PC1

Answer to AIDS in Africa

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This is the fourth December issue in a row in which Links will report on Peter Chappell's search for a homeopathic answer to AIDS in Africa. As editors of Links we have followed this process with interest, and ultimately decided to go to Africa to get a first-hand impression of Peter's work. Here we present a detailed independent analysis of the results of his remedy PC1 for AIDS.

Introduction
In December 2001 Peter wrote:

Dear Friend,
I am here in Addis Ababa, Ethiopia, on a mission impossible, to see if it's possible to use conventional or unconventional homeopathic principles and practices to stop, delay, or reduce the effects, prolong life or cure HIV/AIDS on a wide scale, treating millions. Five thousand people, including 1500 children, are dying daily in Sub-Saharan Africa of AIDS. I am looking for a colleague to help me.
I will try to paint a very realistic picture below, so you do not face any surprises if you decide to come!
… What I would like is an assistant/co-worker to come and live here and work with me on this project. To help, to imagine, to create, to envision, to implement, to monitor - someone with practical down-to-earth capabilities.

He continues by describing the kind of cases he was seeing in Ethiopia and the circumstances under which he did his work.

In the same period, Peter wrote an e-mail that was forwarded to many homeopaths asking for assistance in finding a remedy for HIV/AIDS.

I am here in Ethiopia trying to find an effective homeopathic approach to HIV/AIDS…
I am looking for an epidemic approach.

In this e-mail he described all his observations with people suffering from AIDS, including their response to the diagnosis and their cultural background, and asked for assistance in analysing the genus epidemicus of AIDS. He also made clear that the racial, socio-economic and cultural background of people suffering from AIDS differed around the world, and that this might imply different approaches/remedies needed to treat the epidemic.

Designing a remedy for HIV/AIDS
Only a few months later, Peter wrote again and made the first mention of a remedy he had designed for HIV/AIDS. Apparently the assistance he asked for had not brought up a satisfactory remedy from the existing materia medica, so Peter 'imagined, created, envisioned and implemented' his own remedy.

I am happy to send you this preview of my website that will go 'live' in a few weeks. I would welcome your feedback, gut reactions, etc., to this information.
I am trying to steer a path that gets this approach past the official, legal, medical, etc., hurdles and gets it into use quickly and on a large scale, given the situation.
The name Holy Water is chosen to bypass these obstacles, because it reflects a traditional approach, and is ethically accurate. But it might prove equally a handicap being very anti scientific.
Let me know what you think.

Later the name of the remedy changed into Chappell Healing Water, and again later into simply PC1.

In Links 4/2002 under the heading 'The successful homeopathic treatment of HIV/AIDS' Peter reported about his experiences with this new remedy.
The introduction of the article is typical of Peter:

I was tempted to write a scientific paper, but in truth that is completely contrary to my nature, and so this is written as a human story with significant homeopathic content.

Two years ago, there was a force building in me, a very overpowering sense that I could do something to help with HIV/AIDS in Africa. Initially I resisted it for a year because my logical mind said 'you must be mad', and because of having no HIV experience. After a year I conceded to this invisible inner force, and I reluctantly supposed that my thirty years of homeopathic experience, my talent at creative problem solving and inventing things, and my experiences in putting homeopathy on the ground in fifteen or so countries somehow uniquely equipped me for the task. Prior to starting I read what was published in the homeopathic world and some in the conventional field.

Peter continued by narrating the story of how he came to design the remedy PC1 for HIV/AIDS, on what totality he had based it, and what his experience using other homeopathic remedies was.

Simple individualistic homeopathy works fine for HIV/AIDS in vital people. They get well fast, stay well and remain well even ten months after the first dose.

I also tried the AIDS nosode but I found it brutal, proving easily and ineffective. I experimented with many different approaches but my conclusion was very simple. Good, old, individualistic polycrests are highly effective.

The fact though is that we are not talking about treating a handful of patients. AIDS is a pandemic touching millions of people, so if we want to deal with this pandemic homeopathically we need to find an approach that allows for treating millions of people. Training thousands of people as classical homeopaths would take decades. But dispensing one remedy for HIV/AIDS throughout Africa that can be given to anybody with a positive HIV blood test provides a far more realistic option.

My next thoughts were about how to discover the homeopathic remedy for HIV/AIDS that

addressed the problem as an epidemic. Having concluded that there is no system to this bequeathed by the genius of Hahnemann or any of his followers beyond random exploration (though the systems of classification are now pointing in the right direction for this to be less random) I realised that I needed to think/operate outside the conventional mindsets of our civilisation, to work as a metaphysician. I personally think Hahnemann did this unconsciously in the selection of the remedies he developed. This powerful set of polycrests may yet prove to mirror the core archetypes in the human race with sufficient similarity to be 'good enough' for healing purposes. The current efforts to prove everything, great as they are, may prove somewhat unfulfilling by comparison.

My next observation is that there is no logical, analytical way of discovering the new homeopathic remedy to match the materia medica you seek.

Using his pre-homeopathic background as a student in abstract mathematics and researcher in electro-magnetism Peter envisioned a way of designing a remedy for HIV/AIDS using these assets. In his book on the subject, to be published at the end of 2004, Peter explains his method:

The principles of remedy design I used are these:
- *Taking the idea that Like creates Like as the meta remedy design principal.*
- *Forming on a metaphysical level using divine consciousness the likeness concept of the disease, from its consciousness, its purpose, its psychology, its action in the body, its totality of symptoms - a spiritual disease essence, its divine purpose.*
- *Translating this into a mathematical formulation using a branch of abstract mathematics similar to fractal mathematics (that allows love as an ingredient). This is higher mathematics.*
- *Transforming the mathematical formula into an electronic signal, like a Fourier Transform - standard technology.*
- *Putting the electronic signal through a coil around a ferrite C-shaped core so that it becomes a magnetic field - standard technology.*
- *Succussing a vial of liquid, alcohol + water, in the field, in the gap in the C core - standard homeopathic remedy preparation.*

Thereby making a remedy in the likeness of the disease.

In the December 2003 issue of Links there was a follow-up on the experience with PC1 for the treatment of AIDS. Not only did Peter himself report good results, but other homeopaths in different countries confirmed the efficacy of the remedy. Only in western countries did the results not seem to be as good, most likely due to the fact that the totality on which the remedy was based (African background) was too different.

The next time that I was able to receive more information on PC1 was at the ECCH conference in Egmond aan Zee, June 2003. First, Peter made a presentation, but I was already familiar with the content of his talk. A second lecture on PC1, given by Malcolm *Smith,* I found absolutely fascinating. It was the case of an HIV-positive patient with severe depression. This man had received several homeopathic remedies that had not helped, and finally received PC1. This patient, as was shown in several follow-ups, responded wonderfully to the remedy. In describing his depression he said that he felt nobody loved him, but after PC1, he narrated in tears how since the remedy he was overwhelmed with a deep love for all of mankind. The feeling that others did not love him had simply ceased being an issue. Considering the obvious connection

between love, sex and AIDS I found this effect of PC1 remarkable. I suggested to Corrie Hiwat, co-editor of Links, that we go to Africa together and see the results for ourselves.

Malawi
From February 2004 on, Peter spent three months at the Eva Demaya Centre in Luviri, Malawi. This centre, founded by Jacqueline *Kouwenhoven*, gave him the opportunity to treat a good number of HIV/AIDS patients with PC1. A special clinic was built, as well as a laboratory for blood tests and a pharmacy for preparing and storing the remedy.

When Corrie and I decided to go to Africa (arriving five months after Peter left) to evaluate the results with PC1, we were happy that Jacqueline welcomed us to stay ~~in~~ at her centre. In preparation for our visit she had informed all patients on whom she had used PC1 and had invited them to come to the clinic during our stay. To encourage them she even offered to pay for their transport, to give out PC1 for free to those that needed a new bottle, as well as a small financial bonus. She also arranged for someone to take care of testing patients for HIV, as well as a person to translate for us.

Methodology
We were very well aware that anything close to a randomised controlled trial was far from what would be possible at this stage in Malawi. The aim of our research was data collection. At the time that Peter Chappell was in Malawi, a standard form was used to score each HIV/AIDS patient. This form had been fine-tuned over time, and gave us the opportunity to score the same parameters now and to compare them with those noted during intake.

We were able to gather the following information and symptoms:
• Age
• Sex
• Result of HIV test
• Number of weeks since starting with PC1
• Whether the remedy was still being taken
• Weight in kilos

Then there were symptoms that were scored on a 0-5 scale.

Symptom Grades
0 = completely well/better, no symptom any more
1 = noticeable, mild, irritating, occasionally, part of the time, an inconvenience, it hurts a bit
2 = most of the time, can't easily ignore, bit restrictive, it bothers me a lot
3 = constant, all of the time, can't ignore, restricts activity at times
4 = severe, all the time, intense, strong, incapacitating, overwhelming, I am in pain
5 = critical, intense, overwhelming, all-consuming, help me, desperate

In-between scores could be used as well.

The 0-5 scale was used for the following symptoms:

• Weakness/strength
• Appetite

• General body pains
• Specific pains
• Breathing problems and cough
• Eruptions
• Incidence and severity of malaria
• Incidence and severity of TB
• Food supply check-up
• Safe sex check-up

To get an impression of how much the disease was influencing an individual's life, a 'Reverse Karnofsky Score' was used.

Reverse Karnofsky Score
0 = Completely Well
10 = Normal, a few mild Symptoms
20 = Normal with an effort, moderate Symptoms
30 = Look after self but can't work
40 = Needs a bit of assistance, mostly self-sufficient
50 = Frequent support and medicines needed
60 = Disabled, special care needed
70 = Severely disabled, hospital care needed, no acute danger
80 = Seriously sick in hospital
90 = Dying
100 = Dead

Also here, in-between scores like 5, 15 etc could be used to reflect in-between states and changes.

Results
Ultimately 54 patients were included for analysis, of which 23 were male and 31 were female. Six were excluded - two because they refused to be tested, two because no test result was available, and two because they tested negative. All patients were tested again, and those who tested positive in the past were positive again. Eight people had received PC1 in the past without being tested. Of these, seven tested positive.
The average age of the group was 35.6 years old (n=53; the age of one patient was unknown); the males were 37 years old on average, the females 34.6 years.
The amount of time between receiving the remedy PC1 for the first time and the follow-up was 19.9 weeks on average (ranging from 1 to 45 weeks).
Since the initial weight of not all patients was noted at intake, only 48 patients could be evaluated on this item.
The Reverse Karnofsky Score was also not noted with all patients, and therefore the "n" for this item is 51.

See table 1 for the results.

	n	intake	follow-up	Change

Weakness	54	1,79	0,62	> 65,36%
Appetite	54	1,48	0,29	> 80,41%
Weight	48	49,95	53,42	> 6,95%
General pains	54	0,72	0,22	> 69,44%
Specific pains	54	0,65	0,21	> 67,69%
Breathing/cough	54	0,59	0,30	> 49,15%
Eruptions	54	0,55	0,28	> 45,45%
Malaria	54	0,80	0,18	> 77,50%
TBC	54	0,02	0,00	> 100%
Food supply	54	0,55	0,49	> 10,91%
Safe sex	54	0,15	0,20	< 33,33%
Karnofsky score	51	26,86	10,00	> 62,77%
Taking PC remedy	54	0 %	54 %	
Prescription PC	54	100 %	96 %	

Table 1: development of symptoms after average of 19.9 weeks

Appetite and weight
Generally, the patients had improved on all items that could be evaluated. The most objective one was their weight, which increased by seven percent on average. This is also connected to their increase in appetite. A lack of appetite was one of the strongest symptoms at the time of intake, and from the follow-up it was clear that it was also one of the symptoms improving very rapidly once PC1 was taken.

General and specific pains
Pains subsided considerably. Where mentioned in the follow-up, they still occurred in patients with a short follow-up, or in cases that had not taken the remedy for a long time, and had symptoms coming back.

Breathing and cough
Here also a clear improvement of 50%.

Eruptions
Like the other symptoms mentioned above, not everything patients complained of was/is directly connected to AIDS. Despite this impurity in the data, here also we see a considerable decrease in symptoms: 45 percent.

Malaria
What was really impressive was the reduced incidence of malaria in patients once they started with PC1. Most patients who had regularly suffered from malaria before taking PC1 simply told us that since taking the remedy, no malarial symptoms had occurred. This would indicate an almost immediate and strong improvement in the immune system. The incidence of malaria is season-linked, so we checked the figures at the centre for this. The largest number of patients coming to the centre for the treatment of malaria come in the months April to June, with May as the peak month. Most patients included in our data had started taking PC1 just before, or in April. So the sudden reduced incidence of malaria in this group occurred despite the increase of malaria in the area.

Tuberculosis
The incidence of tuberculosis (as far as could be proven: many of the breathing/coughing symptoms could be TB related) was too low to evaluate. Many AIDS patients who are in a very

bad stage and are hospitalised end up in a TB ward. This is first of all because there is no ward for AIDS patients. Secondly many AIDS patients in advanced stages also suffer from TB. Since AIDS is a great taboo in Malawi (and the rest of Africa) people would rather admit to having TB than AIDS.

Food supply
The food supply in Malawi is precarious in the rainy season. Food grows, but is not yet harvested. The data we gathered did not show a big difference. From talking to people, we got the impression that for many the food supply was marginal and consisted of one staple – maize - most of the time. In the rainy season, people might easily have a meal only twice a week. The inadequate food supply was also a serious factor for the HIV/AIDS patients. A remedy alone is not enough for the more advanced cases. Owing to bad appetite they had not been eating enough for a long time and the recurrent infections they suffered from had depleted their bodies even more. So a good supply of food is one of the many factors that are crucial in dealing with HIV/AIDS in Africa.

Safe sex
This was the only item on which the group scored worse during the follow-up. Safe sex is a big problem in Africa for many reasons and is another important factor (see also Peter Chappell's articles in Links 4/2002 and 4/2003). Some of the patients we saw who had not used PC1 for several months seemed to have a slight return of symptoms again. One of the reasons for this could be that they are being re-infected regularly due to unsafe sex. And even when people do use condoms, the storage conditions and inexpert use is sometimes makes them unreliable.

Reversed Karnofsky score
The reversed Karnofsky score of the surviving group at the time of intake was 26,86 (= can look after themselves but not fully work) and was 10,0 (= only mild symptoms) at the time of follow-up. Asking the patients how they were in between, the impression was that for the majority the score went close to zero, but after some months (our impression was about three months), especially in the initially more severe cases, symptoms were coming back.

Taking PC?
At the time of the follow-up we did, 25 out of the 54 patients were not taking PC1 any longer. Based on Peter Chappell's instruction we gave these patients PC1 again in cases that still/again had symptoms. In cases that were symptom-free, we prescribed PC2. This remedy has been designed as a follow-up treatment after PC1 with the intention of making completely sero-negative. The effect of PC2 has not yet been able evaluated.

Deceased patients
Reading the files and talking to the patients produces a devastating picture of the impact that AIDS has on the people of Malawi. Many times patients had already lost their partner or even children to AIDS. The very backbone of the society, the middle generation, is being wiped out. Parents burying their children – a common thing to Africa due to the many diseases the continent has dealt with for ages – has even become more common.

In total, 131 patients who had received PC1 before we visited the Eva Demaya Centre had been invited to come for a follow-up. The invitation letters were

delivered personally. Because of that, we knew exactly how many of the people who were invited were deceased. Eighteen patients were deceased. Nine of them had record forms. Two of them had not been tested for HIV and had to be excluded from the analysis. The other nine had just come to buy a bottle of PC1 (which is provided along with AIDS education) and all that was known about them was their address.

The seven deceased HIV-positive patients who could be analysed were in a clearly worse condition at the time of their intake than the 54 patients we were able to include in the follow-up. (See table 2)

	n	alive	n	deceased
Weakness	54	1,79	7	2,71
Appetite	54	1,48	7	2,43
Weight	48	49,95	6	44,58
General pains	54	0,72	7	0,5
Specific pains	54	0,65	7	1,36
Breathing/cough	54	0,59	7	0,57
Eruptions	54	0,55	7	0,29
Malaria	54	0,80	7	0,14
TBC	54	0,02	7	0
Food supply	54	0,55	7	0,71
Safe sex	54	0,15	7	0
Karnofsky score	51	26,86	6	47,5
Taking PC remedy	54	0 %	7	0%
Prescription PC	54	100 %	7	100%

Table 2: symptoms at intake of alive and deceased group

The group with an average age of 34 years old consisted of three males and four females.
This group scored much worse on weakness, appetite and body weight. The average weight of this group was more than five kilos less than the surviving group, despite the fact that the deceased group did not contain children, while the surviving group contained several children. The reversed Karnofsky score of the deceased group at the beginning of treatment was 47,5 on average (= in need of frequent support and unable to work) opposed to 26,86 (= can look after themselves but not fully work) for the patients that were still alive.

From six patients of the seven analysed deceased patients follow-ups were recorded. These show that five out of six were actually improving on most parameters in the first weeks after starting with PC1.

After an average period of 3,8 weeks the following changes were recorded (table 3):

	n	intake	follow-up	difference

Weakness	6	2,67	1,67	> 37,45%
Appetite	6	2,50	1,08	> 56,80%
Weight	5	45,30	42,60	< 5,96%
General pains	6	0,58	0,42	> 27,59%
Specific pains	6	1,08	0,33	> 69,44%
Breathing/cough	6	0,67	0,83	< 23,88%
Eruptions	6	0,33	0	> 100%
Malaria	6	0,17	0	> 100%
TBC	6	0	0	-
Food supply	6	1	0,5	> 50%
Safe sex	6	0	0	-
Karnofsky score	5	47,00	32,40	> 31,06%

Table 2: symptoms at intake and on follow-up in deceased group (n=6; average duration of follow-up 3,8 weeks)

A bottle of PC1 contains enough of the remedy for a period of three months. The impression, suggested by this data as well as from talking to the surviving group, is that almost all patients did well on the remedy, but that after they finished the bottle, some fell back. The worst cases fell back quickly, while the group who were relatively better when they started treatment became symptom-free and stayed well for at least several months, and possibly permanently.

Conclusions

The data we gathered suggests a very high efficacy for PC1 in the treatment of HIV/AIDS in Malawi. The data does not prove anything from a scientific point of view, but is very convincing when you sit and talk to the patients as we did. An experience that Corrie and I shared was that after having seen dozens of cases, we felt very confident in prescribing PC1 to new patients. In classical homeopathy it is often not easy to find 'the' remedy for a patient, but at some point we felt more confident in prescribing PC1 to people with AIDS, than in giving *Calcarea* to a child with a running nose.

The results are so promising in our opinion that further research is highly recommended. While waiting for any such results, the remedy should be made widely available to the people needing treatment. These people literally have nothing to lose, and, as is the case in the majority of Africa, do not receive ARVs as an alternative either. Using the remedy in more locations will also present an opportunity to gather more data that can either confirm or contradict our findings.

A good follow-up is difficult in Africa because patient compliance is low due to many factors. To get good and lasting results with PC1 for HIV/AIDS, the data gathered suggests that regular and long-term follow-up is essential.

Even if PC1 continues to fulfil the promise it has shown until now, it does not mean that the HIV/AIDS problem in Africa is solved. Getting the remedy to the millions of people who could use it is an enormous task. It is possible, but the main prerequisite is the will to make it happen. Every day, somebody claims to have found a cure for HIV/AIDS, so one can imagine that officials have become very sceptical. Add to that the background of PC1 and of homeopathy, and the

complications are obvious. Add further the lobby groups for ARVs and the commercial interest involved, and one might start to wonder whether PC1 could ever get the fair chance it deserves. But even if there were an all-African network promoting, prescribing and distributing PC1, the pandemic would still not be over. In addition to medication many other aspects would have to be addressed:

- Promotion campaigns for safe sex are almost universally in place in Africa and are essential
- Malnutrition is a great complicating factor
- The incidence of malaria and TB are other complicating factors

Since AIDS is an epidemic, or rather pandemic, we have the benefit of working with the same strategy/remedy for all infected people. Prescribing PC1 to those who have developed symptoms and have been tested HIV-positive will not in itself stop the epidemic. Testing all relatives and contacts of an HIV-positive person could be a good strategy, but the great taboo surrounding AIDS prevents people from coming out and informing others. My suggestion is that the remedy should be offered for prevention as well as treatment. The effect of the remedy is that it boosts the immunity of people, and in a community where people are infecting each other, regularly treating the whole group seems a logical and practical approach. Besides that we should be aware of the fact that we are actually not dealing with diseased individuals but with a diseased group. This group consists of HIV-positive and HIV-negative people. Just as we administer a remedy fitting the totality of the whole individual in a case of recurrent otitis media, we can give a remedy to the whole group who suffers the consequences of an epidemic. Administering the remedy to as many individuals as possible can be expected to have a better effect on the epidemic. If this were to be done as simultaneously as possible, the effect could be expected to be greater. This is logical in terms of physical (re-) infection as well as in terms of an energetic effect on the totality of the AIDS-miasm as such. (See for a more extensive discussion my article in Links issue 3/2004, page 180, 'Transpersonal realms in homeopathy'.)

It seems to me that at this point, all possible strategies should be applied to test and promote the remedy – top-down as well as bottom-up. Small centres like the Eva Demaya Centre in Luviri can play a great role in building up experience with the remedy, and anyone reading this article who knows of a centre anywhere in Africa that would be willing to try the remedy out is invited to contact me or Peter Chappell.

Homeopaths who have the opportunity to prescribe PC1 to their HIV/AIDS patients are invited to offer this possibility to their patients. The remedy can easily be ordered on the Internet (www.helios.com) or at the Hahnemann Pharmacy in the Netherlands (recept@hahnemann.nl). More information for homeopaths on Peter Chappell's approach can be found at www.peterchappell.net

The effect of PC1 on HIV/AIDS in developed countries seems to be less than in Africa and other underdeveloped regions. Peter is working on a special approach to this group, but in the meantime it would be best to be cautious and not raise expectations too high for patients in the West. An important complicating factor might be the simultaneous use of ARVs (recently reported experience with the use of PC1 in South Africa: patients responded very well, except for those that used ARVs as well).

Data will have to be recorded and collected. The analysis of this would then have to be published in journals including non-homeopathic ones, so that patients, doctors, journalists, GOs and

NGOs, policymakers, etc., could be informed.

Other PC remedies
The concept used by Peter Chappell in designing PC1 has been extended to other diseases. While in Malawi we had the opportunity to evaluate mainly the effects of PC remedies on malaria. The results with PC1 for malaria in HIV-positive patients are mentioned above. HIV-negative patients who suffered from malaria were treated with PC-Malaria, a remedy designed in a similar way to PC1, but now for the totality of the malaria epidemic. The results we saw from this remedy were similar to that of PC1. People who suffered from malaria regularly simply stopped having symptoms. In most of these cases we had a follow-up of about six months. Peter has designed more remedies for a variety of diagnoses. In a separate paper I intend to report on my first experiences with these.

I would like to end with a phrase used in one of Peter's first articles on PC1 in Links.

'My first observation is that if you are deeply inspired you can move mountains.'

It seems to me that Peter's inspired work has already developed the tools to move the mountain called HIV/AIDS. At this point he can use a hand, many hands.

For more information
- www.vitalremedies.com: more information for homeopaths on PC1
- office@homeolinks.nl: to order Peter's book 'The Second Simillimum'.

To order remedies
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