MMS1, CDH and CDS Equivalents and How to Use

by Jim Humble 16 Feb 2015

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For some time there has been the idea that since MMS1 (activated MMS) has been used for years and has been successful, therefore when using CDS and CDH that we need to consider using equal amounts to that of MMS1 in our sacramental protocols. In other words, for a couple of years, when advising people who are using CDS/CDH to recover their health, we have almost always tried to make the value of the solution of CDS/CDH equal the value of the solution we use when using MMS1. That may sound right at first, however, we must not overlook one very important point and that is that the three, MMS1, CDS and CDH are all three different solutions and they all react differently in stomach digestive acid. And this fact, that all three act different in stomach acid creates a problem when trying to compare the three as far as equivalents go, and this may be causing people to get less than optimum results due to under dosing when using CDS/CDH.

In reading this newsletter please keep in mind that MMS1 equals activated MMS. Also one ml (milliliter) equals one cc (cubic centimeter). For simplicity sake, we will only refer to mls in this paper.

I am giving a very basic explanation here, for those who want a more detailed explanation we are going to put out a more technical paper in the future, but for now to put it simply, say a person takes a 3-drop dose of MMS1, depending on the amount of stomach acid that person has present at the time they take their 3-drop dose, that same dose may be more potent or less potent because the stomach acid can further activate the MMS1 in the stomach. The amount of stomach acid present in the stomach at the time of ingesting CDS/CDH also has bearing on how potent those doses will be as well, but all three forms—MMS1, CDS, and CDH react somewhat differently in the stomach. (CDS cannot increase in ClO2 content because it has no residual sodium chlorite.)

This, coupled with the fact that **stomach acid is changing throughout the day**, makes it difficult if not impossible to predict that so many drops of MMS1 will equal so many mls of CDS or CDH in the stomach.

We taught for some years that it is possible to determine how much CDS/CDH it takes to equal a certain amount of MMS1. But we have since learned that that really isn't possible because of what we are talking about here; that the stomach digestive acid, HCl, varies widely. I wish we had a few million dollars to research all of these questions, but never-the-less we have determined that the stomach acid further activates MMS and can increase the strength of MMS as widely as the stomach acid varies. So because of this variation we cannot say how much CDS/CDH that 1 drop of MMS1 will equal. Therefore in using Protocol 1000 or 2000 with CDS/CDH we must increase the doses according to the same rules that apply to MMS1 and that is, only increase as much as the body will allow by not feeling worse than the disease is making you feel. In so doing we cannot make CDS/CDH equal to MMS1 doses. Again they cannot equal one another as the stomach acid can vary in a minute or two, or three, and change the equation.

At the risk of boring you, I want to say it again as this is a new concept for many people: Stomach acid varies in quantity and strength throughout the day. It varies with the amount and kind of food one

eats (poor diet or processed foods will have a bearing on stomach acid), or it can vary with the amount of liquid one drinks that would dilute the acid, or with the amount of exercise one has done, or it can vary with age—these are just a few things that can affect the stomach acid. (70 million people suffer from digestive problems in the United States alone—this is likely to affect their stomach acid!) The fact is we cannot predict the acid content in the stomach. Myself and others have run tests simulating stomach acid and seeing how the various forms of MMS react in what is considered "normal" stomach acid (60 ml of stomach acid). But again, though we can do this in the lab, we cannot really predict the amount of acid in any person's stomach at any given time, in part, because of the factors I have mentioned above. This is all the more true if a person is sick, as a sick person seldom has "normal" stomach acid.

Because the stomach acid cannot be predicted, the value of the amount of chlorine dioxide that will be produced cannot be predicted. That means that when a drop of MMS1 hits the stomach acid you simply cannot say what amount of chlorine dioxide will be produced and thus how many mls (in CDS or CDH) the drop will equal. So because we simply cannot predict the amount of stomach acid that will be present at any given time, there is simply no way of ever comparing drops of MMS1 against mls of CDS or CDH.

So in following the sacramental protocols of our Church, both CDS and CDH need to be used in the protocols according to their own merits and not because we believe a certain number of mls of CDS or CDH somehow equal a certain number of MMS1 drops.

Since each human body is different, the amount that MMS1 equals in mls will always be different. It is, in fact, easier to use CDS and CDH according to their own merits than it is to try to figure out how much each ml equals in drops of MMS1.

Using CDS and CDH (both at 3000 ppm) in the Protocols:

It's simple, although CDS and CDH are not exactly the same, you would always start the Protocols by doing the Starting Procedure. The purpose of the Starting Procedure (taking very low doses of MMS for four days) is to allow your body to get accustom to chlorine dioxide. In addition this can, in the long run, help you avoid having unnecessary uncomfortable feelings of nausea, diarrhea or vomiting.

Starting Procedure with CDS/CDH:

• Use a 1/4 ml dose every hour for 8 hours for the first day.

• Use a 1/2 ml dose every hour for 8 hours for the 2nd and 3rd days.

• Use a 3/4 ml dose every hour for 8 hours for the 4th day.

• On the 5th day, start Protocol 1000.

Note: Each dose should be mixed in ½ cup (4 oz or 120 mls) of water.

Protocol 1000 with CDS/CDH:

• After completing four days of the Starting Procedure, on the 5th day begin Protocol 1000 by dosing 1 ml for each hour, however you can begin increasing the size of your doses for each hour right away if it seems OK to you, in other words if your body is handling it with no problems (diarrhea, nausea, etc.), just don't make yourself sicker than you already are with your sickness. If you should feel nausea or diarrhea, reduce your dose by 50%, and work back up when you feel comfortable with

doing so. Listen to your body and increase steadily. For example, some people may want to increase a little bit each day, so maybe yesterday they took eight 1 ½ ml doses and today they'll take eight 2 ml doses. Others may want to go faster and increase **each dose** by ¼ ml or even ½ ml so that by the end of the 5th day, they will have reached the maximum dose size for Protocol 1000.

• For CDS you should never increase to more than 6 ml an hour for the entire protocol. If this causes your throat to feel like it is burning add more water to the dose.

• For CDH never increase beyond 3 ml and hour for the entire protocol.

Note: The above is only for Protocol 1000.

Protocol 2000 with CDS/CDH:

• For Protocol 2000, just like with MMS1, you want to increase your doses to take as much as you can handle but without getting sick. So continue to increase either CDS or CDH as much as possible without getting sicker from your dosing, such as feeling nausea, vomiting or diarrhea.

• Always increase your dosing at a steady pace. As suggested above, this may differ from person to person, go at a pace that your body is happy with, and find what works for you.

So you see? These are the same instructions as given for MMS1 drops without trying to make CDS or CDH mls equal a certain number of MMS1 drops. I feel that this will be much more effective when using CDS/CDH.

Important Details:

• I want to make clear here that it is OK to ingest CDS and CDH for your Sacramental Protocols (as I have explained above).

• From reports we have received from around the world, I would like to mention that up to this point MMS1, when used by making a new dose each hour, has thus far proven to be most effective.

• In addition, using MMS1 to make up all your doses for the entire day in a single bottle or jar has proven less effective than mixing your doses up fresh on an hourly basis. If you have no other option than to make an all day bottle, due to your work, or some other circumstances, by all means do it. The eight hour bottle is certainly better than not taking MMS at all. But the better choice is to make your dose fresh each time if possible. We often suggest to people to do a combination of the two if there is no other choice. For example, if you have to enter a meeting and you know you cannot step out in an hour to mix your dose, you may want to mix up in a bottle enough doses for a two or three hour period, but as soon as you can go back to mixing fresh doses each hour, by all means do so.

In conclusion:

I expect CDS/CDH to be more effective when used as given in the protocols above (for all the reasons mentioned). This is a big change in the way we viewed these things in the past, but you can know it is safe to take this way (following what your body is telling you of course) as thousands of people have ingested CDS and CDH in every quantity suggested here. But I want to also say that in spite of the fact that we have used CDS/CDH many ways, that what we have suggested above is new and thus it is an ongoing process and we will have to observe and see how it works. Remember, stick to the safeguards of the protocol. Anytime you are feeling sick from your dosing no matter what form of MMS you are using, (MMS1, CDS, or CDH) drop back on the amount you are taking until it passes,

then try to build up from there. If something is working don't change, continue with what you are doing until well. If something isn't working and you see no progress at all after two weeks, go up to the next level of the protocol.

As we continue to receive feedback from people using CDS/CDH around the world, we will keep you informed. Please let us know what you think and how you do.

Get well and stay safe,

Archbishop Jim Humble

G2C FORUM COMMENTS BELOW

CLO2 16 Feb 2015 09:27 #49043

I agree with Jim Humble that stomach acid varies throughout the day and therefore we don't know how much additional CLO2 will be released, if any, when MMS1 and CDH are ingested.

We know that both MMS1 and CDH are not fully activated, by design, externally. MMS1 is about 15% activated and CDH4% about 50% activated. That is, the MMS (22.4% sodium chlorite solution) in both MMS1 and CDH are not fully activated outside the body.

Since each milliliter of CDH4% (McRae-Lackney recipe, only) is made from 1 drop of MMS and a 1 drop dose of MMS1 is also made from 1 drop of MMS, they both have the same potential to produce the same amount of CLO2. Part of the possible CLO2 is made outside the body and the rest of the possible CLO2 may be released in a stomach, depending on how much stomach acid is present.

When we talk about maximum hourly dosage when using Protocol 1000, MMS1 is limited to 3 drops of activated MMS (MMS1). Since a 3 drop dose of MMS1 is made from 3 drops of MMS and 3ml of CDH4% is also made from 3 drops of MMS, then the maximum hourly dose using P1000 for CDH is 3ml per hour. Jim states that fact when he said: *"• For CDH never increase beyond 3 ml an hour for the entire protocol. Note: The above is only for Protocol 1000."*

Jim implied that 3ml of CDH4% can be equal to a 3 drop dose of MMS1 in a perfect stomach; one with adequate acid to release the rest of the CLO2 contained in the unreacted MMS.

If a stomach has zero acid, then neither MMS1 nor CDH4% will activate any further than they did externally. In this case, one will get more CLO2 from using CDH4% than from MMS1 because CDH4% is more fully activated externally than MMS1.

Note that he also said that CDS can not increase in CLO2 content in a stomach, whether or not there is adequate stomach acid or none. That is because *"CDS cannot increase in ClO2 content because it has no residual sodium chlorite."*

In the case of a stomach having little or no acid, in order to get adequate CLO2 to reach P1000's maximum allowed amount of CLO2, there are two Sacraments that will provide more CLO2 than MMS1 or CDH4% can provide over their externally activated amounts of CLO2. Those two Sacraments are CDS and MMS1 tablets.

MMS1 tablets contain their own activator and will fully activate in plain water. So if you ingest one size 2 MMS1 tablet with water, you will get the maximum amount of CLO2 that P1000 calls for.

If you ingest 6ml of 3000ppm CDS you will also get the maximum amount of CLO2 that P1000 calls for. There is some math to prove that point that I will not get into here. There is also visual evidence to prove that statement.

Jim also stated in the newsletter that: *"• For CDS you should never increase to more than 6 ml an hour for the entire protocol."* That implies that 6ml of CDS will provide the maximum amount of CLO2 that P1000 calls for, which I agree with.

As Jim said, after the Starting Procedure, increase dosing slowly up to the maximum that P1000 calls for: *"• For CDS you should never increase to more than 6 ml an hour for the entire protocol. If this causes your throat to feel like it is burning add more water to the dose.*

• For CDH never increase beyond 3 ml an hour for the entire protocol.

Note: The above is only for Protocol 1000."

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truther 16 Feb 2015 20:53 #49044

I wanted to ask what actually is the case with CDH and CDS. We're saying there is problem because it's difficult to assess how much ClO2 would be produced (depending on the acidity of stomach and so on). BTW, using CDS we always know how much ClO2 we have taken.

But what I mean. It's said MMS1 is activated in the company of acids, so in theory it shouldn't activate after leaving stomach as the environment of intestines is rather alkaline. We want to have all the MMS1 to be activated to make use of ClO2. When we ingest CDH or CDS it's said to be neutralized to some extent in the stomach. But it can't just disappear, this must be somehow absorbed from the stomach to the blood. Isn't it what we want to achieve?

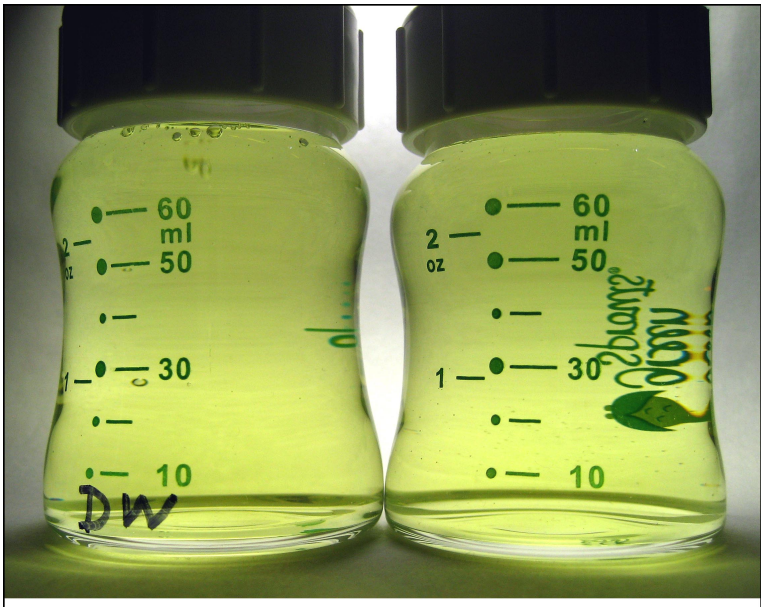
May it be possible that some portion of MMS is activated in intestines? What about not acidified sodium chlorite (NaClO2), does it have antimicrobial properties likewise ClO2? Could it be sodium chlorite activated in the intestines or it's unactivated form that differs the effects of activated MMS1, CDH and CDS?

CLO2 17 Feb 2015 02:41 #49046

Truther you said:

"When we ingest CDH or CDS it's said to be neutralized to some extent in the stomach."

Jim sent out an apology saying that he was wrong to say CLO2 contained in CDS and CDH diminished or dropped to zero in a stomach, because of faulty testing. Here are two pictures showing CDS in distilled water and simulated stomach acid and you can see there is no CLO2 reduction in simulated stomach acid.



Left bottle 60ml distilled water + 10ml CDS
Right bottle 60ml 0.5% HCL + 10ml CDS
Photo taken 13 mins after CDS was made.

2 January 2015
by CL

Yes, with CDS we know the CLO2 content, because it is only activated outside the body where we can measure it. With MMS1 and CDH we can measure the CLO2 that is released externally, but there is some SC that is not activated and we expect it to activate in a stomach with sufficient acid, but we don't know how much more CLO2 will be released which is dependent on the amount of stomach acid available when MMS1 or CDH is in a stomach.

If you use the new MMS1 Tablets we do know the amount of CLO2 as it contains its own activator and will activate in plain water.

Besides the acid usually found in a stomach to activate MMS (22.4% sodium chlorite solution), I don't think we know where else CLO2 could be released. Lab testing would be nice, but it is expensive.

SEE DOSING CHART BELOW

Using CDS and CDH with Protocols			
	Equivalent Doses for		
	P1000 • P1000+ • P2000		
	Dosage Chart for CDS & CDH		
MMS1	CDS	CDH	CLO2 mg*
1 drop	2 ml	1 ml	6.7
2 drops	4 ml	2 ml	13.4
3 drops	7 ml	3 ml	20.1
4 drops	9 ml	4 ml	26.8
5 drops	11 ml	5 ml	33.5
6 drops	13 ml	6 ml	40.2
7 drops	15 ml	7 ml	46.9
8 drops	18 ml	8 ml	53.6
9 drops	20 ml	9 ml	60.3
10 drops	22 ml	10 ml	67.0
11 drops	24 ml	11 ml	73.7
12 drops	27 ml	12 ml	80.4
NOTE: CDH McRae-Lackney Recipe only			
NOTE: CDS 3000 ppm only			
Doses are equivalent when adequate stomach acids are present to fully activate residual sodium chlorite in MMS1 & CDH. Does not apply to CDS. CLO2 mg* (max possible)			