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Research

Novel Immune Supportive Treatment of HIV/AIDS Comparative outcomes study in rural clinics in Africa

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Abstract

Introduction

This research aims at demonstrating that the immune system of HIV-positive patients can be enhanced using a remedy created in 2002 by Peter Chappell named PC1, based on the symptom totality of AIDS in Africa.

Method

This was a naturalistic, non-randomised outcome study with 3 comparisons: group 1 using only anti-retroviral drugs (ARVs) (n=99), group 2 using ARVs+PC1 (n=81) and group 3 using only PC1 (n=88). Patients were followed up for 6 months. Dependent blood sample-based variables were CD4-count and Viral Load. Dependent clinical variables were appetite, weight gain/loss, fatigue and weakness.

Results

A robust analysis was done on all variables, computing the differences between the base-line and the data from the last follow-up. A non-parametric statistical analysis showed that changes in all the variables are highly significant. The PC1-only group always has the best outcomes, the PC1+ARVs group second best, and ARVs-only group is always worst performing of the three groups.

Conclusion

We found evidence that PC1 effectively restores health in HIV-positive patients in Africa within a few months and will prevent patients from relapsing with

continuing treatment. It gives first evidence that the immune system can be restored and enhanced by using PC1. It also suggests that PC1 reduces the Viral Load. This first epidemiological comparative study shows that PC1 is a feasible treatment that can either be given alone or combined with ARV therapy in African HIV/AIDS patients and might thus be an inexpensive and safe therapy. Further work with longer periods of follow-up and randomized comparisons is needed to clarify the robustness of this finding.

Keywords: Homeopathy, HIV, Viral Load, CD4

Introduction

Despite the availability of ARVs, AIDS is still affecting many Africans.1 Unwanted side-effects2 and increasing therapy-resistance3 are serious complications, while care for AIDS-patients weighs heavily on health services.

In 2002, when homeopath Peter Chappell went to Africa, there was basically no treatment available for HIV/AIDS. PC1, the remedy he created then, has been used by ten-thousands of patients in sub-Saharan Africa.4-6 Ever since 2002, consistent positive clinical results as well as raised CD4-counts have been reported from Ethiopia (2002), Honduras (2003), India (2003), South Africa (2003), Malawi (2004), Nigeria (2005), Rwanda (2005), Central African Republic (2006), Cambodia (2007), Ghana (2007), Kenya (2007), Lesotho (2008), DR Congo (2009), Tanzania (2011), and Uganda (2013).4-10 For determining whether PC1 can be an effective part of AIDS-treatment, a study was conducted in Kenya, which has the third-largest HIV epidemic in the world with 1.6 million people living with HIV in 2018.11

Background

The Novel Immune Supportive Treatment called PC1 is a medicine that can stimulate the immune system (increase CD4 levels) and restore health in HIV-positive persons. Recent advances in quantum biology demonstrate that coherence is a key quantum phenomenon supporting life dynamics. Coherent phenomena are well explained by quantum field theory (QFT), and might be the basis of the homeopathic law of similars. Water is essential for life, and water memory plays a fundamental role in coherent phenomena within living organisms.12,13 The symptom totality of AIDS in Africa has been imprinted in water directly using a special process developed by Peter Chappell.4,5 PC1 can be prescribed in all phases because it has been shown to be safe and has no side effects.

In Kenya (2013) 77 HIV-positive persons were given PC1 in a governmental clinic and were followed-up for 3 months. These patients had not been put on ARVs yet. At base-line their mean CD4-count was 600 cells/mm3 (ranging from 289 to 2304). After 3 months of using PC1 the average CD4-count had risen to 641,3 cells/mm3, instead of 582 cells/mm3, which was expected without intervention.14 Not a single patient had a lower CD4-count than at base-line. With PC1 the CD4-count rose immediately with improved immunity and reduced opportunistic infections as a result4,5. Using both PC1 and ARVs within a treatment protocol therefore suggests a win-win situation.

Many HIV-positive persons refuse ARVs out of fear of side-effects.2 PC1 has been used since 2002. Clinical experience indicates that

PC1 does not induce side-effects while it considerably reduces the side-effects of ARVs. Offering PC1 alongside ARVs may increase therapy compliance to ARVs. PC1 is a safe alternative for those that refuse ARVs. Clinical experience indicates that ARVs are more effective in combination with PC1. If patients stop responding to ARVs, twenty years of experience show that they will respond to PC1. The costs of PC1 are 10% of the costs of 1st line ART, and 0,5-3% of 2nd or 3rd line ART. Considering the above, there are many reasons to investigate the effectiveness of PC1 for the treatment of HIV/AIDS in Africa.

Purpose

The purpose of this study was to investigate the underlying hypothesis that PC1 effectively restores health in HIV-positive patients.

Justification

If the indications from unsystematic experience and anecdotal evidence are confirmed, PC1 may be assumed to significantly alleviate or even fully remove symptoms of AIDS. This treatment is inexpensive and safe, while the administration of the remedy and treatment follow-up are very simple. Thus, the potential impact is major and the positive health care impact is considerable.

Materials and Methods

This was a non-randomised outcome study with different groups for comparison. Since it was a naturalistic field study with the primary aim of serving patients and since no clear data had been available earlier, randomisation was considered unethical and comparison groups were constructed naturally as they occurred and as patients chose their treatment option. Outpatients of all ages were recruited from Nyanza-province in Kenya, representing a broad cross section of the population. The recruitment of patients was done in three HIV/AIDS clinics. All newly identified HIV-positive patients were included in the study. Following the national AIDS-protocol, all patients were offered ARVs.[i] In two study clinics all newly tested HIV-positive patients were offered PC1 alongside ARVs. New patients from a third clinic were used as a control group and only received ARVs. If patients in this clinic refused ARVs they were offered PC1. Only new patients were included in this study. Patients already known to the clinics that refused ARVs were approached by peer educators and offered PC1. The patients were divided as follows.

1. ‘ARVs-only’: Patients with a positive HIV-test were prescribed ARVs.
2. ‘ARVs+PC1’: Patients with a positive HIV-test were prescribed ARVs and PC1.
3. ‘PC1-only’: Patients with a positive HIV-test that refused ARVs were prescribed PC1.

The inclusion phase was six months. As no previous data were available, a formal power analysis could not be conducted. With 100 patients per group, medium sized effects of d = 0.5 are detectable with 90% power, and were deemed clinically and scientifically relevant. At two monthly visits patients were provided with new medication while the clinician filled out the study form together with them.

[i] First-line ARVs used in the research clinics according governmental guidelines: 3-15 years (< 35 kg body weight): ABC + 3TC + EFV; 3-15 years (≥ 35 kg body weight) + >15 years: TDF + 3TC + EFV (ABC=Abacavir; 3TC=Lamuvidine; EFV=Efavirenz)

Organization of PC1

PC1 is a remedy that Peter Chappell devised following the homeopathic law of similars, using the totality of AIDS-symptoms in Africa and using intentional imprinting of this symptom picture as a remedy in water. This stock-imprint remedy is then dispersed over globules, following homeopathic pharmaceutical practices. PC1 was prepared by Hahnemann Pharmacy (Netherlands). All supplies were stored in a locked cupboard. Patients received 20 ml dropper bottles with a dilution of 1 granule[ii] per bottle in mineral water containing 20% medicinal alcohol.

The study clinicians recruited patients, instructed them and provided them with PC1 daily. Once a week a Data Manager and Study Assistant gathered and completed all data from the three clinics. A dosage of five drops of PC1 was taken once daily. Whether patients actually used PC1 and/or ARVs was checked at every follow-up.

Outcomes and Measures

Blood sample-based variables were CD4-count and Viral Load. Clinical variables were appetite, weight gain/loss, fatigue, weakness. Appetite, fatigue and weakness were measured on a 0-5 point scale. Kenyan protocol is to measure CD4-counts only at first intake. In this study the VL and CD4-counts were both measured again at six months.

Ethical considerations

The protocol was based on the biomedical research recommendations of the Declaration of Helsinki and has been thoroughly reviewed by the Research Ethics Committee of Northampton University and the Department of Health Sciences of the University of York. Their points of scientific and ethical concern have been "appropriately dealt with". All patients were asked to give their informed consent on a form translated into Luo, the local language.

PC1 is theoretically absolutely free of any side-effects, nor can it give any unwanted interactions with other medication.[iii] Practically, since 2002, no side-effects have been reported with PC1, nor adverse effects in patients using ARVs.
The risks for patients to take PC1 are considered very low, while the benefits can be large. For any adverse effects to PC1 during this study, the ARHF carried the responsibility and financial consequences. The risk of not receiving proven conventional treatment was non-existent, as no randomisation was employed and all patients who accepted ARVs also received them.

The risk of taking blood samples is low since qualified and medically certified personnel performed blood draws and clean disposable needles were used exclusively. To measure CD4-count an extra blood sample was taken at six months. As, according to Kenyan protocol, at that time blood was already meant to be taken to measure the Viral Load, this added no extra risk or discomfort to the health of patients. All patients entered the study voluntarily and they were free at all times to stop medication or coming for follow-ups. All Case Record Files were kept safe by the study clinicians and everything was done to safeguard confidentiality. All patients received an identity code, so their names were not

[ii] These milk sugar granules contain traces of water and alcohol from the liquid PC1 preparation prepared by the pharmacy according to a fixed protocol.

[iii] See previous footnote.

to be used in any communication outside the clinics, unless it would be for the sake of their own well-being.

Statistics

Robust non-parametric statistics were used, as randomization was not possible and without the possibility of collecting more information and including more cases, controlling for confounding statistically would only convey an image of quasi-control.
For the statistical analysis of differential effects we used, apart from robust descriptors pre- to post-difference measures, which take into account the different initial scores of the groups. We then tested the differences using non-parametric analysis across the three groups and, if differences were significant, separate Mann-Whitney tests. We used a nominally corrected p-value of p = 0.05, which has to be corrected by six tests, using a very conservative Bonferroni correction. This would yield a significance level of p = .0083 for the Kruskal-Wallis analysis. We report the nominal p-values of the tests. This analytical approach is deliberately very conservative, as we wanted to err on the conservative side and not attribute an effect to a treatment, where there is none. Missing data were not replaced and missing cases were excluded from the analysis. We describe the full cohort and the number of cases available.

Results

The groups were quite different clinically at the beginning, with the PC1-only group mostly worse off. [Table 1] This is because patients were included in this group that refused ARVs, and to include enough of them also patients were approached that had tested HIV-positive longer ago. It is to be expected that the difference values are largest for them, because there is also a larger tendency for regression to the mean, but that does not explain the large difference.

The data of 32 out of 300 patients have not been completed. [See Graph 1]

Assessment of 268 patients were included in the final analysis:

- ARVs-only group (N=99): 66 females, 33 males
- ARVs+PC1 group (N=81): 52 females, 29 males
- PC1-only group (N=88): 62 females, 26 males

The gender difference in patients included in the study is explained by higher infection rates[15], gender inequality[11], and stigma in men[16].

Blood sample-based variables.

CD4-count the PC1-only group significantly outperformed the ARVs-only group (p=0.000004) and the ARVs + PC1 group (p=0.000871). Median CD4 count in healthy Kenyans is 920 (343-1493cells/m^3). [See Graph 2][17]

Viral Load, again the PC1-only group significantly outperformed the ARVs-only group (p<0.000001) and the ARVs + PC1 group (p=0.000019), while the ARVs+PC1 group significantly outperformed the ARVs only group (p=0.001312). The viral load (amount of HIV copies per ml blood) is undetectable below 40-75 copies/ml.[18] [See Graph 3]

Clinical variables.

Regarding the change in weight the PC1-only group significantly outperformed the other groups (ARVs-only p=0.000002; ARVs+PC1 p=0.003786). [See Graph 4] An analysis was done on all variables. [Table 2] The analysis showed a strong effect in the data. All the variables are

highly significant, mainly in the way that the PC1-only group always shows the strongest improvement, the PC1+ARVs group follows, and the ARVs-only group is always last. [Table 3] As the PC1-only group on average started treatment with a higher Viral Load and a lower CD4-count than the two other groups, 32 patients from this group were followed-up for another six months. [Table 4] The table shows further improvement of all three variables.

Limitations

For a study performed in rural Africa a drop-out rate of 10% may actually be a good result. During the study, all over Kenya, the government fired all peer-educators that could have tracked missing patients down so the issue of patient compliance remains unclear.

Data that can help to understand compliance:

- Clinic 1 outperformed the other 2 clinics by recruiting most patients and losing contact with only 3 out of 129 patients
- Patients that use ARVs need to collect new remedies regularly. In clinic 1 follow ups are missing of only 1% of the patients on ARVs and in clinic 3 this percentage is 26%. That patients dropped out of ART in such different numbers is not very likely.
- In clinic 3 follow ups are missing of only 3% of the patients that used PC1 only; in clinic 1 this was 6% while in clinic 2 this was 22%. That patients dropped out of PC1 treatment in such different numbers is also not very likely.
- Heavy rains and floods during the time the first follow-ups were to take place influenced patient compliance.
- Several patients turned out to have provided wrong addresses and phone numbers, so they could not be traced to find out why they did not return for follow-up. The taboo around being HIV-positive is the most likely cause. If patients then improve on PC1 this may be an extra reason not to return for follow-up.
- The study team was able to motivate some of the peer educators to keep supporting the study after the government stopped paying for them, but not all of them complied.

The excellent follow-up data from clinic 1 make it unlikely that in the other 2 clinics' data are missing because patients stopped treatment. The compliance of the clinicians is more likely to have caused the big differences. Some factors:

- Clinic 1 was in a remote area which was less affected by unrest. During the study some clinicians were placed elsewhere and new clinicians had to take over some of the patients included in the study. The cooperation of these new clinicians was not always equal to that of those we had fully trained and informed before the study started.
- The data do not suggest that patient compliance was dependent on the form of treatment; there is no consistent pattern indicating this. In clinic 2 and 3 there is no difference between those receiving ARVs+PC1 and those receiving PC1 only that would suggest FUs are depending on the kind of treatment received.

In conclusion, the data do not suggest that the kind of treatment patients

received is connected to the drop-out rate.

Discussion

The hypothesis underlying this study, that PC1 effectively restores health in HIV-positive patients within a few months and with continuation of the treatment will prevent patients to relapse, is positively confirmed in this study. In addition, this study confirms the observations made ever since 2002 in several African countries, namely that HIV-positive patients using PC1 improve in clinical variables. It also confirms a rapid rise of immunity (CD4-count) against opportunistic infections.

In the PC1-only group not a single patient had a higher VL after six months of treatment, suggesting that therapy resistance had not occurred, whereas in the ARVs-only group six patients showed increased VL. It demonstrates that PC1 can restore the immune system and reduce the Viral Load. The study substantiates the claimed results with PC1 as reported from several countries since 2002.[4,5] After six months of treatment, six patients in the PC1-only group had a Viral Load that was undetectable. The outcome of this study suggests that PC1 also considerately lowers the Viral Load, even faster than ARVs, and that the VL in time becomes undetectable.

The study suggests that there is a safe and effective alternative for those patients that for whatever reason refuse to take ARVs. A rigorous three-year epidemiological outcomes study, or if feasible, a randomised study would be a next step.

Conclusion

This first epidemiological comparative study shows that PC1 is a feasible treatment that can either be given alone or combined with ARV therapy in African HIV/AIDS patients and might thus be an inexpensive and safe therapy.

Conflicts of interests

The authors declare that there is no conflict of interest.

Author's contribution

H. van der Zee and H. Walach contributed to the design and implementation of the research, to the analysis of the results and to the writing of the manuscript.

STROBE Statement

All STROBE requirements were met.

Acknowledgments and Celebration

Peter Chappell FSHom deserves nothing but praise for having created the remedy PC1 for those in need of it, and for not commercializing it.
After a rich and colourful life Peter Chappell left the body on December 26. He was 82 years old. Without him this article could not have been written. He created a new advance in medicine on how to effectively treat and prevent infectious diseases, of which HIV/AIDS is just one example. Many that truly came to understand the magnitude and impact of Peter's legacy have called it worthy of a Nobel Price.

This study was only possible thanks to donations received by ARHF and to the commitment of the team in Kenya – study clinicians, peer educators, lab technician, study assistant, data manager and study coordinator.

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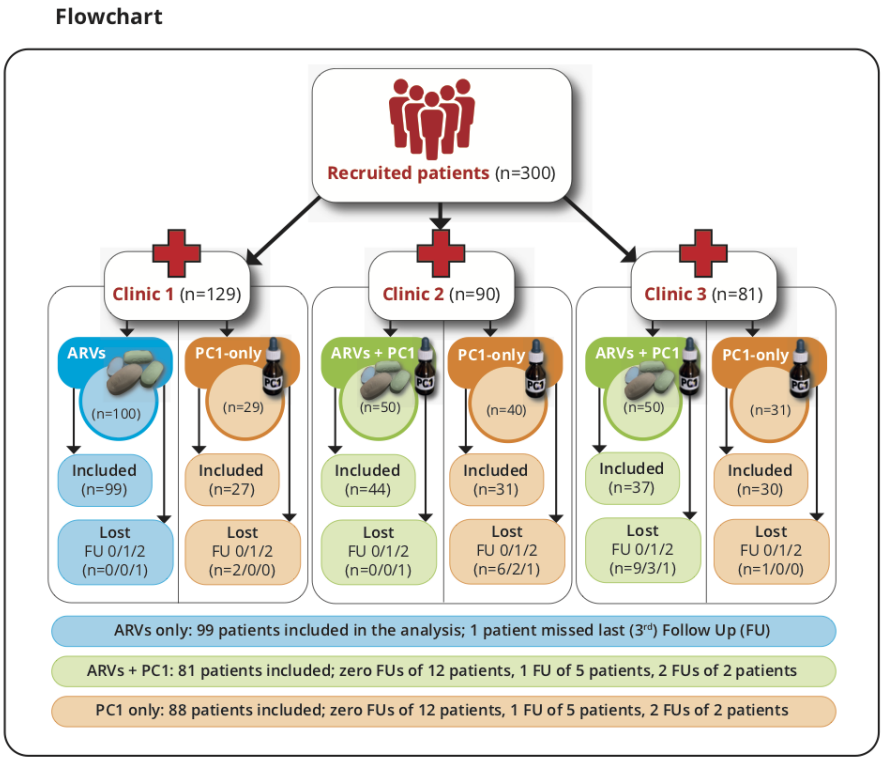
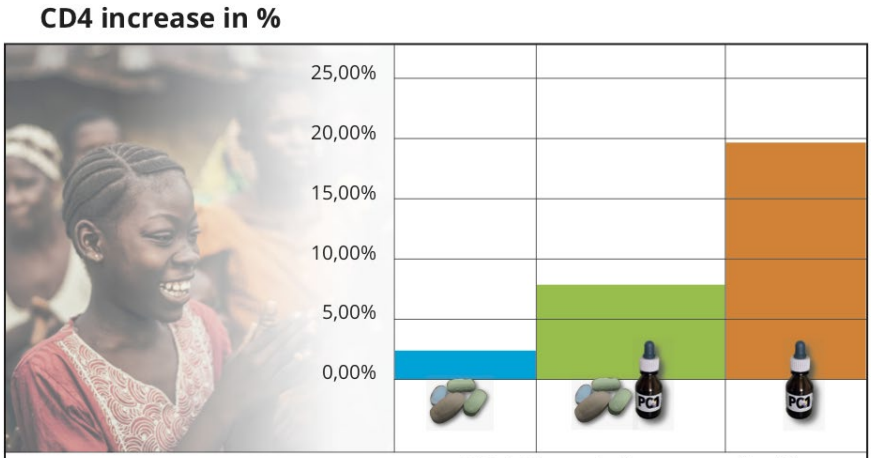
Graphs

Graph 1:
Trial flow



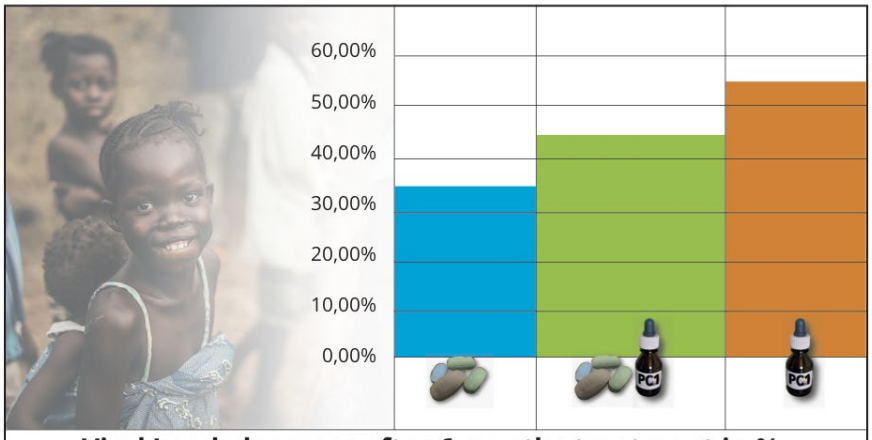
Graph 2:
Percentage of increase of CD4-count after six months treatment in cells/m³



CD4 Count: increase in %

	ARVs	ARVs + PC1	PC1
CD4 before	565,38	504,09	353,28
CD4 after	579,4	541,23	423,27
CD4 Increase	2,48%	7,37%	19,81%
	99 patients	81 patients	88 patients

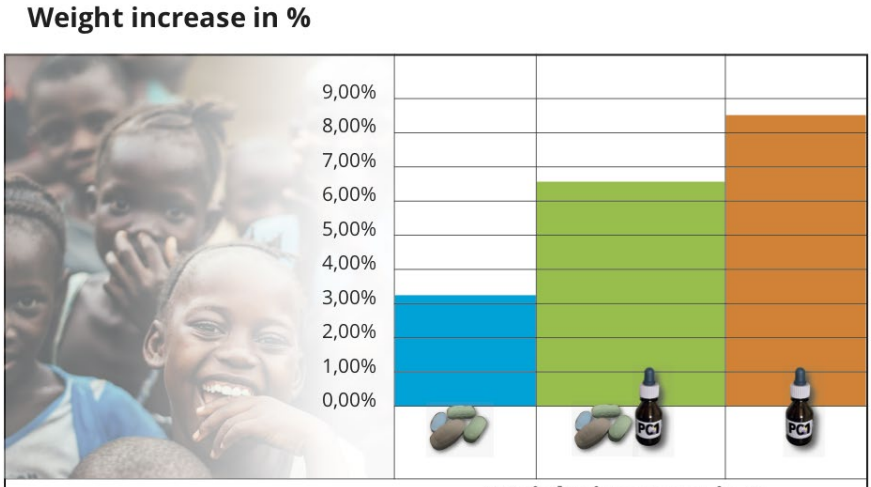
Graph 3:
Percentage of decrease of Viral Load after six months treatment in copies/ml



Viral Load: decrease after 6 months treatment in %

	ARVs	ARVs + PC1	PC1
Viral load before	1940,23	3112,63	7799,05
Viral load after	1268,38	1755,14	3638,23
Decrease in %	34,63%	43,61%	53,35%
	99 patients	81 patients	88 patients

Graph 4:
Percentage of weight increase in kilos after six months of treatment.



Weight increase in %

	ARVs	ARVs + PC1	PC1
Weight before	56,45	57,54	55,34
Weight after	58,3	61,36	60,01
Increase in %	3,28%	6,64%	8,44%
	99 patients	81 patients	88 patients

Tables

Table 1:
Baseline Data and Demographics, mean (standard deviation)

Variable	Group 1 ARVs only (n= 100) (67 F; 33 M)	Group 3 PC1 only (n= 100) (70 F; 30 M)	Group 2 ARVs+PC1 (n= 100) (69 F; 31 M)	Total (n = 300) (206 F; 94 M)
CD4 count (cells/mm$^{3)}$	566,81 (273,25)	360,22 (159,04)	498,24 (189,4)	474, 09 (228,87)
Viral load	1922,8 (3813,0)	77445 (6647,7)	3533,1 (4103,9)	4400,56 (5574,06)
Intake weight (kg)	56,49 (12,3)	56,62 (12,5)	57,21 (11,1)	56,77 (11,9)
Intake height (cm)	163,84 (13,0)	161,31 (14,52)	162,74 (12,4)	162,63 (13,3)
Weakness *	1,34 (0,54)	2,04 (0,79)	2,30 (0,66)	1,89 (0,78)
Tiredness *	1,46 (0,59)	2,26 (0,82)	2,40 (0,70)	2,04 (0,82)
Appetite *	2,53 (0,70)	2,09 (0,70)	1,93 (0,45)	2,18 (0,68)

* (1: not at all – 5: extreme)

Table 2:
Breakdown tables of descriptive statistics.

Breakdown Tables of Descriptive Statistics Smallest N for any variable: 268					
CD4 count					
Treatment	Mean difference	Confidence -95,000%	Confidence +95,000%	N	Standard deviation
ARVs-only	28,33	17,43	39,23	99	54,66
ARVs+PC1	36,52	20,45	52,59	81	72,69
PC1-only	69,11	52,99	85,24	88	76,10
All groups	44,20	35,79	52,60	268	69,87
Viral load					
Treatment	Mean difference	Confidence -95,000%	Confidence +95,000%	N	Standard deviation
ARVs-only	672,60	343,33	1001,86	99	1650,90
ARVs+PC1	1512,27	1066,65	1957,90	81	2015,32
PC1-only	4139,57	3175,34	5103,80	88	4550,82
All groups	2064,79	1662,37	2467,20	268	3345,97
Weight					
Treatment	Mean difference	Confidence -95,000%	Confidence +95,000%	N	Standard deviation
ARVs-only	2,00	1,60	2,40	99	1,99
ARVs+PC1	3,07	2,56	3,59	81	2,31
PC1-only	3,36	2,90	3,83	88	2,21
All groups	2,77	2,50	3,04	268	2,24
Appetite					
Treatment	Mean difference	Confidence -95,000%	Confidence +95,000%	N	Standard deviation
ARVs-only	0,63	0,44	0,81	99	0,92
ARVs+PC1	1,10	0,94	1,26	81	0,72
PC1-only	1,02	0,84	1,21	88	0,88
All groups	0,90	0,79	1,00	268	0,87
Fatigue					
Treatment	Mean difference	Confidence -95,000%	Confidence +95,000%	N	Standard deviation
ARVs-only	0,32	0,18	0,46	99	0,70
ARVs+PC1	1,30	1,12	1,47	81	0,78
PC1-only	1,16	0,98	1,34	88	0,84
All groups	0,89	0,79	1,00	268	0,89
Weakness					
Treatment	Mean difference	Confidence -95,000%	Confidence +95,000%	N	Standard deviation
ARVs-only	0,13	-0,00	0,26	99	0,66
ARVs+PC1	1,07	0,90	1,25	81	0,79
PC1-only	0,75	0,54	0,96	88	0,97
All groups	0,62	0,51	0,73	268	0,90

Table 3:
Comparisons of p values (red highlight signifies significant difference between the pairs of variables).

Multiple comparisons p values (2-tailed)			
CD4 count			
Kruskal-Wallis test: H (2, N=268) =25,35691 p=,0000			
Treatment	ARVs-only R:112,88	PC1+ARVs R:124,64	PC1-only R:167,89
ARVs-only		0,9	0,000004
ARVs+PC1	0,9		0,0009
PC1-only	0,000004	0,0009	
Viral load			
Kruskal-Wallis test: H (2, N=268) =70,20558 p=,0000			
Treatment	ARVs-only R:112,88	PC1+ARVs R:124,64	PC1-only R:167,89
ARVs-only		0,001	0,000000
ARVs+PC1	0,001		0,00002
PC1-only	0,000000	0,00002	
Weight			
Kruskal-Wallis test: H (2, N=268) =26,32698 p=,0000			
Treatment	ARVs-only R:112,88	PC1+ARVs R:124,64	PC1-only R:167,89
ARVs-only		0,004	0,000002
ARVs+PC1	0,004		1
PC1-only	0,000002	1	
Appetite			
Kruskal-Wallis test: H (2, N=268) = p=,0000			
Treatment	ARVs-only R:112,88	PC1+ARVs R:124,64	PC1-only R:167,89
ARVs-only		0,0003	0,0008
ARVs+PC1	0,0003		1
PC1-only	0,0008	1	
Fatigue			
Kruskal-Wallis test: H (2, N=268) = p=,0000			
Treatment	ARVs-only R:112,88	PC1+ARVs R:124,64	PC1-only R:167,89
ARVs-only		0,000000	0,000000
ARVs+PC1	0,000000		0,7
PC1-only	0,000000	0,7	
Weakness			
Kruskal-Wallis test: H (2, N=268) = p=,0000			
Treatment	ARVs-only R:112,88	PC1+ARVs R:124,64	PC1-only R:167,89
ARVs-only		0,000000	0,000007
ARVs+PC1	0,000000		0,7
PC1-only	0,000007	0,7	

Table 4:
Follow-up of an extra six months of 32 patients in the PC1-only group.

	Baseline	At 6 months	At 12 months
CD4-count in cells/mm^3	349	431	466
Viral Load in copies/ml	8.226	3.930	2.352
Weight in kilos	54	57	58

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Bio:

Harry van der Zee, MD

Harry van der Zee has practised as homeopathic physician in the Netherlands since 1987 and has been teaching homeopathy around the globe. From 1996-2018 he was editor-in-chief of *Homœopathic Links* – international journal for classical homeopathy. He has investigated the importance of the birth experience in homeopathic case-taking and published two books on the subject – *Miasms in Labour* (2000) and *Homeopathy for Birth Trauma* (2007). Through this work he has been able to meaningfully connect the homeopathic theory of miasms (hereditary archetypes connected to chronic diseases) with the individuation process, and thus provide a theoretical basis for understanding the role and purpose of individual and collective diseases in the process of human evolution.

Since 2004 Harry is involved in projects in Africa and has moved from treating individuals and their diseases to finding solutions for collective derangements of the vital force as expressed in epidemic diseases and mass trauma. In 2007 he co-founded the *Amma Resonance Healing Foundation*, which focuses on treating and preventing epidemics, trauma and lifestyle diseases in developing countries (www.ARHF.nl). Harry has trained health professionals in many African countries that now independently treat epidemics, trauma and chronic diseases using the PC Remedies provided to them by ARHF, and he has trained homeopaths that want to work as volunteers in low-income countries and disaster areas. In 2023 ARHF for the first time reached 1 million children and adults with its programs.

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