Is HIV to AIDS what SARS-CoV-2 is to COVID?

by Torsten Engelbrecht, Kelly Brogan MD,
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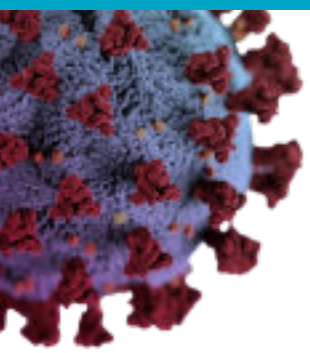


Is HIV to AIDS what SARS-CoV-2 is to COVID?

"The idea that certain microbes - above all fungi, bacteria and viruses - are our great opponents in battle, causing certain diseases that must be fought with special chemical bombs, has buried itself deep into the collective conscience. But a dig through history reveals that the Western world has only been dominated by the medial dogma of 'one disease, one cause, one miracle pill' since the end of the 19th century with the emergence of the pharmaceutical industry. Prior to that, we had a very different mindset, and even today, there are still traces everywhere of this different consciousness."

– excerpt from the book "Virus Mania" by Engelbrecht et al

IMAGINE AN ENEMY THAT IS INVISIBLE, like a ghost or demon, except to those who have special visionary powers. It lurks in unsuspecting places, turning every person and every place into a potential threat. Once it takes hold, there's no stopping it without the help of an arsenal of powerful poisons provided by the trusted protectors who are practiced at such exorcisms and know that their work inevitably results in some collateral damage. It's a necessary sacrifice to exterminate the enemy. All bow to those who might protect us from this demonic takeover. There is no sacrifice too great if it promises to save us from such possession.

What if we told you that there is as much evidence for germs causing (or being the primary cause of) illness as there is for demonic possession with invisible entities that make us cough, purge, and waste away? And what if our collective belief in contagion, infection, and associated precautions, preventatives, and treatments is actually a *belief system* that has been leveraged for a century in service of population control and even depopulation?

We assert that the notion of the SARS-CoV-2 virus causing "COVID" is a recapitulation of the international infectious disease coup that took hold in the 1980s, namely, that HIV causes AIDS. The aim here is to present our findings to propose that AIDS was a dress rehearsal for the present entrapment of citizens worldwide using the dominant COVID narrative.

But let's back up to confirm that our definitions are well-clarified.

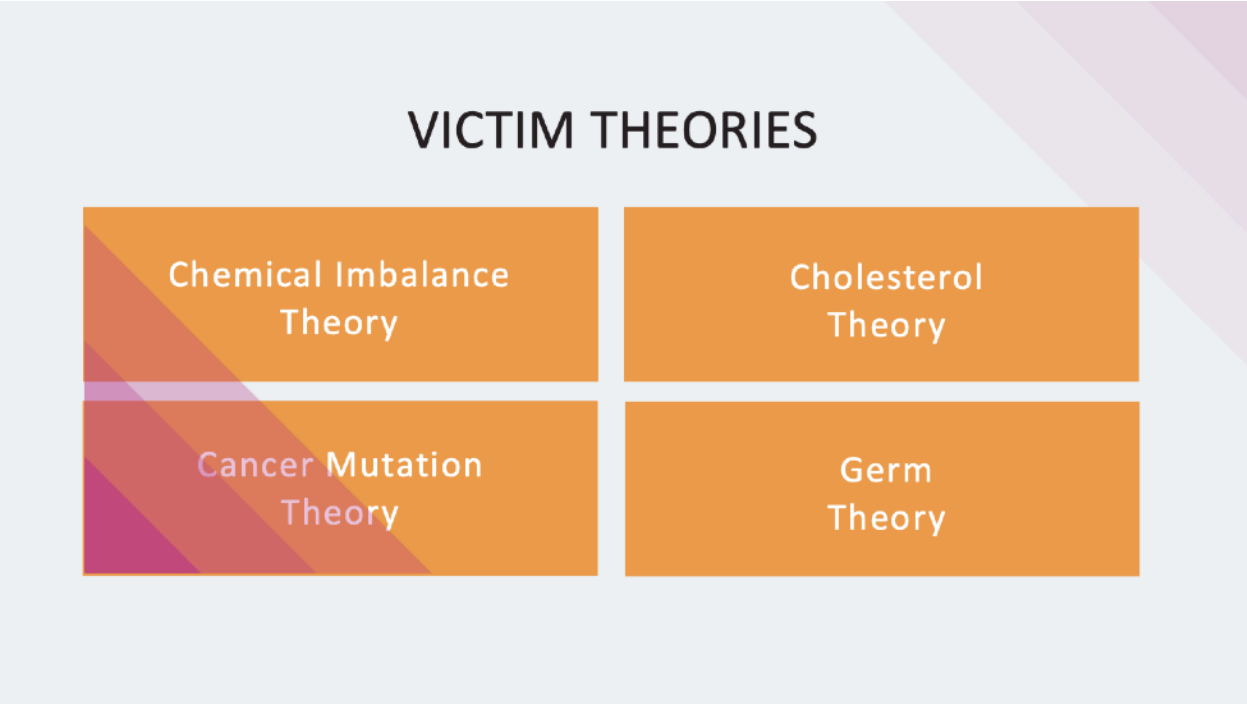
What exactly is the consensus theory of infection and contagion, otherwise known as *germ theory?*

Germ theory posits that microbes - including unmoving fragments of enveloped genetic material referred to as viruses - cause illness through exposure, bodily invasion, and replication, ultimately leading to disease, disability and death. Seems obvious, right? This theory also happens to be foundational to the Western allopathic medical system and the justification for public health measures imposed

in violation of bodily sovereignty (for example, mandated vaccination in exchange for “privileges” which may actually be inalienable rights). But what if germ theory and associated premises represent an incomplete (or complete mis!) understanding? What if the establishment's foundational validation of germ theory, called Koch’s postulates, have never actually been fulfilled by a single, so-called infectious agent? Koch’s postulates essentially state that a microbe must be isolated and purified from a sick person and then used to cause the same symptoms when introduced to another host. Furthermore, this microbe must be found in symptomatic people and not found in people without sickness symptoms. Given the lack of validation of Koch’s postulates, germ theory demands further inquiry.

But inquiry of this kind is not permitted because we have not yet acknowledged that medicine, itself, is a belief system. Many have believed, for example, that there is such a thing as a **chemical imbalance** that causes mental illness and that this imbalance must be managed with medications for life. These beliefs put the believer in a position of helplessness relative to a bigger force that they cannot match but can only mitigate. These beliefs keep us dependent victims, helpless in the face of our problems. They keep us fighting a war that can never actually be won because we are empowering the seeming enemy through our belief that this

enemy has power over us! **Belief in germs spreading and causing disease is what allows us, as a collective, to remain in the child psychology of fighting the bad enemy we seek to one day beat with the help of the parent we always hoped would protect us.** It is black-and-white survivalist thinking that keeps us stuck, afraid, and dependent on a system that tells us which people are safe and which are unsafe, and even invites us to police ourselves and others in the name of safety. It is also what leads us to dehumanize and objectify one another, wrapped up in the illusion that we are somehow made up of entirely different goodness than those whom we judge. It may feel to you like these are facts, not beliefs, but that's how all beliefs feel until we recognize that we have a choice to live by them…or to think differently.



The scientism alphabet

It is perfectly okay to be wrong and change your views; in fact, **that is what science is fundamentally about: a continual reckoning with inconsistencies and contradictions that reveal the tortuous path to truth.** If we had all the answers, there would be no need for scientific experiments. What has happened to science, however, is that it has become **scientism**, an ideological system of assumptions that render it dogma, complete with taboos that are never to be spoken of, addressed, or researched. Just think about the so-called "central dogma of biology," the idea that specific sequences of DNA become RNA and then build the proteins that comprise your cells. In contrast to the idyllic view of scientists performing discovery-oriented experiments to illuminate the fundamental nature of biology, the minds on the frontlines of research are strangled by government funding sources that prize profitable outcomes, by journals bought by industry, and by the reflexive moralistic condemnation of anyone seeking to make inquiries into the status quo.

This medical-scientific-industrial marriage has brought us many a meme that we hold onto, societally, as unquestioned truths:

- That **depression is a chemical imbalance**
- That **cholesterol causes heart disease**
- That **exposure to germs equals deadly infection, and vaccines protect**
- That **cancer is a genetic time bomb and caused above all by mutated genes**
- That **HIV causes AIDS, the equivalent of certain death**
- That **inherited genes cause illness**

Assumptions: Accepted practice of medicine and science rests on uninterrogated assumptions

One of the most compelling studies to interrogate the assumptions around contagion and germ theory was conducted by the Public Health Service and the US Navy under the supervision of Dr. Milton Rosenau in 1918 in healthy volunteers at multiple locations.

His volunteers first received one strain and then several strains of a bacterium called *Pfeiffer's bacillus* by spray and swab into their noses and throats and then into their eyes. When that procedure failed to produce disease, other people were inoculated with mixtures of other organisms isolated from the throats and noses of influenza patients. Next, some volunteers received injections of blood from influenza patients. Finally, 13 of the volunteers were taken into an influenza ward and exposed to 10 influenza patients each. Each volunteer was to shake hands with each patient, to talk with them at close range, and to permit them to cough directly into their face. None of the volunteers in these experiments developed influenza. Rosenau was clearly puzzled, and he cautioned against drawing conclusions from negative results. He ended his article in *JAMA* with a telling acknowledgement:

"We entered the outbreak with a notion that we knew the cause of the disease, and were quite sure we knew how it was transmitted from person to person. Perhaps, if we have learned anything, it is that we are not quite sure what we know about the disease."[1]

We have made such assumptions with infections like measles (and induced mass hysteria), even though the foundational aspects of the assumption have been called into question. Did you know that **Dr. Stefan Lanka**, himself a virologist, won a case in a high German court in 2016 when he challenged the evidence for the *existence* of the measles virus? He stated, "In the course of my studies, I and others have not been able to find proof of the existence of disease-causing viruses anywhere."

Meanwhile, the greatest honor of having given space to the topic of "missing virus detection" in the scientific discussion goes to the Australian Eleni Papadopulos-Eleopulos with her fundamental criticism of HIV being a potentially deadly virus.[2]

The challenge that assumptions present is that of *petitio principia*, or an effort to prove a claim through the declaration that the claim is already true. For example, a person claims that the virus caused the symptoms and then calibrates the diagnostic tests based on patients with symptoms.

***B**elief: Accepted practice of conventional medicine and science is a belief-based approach to understanding the human body and experience*

> *"The fact that the RNA sequences that the scientists extracted from the tissue samples and which the SARS-CoV-2 RT-PCR tests were finally 'calibrated' belong to a new pathogenic virus called SARS-CoV-2 is therefore based on faith alone, not on sound research."*
>
> – excerpt from Virus Mania by Engelbrecht et al

In medicine, the role of belief is referred to as the placebo effect and effectively dismissed as a statistical nuisance. The truth is that the entire fabric of conventional medicine rests on belief in the system itself. The role of belief in scientism is cloaked in the purported objectivism of science and standardization of medicine, and we are led to perceive "alternative medicine" is based on belief while conventional medicine is based on "facts." Importantly, **nocebo** research has demonstrated that a loss of faith or belief in the intervention (typically pharmaceutical) results in a loss of effect.

Probably the most powerful demonstration of this was a study entitled **The Role of Patient Expectancy in Placebo and Nocebo Effects in Antidepressant Trials** . In this study, 673 people who had been diagnosed with depression were given fluoxetine (generic Prozac) for 12 weeks. At the 12 week point, all patients were informed that they would be randomized to placebo or continued on fluoxetine. Notably, BOTH the participants who continued on fluoxetine and those who were switched to placebo developed worsening depressive symptoms, suggesting two noncompeting interpretations:

1. The initial effect was attributable to placebo since all patients *knew* they were receiving treatment (the study was open label)
2. The loss of benefit with the introduction of the *possibility* of being randomized to placebo is the *undoing* of the placebo effect, or the nocebo effect.

This trial is one of many that demonstrate the most important factor in medical outcomes is belief and associated **mindset**.

> *"It is simply no longer possible to believe much of the clinical research that is published, or to rely on the judgment of trusted physicians or authoritative medical guidelines. I take no pleasure in this conclusion, which I reached slowly and reluctantly over my two decades as an editor of the New England Journal of Medicine."*
>
> *– Marcia Angell*

Consensus: Accepted practice of medicine and science rests on commonly adopted interventions rather than proven approaches

Back before the Cochrane Database was co-opted, they wrote about something called "consensus medicine," which is, as it sounds, the practice of medicine that is based not on evidence, but on what is most commonly being done.

A provocative and important piece in the Mayo Clinic Proceedings posed the question:

> *"How many contemporary medical practices are not any better than or are worse than doing nothing or doing something else that is simpler or less expensive? This is an important question, given the negative repercussions for patients and the health care system of continuing to endorse futile, inefficient, expensive, or harmful interventions, tests, or management strategies."*

In this **investigation**, Prasad and colleagues analyzed 2,044 articles that were originally published in the New England Journal of Medicine from 2001 to 2010 and classified the articles based on whether they tested a new or existing treatment and whether the results challenged or supported the treatment's efficacy. **They found that 40.2% of the articles argued for "medical reversal," recommending to stop a treatment because it was not actually evidenced-based.** Over 10 years, a total of 128 medical practices were brought into the harsh light of evidence, meaning that a major memo should have been disseminated and doctors around

the country made aware of the need to change what they were doing. Further, these studies should have alerted us to the evidence calling the practice into question. To the contrary, Prasad et al discuss:

> *"Although there is a weak evidence base for some practice, it gains acceptance largely through vocal support from prominent advocates and faith that the mechanism of action is sound. Later, future trials undermine the therapy, but removing the contradicted practice often proves challenging."*

They reference a related review in the British Medical Journal that evaluated 3,000 medical practices and found that more than **one third are effective or likely to be, 15% are harmful, and 50% are unknown**. It's important to note that many of these short-term trials do not pick up treatment harms that take months or years to emerge and that establishing risk is much more complex than demonstrating efficacy.

A common practice of the pharmaceutical industry is to create and widely share "studies" intended to assure the public of safety and to erase any concerns about risk for various treatments. Only after decades of accumulated damage is the unavoidable population-based data able to overturn the pharmaceutical agenda. We've seen this over and over again; a few examples include cigarettes, diethylstilboestrol (DES), thalidomide, COX inhibitors, **BPA**, and the relationship between neurological damage and **vaccination**.

D*ogma: Accepted practice of medicine and science rests on dogmatic defense of assumptions, belief, and consensus with dismissal, marginalization, and silencing of dissent*

Germ theory has been placed in a position of supremacy without adequate evidence. This monolithic belief system is upheld and defended as the only legitimate and unquestionable worldview for infectious disease by the demand

for conformity and compliance through coercion, shaming, and bullying by the medical establishment.

You might notice that debating "science" is ineffective. You might also notice that dissenters such as the authors of this paper are typically character-assassinated through controlled media outlets rather than invited to reasonable debate. These are not the tools of sincere scientific inquiry in service of human wellbeing, but instead the tools that a brotherhood-led cult would employ to silence any rogue voices.

What can we learn from the AIDS epidemic?

Similar to mental illnesses, AIDS is a *syndrome* of more than 25 diseases and not a defined disease entity in itself. AIDS even has different diagnostic criteria in different parts of the world. Notably, part of the definition of AIDS is the presence of antibodies specific for the so-called Human Immunodeficiency Virus (HIV), though a person with circulating "HIV" antibodies is not necessarily sick, nor do we know that they will become so (since natural history studies that controlled for lifestyle factors have not been done). Ultimately, because the diagnosis of AIDS has been defined by the detection of HIV antibodies, we have not needed to scientifically establish causality. In fact, to date, no one - Luc Montagnier and Robert Gallo included - has been able to present to find a mechanistic study showing how the HIV virus translates into AIDS symptoms.[3]

Because of this lack of causality, two people presenting with symptoms of a given disease in the long list of AIDS-defining illnesses may be given totally different diagnoses. For instance, if one person tests as so-called HIV-positive, they are labeled with AIDS, and the other, with a negative HIV test, is simply diagnosed with the presenting diseases themselves, such as *Pneumocystis carinii* pneumonia (PCP) or Kaposi's sarcoma. The **hexing power** of the AIDS diagnosis is, of course, not to be lightly dismissed as we learn more about the power of the **nocebo effect** to negatively influence the immune system. And we cannot dismiss the myriad of other factors, including the use of recreational and prescribed pharmaceutical drugs, that contribute to severe immunosuppression.

People referred to as AIDS patients may be affected by immunosuppression that leads to opportunistic infections, but this phenomenon has been observed prior to AIDS and is associated with many other conditions. These conditions include severe combined immuno-deficiency (SCID), agammaglobulinemia, blood cancers, aplastic anemia, transplant surgery, intravenous drug use, and chemotherapy.

What HIV/AIDS and SARS-CoV-2/COVID have in common

"I'm not going to change the facts around because I believe in something and feel like manipulating somebody's behavior by stretching what I really know. I think it's always the right thing and the safe thing for a scientist to speak one's mind from the facts. If you can't figure out why you believe something, then you'd better make it clear that you're speaking as a religious person."

– Kary Mullis, Nobel-prize winning inventor of PCR

1. There is a claim of a new virus, but the virus was never conclusively demonstrated to exist nor cause a novel disease.

HIV is said to belong to a class of viruses called retroviruses. In order to prove this claim, HIV must be isolated as a pure virus so that it can be imaged with an electron microscope. However, all electron micrographs of so-called HIV taken in the mid-1980s did not come from a patient's blood, but instead from lab-made cell culture soup. In some cases, the cells had been cooked up for a week in a Petri dish.

Moreover, it was presumed that the (indirectly detected) presence of an enzyme called reverse transcriptase was sufficient to prove the existence of a retrovirus and even a viral infection of the tested cells in culture. In 1983, Luc Montagnier of the Institut Pasteur in Paris published an article in *Science* asserting that his research team had found a new retrovirus, which would later be named HIV. This claim was made after only reverse transcriptase activity had been observed in cell culture

But there was no scientific proof for this conclusion. Eleven years before, in 1972, Temin and Baltimore had stated that "reverse transcriptase is a property that is innate to all cells and is not restricted to retroviruses." And even Françoise Barré-Sinoussi and Jean Claude Chermann, the most important co-authors of Montagnier's 1983 *Science* paper, concluded in 1973 that reverse transcriptase is not specific to retroviruses, but rather exists in all cells. In other words, if the enzyme reverse transcriptase is found in a laboratory culture, one cannot conclude, as Montagnier did, that a retrovirus, let alone a specific strain of retrovirus, has been found.[4]

Viral characterization was essentially on hold until 1997, when Hans Gelderblom of the Robert Koch-Institute in Berlin rekindled efforts to visualize the HIV virus. But Gelderblom's article, published in the journal *Virology*, leaves out the purification and characterization of the virus and merely states that the protein p24 was found, not providing proof that the particles are HIV. The second image of an AIDS patient's blood came from the American National Cancer Institute. In this case, the protein and RNA particles that were made visible did not have morphology typical of retroviruses.

Additionally, mainstream AIDS researchers claim that proteins like p24 and p18 are specific to HIV, and they use them as surrogate HIV markers, but in fact these markers are also found in a number of so-called "uninfected" human tissue samples. Even Luc Montagnier later admitted in an interview with the journal *Continuum* in 1997 that even after "Roman effort" with electron micrographs of the cell culture that detected alleged HIV, no particles were visible with "morphology typical of retroviruses."

The fact that a clear image of HIV particles with retrovirus morphology has not been produced, despite an enormous amount of financial resources and public interest, is suspicious at best and malicious at worst.

> *"'This patient has tuberculosis, that one chronic diarrhea, this one malaria and that one leprosy' - all diseases that have been known in Africa for ages. But then everything was rediagnosed as AIDS - out of fear of AIDS.'"*
>
> *– Neville Hodgkinson quoted in Virus Mania*[5]

In the case of SARS-CoV-2, in a request for a study which shows complete isolation and purification of the particles claimed to be SARS-CoV-2, Michael Laue from one of the world's most important representatives of the COVID-19 "pandemic," the German Robert Koch Institute (RKI), answered that: "I am not aware of a paper which purified isolated SARS-CoV-2." This is a remarkable admission of failure and in line with the statements that Torsten Engelbrecht et al. presented in the article "COVID-19 PCR Tests Are Scientifically Meaningless," which *OffGuardian* published on June 27th, 2020. This was the first worldwide article outlining in detail why SARS-CoV-2 PCR tests are worthless for the diagnosis of a viral infection.

One of the crucial points in this analysis was the claim by 'science' of a new and potentially deadly virus SARS-CoV-2, given that the studies claiming "isolation" failed to isolate the particles said to be the new virus.

This is confirmed by the answers of the respective studies' scientists to our inquiry, which are shown in a table in our piece — among them the world's most important

paper when it comes to the claim of having detected SARS-CoV-2 (by Zhu et al.), published in the *New England Journal of Medicine* on February 20, 2020, and now even the RKI.

Additionally, Christine Massey, a Canadian former biostatistician in the field of cancer research, and a colleague of hers in New Zealand, Michael Speth, as well as several individuals around the world (most of whom prefer to remain anonymous) have submitted Freedom of Information requests to dozens of health and science institutions and a handful of political offices around the world.

They are seeking any records that describe the isolation of a SARS-COV-2 virus from any unadulterated sample taken from a diseased patient.

Responses from Study Authors to the Question: Do your electron micrographs show the purified virus?

Study	Replying Author	Answer	Date of Answer
Sharon R. Lewin et al. Isolation and rapid sharing of the 2019 novel coronavirus (SARS - CoV - 2) from the first patient diagnosed with COVID - 19 in Australia, *The Medical Journal of Australia*, June 2020, pp. 459-462	Jason A. Roberts and Julian Druce	"The nucleic acid extraction was performed on isolate material recovered from infected cells. This material was not centrifuged, so was not purified through sucrose gradient to have a density band as such. The EM images were obtained directly from cell culture material."	October 5, 2020
Leo L. M. Poon; Malik Peiris. Emergence of a novel human coronavirus threatening human health, *Nature Medicine*, March 2020	Malik Peiris	"The image is the virus budding from an infected cell. It is not purified virus."	May 12, 2020
Myung-Guk Han et al. Identification of Coronavirus Isolated from a Patient in Korea with COVID-19, *Osong Public Health and Research Perspectives*, February 2020	Myung-Guk Han	"We could not estimate the degree of purification because we do not purify and concentrate the virus cultured in cells."	May 6, 2020
Wan Beom Park et al. Virus Isolation from the First Patient with SARS-CoV-2 in Korea, *Journal of Korean Medical Science*, February 24, 2020	Wan Beom Park	"We did not obtain an electron micrograph showing the degree of purification."	March 19, 2020
Na Zhu et al. A Novel Coronavirus from Patients with Pneumonia in China, 2019, *New England Journal of Medicine*, February 20, 2020	Wenjie Tan	"[We show] an image of sedimented virus particles, not purified ones."	March 18, 2020

Source: Engelbrecht, Torsten; Demeter, Konstantin, COVID-19 PCR Tests Are Scientifically Meaningless, OffGuardian, *27. June 2020; research by Torsten Engelbrecht*

As of the date of this writing, all 68 responding institutions/offices failed to provide or cite any record describing "SARS-COV-2" isolation, and Germany's Ministry of Health ignored their FOI request altogether.

The German entrepreneur Samuel Eckert asked health authorities from various cities, such as Munich, Dusseldorf, and Zurich, for a study proving complete

isolation and purification of so-called SARS-CoV-2. He has not obtained any answer. Eckert even offered €230,000 to Christian Drosten if he can provide any published evidence that scientifically prove the process of isolation of SARS-CoV-2 and its genetic substance. The deadline (December 31, 2020) has passed without Drosten responding to Eckert. In another attempt, the German journalist Hans Tolzin offered a reward of €100,000 for a scientific publication outlining a successful infection attempt with the specific SARS-CoV-2 reliably resulting in respiratory illness in the test subjects. No responses had been submitted.

Moreover, the electron micrographs printed in the relevant studies, which show particles that are supposed to represent SARS-CoV-2, reveal that these particles show extreme variations in size. In fact, the diameters range from 60 to 140 nanometers (nm). A virus that has such extreme size variation cannot actually exist.

According to virology principles, each virus has a fairly stable structure. Recently, the Wikipedia entry on coronavirus was changed to now report that “Each SARS-CoV-2 virion has a diameter of about 50 to 200 nm.” That would be like saying that a person varies his height from 1 to 4 meters according to circumstances![6]

2. There is the declaration of a new disease that is caused by said theoretical virus based on very few case observations while the media reports multitudes of new cases.

Contrary to public pronouncements, neither AIDS nor COVID-19 are new diseases. In late 1980 and early 1981, UCLA researcher Michael Gottlieb inexplicably initiated a campaign to promote the belief that there was a "new" contagious disease spreading among gay men—based on a mere 5 cases! Common "lifestyle" factors were summarily dismissed, most notably the frequent use of nitrite inhalants ("poppers"), a recreational drug widely used by gay men, including all 5 of these first reported "AIDS" cases. Gottlieb's efforts to lobby the CDC and news media to support his single-minded "viral causation" campaign proved highly successful, and he helped launch the multi-trillion dollar "AIDS" industry.

The afflicted patients suffered from the pulmonary disease pneumocystis carinii pneumonia (PCP), which was highly unusual for young men in their prime. Older adults, those on immunosuppressive medication, or babies born with an immune deficiency are the usual victims. The AIDS medical researchers apparently took no other factors into account concerning the cause of PCP, such as the patients' drug use.

Instead, the medical establishment and the CDC gave the impression that the cause of PCP was completely mystifying, setting up the launch of a new disease. The CDC eagerly embraced Gottlieb's theses: "Hot stuff, hot stuff," cheered the CDC's James Curran. It was so "hot," that, on June 5 1981, the CDC heralded it as a red-hot piece of news in their weekly bulletin, the *Morbidity and Mortality Weekly Report* (*MMWR*), which is also a preferred information source for the media.

In this *MMWR*, it was immediately conjectured that this mysterious new disease could have been caused by sexual contact, and was thus infectious. In fact, there was no evidence at all for such speculation, for the patients neither knew each other, nor had common sexual contacts or acquaintances, nor had they comparable histories of sexually transmitted diseases.

"Sex, being three billion years old, is not specific to any one group—and thus naturally does not come into question as a possible explanation for a new sort of disease," pointed out microbiologist Peter Duesberg of the University of California, Berkeley. "But buried in Gottlieb's paper was another common risk factor [criminally neglected by the CDC] that linked the five patients much more specifically than sex." These risk factors included a highly toxic lifestyle and use of recreational drugs that were frequently consumed in the gay scene, primarily poppers.[7]

Similarly, there are also no specific symptoms related to so-called COVID-19. The notion that "COVID-19" is not a new disease was confirmed by Thomas Löscher, an infectious diseases physician, who stated in an email that "for most respiratory diseases there are no unmistakable specific symptoms. Therefore, a differentiation of the different pathogens is purely clinically impossible."[8] This was

confirmed by the journal *Deutsches Ärzteblatt* on January 11, 2021: “The findings on computer tomograph are not specific to COVID-19, but may also be present in other pneumonias.”[9]

This means that COVID-19 can only be diagnosed on the basis of a "positive" PCR test. But these SARS-CoV-2 RT-qPCR tests are completely unsuitable for the diagnosis of COVID-19; to understand why these tests are scientifically meaningless, please read the detailed description in the subchapter “Total Failure of the PCR Test: No Gold Standard, No ‘Viral Load’ Measurement, Not for Diagnostic Purposes” of the book “**Virus Mania**” by Torsten Engelbrecht et al.[10]

We posit that AIDS and COVID-19 are purely test pandemics. They are not "virus pandemics," but instead an antibody test pandemic (AIDS) and a PCR test pandemic (COVID-19).

While in the case of AIDS, it was falsely claimed that five gay men were responsible for the start of the epidemic, in the case of COVID-19, it was 41 people who were claimed to have been infected with SARS-CoV-2 at the Huanan Seafood Market, Wuhan, without a shred of evidence to support this claim.[11]

3. Unvalidated and manipulated testing protocols are used to define cases of the illness.

This seminal article lists 66 different factors known to trigger a "positive" HIV antibody test, clearly showing that this diagnostic test is nonspecific:

WHOSE ANTIBODIES ARE THEY ANYWAY?
Factors Known to Cause False Positive HIV Antibody Test Results
http://www.virusmyth.com/aids/hiv/cjtestfp.htm

Dr. Roberto Giraldo, who worked in a Manhattan hospital laboratory performing HIV diagnostic tests, revealed that blood serum was routinely diluted 1:400 before performing the Enzyme-Linked Immunosorbent Assay (ELISA) HIV antibody test. However, on a large group of undiluted specimens, all samples which previously returned a "negative" result suddenly became "positive."

As Thomas Zuck of the FDA warned in 1986, ELISA antibody tests were not designed specifically to detect HIV. The first HIV antibody test, which was developed in 1985, was designed to screen blood products, not to diagnose AIDS; this was also stated in the study "Human Immunodeficiency Virus Diagnostic Testing: 30 Years of Evolution."[12] Furthermore, the German weekly newspaper *Die Woche* wrote in 1993 that HIV tests "also reacted in people who had survived tuberculosis;" additionally, dozens of other symptoms, including pregnancy or flu, could cause a "positive" reaction).

In case of COVID-19, the linchpin was the **PCR test**. But the SARS-CoV-2 RT-qPCR tests are unsuitable for the diagnosis of COVID-19, mainly because there is no proof that the particles claimed to be SARS-CoV-2 are "evil" viruses and there is no solid gold standard for the PCR tests. These tests cannot detect infections nor measure the viral load of a patient (see the subchapter "Total Failure of the PCR Test: No Gold Standard, No 'Viral Load' Measurement, Not for Diagnostic Purposes" of the book "Virus Mania" by Torsten Engelbrecht et al.).[13]

4. Then (mid-1980s) as now (2020/2021), Anthony Fauci was one of the key players in the global virus business.

Anthony Fauci is an American physician-scientist and immunologist who serves as the director of the U.S. National Institute of Allergy and Infectious Diseases (NIAID) and the chief medical advisor to the president. As a physician with the National Institutes of Health (NIH), Fauci has worked in the American public health sector in various capacities for more than 50 years, and he has acted as an advisor to every US president since Reagan.

After completing his medical residency in 1968, Fauci joined the NIH as a clinical associate in the NIAID Laboratory of Clinical Investigation (LCI). He became head of the LCI's Clinical Physiology Section in 1974, and in 1980 was appointed chief of the NIAID's Laboratory of Immunoregulation. In 1984, he became director of the NIAID, a position he still holds. Fauci has been offered the position of director of the NIH several times, but he has declined each time.

Fauci has been at the forefront of US efforts to contend with viral diseases like HIV/AIDS, SARS, the Swine flu, MERS, Ebola, and COVID-19. As the planet's "Virus Tsar" since 1984, Fauci has spread misinformation and ignored critical questions. Under Fauci's aegis, Robert Gallo was able to promote his unfounded HIV/AIDS thesis to the world as the eternal truth. Fauci also succeeded in the mid-1980s in spreading the alleged "HIV test" worldwide, and in 1987, he presided over the fraudulent approval of zidovudine (AZT) for AIDS.

In the decades that followed, Fauci continued to spread one untruth after another. With the bird flu, he predicted "two to seven million deaths" worldwide, whereas in reality, according to official figures, only 100 deaths were counted. With the swine flu vaccine, he claimed that it was only "very, very, very rarely" associated with severe side effects, although the data for such statements was not even available and later it became apparent that there were many side effects, including severe neurological complications.

Fauci has recommended "pre-exposure prophylaxis" (PrEP) in the context of AIDS, suggesting that even people who are "HIV-negative" take medication "just in case." But when Torsten Engelbrecht, one of the authors of this paper, asked Fauci to back up his claims, he refused to comment on whether there was any solid scientific evidence for PrEP. Hillary Hoffman from the communications department of NIAID merely just let him know: "Dr. Fauci respectfully declines to respond to the questions that you emailed."

Fauci's pattern of not wanting to answer critical questions pervades his entire career. For example, in 1987, NBC News reporter Perri Peltz wanted to confront

Fauci with criticisms about the AZT approval study, but he characteristically refused. "Welcome to the club, Perri!" wrote John Lauritsen in his book "The AIDS War: Propaganda, Profiteering and Genocide from the Medical-Industrial Complex." According to Lauritsen, Fauci also "refused to speak to the BBC, Canadian Broadcasting Corporation Radio, Channel 4 (London) television, Italian television, The New Scientist, and Jack Anderson" about the fraudulent 1987 AZT trial.

Two years before that, on October 2, 1985, Rock Hudson, who gave HIV/AIDS "a face," died during Fauci's term in office. And just like Roy Horn in 2020, world-famous stars in the early days of the "AIDS era" were experimented on with potentially lethal drugs. The first really famous victim was Hudson, who was treated with agents such as HPA-23, a drug for which no scientifically-controlled studies had been carried out. Though there was no proof of efficacy with regards to Hudson's illness, the liver-damaging and potentially lethal effects alone were sufficiently documented, and the highly toxic effects were especially dangerous for patients that already had underlying health problems.

Sounds a lot like COVID-19, except that there are 35 years in between[14] [15] (see also point 8 below).

5. Hexing or the nocebo effect of a "positive" test drives illness and negative outcomes secondary to media fearmongering.

The influence of *doom and gloom* messaging from the authorities, the 'experts,' is an aspect that is often overlooked or not even considered as a factor in the deterioration of our health. The nocebo effect occurs when a patient's negative expectations of a treatment cause the treatment to have an even more negative effect. Similarly, this nocebo effect could also occur when the threat of a deadly pandemic is thrust upon the many. Some will immediately start producing dis-ease symptoms if they believe these pronouncements without question, especially if they are found to be 'positive' after being tested.

This is very likely what has happened since March 2020 when the COVID-19 pandemic was first declared. There has clearly been a worldwide avalanche of frightening rhetoric broadcasted via governments and mainstream media. The threat of vast numbers of cases and deaths have been continually projected onto the public, demanding they must strictly adhere to the government regulations. This has put the believers instantly into a state of fear whereby they blindly accept the frightening prophecies without question.

Whether or not the highly questionable disease diagnosis is considered either symptomatic or asymptomatic, the psychological effect of a negative prognosis on an individual can be profound if they believe they are 'infected'. Equally, this manufactured fear coming from positive test result could evolve into the fear of others 'infecting' you, or that you will 'infect' others, such as your grandmother.

A positive COVID-19 test result will create varying degrees of fear and anxiety depending on the individual's belief system. For some there will be many anxieties emerging after a positive test result. For example, Will I survive? Will I be responsible for transmitting disease and cause a fatality? And so on. It is hard to know how many symptoms of disease are caused by these fears rather than any illness.

As the COVID 'pandemic' has been in progress for over fourteen months, some people have unraveled into a chronic state of anxiety, particularly if they have received one or more 'positive' test results. An excessive or persistent state of anxiety can have a devastating effect on your physical and mental health, resulting in a variety of symptoms.[16]

Those who are more susceptible to psychosomatic illness are especially likely to experience a deterioration of health and, given the ever-widening symptomology of COVID-19, they may start producing some of these symptoms.

Parallels can be drawn to the time when AIDS was declared and terror spread across the globe during the 1980s. This was followed by the growth in numbers of

HIV positive test results. These questionable test results were like receiving a death sentence for some.

Early on in the so-called AIDS epidemic, gay journalist and former statistician John Lauritsen correctly identified the psychological dangers of informing people that they were infected with an invariably fatal "virus." Out of fear, many of these individuals succumbed to the media blitz promoting highly toxic "AIDS treatments" which, combined with the extreme fear, led to a self-fulfilling prophecy. Many other people simply committed suicide after receiving their "test results."

Has the suicide rate increased since the COVID pandemic emerged? At the time of writing, “apparently not,” according to a recently published BMJ article.[17] However, the aftermath is uncertain. Unemployment, bankruptcy, loss of hopefulness and fear of what the future may hold all have the potential to increase the suicide rate. Only time will tell. Lauritsen pointed out in his 1991 article: ‘There can be no doubt that extreme and chronic fear, depression, stress, and grief are capable of causing illness and death.’[18]

Lauritsen referred to a 1984 published paper by Casper Schmidt in the *Journal of Psychohistory* about the effects of psychosomatic illness entitled: "The Group-Fantasy Origins of AIDS". Schmidt proposed that ‘chronic and inescapable fear can elicit a biochemical reaction in the body, which in time causes "psychogenically-reduced cell-mediated immunity." He maintained that this hypothesis has fulfilled the animal model for "AIDS," inasmuch as laboratory animals subjected to inescapable threats have developed immune deficiency.’

It almost goes without saying that Schmidt’s hypothesis was unwelcomed and dismissed by mainstream medicine. As a consequence, the term *denier* or *denialist* is attached to any individual proposing an alternative stance on a subject, eg AIDS denier.[19] This labelling is presently being used for any individual, especially any academics, who question either the SARS-CoV-2 and/or COVID-19. They are instantly placed into the realms of denialism.

Another paper Lauritsen cited in his article was the 1990 "Programmed to Die: Cultural Hypnosis and AIDS" manuscript by Michael Ellner and Andrew Cort. According to Lauritsen, the authors state: 'Bone pointing, or voodoo death, is a well-documented hypnotic phenomenon that clearly demonstrates the awesome power of belief. There are people in Africa, Haiti and Australia with the belief that the shaman (or witch doctor) has power over life and death. For them, being the target of a bone pointed by such an authority can be fatal. The hex is harmless to a non-believer; but to a believer it is deadly. After having a bone pointed at them, healthy people go home and obediently die.'

Knowingly misusing inappropriate PCR testing and other similar methods will not only lead to false results but may also be detrimental to those who believe their diagnosis. Lauritsen refers to a phrase summed up by an East Berlin writer: "Nicht das Virus, sondern die Diagnose totet". ("The virus doesn't kill, the diagnosis does.")

6. Celebrities and horror images spread via TV channels and social media are used to reinforce virus dogma.

In the case of HIV/AIDS, the horror images spread via TV channels came especially from suffering and dying celebrities. A kind of "big bang" for the HIV=AIDS narrative was when Hollywood actor Rock Hudson, a tall image of American masculinity, was presented to the world as the first megastar with AIDS in the mid-1980s. In July 1985, Hudson revealed to the public that he had AIDS (a year after his "positive" test), and died only a few months later. Hudson's death brought the AIDS phenomenon out of the gay community and conveyed the message that a real epidemic was underway.

People were told that if AIDS can affect someone like Hudson, it can affect anyone, men and women alike. However, Rock Hudson had been drinking and chain-smoking for decades, which is very damaging to the liver and the body as a whole, and he had undergone heart surgery at the age of 56. In this unstable physical state, Hudson received experimental drugs such as HPA-23 for at least twelve months before his death. This highly toxic medication may have played a crucial

part in Hudson's death in October 1985. Remarkably, Hudson's male partner had tested "negative" and had no AIDS symptoms, something that clearly speaks against AIDS being a viral disease as well.[20]

Other celebrities whose deaths were used to set the HIV=AIDS dogma in stone were Freddie Mercury, Rudolf Nureyev, and Arthur Ashe. Freddie Mercury, former frontman of British rock band Queen and who was bisexual, was terrified by the "positive" test result and took his doctor's advice to begin taking AZT. Mercury belonged to the first generation of patients who received the full AZT load. At the end, he looked like a skeleton and died in November 1991 at the age of 45.

Rudolf Nureyev, held by many to be the greatest ballet dancer of all time, also began taking AZT at the end of the 1980s. Nureyev was HIV "positive," but otherwise he was completely healthy. His personal physician, Michel Canesi, recognized the deadly effects of AZT and even warned him about the drug. But Nureyev proclaimed, "I want that drug!" Ultimately, he died in Paris in 1993, the same year that former Wimbledon champion Arthur Ashe met his maker at the age of 49 after he had been declared HIV "positive" in 1988 and his doctor prescribed an extremely high AZT dose. Ashe wanted to stop taking AZT, but he didn't dare: "What will I tell my doctors?" he asked the *New York Daily News*.

What American tennis legend Ashe didn't have the heart to do - resist the pressure of prevailing AIDS medicine and decide against taking AZT - apparently saved the life of basketball megastar Earvin "Magic" Johnson. At the end of 1991, Magic shocked the world with the news he had tested HIV "positive." "It can happen to anybody, even Magic Johnson," said *Time magazine* on 18 November 1991.

There was no evidence to support the claim that he had been infected with a virus named HIV. Magic Johnson had just tested "positive," but at the same time, he was the picture of health, until Fauci and his personal doctor, the New York AIDS researcher David Ho, insistently advised Johnson to take AZT. Johnson followed their advice, and his health rapidly deteriorated. Unfortunately, virus mania was by

then so dominant that nobody thought that the extremely toxic medications could have caused Magic's serious health problems.

In the summer of 1992, after the media announced his retirement from basketball in late 1991, he even led the US basketball team to the gold medal at the Olympic Games in Barcelona. This was a grandiose achievement, and had he still been under the influence of AZT, there was no way he could have accomplished such a thing.[21]

In the case of SARS-CoV-2/COVID-19, the death of magician Roy Horn as well as countless horror scenes burned a groundless virus dogma into people's minds. Horn, the legendary magician of Siegfried & Roy, passed away on May 8, 2020 at the age of 75 years in Las Vegas after being treated with the highly toxic drug Remdesivir. He was the first megastar worldwide who was said to have died from COVID-19 and thus from the so-called coronavirus SARS-CoV-2. However, again there is no evidence to support this story. In fact, Horn was in such poor health that it seems downright absurd to ignore non-viral factors such as his cancer disease as well as the administration of Remdesivir as the cause of his sad demise.[22]

By mid-March 2020, media coverage was practically dominated by only one topic: that the corona-related death toll in Italy had skyrocketed. Of course, the reporting was always based on the narrative "SARS-CoV-2 = death" and was accompanied by dramatic pictures of coffins without end, queues of military vehicles, and overburdened hospitals. The horrific pictures from Italy and other parts of the world that were circulated around the globe via TV and social media, alongside drastic warnings from virologists of a deadly virus, firmly established the scary virus story in many people's minds.

7. Financial incentives drive increased testing, diagnosis, and treatment.

Federal funding for HIV research has increased significantly over time, rising in the US from a few hundred thousand dollars in 1982 to more than $34.8 billion in 2019. Between 1981 and 2006, US taxpayers shelled out $190 billion for AIDS research that was focused almost exclusively on the deadly virus hypothesis and the

development of treatments. The same amount of taxpayer money went to AIDS research in America in the five years between 2014 and 2019. The global HIV drug market was valued at $30.8 million in 2019, and it is expected to reach $36.5 million by 2027.

We posit that HIV/AIDS served as the salvation for the medical industry. By the late 1970s, medical experts lobbed damning critiques against mainstream cancer research, which was the part of the medical industry which devoured by far the most money. Medical scientists "had credited the retroviruses with every nasty thing —above all the triggering of cancer—and have to accept constant mockery and countless defeats," the German news magazine *Der Spiegel* pointed out in 1986.

In addition to cancer, the concept that viruses are key causal factors has not been established for other diseases either. One notorious example is the swine flu disaster of 1976. David Lewis, a young American recruit, collapsed during a march, and so-called epidemic experts swooped in claiming they had isolated a swine flu virus from his lung.

At the behest of the medical establishment, and particularly the CDC, the US President Gerald Ford appeared on TV urging all Americans to get vaccinated against an imminent deadly swine flu epidemic. Just like the COVID-19, SARS, and the avian flu fearmongers, Ford used the great Spanish flu pandemic of 1918 to scare the public into action.

Approximately 50 million US citizens rushed to local health centers for injections of a substance that had been hastily thrown on the market. It produced strong side effects in 20 to 40 percent of recipients, including paralysis and death. Consequent damage claims climbed to $2.7 billion. In the end, CDC director David Spencer, who had even set up a swine flu "war room" to bolster public and media support, lost his job. The bitter irony was that there were no, or only very isolated, reports of swine flu.

Consequently, at the end of the 1970s, the US National Institute of Health (NIH) came into unsettled political waters, similar to the CDC, which was extensively

restructured at the beginning of the 1980s. As a result, the CDC and NIH, both powerful organizations of health politics and biomedical science, had to redeem themselves. A new "war" would, of course, be the best thing. Despite perpetual setbacks, an "infectious disease" remained the most effective way to catch public attention and open government pockets.

In fact, Red Cross officer Paul Cumming told the *San Francisco Chronicle* in 1994 that "the CDC increasingly needed a major epidemic" at the beginning of the 80s "to justify its existence." And the HIV/AIDS theory was just that.

"All the old virus hunters from the National Cancer Institute put new signs on their doors and became AIDS researchers. Reagan sent up about a billion dollars just for starters," according to Kary Mullis, Nobel laureate for Chemistry in 1993. "And suddenly everybody who could claim to be any kind of medical scientist and who hadn't had anything much to do lately was fully employed. They still are."

One of the best known people who jumped over from cancer research to AIDS research is Robert Gallo. Along with Montagnier, Gallo was also considered to be the discoverer of the "AIDS virus" and enjoys worldwide fame, reaching millionaire status. On the other hand, he had almost lost his reputation as a cancer researcher after his viral hypotheses on diseases like leukemia imploded. "HIV didn't suddenly pop out of the rain forest or Haiti," writes Mullis. "It just popped into Bob Gallo's hands at a time when he needed a new career."[23]

And the HIV/AIDS story started with big lies. The most important one was announced in April 1984 by Gallo, working under Anthony Fauci, when he claimed in a press conference that gained worldwide attention that "*the probable cause of AIDS has been found.*"

Gallo's papers were printed in the journal *Science* after his press conference and also after he had filed a patent application for an antibody test that was later misleadingly named "HIV test." Thus, nobody was able to review his work prior to his spectacular TV appearance and for some time afterwards. This presented a

severe breach of professional scientific etiquette. And as review later showed, Gallo's studies did not deliver any proof for the virus thesis.[24] [25]

Additionally, the development of the tests was also primarily about license fees, which lead to vast financial gain.[26] For instance, the global HIV diagnostics market was valued at around $ 2.2 billion in 2014,[27] and this market is projected to reach $3.88 billion by 2021.

In 1995, *Der Spiegel* described the greed for money and fame associated with HIV/AIDS as follows: "Even with the greats of the AIDS establishment, Gallo does not hold back on psychiatric diagnoses. [According to Gallo,] one is a 'control freak', the next is 'uncreative' and has a 'complex' because of it, a third is—'can I be honest?'—just plain 'crazy.' [Gallo's] impetuous anger is real when he speaks of the fight for power in the AIDS business, the fight for the money pot, the spiteful jealousy of prestige. With AIDS a lot of money is at stake—and above all fame."[28]

8. Toxic pharmaceutical interventions/"preventatives" and illicit drugs result in adverse effects and death that is then attributed to the purported "virus."

There is solid reason to conclude that symptoms we associate with AIDS result from the antiretroviral drugs and not from the so-called HIV virus. Indeed, published studies suggest that the drug toxicity associated with AIDS treatment may very well be the driver of most deaths.[29] [30] [31]. In the words of Matt Irwin, MD,[32] "Many drugs regularly used to treat people diagnosed as HIV-positive have severe immunosuppressive effects, as well as other serious adverse effects. These include corticosteroids, Zidovudine (AZT), other drugs in the same class as AZT, certain antibiotics, and protease inhibitors…corticosteroids induce immunosuppression that is claimed to be caused by HIV, with lowered CD4 counts and sparing of CD8 cells as well as sparing of antibody production."

Glaxo Wellcome puts the following warning in bold-faced caps at the start of the section in the 1999 Physician's Desk Reference that describes AZT (which is a common antiretroviral drug originally developed for cancer).[33]

> ***"RETROVIR (ZIDOVUDINE, AZT) MAY BE ASSOCIATED WITH SEVERE HEMATOLOGIC TOXICITY INCLUDING GRANULOCYTOPENIA AND SEVERE ANEMIA PARTICULARLY IN PATIENTS WITH ADVANCED HIV DISEASE (SEE WARNINGS). PROLONGED USE OF RETROVIR HAS ALSO BEEN ASSOCIATED WITH SYMPTOMATIC MYOPATHY SIMILAR TO THAT PRODUCED BY HUMAN IMMUNODEFICIENCY VIRUS."*** *(PDR 1999).*

An earlier version of the PDR that was published in 1992 made the connection even clearer:

> *It is often difficult to distinguish adverse events possibly associated with Zidovudine (AZT) administration from underlying signs of HIV disease or intercurrent illness. (PDR 1992)*

Another recent study found that the antiretroviral drug Elvitegravir may severely damage adaptive immune cells, namely B cells, likely contributing to chronic immunosuppression.[34]

As mentioned earlier, the first people to be diagnosed as AIDS patients in the US were consumers of drugs like poppers, cocaine, LSD, heroin, ecstasy, and amphetamines, all of which have devastating effects on the immune system. The destructive process of poppers converting into nitric oxide and damaging tissues is particularly noticeable in the lungs, since poppers are inhaled and dead organic material is produced, and fungi enter the area to ingest and metabolize this damaged tissue "waste." This explains why so many "AIDS patients" termed AIDS cases, suffer from pneumocystis carinii pneumonia (PCP), a lung disease typically associated with strong fungal infestation and decay.

These patients' immune systems are weakened, which "is the common denominator for the development of PCP," according to Harrison's Principles of Internal Medicine.

And the “disease [the immune deficiency upon which PCP develops] can be produced in laboratory rats by starvation or by treatment with either corticosteroids [cortisone] or cyclophosphamides”—i.e. with cell-inhibiting substances that are destructive to the immune system, just like so-called AIDS therapeutics.

Therefore, HIV is not needed to cause AIDS-associated symptoms. Studies show that a stress factor, like the effects of drugs, can trigger a new arrangement of genetic sequences in cells, forming particles that are interpreted by the medical industry as viruses invading from the outside (without any proof), instead of vesicles produced endogenously.[35]

In relation to COVID-19, prophecies of doom, such as that of Germany's chief virologist Drosten on March 6 that "278,000 corona fatalities are to be expected" in Germany or that of British disease modeller Neil Ferguson, who predicted about 510,000 corona deaths in mid-March 2020 for the UK and 2.2 million deaths for the US if lockdown measures were not immediately implemented, gave politicians the green light for a strict lockdown. But not only did such horror scenarios lack any scientific basis even then, but also the hard data show that in numerous countries, including Germany, there was no excess mortality at all in the time period in question, and that even for increased mortalities seen in countries such as Italy, Spain, France, England, or America, a virus cannot be established as the definitive cause. Instead, the evidence suggests that it was primarily the mass administration of preparations such as hydroxychloroquine, Kaletra, or azithromycin that caused countless people to die prematurely and create an excess mortality, but only within a very short period of time around April 2020 (which also speaks against the virus hypothesis).[36]

9. There are no solid placebo-controlled trials for the drugs that are touted as the one and only lifeline.

In July 1987, the *New England Journal of Medicine* published the results of the Phase II clinical trials of the first FDA-approved AIDS treatment, AZT. Although these clinical trials by Fischl et al. were claimed to be "double-blind, placebo-controlled,"

the study had become unblinded very early on, and an unknown number of patients in the "placebo" arm were actually taking AZT. The study was characterized by numerous protocol violations, poor record-keeping, and extreme sloppiness, as exposed by journalist John Lauritsen, who discovered these serious problems after obtaining multiple documents (which were heavily censored) through several *FOI* requests. This Phase II study, intended to determine the safety and efficacy of AZT, included a relatively small sample size of 282 patients, 95% of whom never completed the full 24 weeks of the study. (The mean duration was 17.3 weeks.)

Although FDA officials were fully aware that the study had become unblinded and that the data had become corrupted, they nonetheless decided to include *ALL* of the bad data in their analysis, and the drug was approved. A Phase III clinical trial of AZT, with a larger number of patients, was later conducted, although this study experienced many of the same serious problems as the Phase II trials. This study was prematurely terminated after it was declared that there was a significantly improved outcome for the patients who were receiving the drug, and the FDA announced that it would be "unethical" not to immediately unblind the study and offer AZT to the patients who had been receiving the placebo.

The study was planned as a "double-blind" trial, which means that the drug was supposed to be labelled and the study conducted in such a way that neither doctors nor patients knew whether AZT or a placebo was being administered. In practice, the AZT trial became unblinded rather quickly. An FDA medical officer wrote: "the fact that the treatment groups unblinded themselves early could have resulted in bias in the workup of patients."

The study became unblinded among the patients as a result of differences in taste between AZT and the placebo.... This difference was corrected and the placebo capsules replaced with new ones after early reports were received of patients breaking the capsules and tasting the medication...

Other patients discovered what medication they were receiving by taking their capsules to chemists for analysis. In some instances, patients pooled and shared

their medication, thus ensuring that all of them could receive at least some AZT. Other patients, who found out their medication was only a placebo, took Ribavirin that had been smuggled in from Mexico.

From the standpoint of the doctors, the study unblinded itself through the strikingly different blood profiles of the two treatment groups. No attempt was made to blind the blood results from any of the doctors in the medical centers at which the trials were held. According to an FDA analyst: “The treatment groups may have unblinded themselves to a large extent during the first two months due to drug-induced erythrocyte macrocytosis…”

And since the AZT trial was not blinded, the entire study was invalid and worthless. On this basis alone, FDA approval of the drug was neither proper nor legal.

In fact, Swiss newspaper *Weltwoche* termed the experiment a “gigantic botch-up” and *NBC News* in New York branded the experiments, conducted across the US, as “seriously flawed.” Mind you, the Fischl study was not the only one that was declared to be placebo-controlled in the context of AIDS and AZT. Furthermore, the Concorde study,[37] published in the *Lancet* in 1994, and the *Nature* paper by Darby et al. both showed that AZT shortens life.

The Concorde study, carried out between 1988 and 1991, showed that the group receiving AZT experienced "more deaths and more frequent discontinuation of therapy due to severe side effects” than the placebo group.

The results were all the more remarkable when one considers that AZT was administered to the test persons in a noticeably reduced dose (1,000 mg instead of 1,500 mg per day as was usual at the time and as was given also to the participants of the Fischl study).

AZT also received a damning verdict from the Darby study, which appeared in *Nature* in September 1995.[38] In this work, the death rates of hemophiliacs in England who had tested "HIV positive" were compared with those of the "negatively" tested hemophiliacs for the period 1985 to 1992. The result was that

from 1985/1986 onwards, the death rate of hemophiliacs tested "positive" started to increase, and from 1987 onwards, their death curve went up even more steeply. In comparison, the death rate of hemophiliacs who tested negative for "HIV" remained virtually unchanged.

For orthodox medicine, this was proof that HIV was responsible for the increase in death rates among "HIV-positive" hemophiliacs. But this conclusion is not tenable. Rather, the emergence of total AIDS hysteria and the accompanying mass administration of highly toxic drugs was the cause of the sudden rise in the death rate among "positive" hemophiliacs. Thus, the "HIV tests" came into mass use shortly after their introduction in 1984/1985. At the same time, almost everyone in the world at that time already had the formula "positive test = HIV infection = AIDS = death sentence" firmly stored in their minds. This makes the increase in the death rate among hemophiliacs from 1985 onwards easy to explain as all those who had received a "positive" test result were put into a kind of shock, whereupon many of them committed suicide. Moreover, with a "positive" test result (no matter how healthy or sick), they were automatically treated with all kinds of substances, no matter how toxic, and administered as permanent medication, including anti-fungal preparations or the antibiotic Eusaprim, which inhibits cell division, as well as highly toxic antiviral drugs.

Der Spiegel, for example, noted in August 1985: "More than a dozen different drugs are undergoing clinical trials in the U.S. alone—all of them so far not very successful and burdened with the most serious side effects. The substance 'HPA 23,' developed at the Louis Pasteur Institute...also has its pitfalls. In Paris a clinical study on 33 test persons with 'HPA 23' is running, but in quite a few patients the drug had to be discontinued again because blood and liver were extremely damaged."

In the context of COVID-19, the parallel to the Fischl study was, in a sense, the pivotal study of Gilead Sciences' drug Remdesivir, which had been fast-tracked in the US and approved for emergency use only on May 2, 2020. This study was also essentially fraudulent, and yet it led to the approval of the first drug intended for the treatment of COVID-19 patients; and, just like AZT, this compound was touted as the great hope.

Remdesivir inhibits cell reproduction and can lead to premature death, especially in the elderly with comorbidities, and its most serious side effects include multi-organ dysfunction, septic shock, and respiratory failure. Additionally, in experiments with so-called Ebola patients, it was found that the drug elevates liver enzyme values, which can be a sign of liver damage.

The fact that Remdesivir was presented as the savior for COVID-19 patients can only be described as scandalous. In late April 2020, Anthony Fauci claimed that a study had found that Remdesivir would reduce recovery time and reduce mortality.

But an article from the Alliance for Human Research and Protection (AHRP) entitled "Fauci's Promotional Hype Catapults Gilead's Remdesivir" brought up a sensitive subject: Fauci had a vested interest in this drug. He sponsored the clinical trial whose detailed results have not been peer-reviewed. Additionally, he declared the tenuous results to be 'highly significant,' and pronounced Remdesivir to be the new 'standard of care.' Fauci made the promotional pronouncement while sitting on a couch in the White House, without providing a detailed news release or a briefing at a medical meeting or in a scientific journal, as is the norm to allow scientists and researchers to review the data.

When he was asked about a Chinese study published in *The Lancet* on April 29th, 2020, a trial that was stopped because of serious adverse events in 16 (12%) of the patients compared to 4 (5%) of patients in the placebo group, Fauci dismissed the study as 'not adequate.'

But whereas the Chinese study that Fauci denigrated was a randomized, double-blind, placebo-controlled, multi-center study that was peer-reviewed and published in *The Lancet*, with all data available, the NIAID-Gilead study results have not been published in peer-reviewed literature, nor have details of the findings been disclosed. "However, they were publicly promoted by the head of the federal agency that conducted the study, from the White House," as the AHRP underlined. "What better free advertisement?"[39]

10. The concept of 'asymptomatic carriers' and associated testing and precautions recommended to healthy people is manufactured and leveraged.

In 1993, the CDC redefined the official meaning of an "AIDS case," causing many "asymptomatic" people with an "HIV positive" diagnosis to immediately qualify as an "AIDS case" in the absence of any true health symptoms. The definition of an AIDS case in the USA was broadened to include people who had a count of CD4+ lymphocytes below 200 cells per microliter. The old definition required that an "AIDS case" represented someone who was actually ill with at least one "AIDS-defining opportunistic infection." This change more than doubled the number of "AIDS cases" overnight, giving the false impression of an increase in cases over time.

Furthermore, a look at the CDC statistics before 1993 (and 2003 statistics from the Robert Koch-Institute) shows that the number of AIDS deaths in the USA and in Germany had already peaked in 1991, and then decreased in the years following. Thus, the multiple combination therapy (HAART) and protease inhibitors that were introduced in 1995/1996 cannot be responsible for this decrease. Newer CDC statistics, however, do show that the mortality peak lies approximately in 1995/1996. How can this be?

According to statistician Vladimir Koliadin, who analyzed the mortality data, this is due to the significant redefining of what counts as an AIDS case that occurred in 1993, ensuring that the peak and decline of AIDS cases centered on the introduction of treatments in the mid-1990s. “If public and policy makers would have realized that the epidemic of AIDS was declining, this might have resulted in reduction of budgets for AIDS research and prevention programs, including the budget of the CDC themselves,” said Koliadin. “Expansion of the definition of AIDS in 1993 helped to disguise the downward trend in epidemic of AIDS. It is reasonable to suppose that an essential motive behind the implementation of the new definition of AIDS just in 1993 was strong unwillingness of the CDC to reveal the declining trend of AIDS epidemic.”

Additionally, a meta-analysis of data from Europe, Australia, and Canada shows that in 1995, patients used combination therapy only 0.5 percent of their treatment time. In 1996, the value increased to 4.7 percent, which is still extremely low. Former CDC director James Curran told CNN that, at the time, "less than 10 percent of infected Americans had access to these new therapies, or were taking them."

Ten years later, while the media celebrated HAART's 10th birthday, the *Lancet* published a study that challenged the propaganda about HAART, showing that decreases in so-called viral load did not "translate into a decrease in mortality" for people taking these highly toxic AIDS drug combinations. The multi-center study—the largest and longest of its kind—tracked the effects of HAART on 22,000 previously treatment-naïve HIV "positives" between 1995 and 2003 at 12 locations in Europe and the USA. The study's results refute popular claims that the newer HAART meds extend life and improve Health.

Commenting on the article, Felix de Fries of Study Group AIDS-Therapy in Zurich, Switzerland had this to say: "The *Lancet* study shows that after a short period of time, HAART treatment led to increases in precisely those opportunistic diseases that define AIDS from fungal infections of the lungs, skin, and intestines to various mycobacterial infections." De Fries also notes that HAART has led to no sustained increases in CD4 cell counts, no reduction in AIDS-defining illness, and no decrease in mortality rates; its use is also associated with a list of serious adverse events such as cardiovascular disease, lipodystrophy, lactic acidosis, liver and kidney failure, osteoporosis, thyroid dysfunction, neuropathy, and cancers among users.

We must also recognize that there are so-called long-term AIDS survivors or "non-progressors". Common to these "positive" people is the fact that they have rejected AIDS medications from the start or only took them for a short time. Many of them are or were still alive 20 years after they tested "positive."

The AIDS establishment calls these HIV "positive" individuals who reject AIDS medications "elite controllers," as if they are somehow super-human. The establishment now claims that 2 percent of AIDS patients may fit this category, but

only a large controlled global study (which has not been done) would be able to determine the exact number of HIV “positive“ individuals who remain healthy without taking AIDS drugs. However, the number of “elite controllers” is probably much higher, yet the “vast majority of [so-called] HIV-“positives“ are long-term survivors!” as Berkeley microbiologist Peter Duesberg states. “Worldwide they number many, many millions.” And indeed, in industrialized countries, the majority of those testing "positive" for "HIV" are asymptomatic.[40]

The same holds for COVID-19: Here, too, the majority of those testing "positive" are symptom-free. Here, the topic of "infection by the symptomless" was taken to the extreme of absurdity.

The false claim that a human being can pass on a virus without symptoms is particularly perfidious since it corrodes society; everyone sees in his fellow human being only a highly dangerous virus slinger and reacts to this with disgust, aggression, or fear and panic. Since even school children are indoctrinated by parents and teachers in this sense, massive behavioral and developmental disorders are already foreseeable. Unfortunately, the media manipulation unleashed with COVID-19 has managed to spread such levels of terror that the idea that the other is a danger to be avoided becomes normal and too widely accepted. The World Health Organization, that today is increasingly in the hands of Bill Gates (as before, historically, it had been in the hands of the Rockefellers, of whom Gates is in many ways an emanation), prefers to use the term "physical distancing,” perhaps so as not to make it too clear that the distancing measures adopted affect and tend to destroy sociality.

Behind this approach is the idea that the SARS-CoV-2 virus is transmitted by air or through the nebulized droplets from those who cough, sneeze, or speak. We have heard different contradictory theories because all these theories about viral transmission are only hypotheses that have never been proven; even the WHO acknowledges that "the evidence is not convincing.” The only studies in which the transmission of a coronavirus (not SARS-CoV-2) by air has been preliminarily "proven" have been carried out in hospitals and nursing homes, places that are known to produce all types of infections due to poor hygienic conditions.[41]

No study has ever shown transmission of viruses in open environments or in closed but well-ventilated environments. Even assuming that there is this transmission by air, it has been stressed that, for the "contagion" to occur, it is necessary that the people between whom the alleged transmission occurs are in close contact for at least 45 minutes.[42]

The assumption of a pre-symptomatic infection has been massively attacked in the technical literature.[43] The immunologist Beda Stadler, professor emeritus at the University of Bern, has pointed out in a highly regarded article in the Swiss *Weltwoche* that the idea that viruses could multiply uncontrollably in the human body without us noticing is immunologically unthinkable. However, it is precisely this uncontrolled multiplication that could theoretically generate the risk of infection in the first place.[44] It can hardly come as a surprise that not a single asymptomatic transmission of SARS CoV-2 could be detected for the coronavirus outbreak in Wuhan.[45]

Incidentally, this false factual claim began with a case report in the March 5, 2020, edition of the *New England Journal of Medicine*.[46] This article claimed that a symptomless Chinese businesswoman had met four employees of a local company in Munich, all of whom subsequently contracted COVID-19. Then in Wuhan, this woman tested “positive” for SARS-CoV-2. This was taken as the ultimate proof that symptomless people could also be contagious.

This case report had already been published as a preprint on January 30, 2020. On February 3, however, a commentary appeared that noted that the woman from China did indeed have symptoms and was merely suppressing them with the help of medication.[47] This had resulted in conversations with this woman, which were omitted in the case report.

Nevertheless, the case report was printed and represents an outright scientific fraud in that this case report was not immediately retracted after the error became known. A follow-up study, which appeared on May 15, 2020 in *The Lancet,* traced the "outbreak cluster" in the Munich company and suddenly brought to light that the woman from China had still had contact with her COVID-19-sick parents shortly

before her trip to Munich - a finding that had still been suppressed in the case report of March 5, 2020.[48] The study in *The Lancet* contains numerous inconsistencies both in itself and in relation to the case report of February 3, 2020, which have already been reviewed elsewhere.[49]

In short, all the radical distancing measures imposed by the various governments that are aimed at preventing viral transmission are based on a hypothesis that has never been proven and without convincing evidence to support it.

11. Epidemiology renders the virus hypothesis ad absurdum for both AIDS and COVID-19.

In the context of HIV/AIDS, the simple and yet "politically incorrect truth is rarely spoken out loud: the dreaded heterosexual epidemic never happened," reported Kevin Gray of US magazine *Details* in early 2004. The "degree of epidemic" in the population of developed nations has remained practically unchanged. In the US, for example, the number of those termed HIV-infected has remained stable at one million people since 1985 (which corresponds to a fraction of one percent of the population). But if HIV were actually a new sexually-transmitted virus, there should have been an exponential rise (and fall) in case numbers.

Additionally, in wealthy countries like the US and Germany, according to official statistics, homosexuals have always made up around 50 percent of all AIDS patients, and intravenous drug users about 30 percent, and seven percent are both. With this, almost all AIDS patients are men who lead a self-destructive lifestyle with toxic drugs, medications, and such. In contrast, the official statistics say that in poor countries:

- A much larger proportion of the population has AIDS.
- Men and women are equally affected.
- Primarily, malnourished people suffer from AIDS.

These differences in statistics suggest that AIDS symptoms are triggered by environmental factors like drugs, medications, and insufficient nutrition. And it clearly speaks against the presumption that a virus "that moves like a phenomenon of globalization—just like data streams, financial rivers, migration waves, jet planes—fast, borderless, and incalculable," is at work here, as the German weekly newspaper *Die Zeit* urgently warned on its front page in 2004.

Such a pathogen would inevitably have to attack all people in all countries of the world equally: men and women, straight and gay, African and European; not, as statistics reveal, in a racial and gender-biased way, attacking certain populations at different rates. Or as *Der Spiegel* put it in 1983 in its article "Eine Epidemie, die erst beginnt" ("An epidemic that is just beginning"): "Microorganisms do not normally distinguish between child and old person, man and woman, homosexual and heterosexual."

Similarly with COVID-19, the epidemiology shows that no virus can be at work in the way we are told it is. For example, in Switzerland, empirical evidence raised suspicions that a major cause of excess mortality was also due to drugs after 16 hospitals joined the SOLIDARITY study. Data from the Federal Statistical Office show that significant excess mortality was only evident in the Italian-speaking canton of Ticino and the French-speaking part of the country, but not in the German-speaking region of Zurich. Zurich, with its 1,521,000 inhabitants, had about the same number of deaths as Ticino, despite the latter's much smaller population of 353,000 inhabitants. The idea that a respiratory virus would attack Switzerland's cantons in such different ways is completely irrational.

Another factor for excess mortality was the widespread use of intubation and subsequent ventilation of COVID-19 patients. In fact, intubation and ventilation are extremely intrusive and harsh measures, usually done with people at risk of imminent death and generally already in a comatose state. In December 2020, German news site *focus.de* published the article "Too high mortality due to intubation—pulmonologist: 'Early ventilation is biggest mistake in the fight against corona,' in which pulmonologist Thomas Voshaar states that intubation causes the

mortality of those labelled as COVID-19 victims to rise extremely. “Fifty percent of invasively ventilated COVID-19 patients die. This is a clear sign that we need to take a different approach in medicine,” Voshaar appeals to colleagues. Unfortunately, this appeal also went unheard.”[50]

12. Persecution, censorship, and condemnation comes to all who demand evidence of the existence of a novel disease-causing pathogen.

We are not witnessing viral epidemics; we are witnessing epidemics of fear and tests. And both the media and Big Pharma carry most of the responsibility for amplifying fears: the fears that happen, incidentally, to always ignite fantastically profitable business. Research hypotheses covering these areas of virus research are essentially never scientifically verified with appropriate controls. Instead, they are established by “consensus.” This is then rapidly reshaped into a dogma, efficiently perpetuated in a quasi-religious manner by the media, including ensuring that research funding is restricted to projects supporting the dogma, excluding research into alternative hypotheses. A key tool to keep dissenting voices out of the debate is censorship at various levels, ranging from the popular media to scientific publications.

The story of geneticist Barbara McClintock is a prime example of censorship and condemnation. In her Nobel Prize paper from 1983, she reports that the genetic material of living beings can alter by being hit by “shocks.” These shocks can be toxins, but can also be from other materials that produced stress in the test-tube. This in turn can lead to the formation of new genetic sequences, which were unverifiable before.

Long ago, scientists observed that toxins in the body could produce these physiological reactions, yet current medicine sees this only from the perspective of exogenous viruses. In 1954, scientist Ralph Scobey reported in the journal *Archives of Pediatrics* that herpes simplex had developed after the injection of vaccines, the drinking of milk or the ingestion of certain foodstuffs; while herpes zoster (shingles) arose after ingestion or injection of heavy metals like arsenic and bismuth or alcohol.

It is also conceivable that toxic drugs like poppers or immunosuppressive medications like antibiotics and antivirals could trigger oxidative stress and damage cells. As a result, antibody production is "stirred up," creating "positive" antibody tests. Additionally, new genetic sequences are expressed through this process, which are then picked up by the PCR tests—all this, mind you, without a pathogenic virus that attacks from outside.

But prevailing medicine condemns such thoughts as heresy. The orthodoxy fought against McClintock's concept of "jumping genes" for decades to protect their model of a completely stable genetic framework. Here, they had not merely ignored McClintock, but even became downright "hostile," according to McClintock. "Looking back, it is painful to see how extremely fixated many scientists are on the dominant assumptions, on which they have tacitly agreed," McClintock wrote in 1973, shortly after the medical establishment admitted, finally, that she had been right. "One simply has to wait for the right time for a change in conception."

However, McClintock had no time to brace herself against the prevailing HIV = AIDS dogma. She did voice criticism that it had never been proven to cause AIDS, but the Nobel Prize winner died in 1992, shortly after increased numbers of critics of the HIV = AIDS dogma emerged on to the scene.

One of the most prominent among them was/is Peter Duesberg, member of the National Academy of Sciences, the USA's highest scientific committee, and one of the best-known cancer researchers in the world. He was one of the first critics to dispute the cause of AIDS, but his first major critique did not appear until 1987, in the journal *Cancer Research*—in other words, at a time when virus panic had already bombarded the public conscience for many years.

And, as those days and years ticked by, it became less and less likely that advocates of the "AIDS virus" theory would back-pedal, since they had already heavily invested financially, personally, and professionally in HIV. Be it in the *Spiegel*, *Die Zeit*, *The New York Times*, *Time,* or *Newsweek*—the AIDS orthodoxy's theory had been championed everywhere. Researchers such as Gallo found themselves simply unable to retreat

from their original claims because “stakes are too high now,” noted American journalist Celia Farber. “Gallo stands to make a lot of money from patent rights on this virus. His entire reputation depends on the virus. If HIV is not the cause of AIDS, there’s nothing left for Gallo. If it’s not a retrovirus, Gallo would become irrelevant.”

In the end, all those who criticized the HIV = AIDS dogma completely lost their reputation. Not only Duesberg, but also many, many others such as Harvard microbiologist Charles Thomas, who founded the organization “Rethinking AIDS” at the beginning of the 1990s (renamed “Reappraising AIDS” in 1994—and renamed later again “Rethinking AIDS”) as well as the Australian Perth Group with its “head” Eleni Papadopulos-Eleopulos, who pioneered the absolutely well-founded idea that HIV has never been proven to be a "bad" virus.[51]

The absolutely same phenomenon can be observed with COVID-19. Whoever dares to fundamentally question the official COVID-19 narrative is dismissed by the mainstream media and politics as irresponsible, or even extreme right-wing or Nazi.

Media efforts to malign, deplatform, censor, and even bring criminal charges to any of those who might question the mainstream narrative are now coming to full manifestation in the era of the current psychological operation. The collusion of social media, prominent services such as YouTube, “for the people” publishers such as **NPR**, and even digital newsletter providers have streamlined the available information so as to be consistent with the orthodox programming on the virus, its lethality, its prominence, and the efficacy and necessity of associated testing and interventions. The orchestration of this response to “dissenters” is so extreme that it is, itself, giving rise to the birth of uncontrolled and decentralized communications and media platforms.

So what might actually "cause" what we call infection?

Fundamentally, because we have been under the spell of germ theory for over a century, we don’t know what the causes of “infection” are. Here we offer some possibilities.

1. Fear: the role of psychology in biology

We are seeing first-hand that fear itself can spread, just like a classical contagion model, with no verified germ required. Perhaps it's time to interrogate our assumptions when it comes to antiquated biological tenets that speak to spread as solely infectious.

Even in the primary published literature, there are researchers questioning models of influenza spread based on the observation that symptoms arise, simultaneously, around the world, at a rate that can't be explained by person-to-person transmission.[2] I have also came across interesting studies like one that found cold symptoms were only expressed in individuals who self-rated their health as poor, even though all the volunteers were inoculated with virus.[3]

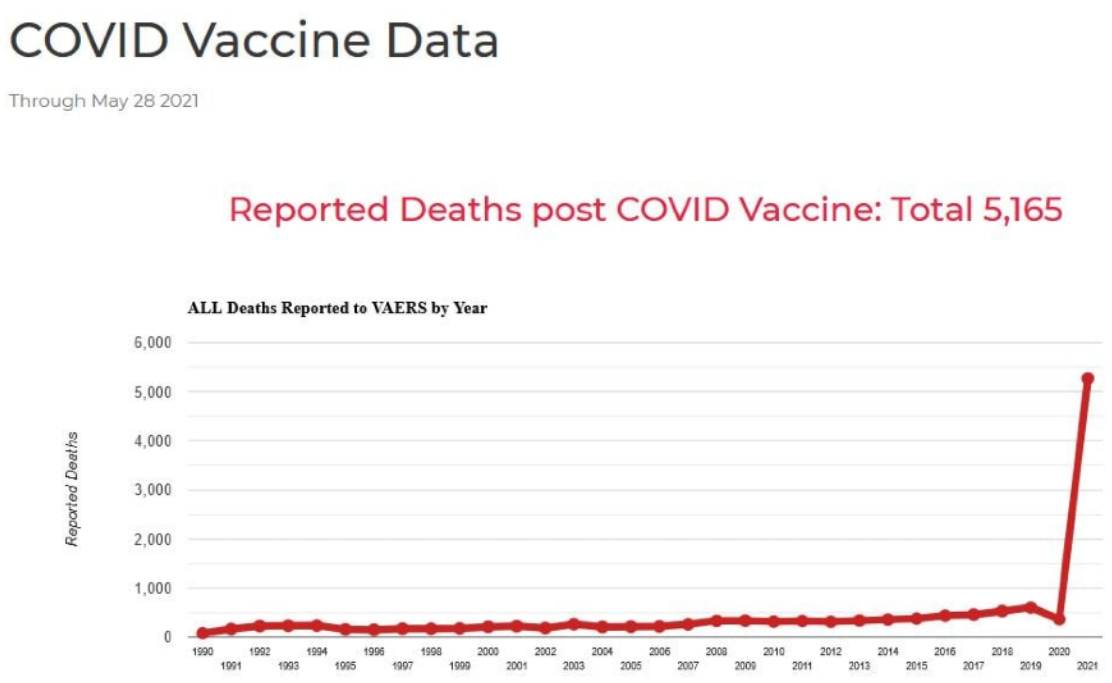
2. Co-exposure

There are also models that explore seeming infection spread as the excretion of bodily toxicant burden from sources such as non-native radiation, processed food, industrial chemicals, pharmaceuticals, and vaccines, which would impact those who

are co-located and exposed to similar environmental assaults in ways that could appear like pathogen-based spread.

Examining the case of polio, we see that polio-associated symptoms were actually induced by widespread Lead Arsenate and, later, **DDT exposure**, and symptoms suddenly declined with the introduction of the vaccine. At that point, polio symptoms were conveniently renamed 'acute flacid paralysis' as an epidemiologic sleight of hand. Here we can see that the infectious meme can obscure very real environmental causes of illness.

The US COVID vaccine data, for example, also clearly shows that illness and death is associated with a toxin, in this case a vaccine that is actually not a classical vaccine, but a gene therapy.



Source: **https://www.openvaers.com/covid-data/mortality**

3. Detox

Illness may be a form of cellular discharge, and microbes may be considered saprophytes, which help process dead or decaying matter, that colonize parts of the body to clear away cellular waste.

Acute detox episodes may be triggered by environmental changes, such as the drop in temperature and humidity in the winter. There may be other means of exchanging information among people, such as exosomes, pheromones, and acoustic or electromagnetic resonance, as messenger warnings to unload cellular debris. This invisible crosstalk will be an exciting area for future research.

4. Nutrition

Dr. Nicholas Gonzalez, a pioneer in the role of personalized nutrition for the autonomic nervous system, shared about a case of Keshan's disease in China where a fatal cardiomyopathy was thought to be caused by coxsackie virus, and with a vaccine poised for distribution, it was discovered that selenium-depleted soil was actually the reversible driver of these seemingly contagious symptoms. Nutritional imbalances and deficiencies are a major driver of what can otherwise appear to be infectious illness. Blood sugar dysregulation, food antigenicity, micronutrient deficiency, and even mismatch of dietary type can drive the expression of symptoms that are ultimately there to alert us to the importance of proper diet.

5. GNM

Some of us have found German New Medicine to be an intriguing framework that turns presumed causality on its head and helps us to see that symptoms are a wise response on the part of the body, rather than a problem, and that there's no war going on inside or out. In this model, microbes assist in restructuring and repairing tissue adaptations to biological threats or shocks and the expression of symptoms typically occurs in the resolution phase of these disturbances. Learn more here.

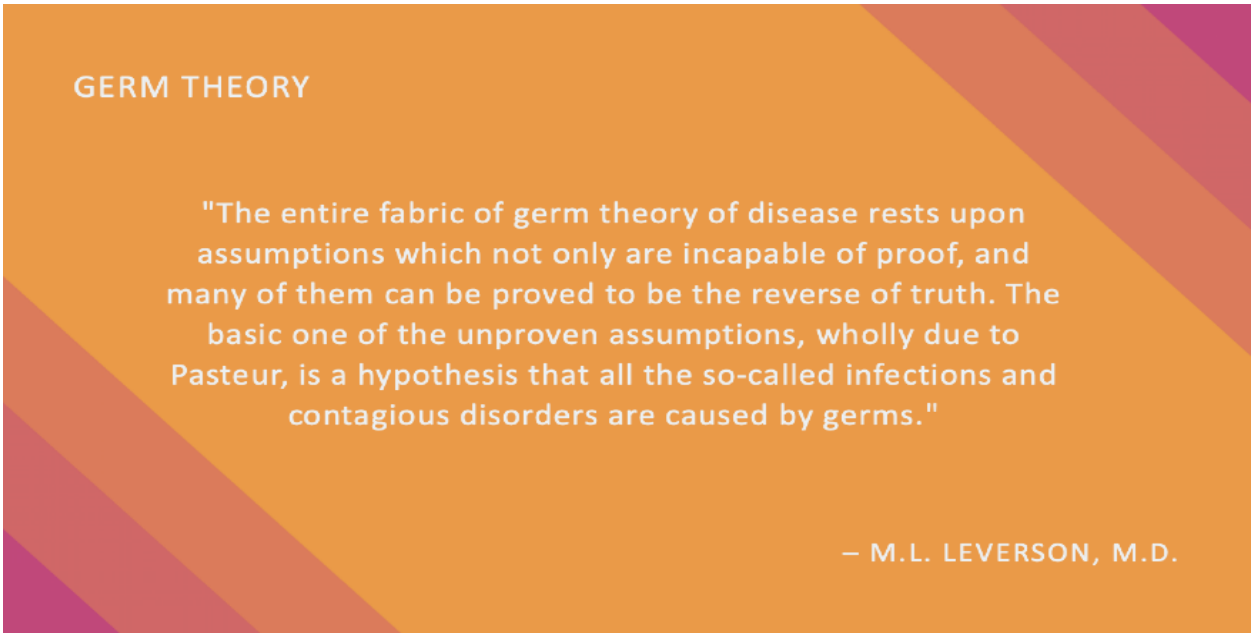
All of these suggested models of infectious illness are intercompatible and centered in the concept that nature is a self-healing system. There are no invisible invaders

beyond our control and no need to take synthetic potions categorized as “against life" (antibiotics). We are at war, but not with viruses. The war is a conflict of information and spiritual enlightenment. The enemy is pushing us further from nature and our true spirit of self-empowerment, cooperation, and love. We must now realize the trick and free ourselves. Our health and life is in the balance.

Fool me once, shame on you…fool me twice…

The infectious disease scare playbook has been exposed to the extent that we can command our fear responses and reject the latest, greatest media-making virus. We can choose to remember that we are each personally responsible for our own health and no one else can “protect us,” including a private-government apparatus that has never shown any interest in the welfare, health, and vitality of the populace.

Pattern recognition has the capacity to elucidate what might otherwise appear frighteningly arbitrary so that we can choose from a place of empowerment. We want to be empowered when we navigate sociologic experiments like testing, **mask wearing**, and **vaccination**, and as we retain our trust in the body in the face of symptoms, should they arise. If you access the knowing that the body does not make mistakes and is always you showing you about you, then there is far less room for the government in the journey of self-discovery that is health.



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Magdalene Taylor, director & editor of The Informed Parent (TiP). Magdalene, one of the founders of TiP which emerged in September 1992, started to investigate vaccination in 1991 from a position of believing in the procedure. This belief was based on trust of the medical authority, however the more research she came across the more her concerns grew that the public were only being presented a very bias angle on the subject. Since 1994, Magdalene single-handedly continues running TiP, producing a regular newsletter, which has now been in publication for nearly 29 years. **InformedParent.co.uk**.

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