by sober factual analysis.

"According to predictions presented in Durban by two American officials, the Bureau of Statistics and the Agency for International Development (AID), life expectancy in Botswana is 29 years, in South Africa, Swaziland, and Namibia 30 years — the most pessimistic prediction on the catastrophic development so far. On the other hand, Mbeki said at the opening of the congress that poverty is the greatest cause of death in the world and the most important reason for disease and suffering. At least indirectly he expressed doubt on the extent of the AIDS catastrophe in South Africa. In Botswana every third person in the sexually active population is infected, the highest percentage on Earth. In South Africa 4.2 million people carry the virus — every fifth adult — more than in any other country in the world. From 2003 on, according to new American studies, the population in South Africa and Botswana will shrink. Some 70% of the 334 million HIV victims and almost all of the 11 million AIDS orphans of the world live in sub-Sahara Africa. In Mbeki’s opening speech to the congress — where more than 11,000 doctors, scientists, and AIDS activists met for more than six days — he even disappointed hopes of those from his area that he would change his controversial position on the cause and combating of AIDS. He said one could not simply place all the blame on a virus but avoided comments on the link between HIV and AIDS. In contrast to the overwhelming opinion of the scientists, he obviously did not consider this link crucial. In a letter to the South African

opposition leader Leon, Mbeki repeated his doubts on the effectiveness of AIDS medicine, which unsettled scientists all the more. The South African health minister, Dr. Manto Tschambalala-Msimang, also expressed this doubt. She said on the second day of the congress that the effect and possible danger of the drug Nevirapine must be checked carefully before it could be used in South Africa. The German pharmaceutical enterprise Boehringer Ingelheim, manufacturer of Nevirapine, that could greatly reduce transmission of AIDS from mothers to their unborn children or after the birth through mother milk, had offered to supply the drug to South Africa and other developing countries without cost for five years." *Frankfurter Allgemeine Zeitung "Weitere Kontroversen auf dem AIDS-Gipfel in Durban"* 11 July 2000.

Nevirapine is a so-called non-nucleoside analogue substance used as a "HIV" replication inhibitor. Analogous to AZT, the substance inhibits the maturing of antibodies producing bone-marrow cells and can cause a "HIV-negative" result in the "HIV" test for newborns. A critical analysis of currently available data shows that Nevirapine exercises just as little "anti-HIV" effects as AZT (Papadopoulos-Eleopulos *et al*., 1999, *Current Med. Research and Opinion* 15, suppl. 1: pp. 1-45).

Anyone who looks at the pseudo-logic of the HIV/AIDS theory rationally does not need "careful study of the effect and possible danger of the Nevirapine resource", because there is just as little indication for use of this immunotoxic substance as for AZT. On the contrary there are only strict contraindications.

Anyone who has not understood the pseudo-logic of the HIV/AIDS theory must keep in mind that AZT, Nevirapine, and other so-called antiviral AIDS medicines could not inhibit "HIV" either if somebody had validated the existence of the "HIV". Even in this case, there is no indication for "careful study on the effect and possible danger of the Nevirapine resource", but there are clear contraindications.

Anyone who considers the pseudo-logic of the HIV/AIDS theory to be correct because the great majority of physicians present it as correct for rational reasons will be forced theoretically and experimentally to make "careful study of the effect and possible danger of the Nevirapine resource". Instead one will be forced to study carefully — under pressure from the rationally incomprehensible public assertion that every second young person must die from the fatal "HIV" infection — experimental use of Nevirapine and other so-called antiviral AIDS medicines in treating pregnant women, newborns, children, young people, other women, and men. The tragedy of the HIV/AIDS medicine in Western countries during the past 14 years has established this predictable fact sufficiently.

The result of giving "careful study" to prescribing Nevirapine, AZT, etc. to "HIV"-positive pregnant women and their newborns in South Africa and other developing countries would be programmed from the outset. The effects of Nevirapine, etc., would only prove that unspecified antibodies can be manipulated toxically. According to random statistical distribution of the substance by pharmacokinetics and pharmacodynamics, a portion of newborn children of mothers testing "HIV-positive" during pregnancy would react "HIV-positive" to the unsuitable (because unspecific)

test while another portion would test “HIV-negative”. This pseudo-proof of inhibiting the “HIV” at the cost of serious immunotoxic damages that have been found to appear biologically after brief medication with so-called AIDS medication would justify regular use of Nevirapine or its competitors by millions of pregnant women and newborns. The immunotoxic damages appearing would be blamed on the “HIV”. Nobody would any longer be prepared to discuss the verifiable fact that the HIV/AIDS medicine specialists, despite knowing better, had confused cause and effect. And the cell-biology counter-regulations constantly resulting from immune-system stress would be explained as proof of the “lethal HIV”.

The free offer for “basic study” of Nevirapine, for example, was presented in competition to other pharmaceutical firms and their toxic products. The payback for the manufacturer would multiply after five years. In the long term the South African government would be hopelessly handed over to a dictatorship by the pharmaceutical concerns and practitioners of “HIV” laboratory medicine through this refined marketing ploy. However, the manipulated world citizenry would honor the South African government’s immunotoxic mass poisoning of its own people, and the accusation of “lack of will in political leadership” (*Der Spiegel*, 3 July 2000) would no longer be heard.

If the fundamental findings of NO gas research and other biomedical research sectors during the early 1980s had already been known, nobody would have needed an explanation concerning development of opportunistic infections (AIDS) by “HIV”. Nobody would have considered it necessary for laboratories to act in designing a “HIV” test. And nobody would have been able to justify thorough research on the effect and possible dangers of immunotoxic substances paradoxically to treat people with acquired immunodeficiencies.

One would have established and verified the antioxidant state of endangered and diseased people, that the antioxidant deficits and NO gas inhibition of immune cells are present long before the manifest appearance of opportunistic infections. One would have recognized the specific risks of endangered and diseased immunodeficient patients in Western countries and developing countries. And would have tried to avoid this through preventive medicine and to restore the immunobalance through targeted compensatory therapy and inhibition of cell-biology counter-regulation.

This is not the first time in medical history that serious vitamin-deficiency diseases, for instance, have been confused with viral infections. As an answer, the “HIV” propaganda headquarters of the United Nations (UNAIDS) has pointed accusingly to the conduct of President Mbeki:

“If things continue in this manner, all efforts invested in development aid will have been for nothing, which would naturally have an impact on the world economy. In the worst case, anarchy threatens.” (*Der Spiegel: “Zeitbombe vor der Haustür“*, 10 July 2000). The veiled political blackmail could hardly have been expressed more clearly.

However, the propaganda noise of paranoics serving the pharmaceutical industry could not entirely cover up the fact that even medical advocates of the organized mass poisoning supported the critical position of the South African government.

“The problem for most of those affected today is still the side effects of therapy,” *Der Spiegel* reported, "Experts even consider it possible “that in 10 years this will result in widespread coronaries among those infected with HIV. And even cancerous diseases could become the problem then due to weakened immune systems" (through the “side effects of therapy”) (*Der Spiegel, “Zukunft der Todgeweihten”,* 10 July 2000).

It could hardly be more absurd: The same toxic mixers who assert that immunotoxic so-called antiviral AIDS medicines would prevent immune-cell weaknesses now predict as experts that the same immunotoxically treated patients would develop widespread coronaries and also cancerous diseases “due to immune systems weakened by the side effects of therapy.”

The biological truth is that, viewed objectively, all so-called antiviral AIDS medicines can cause immune deficiencies, heart muscle weakness, and transformations of cells into cancer cells due to inhibition of cell respiration. This is especially true among people whose immune systems are already weakened. But AIDS medication cannot inhibit any “HIV”, even if the existence of “HIV” were to be detected by somebody.

The course of discussion at the 13th World AIDS Congress had confirmed the view of the *Wall Street Journal* in 1996 that “HIV-positives” and AIDS patients treated with so-called antiviral AIDS medicines “are practically the guinea pigs of drug research in one of the largest and costliest medical experiments of our time.”

The South African government has been the first in the world to counter the uninhibited running amok of “HIV”/AIDS medicine and its profiteers with rational and humanitarian standards. The consequence must again be to recognize fundamental findings on the ancient laws of co-evolution between humans and microbes in healthcare and social policies. The AIDS problem demonstrates civilization’s vulnerability if the manipulative potential of modern medicine is abused to exploit humanity worldwide by staging irrational fear of epidemics without effective and rational countercontrols. The deceptive strategies of the virus hunters and their propagandists and profiteers are more insidious than the old colonialism, since the human right to life and freedom from bodily harm is being annulled under the mask of humanitarian aid instead of the scientifically validated real causes of AIDS being treated with the nontoxic resources available.

HIV/AIDS medicine has produced monstrous problems, but it has not solved a single problem. The expiry dates of the promised healings become ever shorter, the means of disinformation ever more incredible, and medical ethics has long been forgotten. For 16 years the prospect has been held out of developing sera against the “HIV” during the next 2-10 years. This occurred for the first time in April 1984 when the American government announced the national doctrine “HIV is the most probably cause of AIDS”. (It remains a mystery today how one wanted to develop a serum against a “probable” cause.) Since then the trick play has been repeated regularly by

promising an “anti-HIV” serum before and during every World AIDS Congress. These are the simple methods applied at the stock market to maintain the capital flow for new research money. Yet the feeling of being threatened must be raised each time at the propaganda level at the cost of people in developing countries. The congenital defect of HIV/AIDS medicine was the patent office registration by the discoverer of the “HIV” test before submitting it to any scientific publication. The premature commercialization corrupted HIV/AIDS medicine from the very start.

The findings of NO research, cytokine research, and cell symbiosis research are available to anybody free of patent for preventive and therapeutic use.

Heinrich Kremer, M.D., medical director emeritus, 1968-1975 head of social therapy for addicts, sexual offenders, and people with personality disturbances at Berlin Tegel (pilot project of the Federal German government on reform of the penal system) has retired from federal service in 1988 as medical director of the clinic specializing in youth and young-adult drug addiction (model study of the federal government in Brauel, Lower Saxony) due to differences on medical and professional ethics in regard to drug and AIDS policy. Since 1988 he has worked in basic research on cancer and AIDS, from 1995-1999 with Prof. Alfred Hässig as cooperative member of the Study Group Nutrition and Immunity (Berne).

Comparison of Predictions between HIV/AIDS Theory and NO Research on Cause and Incidence of Tuberculosis and Other Opportunistic Infections and Real Scientific Findings

A. Predictions of HIV/AIDS Theory

1. Exposure and disposition:
   - Transmission of "HIV" by sexual exposure
   - Sexual transmission possible to anyone without special disposition
   - Transmission from mother to child, women to men, men to women, men to men

2. Immune system anomalies:
   - Sharp reduction in number of T-helper immune cells in blood serum (TH cells) resulting from destruction of TH cells by "HIV".
   - Positive "HIV" test: reaction to test protein with antibodies in blood serum that should only occur again "HIV" protein
   - Molecular "HIV" markers: characteristic only for "HIV"

3. Opportunistic infections (AIDS):
   - Immune system deficiencies in combating tuberculosis, fungal, and parasite pathogens resulting from destruction of TH cells by "HIV"

4. Prevention and therapy:
   - Inhibited reproduction of "HIV" by "antiviral AIDS" medicines
   - Anti-microbial treatment with chemical antibiotics

B. Predictions of NO Research

1. Exposure and disposition:
   - Increased exposure to *M tuberculosis* and other mycobacteria, fungal, and parasite pathogens resulting from higher epidemic rates in the total population
   - Too few preventive check-ups, low medical standards, lack of hygiene, and other factors
   - Increased disposition due to undernourishment and malnutrition, burdening work, housing, and living conditions, more frequent burdens from other chronic infections

2. Immune system anomalies:
   - Functional change in TH cells after intensive and/or long-lasting NO over-stimulation
   - Maturation arrest and accelerating death of NO gas-producing TH1 cells as result of exhaustion and/or low acceptance or synthesis of antioxidants for detoxification
   - Dominance and emigration of non-NO gas-producing TH2 cells from the blood serum (TH1-TH2 switch)
   - Increased antibody production influenced by type 2 cytokines of TH2 cells

- Positive “HIV” test: unspecified reaction of test protein with antibodies that would form against antigens of tuberculosis and other mycobacterial pathogens as well as fungal and parasitic pathogens
- Molecular “HIV” markers: characteristic cell products resulting from cell biology counter-regulations, primarily by NO over-stimulation and secondarily by NO inhibition due to insufficiently eliminated intracellular infection with mycobacteria as well as fungal and parasitic microbes

3. Opportunistic infections (AIDS):
   - Poor elimination of intracellular tuberculosis and other mycobacterial pathogens as well as fungal and parasitic pathogens including after TH1-TH2 switch with surviving TH2 dominance
   - Characteristic with inhibited NO gas production by TH1 cells after previously intensive and/or long-lasting NO gas over-stimulation
   - Exhaustion of antioxidant detoxification and/or lack of antioxidants (reduced synthesis and/or reduced nutrient supply)

4. Prevention and therapy:
   - Antioxidant compensation therapy and inhibition of cell-biology counter-regulation to restore the balance of immune cells and other cell systems
   - Nontoxic anti-microbial treatment

C. Current Scientific and Medical Findings

1. Exposure and disposition:
   - Continuous decline in the prevalence and incidence of tuberculosis and other infections in Western countries during the 1840-1940 period to a very low level by improving working, housing, and living conditions, hygiene, nutrition, and medical standards before the introduction of chemotherapy, BCG, and other immunizations (L.A. Sagan, *The Health of the Nations: True causes of Sickness and Well-Being,* Basic Books, New York, 1997).

2. Immune system anomalies:
   - TH1-TH2 switch and surviving TH2 dominance as well as inhibition of NO gas production in TH1 cells in case of all chronic mycobacteria as well as fungal, parasitic, and worm infections among others Increased antibody production influenced by dominant type 2 cytokin patterns of TH2 cells with all chronic mycobacterial, fungal, parasitic, and worm infections among others.
   - Positive “HIV” test: very high rates of false-positive ELISA and WB “HIV” test results with mycobacterial infections (*M. tuberculosis, M. Leprae, M. avium intracellulare*) and fungal infections (including pneumocystis carinii, candida, cryptococcus, coccidoides, histoplasma)
   - Molecular “HIV” markers as a result of intensive or long-lasting nitrous and pro-oxidant stress ubiquitous in human cell systems as characteristic regeneration enzymes, regenerative cytokines, and stress protein. (Lincoln *et al., Nitric Oxide in Health and Disease*, Cambridge University Press, Cambridge, UK, 1997; Lucey *et al., Clinic. Microbiol. Rev* 9 [4], 1996: 532-562; Kashala *et al., J. Infect Dis* 169, 1994: 296-304; Papadopulos-Eleopulos *et al., Curr. Med. Res. And*

Opinion 13 [10], 1997: 627-634; Temin, *Mol. Biol. Evol*. 2, 1985: 455-468; Teng *et al., Nature* 386, 1997: 31-32; Brattsand *et al. Aliment Pharmacol Ther.* 10, 1996 [Suppl. 2]: 81-90; Del Prete*, Int. Rev. Immunol*. 16 [3-4], 1998: 427-455).

3. Opportunitistic infections (AIDS):
   - Characteristic in case of TH2 dominance (Lucey *et al., Clin. Microbiol. Rev*. 9 [4], 1996: 532-562; Abbas *et al., Nature* 383, 1996: 787-793; Mosmann *et al., Immunolog. Today* 17 [3], 1996: 138-146)
   - Characteristic in case of NO gas-production inhibition (Lincoln, *Nitric Oxide in Health and Disease*, Cambridge University Press, Cambridge, UK, 1997)
   - Characteristic systemic exhaustion of antioxidant detoxification among HIV-positives and AIDS patients lacking symptoms (Buhl *et al., Lancet* 2, 1989: 1,294-1,296; Greenspan, *Medical Hypothesis* 40, 1993: 85-92)
   - Characteristic nutrient antioxidant shortage (Beisel, *J Nutr*., 126 1996: 1,611S-2,615S; Bower, *Nutrition in Clin. Pract*. 5, 1990: 189-195)

4. Prevention and therapy:
   - Dramatic increase of TH1 cells and stable balance of Th1-Th2 immune cell production after high doses of compensatory therapy with antioxidants (Herzenberg *et al., Proc Natl. Acad. Sci USA* 94, 1997: 1,967-1972; Greenspan, *Medical Hypothesis* 40, 1993: 85-92).
   - Successful treatment of lethal parasitic and fungal infections as well as transformed tumor cells by inhibiting cell-biology counter-regulations (polyamine and prostaglandin inhibition) (Sjoerdsma *et al., Trans Assoc. Am. Phys*. 97, 1984: 70; Subbaramaiah *et al., P.S.E.B.M.* 216, 1997: 201-210; Stone *et al., J Cell Biochem*. Suppl. 22, 1995: 169-180)