HIV Positive without Treatment...and Healthy!

People with HIV and no symptoms have studied the flaws in the HIV=AIDS theory and stopped taking their medications—without any harmful effects. Health authorities recommend drug therapy from the first sign of HIV diagnosis, despite the unreliability of testing methods.

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Why must people submit themselves to triple, highly active antiretroviral therapy (HAART) as soon as they are diagnosed HIV positive? This question goes against official recommendations but is at the core of the life experiences of many HIV positives who, after having enquired on the web and carefully considered the information they found, decided to abandon the "medicalisation of fear" and stop their treatment. And, surprisingly, their health has not deteriorated!

This little-studied phenomenon is qualified as extraordinarily rare by "HIV specialists". Could those experts have got it wrong, pushing patients into unjustified and expensive medical care? This is what this investigation, dedicated to the diagnosis and medical follow-up of HIV positivity, reveals.

Facts and Figures

According to a 2014 UNAIDS report, 35 million people worldwide are estimated to be infected with HIV (human immunodeficiency virus). These figures are comparable to cancer prevalence. Every year, nearly US$20 billion is spent on research. The report also noted that in 2013 there were 1.5 million deaths related to AIDS (acquired immune deficiency syndrome).[1]

Apparently, as the media remind us every year, it is a global disaster. However, such figures should be strongly questioned—and have been ever since epidemiologist James Chin, MD, former director of the World Health Organization (WHO) AIDS program and author of *The AIDS Pandemic: The Collision of Epidemiology with Political Correctness*[2], set the cat among the pigeons. In his book, Dr Chin demonstrates that the statistics concerning the prevalence of HIV infection have been exaggerated in order to maintain the fear of an explosion of the epidemic into the general population—an explosion which has been predicted often but never observed. However, Chin, who is by no means a dissident who would question the HIV=AIDS theory, wrote (p. vi): "HIV prevalence is low in most populations throughout the world[3] and can be expected to remain low, not because of effective HIV prevention programs but simply because HIV infection rates can rise only to the level(s) permitted by the prevailing patterns and prevalence of HIV risk behaviors and the prevalence of facilitating and protective factors. The vast majority of the world's populations do not have sufficient HIV risk behaviors to sustain significant epidemic HIV transmission."

The HIV Testing Hoax

Officially, the USA now has around 1.2 million people living with HIV, with one in seven of these unaware that they have HIV.[4] In Australia, an estimated 27,150 people live with HIV. In 2014, 1,081 people were diagnosed with HIV.[5] In France each year, more than 6,000 people discover their HIV positivity by means of the ELISA and western blot tests, which is confirmed by their count

of CD4 cells (T-cells) or viral load (the amount of virus in the blood).[6]

With regard to the arguments brought by a large number of scientists (see Afterword, "What if everything you've learned about AIDS is wrong?"), the published counts of HIV-positive people should be taken with a grain of salt because screening tests are not reliable. Furthermore, many publications exist showing 70 conditions that can generate a false positive.[7]

"This HIV test story is a huge hoax!" rages William[8], a 53-year-old HIV-positive Frenchman who was diagnosed in August 2014. After 11 months of triple therapy, this father finally stopped his treatment. He took this decision in November 2015 after having reviewed the medical literature.

Within William, the announcement of HIV positivity started a chain reaction which led him to discover "the incredible truth". After the "enormous shock" of the diagnosis, he experienced sheer incomprehension: "I've always had a healthy sexual life. I am not on drugs. I do not smoke. I do sports; I have an athlete's body. I was married for 20 years. I lived with a girlfriend for seven years. So when I did the test at the time of becoming involved in a new relationship, my first reaction was, 'No, this can't be possible!'"

After the incomprehension came the acceptance: "I underwent a lot of pressure as it is not possible to resist these doctors who kept telling me, 'If you do not take the therapy for yourself, take it for your children'. Announcing my HIV status to my children was in itself a traumatising experience, and it took me a good month before resigning myself to taking the medicines."

Not long after, William would follow his initial intuition: "Taking advantage of a professional break, I consumed considerable amounts of information until I realised that, finally, I was facing the biggest scam of the century. Then I passed the stage of questioning. The 'viral load' is nothing but absolute bullshit! And I am certainly not going to be a guinea pig for the AIDS industry. Rather than engage in arm-wrestling with the doctors, I am going to let them keep believing in their theory. What really matters to me is how I feel. And I feel great!"

The official line is that without triple-therapy "AIDS cocktails"—consisting of three drugs from at least two different classes—one cannot survive HIV infection. But in reality, William said that he is absolutely sure he will remain healthy, especially because of his very healthy lifestyle. He denounces a dehumanised medicine which defines the health status of so-called HIV-positive people solely on the basis of two controversial laboratory test results without any clinical observations.

The technique of PCR (polymerase chain reaction), used to identify and quantify HIV, the so-called "AIDS virus", is not only denounced by its very inventor, Dr Kary Mullis... but also by a large number of specialists...

The Viral Load: An Unsuitable Marker

Officially, the viral load describes the number of virus particles in the blood and is a marker of disease progression. "False!", argue the dissident scientists. The technique of PCR (polymerase chain reaction), used to identify and quantify HIV, the so-called "AIDS virus", is not only denounced by its very inventor, Dr Kary Mullis, who shared the 1993 Nobel Prize in Chemistry for this discovery, but also by a large number of specialists such as Professor Etienne de Harven, a pioneer of electron microscopy. Nevertheless, this test continues to be used with absolute confidence.

As Matt Irwin, MD, explains: "When [the viral load tests] are done on the serum of people considered HIV-negative, 3% to 10% of them commonly have positive viral loads, and the highest reported rate of false positive results is a remarkable 60% (HIV surrogate marker coll. group 2000). Although most cases reported have false viral loads of 10,000 or less, there have been reports of false positive viral loads as high as 100,000 copies per milliliter. In the United States, where the prevalence of HIV is about 1 in 250 people (0.4%), a false positive rate of only 2% would still mean that random screening of the population would result in 5 false positives for every true positive, and a false positive rate of 10% would result in 25 false positives for every true positive. The most likely explanation for this high false positive rate is that HIV-RNA assays commonly react with non-HIV RNA, such as that produced by normal human cells and other microbes."[9]

According to Roberto Giraldo, MD, an infectious diseases specialist as well as a board member of The Group for the Scientific Reappraisal of the HIV/AIDS Hypothesis (Rethinking AIDS[10]): "…Since the viral load results are given in copies per ml of plasma…AIDS researchers, health care professionals, and lay people may think that they represent copies or counts of the virus itself… However, the viral load test only makes copies of fragments of nucleic acids. It does not count HIV itself. A positive viral load test cannot be regarded

as signifying the presence of the whole HIV genome, and therefore the test cannot be used to measure virus."[11]

Bertrand, a 34-year-old HIV-positive Frenchman who was diagnosed seven years ago, said: "When the doctor tells you that your viral load is measured in hundreds of thousands of copies, even in millions for some, that really freaks you out!" Although he already had a viral load of around 250,000 copies (against a maximum of 2,000 to avoid the combination therapy), he never wanted to take any treatment. Surprisingly, in spite of the unfavourable forecasts of the doctors, his viral load spontaneously fell to 11,500; in fact, it has never stabilised, oscillating randomly around 40,000 copies.

William, mentioned earlier, added to his testimony: "In a general way, I avoid following carefully the quarterly measurements as it remains a source of chronic stress that could undermine my immunity." Doctors and researchers indeed underestimate the deleterious impact or "nocebo" effect of the announcement of poor results, which is capable of eliciting an immune drop (depression, stress) in some HIV-positive persons who are anxious or emotionally vulnerable to HIV medical discourse. William noted: "We have to be mentally very strong to resist the brainwashing and remain anchored in our convictions!"

The CD4/T-Cell Count Marker

The HIV=AIDS theory says that having a CD4 or T-cell count below 350 is also a sign of viral activity because this is the type of immune cell that HIV attacks and destroys. A count of 350 would then justify the initiation of treatment. A CD4 rate of less than 200 is considered to indicate an advanced stage of infection, and in the United States it is enough for a diagnosis of full-blown AIDS despite the absence of opportunistic infections. But here again, for HIV=AIDS dissidents, there is no scientific evidence proving that HIV preferentially destroys T-cells or has any toxic effect on these immune cells.

The counting method itself poses numerous reliability problems. Flow cytometry techniques (to determine the counts of every type of immune cell) require a sophisticated level of technical skill which is difficult to reproduce from one laboratory to another. Official notifications on Aidsmap.com concede that it's best to monitor the trends in T-cell count over time. If possible, it's also advisable for the T-cell count to be measured in the same clinic and at approximately the same time of day on each visit. It's suggested that people suffering from an infection, such as flu or herpes, should delay the testing until they feel better.[12]

Bertrand, mentioned above, who has been without treatment for seven years, noted: "Over the tests, I was able to notice significant variation in my count, without an apparent link to my health. It had already gone down to 220 CD4, and then it rose up naturally. On average, it would yo-yo around 350, without ever exceeding 500." This example undermines the insidious argument of the health authorities which ensure that *only* treatment can bring CD4 counts back up or prevent a runaway viral load.

Pressure on Parents

Speaking of her experience, Sabine said: "When in 2004 I was informed of my HIV positivity during a routine exam, I saw myself dying. At that time, I knew nothing about the HIV=AIDS controversy. By educating myself on the Internet, I have gradually become convinced of the nonexistence of the virus. I have never taken any ARV [antiretroviral] treatment and my health has always remained good."

Sabine's story might have ended there, especially in Switzerland, a country of complementary medicines, except that a few years later Sabine gave birth at home to her second child, in agreement with her new companion who is aware of her HIV positivity. As happens to many children, her baby, then three months old, had to be admitted to hospital because of worrying symptoms. On this occasion, the doctors found Sabine's medical record and discovered her HIV positivity. The child was immediately placed under triple therapy solely on the basis of the CD4 cell count and the viral load (without ELISA or western blot tests, which have been found to be unreliable in infants). This was the beginning of a two-month stay in intensive care at the hospital, where the child underwent a battery of tests resulting in all kinds of interventions:

...for HIV=AIDS dissidents, there is no scientific evidence proving that HIV preferentially destroys T-cells or has any toxic effect on these immune cells.

"Following a scan, a small lump appeared on a lung," said Sabine. "My baby underwent a bronchial lavage under general anaesthesia, following which they put a central line in his breast in order to administer all the medication. After a second general anaesthesia, some water was found on the lungs, which required intubation. After two months, they let us take him home with the obligation to give him the triple therapy. Quickly we decreased, then stopped the treatment. Our son got better and his CD4 and viral load tests were pretty good for the medical profession—until the day when they measured the dose of medication in the blood and found no trace of the treatment! Finally, I was reported by the hospital to the Child Protection Court. A few months later, I was sentenced by the court and my parental rights were restricted. From then on, we were controlled by a doctor."

In the denunciation letter to the judge, the hospital

wrote: "The child has been without any effective treatment for several months already. Right now, he is clinically healthy. Unfortunately, his blood tests are very disturbing, showing that the virus is very active and that the child has a very real risk of complications (progression to AIDS, or even death) that could occur soon."

For six months, nurses came morning and evening to check that Sabine's son was receiving treatment. Since the middle of 2014, the child has thus been under triple therapy. Meanwhile, Sabine was working on letting go. She turned to quantum medicine to mitigate the trauma: "I am hopeful because his treatment will be augmented by alternative practitioners. But his chemical treatment will last until my son reaches the age of majority, as long as his T-cell counts and viral load are not in the desirable range. The irony is that I am now waiting for results of an analysis that I don't even believe in."

In the boy's medical record, which we were able to consult, the smugness of the doctors oozes from between the lines: "Parents whose interaction with their baby is extremely well adjusted and empathic, while expressing no sense of responsibility, or feelings of sadness, anxiety or anger with regard to the situation. The mother rationalises using a very solid and well-built model of thought. A very paradoxical situation, in connection with the parental functioning (denial of the consequences of the disease and risks of transmission)."

Yet the parents' attitude is as rational as the scientific literature which questions these treatments. Sabine's situation reveals the omnipotence of the current dogma which can quickly dish out punishment when its prescriptions are not respected.

But it is not just AIDS treatment which can deprive parents of their freedom of choice regarding health: this can also apply to vaccinations and cancer treatment, and maybe soon to autism and hyperactivity. Families had better watch out!

In reality, there are *no reliable statistics* on the number of healthy HIV-positive persons not taking triple therapy. We are therefore entitled to wonder if the "natural control of HIV" is not within the reach of the majority of HIV-positive people.

Escape from Abusive Treatments

The pressure is not less on adults. Here is the story of Etienne, who endured a heavy medical protocol continuously from 1993 (AZT, or azidothymidine, at first, then double therapy and then triple therapy) until 2013—in total, 20 years of antiretroviral therapy from which he only escaped thanks to the Internet!

"During all these years, I behaved like a good little soldier," Etienne said. "I still do not know how I could bear all this medicine, especially since my fear of death encouraged me to use drugs. With my face of a zombie, I could not hide that I was HIV positive—until the day I came across a Facebook post. I went to the Rethinking AIDS association website. I read many books, in particular Peter Duesberg's. There was nothing more wonderful to read! The hoax appeared to me so obvious that I did not doubt after five minutes. When I saw my doctor again and told him that I had stopped the treatment, he was speechless. Now that I don't want him to measure my CD4 counts and viral load any more, I tell him, 'I would rather you have a look at my level of vitamin D'!"

Another Look at HIV Controllers

Etienne is a survivor of both HIV and triple therapy—"proof" of the efficacy of triple therapy, his doctor will probably argue. But is it really proof, since triple therapy has never been tested against placebos (see below)? Is Etienne not an "HIV controller"[13], that is to say a patient who naturally controls the progress of HIV? Officially, the answer is no! This is because Etienne does not fit the very narrow definition of this population, estimated at only 0.5% to 1.0% of all HIV-positive persons.

Indeed, to be considered an HIV controller, it is necessary to: (1) *never have received any treatment* (which is unusual in the Western world); and (2) have a viral load at baseline below 2,000 copies and eventually reduced to below 400 copies. These are very selective criteria. This is also why Bertrand cannot be considered an HIV controller in spite of a total absence of treatment for seven years: his laboratory results (profits) are not *normal*! And we cannot speak of Sabine as an HIV controller, despite her 10 years without treatment, because she never wanted her measurements to be taken. As for William, it has been only one year since he stopped taking medicine and his initial measurements disqualified him.

In reality, there are *no reliable statistics* on the number of healthy HIV-positive persons not taking triple therapy. We are therefore entitled to wonder if the "natural control of HIV" is not within the reach of the majority of HIV-positive people. On our part, it took only a day of research on social networks to find and interview four asymptomatic HIV-positive persons not taking treatment. But the medical profession simply cannot believe that this phenomenon exists on a large scale. As

one of the specialists, Prof. Olivier Lambotte, studying HIV controllers at ANRS (the French AIDS research agency) pointed out: "Those who have not progressed to AIDS, *after stopping the treatment*, are fewer than twenty."[14] (Emphasis added.)

This specialist is referring to the ANRS VISCONTI (viro-immunological sustained control after treatment interruption) study which identified 14 patients in France who had a remission that, in certain cases, lasted 13 years after interruption of the antiretroviral treatments. But this study was only interested in patients who had started treatment within three months after the primary infection, which led his coordinator, Prof. Christine Rouzioux, to claim: "Early treatment has probably limited the expansion of the viral reservoirs, and has protected their immune responses. This…allowed control of the infection after stopping treatment."[15] Translation: it is necessary, as soon as possible, to put all HIV-positive people under treatment! Not doing so would therefore be an infringement of medical ethics.

In fact, there are strong indications that the majority of patients, especially in populations that are not at risk, are improperly started on treatment.

This hypothesis is supported by David Crowe, President of Rethinking AIDS: "This is completely circular logic. Because they assumed that *everyone* was at risk, when they found out that this wasn't true, and that everyone was on toxic drugs, they then said, 'Well, maybe not everyone, but almost everyone'. Nobody knows how many HIV+ people would remain symptom free without drugs. In addition, it is estimated that there are millions of people worldwide who are HIV+ and don't know it. Presumably many of these people have not sought medical assistance because they are symptom free. Furthermore, the average time from infection to 'AIDS' is estimated to be 10 years. It is unlikely that many HIV+ people who trust their doctors will be allowed to go medication free for 10 years, therefore there is no way of telling whether they are normal progressors or long-term non-progressors."[16]

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No Double-Blind Trials for Triple Therapy

Contrary to the requirements of good science, AIDS therapies enjoy the same exemption as vaccines.[17] Everyone is so sure of their benefits that antiretrovirals no longer have to comply with the basic rules of clinical trials for placing new drugs on the market.

As David Crowe said: "Only the early studies of AZT even claimed to use a placebo. Not only did those find very little benefit after any reasonable length of time, but it was seen that those taking AZT were much more likely to need blood transfusions. And the trials were corrupted, as evidenced by several articles by John Lauritsen, collected in his free online book *Poison by Prescription*.[18] The trials of cART, combination therapy, have two fundamental flaws. First, they can only show that cART is less toxic than the highly toxic AZT. Although many combinations used to include AZT, it was at a much lower dose (200 or 300 mg/day versus up to 1500 mg in the early trials of AZT). Secondly, they do not monitor for improved health, but just for improved CD4 counts and so-called viral load."[19] Thus, nothing is really proved!

Worse, triple therapy only changes the type of illnesses. We shall simply quote a 2005 study concerning patients under triple therapy arriving at hospital: "As the HAART era progressed, the holes in the HAART armor became more apparent. Although patients were not having as many opportunistic infections, there was still a relatively high incidence of certain HIV associated malignancies…deaths related to end stage liver disease [almost certainly caused by the drugs] were more common than deaths from opportunistic infections… Hospitalizations for lactic acidosis, reconstitution syndromes [which are opportunistic infections occurring shortly after starting AIDS drugs] and late stage complications related to HAART were becoming more apparent. Some authors also noted an increase in mortality and hospital admission rate as the HAART era progressed."[20]

Ignored Alternative Treatments

All around the world, there are alternative doctors who specialise in the field of AIDS and are especially active within organisations such as Alive and Well[21] and Heal[22] or are on a list published online on the Rethinking AIDS website. This is proof that all options for possible treatments are not given to patients. On the contrary, patients are intentionally diverted from them by coercion or, if necessary, by judicial power.

"These [alternative] treatments should be covered by health insurance or supported by national systems of health" is a statement written into the Declaration of Pont-du-Gard at a conference of dissidents in France in June 2012.[23] This a great idea, but dreaming is useless in the current context where the financial stakes are so huge, especially as this is about treatments for life.

Changing approaches to immune deficiency treatment would dramatically reduce income for the industry. There would be indirect and difficult-to-estimate financial losses resulting from lower sales of drugs for opportunistic infections associated with either the disease or the side effects of triple therapy.

Treatment Costs to Make a Person Go Pale!

Triple therapy costs between 1,000 and 1,500 euros per month, the equivalent of a minimum income![24] With this sum, every patient could instead consult with world specialists in complementary medicine… But, "the global market for anti-AIDS treatments reached approximately [US]$13 billion in 2009. It increases by 13% per year, and should exceed $17 billion by 2018, just in Europe and the United States", the French newspaper *Le Figaro* reminds us.[25]

In 2015, globally, nearly 16 million HIV-positive people were under treatment[26], compared to 9.7 million in late 2012![27] This huge increase is due to the efforts of global health authorities which now recommend treatment from the time of first awareness of HIV status, even without any clinical signs of diseases and independently of the results of laboratory analysis.[28]

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The WHO recommendations of June 2013 "include providing antiretroviral therapy—irrespective of their CD4 count—to all children with HIV under 5 years of age, all pregnant and breastfeeding women with HIV, and to all HIV-positive partners where one partner in the relationship is uninfected". The stated objective is "ensuring that all 26 million people eligible for treatment have access—not one person less".[29]

This medicalisation of fear continues to widen the indications for treatment—a common sales technique for laboratories, but not necessarily for the benefit of patients' health.

Conflicts of Interest

David Crowe noted: "Government agencies should be independent, but there is a 'revolving door' at the top. This closely aligns the government agencies with the needs of the pharmaceutical companies. In addition, in the time of Ronald Reagan, the FDA [Food and Drug Administration] started to take fees from drug companies for drug approvals. This encourages swift approval of new drug applications which helps fund the FDA. Instead of being an independent agency, the FDA has become a rubber stamp for new drugs. The fact that quite a few drugs are pulled off the market after approval is an indication that the approval process has major problems. This rarely happens with AIDS drugs simply because people diagnosed with AIDS are believed to have a fatal condition so most drug side effects will be blamed on HIV, not the drugs."[30] Circular logic…

The French AIDS agency, ANRS, is a good illustration of the problem of conflicts of interest: "All members of its committees are under multiple contracts with the firms that produce the drugs they have to evaluate," says Professor Philippe Even in his latest book *Corruptions and Credulity in Medicine*.[31] For example, for this article we looked for statements of conflicts of interest among the scientists who drafted the September 2015 report on the ANRS Pre-exposure Prophylaxis (PrEP).[32] This report recommended more extensive use of Gilead's Truvada®[33], which was indeed announced by France's Minister of Health in November 2015. But all the 23 experts except one have links, sometimes very close, with the antiretroviral industry, among which several ties are with Gilead laboratories. However, these links are minimised because they were only declared for "work on PrEP in the period since the referral by ANRS and CNS (April–July 2015)".[34]

It would take a whole article to explain the extreme flaws in the ANRS recommendations. In any case, ANRS cannot be considered an independent agency since its experts flirt with industry! Besides, this recent ANRS report, favourable to the prescription of antiretrovirals for HIV-negative people considered to be at risk, is based on the Ipergay study, led by ANRS itself, which concludes that Gilead's Truvada is effective—but the trial has created debate about ethical questions and conflicts of interest. This study cost the French public more than one million euros, all this being a saving for the lab![35]

"It is often said that ANRS is a unique institution in the world of research, due to both its mode of organisation and how it is financed," boasts the agency's director in the 2013–14 activity report.[36] This is actually the French health agency to which the most blank cheques are signed for its trials and where vigilance on conflict of interest is the least.

Afterword: What if Everything You've Learned about AIDS is Wrong?

The following statement was made in 1994 by Dr Kary Mullis, co-winner of the 1993 Nobel Prize in Chemistry, and two colleagues who are among 2,600 scientists and researchers from the "dissident" group Rethinking AIDS: "Although more than 75,000 scientific papers have been published on AIDS, no paper has seriously considered all relevant evidence and attempted to prove that HIV

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causes AIDS. Some papers respond to specific objections but begin by assuming that HIV causes AIDS, which is the very question at issue. If such a paper were possible to write, it would have been written, and been the most widely cited scientific publication of this century. Since such papers do not exist, it is impossible to refute or substantiate the arguments they might contain."[37]

The Rethinking AIDS group was founded in 1991, inspired by Dr Peter Duesberg, Professor of Molecular Biology at the University of California at Berkeley, who in 1987 was the first to express doubt publicly about the HIV=AIDS hypothesis.[38] Among the prominent scientists who share the analysis of the Rethinking AIDS founding letter[39] are Etienne de Harven, MD, a pathologist who pioneered research on retroviruses, and Gordon Stewart, MD, Emeritus Professor of Public Health at the University of Glasgow and a former WHO adviser on AIDS. These are internationally renowned experts who know what they're talking about… ∞

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