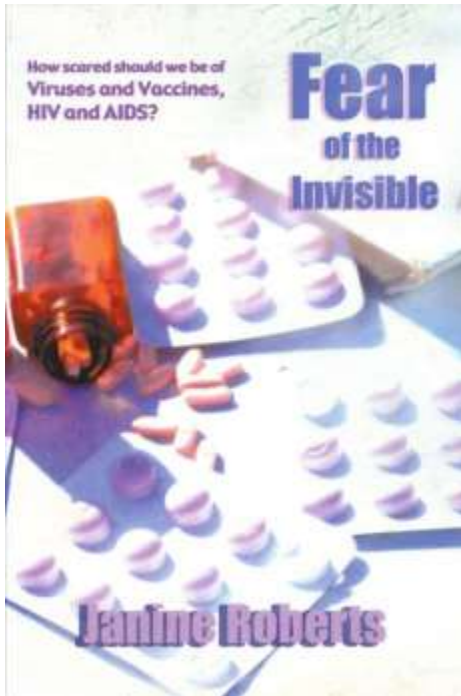


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# Fear of the invisible

93-117 minutes

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Book Review

## ***An investigation of viruses and vaccines, HIV and AIDS***

by Janine Roberts, Bristol: Impact Investigative Media Productions, 2nd ed., 2009, 314 pages

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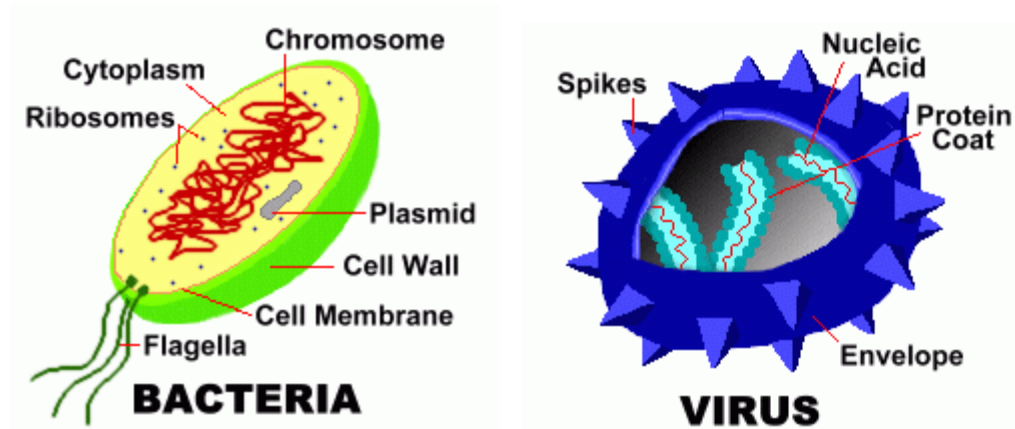
In *Fear of the Invisible*, investigative journalist Janine Roberts describes her 12-year exploration of many fields of 'big medicine'. Beginning as a firm believer in the official theory of harmful viral invaders and the effectiveness of vaccines, she was dismayed by what she discovered, and eventually arrived at a broader and very different perspective on the causes of disease. She writes:

We have been taught to greatly fear viruses, yet scientists have long known that these are fundamental parts of life, made by the millions by all healthy cells. I hope this book will help by combating this fear, this damning of the invisible because we do not understand it. Without this fear, hopefully the focus in medical research will shift to the environmental toxins that really do put us, and our world, gravely at risk. (p. xi)

## Germ theory of disease

The prevailing view today is that major illnesses are caused by microbes – i.e. bacteria and viruses. One of the first advocates of this 'germ theory' was Girolamo Fracastoro of Venice, who in 1546 blamed diseases on minute, rapidly multiplying, infectious organisms. Since the microscope had not yet been

invented, his theory could not be substantiated. The microscope was invented in the 17th century and led to the discovery of the cell, and also of bacteria – single-celled microorganisms which, since they have no cell nucleus, are classed as prokaryotes.



Bacteria are typically a few micrometres (thousandths of a millimetre) in length, while viruses range from 10 to 300 nanometres (millionths of a millimetre) in diameter.

The terms 'virus' and 'vaccination' were first used in the 18th century. Cows ('vacca' in Latin, hence 'vaccination') suffer from a mild form of smallpox called cowpox, and a scientist called Edward Jenner heard of a rural belief that people who got cowpox never seemed to be affected by the much more serious smallpox. So he took pus from an open sore on the hand of a milkmaid whose cow had cowpox, and injected it into his gardener's son in the hope that it would protect him against smallpox. He called the pus his 'virus', a Latin word meaning 'poisonous fluid'. He claimed it was pure and

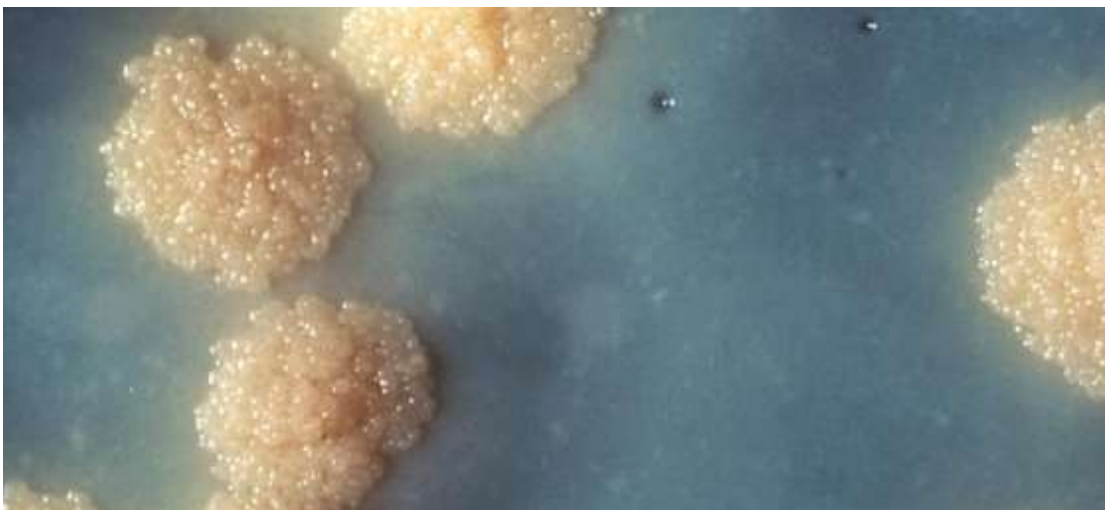
uncontaminated, but we now know it would have contained many kinds of microbes and toxins.

In 1800 a doctor attacked Jenner's method because of its failures, but Jenner claimed that these must be due to contaminated needles being used to inject his cowpox virus. The UK government made his smallpox vaccine compulsory in 1853, but thousands of parents preferred to be fined or imprisoned rather than give it to their children, as it frequently produced illness. Although Jenner is credited with inventing vaccination, he had learned of it from a milkmaid. The Chinese had practised something similar, but somewhat subtler, for 3000 years: they recommended sniffing powdered smallpox scabs to induce immunity to smallpox.

In the 19th century, Louis Pasteur further developed the germ theory. His description of microorganisms in milk led to the 'pasteurization' process named after him. He was also given credit for developing anthrax, cholera and rabies vaccines, and researched how to reduce the virulence of 'germs' for use in vaccines. Another French scientist, Antoine Béchamp, had actually discovered that airborne microorganisms caused fermentation in wine and milk six years before Pasteur, and accused him of plagiarism. Instead of seeing these microorganisms primarily as our enemies, he stressed their emergence from our own cells and their value to us, regarding them as the consequence of disease and cell death rather than their cause. Pasteur put more emphasis on their role in

illnesses and received credit for establishing the germ theory, but he too depicted bacteria primarily as useful.

The prevailing modern idea of microbes as pathogenic invaders that we must destroy at any cost owes a lot to the Prussian physician Robert Koch, who was awarded a Nobel Prize in 1905 for linking tuberculosis (TB) to a mycobacterium. He formulated the four 'Koch postulates' which are still taught today and embody his belief that there is one microbe per disease: 1. the microbe must be present in every case of the disease; 2. the microbe must be isolated from the host and grown in vitro (i.e. in the laboratory); 3. the disease must be produced when a pure culture of the microbe is inoculated into a healthy susceptible host; 4. the same microbe must be recovered from the experimentally infected host. However, Koch found it difficult to fulfil all four postulates. We now know that nearly everyone has the tuberculosis mycobacterium in them, along with fungi that cause a deadly pneumonia (PCP), and countless other microbes, but they are normally harmless unless our immune system is impaired by other factors.





Mycobacterium tuberculosis. (en.wikipedia.org)

Koch rightly criticized Pasteur's description of liquid samples taken from diseased patients as 'isolates' of particular microbes, saying that they could not possibly contain only one kind of pathogen. For instance, he wrote of the Pasteur rabies vaccine: 'Pasteur is content to inoculate with slime taken from the nose of the dead animal, which, exactly like saliva, was certainly contaminated with many other bacteria' (p. 43). He also noted that different bacteria could cause similar disease symptoms.

In 1909 Karl Landsteiner and Erwin Popper began their hunt for the cause of polio, in response to major epidemics of paralytic polio in Sweden and the United States. They were unable to find a bacterium to blame so they guessed that there must be minute forms of bacteria able to pass through all available filters. They called them 'mini-bacteria' and 'viruses'. Viruses are about a billionth of the size of a cell, and anything equally small will pass through the filters with them, including DNA and RNA fragments, proteins, prions (infectious agents composed mainly of protein), mycoplasmas (tiny parasitic bacteria lacking a cell wall), and chemical toxins. This problem of isolating or purifying viruses is crucial to the rest of this story. Most viral 'isolates' are little more than filtered cell

cultures containing many contaminants, in which a particular virus is presumed present.

In 1931 the electron microscope was invented. When tiny particles were seen in fluid from sick people, they were called viruses. When they were seen surrounding and entering damaged cells, they were assumed to be infecting the cells and causing the cell damage. We now know that healthy cells communicate with one another by exchanging particles known as exosomes, microvesicles and retroviruses; they carry genetic material which is then absorbed by the recipient cell. Cells under stress try to defend themselves by mutating, and the exchange of viral-like particles is part of this process. This shows the need for caution in interpreting such images. But, as we shall see, scientists have failed to exercise such caution and have built the theory of pathogenic viruses on very flimsy evidence.

## **Vaccine hazards and toxins**

### **A witches' brew**

The key ingredient in vaccines is the virus or bacterium that is believed to cause the disease in question. The viruses are usually grown in a culture of animal or human cells, which are stimulated with toxic chemicals so that they produce more viruses. The viruses used in vaccines are either 'living' but weakened, or 'dead'. (This terminology is a little odd as viruses are officially not believed to be alive, because they are

unable to reproduce by themselves.) ‘Dead’ viruses have been poisoned with formaldehyde. ‘Live’ viruses are weakened, or attenuated, by subjecting the cultures in which they are grown to extreme stresses, so that they produce mutated viruses. The purpose of a vaccine is to trick the body into producing antibodies to a particular disease by using a less virulent form of the virus as a trigger. The antibodies are then assumed to provide protection against the virus in question – even though it is well established that *antibodies are not a measure of immunity* ([whale.to](http://whale.to)).

Government health authorities constantly repeat that vaccines are safe and effective. Since vaccine effectiveness is usually determined by their ability to cause antibody production, commonly heard claims of ‘90% effectiveness’ are meaningless. As for vaccine safety, government scientists, health officials and vaccine manufacturers often hold conferences to discuss the potential dangers of vaccines, and what they say behind closed doors bears no resemblance to the message presented in public. Janine Roberts succeeded in gaining access to several of these conferences, and was asked by a senior government doctor not to divulge what she had heard for fear of creating a panic (p. 78).

Vaccines contain suspensions from manufacturers’ incubation tanks in which viruses are produced from substrates such as mashed bird embryos, minced monkey kidneys and cloned human cells. These suspensions are filtered before use but



only to remove particles larger than viruses. Vaccines therefore contain a witches' brew of viruses that should or should not be there, bits of decayed viruses and cells, fragments of DNA and RNA genetic codes, proteins, enzymes, chemicals and perhaps prions. Vaccines are monitored only for the presence of a few well-known pathogens, and are thrown away only if these are found. Top scientists and officials admit that vaccines are 'primitive', 'crude' and highly contaminated, and that there is no easy and economical way to purify them.

Scientists fear that contaminating DNA might combine to create a mutant viral strain that could easily end up in the individual doses of vaccine. In 1986, the US government told vaccine manufacturers that some of the contaminating DNA could stay. It recommended a weight limit of 100 picograms per dose, but when manufacturers failed to comply, it decided to allow 100 times more contaminating DNA in most vaccines. But even this lower standard could not be met. Most vaccines have not even been checked for residual DNA (pp. 75-6).

The World Health Organization (WHO) and national health authorities have quietly permitted vaccines to contain a 'low level' of viral contamination, because manufacturers cannot remove it cheaply. The WHO's acceptable level is  $10^6$  to  $10^7$  possible viral particles per millilitre for the substrates on which vaccines are grown. They publicly say that this presents a 'theoretical' safety concern, but the conferences that Roberts

attended revealed that they are really very concerned (p. 81).

Many laboratories have found simian virus 40 (SV40) in human cancers and it is thought to have invaded humans through polio and adenovirus vaccines produced in mashed-up cells from monkey kidneys or testicles. Between 1955 and 1976 some two million monkeys were slaughtered to make the polio vaccine, and nearly as many died during transportation. SV40 has not been proved to cause cancer; toxins and cellular fragments in the vaccine culture could also cause cell damage. Other monkey viruses known to have contaminated the polio vaccine include simian cytomegalovirus (SCMV).

The discovery of monkey viruses in vaccines was originally kept secret for fear of sparking public hysteria. The modern Salk polio vaccine, under the brand name IPOL, is grown in a continuous (i.e. cancerous) line of monkey kidney cells (even though kidneys collect toxins), supplemented by newborn calf serum. This is filtered to remove large fragments then spun rapidly. The filtered-off fluid is the vaccine. Roberts was shocked to learn that modern polio vaccines are still contaminated with SV40.

The mumps and measles viruses used in the MMR (measles, mumps and rubella) vaccine are grown in fertilized chicken eggs, as are the viruses for influenza, yellow fever and smallpox vaccines. The rubella virus for MMR is produced in cells originating from an aborted human fetus. All egg-based vaccines are known to be contaminated, e.g. with avian

leukosis virus, which has been linked to leukaemia.

Vaccines also contain antibiotics and various preserving chemicals, such as hydrolyzed gelatin (porcine), monosodium glutamate and hydrochloric acid. The pork-derived enzyme trypsin is sometimes used to break up monkey cells and other flesh in the vaccine cultures and encourage the production of viruses. In some vaccines, the viruses are poisoned and 'killed' by adding formaldehyde. In the case of the modern polio vaccine, each dose contains up to 0.02% of formaldehyde (200 parts per million). Formaldehyde is recognized as a human carcinogen, and at levels above 0.1 ppm, exposure causes a burning sensation in the eyes, nose and throat; nausea; coughing; chest tightness; wheezing; and skin rashes. Exposure to formaldehyde may increase the risk of developing amyotrophic lateral sclerosis (ALS), also known as Lou Gehrig's disease – a fatal progressive neurodegenerative disease affecting the nerve cells of the brain and spinal cord, leading to paralysis.

Mercury (thimerosal) is added to some vaccines as a preservative, and aluminium is added as an adjuvant to enhance the immune response. Both metals are toxic and mercury is associated with brain diseases. The US Environmental Protection Agency's safety standard for mercury is 0.1 microgram per kilogram of body weight per day, or 7 micrograms for a 70 kg adult. Yet in 2003, it was estimated that fully vaccinated children receive as much as

237.5 micrograms of mercury from vaccines in doses of up to 25 micrograms each. Mercury is now being reduced in or eliminated from vaccines, but is still used in the tetanus and flu vaccines (to save money), and is still present in trace amounts in many vaccines.

Injected or inhaled metals have long been associated with severe muscle damage. Arsenic and lead seriously damage arm and leg muscles, causing cases previously diagnosed as polio. We now know that aluminium-enhanced vaccines can produce disabling muscle damage. Aluminium is also being found in the brains of people with Alzheimer's. Having many vaccine jabs in the same muscle can cause paralysis in that arm, a disorder known as 'provocation polio'.





‘Fillet of a fenny snake,  
In the cauldron boil and bake;  
Eye of newt and toe of frog,  
Wool of bat and tongue of dog,  
Adder’s fork and blind-worm’s sting,  
Lizard’s leg and howlet’s wing,  
For a charm of powerful trouble,  
Like a hell-broth boil and bubble.’

It sounds like the three witches in Shakespeare’s *Macbeth* ([Act 4, Scene 1](#)) were brewing up a medieval vaccine. 🧪  
([farm3.static.flickr.com](#))

### ***Side effects and long-term damage***

WHO reports say that symptomatic local reactions can be expected in about 10% of vaccine recipients, though DTP (diphtheria, tetanus and pertussis) vaccine causes minor local reactions such as pain, swelling from water retention, and inflammation in 40 to 80% of vaccinees. Fever occurs in up to 10% of vaccine recipients, except for DTP where the figure is

about 50%. After MMR vaccination, 10% have local pain or swelling, and fever and rashes occur in 5 to 15% up to 10 days after receiving the vaccine, though among children aged 13-18 months, 32% develop moderate or severe fever.

Febrile (brain) seizures occur in 333 in every million cases. This means that 2664 children were expected to have febrile seizures as a result of the UK's 1994 MR (measles and rubella) vaccination of 8 million children, whereas without the campaign only 170 children were expected to be infected with measles. Moreover, a natural measles virus infection causes permanent brain damage in only 1 in 2000 infected persons (pp. 6-7).

The WHO warns that live vaccines should not to be given to individuals who are pregnant, have immune deficiency diseases or are immunosuppressed due to malignant disease, therapy with immunosuppressive agents, or irradiation. But checks that children's immune systems are already in good order are hardly ever made before vaccination. The WHO is currently rushing out vaccines for millions of severely malnourished, immune-system compromised children in poverty stricken regions of the world.

Janine Roberts began her investigation in response to requests from parents of children who became brain damaged after being vaccinated. In 1992, for example, 13-month-old Robert Fletcher suffered febrile fits after receiving MMR and Hib meningitis vaccines. One lasted 45 minutes, which starved

his brain cells of oxygen, causing permanent brain damage. Such effects are a recognized vaccine risk. Robert began to fall ill 10 days later, and soon his speech skills vanished. Today, he is permanently cared for by his parents (pp. 42-3).

Before having her 12-year-old son Sam vaccinated with the MR vaccine, an Englishwoman called Karen enquired whether it would be safe, given his mild asthma. She was told not to worry. But four weeks after being vaccinated, Sam started falling down and going blank. Later he was confined to a wheelchair and lost the power of speech, and was expected sooner or later to slip into a coma and eventually die (p. 5).

Susan Hamlyn's son Francis came down with juvenile arthritis a month after being immunized. This is a known side effect of the rubella vaccine. He was barely able to walk due to the pain, and was no longer able to play the trombone because he was too weak to lift it. The Secretary of State for Health admitted that there had been several similar reports and they were being investigated (p. 6).

Julia Powell of Wales told Roberts that her 5-year-old son, David, became severely arthritic after his rubella vaccination:

He would spend endless nights screaming with the pain. He couldn't run. He walked like a crippled old man. He had splints put on his legs to straighten them at night. He wore a plaster on his arm to straighten it. He is now going into remission but the hospital said the arthritis would never leave him. It can return and cripple him at any time. (p. 3)

Vaccine scientists worry that the contaminants and toxins in vaccines – including mercury, aluminium and contaminating DNA – may help to cause autoimmune diseases (including autistic spectrum disorder/ASD, asthma and allergies), brain disorders and cancers in later life. Alongside toxins from intensive vaccination, environmental pollutants may also accumulate in us and cause severe damage. The incidence of ASD in the US rose from 1 in 10,000 children in the early 1980s to 1 in 150 in 2008. In 2007 it was calculated that 1 in 58 boys in the UK were autistic. This explosive increase started after we began to repeatedly vaccinate children. Some scientists have found traces of the measles virus in the gut, blood and even brain of autistic children and in the brains of victims of multiple sclerosis, and this probably means that the various contaminants spread with the measles virus are also present.



Universal symbol warning of toxic substances or



environments.

Some scientists believe that the main cause of autism is damage to cells' mitochondria (which provide most of a cell's energy) from toxins accumulating from vaccines or other causes. A meeting of government scientists and the vaccine industry was called in 2000 because a scientist from the US Centers for Disease Control and Prevention (CDC) found a statistically significant relationship between mercury in vaccines and several neurological conditions, possibly including autism. The CDC subsequently issued a report claiming that vaccines could not cause autism. However, it was later forced to admit to the US Congress that it had reversed its original finding of a link between thimerosal-containing vaccines and autism by arbitrarily reprocessing the statistics (p. 86).





([www.encognitive.com](http://www.encognitive.com))

In 2007 a US court and government experts accepted that vaccination played a significant role in making 9-year-old Hannah Poling autistic. This test case opened the door for compensation for many affected by the autism epidemic. She had fallen ill on the same day that she had received nine vaccines. In 2008 the US government further conceded that Hannah's autistic brain disease was caused by vaccine-induced fever and overstimulation of her immune system (pp. 91-2).

The hazards of vaccination are undeniable. Roberts writes (p. 92):

[V]accines are full of chemicals, toxins and biological particles from different species. These are directly injected into the child's blood and muscles, bypassing most of their immune systems. [Children] are injected with 30 or more vaccines in the first two years of life during a time when their brain is being formed and is particularly vulnerable – and both autism and attention deficit disorder are brain disorders that begin in early childhood.

Roberts questions whether children need all these vaccines when they have for centuries gained lifelong immunity to most

diseases from natural exposure coupled with good nutrition and clean water (p. 93). However, with estimated revenue from childhood vaccines in the US now standing at over \$2.4 billion a year, resistance to change is likely to be fierce.

### ***Polio: vaccine and causes***

The polio vaccine has proved very dangerous. The Salk vaccine was launched in the US in 1955. Within two weeks of being vaccinated, over 260 children fell ill with polio, of whom nearly 200 were paralyzed and 11 died. The public was told there was nothing to worry about as President Eisenhower's grandson had suffered no ill effects from the vaccine! Reports of polio among the vaccinated continued to come in, and in 9 out of 10 cases the paralysis occurred in the arms in which the vaccine had been injected. Nearly half of all polio cases reported were in vaccinated children.

By January 1957, 17 US states stopped distributing the polio vaccine. Polio cases rose by 300 to 400% in the five states or cities that made the Salk vaccine compulsory by law. Infantile paralysis cases increased after the introduction of the vaccine by 50% from 1957 to 1958 and by 80% from 1958 to 1959 (pp. 64-5). The Salk vaccine was officially withdrawn in 1961, but a new version (IPOL) was introduced recently. The Sabin polio vaccine was released in 1962; unlike the Salk vaccine, it uses weakened, 'living' poliovirus, and is administered on sugar cubes. The Sabin vaccine is now out of use in the West, as it,

too, is blamed for causing some polio cases, but it is considered suitable for third-world children.

In 1960 the Merck Corporation informed the US surgeon general that both the Sabin and Salk polio vaccines were so contaminated with monkey viruses that it was far too dangerous to manufacture them, but government safety regulators allowed production to continue. In the USA between 1955 and 1963 contaminated polio vaccine was given to 90% of all children and 60% of adults, and has since been given to hundreds of millions more (p. 36). Vaccine safety experts testified to the US Congress in 1972 that monkey kidneys were 'a veritable storehouse for the most dangerous kinds of contaminating viruses ... the "dirtiest" organs known', and warned that continued use of these contaminated vaccines would lead to unprecedented cancer epidemics – but their warnings were ignored (p. 32). Fortunately, the contaminating viruses in vaccines are not as harmful as is commonly believed.

To make it look like the polio vaccine was being effective, the health authorities rewrote the rules for polio diagnosis. Previously, doctors had diagnosed polio if a patient had paralytic symptoms for 24 hours, but this period was now increased to at least 60 days. It was also decreed that all cases of polio occurring within 30 days of vaccination were to be recorded as 'preexisting' – rather than as possibly caused by the vaccine. Cases involving muscular weakness and

widespread pain but not paralysis were henceforth diagnosed as viral or aseptic meningitis rather than polio – even if traces of the polio virus were found. Other cases previously diagnosed as polio were reclassified as cerebral palsy, Guillain-Barré syndrome, or muscular dystrophy. The authorities also decided that patients with the classic symptoms of paralytic polio were to be diagnosed as having acute flaccid paralysis (AFP) if no poliovirus could be found in two of their turds. These tests revealed that the virus could not be found in about half the cases. Roberts describes the polio vaccine saga as ‘an incredible case of medical fraud’, and says that the new rules for polio diagnosis are a perfect way to hide vaccine failure (p. 66).

Most scientists ignore the strong evidence linking polio to neurotoxins, which damage or kill neurons (pp. 55-62; [harpub.co.cc](http://harpub.co.cc)). Polio (palsy) has been around for centuries and was long associated with metalworking – possibly due to lead and arsenic in the metals being processed. During the major US polio epidemics from the 1890s onwards, doctors treating polio victims sometimes blamed the illness on powerful new pesticides, particularly those sprayed on crops and orchards in summer and autumn, when the epidemics struck. Many children went down with polio immediately after eating fresh fruit. The pesticides contained neurotoxins, which killed insects by paralysing them. Lead arsenate was introduced as a summer-sprayed pesticide in the US and parts of Europe at the end of the 19th century, immediately before the polio

epidemics started, and was then used intensively for about 50 years. The UK banned apple imports from the US because they were so heavily polluted with lead arsenate. Calcium arsenate was introduced in 1907.

Some organophosphate chemicals (also found in certain pesticides) can cause death or loss of a portion of a nerve cell, and organophosphates were introduced in the US just before the major polio epidemics of 1950-52. Other pesticides that might cause paralysis include the organochloride DDT, which was introduced in the 1940s and soon replaced lead arsenate as the pesticide of choice. It causes lesions in the spinal cord resembling those in human polio. Both DDT and the more powerful organochloride pesticide DDE penetrate the blood-brain barrier that protects the central nervous system. The greater use of household insecticides by middle-class families could explain why, in contrast to other epidemics, it was mostly middle-class children who got polio. From the early 1950s recognition of the danger of overusing pesticides grew, and less persistent pesticides were introduced. But today thousands of children are still being paralyzed in regions where heavy-metal pesticides are widely used.

Some doctors reported success in treating polio cases using dimercaprol (which is still used to treat heavy-metal poisoning), ascorbic acid (another anti-toxin), and massive doses of vitamin C. But the public health authorities and the WHO have stubbornly ignored these reports, and claim there

is no cure for polio.

## Have viruses been isolated?

Scientists who oppose the official theory that a retrovirus called HIV (human immunodeficiency virus) is the cause of AIDS (acquired immune deficiency syndrome) fall into two main camps: those (like [Peter Duesberg](#)) who say that HIV is a real retrovirus but, like other retroviruses, is harmless and cannot cause AIDS; and those (like Eleni Papadopulos and Val Turner of the [Perth Group](#)) who argue that since HIV has never been isolated in pure form, it has not been proved to exist, and the proteins considered to be fragments of HIV are actually produced by our own cells, particularly when under stress from other causes.

To those who argue that HIV has never been isolated free from cellular contaminants and debris, proponents of the official HIV=AIDS theory put forward an extraordinary argument: *no pathogenic virus has ever been isolated* in the manner demanded by their opponents, so if HIV doesn't exist, that would mean that the same would apply to the viruses said to cause polio, measles, flu, mumps, etc. ([thepertthgroup.com](#)). When Janine Roberts came across this argument, instead of concluding that since 'everyone knows' that other viruses exist and cause disease therefore HIV must exist and cause AIDS (an argument devoid of logic), she decided to take a closer look at what we really know about other viruses. She was

shocked by what she discovered.

In 1909 Landsteiner and Popper took the spinal cord from a 9-year-old polio victim, minced it up and mixed it with water. Presuming that the resulting suspension contained the poliovirus, they injected a cup of it into two monkeys; one of them was killed immediately and the other was slowly paralyzed. This experiment was hailed as proof that a virus, or 'filterable agent', caused polio – despite the fact that the liquid injected would also have contained cell debris, blood, DNA, RNA, proteins, enzymes, toxins, and possibly a variety of viruses. The suffering inflicted on the animals involved in such experiments was, and still is, widely considered an acceptable price to pay for 'advancing' human knowledge – which says a lot about our civilization.

In 1910 Simon Flexner and Paul Lewis succeeded in apparently passing paralysis from one monkey to another by injecting a suspension of ground-up human backbone from a polio victim into a monkey's brain, then extracting fluid from its brain and injecting this into another monkey's brain, and so on. They, too, did not consider the multitude of other contaminants that could have been in this toxic stew, or ask themselves why the monkeys only became paralyzed if it was injected directly into their brains, thereby bypassing their immune systems. Nor did they consider that since the human material being put into the monkeys was alien to them, this could also be what was poisoning them. Yet this experiment

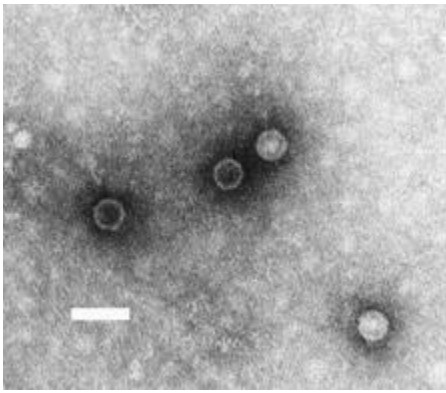


was celebrated as further evidence that polio is caused by an infectious virus (pp. 45-6).

In 1948, in another famous experiment, two scientists injected the diluted excrement of polio victims into the brains of suckling mice (3-7 days old), resulting in them becoming paralyzed. Although hailed as the successful 'isolation' of a virus that had been proved to cause polio in humans, this experiment proved only that paralysis could be induced in baby mice by injecting diseased human excrement into their brains. The hunt for the poliovirus began in the 1890s but by the 1950s no virus had been isolated and proved to cause polio: 'What were being experimented with, and named as polio viruses, were fluids from cultures, and filtered extracts from diseased tissues and even from the excrement of sick children' (p. 54).

Under the electron microscope, a small ball-like particle, 24-30 nanometres wide, was located in diluted excrement of both healthy and sick humans and called the poliovirus. It was therefore classified as a gut virus (enterovirus), but no one has explained how a virus in the gut can cause polio in backbone and brain nerve tissues. Moreover, the poliovirus was recently reclassified as an enterovirus produced solely by humans (HEV), but since human viruses do not normally cause disease in humans, the 'poliovirus' would have to be highly unusual if it is the real cause of polio (p. 49)



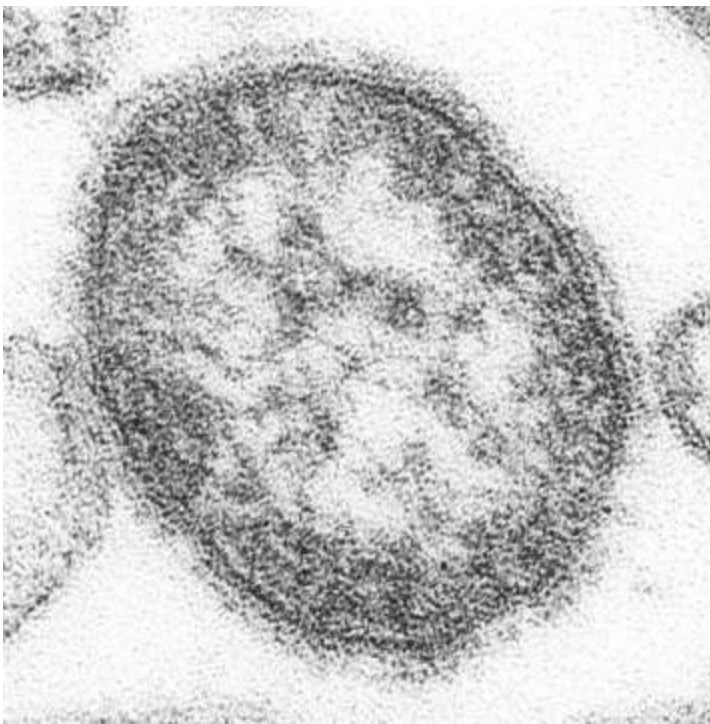


Electronmicrograph said to show poliovirus. (en.wikipedia.org)

The tale of how the measles virus was first discovered and processed to make measles vaccines is equally disturbing (pp. 84-5). In the 1950s a team of scientists led by John Enders obtained some fluid – throat washings and blood – from a boy with measles called David Edmonston. When this was added to human post-natal cells in the lab, the cells became ill. This was taken to mean that a measles virus might be present. When this fluid was added to human cervical cancer cells and human carcinoma cells, the cells became even sicker. Under the microscope, giant multinuclear cells could be seen in the cultures, which was interpreted as a sign that the measles virus had distorted them, not that the cancers might be getting more malignant.

After the fluid had been ‘passaged’ 23 times from one culture of human kidney cells to another and then 19 times through cultures of human amnion cells, the cells in the cultures began to assume highly deformed shapes. The team then tested the resulting cell culture fluid on monkeys and some got a mild illness in some respects resembling measles. This was taken

as evidence that this toxic mix of mutant cells was a measles virus 'isolate' – known as the 'Edmonston isolate'. Next, the culture with highly disordered cells was passaged nine times through amnion cells and then added to fertilized eggs. Some of the chick cells took on similar deformed shapes to those observed earlier. This Edmonston strain – containing mutated particles from poisoned bird cells – became the basis for some of our major measles vaccines.



Electronmicrograph of a measles virus, 100-200 nanometres in diameter. (en.wikipedia.org)

In case anyone thinks that virus isolation procedures have improved since the 1950s, here is the procedure for isolating the measles virus recommended by the Centers for Disease Control and Prevention (CDC) (pp. 84, 252). Prepare a culture of cells from marmoset monkeys by 'immortalizing' them, i.e.

making them cancerous. (To save money, measles and MMR vaccine manufacturers use cells from mashed chicken embryos instead.) Wearing rubber gloves and splash goggles, add a toxin called trypsin, which poisons the cells and causes some to fall away. Add nutrients and glucose and leave the cells alone for two or three days.

Next add to the cell culture a small sample of urine or fluid from the nose or mouth from a measles patient, and place the culture in an incubation chamber. After an hour, inspect the cells under the microscope to see if any are rounded, distorted, or floating free, as they were immediately after trypsin was added. If they *are*, the CDC calls this proof that measles virus is present and is causing this illness. There is apparently no need to see the virus or to isolate it from the rest of the poisoned cell culture. The CDC says that if 50% of the cells are now distorted, the culture can be labelled 'isolated measles-virus stock'. If less than 50% are ill at this stage, two antibiotics are added and if, when viewed a day later under the microscope, there are signs that cells have died or floated free, the culture can then be labelled 'isolated measles-virus stock.'

This procedure is astounding. The CDC makes no mention of the need to have a control culture, to isolate the measles virus from particles or toxins produced by the poisoned monkey cells, or to observe the virus with an electron microscope. No measles-like symptoms are looked for in the culture. There is

no consideration of how the virus may cause cell deformation, let alone the specific symptoms of measles, or of the role played by the toxin added, or the fact that all cells placed under stress readily mutate.

The fluid filtered off from a culture of this 'isolate' is used as a vaccine. The children vaccinated will produce antibodies against all the numerous contaminants and toxins it contains, not just any measles virus present. So the filth contained in vaccines certainly 'stimulates' the immune system, but it may also overstimulate or overwhelm it. Measles in humans usually does little harm, but some cases are very serious. It is said to kill in the manner of 'HIV', by damaging the immune system so that other diseases linked to bacteria, particularly pneumonia and diarrhoea, make the child seriously ill. But there is no proof as yet that a virus is in any way involved.

The symptoms of a cold are associated with at least 200 different types of virus and various environmental factors. Rhinovirus is found in about half of colds but this comes in over 100 serotypes, meaning over a hundred antibodies attach to different types of them, so this virus cannot be tested for easily with an antibody test.

Rhinovirus is preferentially produced in the lab by using human cervical cancer cells (HeLa) – something inexplicable. How can they say the virus is present and 'isolated' when such cells show extra symptoms of illness? How can they deduce the cells have a cold? All that can be said for certain is

that during colds we produce a multitude of different viruses along with the many other elements that travel in the fluids spread by sneezes. (p. 253)

If viruses (or fragments of them) cannot be found in studies of illnesses blamed on them, they are said to be 'clever at mutating'.

Virologists rarely attempt the very difficult task of identifying the presence of a whole virus. When they say they have found SV40 in a patient, or the bird flu virus in a dead bird ([klein-klein-aktion.de](http://klein-klein-aktion.de)), or any other virus, they do not mean they have found a whole virus – merely a tiny fragment of genetic code said to be unique to a viral species. But it is virtually impossible to prove uniqueness when so many viral species have mutating codes and so many remain to be discovered – experts say we have studied at most 0.4% of those that exist.

Even when a genetic segment is reliably proved to be part of the genetic code of a protein belonging to a particular virus, this only indicates the protein's prior presence, not that of the whole virus. It is strange that SV40 genetic code is only found in cancer cells whereas if they really are invading, and not produced locally, they would need to travel through other cells to get there. Sometimes cancer arises without them being present at all. In one experiment all the female rats got breast cancer after being injected with a filtered laboratory culture containing SV40, but no SV40 code was found in those cancers. It is worth remembering that Nixon's 'war on cancer'

in the 1970s was based on the theory that viruses cause cancers, but it flopped badly, finding practically no viruses linked to human cancers.

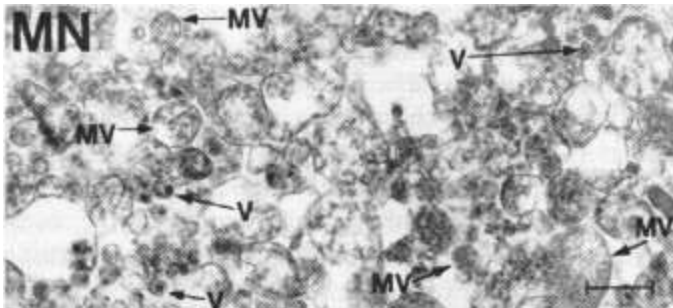
### ***HIV: a grand delusion***

Scientists have said for years that HIV is the necessary and sufficient cause of AIDS. HIV is said to be a retrovirus and to destroy CD4+ T-cells (which play a key role in our immune system), even though retroviruses are generally harmless. Despite spending some \$200 billion on AIDS research over the past 25 years, scientists still don't know how HIV destroys T-cells – all they have is a bunch of competing hypotheses. In 2006 [Benigno Rodriguez](#) et al. published a paper in the *Journal of the American Medical Association* which concluded that HIV cannot be responsible for more than 5-8% of the loss of CD4 immune cells that is necessary to cause AIDS. Since this paper has not been challenged by other AIDS scientists, it drastically alters the mainstream position as it implies that 'HIV' is *not* sufficient to cause AIDS.

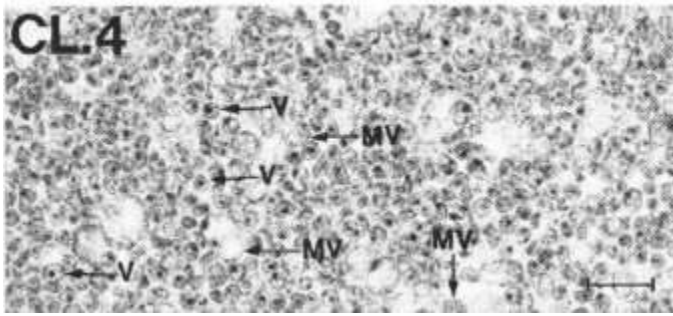
HIV has never been observed under an electron microscope in the uncultured blood plasma of AIDS patients. Particles claimed to be HIV have only been observed in cell cultures that have been stimulated by certain chemicals or irradiated. The first and only micrographs of 'purified HIV' were published in 1997 by two groups of scientists – a US team led by Julian Bess and a Franco-German team led by Pablo Gluschkof.

They admitted that the vast majority of the material in the images consisted of microvesicles, i.e. cellular fragments, but claimed that some particles looked like retroviruses and were 'HIV'.

Yet none of these particles had all the morphological characteristics of retroviruses, or even their principal characteristics: a diameter of 100-120 nanometres (officially reduced to 80-100 nm in 2000), and surface spikes and knobs. In the Franco-German study the average 'HIV' diameter was 136 nm and no particles were smaller than 120 nm. In the US study the corresponding dimensions were 236 nm and 160 nm. In other words, the American 'HIV' is about twice the diameter of the European 'HIV'. In addition, of the 12 proteins that allegedly compose HIV, only three were detected by Bess et al., but they were found not only in the material supposedly containing 'HIV' particles but also in the material without it – only the quantities were different. The Perth Group concludes: 'This is as good an evidence as one can get that nobody has: (1) proven the existence of the "HIV" particles; (2) purified the "HIV" particles; (3) proven the existence of "HIV" proteins and RNA' ([theperthgroup.com](http://theperthgroup.com)). HIV differs from all other retroviruses in this respect.

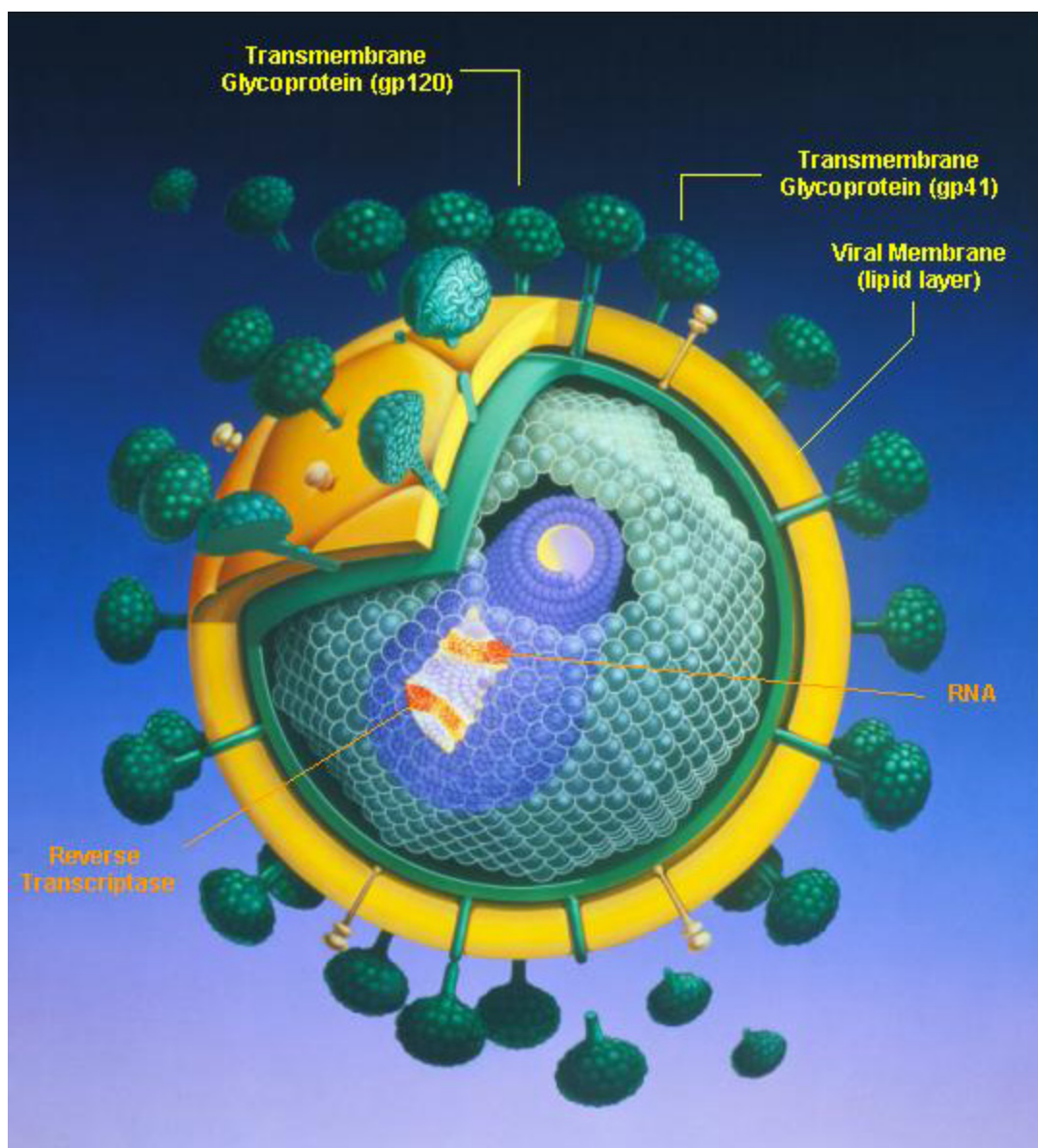


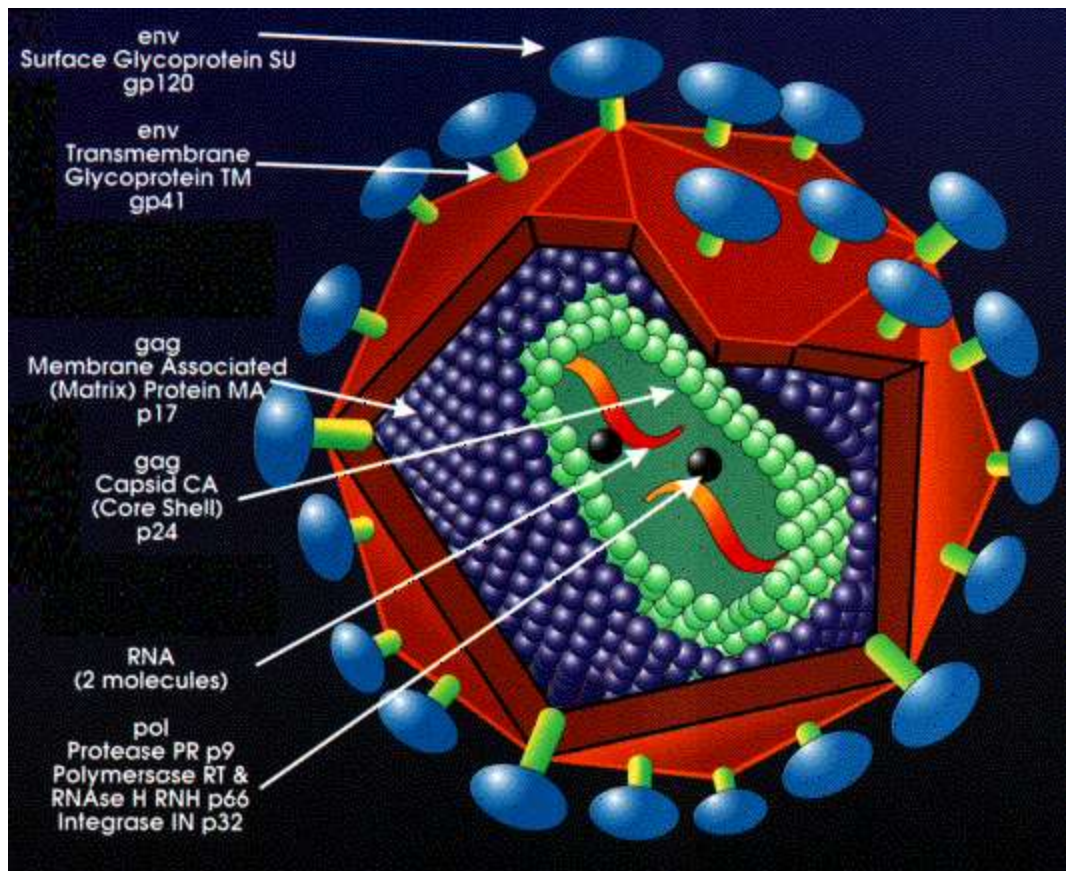




Electronmicrographs of 'HIV' published by Bess et al. in 1997. Particles marked 'MV' are said to be normal microvesicles and those marked 'V' are said to be HIV. (p. 228)

Many different colourful images of HIV can found on the internet, but they are largely the product of artistic imagination ([fearoftheinvisible.com](http://fearoftheinvisible.com)).





Computer-generated images of HIV. None of the proteins that supposedly compose the virus are specific to HIV.

([vircolab.com](http://vircolab.com); [biology.kenyon.edu](http://biology.kenyon.edu))

AIDS scientists say that the reason it is impossible to find whole particles of 'HIV' in patients' blood is because HIV is very 'cunning' and able to disguise itself. What they *do* find are fragments of genetic code that they claim belong to HIV.

These fragments might also be produced by cellular breakdown, caused for example by long-term drug abuse or severe malnutrition. Moreover, the fragments differ from one patient to another, leading scientists to conclude that no two HIV genomes are the same even from the same person.

Some have said that in samples taken from any one patient

they can find more than 100 million genetically distinct variants of HIV (p. 272). This is attributed to HIV's ability to protect itself by constantly mutating. Robert Gallo, one of the inventors of the 'AIDS virus', stated in 2007 that HIV's genome is rapidly and constantly mutating into 'so many forms that I cannot keep track of them' (p. 184). AIDS scientists have a blueprint of HIV in mind to which they try to fit the genetic fragments. When they find bits that don't fit in, they claim that they must have mutated. But as Roberts (p. 272) says, 'this phenomenon can be explained by cellular breakdown within a very ill person, or by accepting retroviruses as basically messenger RNA vesicles that can carry different codes'.

HIV experts cannot even agree what subfamily or genus of retroviruses HIV belongs to; the confusion is equivalent to not being able to distinguish between a human, a chimpanzee and a gorilla. In many cases of cancer cases, RNA sequences are found that differ from two 'HIV' genes by 10%. HIV experts argue that this figure is so high that it proves that HIV is distinct from the possible cancer-related retrovirus. Yet the same experts have no difficulty believing that 'HIV' genomes can vary by up to 35%. A more sober assessment would be that no one has proved 'HIV' RNA to be a unique molecular entity. Some scientists say they have cloned 'HIV' from genetic code fragments, but given their inability to isolate 'real' HIV, they have no way of backing up their claims.

For most virologists, 'isolate' does not mean obtaining a pure

sample of a virus free of all contaminants. They say that this is an expensive and difficult task that modern technology has made irrelevant. Viruses are 'isolated' by indirectly detecting their presence in a cell culture. A sample of fluid thought to contain a particular virus is added to a suitable cell line and the virus's presence is determined by a variety of methods: by a change in the appearance of the cells, by their death, by the release of a particular protein assumed to be from the virus, or by detecting part of the genetic sequences assumed to be of the virus.

The minute fragments of genetic code detected are typically less than a thousandth of the entire genome. Their detection is facilitated by multiplying them many millions of times using a technique known as polymerase chain reaction (PCR). Kary Mullis, who received a Nobel Prize for inventing PCR, says that it is being misused in HIV research. It is a method for studying genetic code fragments and matching them to similar fragments, not for identifying viruses as the cause of AIDS or any other illness. He says that humans are full of retroviruses, which have never been shown to kill anybody, and that the mystery of 'HIV' has been generated by the \$2 billion a year being spent on it (p. 191).

Sometimes scientists look for the genetic codes of the proteins used in the HIV test, wrongly presuming that these have been proved to belong exclusively to HIV. One of the main proteins associated with HIV is p24. Since HIV is believed to be a

retrovirus, reverse transcriptase (RT) activity is also seen as a sign of its presence. But both p24 and RT are well known to be normal constituents of healthy cells. Later it was claimed that p24 and RT from HIV have unique genetic code features that make them different from the common kinds, but it is impossible to identify unique features of a virus's proteins and enzymes without first isolating the virus.

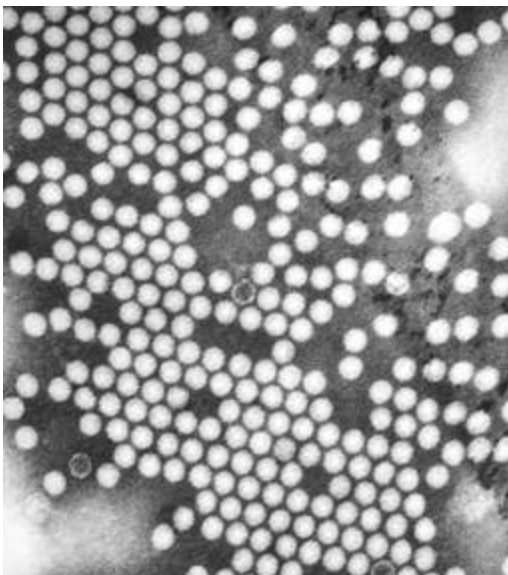
Many virologists equate the ability to grow a virus in a cell culture with the 'isolation' of that virus. To persuade blood cells to produce 'HIV', scientists stimulate them with chemicals such as PHA, which induces cell division and RT activity, and causes red blood cells to clump together. They then add a sample from a patient. Any resulting damage is assumed to be caused by an unseen virus in the sample from the patient, not by PHA. To persuade cells to produce flu viruses, scientists use things like trypsin, an enzyme that breaks down proteins. The established theory is that a virus infects cells and this makes them produce more such viruses. But an important part of the process is exposing the cells to toxic chemicals, with different chemicals being used to produce different viruses. It makes no sense to add a toxin and then blame the resulting illness solely on a virus. Roberts writes (p. 251):

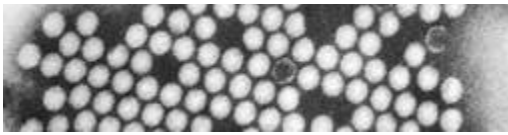
Confirmation that a virus is responsible for an illness is now usually sought through experiments in which cells are exposed to 2-3 milligrams of fluid from a sick patient. If the cells then fall ill, it is often simply assumed this is caused by a



virus in the fluid, while other elements that may cause this are not tested for, such as free DNA, proteins, cellular debris, other viruses, mycoplasmas, possibly prions and of course toxins.

Clearly, 'HIV' is extremely elusive. Like the Perth Group, virologist and evolutionary biologist Stefan Lanka contends that it does not exist. He says that all genuine retroviruses are the body's own creations and are harmless – and therefore should not really be called viruses. He also says he knows of no evidence for the complete isolation of any pathogenic virus. He interprets the published electronmicrographs of disease viruses as either showing parts of the intra- and intercellular transport system (such as vesicles), or structures that arise from improper preparation of samples for the electron microscope ([neue-medizin.com](http://neue-medizin.com); [whale.to](http://whale.to)). And even if a virus were to be properly isolated, proving that it is the cause of disease would require controlled experiments far more rigorous than those conducted to date.





Electronmicrograph of 'poliovirus'. Stefan Lanka argues that the particles are artificial, 'generated by suction of an indifferent mass through a very fine filter into a vacuum'. ([wadsworth.org](http://wadsworth.org))

## HIV/AIDS: a deadly scandal

The first victims of AIDS in the late 1970s and early 80s were suffering from fungal pneumonia (the main cause of death), thrush and/or skin cancer. Most of them were gay males who participated in the partying scene, were highly promiscuous, and made widespread use of recreational drugs, especially inhalants such as poppers (amyl nitrite), along with crack cocaine, LSD and crystal meth. They were also being prescribed steroids and antibiotics for multiple sexually transmitted diseases. All these drugs are immunosuppressant. Numerous papers were published arguing that AIDS resulted mainly from exposure to toxic drugs, and some doctors reported curing some cases of AIDS by using antitoxins.

In 1982 the Centers for Disease Control and Prevention (CDC) announced that the cause of AIDS must be an unknown virus and ordered that all the research they funded on AIDS should be directed towards finding it. The Food and Drug Administration (FDA) also redirected its funds, and its research into AIDS-related toxins ceased. In April 1984,



Robert Gallo, who worked for the National Cancer Institute (NCI) of the National Institutes of Health (NIH), announced that his laboratory had succeeded in proving that a retrovirus was the cause of AIDS.

### ***Gallo's fraud***

In 1982, Gallo announced finding traces of a new retrovirus, which he named HTLV-3, in the blood of AIDS patients. But all his efforts in 1982 and 1983 to prove that HTLV-3 caused AIDS ended in failure. In 1983, Luc Montagnier and his colleagues at the Pasteur Institute in Paris announced that they had found and purified the virus that probably caused AIDS, and named it LAV. The two laboratories were in the habit of exchanging samples, and Gallo declared that *he* had found the virus first, and that the French scientists' LAV was his own virus. At his request, the French sent him a sample containing their virus, on condition that he did not make commercial use of it.

Gallo and several of his assistants published four key papers in *Science* in May 1984, claiming to prove that HTLV-3 was the cause of AIDS. The experiments were conducted by Gallo's assistant, Mikulas Popovic, while Gallo was away in Europe already boasting of their success. The papers were submitted at the end of March, after Gallo's return. He then briefed the Department of Health on his discoveries, and leaked information to the press. This forced the Reagan

administration to swiftly lodge the relevant patent papers and make his discovery public before the supporting scientific papers could be peer-reviewed and published. The press ignored the Health Secretary's caution at a press conference on 23 April that Gallo had only found the 'probable' cause of AIDS. Three days later the leading science journal *Nature* ran the headline: 'Causation of AIDS revealed'.

The French immediately began legal action, claiming that Gallo and Popovic had illegally used the loaned French-discovered virus LAV. After three years of wrangling, the two sides agreed to rename their virus HIV and share the patent; Gallo, Popovic and Montagnier would each receive \$100,000 a year in royalties. But in 1989 journalist John Crewdson published a lengthy article detailing how Gallo had purloined the French virus for his vital 1984 experiments after failing with his own virus. The French threatened further legal action and as a result several high-level investigations, lasting until 1995, were carried into possible fraud in Gallo's HIV research. Despite efforts to water down the findings, they were still damning – yet they have been quietly buried and forgotten.

Among the documents the investigations unearthed, Janine Roberts found the draft of the key *Science* paper, whose lead author was Popovic, which supposedly proved that HIV caused AIDS by killing T-cells. It had been typed by Popovic, and Gallo was given the draft on his return from Europe, a few days before the papers went to the publisher. But Gallo

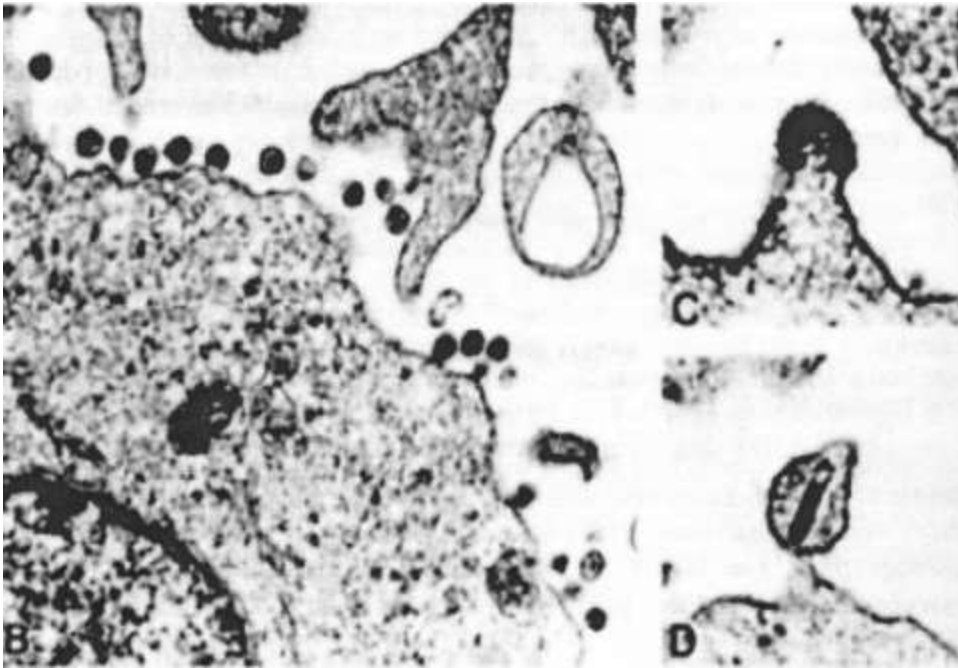
extensively rewrote the paper in his own hand before submitting it. For instance, he changed the title of the paper, to claim that they had isolated the virus, even though the paper described no experiments to isolate it. He deleted a statement that they had knowingly used the French virus. He also deleted the following sentence: 'Despite intensive research efforts, the causative agent of AIDS has not yet been identified', and replaced it with a statement that their findings suggested that their HTLV retrovirus caused AIDS. Yet even the published paper presents no evidence proving that HIV kills T-cells.

[T]he paper simply stated that proteins thought to be from a virus were found in serum samples from less than half of the AIDS patients tested. This was not just weak evidence. It established no causal relationship at all. (p. 131)

In 1994 Gallo admitted that they not found HIV DNA in T-cells. This meant his team had not provably found a single HIV-infected T-cell. Popovic and Gallo assumed, without any justification, that the reverse transcriptase (RT) activity and p24 protein they detected in their patients' blood indicated the presence of their retrovirus. Yet RT is part of all our cells as well as of all retroviruses and of some viruses, and p24 is present in all human cells and is released into the blood when cells die. The *Science* papers argue that 'HIV proteins' are proved to be from HIV because antibodies proved to be against HIV attack them, and that these antibodies are proved

to be against HIV because they attack these proteins – a circular argument.

Gallo sent Matthew Gonda, another NCI employee, some samples he believed to contain HIV and asked him to make electron microscope images of the virus for use in his 1984 articles. One of the *Science* articles contains four micrographs credited to Gonda, and Gallo declares that all the particles are of the right shape and size to be HTLV-3. Yet in his reply to Gallo, received a few days before the articles were submitted, Gonda himself said that the particles thought to be HIV were at least 50% smaller than they should be if they were retroviruses, and were simply cellular debris.



Electron microscope image of HTLV-3 published by Gallo in *Science* in 1984. The large object on the left is part of a blood cell, and the dots around it are supposed to be HTLV-3. The scientist who made the image said it showed no extracellular

virus-like particles at all. (p. 142)

Given the weakness of Gallo's arguments, it is easier to understand his subsequent behaviour:

[A]gainst all scientific norms, he afterwards refused samples of his culture and virus to scientists whom he suspected might want to verify his conclusions and imposed on others an outrageous agreement that they would not use them to attempt to repeat these experiments. It may also explain why Gallo documented their experiments so badly, according to the ORI [Office of Research Integrity] ten years later, that it had proved impossible to repeat them, leaving scientists, and all of us, having to rely on trust that he got things right. (p. 140)

In 1991, an 18-month investigation by the NIH into Gallo's 1984 article reporting the isolation of the AIDS virus concluded that it was 'riddled with fabrication, falsification, misleading statements and errors'. Yet the same article is cited today as establishing for all time that HIV causes AIDS (p. 121).

In 1993, the Office of Research Integrity (ORI) drew up a devastating indictment against Gallo, saying that he 'repeatedly misrepresents, distorts and suppresses data in such a way as to enhance his own claim to priority and primacy in AIDS research', that the key *Science* paper 'contains numerous falsifications', and that he had 'impeded scientists wanting to follow up on his research'. The adjudication panel, which consisted of lawyers, accepted that

Popovic had published careless, inaccurate and deceptive research but still deemed him innocent because 'intent to deceive' had not been proved. As a result, ORI felt it had no choice but to drop its attempt to find Gallo guilty of scientific misconduct as it could not prove intent.

A congressional subcommittee headed by John Dingell then heard evidence from the US Secret Service. The latter had been asked to examine for fraud the laboratory documents Gallo had submitted as legal evidence, and discovered that many had been altered and 'fixed' before being presented. This evidence of criminal fraud was presented to the state attorney general in January 1994, but he ruled it was 'out of time', as more than five years had passed since the alleged fraud had taken place. Gallo therefore escaped prosecution on a technicality.

The Dingell Inquiry never reached a formal conclusion because when the Republican Party took control of Congress in 1994, it promptly killed the investigation of the Reagan-endorsed Gallo. However, Dingell's staff published an unofficial report. It rejected Gallo's claims to have isolated HIV in dozens of AIDS patients in 1982 and 1983 by detecting antibodies specific to it, because it is impossible to prove an antibody targets the AIDS virus before proving what virus causes AIDS. Gallo admitted under interrogation that he had only detected the enzyme RT, not the virus. The report also referred to Gallo's systematic rewriting of the key *Science*

paper. It concluded that his behaviour had led to 'a corpus of scientific papers polluted with systematic exaggerations and outright falsehoods of unprecedented proportions' (pp. 125-6). But the *Science* papers were never withdrawn or even corrected. Few AIDS scientists today know that these seminal papers – among the most cited in the world – were thoroughly discredited by eminent scientists. As Roberts says, this is 'totally amazing, almost unbelievable' (p. 126).

The upshot was that the US gave the French millions in profit from the AIDS test patent. Gallo was forced to leave the National Cancer Institute, and proceeded to set up his own Institute of Human Virology. He often repeats the discredited claims made in the *Science* papers. And today the White House, the Bill Gates Foundation and the US Defense Department generously fund his Institute, which advises African governments on AIDS and develops new HIV tests and treatments.

Luc Montagnier's claim that his team had purified 'HIV' in 1983 is equally false. It was based on the fact that their patients' serum contained antibodies that reacted with the p24 protein and also showed signs of reverse transcriptase activity. In 1997 he admitted that they had not found any particles with the morphology typical of retroviruses in the serum, let alone a specific retrovirus; 'I repeat, we did not purify', he said. In 2005 one of Montagnier's coauthors said that the reason they did not publish any electronmicrographs of purified HIV was

because they never saw any virus particles in the 'purified virus' – only cellular debris (p. 194; [theperthgroup.com](http://theperthgroup.com)). Yet in 2008 Montagnier was awarded a Nobel Prize for discovering HIV in 1983.

### ***AIDS and sex***

AIDS was immediately assumed to be caused by a sexually transmitted virus due to the high level of promiscuity among the gay males who first succumbed to it. It was therefore predicted that AIDS would soon affect heterosexuals to the same degree as homosexuals. In 1985 the CDC created panic by announcing that over 1.5 million American heterosexuals were already infected and would die within two years.

Needless to say, nothing of the kind ever happened. In the West it is still mostly gay men who are getting AIDS – accounting for 84% of AIDS patients in the UK. The sexual transmission of the 'AIDS virus' is also contradicted by the fact that increases in infections with sexually transmitted diseases do not correlate with increased HIV infection and by the absence of HIV among female sex workers who do not use intravenous drugs.

The largest ever scientific study of the risk of HIV infection through heterosexual sex was conducted by Nancy Padian in 1997 (pp. 149-51). For several years she monitored a large number of couples, of which one partner was HIV-positive at the start of the study. But despite a quarter not using condoms



consistently, not a single case of HIV transmission was found. Neither failure to use a condom, total number of sexual partners, nor lifetime number of sexually transmitted diseases was correlated with infection. By making the unwarranted assumption that the couples she had excluded from her study because both partners were already HIV-positive must have previously infected each other through sex, she estimated that an HIV-positive man would pass on HIV once in 1000 acts of unprotected intercourse and an HIV-positive woman would infect a man once in 8000 unprotected acts.

This poses a major problem: in Africa, females are infected by HIV to at least the same degree as men and this is attributed mainly to heterosexual transmission, but this would require a monumental amount of sex. Despite there being no evidence that Africans are far more promiscuous than westerners, HIV=AIDS proponents still tend to believe that black people are sex-crazed.

### ***AIDS redefined***

Unlike other viruses, HIV is not believed to cause a specific disease of its own (strictly speaking, AIDS is a syndrome, not a disease); instead, it is said to attack the immune system, making people more susceptible to a large number of existing diseases. In 1981-82 AIDS was mainly characterized by three illnesses: fungal pneumonia (PCP), thrush (Candida), and skin cancer (Kaposi's sarcoma). After HIV had been declared the

cause of AIDS in 1984, the presence of the virus became the major AIDS-defining condition; since HIV itself could not be detected in patients, finding antibodies to 'HIV proteins' was considered sufficient. If antibodies were found, people were told they would be dead within 10 years.

In 1987 the CDC instructed doctors to diagnose AIDS even in HIV-negative people if they suffered from any of the AIDS-indicating illnesses on its list and had a CD4 T-cell count below 400 per microlitre. To the original three illnesses on the list, the CDC now added a further 14. A person who tested HIV-positive could also be diagnosed with AIDS if they had just one of the illnesses on a long and different list, which included septicaemia, pneumonia, meningitis, bone or joint infection, or a bacterial abscess in an internal organ. Finally, a person could be diagnosed with AIDS if they were HIV-negative and had an opportunistic disease not on the AIDS list (including bronchitis and a persistent herpes ulcer) but had been exposed to other people with AIDS. The new definition caused AIDS cases in the US to shoot up by 280% – which was excellent news for the AIDS industry.

The last major redefinition of AIDS took place in 1993, and again more than doubled the size of the epidemic. This time the CDC allowed AIDS to be diagnosed in people who had none of the AIDS-indicating illnesses, and even no symptoms of illness at all, if they had a CD4 count of below 200 per microlitre (in the UK a person was required to be both HIV-

positive and have a CD4 count below 300). In addition, three diseases were added to the list of 23 AIDS-indicating illnesses: TB, bacterial pneumonia, and invasive cervical cancer. The addition of TB greatly swelled the numbers of the poor diagnosed with AIDS. The number of women said to have AIDS went up by 300% in the US.

There is no clear connection between severity of illness and the number of T-cells. One study found that the number of T-cells in a healthy person can range from 237 to 1817. Factors that can reduce the number of T-cells include chronic drug addiction, severe malnutrition, chronic fatigue syndrome, and the stress of being told you are HIV-positive and are going to die.

### ***AIDS tests***

HIV tests look for antibodies to 'HIV proteins'. As Roberts says, 'there is something very odd about using an antibody test to identify the presence of a virus – for antibodies are said to remove viruses – and to persist in the blood, giving us continued protection, long after the virus is defeated and removed' (p. 196). Antibodies do not always stop us getting a disease, but to conclude from their presence that we're doomed is certainly rather peculiar.

It is estimated that humans naturally produce some 10 billion different antibodies. Antibodies are molecules created by certain white blood cells (B-cells) to mark foreign molecules

for destruction by sticking onto particular surface features of them. For the HIV antibody tests to be accurate, the antibodies must react solely with HIV proteins (or antigens, i.e. substances provoking an immune response). It is now well established that antibodies can react with multiple antigens – a fact generally ignored by AIDS scientists ([theperthgroup.com](http://theperthgroup.com), pp. 86-91). Even the manufacturers of HIV tests admit that the tests are unreliable. The following medical conditions may give a false-positive result: multiple pregnancies, blood transfusions, vaccination against flu/tetanus/hepatitis/HIV, malaria, kidney failure, liver failure, rheumatoid arthritis, herpes, hepatitis, tuberculosis, fungal infestations, leprosy and autoimmune diseases (pp. 198-9).

The main HIV test is the ELISA blood test. It involves exposing the patient's blood to the 'HIV proteins' provided in the test kit. If enough antibodies in the blood adhere to these proteins, this produces a colour change that indicates a positive result. First, however, the blood sample is diluted 400 times – a highly unusual requirement. This is because without dilution so many people would test positive for HIV that the results would not be credible. 'HIV proteins' may simply be a natural signal of cellular death but barely detectable in a healthy person (p. 227).

If blood gives a positive result in the ELISA test, further tests are performed. In the US the Western Blot test is used, which again looks for antibodies. The sample is separately exposed

to several HIV proteins, giving a separate reading for each one. For a positive result, some countries require that two proteins test positive, while others demand three or four. So whether somebody is HIV-positive or -negative may depend on what country they're in. In the UK the Western Blot is viewed with suspicion, so two other tests are usually performed. The p24 test can be one of them though nowadays it tends to be incorporated in the blood test. As already noted, p24 is a normal part of healthy cells and plays a key role in the creation of the vesicles our cells use as transports. In one experiment p24 was detected in 70% of healthy and HIV-negative people, while in another it was found in only 24% of HIV-positive people.

The 'viral load' test is used to monitor the progress of HIV infection and the response to antiretroviral treatment. It uses the polymerase chain reaction (PCR) technique to search a sample of blood for tiny fragments of genetic code said to come from HIV. However, there is no clear correlation between a high viral load and ill health. Each of our cells contains about five feet of DNA, much of it coming from retroviruses, and when our cells naturally die, a vast amount of this genetic code is fragmented out into our blood. Many events, including vaccinations, may sharply increase the numbers of relevant genetic code fragments in our blood.

Although hundreds of billions of dollars have been spent on AIDS research, no cure or vaccine has been found. In 2007

the Merck anti-HIV vaccine trials were abandoned when it was found that those who had been vaccinated were more likely to get immunodeficiency disorders than those who had not (p. 203).

### ***Africa's epidemic***

It is common knowledge that AIDS is rampant in Africa and affects males and females alike. But few are aware that AIDS is diagnosed entirely differently in most of Africa. Under the WHO's Bangui definition, Africans are diagnosed with AIDS if they score at least 12 points based on a list of symptoms which includes: over 10% weight loss (4 points), protracted weakness (4), prolonged fevers for a month or more (3), prolonged diarrhoea (3), thrush (4), persistent cutaneous herpes (4), shingles (4), persistent itching (4), and a cough (2). Such symptoms are of course common to many diseases ultimately caused by poverty, malnutrition, unclean water supplies and lack of sanitation.

Despite the artificial 'AIDS epidemic', the WHO says that there are more cases of TB and malaria every year in Africa than the total number of African AIDS cases reported since 1982. But less than a hundredth of the money spent on chasing the AIDS virus is currently spent on fighting TB or malaria (which can both give false-positive results on the HIV test). African governments are under enormous pressure to divert resources to pay for expensive antiretroviral medicines. And

doctors are tempted to use the lax standards of the Bangui definition to declare that their patients have AIDS in order to secure desperately needed funds.

Only in South Africa is an HIV test now compulsory. The WHO calculates its AIDS epidemic statistics for South Africa from the presence of 'HIV antibodies' in blood tests done on a few thousand pregnant women attending clinics – despite research showing that healthy human placentas often contain retroviruses that give a false-positive result.

WHO field reports show that around 70,000 Africans a year test HIV-positive, but its annual estimate for AIDS in Africa is calculated by multiplying these reported cases by a large 'error factor' to account for 'underreporting'. In 1996 it multiplied the number of registered AIDS cases by 12, and in 1997 by 17. Something similar happens in Asia. In the Philippines, the health minister initially multiplied the 50 detected HIV/AIDS cases by 1000 to obtain an estimate of 50,000. Reported AIDS cases in most developing countries are therefore unreliable.

### ***Antiretroviral drugs***

Antiretrovirals are not designed to specifically target HIV but instead to destroy all retroviruses, most of which are native to us. The drugs fall into three categories: nucleoside RT inhibitors, non-nucleoside RT inhibitors, and protease inhibitors.

Nucleoside RT inhibitors target the bone marrow cells that make our red blood cells and hinder their ability to use reverse transcriptase (RT), which is vital to our cells' ability to make new cells; these drugs are also known as 'DNA chain terminators'. They inhibit mitochondrial DNA synthesis, resulting in severe lack of energy, chronic body wasting, and greater susceptibility to infections – all symptoms of AIDS. These drugs include AZT, which is marketed today as Retrovir or Zidovudine. When first developed as chemotherapy against leukaemia, AZT was rejected as too dangerous because it killed the blood cells it was meant to save. With the emergence of AIDS, the US health authorities gave it a three-month safety trial but this went seriously wrong when patients in the placebo group insisted on moving to the group taking AZT. The need for a drug against HIV was judged to be so urgent that it was still released. Within two years, one third of the patients given AZT in the trial were dead. Today the dose of AZT has been sharply cut, but many patients still develop serious anaemia and require blood transfusions. In May 2000, the inventor of AZT, Richard Beltz, wrote to [Anthony Brink](#), who campaigns against the use of antiretrovirals in South Africa, to wish him success in stopping the use of AZT, due to its toxicity and devastating side effects (pp. 207-8).

Deadly toxic chemical hazard warning on tiny 25 mg bottles of AZT supplied by Sigma Chemical Co. to research laboratories. Patients, who do not get to see this label, are prescribed a daily dose 20 to 50 times greater.



([communicationagents.com](http://communicationagents.com))

Non-nucleoside RT inhibitors attach drug particles to RT within cells to prevent it from working, thus helping to stop cells from making retroviruses. One of these drugs is Nevirapine. The CDC warns that it can produce liver damage severe enough to require liver transplants and has caused death. The US has banned its use for pregnant American women, but the drug is still prescribed for pregnant mothers and others in Africa, with strong support from pro-antiretroviral activists and international agencies.

Protease inhibitors target the protease (an enzyme that digests proteins) used by our cells to enable the creation of more cells. One study found that levels of blood lipids high enough to cause cardiovascular morbidity occurred in 74% of patients on these drugs (p. 208).

Nowadays, patients are usually given a cocktail of three antiretroviral drugs as part of highly active antiretroviral treatment (HAART). The value of the antiretroviral drug market is expected to rise from \$9.3 billion in 2007 to \$15.1 billion in 2017 ([pipelinereview.com](http://pipelinereview.com)).

Antiretrovirals are designed not to cure but to extend the life of those with AIDS. Yet the Food and Drug Administration (FDA) requires all ARV manufacturers to supply a package insert stating that the drugs are not proved to increase survival. The insert for Glaxo's Ziagen drug says: 'At this time there is no evidence that Ziagen will help you live longer or have fewer of

the medical problems associated with HIV or AIDS.’ Merck’s protease inhibitor insert states: ‘It is not yet known whether Crixivan will extend your life or reduce your chances of getting other illnesses associated with HIV.’ The disclaimer for Boehringer Ingelheim’s Nevirapine reads: ‘At present, there are no results from controlled clinical trials evaluating the effects [on] the incidence of opportunistic infections or survival’ (p. 212).

In 2008, pharmaceutical companies were conducting 15 antiretroviral drug trials using HIV-positive children from Incarnation, a Christian home for orphans based in New York. In some cases the drugs are forcibly administered through surgically inserted stomach tubes. One experiment evaluates the effect of drugs on children from one month old who at the start had no symptoms of AIDS. In another, children from four years old are given cocktails of seven antiretroviral drugs in higher-than-usual doses as a ‘salvage therapy’ for advanced AIDS patients. An earlier trial in the USA, in which AZT was given to HIV-positive pregnant women, was halted when their children started to be born with too many fingers and toes (pp. 212-13).

Antiretroviral drugs have often been released without long-term safety studies and placebo trials mandatory for other drugs, on the grounds that AIDS is a medical emergency. But there is no denying that the side effects of these drugs are difficult to distinguish from the symptoms of AIDS itself.

GlaxoSmithKline (GSK) bluntly warns: 'Prolonged use of Retrovir [AZT] has been associated with systematic myopathy [body wasting] similar to that produced by human immunodeficiency virus.' A medical study in 2003 found that 'opportunistic infections, AIDS-associated malignant conditions and other non-infectious diseases ... often appeared shortly after the introduction of HAART' (p. 206).

In an attempt to hide the fact that antiretroviral drugs help bring about AIDS, the illnesses caused by these drugs have now been made an illness in their own right, known as immune reconstitution syndrome (IRS) or immune reconstitution inflammatory syndrome (IRIS). It has many of the same associated illnesses as AIDS, including Kaposi's sarcoma, mycobacterium avium complex disease (MAC), tuberculosis (TB), Cryptococcus, Pneumocystis pneumonia (PCP), Cytomegalovirus, Histoplasmosis, herpes, leukoencephalopathy, leprosy, meningitis, and lymphoma (p. 211).

Today liver disease has become the leading cause of death among HIV patients on antiviral medicines in the US. Liver disease is not listed as an AIDS disease, but it is often related to exposure to toxins. One AIDS researcher called this the 'dark side' of antiretroviral drugs (p. 208). Other major side effects are cancers and heart disease – again major killers in AIDS cases. A study in 2000 concluded: 'There is growing concern about the long-term toxicity and adverse effects of

therapy, including liver damage and mitochondrial toxicity caused by nucleosides, the most studied anti-HIV drugs' (p. 207).

In the early days, ARV drugs killed patients quickly, but this is no longer the case. Some patients on antiretrovirals report health improvements, at least in the short term. The main reason why some patients on antiretrovirals may live longer is that in western countries more and more *healthy* people are being given the drugs. In the 1980s, most patients were only diagnosed with AIDS after coming down with deadly fungal pneumonia. But by 1997 (the last time the CDC published this statistic), 61% of all new AIDS patients in the US had no symptoms of any of the AIDS-defining illnesses. In the UK, although some 70,000 people have been found HIV-positive since 1984, less than 800 have been diagnosed with AIDS. Yet 38,000 of these HIV-positives have now been prescribed HAART. In Africa, on the other hand, people normally need to have symptoms of illness to be diagnosed as 'HIV-infected', so they survive for much less time on these drugs.

Other important factors in patients' response to antiretroviral drugs include the following: the drug doses have been lowered and their compositions are now constantly changed to reduce toxicity; they can act as powerful antibiotic and antioxidant agents (e.g. against *Candida* and PCP); our cells initially produce extra CD4 cells as a defence against the toxins, until they become overwhelmed; antifungal and antimycobacterial

medicines are commonly prescribed for HIV patients alongside antiretrovirals, and are even given priority over antiretrovirals on the grounds that antiretrovirals interfere with the former's effectiveness.

Numerous HIV-positive people who have refused antiretroviral treatment remain in good health; they are known as 'long-term non-progressors' or 'elite controllers'. However, those whose immune systems are already beyond repair will die. The UK government's Health Agency reported in 2007 that those who refused antiretroviral treatment account for 4.7% of deaths among the HIV-infected (p. 212). Or to put it another way: 95.3% of those who died were on antiretrovirals.

### ***What causes AIDS?***

A host of factors can impair our immune system and ultimately cause 'AIDS'. The role of immunosuppressant recreational and prescribed drugs in a large proportion of western AIDS cases is well established. Statistics reveal an 80 to 90% correlation between the use of nitrite inhalants (poppers) in the early AIDS cases in the USA and UK, and a 60% correlation with crack cocaine. This contrasts with a 10 to 15% exposure to injected drugs. Yet today only injected drugs are officially listed as a risk factor for AIDS.

AIDS was originally called gay-related immune deficiency (GRID). Many gays lobbied hard against the illness being linked to their lifestyle and hoped a virus would be found to be

its cause. Charges of homophobia were levelled at toxicologists who continued to blame drugs, while others in the gay community began an active campaign against poppers (which were used to intensify orgasm and facilitate anal sex by relaxing the sphincter). However, the campaign was undermined when the CDC stupidly declared poppers 'safe'.

Many scientists openly disagreed with the CDC's declaration in 1984 that a virus caused AIDS. Some FDA scientists accused the CDC of inventing a viral epidemic to give jobs to its virologists. The CDC and its parallel institution, the NIH, ended the investigation of poppers, even rejecting the cures toxicologists had suggested and tested for AIDS, on the grounds that antitoxins could not work against a virus.

In the 1980s a significant number of people tested HIV-positive who were not taking any recreational drugs, particularly among haemophiliacs. Blood supplies also tested positive to an extent that could not be explained by drug addiction. And Africans were testing positive who did not take such drugs. But testing positive does not mean that one must be infected with 'HIV', since many medical conditions can give a positive result, including fungal and mycobacterial infections.

The Perth Group argues convincingly that no one has ever isolated pure 'HIV', and that all the proteins that the orthodox AIDS theory interprets as components of HIV or of antibodies to 'HIV' can be expressed by the DNA of any cell in the human body subjected to a sufficiently high level of oxidizing damage,

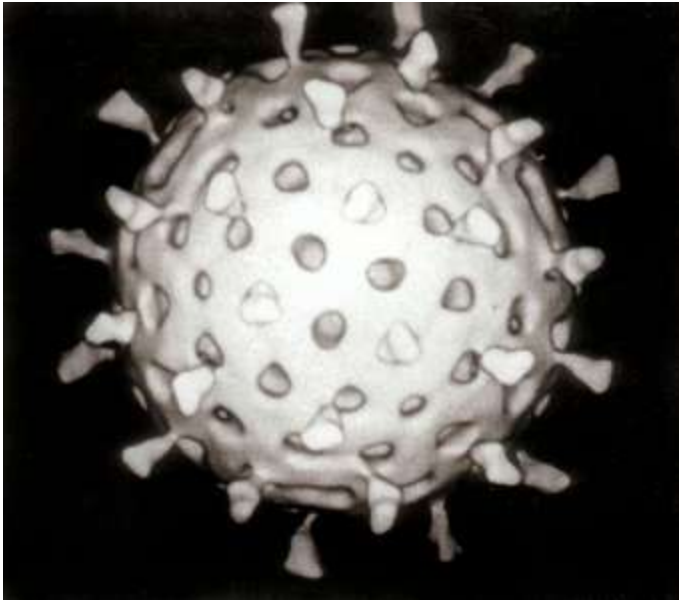
caused for example by chemicals (including recreational and prescribed drugs) or by malnutrition and unclean water supplies. Even Luc Montagnier – even though he still believes in the ‘AIDS virus’ which he helped to invent and which has made him so rich and famous – now says that the major killer of the cells in AIDS patients is oxidative stress.

Janine Roberts relates how some of her contacts and associates became very hostile and emotional when they learned that her research had forced her to question the orthodox HIV=AIDS theory; they dismissed her as a ‘denialist’ and treated her like a heretic. Roberts comments, ‘it is now fashionable among the great and good, among journalists and NGOs, to wear the HIV/AIDS theory as if it is a Bob Geldof endorsed fashion accessory that puts one among the saints’ (p. 169). Yet the theory is untenable and has done untold harm. For many people, unfortunately, it is extremely lucrative.

## **Cells, viruses and health**

A virus is approximately a billion times smaller than a cell. All viruses are produced by cells, whether from humans, animals, plants, fungi, or bacteria. There are said to be millions of different types, of which 5000 have been described in detail. They are made up of short segments of genetic material – DNA or RNA – surrounded by a protein coat, sometimes protected by an outer spiky layer called a lipid envelope. Unlike bacteria, viruses have no metabolism; they are inert

and unable to reproduce outside cells, but reproduce within cells through self-assembly. They are officially labelled 'dead', though that does not stop virologists from describing them as cunning invaders that hijack cells, force them to serve their needs, and trigger unknown cellular processes that result in cell damage or death. There is no convincing evidence that once a virus has been absorbed by a cell, it remains independently alive and is more the parent of viruses subsequently produced by that cell than is the cell itself (p. 253).



Computer-assisted reconstruction of a rotavirus particle, believed to cause viral gastroenteritis. (en.wikipedia.org)

Cells naturally produce viral-like particles without being invaded, both when healthy and sick. Janine Roberts explains (pp. ix-x):

Scientists like Barbara McClintock, who won a Nobel Prize for

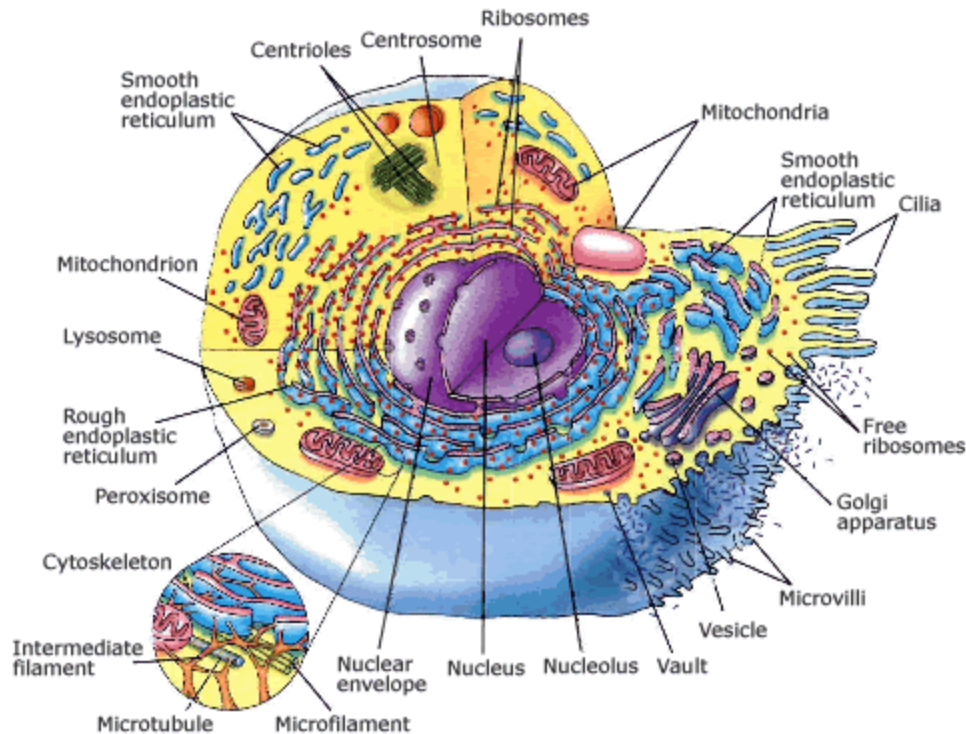


finding that cells operate with intelligence and seek to repair themselves, have given us a very different understanding of the particles they make. We now know that our cells create multitudes of tiny transport particles (vesicles) to carry the proteins and genetic codes needed within and between cells. The ones that travel between cells, those our cells use to communicate with each other – are puzzlingly just like those that we have long blamed for illnesses.

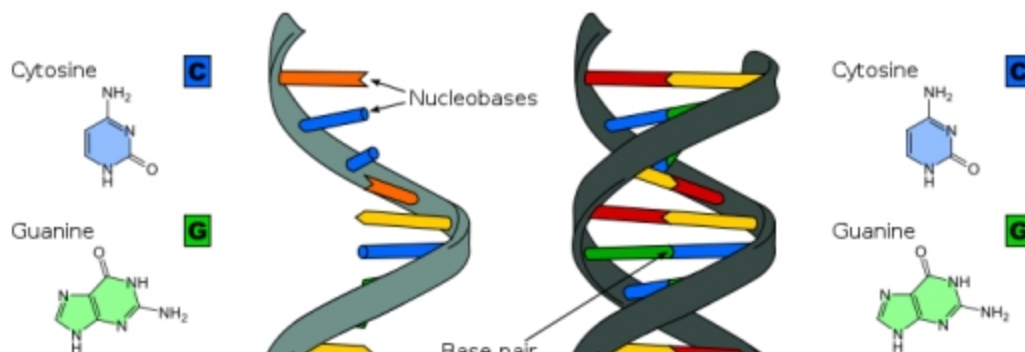
It now seems that we may have misconceived the virus; that most of them could well be simply inert messages in envelopes carried from cell to cell. In the last ten years scientists have begun to call them 'exosomes', 'particles that leave the body' of the cell, removing the inference that the word 'virus' carries, of them being dangerous by nature. Distinguishing the healthy particle from the pathogenic is now an enormous problem for the virologist, for it has been discovered that our cells make them all in the same way, in the very same place. It also seems we cannot stop this process without risking severely damaging our cells.

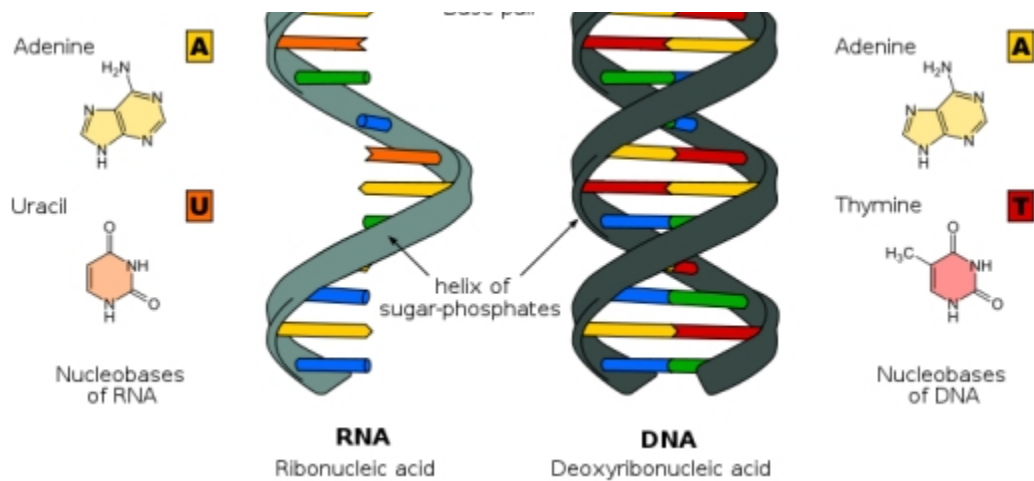
So, perhaps we need to halt the juggernaut of virology with its virus hunt, and look to see if there is another way of helping us keep healthy. We need to know how we can strengthen the malnourished cell, rather than use the many medicines that try to prevent it from making particles by interfering with its essential processes. We need to know if a poisoned cell may produce unhealthy messengers or viruses. We need to learn far more about cells – for only now are we starting to

understand how they communicate and the very important role played in this by the particles we had totally demonised as viruses.



A eukaryotic cell. Prokaryotic cells (e.g. bacteria) lack nuclei and most other organelles (small organs) while eukaryotic cells have both. Lynn Margulis was the first to argue that certain organelles (such as mitochondria) were once independent prokaryotic bacteria, which formed symbiotic partnerships with other cells. ([ez002.k12.sd.us](http://ez002.k12.sd.us))

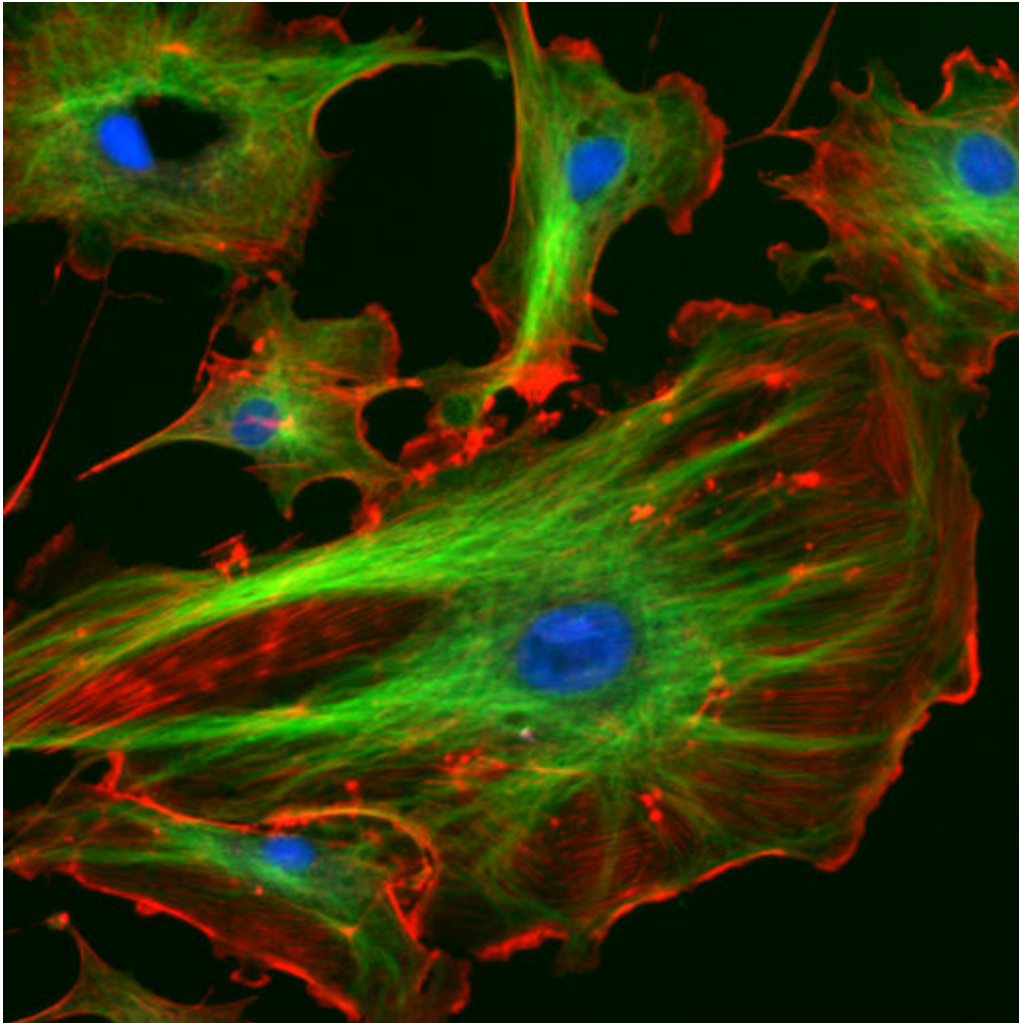




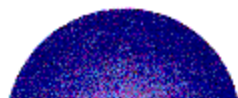
Ribonucleic acid (RNA) is a simpler form of deoxyribonucleic acid (DNA), and is believed to have evolved first. RNA is usually a single-stranded molecule with short chains of nucleotides, while DNA is a double-stranded helix with long chains of nucleotides. Messenger RNA (mRNA) relays the genetic information from DNA in the cell nucleus to the ribosomes where proteins are made. 'DNA makes RNA makes proteins' became the central dogma of molecular biology. Later it was discovered that retroviruses can reverse this flow of genetic information by turning their mRNA into DNA using the enzyme reverse transcriptase (RT).  
(commons.wikimedia.org)

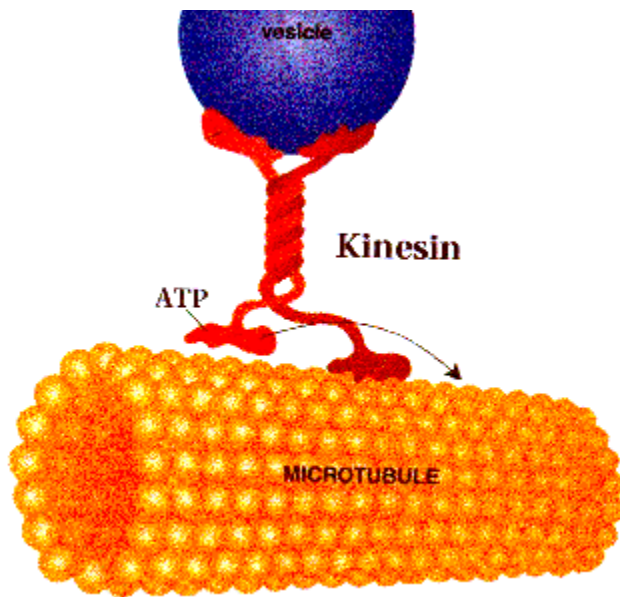
An adult human contains about 100 trillion cells, and for us to survive, these must work together, communicate with one another, and learn from each other. Cells produce hollow particles known as transport vesicles to carry cellular material both within a cell and to other cells. Within a cell, they carry their cargo (protein, enzymes and DNA) along intricate road systems of microtubules (hollow cylinders), linked to a finer

network of actin threads or nanotubes. Both networks constantly carry thousands of moving particles, supplying materials for some 100,000 chemical reactions per second. There are also nanotube bridges slung from cell to cell, carrying vesicles, proteins, organelles and possibly retroviruses.



Endothelial cells (i.e. cells lining the interior surface of blood vessels) under the microscope. Nuclei are stained blue, microtubules green, and actin filaments red. (en.wikipedia.org)





Kinesin transport molecule 'walking' along a microtubule, carrying a vesicle. The two feet, powered by ATP molecules, take precise steps of 8 nanometres, at the rate of about 100 steps a second. The microtubule is 25 nm wide and vesicles can be over 500 nm wide (pp. 233-4).

Transposons are mobile genetic elements that manipulate and transport DNA sequences to new places within a cell's genome. A retrotransposon uses RNA rather than DNA. It translates a segment of the cell's DNA into RNA, manipulates it, changes it back into DNA and reinserts it into the cell's genome in a new position – a process called transposition. Transposons and retrotransposons therefore enable cells to adjust their genetic codes to fight off toxins and meet environmental challenges. By appending an additional piece of code, a cell can transform its retrotransposons, give them the ability to travel between cells with their variable load of genetic codes, or make them into retroviruses.

All viruses cease to exist within a few hours or days after they enter a cell, which immediately takes them to pieces. In the case of retroviruses, their genetic code is absorbed into the cell's own DNA. The genetic codes of other viruses go elsewhere, often to the cell's cytoplasm. The reason retroviruses were initially discovered near tumour cells may be that they were helping cells fight pathogens and repair themselves. This might also explain why they are found entering and leaving T-cells, a phenomenon long associated with 'HIV infection'.

Many biologists today are no longer automatically naming all travelling elements viruses. Many are now called exosomes – a generic term for cellular vesicles containing DNA and RNA that are released into extracellular space and absorbed by other cells. Several scientists have recently placed the retroviral family, including 'HIV', among the exosomes.

Our cells use massive amounts of information with great computational skill, having in their DNA a massive 'read-write' memory. We can think of viruses, exosomes and retroviruses as the natural flash memory sticks used by cells to share encoded information with each other. By using a base of four – the four nucleotides of DNA or RNA – to encode information, rather than the base of two used by computers, our cells can pack an incredible amount of information into extremely small spaces (p. 244). DNA has a data density of over half a million gigabits per square centimetre – about 100,000 times greater

than a hard drive.

Cells communicate not only by means of exosomes or 'viruses' but also by movement, electric currents, chemical emissions (smells), magnetic fields, and almost instantaneous light signals. Water within the cell, rich in salts, preserves information and, as it flows, it generates the electric currents needed for signals sent through the nerves. When exposed to radiation or other causes of DNA damage, cells can produce the specialist p53 protein, which vibrates when it detects DNA damage.

Other molecules apparently vibrate to help regulate genes, almost as if they are talking. P53 molecules play an important role in regulating the production of exosomes and retroviruses – and thus also help to move information between cells. (p. 245)

Barbara McClintock's discovery that cells intelligently respond to the environment contradicts the darwinian theory, which is based on the idea that cells make random decisions. James A. Shapiro says (p. 257): 'We have progressed from the Constant Genome, subject only to random, localized changes at a more or less constant mutation rate, to the Fluid Genome, subject to episodic, massive and non-random reorganizations capable of producing new functional architectures.' This is a far cry from the reductionist, mechanical view of life. An instinctive intelligence exists at the cellular level in all parts of our bodies; from a theosophical perspective, this intelligence



arises mainly from the more ethereal aspects of each physical cell or organ rather than from their physical constituents. After giving examples of 'self-organization' in nature, Roberts suggests that life and consciousness 'are woven into the very fabric of our universe' (p. 258). The theosophic tradition would endorse this, adding that our physical world is merely the outer shell of inner, subtler, interpenetrating planes of consciousness-substance.

### ***Bacteria, viruses and disease***

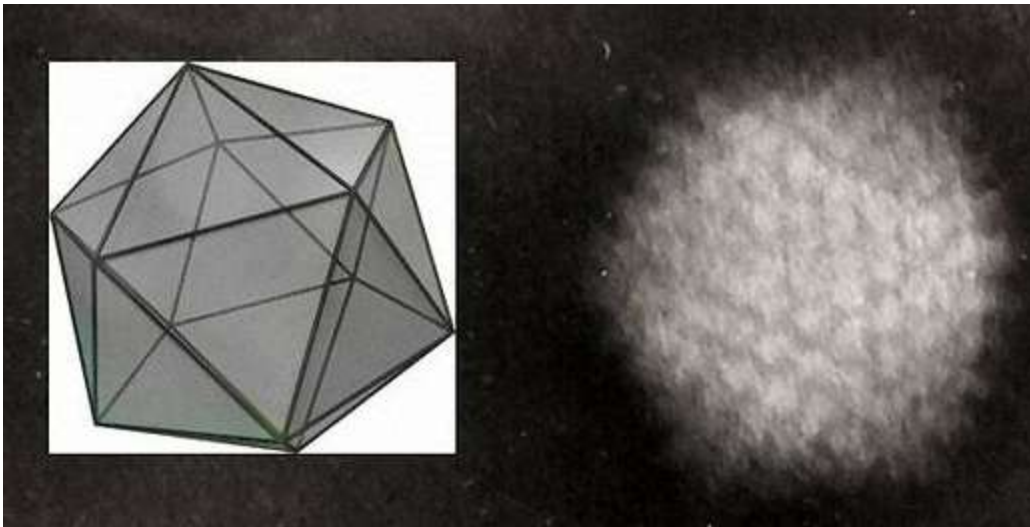
Nine out of every 10 cells in our body are bacteria. They can make toxins to kill pathogens, change their DNA, and make viruses that carry messages to other bacteria. Using the enzyme RT, they can change the proteins making up their 'skin' so that it is harder for enemies to recognize them. They can also take on specialized functions to serve the collective good of their colony. The smallest bacteria are called mycoplasmas, which are true parasites capable of living inside cells without harming them. For instance, we all have the tuberculosis mycoplasma within us. But only when our resistance weakens for one reason or another do we succumb to one or more of the pathogens living within us.

Bacteria sometimes take on the role of scavengers. They can multiply within us when cells die during a severe illness. As soon as they have completed this scavenging work, the bacterial numbers will naturally decline.



However, when human cells are severely diseased, bacterial cells may multiply out of control and produce toxic by-products, as in severe TB. Bacteria are intelligent cells that might well prefer to cooperate, but they might put their own survival first when necessary. They also bond with other bacterial cells to form self-protective 'biofilms' that are often hazardous to us. The NIH states that '80% of chronic infections are biofilm related' (and thus not viral). (p. 246)

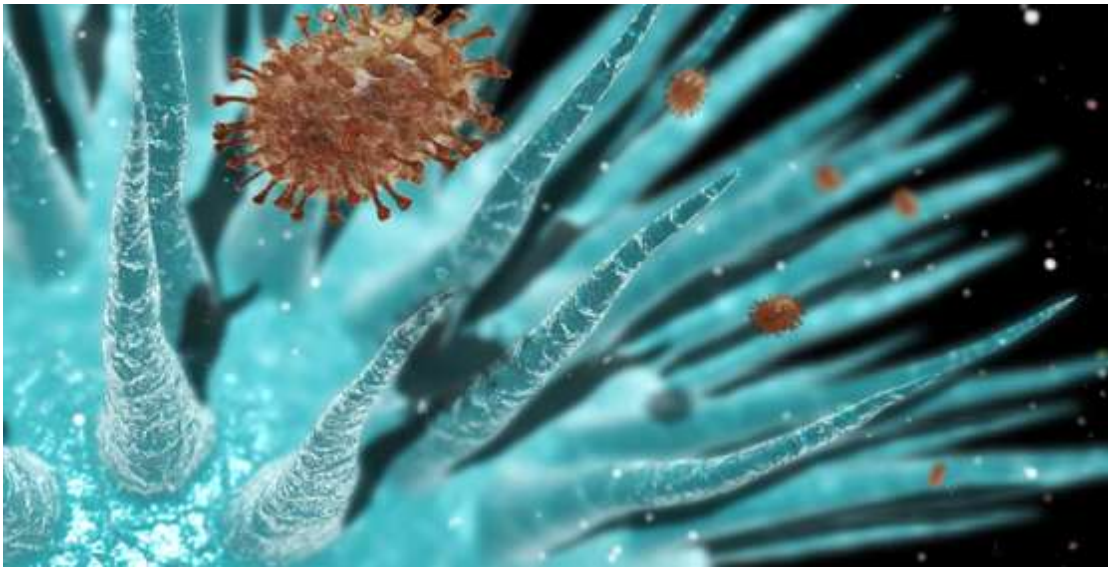
Viruses are commonly blamed for illnesses that seem to be easily passed from one person to another. They are unaffected by antibiotics; our only medical weapons against them are said to be vaccination and powerful chemotherapy-type drugs designed to stop cells from making viruses rather than to attack the virus itself. Roberts argues that viruses have been wrongly blamed for many diseases, including polio, flu, and AIDS. The devastating 1918 flu epidemic, for example, turned out to be primarily due to the victims being infected with bacteria, rather than a flu virus (p. 105). Although flu is commonly assumed to be spread by coughing, experiments to see whether people infected with a rhinovirus transmit it to people sitting opposite at a table proved unsuccessful. Equally unsuccessful was the transmission of influenza from one spouse to the other. What *is* certain is that our resistance to infections heavily depends on our living conditions, lifestyle, diet, and state of mind. For instance, living in crowded, unventilated and overheated rooms weakens our defences, as do stress, depression, grief, etc.



Electronmicrograph of an adenovirus, 90-100 nm in diameter, with an icosahedral structure. There are 53 described serotypes in humans, and they are said to be responsible for 5-10% of upper respiratory infections in children and many infections in adults. (en.wikipedia.org)

Research indicates that cellular stress, illness or malnourishment often precedes the production of viruses rather than the reverse. For example, a deficiency in selenium, a metal our cells use as an antioxidant, can precede the symptoms of colds, flu and even AIDS. Selenium deficiency makes cells ill with oxidative stress without any need for a viral illness, and these cells could produce viral-like particles as waste or for repair purposes. It has also been found that when cells are suffering from oxidative DNA damage (such as from chemotherapy), they are more likely to get hepatitis – which is then blamed on infection by hepatitis C virus (HCV).





‘Conceptual image’ of an influenza virus (brown) invading cilia (blue). ([janezlifeandtimes.wordpress.com](http://janezlifeandtimes.wordpress.com))

President Nixon declared a ‘war on cancer’ in 1971, predicting victory within five years. But the hunt for the viruses responsible for cancer ended in almost total failure. It was soon recognized that the major causes of cancers are toxins such as asbestos, tar and tobacco smoke, or damaging radiation. Many illnesses, including cancer, heart disease and different kinds of inflammation, are linked to disturbances in the DNA transcription process that is vital to cellular communications.

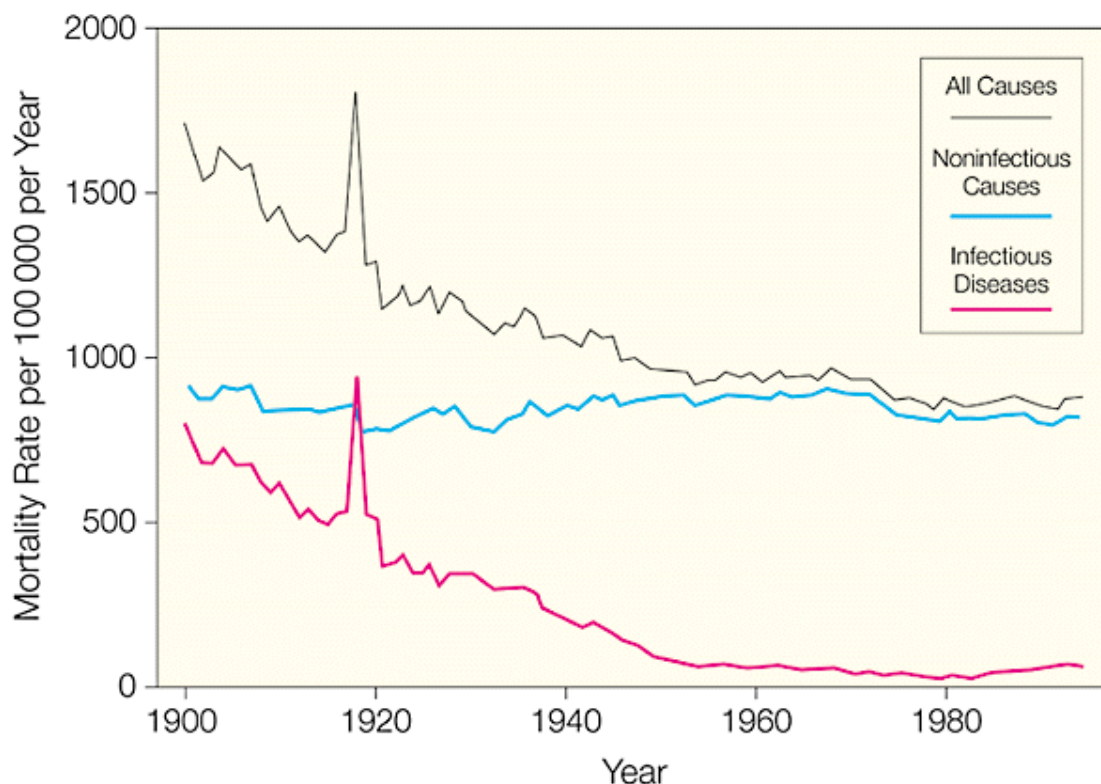
Janine Roberts does not exclude the possibility that there *are* pathogenic viruses, but she argues that this has not yet been established convincingly. Distressed cells might sometimes wrongly encode the viruses they send out, which then misinform other cells, or they might misinterpret the viruses or messenger vesicles they receive. As we have seen, no virus

has ever been isolated directly from a sick patient's cells. Since 'scientists have long known that the guaranteed way to make cells produce viruses in the laboratory, including flu and measles virus, is not primarily by getting them infected, but by exposing them to stress and toxins' (p. 249), more research ought to be carried out into the role of toxins in causing measles, mumps, flu, colds, etc. Similar viruses may be associated with similar diseases because cells respond in a similar way to specific challenges. Vitamin A deficiency is also implicated in measles. Beriberi and pellagra are examples of other diseases caused by nutritional deficiencies, but which were once blamed on bacteria.

If vaccines containing viruses are sometimes effective wouldn't this prove that the viral theory on which they are based is correct? First, as mentioned earlier, vaccine 'effectiveness' is measured by their ability to trigger antibody production – but antibodies do not guarantee immunity. Second, the presence of specific viruses in vaccines is assumed – not proved by observing the virus in question. Third, vaccines, even if they do contain a particular virus, also contain a wide range of other contaminants and toxins, and each of these will trigger an antibody response. So there is no doubt that the shock of vaccination stimulates antibody production. But it also entails many risks, especially since this toxic stew is usually injected directly into our muscles or bloodstream. A significant minority of vaccinees suffer adverse effects, and those whose immune systems are already

impaired or stressed or who have particular susceptibilities to certain vaccine ingredients can suffer serious side effects, permanent disabilities, or even death.

A far safer way of strengthening our immune system is homeopathy (see [Vaccination and homeopathy](#)). Like vaccines, homeopathic remedies often contain toxic substances, but these are diluted ('potentized') again and again and again until *no physical molecules* remain; they act on an inner, subtler level of our constitution. Vaccination can be regarded as a crude, dirty and grossly materialistic form of homeopathy.



Mortality rates for noninfectious causes, infectious diseases (bacterial and viral) and all causes in the US.

([jama.ama-assn.org](http://jama.ama-assn.org))

Most of the great epidemics of the past were successfully fought with clean water and improved nutrition and sanitation before most of the common vaccines were invented (see [Vaccination and homeopathy](#), section 3). Westerners have now moved into an age of degenerative and man-made diseases and away from infectious diseases, with the major causes being toxins and stress. But it is still 'viral dangers' that hog our medical research funds. Toxins from pesticides, drugs and other pollutants steadily accumulate and weaken our resistance, eventually wrecking our cells' protective abilities. Weaknesses in our character – which, from a theosophical perspective, is the product of multiple incarnations – may also predispose us to certain illnesses (see [Health and disease](#)).





([myspace.com/souldreams8](http://myspace.com/souldreams8))

In his introduction to *Fear of the Invisible*, Dr Roberto Giraldo writes (p. vi):

Our positive and negative emotions stimulate biochemical processes that can either heal or harm many of the body's tissues, organs and systems, especially the immune system. Therefore, the power of the mind and of our consciousness has a great capacity for good as well as for ill. ...

We are born with a gift from God: our inner physician and our inner pharmacy. Hippocrates (460-337 B.C.) said that 'the power of the patient's self-healing is essential and we must stimulate it.' The father of homeopathy, Samuel Hahnemann (1755-1843) said 'the homeopathic remedies work by stimulating the patient's defence mechanisms.' Dr. Albert Schweitzer (1875-1965) explained: 'In the interior of each patient there is a physician and we accomplish our mission when we help our patients stay in contact with their inner physician.'

Our bodies are the natural home for vast herds of bacteria and viruses. The vast majority of our cells are bacteria, which normally live in harmony with us and even process our food for us. Janine Roberts writes (p. 261):

As long as the whole exists in harmony, we basically stay healthy. They will serve us and not hurt us. Nearly all the so-called dangerous germs, such as TB bacteria, are inseparable and normally harmless companions that are only dangerous

when other factors seriously weaken our cells. ...

[W]e are made from cells capable of independent life that co-ordinate activity between themselves to sustain us! We are multi-species cities in which communications between inhabitants are absolutely vital to our continued communal health. ...

Surely it is time to leave behind this ugly obsession with unseen dangers – particularly from what are nothing more or less than cellular messengers – and to turn our attention to caring for the utterly marvellous cells of which we are made; that protect us well, that will make healthy viruses or exosomes when they are well nourished and not poisoned. Then we could appreciate the wonder we all are. We synthesize the intelligence of our cells. We are the natural masters of the life enjoyed by billions of cells and part of the greater dance that weaves our universe together.

Health of planet and body are preserved in the same way. Keep both unpolluted and unstressed. Enjoy having such inner and outer worlds to explore – and to nurture.

And don't let anyone use fear to manipulate you.

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by David Pratt. November 2010.

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[HIV=AIDS=Death: a killer myth](#)

[Vaccination and homeopathy](#)

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