Thomas J. Busse on behalf of
Health Education AIDS Liaison (HEAL), PDX
Testimony in Opposition to HB 2574

February 2, 2023
To Members of the Oregon Legislature:

I have been involved in AIDS activism (including PEP policies) for over two decades as a critic of the AIDS Establishment with such organizations as ACT-UP/San Francisco and the Health Education AIDS Liaison (HEAL), a national grassroots support network without ties to the drug industry assisting people with a positive HIV diagnosis to take charge of their lives.

The sponsor of this bill, the **Cascade AIDS Project (CAP), is funded by at least $500,000 annually by PEP's manufacturers** – principally Gilead Sciences. **This is a classic case of both "Astro-Turf" advocacy as well as "AIDS Exceptionalism."** This bill raises the cost of healthcare for all Oregonians while providing negative clinical benefit. This does not mean the bill's sponsor, Rep. Nosse, is aware of the bill's potential harm, but that's the nature of the AIDS Medical Establishment: Big Pharma creates AIDS Service Organizations seemingly on behalf of society backed by CDC dogma, gathers sincere activists to the cause, then quietly weaponizes them to promote Pharma-friendly policies against the best interests of Rep. Nosse's constituency.

The purpose of this bill is to legislate an unsupported "standard of care" for the benefit of Big Pharma's bottom line by increasing AIDS drug inventories at Oregon Healthcare facilities and promoting their harmful and unnecessary use. This bill is a solution in search of the nonexistent problem of occupational AIDS in healthcare workers. 42 years into 'AIDS' there is not one published case of occupational AIDS in the medical literature. The Oregon Health Authority's own HIV surveillance report records zero confirmed occupational AIDS cases. Meanwhile, promotion of PEP drives irrational and unnecessary fear of HIV from single exposures by replacing honest informed consent and risk assessment via uncritical Big Pharma-rigged guidelines. Hospitals stock all sorts of drugs without state legislation. Why is HIV so special? **AIDS Exceptionalism furthers stigma.**

From an evidence-based medicine perspective, when considering a preventative intervention, one must calculate the "Number Needed to Treat." This ideally should be close to one. With occupational encounters, according to the CDC, a healthcare worker must be exposed 1000 times to develop HIV antibodies [1]. Assuming 1000 healthcare workers go on PEP, and every needlestick was a true occupational exposure (many exposures are from individuals with unknown statuses) and none of those exposures were from "viral load suppressed" people, this is an absurdly high Number Needed to Treat for PEP. Moreover, many Oregon HIV positives are probable false positives because rural Oregon is a low prevalence population. On top of this – HIV-associated antibodies are only a surrogate marker – not a clinical outcome. Given the lack of observed occupational cases of clinical AIDS, this surrogate marker fails to validate to positive clinical outcomes in this perceived risk group – extending life or preventing AIDS-defining conditions. As a result, **the Number Needed to Treat for PEP in healthcare workers rises to infinity** and we have an epidemic of very expensive urine.

Against this, there is **NOT ONE randomized controlled clinical trial to determine PEP's effectiveness**

1. For recreational drug users who "share needles," it's 430 – lower because the drugs themselves reduce immunity but still too high to explain HIV prevalence in this risk category unless one admits that impure street drugs might cause false positives on HIV antibody tests.

(assuming it even exists) preventing even that single seroconversion. because such a trial would be considered unethical. The CDC's 2013 PEP guidelines do not reference a single "Level 1" study[2]. All we have are low-quality retrospective and observational studies cherry picked by the CDC plagued with bias and circular reasoning evaluated on problematic surrogate markers that have repeatedly fallen apart or Simian Immunodeficiency Virus models completely unrelated to HIV.

Meanwhile, PEP drugs come with substantial risk. They carry black box warnings, are highly hepatoxic, and are carcinogens, mutagens, and teratogens. Treating 1000 healthcare workers with PEP, one can expect at least 30 serious adverse events. **The risk of PEP outweighs the benefit IN EVERY CASE.** Healthcare workers know about the toxicities of these drugs, but when there is an official policy in place that unquestioningly follows the CDC's unsubstantiated "best practices," those who go against the policy and refuse the recommended drugs risk being labeled as "noncompliant" or "potentially infectious" and can even have their ability to work suspended in the months following exposure where they refuse to take the toxic drugs.

In my experience, the vast majority of PEP prescriptions are dispensed to worry-worts who feel guilty after a single unprotected sexual encounter with a person of unknown HIV status. They demand PEP because they've heard propaganda from Pharma-funded CAP. What such individuals are not told is the risk of HIV from sexual transmission is officially 1 in 1000 exposures, and this rises to 1 in 9000 exposures for insertive intercourse. The problem here is individuals seeking PEP are not random, meaning you could never have a clinical trial to show PEP actually works. **There is NO EVIDENCE for efficacy.**

The story of PEP begins in 1989 when Anthony Fauci, on the basis of no data, made it up. Overnight, hospitals across the country started to purchase and stockpile expensive AZT – a clinical disaster recently retold in Chapter 4 of RFK Jr.'s excellent "The Real Anthony Fauci." I first started looking at PEP in the 2000's when ACT-UP/San Francisco unsuccessfully tried to stop mandated PEP in the California Dept. of Corrections. **Wardens had figured out they could punish and torture undesirable inmates with PEP** by claiming to hear a report of prison rape. Based on these unconfirmed reports, the wardens would force inmates to take courses of PEP at intolerably high doses "to save money in the long run." When inmates died from inevitable PEP drug toxicities, medical examiners would invariably claim they died of "fast onset AIDS." The practice still goes on nationwide, and **Pharma-Fronts like CAP do nothing about it**. Instead, the AIDS establishment steps back and says, "oh, isn't it wonderful we are getting people the drugs they need!"

PEP can also be abused recreationally, and there are cases of faked claims of exposure to obtain the drugs. The drug Sustiva (Efavirenz) recommended by the CDC for PEP is nothing more than a highly addictive psychoactive placebo Big Pharma developed to put into combination ARV pills to addict HIV positives to their medication regimes (with withdrawal symptoms inevitably diagnosed by dumb doctors as 'AIDS'). Sustiva can be snorted and smoked, has LSD-like properties, and its metabolites operate on the benzodiazapine receptors.

Policymakers would be wise to question the pharmaceutical industry payments to Oregon Health Authority-funded nonprofits like CAP. I should note CAP's "CAPitol Idea" lobbying program is funded by pharmaceutical interests and through the profits of HIV drugs dispensed through CAP's Avita 430b pharmacy. From 1982-2019, the US Government has spent $530 Billion on AID$ building a Big Pharma behemoth targeting vulnerable communities with false promises and toxic drugs.

2 Updated U.S. Public Health Service guidelines for the management of occupational exposures to HIV and recommendations for postexposure prophylaxis. (cdc.gov)